THE HOUSING PROBLEMS OF THE FUTURE ELDERLY POPULATION

A Report Prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century

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EXECUTIVE SUMMARY

BACKGROUND

The New Shelter and Care Reality

Portrayals of becoming old in America present a set of conflicting images. These range from the active and leisure-pursuing "youthful" older person occupying the traditional single-family home fronting a golf course to the decrepit and bedbound individual languishing in a sterile nursing home bed. Most older Americans do not fit neatly into either of these categories, but these starkly different images underscore an undeniable reality. Even as older Americans are an extraordinarily diverse group of individuals with very different economic means, life styles, cultural backgrounds, health conditions, and personal capabilities, our society is preoccupied with categorizing older Americans based on whether they can live independently, take care of themselves, and vigorously pursue everyday taken-for-granted activities. This emphasis on using frailty as a basis to compartmentalize older people is not new. Rather, what has changed is that these judgments have become intimately linked with the type of residential settings in which they live. Thus we are now increasingly concerned not with just the affordability and the physical conditions of the dwellings occupied by older Americans, but whether as support and care environments, they also make it easier or more difficult for older persons to cope with their vulnerabilities, enjoy a relatively independent life style, and maintain self-dignity.

The reasons for this very important change in mindset are straightforward. For a longtime, it was convenient to believe that the residential accommodations of older persons could be simply distinguished as either providing shelter or care. The boundaries were clear-cut. Frail older persons belonged in nursing homes; non-frail older persons belonged in their conventional residences. It became increasingly clear, however, that almost all types of individual limitation and most chronic health conditions, save perhaps the cognitive declines of individuals with Alzheimer's Disease who exhibited violent and abusive behaviors, could be accommodated in various types of housing arrangements. It was acknowledged that with appropriate family supports, staffing, supportive services, technological resources, and a flexible regulatory environment, physically and cognitively frail older persons would have greater residential choices. Older consumers themselves contributed to this change in perspective, as they increasingly expressed a preference to occupy settings that more resembled their familiar conventional dwellings than a hospital. They wanted the best of both worlds, a setting that linked them to needed social, medical, and service supports, but also one that preserved the autonomy and normalcy of their past life-styles.

Consequently, various new options emerged that allowed older persons to deal with their physical and cognitive limitations without entering a nursing home. They could stay put in their conventional dwellings, where they enlisted combinations of family members, paid staff, home-delivered and community-based services. They could also move to various types of supportive seniors housing that offered shelter, personal care, and nursing services under the same roof, but in a much less regulated and institutionalized setting. The assisted living facility became the most important exemplar that displayed the full potential of this new shelter and care reality. What were once clear-cut boundaries between the housing and the long-term care environments became increasingly blurred.

Assessing the overall quality of life offered to older occupants in these different alternatives also became more challenging. These places had to be judged not only as typical shelter, but also as care environments. Although they received mixed reviews for their ability to accommodate frail older persons, and yet not look or function like an institution, the evaluations of these facilities were positively biased. This was not surprising because the new hybrid collection of shelter and care settings was consistently compared to an alternative that was considered so deplorable, namely the nursing home with its medicalized and highly regulated organizational, physical, and social environment that crushed individual autonomy and independence. These assessments also confirmed the importance of traditional indicators of a housing arrangement's quality, namely, its physical quality and affordability. Dwellings that were an intolerable expense burden for their occupants or that were in poor physical condition or lacked appropriate physical design modifications obviously presented difficulties for both their healthy and unhealthy older occupants. Moreover, the population risk factors that typically predicted the presence of traditional housing problems also predicted which groups of older persons were likely to be in settings offering inadequate care. The subgroups of vulnerable seniors were in familiar categories: the low-income, those who could not depend on a spouse or lived alone, the less educated, members of ethnic and racial minorities, and the very old.

Despite the substantial growth and greater presence of these new shelter and care options, there was another painful realization: they were not equally available to all elderly constituencies. The most potent barrier, however, had less to do with care or quality restrictions than with their affordability. Lower income older persons still found that those housing arrangements offering an alternative to nursing home living were few in number and offered an inferior package of service benefits when they were available. Thus, only a narrow segment of the American old was enjoying the full benefits of the new noninstitutional paradigm. Even as the private sector was vigorously pitching its products to a well-defined upper-income clientele, Federal, State, and local governments were much slower to recognize the desirability and feasibility of these new shelter and care strategies. Nor did they immediately recognize that by failing to respond, they magnified the unequal status of lower income older Americans.

The eventual response by the public sector resulted in piecemeal efforts to make the full complement of shelter and care options now enjoyed by wealthier elderly available to low-income seniors. Stakeholders in the public sector, however, have not been able to agree on what is an appropriate organizational and financial commitment. The current dialog makes it painfully clear that many stakeholders are blissfully unaware of the magnitude of the unmet shelter and care needs of low-income Americans. It has also highlighted the equivocalness felt by stakeholders regarding whether low-income elderly should enjoy the same shelter and care alternatives as wealthier older Americans. Even when well-meaning housing sponsors step forward to create shelter and care options that are affordable to the low-income senior, they often confront administrative and financial roadblocks from segmented bureaucracies and organizations that act as if health and housing concerns are worlds apart. Even more perniciously, proposed shelter and care products for poor elderly are having to be justified not for their obvious benefits to older consumers, their family members, and inevitably to their State's and locality's long-term care system, but rather on whether they are less costly to build and operate than other housing and long-term care alternatives – tests, we do not need reminding, that housing alternatives targeted to wealthier elderly never had to pass.

This "standard" without doubt has had the effect of squelching what would otherwise be a very strong demand for these alternative shelter and care settings by low-income elderly. We must also recall that the major financial and health programs that were created for older persons, Social Security, Medicare, and Medicaid, were not initiated because they saved money relative to some other alternative.

As we enter this new millennium, we are coming uncomfortably close to engaging the demands and challenges that will be created by the large and inevitable growth of the future old. As many times as we have seen and heard the numbers that describe the onset of this large age wave, we still need constant reminders of its imminence (Figures 1 and 2). This society will have to overcome major obstacles to respond effectively to the unmet housing needs of all older Americans. It must not only continue to identify and aggressively respond to a large number and share of both low- and high-income persons who are not now living in good quality and affordable housing. Additionally, it must embrace the new shelter and care paradigm as not just an option for the wealthy, but also as an equally available option for the poor elderly. Now is the time to prepare for what will certainly be the unprecedented shelter and care demands of a large boomer population entering old age. This report will demonstrate that large unmet housing needs of older Americans—especially in the low-income brackets—run the gamut from the traditional shelter affordability and quality concerns to the inadequacy of affordable opportunities that integrate shelter and care in noninstitutional environments. Amidst all the predictions regarding how the future old will impact our society, there is one certainty. To address the large unmet shelter and care needs of low-income seniors, keeping the status quo is untenable.

The Goals of This Report

The focus of this report is on how the current unmet shelter and care needs of older Americans will change over the next twenty years – in 2020. It has four goals:

1. To investigate the growth in the current number of older households that will be at risk of occupying unaffordable housing in poor physical condition;

2. To estimate the amount of affordable and good quality housing that will be necessary to accommodate this projected growth;

3. To estimate the growth in the current number of older and frail – physically and cognitively limited – persons who will require supportive services allowing them to live in an independent, autonomous, and safe living environment;

4. To examine the most important factors that will influence the availability of affordable and supportive shelter and care settings.

The following tasks will be completed:

- Identify the number and prevalence of older American households that are occupying housing that is unaffordable or in poor physical condition. Based on current numbers,

estimate the number of households that will confront these problems in the year 2020 and the number of needed affordable units to alleviate their problems.

- Identify the presence of these problems among homeowners, renters in private market dwellings, and renters in government-subsidized rental housing and the role of government programs in alleviating these problems.

- Identify the subgroups of older households that are most at risk of occupying unaffordable and poor quality housing. Specifically assess the number of low-income households with these unmet needs, but also the number of older households distinguished by chronological age, living arrangements, racial and ethnic membership, and physical and cognitive frailties.

- Identify the number and prevalence of older Americans with physical and cognitive limitations who are most at risk of needing supportive housing arrangements. Based on current numbers, estimate the size of the population that will be at risk in the year 2020. Examine the factors that make it difficult to estimate the size of this future population.

- Evaluate the availability and desirability of two specific affordable housing alternatives that can address the supportive service needs of older Americans: government subsidized rental facilities and government-subsidized assisted living facilities.

- Identify the most important barriers that will restrict the availability of affordable housing that can address the supportive service needs of older Americans.

Methodological Approach

These tasks were completed by carrying out original analyses of two primary data sets: (a) the 1999 Annual Housing Survey for the United States, a household survey sponsored by the U.S. Department of Housing and Urban Development (HUD) and conducted by the U.S. Census Bureau; and (b) household survey data collected from Waves 3 and 5 of the 1996 panel of households as part of the Survey of Income and Program Participation (SIPP).

Projections of the number of elderly households in the year 2020 were based on published projections made by the Joint Center for Housing Studies of Harvard University. Projections of the number of elderly persons in the year 2020 were based on published projections made by the most recent U.S. Census Bureau middle series projections.

FINDINGS

The Shelter and Care Landscape of Older Americans

Older Americans currently occupy a very diverse array of housing types. While much attention is given to this country's 17 million homeowners, over 5.2 million seniors are renters, almost a third of whom are in government-subsidized units. Over 2.3 million seniors are rarely counted because

they live in the households headed by younger persons. Over 3 million persons are in supportive group housing facilities that offer personal care and nursing services in widely variable settings that both resemble hospitals (nursing homes) and recreational resorts (full-service, private pay continuing care retirement communities).

The Economic and Demographic Status of Older Households

Though the poverty rate of older Americans has declined over the past three decades, this income indicator offers a misleadingly positive portrayal of this group's financial means. Relating the incomes of older persons to the median income levels of their metropolitan area or nonmetropolitan area offers a far more realistic indicator that is sensitive to cost-of-living differences. The Department of Housing and Urban Development relies on this income measure when deciding on the need for affordable housing assistance and the eligibility of households for its government assisted rental programs. Over 5.7 million or 27% of older households have "extremely low" incomes that are 30% or less than their area's median; an additional 4.8 million or 23% of older households have substantially low incomes that are between 31% and 50% of their area's median. Altogether, over 10.6 million or 49% of this country's seniors have "very low incomes."

Certain groups of older households are more likely than others to have very low incomes: the old-old, those living alone, the less educated, African Americans, and Hispanics. Older households who are "over-housed," that is who live in excessively large dwellings are also more likely to have lower incomes. These over 3.8 million households are at greater risk of living in unaffordable housing and being unable to pay for their out-of-pocket medical and home care costs because they are burdened with the upkeep and maintenance of unused dwelling space even as they have very low incomes.

Although the low-income status of older homeowners is often de-emphasized because they enjoy substantial equity in the value of their homes, this generalization is at best misleading. As many as 5 million or just over 29% of elderly homeowners are both cash-poor (they have low incomes) and house-poor (their homes are of low value).

It is difficult to predict the income status of tomorrow's seniors. Even in the two years since the data of this report was collected, the income and asset positions of older Americans have deteriorated. Interest-bearing accounts are at historical lows. As one indicator, between 1999 and 2000, real median income (after adjusting for inflation) fell by 2.8% for older men and 3.6% for older women.

Older Households Occupying Unaffordable or Poor Quality Conventional Housing

Over 3 million age 62 and older households now have extremely urgent unmet housing needs. In combination with their extremely low incomes, they occupy dwellings with *"priority"* problems. That is, they pay over 50% of their monthly income on their housing costs (they have a serious housing cost burden) or they occupy dwellings with severe physical deficiencies. Another 2.3 million older households have very urgent unmet housing needs. They have extremely or substantially low incomes (under 50% of their area's median) and either have priority or less serious housing problems. Households with *less serious* housing problems include households who pay

30% to 49% of their monthly incomes on their housing costs (they have a moderate cost burden) or that occupy dwellings with moderate physical problems.

These housing problems are much more prevalent among certain groups of age 65 and older households than others. Households with the lowest incomes, who are renters, and members of ethnic or racial minorities are much more likely to occupy unaffordable or poor quality housing. For example, almost 55% of extremely low-income renters and 43% of extremely low-income owners have priority problems alone.

Certain groups of older homeowners living in unaffordable or poor quality housing are especially vulnerable. There were 725,000 age 65 and older homeowners with low incomes (80% and under of area median) who not only had priority or less serious dwelling problems, but they also lived in dwellings valued under $40,000. Almost 2.5 million older homeowners with low incomes and living in dwellings with priority or serious problems lived in dwellings valued under $100,000. Irrespective of their house values, there were 2,890,000 low-income age 65 and over homeowners earning less than $25,000 annually living in dwellings with priority or less serious problems who reported having either no savings or investments (1,818,000) or savings and investments of less than $25,000 (1,072,000).

Certain groups of older households living in unaffordable or poor quality housing tend to be overlooked in most studies. There were 663,000 age 65 and older households with higher incomes (81% and over area median limit), who also had priority or less serious dwelling problems. Some 548,000 older persons are living in low-income younger households who occupy dwellings that have either priority or less severe housing problems.

As large is the current number of seniors living in unaffordable or poor quality dwellings; tomorrow's numbers of seniors living in such inadequate housing will be staggering. By the year 2020, over 7.5 million age 65 and over households are projected to have extremely or very urgent unmet housing needs. Over 4.7 million age 65 and over households will have moderately or somewhat urgent unmet housing needs.

A small subset of the older households with priority or less serious problems is specifically occupying dwellings in poor physical condition. The physical problems in these dwellings may not only affect the personal well-being of the older occupants, but also the social and economic viability of their neighborhoods. About 809,000 or 5% of age 65 and older owners and 447,000 or 11% of older renters occupied dwellings with either severe or moderate physical problems. These dwellings were more likely to be found in the central cities of metropolitan areas and in rural or nonmetropolitan areas, especially in southern United States. The oldest dwellings, those built 1949 or earlier and at greatest risk of requiring rehabilitation, were especially likely to have these physical deficiencies.

Although older dwellings are at a greater risk of experiencing these physical declines, upgrading and maintenance can help forestall their occurrence. Only 13% of the elderly households occupying dwellings with serious or moderate problems made internal residential alterations; 22% made physical replacements to their dwelling; and 8% initiated maintenance or repair activities.

The Availability of Government-Subsidized Rental Facilities

In 1999, the AHS database enumerated a total of 6.2 million rent-assisted units in the United States of which just under 1.4 million units or 22% were occupied by age 62 and over households. A smaller number, 1.2 million rent-assisted units or 20%, was occupied by age 65 and over households. Other enumerations estimated that in 1999, there were 5.1 million federally subsidized rent-assisted units of which 1.7 million, or about one-third, were occupied by age 62 and over tenants. This report will primarily rely on AHS estimates when assessing the government response to the unmet housing needs of U.S. older households.

The growth of the rent-subsidized housing stock has not kept pace with the needs of a growing elderly population. This is well-illustrated by considering the history of the Section 202 program, considered by advocates and experts to be one of HUD's most successful housing production programs. While the number of units produced under this program has increased over the past several years, the current annual production of just over 7,000 units pales in comparison with historical production levels. The average annual number of Section 202 units was 18,000 in the 1970s, over 15,000 in the first half of the 1980s, and over 11,000 in the second half of the 1980s. Funding for this program has declined from $l.2 billion in fiscal year 1995 to under $700 million, currently.

The loss of subsidized rental units because of expiring Section 8 project-based rental assistance contracts has further exacerbated the effects of producing an inadequate number of new rent-assisted units for older persons. Starting in 1975 HUD signed 20-year contracts with private owners to provide project-based Section 8 subsidies to their properties. These contracts started to expire in 1996. Research estimates that 2,800 elderly-occupied rent-assisted units, primarily in elderly projects, opted out between 1996 and 1998. Another 152,000 units in "elderly" properties are at risk of opting out through 2004. An unknown number of units will be lost from mixed-aged occupancy rent-assisted facilities in the program.

Older households in all income categories are under-represented in rent-assisted housing. Only 5.5% of age 62 and over households that live in conventional housing now occupy rent-subsidized facilities. This compares with 6.2% of age 61 and under households.

National assessments of the need for affordable housing sometimes falsely give the impression that the current occupants of rent-assisted facilities always have relocated from other rental facilities. As emphasized, however, the problems of affordability and poor quality housing are hardly restricted to older renters. Since the group of older homeowners is so large, even small percentages of occupants with housing cost burdens and physical quality deficits will constitute a very large latent demand for rent-assisted facilities. Over a one-year period, 29% of the older occupants that entered rent-assisted housing were previously homeowners.

Rent-assisted older occupants are more likely to be poor, when their incomes are compared with elderly households occupying unassisted rental units. They are also more likely to be African-American, Hispanic, and Asian and they are more likely to be living alone. In contrast, age 75 and over households are somewhat under-represented, suggesting that rent-assisted facilities are either

unwilling or unable to tolerate this more vulnerable group or that this old-old household group is discouraged from seeking admittance.

Rent-subsidized facilities occupied by older households are also not equally available in central cities, the suburbs, and nonmetropolitan areas. Central cities have a higher share of senior-occupied rent-assisted units than would be predicted on the basis of where older households with low incomes and housing problems are located.

Rent-assisted facilities that are designed to eliminate dwelling cost burdens and to provide housing that is in good physical condition are themselves sources of problems. Almost 29% of the l.2 million age 65 and over rent-assisted households have priority problems, while another 28% have less serious problems. Additionally, almost 22.4% of the 152,000 age 62 to 64 households have priority problems, while another 33% have less serious problems. Thus, a total of 683,000 age 65 and over and 84,000 age 62 to 64 rent-assisted households have dwelling problems that presumably should not be found in government-subsidized facilities. HUD attributes some of these problems to survey response error, a result of tenants under-reporting their incomes and over-reporting their gross rents. Methodological artifact is not the only explanation, however. In several of the Federal and State rent-assisted programs, it is possible for tenants to be paying over 30% of their income on their rent. The significant percentage of rent-assisted units with physical deficiencies is also more difficult to explain away.

Currently, 1,216,000 rent-assisted units (AHS definition) occupied by age 65 and over households are serving an at-risk population of 7,075,000 *unassisted* renters and owners identified as having priority or less serious housing problems. This translates into 5.82 *unassisted* older households with dwelling problems for each existing rent-subsidized unit now occupied by an older household.

To estimate the future number of rent-assisted units to address affordability and quality problems of older households, four growth scenarios were proposed. Estimates of future need range from l.6 to 2.3 million rent-assisted units. This would result in rent-assisted household projected growth rates ranging from 33.1% to 86.4%.

Responding Specifically to the Affordability Needs of Older Homeowners

The Home Equity Conversion Mortgage (HECM) insurance program was created by the 1987 National Housing Act and made it possible for older households (age 62 and over) to obtain a federally insured reverse mortgage. This is a financial instrument designed to allow older homeowners with lower incomes (cash-poor), but who occupy relatively high valued homes (house-rich), to borrow against the equity in their dwelling and receive tax-free cash payments, either advanced in one or more lump sums, in a steady stream of monthly income payments, in the form of a purchased annuity, or some combination of these payment types. While consensus exists that the widespread adoption of this mortgage instrument would lead to a significant point decline in the percentage of low-income older homeowners below the poverty level, through 1999 only 40,000 reverse mortgages had been insured under this program. Moreover, the annual number of originating mortgages has never exceeded 10,000. Thus, this program addresses the needs of an extraordinarily small percentage of older homeowners.

Experts explain this low demand by several factors. Central is the reluctance of older homeowners to borrow on their home's equity because they see it as a last resort security blanket. Economic theorists further argue that older homeowners are unlikely to behave as predicted by the life-cycle hypothesis of consumption, proposing that consumers as they became older would draw down their housing equity to obtain greater liquid consumer income. Rather, research shows that even when homeowners move, a large share does not reduce their home equity values. The reluctance to participate in this type program may also be linked to the desire of older homeowners to leave their wealth to their children and their reluctance to take on any forms of new debt. Older persons may be further motivated by the many income or medical assistance programs that do not count the home as an asset when considering eligibility.

State governments have attempted to reduce the property tax burden of older homeowners (and renters) in several ways though State benefits. Most States favor targeting relief to low-income elderly households and forty-four States and the District of Columbia have at least one property tax relief program that treats elderly homeowners more generously than nonelderly homeowners. Despite these programs, property tax burdens remain high for many low-income elderly homeowners, because eligibility is often restricted to homeowners who have very low levels of income or assets and because the participation rate by elderly homeowners in these relief programs is often low.

An AARP investigation found that older homeowners were more aware of and were more likely to apply for homestead exemption programs. About 33% of a group of studied seniors indicated that with more information or with help filling out the applications, they would apply. Another 25% reported that they were unaware of these tax relief options, while 14% did not think they would qualify. The report indicated that further outreach efforts would likely to be effective for all types of property tax relief programs.

Unmet Supportive Service Needs of Elderly in Conventional Unassisted Housing Units

Older persons experience another very different category of housing-related problems when they have physical or cognitive limitations that make it difficult for them to conduct their usual life styles, take care of themselves, or maintain their dwellings without the help of others. Depending on the types and seriousness of their impairments, they may have to adopt one or more of the following options: secure help from family members or move into a family member's home; obtain homemaker assistance, help with personal care, or nursing services from professional paid providers, home-based services, or community care providers; or relocate to a supportive seniors housing option. Older persons that are more at risk of having these limitations and having the fewest options will have one or more the following risk factors: they will be chronologically very old, will be poor, alone, unable to secure any type of assistance from family, less educated, or belong to a racial or ethnic minority.

In 1996, over 5.79 million or 18% of older persons aged 65 and over, who were not in institutions such as nursing homes, had difficulty performing without assistance either their everyday activities of daily living (ADLs) or their instrumental activities of daily living (IADLs). They included about 3.18 million or 10% of older persons with at least one IADL limitation

involving the following activities: preparing meals, doing light housework, taking right amount of medicine, keeping track of money, or bills, and going outside the home. They also included about 2.61 million or 8% of older persons with at least one ADL limitation involving the following activities: getting in and out of bed or a chair, taking a bath or shower, dressing, walking, eating, and using or getting to a toilet. A smaller share of these older persons, 1.19 million or 3.7%, were especially impaired because they had limitations in three or more ADLs.

Older persons with incomes above the 150% poverty threshold are about 50% less likely to suffer from an IADL limitation, 59% less likely to suffer from an ADL limitation, and 60% less likely to have a mental disability than are older persons below the 100% poverty level. The prevalence of these limitations was also much higher for older African Americans and Hispanics, groups also more likely to have lower incomes, than for nonHispanic white seniors. Persons who live alone and who are in "other household" arrangements have substantially higher limitation rates than married couples.

Older persons who are in more than one of the above "higher risk" groups are especially likely to be vulnerable. Almost one million age 75 and over persons, below the 150% poverty income level, and living alone, had difficulty performing without assistance either their everyday activities of daily living (ADLs) or their instrumental activities of daily living (IADLs). A smaller number of these older persons, over 115,000 or over 4% were especially impaired because they had limitations in three or more ADLs.

Older renters (not in government-subsidized rental facilities) are more likely to report having physical limitations than older homeowners, even after considering the age and income differences that also differentiate these two groups. Even though the likelihood of having IADL or ADL limitations is greater among poor older renters, when even a small percentage of poor older homeowners have these limitations, their numbers are very large. Thus, over 1.3 million poor older homeowners have at least one ADL or IADL limitation compared with just under 600,000 poor older unassisted renters. Even these disability patterns tell an incomplete story. The over 440,000 homeowners who are both cash-poor and house-poor and who have at least one IADL or ADL limitation constitute an especially vulnerable group without the financial wherewithal to take care of themselves or their dwellings.

When older persons are afflicted with physical or cognitive limitations, they may abruptly find that their dwelling becomes a more difficult to use and unsafe environment. This very often happens in dwellings that are in relatively good physical condition, that is, do not have the more serious HUD-defined severe or moderate physical deficiencies. Most professionals argue that the home can be physically modified in ways that will enhance the independence of older Americans. If there are appropriate home environmental interventions, it may even be possible to slow the rate of functional decline and reduce the costs of in-home personnel.

The most recent and optimistic analysis found that in 1995 only 45% of elderly households with activity limitations (42% of homeowners and 55% of renters) in need of home modifications had actually made some adjustments. Elderly persons report that their most needed home modifications include handrails or grab bars (401,000 households or 8.4% of households with activity limitations), ramps (311,000 households or 6.5%), easy-access bathrooms (268,000

households or 5.6%), specially equipped telephones (185,000 households or 3.9%, easy access kitchens (144,000 households or 3.0%), elevators or stair lifts (140,000 households or 2.9%), widened doors or hallways (138,000 households or 2.9%), and modified sink faucets or cabinets (105,000 households or 2.2%).

Both consumers and professionals, including homebuilders, remodelers, and human service professionals, have inadequate knowledge of the physical attributes of the home that would benefit from modification. The older dwellings occupied by today's older adults only compound an already difficult situation because they often only deal with the most serious maintenance needs, while they neglect the less visible home hazards needing modification.

Most studies conclude that older persons would be more likely to physically modify their dwellings if government programs were more available and effective. Along with their insufficient budgetary allocations, these programs are less effective for various well-documented reasons.

- There is poor coordination and communication among the numerous organizations and agencies that provide in-home services to older persons—personal care, homemaker care, home repair, modification, and weatherization activities.
- Home modification and repair needs are often inappropriately assessed and thus more education and training is required for those interfacing with the older client.
- A single State or county organization is often absent that is willing to assess and advocate for consumer needs, identify current weaknesses in the delivery of home modifications services, and better organize these efforts.
- Care managers and human service providers insufficiently inform older persons about the importance of making these repairs and modifications.
- Program funds are disproportionately spent on repairs as opposed to home modifications, driven in considerable part by the program mandates of funding sources such as the Community Development Block Grant program.
- The funding provided by Medicare and Medicaid programs do not sufficiently cover the costs of items such as assistive devices, home modifications, and occupational therapist visits.

Researchers agree that between the early 1980s and the late 1990s older Americans were less likely to report having physical or cognitive disabilities. This report projects that by the year 2020 there will be 4.31 million older persons with IADL limitations, 3.62 million older persons with ADL limitations, and 3.58 million older persons with mental disabilities. Most of this future group of older persons with these physical and cognitive limitations will be homeowners. The 26% to 28% projected growth rates of these disabled older populations between 2000 and 2020 will be lower than the projected overall growth rate of the older population, because of the assumed declining disability rates of the future elderly population. The over 3 million of this future older population expected to be frail will be especially disadvantaged because of their low incomes (under 150% of the poverty level).

A major forecasting uncertainty is knowing which options older persons will adopt to address their long-term care needs—remaining in their conventional dwellings relying on family caregivers or professional workers, in supportive senior housing facilities, or in nursing homes.

Currently, about 70% of older persons with either ADL or IADL limitations are found outside of institutions. What this percentage will look like two decades from now is dependent on a host of factors that are difficult to predict. Foremost will be the extent to which family members will be able to shoulder the caregiving burden and the extent to which older persons living in conventional dwellings will be able to afford the cost of long-term care services. The role nursing homes will play in the future long-term care network will also be crucial, but very unclear. This will depend not only on the changing economic costs of providing nursing home care but also the competitive influences of shelter and care alternatives, such as assisted living facilities, continuing care retirement communities, and rent-assisted facilities that can be linked with affordable supportive personal care and health services. Most expect that the nursing home will become increasingly reserved for the most frail. The role of the court system may also be influential as exemplified by the 1999 Supreme Court Decision, *Olmstead v. L.C.* The court ruled that title II of the Americans with Disabilities Act (ADA) prohibited States from unnecessarily institutionalizing persons with disabilities (old and young) and from failing to serve them in the most integrated setting in light of their disabilities. Still, the full implications of the *Olmstead* decision for State programs is unknown.

Unmet Supportive Service Needs of Low-Income Older Households in Conventional Government-Subsidized Rental Units

A substantial share of the older tenants in government-subsidized or rent-assisted housing has physical or cognitive limitations. Overall, about 33% of age 65 and over tenants required assistance with at least one IADL or ADL. This included almost 21% who had at least one IADL limitation and just over 12% who had at least one ADL limitation. Almost 5% of age 65 and over tenants had a level of disability characteristic of the occupants of assisted living facilities or nursing homes because they needed assistance with three or more of their activities of daily living. Some 12% of rent-assisted elderly tenants had a mental disability that seriously interfered with their everyday activities.

The oldest tenants in these housing developments (the old-old or age 75 and over), are especially likely to have physical and cognitive limitations. Overall, 36% of this group required assistance with at least one IADL or ADL limitation and 11% had a mental disability that seriously interfered with their everyday activities. The poorest members of this group, with incomes under the 150% poverty level, were especially vulnerable. Almost 214,000 or over 42% had at least one ADL or IADL limitation. Just less than 6% (29,892) of this group had three or more IADL deficiencies and just under 6% (28,064) had three or more ADL deficiencies, a level of impairment characteristic of the occupants in assisted living facilities or nursing homes.

Poor older occupants of government-subsidized are especially vulnerable:

- They are more likely to be extremely poor.
- They are more likely to live alone (mostly women) and thus are unable to rely on a spouse as a caregiver.
- They are less educated and thus are often unsure about their eligibility for government-sponsored programs, are afraid of and inexperienced in dealing with " system," and lack the sophistication to judge accurately the quality of their assistance. They have difficulty

accessing a bureaucratic system presenting very different application procedures and eligibility requirements and are more apt to confront bureaucratic snafus and infringements on their individual rights.

- They are more likely to be members of racial and ethnic minorities and thus confront cultural and language barriers when accessing needed supportive services.
- They generally have fewer affordable supportive service options and are more dependent on government-financed supportive services.

The services most needed by these older tenants are indicated by the responses of a sample of 573 elder tenants living in eight different HUD privately owned multifamily facilities in Florida. When asked which services they now often needed, the following percentages of elders identified the following as most important: hand-rails or grab-bars in their bathroom (26%); transportation to and from a doctor's appointment (15%); transportation to and from a store (14%); help with their housekeeping chores (11%); emergency button to push or string to pull in their apartment (4%); and hot meals delivered to their apartment (4%). When asked if they had a problem getting affordable transportation to places (not within walking distance) when they needed it, over 25% of the elders had a problem always or most of the time, 15% some of the time, 51% seldom or never, and 8% responded they did not need to go to places. Over 8% of the elders reported they were so sick during the previous six months that were unable to carry on their usual activities for at least a month, and another 12% reported such incapacity for more than a week (but less than a month). Almost 47% of elder tenants reported that they hardly ever worried about things, but 18% reported that they worry about things very often and 36%, fairly often.

These elder tenants also reported difficulty coping with their health and disability-related problems. When asked on whom they could rely on in the event they were sick or disabled, over 34% of the tenants felt they had no person on which to rely and 16% could rely on someone only now and then. Only 37% felt they could rely on someone as long as needed, while 6% could rely on someone for a few weeks or months and 7% for a week or less. When asked where they would relocate if they could no longer live on their own in their apartment because of a health or disability problem, 34% said they did not know, while about 27% said they would move into the residence of a family member, 19% to a group home for the aged, 16% to a nursing home, 1% to a friend, and 4% to a variety of other choices. Two obvious observations: it is unclear whether family members would accommodate those elders seeking assistance, and it is rather frightening that over a third of these residents had no idea how they would cope with the onset of serious frailty.

The Recognition of Need by Political and Professional Stakeholders

The most important stakeholders recognize that the seniors in rent-subsidized housing now have unmet needs. These include: (1) the major advocacy groups; (2) owners, sponsors, and administrators of government-subsidized rental facilities; (3) the Federal government; and (4) State and local governments.

The Elderly Housing Coalition advocacy group concluded:

Many national and State programs have successfully demonstrated that frail low-income residents of federally assisted housing can be helped to age in place through the integration

> *of housing and services. We believe that by making available a continuum of accessible and affordable services, residents will enjoy a better quality of life and will be able to postpone or prevent the need for high cost institutional care.*

The public policy position of the Department of Housing and Urban Development is also sympathetic. It concluded in a report to Congress that the housing occupied by older Americans must not only be affordable and in good condition, it must be also be "appropriate:"

> *As a Nation we are committed to ensuring that our elders are able to age in place in a setting that gives them maximum independence and dignity, while safeguarding their safety and welfare. This means that elderly households must have access to flexible packages of housing and supportive services that are integrated and delivered in ways that have the most potential to meet their desire to age in place.*

Owners, sponsors, and managements of government-subsidized rental housing are also acutely aware of their older tenants' changing profile. The majority (61%) of a national sample of managers of subsidized housing facilities was strongly interested in pursuing onsite and/or near-site health care programs for their residents. A representative sample of rent-assisted administrators in Florida were able to identify three distinctive categories of serious management problems

State and local governments express at least three rationales for targeting and providing affordable supportive services to this group: (1) to make the delivery of home- and community-based services more administratively timely, efficient and cost-effective; (2) to reduce unscheduled tenant-management crises requiring expensive service calls from fire, medical, and human service provider departments/agencies; and (3) to delay the relocation of frail seniors into shelter and care accommodations requiring State expenditures.

Responses to the Unmet Needs of Frail Older Tenants in Rent-Assisted Facilities

Numerous case studies of rent-assisted facilities have described successful approaches to providing frail seniors with strong supportive service environments. A Florida study, for example, found that just over 30% of a representative sample of HUD multifamily privately owned subsidized facilities were offering relatively strong supportive environments to their low-income frail elderly tenants. Another comprehensive examination of the largest Public Housing Authorities in the country reported that about one-fourth to one-third of the elder tenants in these facilities received social, recreational and transportation services, while 15% to 25% received congregate meals, homemaker services, visiting nurses, health screening, friendly visitors and counseling. This report summarizes over 21 of the most successful efforts.

Community-based organizational strategies have fostered low-income residents' independence through a "one-stop shopping" service package funded by a capitation approach (usually combining Medicaid and Medicare funding) that offers frail seniors living in the community a full range of acute and long-term care services provided either at an affordable housing site or at a nearby adult day center. The two most important exemplars are the On Lok and the PACE programs.

The facilities produced under the Section 202 program are more likely than those developed under other of HUD's privately owned multifamily subsidized programs to accommodate successfully the supportive housing needs of their frail older tenants. A 1999 national investigation of 202 facilities confirmed some of the successes enjoyed by this program. Some of the key findings:

- Over 37% of the facilities had professional service coordinators.
- Managers with service coordinators reported that the experience was overwhelmingly positive for both residents and management.
- Most facilities had some support and accessible design features in place (e.g., grab rails, entrance ramps, call buttons).
- Most facilities had at least one disabled-accessible unit.
- Just over one-fourth of the facilities reported having 24-hour on-site personnel.
- Over 90% of facilities had community space for social and recreational facilities; about half the facilities had spaces for congregate dining and visiting services.
- About 23% of the facilities had on-site meal programs. Just over 26% offered housekeeping services provided by either the facility's staff or from an outside human service agency.
- Over 12% of the facilities had staff who offered social work or counseling services.
- About 5% of the facilities provided "assisted living" like services to their tenants

Several studies have shown the success of service coordinators to help rent-assisted older tenants maintain their independent living arrangements. An unofficial estimate is that over 4,000 service coordinators are now working in HUD, Public Housing, and Rural Housing Service facilities and are assisting an estimated 600,000 older persons. Studies have identified the following ways in which managers and residents benefit:

- Residents obtain more health, personal care, homemaking and other supportive services and navigate the human system better.
- Premature institutionalization is avoided because residents have more services available to them to maintain their independence.
- The needs of at-risk and frail residents are more quickly recognized, thereby resulting in more timely service delivery.
- Older residents feel empowered through education to meet their own needs. Thus, they are better able to identify and access needed services.
- Residents feel an increased sense of community and can draw on more informal help from other tenants.
- Residents are living more comfortably and express greater residential satisfaction.
- There are fewer conflicts between older residents and between older residents and management.
- Building managements are relieved of time-consuming and stressful responsibilities having to do with their residents' requests for supportive services. In turn, they have better relationships with both elderly residents and service providers.
- Administrators spend more time on traditional building management roles.

The Congregate Housing Services Program (CHSP) And The Hope For Elderly Independence Demonstration Program (HOPE IV) are both now inactive programs that offered supportive-service and case management services including service coordination to a very small number of facilities and older tenants using a similar funding formula. The major difference in the programs was that HOPE IV was tenant-based, whereas CHSP was project-based. While the CHSP was provided in HUD-assisted congregate housing, HOPE IV was offered to older persons who lived in unassisted housing units throughout the grantee's service area. The conducted evaluations of these programs showed that facility managements were very satisfied with both programs. Both fostered the development of partnerships with other service delivery agencies in the community that helped meet tenant needs. While tenants in both programs received more service than they would have otherwise, nursing home admission rates were not significantly affected.

Three specific Federal programs dependent on the joint participation of both the private and public sectors have helped to increase the availability of affordable supportive service accommodations. These have included: (a) Section 8 Vouchers subsidizing the shelter component costs of privately owned assisted living facilities, (b) Medicaid Waivers subsidizing the care component of assisted living facilities owned by for-profit entities, and (c) the assisted living conversion program, whereby the Federal government funds the re-design of the physical plant of the facility.

Of these, the use of Medicaid Waivers to subsidize the care component of assisted living facilities has been the most successful in creating affordable units for low-income frail older persons. Ideally, the best designed and operated assisted living facilities can accommodate older persons with physical and cognitive deficits who require a protective environment, regular and unscheduled assistance with activities of daily living, and some nursing care. Such facilities provide residents with a "social" or "residential" model of shelter and care that recognizes the importance of maintaining their dignity, independence, control, individuality, and privacy. The architectural setting and organizational environment of this model more closely resembles a residence, an inn, or a hotel than a hospital or nursing home. Unlike more medically oriented long-term care settings, or very small, house-like traditional board and care facilities, residents do not have to share their dwellings, but rather have their own apartments, can lock their doors, and have their own bathroom and kitchen facilities. They have much more say about how they conduct everyday activities, such as when they eat or recreate. Most importantly, they play a more active role in deciding what services they receive and when they receive them. Care and services, rather than delivered as a one size fits all, are individually tailored to meet the specific needs of seniors and the preferences of their families.

In practice, some assisted living facilities fall short of this ideal. This variability in large part results from the assisted living facility option being primarily a creation of State governments and their idiosyncratic influence on its regulatory environment, and how it looks and operates. Even with its downsides, however, the latest investigation of a nationally representative sample of residents and staff in assisted living facilities was generally positive:

> *Assisted living appears to offer an important type of residential long-term care setting for persons with mild or moderate disabilities who cannot safely or securely live alone but do not need the level of care provided in a nursing home. Further, the high privacy or high*

service ALFs provide this care in a setting that has many components valued by consumers, particularly in terms of privacy and environmental autonomy.

As of April 2000, 38 States were able to use their Medicaid waiver programs to subsidize the personal care and nursing services provided in assisted living facilities. States use Medicaid in one of three ways to pay for the service component of the assisted living facility: (1) through their Medicaid State plans; (2) home and community based services (HCBS) 1915(c) Waivers; and (3) through Section 1115 Waivers. Most use the HCBS 1915 (c) Waiver program. This program is serving over 60,000 older persons, an increase of 50% over the previous two-year 40,000 total.

There are several possible downsides to this funding approach. First, by necessity, the ALF alternative must compete with nursing homes and home and community based care for the allocation of a State's limited Medicaid waiver funding. Second, the Medicaid reimbursements and State supplements to the SSI Program must be sufficiently large to attract assisted living providers. Third, and more perversely, the reimbursement value of the Medicaid waiver, in combination with other State supplements may not encourage the quality of care found in private-pay facilities. Fourth, although studies have yet to be conducted on this issue, a strong possibility exists that the use of Medicaid Waivers results in an ALF facility that is excessively regulated and thus inconsistent with the residential or social model of ALF care. Fifth, to subsidize both the shelter and the care components, the assisted living facility's owners must draw on at least two funding sources and thereby invite cumbersome paperwork and bureaucratic hurdles. Sixth, one analysis of this Medicaid funding approach cautions that diverting Medicaid recipients from nursing homes to the presumably less expensive to operate assisted living facility will not necessarily save State governments money.

This report projects that in 2020 the number of assisted living facility *units* will range from 712,707 to 755,302. Currently, it is estimated that 10.3% of the residents in assisted living facilities received subsidies. If this current estimated proportion of subsidized residents remains constant through 2020, then assisted living facilities in 2020 will have to accommodate from 93,229 to 98,801 "subsidized" older persons.

Despite these successful efforts, barriers to successful affordable supportive housing solutions remain. There still exists a large presence of low-income frail seniors who are having difficulty finding affordable supportive settings. It is not for lack of solutions but rather because consensus simply does not exist among the major stakeholders as to who should assume responsibility for this vulnerable group of seniors or what public policy responses are desirable, acceptable, and achievable. It is possible to identify four categories of barriers:

Barriers to Successful Affordable Supportive Housing Solutions

Consensus is lacking as to whether the mandate or mission of the Department of Housing and Urban Development should extend to providing supportive services to assist vulnerable tenants. Many government administrators strongly believe that HUD should not deviate far from its "bricks and mortar" traditions. Many housing facility owners, sponsors, and management firms similarly argue that addressing the supportive housing environment needs of their elderly tenants is not in their job description.

Affordable housing providers fear that by providing supportive services in traditional shelter accommodations, their facilities will unattractively and unrealistically assume the appearance and functions of a nursing home or an assisted living facility. They question whether they have the competence to administer this type of housing, whether they will incur the wrath of the facility's more healthy tenants, or if they will violate State regulations.

Consensus is lacking as to what exactly supportive services should accomplish when they are delivered to rent-subsidized housing facilities. Advocates argue that improving the quality of life of older persons is sufficient reason to provide assistance. Public policy intervention is justified to help them remain in safe and comfortable quarters and minimizing problems they confront in taking care of themselves and their apartments. A related position is held by advocates who argue that if the owners and managements of rent-assisted housing address the needs of their frail tenants, their facilities can be managed more efficiently, less expensively, all the while maintaining better tenant-manager relationships and insuring greater tenant satisfaction. A third group of advocates proposes a very different basis for success. It argues that subsidized supportive services should delay or prevent premature and more costly nursing home admission and thus allow Federal and State governments to realize long-term care cost savings. Unfortunately, this is also the most difficult position to justify. This report argues that this is a highly complicated and difficulty strategy to justify policy implementation and will often fail.

Three categories of barriers make it difficult to package, link, and deliver a community's resources to older clients.

1. Administrative or organizational barriers make it difficult to link together the benefits and services needed by low-income older persons that are offered under very different government programs, levels of government, different types of providers (e.g., nonprofit vs. for profits), and involve very different funding streams. Governmental agencies charged with providing social and health care services often fail to coordinate their efforts with agencies or providers charged with providing affordable housing. Nationally, the Department of Housing and Urban Development and the Department of Health and Human Services have forged few formal linkages. A number of barriers discourage housing-service integration: very different congressional or legislative committees and governmental agencies have responsibility for providing affordable human services at both the Federal and State levels; different and inconsistent geographical boundaries are attached to administrative oversight; and different and complex eligibility rules and funding approaches exist for program participation. The net result of these connectivity lapses is that to older persons, especially who are less educated and knowledgeable about "how the system works," a locality's shelter and care resources can appear very remote from the ways they think of their needs and problems.

2. Most older persons are living in dwelling locations that require them to rely on vehicular transportation to reach family members, caregivers, human service providers, establishments, activities, and organizations. Overcoming such physical distances is obviously of paramount importance. The ability of older persons to easily access everything from a grocery store to a medical clinic obviously will influence whether they can continue

to live independently in their current homes. Case studies, scientific research, and Congressional testimony abound with the horror stories of older persons who have been isolated in their dwellings and unable to secure the most essential of goods and services. Overcoming these geographic barriers can be accomplished via three substitutable delivery modes: (1) by older persons using traditional transportation modes such as private cars or vans, fixed route public transit, and walking to reach their destinations; (2) by older persons availing themselves of demand-responsive transportation services that offer more flexible, sometime door-to-door transportation, as exemplified by subscription bus services, shared-ride taxis, carpooling, vanpooling, and jitney services; and (3) by co-locating the goods and services on the same physical site where older persons live. Communities differ widely as to the extent that these delivery modes are available.

3. It is increasingly possible for older persons to obtain needed services through the use of less traditional modes of delivery, such as information transfer strategies including email, teleconferencing, videoconferencing, and other digital transfer strategies. Undoubtedly, some of the most innovative and helpful future service delivery strategies will be discovered in this domain and will benefit low-income and high-income frail elders alike. The introduction of these innovative connectivity approaches will undoubtedly eliminate many of the current transportation barriers that now prevent older consumers from accessing needed supportive services.

THE HOUSING PROBLEMS OF THE FUTURE ELDERLY POPULATION

BACKGROUND

The New Shelter and Care Reality

Portrayals of becoming old in America present a set of conflicting images. These range from the active and leisure-pursuing "youthful" older person occupying the traditional single-family home fronting a golf course to the decrepit and bedbound individual languishing in a sterile nursing home bed. Most older Americans do not fit neatly into either of these categories, but these starkly different images underscore an undeniable reality. Even as older Americans are an extraordinarily diverse group of individuals with very different economic means, life styles, cultural backgrounds, health conditions, and personal capabilities, our society is preoccupied with categorizing older Americans based on whether they can live independently, take care of themselves, and vigorously pursue everyday taken-for-granted activities. This emphasis on using frailty as a basis to compartmentalize older people is not new. Rather, what has changed is that these judgments have become intimately linked with the type of residential settings in which they live. Thus we are now increasingly concerned not with just the affordability and the physical conditions of the dwellings occupied by older Americans, but whether as support and care environments, they also make it easier or more difficult for older persons to cope with their vulnerabilities, enjoy a relatively independent life style, and maintain self-dignity.

The reasons for this very important change in mindset are straightforward. For a longtime, it was convenient to believe that the residential accommodations of older persons could be simply distinguished as either providing shelter or care. The boundaries were clear-cut. Frail older persons belonged in nursing homes; nonfrail older persons belonged in their conventional residences. It became increasingly clear, however, that almost all types of individual limitation and most chronic health conditions, save perhaps the cognitive declines of individuals with Alzheimer's Disease who exhibited violent and abusive behaviors, could be accommodated in various types of housing arrangements. It was acknowledged that with appropriate family supports, staffing, supportive services, technological resources, and a flexible regulatory environment, physically and cognitively frail older persons would have greater residential choices. Older consumers themselves contributed to this change in perspective, as they increasingly expressed a preference to occupy settings that more resembled their familiar conventional dwellings than a hospital. They wanted the best of both worlds, a setting that linked them to needed social, medical, and service supports, but also one that preserved the autonomy and normalcy of their past life-styles.

Consequently, various new options emerged that allowed older persons to deal with their physical and cognitive limitations without entering a nursing home. They could stay put in their conventional dwellings, where they enlisted combinations of family members, paid staff, home-delivered and community-based services. They could also move to various types of supportive seniors housing that offered shelter, personal care, and nursing services under the same roof, but in a much less regulated and institutionalized setting. The assisted living facility became the most important exemplar that displayed the full potential of this new shelter and care reality.

What were once clear-cut boundaries between the housing and the long-term care environments became increasingly blurred.

Assessing the overall quality of life offered to older occupants in these different alternatives also became more challenging. These places had to be judged not only as typical shelter, but also as care environments. Although they received mixed reviews for their ability to accommodate frail older persons, and yet not look or function like an institution, the evaluations of these facilities were positively biased. This was not surprising because the new hybrid collection of shelter and care settings was consistently compared to an alternative that was considered so deplorable, namely the nursing home with its medicalized and highly regulated organizational, physical, and social environment that crushed individual autonomy and independence. These assessments also confirmed the importance of traditional indicators of a housing arrangement's quality, namely, its physical quality and affordability. Dwellings that were an intolerable expense burden for their occupants or that were in poor physical condition or lacked appropriate physical design modifications obviously presented difficulties for both their healthy and unhealthy older occupants. Moreover, the population risk factors that typically predicted the presence of traditional housing problems also predicted which groups of older persons were likely to be in settings offering inadequate care. The subgroups of vulnerable seniors were in familiar categories: the low-income, those who could not depend on a spouse or lived alone, the less educated, members of ethnic and racial minorities, and the very old.

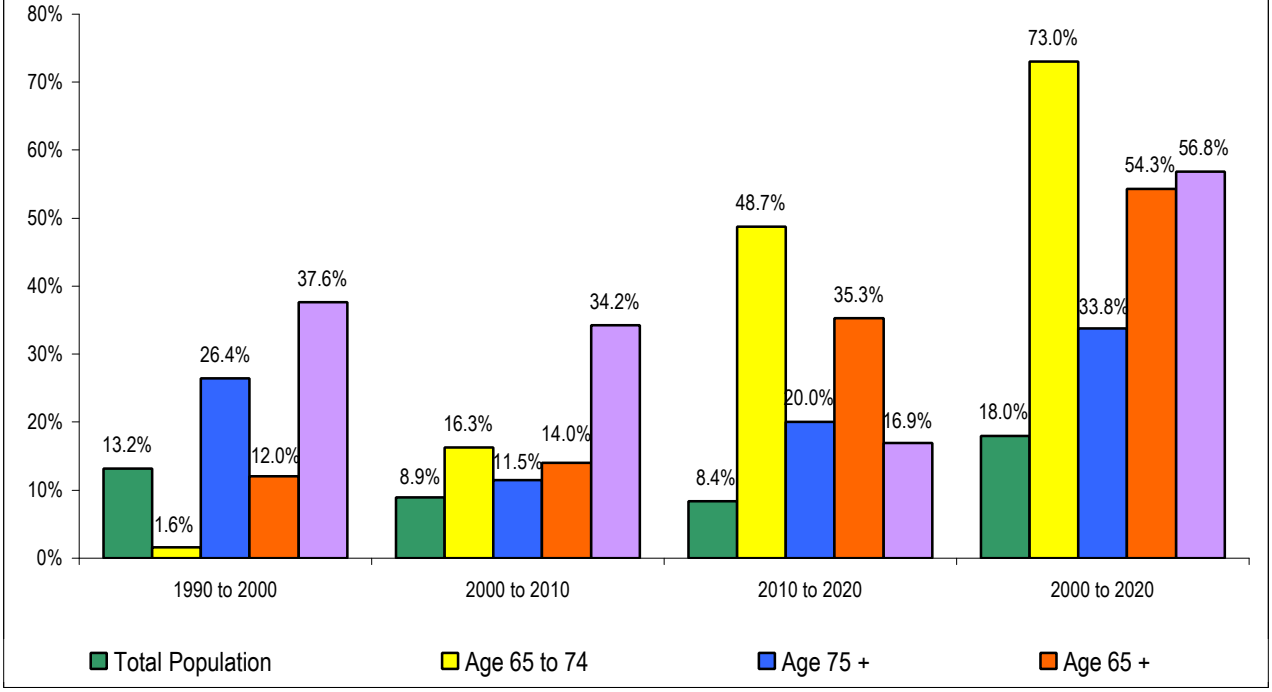
Despite the substantial growth and greater presence of these new shelter and care options, there was another painful realization: they were not equally available to all elderly constituencies. The most potent barrier, however, had less to do with care or quality restrictions than with their affordability. Lower income older persons still found that those housing arrangements offering an alternative to nursing home living were few in number and offered an inferior package of service benefits when they were available. Thus, only a narrow segment of the American old was enjoying the full benefits of the new noninstitutional paradigm. Even as the private sector was vigorously pitching its products to a well-defined upper-income clientele, Federal, State, and local governments were much slower to recognize the desirability and feasibility of these new shelter and care strategies. Nor did they immediately recognize that by failing to respond, they magnified the unequal status of lower income older Americans.

The eventual response by the public sector resulted in piecemeal efforts to make the full complement of shelter and care options now enjoyed by wealthier elderly available to low-income seniors. Stakeholders in the public sector, however, have not been able to agree on what is an appropriate organizational and financial commitment. The current dialog makes it painfully clear that many stakeholders are blissfully unaware of the magnitude of the unmet shelter and care needs of low-income Americans. It has also highlighted the equivocalness felt by stakeholders regarding whether low-income elderly should enjoy the same shelter and care alternatives as wealthier older Americans. Even when well-meaning housing sponsors step forward to create shelter and care options that are affordable to the low-income senior, they often confront administrative and financial roadblocks from segmented bureaucracies and organizations that act as if health and housing concerns are worlds apart. Even more perniciously, proposed shelter and care products for poor elderly are having to be justified not for their obvious benefits to older consumers, their family members, and inevitably to their State's and locality's long-term care system, but rather on whether

they are less costly to build and operate than other housing and long-term care alternatives – tests, we do not need reminding, that housing alternatives targeted to wealthier elderly never had to pass. This "standard" without doubt has had the effect of squelching what would otherwise be a very strong demand for these alternative shelter and care settings by low-income elderly. We must also recall that the major financial and health programs that were created for older persons, Social Security, Medicare, and Medicaid, were not initiated because they saved money relative to some other alternative.

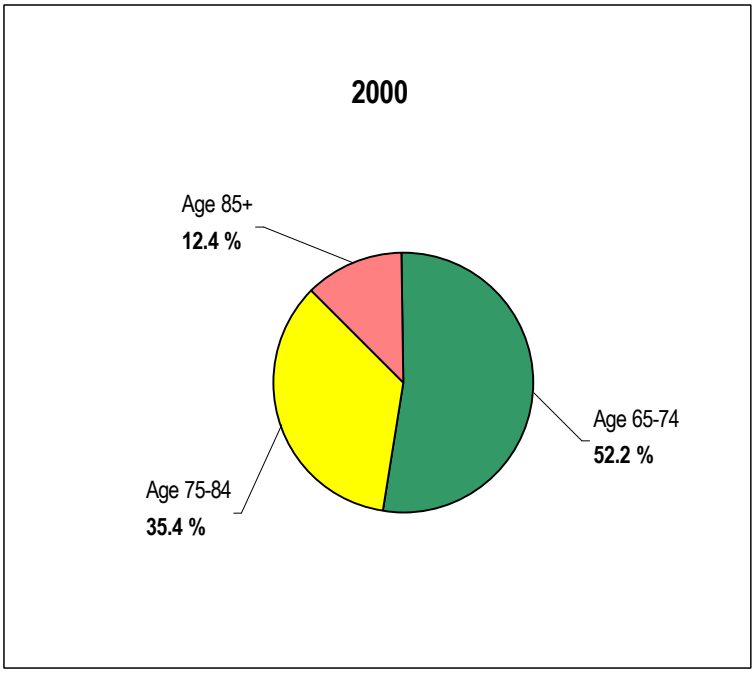
As we enter this new millennium, we are coming uncomfortably close to engaging the demands and challenges that will be created by the large and inevitable growth of the future old. As many times as we have seen and heard the numbers that describe the onset of this large age wave, we still need constant reminders of its imminence (Figures 1 and 2). This society will have to overcome major obstacles to respond effectively to the unmet housing needs of all older Americans. It must not only continue to identify and aggressively respond to a large number and share of both low- and high-income persons who are not now living in good quality and affordable housing. Additionally, it must embrace the new shelter and care paradigm as not just an option for the wealthy, but also as an equally available option for the poor elderly. Now is the time to prepare for what will certainly be the unprecedented shelter and care demands of a large boomer population entering old age. This report will demonstrate that large unmet housing needs of older Americans—especially in the low-income brackets—run the gamut from the traditional shelter affordability and quality concerns to the inadequacy of affordable opportunities that integrate shelter and care in noninstitutional environments. Amidst all the predictions regarding how the future old will impact our society, there is one certainty. To address the large unmet shelter and care needs of low-income seniors, keeping the status quo is untenable.

Figure 1. Projected Population Growth Rates of Age 65 and Over Persons, 2000 to



Source: U.S. Census Bureau, Population Projections Program. 2000. (NP-D1-A) Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin, 1999 to 2100. Washington, DC: U.S. Census Bureau, Department of Commerce. (Middle Series)

Figure 2 Relative Size of the Young Old and Old-Old Population



The Goals of This Report

The focus of this report is on how the current unmet shelter and care needs of older Americans will change over the next twenty years – in 2020. It has four goals:

1. To investigate the growth in the current number of older households that will be at risk of occupying unaffordable housing in poor physical condition;[1]

2. To estimate the amount of affordable and good quality housing that will be necessary to accommodate this projected growth;

3. To estimate the growth in the current number of older and frail – physically and cognitively limited – persons who will require supportive services allowing them to live in an independent, autonomous, and safe living environment;

4. To examine the most important factors that will influence the availability of affordable and supportive shelter and care settings.

The following tasks will be completed:

- Identify the number and prevalence of older American households that are occupying housing that is unaffordable or in poor physical condition. Based on current numbers,

estimate the number of households that will confront these problems in the year 2020 and the number of needed affordable units to alleviate their problems.

- Identify the presence of these problems among homeowners, renters in private market dwellings, and renters in government-subsidized rental housing and the role of government programs in alleviating these problems.

- Identify the subgroups of older households that are most at risk of occupying unaffordable and poor quality housing. Specifically assess the number of low-income households with these unmet needs, but also the number of older households distinguished by chronological age, living arrangements, racial and ethnic membership, and physical and cognitive frailties.

- Identify the number and prevalence of older Americans with physical and cognitive limitations who are most at risk of needing supportive housing arrangements. Based on current numbers, estimate the size of the population that will be at risk in the year 2020. Examine the factors that make it difficult to estimate the size of this future population.

- Evaluate the availability and desirability of two specific affordable housing alternatives that can address the supportive service needs of older Americans: government subsidized rental facilities and government-subsidized assisted living facilities.

- Identify the most important barriers that will restrict the availability of affordable housing that can address the supportive service needs of older Americans.

Methodological Approach

- The primary focus will be on persons or householders age 65 and over.[2] In recognition, however, of the age 62 and over chronological age cutoff of Federal housing programs, the report will also provide current statistical summaries of the housing affordability and dwelling physical quality of the age 62 to 64 household group.

- The affordability and physical condition of the dwellings occupied by older households is based on an original empirical analysis of the 1999 Annual Housing Survey for the United States, a household survey sponsored by the U.S. Department of Housing and Urban Development (HUD) and conducted by the U.S. Census Bureau.[3]

- The presence of physical and cognitive limitations among older persons is based on an original empirical analysis of household survey data collected from Waves 3 and 5 of the 1996 panel of households as part of the Survey of Income and Program Participation (SIPP) (Attachment I).[4]

- Estimates of the future size of older owner and renter-occupied *households* in 2010 and 2020 is based on published projections made by the Joint Center for Housing Studies of Harvard University.[5]

- Estimates of the future size of older *persons* in the same years are based on published projections made by the most recent U.S. Census Bureau middle series projections.[6]

- Estimates of the future unmet housing needs of older households and the availability of future affordable alternatives are based on original empirical projections of 1999 baseline data from the American Housing Survey and the published household projections.

- Estimates of the future size of the physically and cognitively limited older population are based on original empirical projections of baseline data from the survey data collected from Waves 3 and 5 of the 1996 panel of households as part of the Survey of Income and Program Participation (SIPP).

- Along with these original empirical analyses, an extensive review of the relevant academic, professional, and public policy literature allowed assessments of the following issues: the factors influencing the presence of poor quality and unaffordable housing, the public sector's role in providing affordable and supportive housing, the desirability of the assisted living facility alternative, and the barriers constraining the availability of supportive housing.

FINDINGS

The Current Types of Housing Occupied by Older Americans [7]

Older Americans currently occupy a very diverse array of housing types (Table 1). Their accommodations are a product of multifaceted decisions, some made earlier in life, such as the purchase of a house in middle-age, while others reflect more recent adjustments linked with new retirement lifestyles, the disability or death of a spouse, or changes in financial well-being, personal health, and mobility. While most of their dwellings were originally available to all segments of the populations, a significant share (over 10%) were specifically built and marketed to seniors.

Table 1. Major Types of Housing Occupied by Older Householders and Persons (age 65 and over) in the United States, 1999

Type of Housing	Number of Units[a]	Percentage Distribution	Persons	Percentage Distribution
CONVENTIONAL HOUSING UNITS: OLDER HOUSEHOLDERS[b,c]	**21,423,000**	**81.5**	**29,138,000**	**84.5**
Total Owner-Occupied Units	17,196,000	65.4	24,216,000	70.2
1-unit attached or detached	14,846,000	56.5		
2-49 units	836,000	3.2		
50+ units	259,000	1.0		
Manufactured homes	1,255,000	4.8		
Unsubsidized Rental Units	3,011,000	11.5	3,584,000	10.4
Government-Subsidized Rental Units	1,216,000	4.6	1,338,000	3.9

CONVENTIONAL HOUSING UNITS: YOUNGER HOUSEHOLDERS (Under Age 65) OCCUPIED BY AT LEAST ONE OLDER (Age 65 and older) PERSON[c]	**2,166,000**	**8.2**	**2,336,000**	**6.8**
Owner-occupied dwellings	1,789,000	6.8	1,931,000	5.6
Renter-occupied dwellings	377,000	1.4	405,000	1.2
SUPPORTIVE SENIORS HOUSING UNITS	**2,691,266**	**10.2**	**3,002,377**	**8.7**
Congregate Care and CCRC[d] independent living	644,852	2.5	818,962	2.4
Assisted Living[e]	507,414	1.9	644,415	1.9
Skilled Nursing[f]	1,539,000	5.9	1,539,000	4.5
TOTAL UNITS/PERSONS OCCUPIED BY OLDER PERSONS[g]	**26,280,266**	**100.0**	**34,476,377**	**100.0**
All older householders	24,114,266		32,140,377	
All younger householders with elderly occupants	2,166,000		2,336,000	

[a]Numbers all refer to units except for skilled nursing that is reported in beds and that are treated as one-person households.

[b]The householder is the first household member listed on the questionnaire who is an owner or renter of the housing unit.

[c]An unknown, but probably small, percentage of the units in this category are probably counted twice, because the U.S. Census erroneously treats them as households rather than "group housing" and they are also being counted in the "Supportive Seniors Housing Units" category. As this percentage increases in size, it artificially increases the relative share of dwelling units considered as "conventional housing units."

[d]CCRC: Continuing Care Retirement Communities.

[e]Includes Board and Care facilities.

[f]Includes hospital-based facilities, private-pay facilities, and facilities managed by Department of Veterans Affairs.

[g]Including both "Conventional Housing Units" and "Supportive Seniors Housing Units."

Notes for computing households: For the Congregate Care and Independent living units in CCRCs, an occupancy rate of 94.1% was computed. For assisted living facility units, an occupancy rate of 89.4% was computed. Occupancy rates obtained from financial indicators reported in unpublished data from National Investment Conference. A nursing home occupancy rate of 88.35% was computed and the share of beds occupied by age 65 and older persons in nursing homes was computed as 90.29% See: Gabrel, C. and A. Jones. 2000. The National Nursing Home Survey: 1997 Summary, National Center for Health Statistics. Vital Health Statistics 13(147). Washington: U.S. Government Printing Office. In order to count only elderly occupants, the number of assisted living units was reduced by 3.1% and the number of independent living units was reduced by 2.9%.

Notes for computing number of persons: The following assumptions were made. First, of the 2,166,000 nonelderly households occupied by elderly persons, 170,000 households were occupied by two or more persons. For computation purposes, only two elderly persons per households were computed. This will understate the number of older persons to the extent that some households will contain 3 or more elderly persons. To estimate the number of persons occupying supportive senior housing units other than nursing homes, it was assumed that there were I.27 persons per unit.

Source: Supportive Seniors Housing Units data is modified from original tabulations found in Promatura Group, LLC. 2000. *NIC National Supply Estimate of Seniors Housing & Care Properties.* Annapolis, Maryland: National Investment Center for the Seniors Housing & Care Industries. Conventional housing unit data from U.S. Census Bureau. *Current Housing Reports, Series H150/99, American Housing Survey for the United States: 1999.* Washington, DC: U.S. Government Printing Office.

Just over 21.4 million or almost 82% of older (age 65 and over) American householders live in conventional dwellings, those they own or rent in their names. Most occupy traditional single-unit detached or attached dwellings that they own, but a significant share of older households also occupy multiunit structures and manufactured homes. While dwelling ownership is the norm (65%) over 16% of elderly householders rent their accommodations with most (over 7 out of 10) living in private market rate units as opposed to government-subsidized or rent-assisted dwellings.

Another sizable group of older persons live in accommodations owned or rented in the name of a householder who is under age 65. Most studies of elderly housing rarely examine this group, as

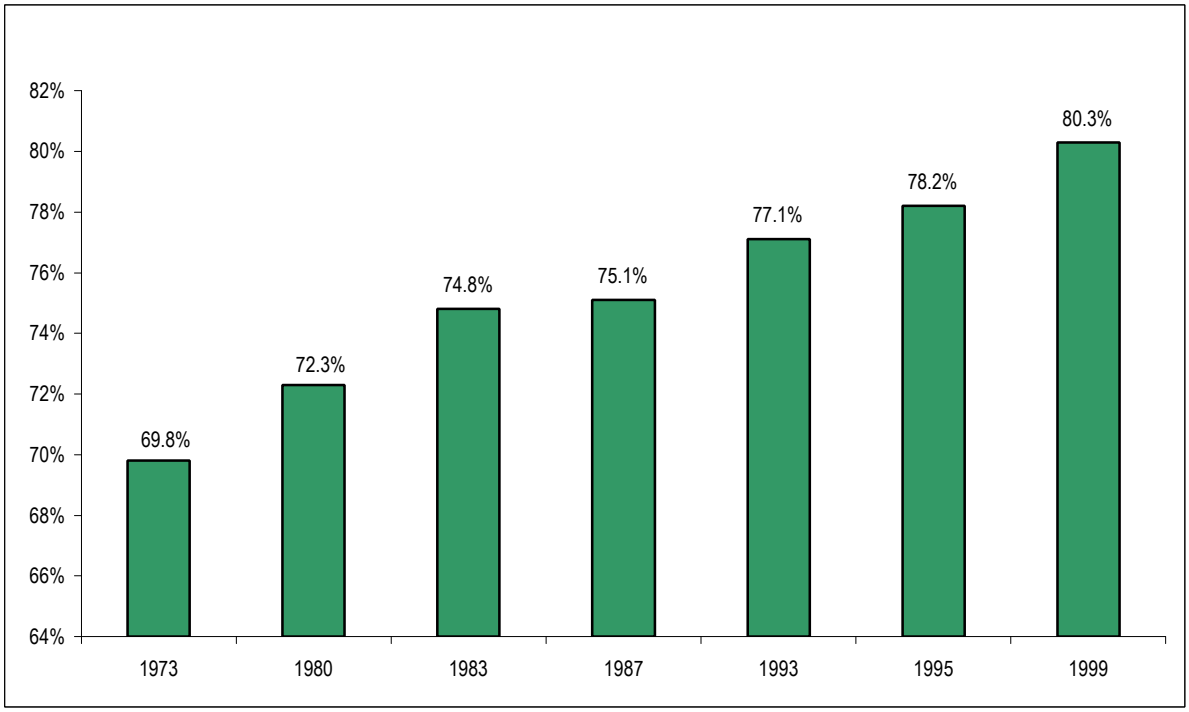
they are not considered “older” householders (previously “heads” of household). Over 2 million older persons (8% of all elderly households) are in this category. They are mostly found in owner-occupied units (6.8%) with a smaller share in rental units (1.4%). There is good reason to believe that this is a more vulnerable group of seniors who have opted to live with younger family members because of difficulties coping with their frailties.

Just under 2.7 million or over 10% of older households occupy accommodations that were targeted to persons in the later stages of life. These supportive seniors housing units are typically built or rehabilitated for older persons who are having trouble living in conventional housing and who variously have chronic health problems, physical, or mental disabilities, or simply are having difficulty conducting their usual everyday activities. The “dwelling units”[8] in this category include: 2.5% in congregate care facilities or in the independent living units of continuing care retirement communities, 1.9% in assisted living facilities; and 5.9% in nursing homes. These differ in significant ways and brief descriptions of each are found in Attachment II.

Homeowners (80% of group) dominate the 21.4 million older households in conventional dwellings. A higher share (83%) of the 11.0 million young-old (age 65 to 74) group of householders are homeowners. Still, 78% of the 10.4 million old-old (age 75 and over) householders are also own their dwellings.

Historically, older households are more likely than at any other time to own their homes (Figure 3). It is projected that these homeownership rates will continue to rise at least through 2020.[9] Between 2000 and 2020, the number of older homeowners is expected to grow by 61% and renter households, by 22% (Figure 4). Young-old homeowners over this period will grow in number at almost twice as fast (78%) as old-old homeowners (41%). By 2020, dwellings are predicted to be owned by 29.3 million or 84% of age 65 and over households and rented by 5.6 million or 16%. The homeownership rate of the future young-old households is expected to reach a record high of 86% (Figure 5).

Figure 3


82%
80%
78%
76%
74%
72%
70%
68%
66%
64%
69.8%
72.3%
74.8%
75.1%
77.1%
78.2%
80.3%
1973
1980
1983
1987
1993
1995
1999

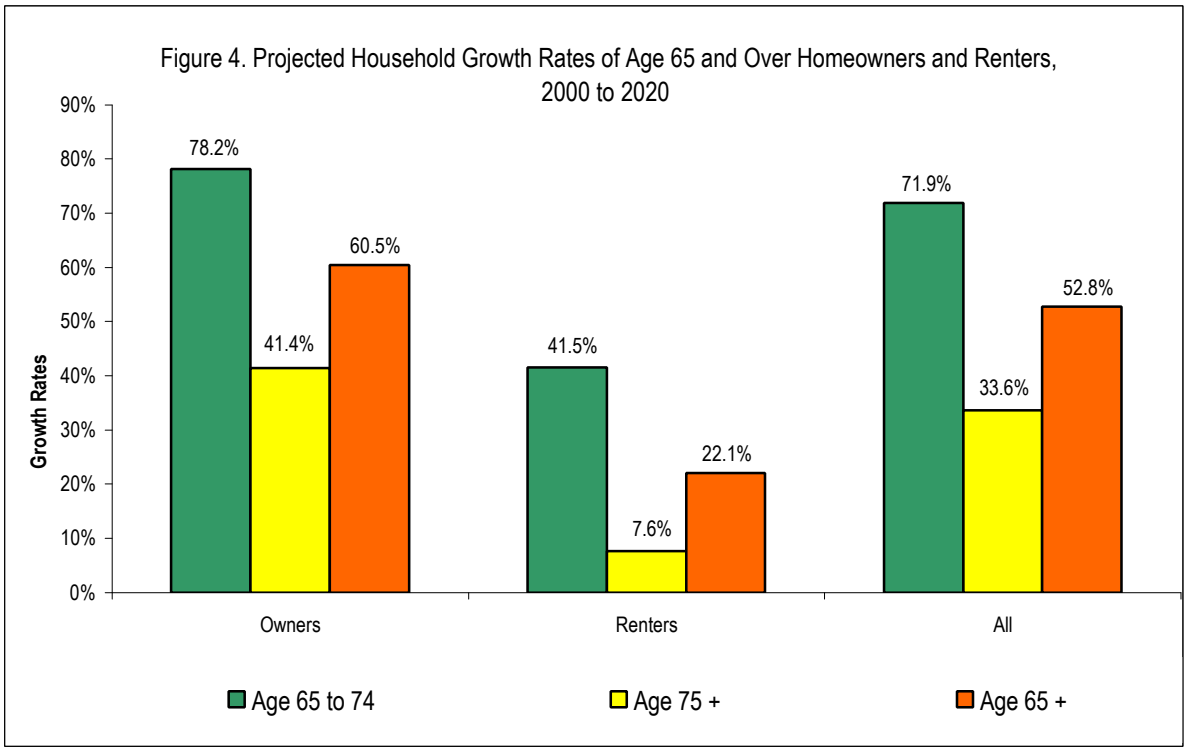
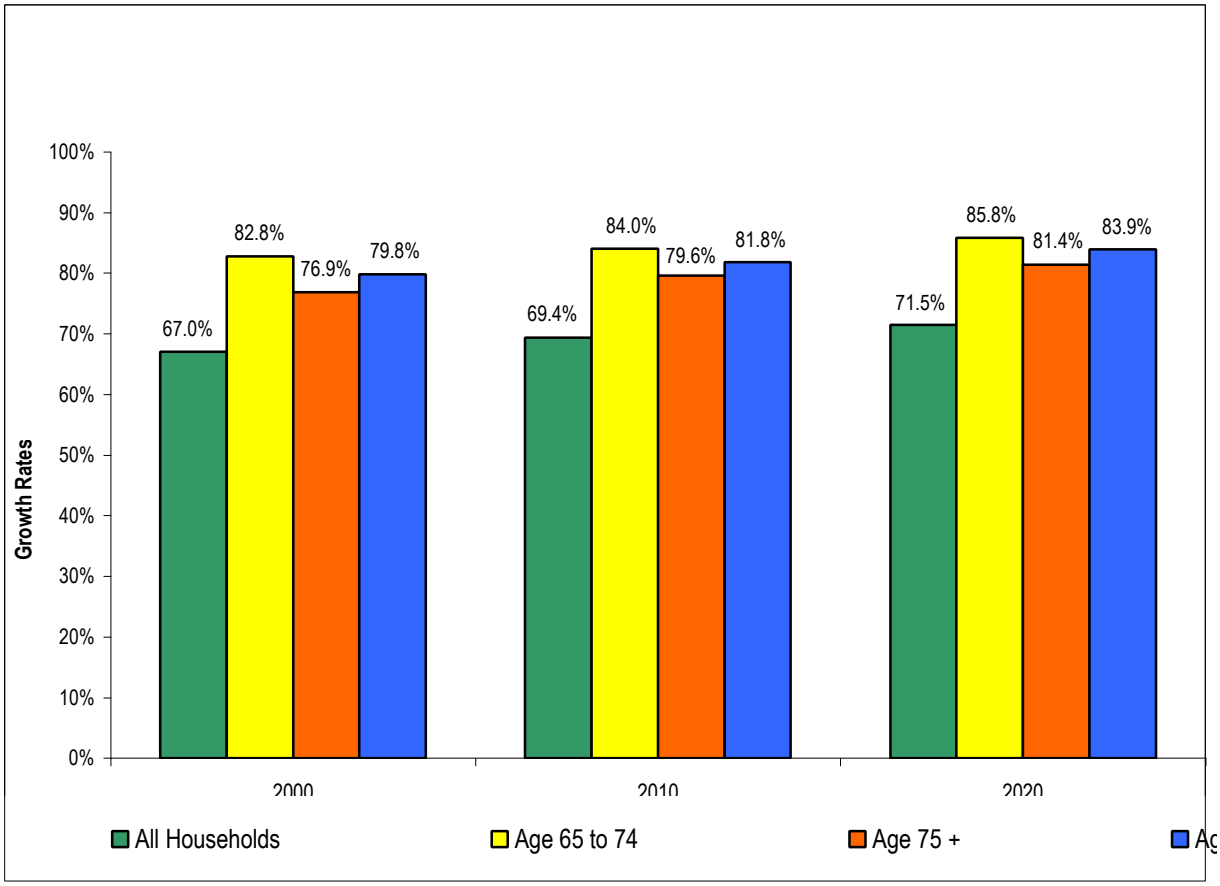


Figure 4. Projected Household Growth Rates of Age 65 and Over Homeowners and Renters, 2000 to 2020
Growth Rates
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78.2%
41.4%
60.5%
41.5%
7.6%
22.1%
71.9%
33.6%
52.8%
Owners
Renters
All
Age 65 to 74
Age 75 +
Age 65 +

Figure 5



The Income and Economic Indicators Underlying Unmet Housing Needs of Older Households Occupying Conventional Dwellings

MEASURES

While many factors influence whether older persons are living in good quality housing consistent with their needs, income and economic indicators are the most pivotal. Yet, professionals and advocates disagree as to what income indicators are most appropriate and what income threshold levels most appropriately define economically needy households or persons. This report relies mostly on two indicators of income status and their selection was primarily driven by their conventional use in similar research and policy analyses.

Typically, the most widely disseminated studies of the housing status of American households, including those conducted by the Department of Housing and Urban Development (HUD), relate the level of income of a household to the median family income of its local area.[10] Each year, HUD estimates an area median family income (AMI) for each metropolitan area and nonmetropolitan county[11] and based on historical precedents assumes that this measure refers to a family of four.[12] To compute the median family income of smaller households, an area's median income is adjusted downward (two-person household = 80% of AMI; one-person household = 70% of AMI). HUD relies on these AMI measures to compute their official income thresholds by which they identify low-income households eligible for their programs. Three such thresholds are most

common: "extremely low income or 30% and under of AMI[13], "very low income" or 50% and under of AMI, and "low income" or 80% and under of AMI.[14] Most HUD programs, along with housing programs administered by other Federal agencies, use the 80% AMI as the upward income limit standard for determining eligibility for its rent-assisted programs.[15] HUD specifically relies on the "very low income" limit standard when estimating the number of U.S. households with "worst case housing needs."

In sharp contrast, studies that measure the disability status or physical limitations of older Americans rely mostly on official poverty level standards to differentiate low-income individuals. Following this convention, this report relies on the 100% and 150% 1999 poverty threshold cutoffs established by the Office of Management and Budget to identify poor and physically and cognitively vulnerable older Americans.[16] The poverty level thresholds, while also adjusted for household size, fundamentally differ from the HUD-computed area median income limits in that they are the same across all geographic areas. As such, they are insensitive to differences in the cost of living found in different places.[17]

A comparison of the alternative low-income limits for one- and two-person households in the United States in 1999 is shown in Table 2. The average Social Security Benefits of selected elderly populations are also shown for comparison purposes. The very different metropolitan and nonmetropolitan area median income limits differentiates this indicator from the poverty level indicator thresholds that are invariant between these urban categories. The very different area median income limits for selected metropolitan areas with higher costs of living are shown in Table 3. It is obvious how the choice of the income level limit definition will dramatically influence the size of the older group considered to be poor. Yet, certain income limit measures offer comparable portrayals. For example, the 100% poverty level threshold is most similar to the 30% area median level threshold, especially in nonmetropolitan areas. Still, many more poor people will be counted under the latter indicator. Similarly, the 150% poverty level is most similar to the 50% area median level threshold, again in nonmetropolitan areas. Still, many more poor people will be counted under the latter indicator.

BACKGROUND

The smaller percentage of the current older population with incomes below the poverty level is pointed to frequently as a measure of its improved economic well-being.[18] Unquestionably, the incomes of older people are higher than in the past, and they have especially benefited from Social Security benefits that have kept up with inflation. This program alone has moved 73% of older persons out of potential poverty status. Over 90% of the elderly population receives Social Security benefits and for the lowest income elderly persons, it constitutes, on average, 67% of their total income.[19] For higher income seniors, asset and pension income have become more important sources.

While only 10.2% of seniors are below the poverty level (in the year, 2000),[20] this statistic offers a misleadingly positive portrayal of this group's economic status. First, like any cross-sectional statistic it is a static view of well-being. From a longitudinal perspective an average of 30% of today's age 60 Americans who become older over the next 25 years will at some point in their lives have incomes that drop them below the poverty level.[21] Second, once older persons enter

poverty, they are much less likely to escape than younger households. The exit rates of the two groups are respectively, 25% and 14%.[22] Third, a significant percentage of older persons, with incomes just above the poverty line (the near poor), are still confronting affordability problems in their current dwellings or are unable to purchase most of the shelter and care alternatives provided by the private sector. Fourth, poverty rate statistics, reporting on the incomes of individuals, give disproportionately greater weight to families (e.g., married couples) than to single-person households. Thus, the measurement of the poverty level of *individuals* (as opposed to households) will tend to understate the greater prevalence of low incomes among one-person elderly households.[23] Fifth, the overall poverty rate disguises the various subgroups of older persons who have especially low incomes. Since 1997, income inequalities *among* older persons has slowly increased.[24] A growing segment of the elderly has moved into higher income brackets, but a large segment remains in the lower income brackets. Sixth, overall, older households have lower incomes than nonelderly households do. In 1999, the median income of age 65 and older householders was $22,812 compared with $46,805 for under age 65 householders.[25] In 1997, "the percentage of elderly households in the lowest income quintile was twice as great as the percentage of nonelderly households in the same quintile."[26] These differences are mediated to some extent by seniors' considerable asset wealth, particularly their home equity positions. Seventh, the poverty rate measure is insensitive to older people's rapidly rising expenditures for their health care and in the instance of frail seniors, on their home- and community-based supportive service costs. A National Academy of Sciences report, recommending more accurate accounting of the costs of basic goods and services, proposed a revised measure that increased the poverty rate of older persons from 10% to over 14%.

Table 2. Alternative Low Income Limits for One- and Two-Person Households and Average Annual Income Entitlements in the United States, By Urban Category, 1999

	United States	Metropolitan Areas	Nonmetropolitan Areas
Area Median Income (four person family)	**$47,800**	**$51,300**	**$35,900**
Poverty Threshold (four person family)	**$16,700**	**$16,700**	**$16,700**
One-Person Older Household			
Area Median Income (AMI)	$33,460	$35,910	$25,130
Extremely low income (30% of AMI)[a]	$10,038	$10,773	$ 7,539
Very low income (50% of AMI)	$16,730	$17,955	$12,565
Low income (80% of AMI)	$26,768	$28,728	$20,104
100% Poverty Level	$ 8,240	$ 8,240	$ 8,240
150% Poverty Level	$12,360	$12,360	$12,360
Supplemental Security Income	$ 6,000	$ 6,000	$ 6,000
300% Special Medicaid Income Rule	$18,000	$18,000	$18,000
Two-Person Older Household			
Area Median Income (AMI)	$38,240	$41,040	$28,720
Extremely low income (30% of AMI)	$11,472	$12,312	$ 8,616
Very low income (50% of AMI)	$19,120	$20,520	$14,360
Lower income (80% of AMI)	$30,592	$32,832	$22,976
100% Poverty Level	$11,060	$11,060	$11,060
150% Poverty Level	$16,590	$16,590	$16,590

Supplemental Security Income (SSI)	$ 9,012	$ 9,012	$ 9,012
300% Special Medicaid Income Rule	$27,036	$27,036	$27,036
Average Annual Social Security Benefits:			
Retired workers	$ 9,648	$ 9,648	$ 9,648
Spouses of retired workers	$ 4,932	$ 4,932	$ 4,932
Disabled Workers	$ 9,048	$ 9,048	$ 9,048
Spouses of disabled workers	$ 2,268	$ 2,268	$ 2,268
Widows and widowers	$ 9,300	$ 9,300	$ 9,300

[a]For any metropolitan area or nonmetropolitan county, the AMI is assumed to refer to a four-person family, because of historical precedents. A one-person AMI is computed by reducing the four-person AMI by .7 and a two-person AMI by .8. Example: the one-person AMI low-income limit for the 30% AMI is .7 x .3 x $47800 or $10,038

[b]In 33 states, "medically indigent" individuals under the Medicaid "Special Income Rule" may earn up to 300% of SSI benefit rate for nursing home care or Home and Community Based Service waivers.

Table 3. Section 8 Income Limits for One-Person Households for Different Income Groups, 1999

Metropolitan Area	Extremely low income (30% of median)	Very low income (50% of median)	Lower income (80% of median)	Area Median Income for One Person
Los Angeles	$10,780	$17,955	$28,735	$35,910
New York	$11,200	$18,690	$29,890	$37,380
Chicago	$13,405	$22,330	$33,460	$44,660
Philadelphia	$13,405	$19,460	$31,150	$38,920
Detroit	$12,705	$21,175	$33,460	$42,350
Washington, D.C.	$16,520	$27,545	$33,460	$55,230
Boston	$13,160	$21,945	$33,460	$43,890
Houston	$11,375	$18,935	$30,310	$37,870
Atlanta	$12,565	$20,965	$33,460	$41,930

Note: The "80 percent of median" limits for each area cannot exceed the national median of $47,800, unless justified by unusually high housing costs in the local area. U.S. Department of Housing and Urban Development. 2000. Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs. Washington: U.S. Department of Housing and Urban Development.

FINDINGS

Relying on the “very low income” area median income limit, just over 10.6 million or about 49% of age 65 and over householders were poor (Figure 6). This included 7.6 million or 44% of older homeowners and 3.0 million or 71% of older renters.[27] Using the more narrow definition of lower income, “extremely low income” or the under 30% area median income limit, results in just fewer than 5.8 million poor older households.[28] To place these estimates in the context of poverty level indicators, Figure 7 shows the prevalence and number of elderly households with incomes below the 100% and 150% poverty level threshold.

Figure 6. Number and Percentage Distribution of Age 65 and Older Households Who Are Below Area Median Income Thresholds

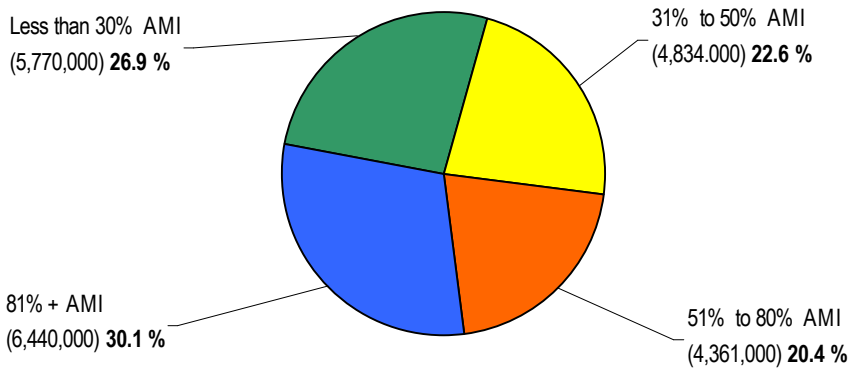
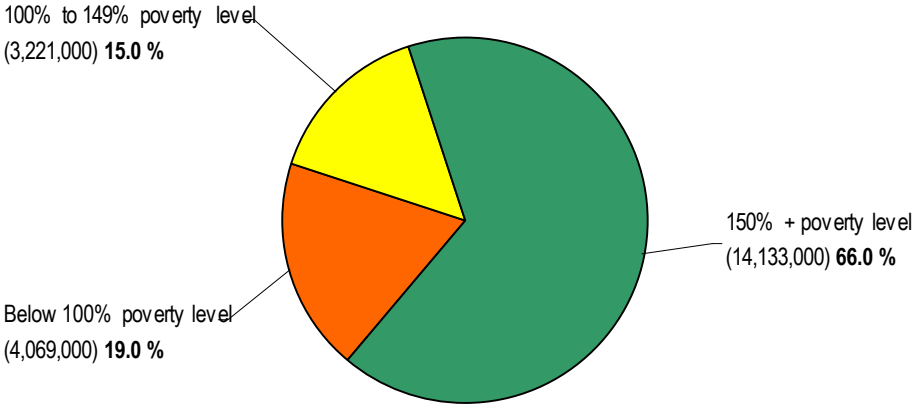


Figure 7. Number and Percentage Distribution of Age 65 and Older Households Who Are Below Poverty Level Thresholds



Certain groups of older households are more likely than others to have very low incomes: the old-old, those living alone, the less educated, African Americans, and Hispanics (Figures 8 and 9). Older households who are "overhoused" are also more likely to have lower incomes. An overhoused household has less than 0.5 persons per bedroom (e.g., an older man living alone in a three bedroom dwelling). These households are at greater risk of living in unaffordable housing and being unable to pay for their out-of-pocket medical and home care costs because they are burdened with the upkeep and maintenance of unused dwelling space even as they have very low incomes. Over 3.8 million or over 22% of older homeowners and 253,000 or almost 6% of older renters are overhoused by this measure.[29] Almost 56% of overhoused age 65 and over homeowners and just under 71% of overhoused older renters have very low incomes (Figure 10). Age 75 and over homeowners are especially likely to be overhoused and almost 64% have very low incomes (Figure 11).

Figure 8. Selected Subgroups of Age 65 and Older Owners with Higher Prevalence of Very Low Incomes, 1999

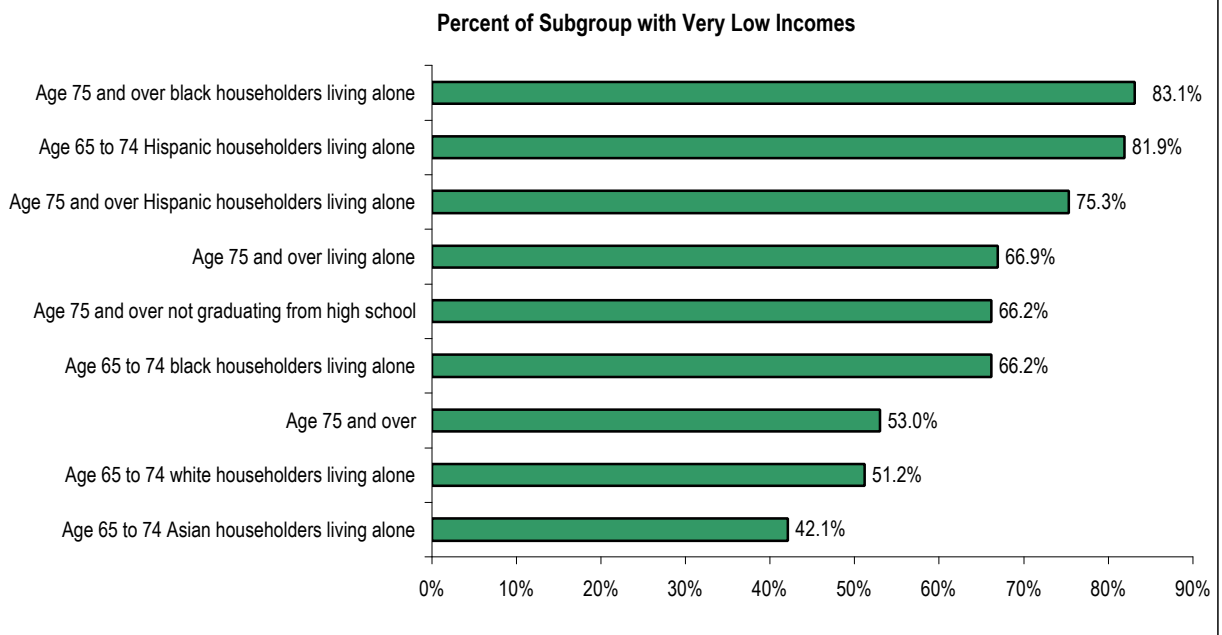


Figure 9. Selected Subgroups of Age 65 and Older Renters with Higher Prevalence of Very Low Incomes, 1999

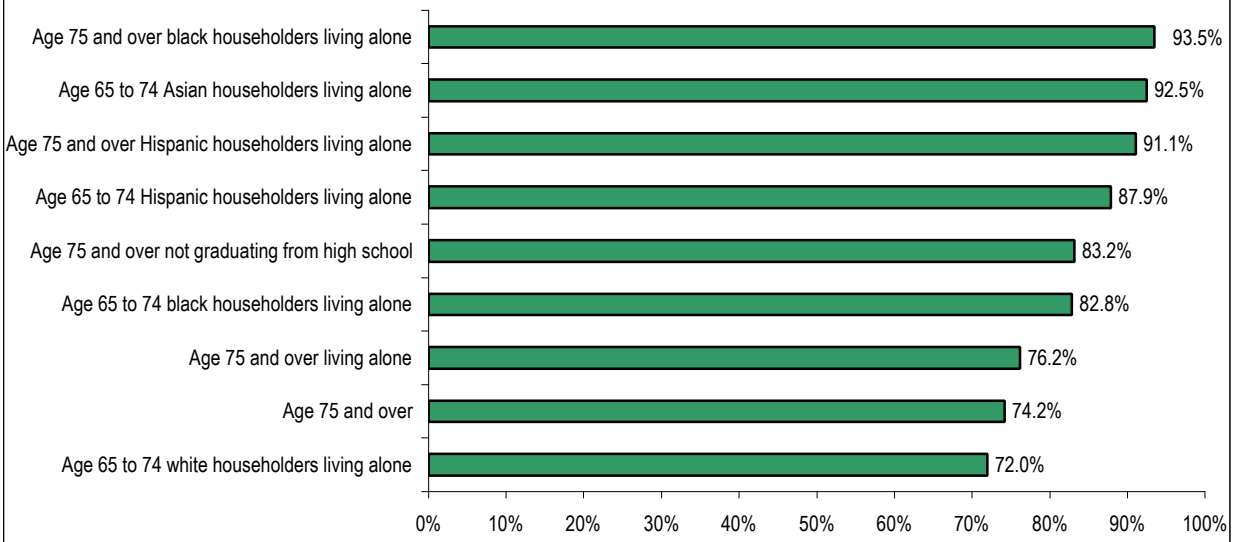


Figure 10 - Total Renters (253,000)

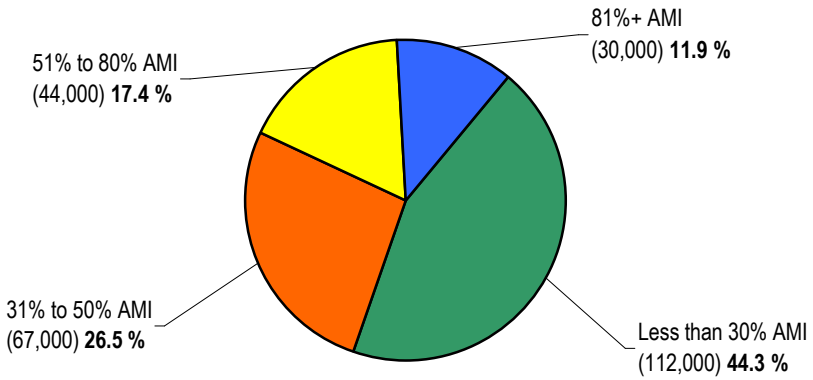
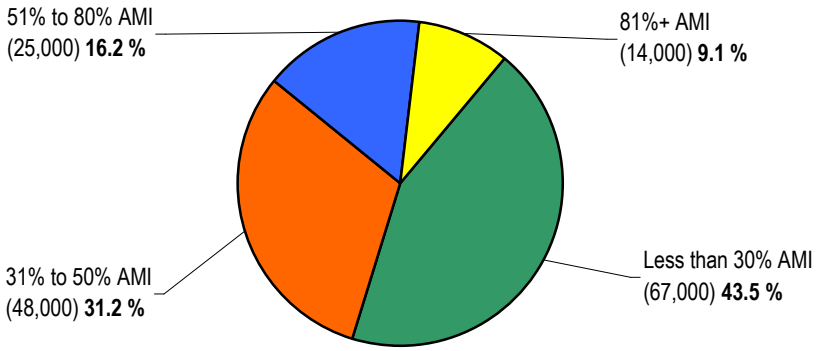


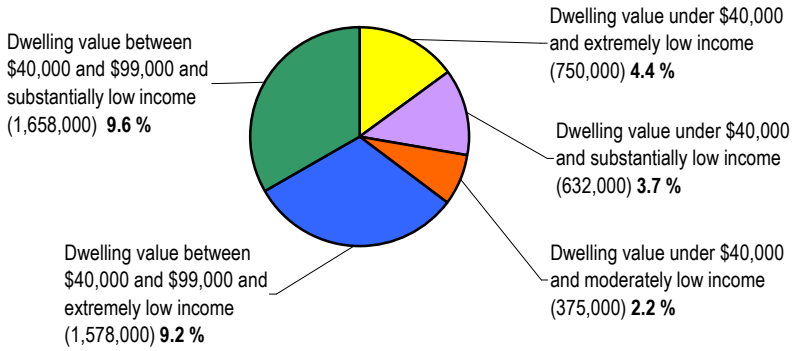
Figure 11 - Total Renters (154,000)



Even controlling for age, race and ethnic background, and living arrangements, higher percentages of older renters have very low income compared with older homeowners (Figures 8 & 9). This gap is even more pronounced because homeowners have the potential of drawing on their greatest asset, the equity in their homes. Of the total home equity wealth ($6.4 trillion) in the United States (in 1995), 31% (almost $2 trillion) was owned by older households, even as they represented but 22% of the country's owner-occupied households.[30] Most older homeowners own their homes free and clear (82%). The median equity value of older householders' dwellings (net of mortgage obligations) was $70,000.[31] Including their home's equity, age 65 and over households had a median net worth of just over $92,000, without it, $24,047. Median net worth, however, declines sharply with age: the median net worth of age 65 to 69 households is $106,408, but only $81,600 for age 75 and over households.

Even these breakdowns offer an incomplete portrayal of the varied economic circumstances of older homeowners. A significant share is both cash poor and house poor. They have low incomes (80% and under of area median) and they cannot rely on their low-valued house as a financial cushion. Depending on the specification of the low-income and house value thresholds, from 750,000 or over 4% of elderly homeowners to just under 5 million or just over 29% of elderly homeowners are both cash-poor and house-poor (Figure 12).[32]

Figure 12. Number and Percent of Age 65 and Over Homeowners Who are Both House-Poor and Cash-Poor



THE FUTURE

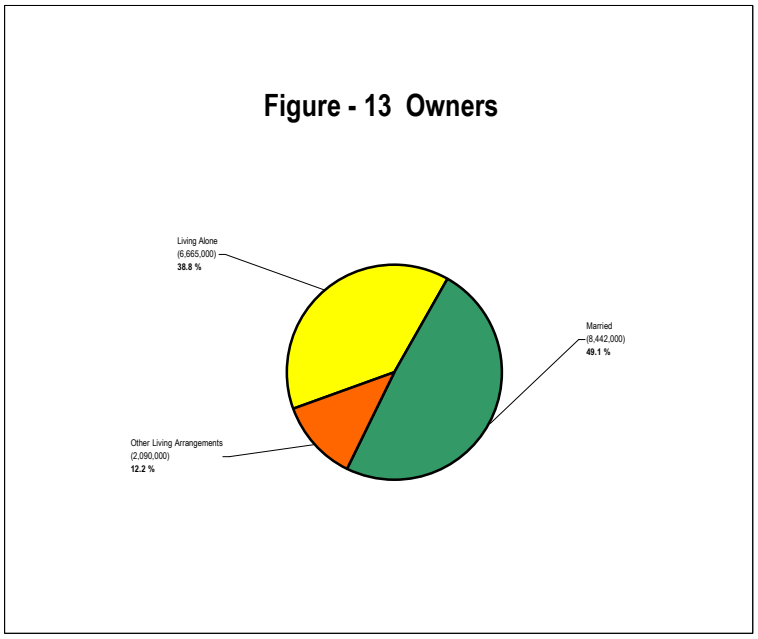
This report does not attempt to predict the future income distributions of older Americans. Its analyses will assume that future older households will have the household income distribution of the current elderly population. Recent events have cogently demonstrated the difficulty of predicting future income distributions. Between 1999 and 2000, for example, real median income (after adjusting for inflation) fell by 2.8% for older men and 3.6% for older women.[33] Furthermore, many older Americans have seen sharp erosion in their financial holdings, specifically in their interest-earning assets. In combination with lower interest rates, it is likely that the share of older persons with lower incomes has significantly increased. Thus, it is likely that the economic problems and related housing problems that many older households are now experiencing will be understated in this report's findings because they rely primarily on 1999 income statistics collected in a much healthier economy. The challenges of predicting an economy over 20 years from now is clearly articulated by Friedland and Summer, who point out that an uncertain future:[34]

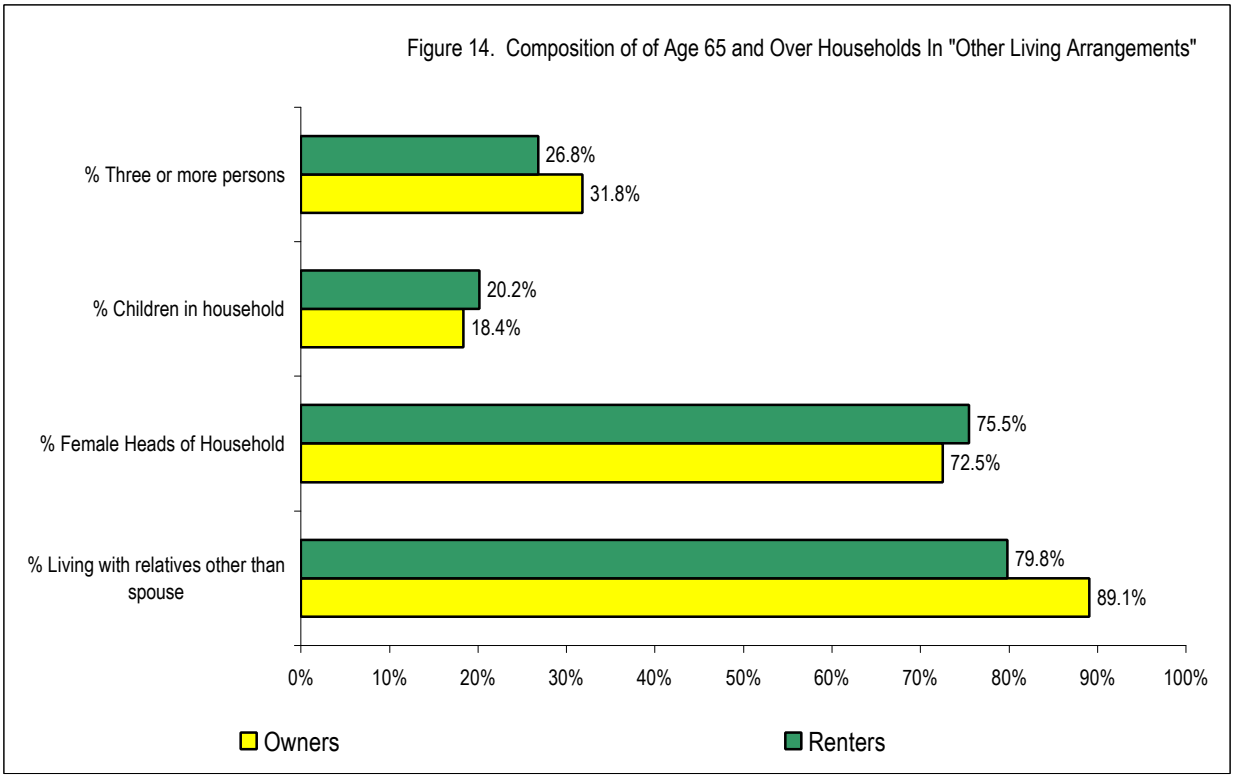
> *…depends on how much baby-boomers save between now and then when they leave the labor force; how old and healthy they are when they retire; the cost, scope, and depth of their health insurance coverage; and their life expectancy. The strength of the economy, the housing market, the private pension system, and the structure of government programs will also affect their financial well-being as elderly Americans.*

The Demographic Indicators Underlying Unmet Housing Needs of Older Households in Conventional Dwellings

Several demographic indicators are also likely to help predict those older households more likely to have housing problems: household living arrangements, racial or ethnic background, and the location of residence. The educational level of older Americans also is an important risk factor, but will not be systematically examined as an influence.

Older households are about evenly split between those who are married (43%) and those who live alone (45%) (Figure 13). The remaining group, "other living arrangements" (12%) consists mostly of female householders living with a relative other than a spouse, usually an adult child or sibling (Figure 14). Older renters are much more likely to live alone (70%) than are owners (39%) who are more likely to be married. Projections of the future distribution of these household arrangements are unavailable.





Almost 16% of older households identify themselves as African-Americans (9%), Hispanics (5%); or Asians (1%), the majority nonHispanic whites (Figure 15). A much higher percentage of older renters (27%) than owners (13%) are members of these minorities. The racial and ethnic composition of older Americans is projected to change substantially over the next two decades. Between 2000 and 2020, the black elderly population will grow at twice the rate of the white elderly population, while the Hispanic elderly population will grow at almost four times this white elderly population rate. Based on these growth projections, in 2020, the minority older population will represent about 23% of the overall older population, up from 16% in the year 2000 (Figures 16 & 17).

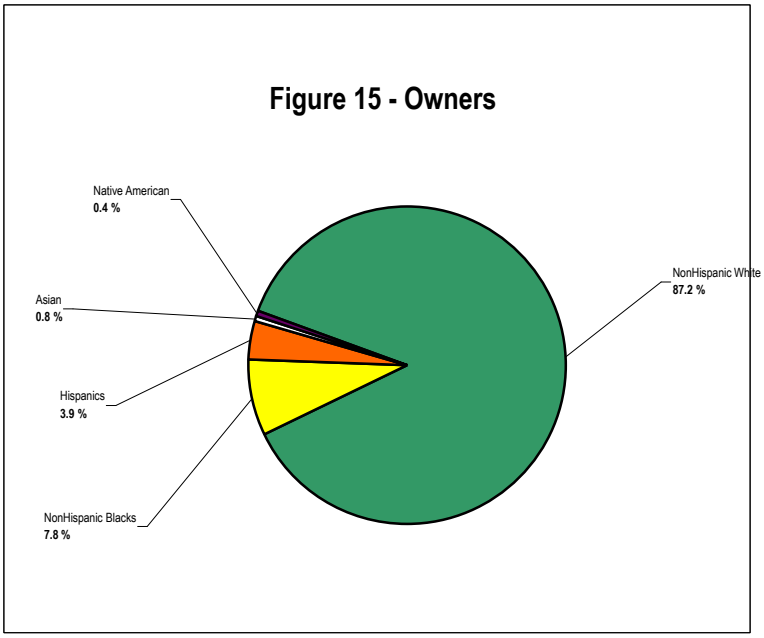


Figure 15 - Owners
Native American
0.4 %
Asian
0.8 %
Hispanics
3.9 %
NonHispanic Blacks
7.8 %
NonHispanic White
87.2 %

Figure 16

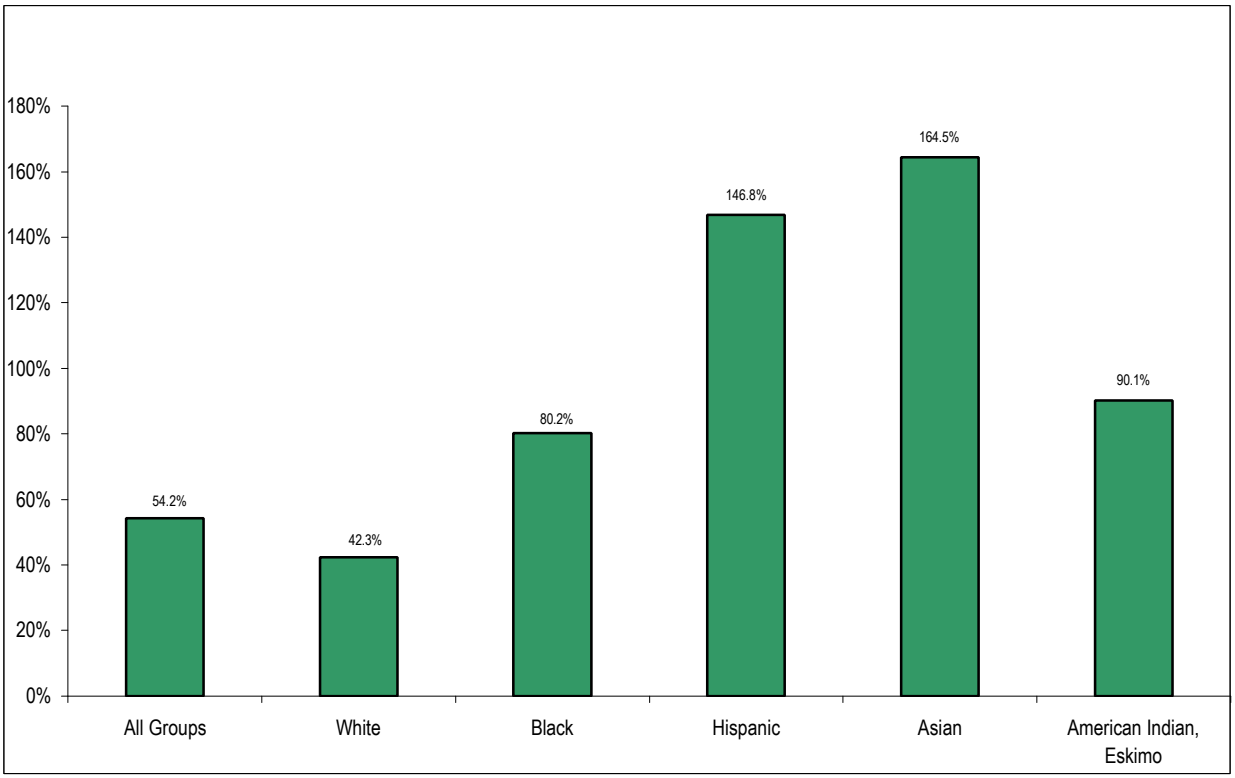
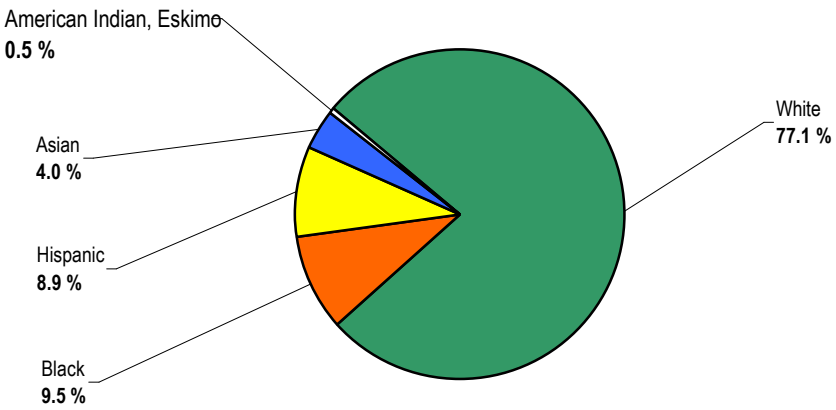

180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
54.2%
42.3%
80.2%
146.8%
164.5%
90.1%
All Groups
White
Black
Hispanic
Asian
American Indian, Eskimo

Figure 17 - Racial Distribution over Age 65 in 2020



Overall, about one-third of age 65 and over householders did not graduate from high school. Old-old and extremely low-income households, however, are especially likely to have low educational attainment (Table 4). Older renters are less educated than older homeowners, even after taking into account age and income differences that also characterize owners and renters. The future older population is predicted to be even better educated, continuing the trend of the past three decades.[35]

Table 4. Percent of Selected Groups of Owners and Renter Without High School Diploma, 1999

Household Groups	Percent Not Graduating From High School		
	Owners	Renters	Total Households
Higher income age 65 and over households	18.1	20.0	18.3
Extremely low-income age 65 to 74 households	38.6	56.0	44.7
Extremely low-income age 75 and over households	49.7	56.2	51.8
Extremely low-income age 75 and over households living alone	49.7	56.6	52.4
Extremely income age 75 and over households in "other households"	59.6	64.6	60.9
Extremely low-income age 65 and over households	45.1	56.1	48.8
Very low-income age 65 to 74 households	34.3	52.2	39.3
Very low-income age 75 and over households	45.6	51.6	47.3
Very low-income age 75 and over households living alone	43.5	50.7	46.0
Very low-income age 75 and over households in "other households"	58.2	63.1	59.3
Very low-income age 65 and over households	40.7	51.8	43.8

Extremely low income: 30% and under of Area Median Income (AMI).

Very low income: 50% and under of Area Median Income (AMI).

Higher income: 81% and over of Area Median Income (AMI).

Older households with lower incomes are more at risk of having other demographic attributes that further increase their chances of experiencing housing problems (Table 5). They are less likely to have high school diploma, are more likely to be overhoused, women in their 70s, and Hispanics or African-Americans.

Table 5. Demographic Profiles of Age 65 and Over Households, By Area Median Income Thresholds, and Tenure, 1999

Characteristics	Age 65 and Over Owners				Age 65 and Over Renters			
	Extremely Low Income	Very Low Income	Low Income	Higher Income	Extremely Low Income	Very Low Income	Low Income	Higher Income
% Under 100% poverty Level	70.0	36.6	24.5	0.0	65.2	42.8	35.3	0.0
% Under 150% poverty Level	96.9	65.9	44.8	0.0	96.5	73.2	60.5	0.0
% Income under $25,000	100.0	98.4	82.6	1.7	100.0	99.2	92.6	1.8
% Not a high school graduate	45.1	40.7	36.9	18.2	56.1	51.8	48.7	19.9
% Overhoused	29.3	28.2	25.3	16.5	5.7	5.9	6.1	5.3
% Moved in past 5 years	9.8	9.5	9.9	13.5	35.2	36.4	37.9	42.5
% Householder age 75 and over	58.3	56.4	52.7	35.8	55.7	57.0	56.2	45.6
% Living alone	56.6	53.9	46.9	23.1	76.4	74.7	72.5	53.2
% Female Householder, No husband	58.1	53.1	46.9	22.4	64.8	63.5	62.1	40.4
% Other households	12.1	10.8	11.8	12.8	10.4	10.3	10.5	17.1
% NonHispanic Black	12.7	10.2	9.2	5.0	20.7	18.0	16.2	7.3
% Hispanic	4.9	4.5	4.1	3.5	10.1	10.0	8.9	5.5
% Dwelling value under $40,000	19.7	18.2	15.5	6.7	n/a	n/a	n/a	n/a
% Dwelling built 1949 or earlier	34.9	34.1	32.4	21.2	30.9	30.3	29.2	23.0

n/a: Not applicable

Extremely low income: 30% and under of area median income (AMI).

Very low income: 50% and under of area median income (AMI).

Low income: 80% and under of area median income (AMI).

Higher income: 81%+ of area median income (AMI).

Older households are not equally found in urban and rural locations. About 45% of older households live in the suburbs of U.S. metropolitan areas; the other 55% are about evenly split between the central cities (of metropolitan areas) and nonmetropolitan (mainly rural) areas. The most suburbanized elderly households are found in the U.S. Northwest and West; the most rural elderly households are found in the South and Midwest. Renters are much more likely to live central cities; homeowners in the suburbs (Table 6).

Table 6. Urban and Rural Locations of Age 65 and Over Households in the United States, By Region, 1999

Urban and Regional Location	Owners		Renters		All Households	
	Number	Percent	Number	Percent	Number	Percent
Age 65 and Over Households						

UNITED STATES	**17,188,000**	**100.0**	**4,232,000**	**100.0**	**21,420,000**	**100.0**
Central cities	4,063,000	23.6	1,808,000	42.7	5,872,000	27.4
Suburbs	8,121,000	47.2	1,587,000	37.5	9,708,000	45.3
Nonmetropolitan areas	5,004,000	29.1	837,000	19.8	5,840,000	27.3
NORTHEAST	**3,343,000**	**100.0**	**1,322,000**	**100.0**	**4,664,000**	**100.0**
Central cities	741,000	22.2	644,000	48.7	1,386,000	29.7
Suburbs	2,044,000	61.1	527,000	39.9	2,570,000	55.1
Nonmetropolitan areas	558,000	16.7	151,000	11.4	708,000	15.2
MIDWEST	**4,237,000**	**100.0**	**925,000**	**100.0**	**5,156,000**	**100.0**
Central cities	952,000	22.5	318,000	34.4	1,268,000	24.6
Suburbs	1,713,000	40.4	319,000	34.5	2,032,000	39.4
Nonmetropolitan areas	1,572,000	37.1	288,000	31.1	1,856,000	36.0
SOUTH	**6,395,000**	**100.0**	**1,161,000**	**100.0**	**7,560,000**	**100.0**
Central cities	1,463,000	22.9	449,000	38.7	1,915,000	25.3
Suburbs	2,768,000	43.3	393,000	33.9	3,161,000	41.8
Nonmetropolitan areas	2,164,000	33.8	319,000	27.5	2,484,000	32.9
WEST	**3,213,000**	**100.0**	**824,000**	**100.0**	**4,040,000**	**100.0**
Central cities	907,000	28.2	397,000	48.2	1,303,000	32.3
Suburbs	1,596,000	49.7	348,000	42.2	1,945,000	48.1
Nonmetropolitan areas	710,000	22.1	79,000	09.6	792,000	19.6

The older householders found in central city, suburban, and rural locations present very different profiles (Table 7). Central cities are occupied by higher percentages of renters, low-income minority households, householders living alone, and households without a high school diploma. Nonmetropolitan areas are occupied by higher percentages of old-old households, households without a high school diploma, and homeowners. Suburbs are more likely to be occupied by higher percentages of white and married households, better educated households, and homeowners. The percentage of households with incomes below 50% of their area median is highest in central cities, but about equally high in central cities and the suburbs.

Table 7. Profile of Age 65 and Over Households in Central Cities, Suburbs, and Nonmetropolitan Areas, 1999

Characteristic	Central Cities	Suburbs	Nonmetropolitan Areas	United States
Age				
% Under 61	78.4	76.8	70.6	75.9
% 62-64	2.8	3.3	3.9	3.3
% 65-74	9.6	10.4	13.1	10.7
% 75+	9.3	9.5	12.4	10.1
Total	100.1	100.0	100.0	100.0
Race and Ethnic Background				
% NonHispanic White	70.3	88.9	90.9	84.4
% NonHispanic Black	19.2	4.8	6.5	9.2
% Hispanic	8.0	4.7	1.8	4.8

% Asian	2.0	1.2	0.1	1.1
% American Indian/Eskimo	0.6	0.4	0.8	0.6
Total	100.1	100.0	100.1	100.1
Household Type				
% Married Couples	35.7	46.2	45.2	43.1
% Living Alone	49.9	41.9	44.9	44.9
% Other Arrangements	14.4	11.9	9.9	12.0
Total	100.0	100.0	100.0	100.0
Level of Education				
% Did Not Graduate From High School	34.3	28.4	40.5	33.3
Income Level				
% Below 100% Poverty Level	21.8	16.0	21.2	19.0
% Below 150% Poverty Level	36.1	29.8	39.0	34.0
% 50% or less than Area Median Income	53.4	48.9	46.5	49.5
Annual Income Under $25,000	60.2	55.7	67.1	60.0
Housing Tenure				
% Homeowners	69.2	83.6	85.7	80.2
Residential Moves				
% Moved in Past 4 years	15.5	17.2	16.4	16.5

Older Households Occupying Unaffordable or Poor Quality Conventional Housing

MEASURES

Two major indicators are relied on to measure the presence of unaffordable or poor quality housing. They are similar in construction to the indicators used by the Department of Housing and Urban Development to assess the worst case housing needs of U.S. households.[36] They are defined as follows:[37]

PRIORITY PROBLEMS: Refers to households with a serious housing cost burden[38] who pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.

LESS SERIOUS PROBLEMS:[39] Refers to households with a moderate housing cost burden who pay 30% to 49% of their monthly incomes on their housing costs or that occupy dwellings with moderate physical problems.[40]

The presence of "severe" and "moderate" physical problems measures the extent to which dwellings have deficiencies in any of the following five categories: plumbing, heating, electric, hallways, and upkeep (see Attachment III for a full description).

The preponderance (just under 94%) of very low-income owners or renters attributed with having priority problems are in this category primarily because they have a *severe* housing cost burden. That is, they spend 50% or more of their income on their housing costs (Figure 18). Another 8% of this group occupies dwellings with *severe* physical problems.[41] These percentages will not add to 100% because a household in the severe housing cost burden category could conceivable also be living in a dwelling with severe physical problems. A small percentage of households (2%) also have *moderate* housing cost burdens (30% to 49% of their income on housing costs) and occupy dwellings with *moderate* physical problems (4.5%). Thus, even though the "priority" problem category primarily consists of households with *severe* cost burdens and *severe* physical problems, some households in these categories will also be afflicted with the less minor problems.[42] The preponderance of the households attributed with having "less serious" problems (about 90%) are in this category because they have a *moderate* housing cost burden, that is, they pay 30% to 49% of their monthly incomes on their housing costs (Figure 19). Just under 15% of this group occupies dwellings with *moderate* physical problems.[43,44]

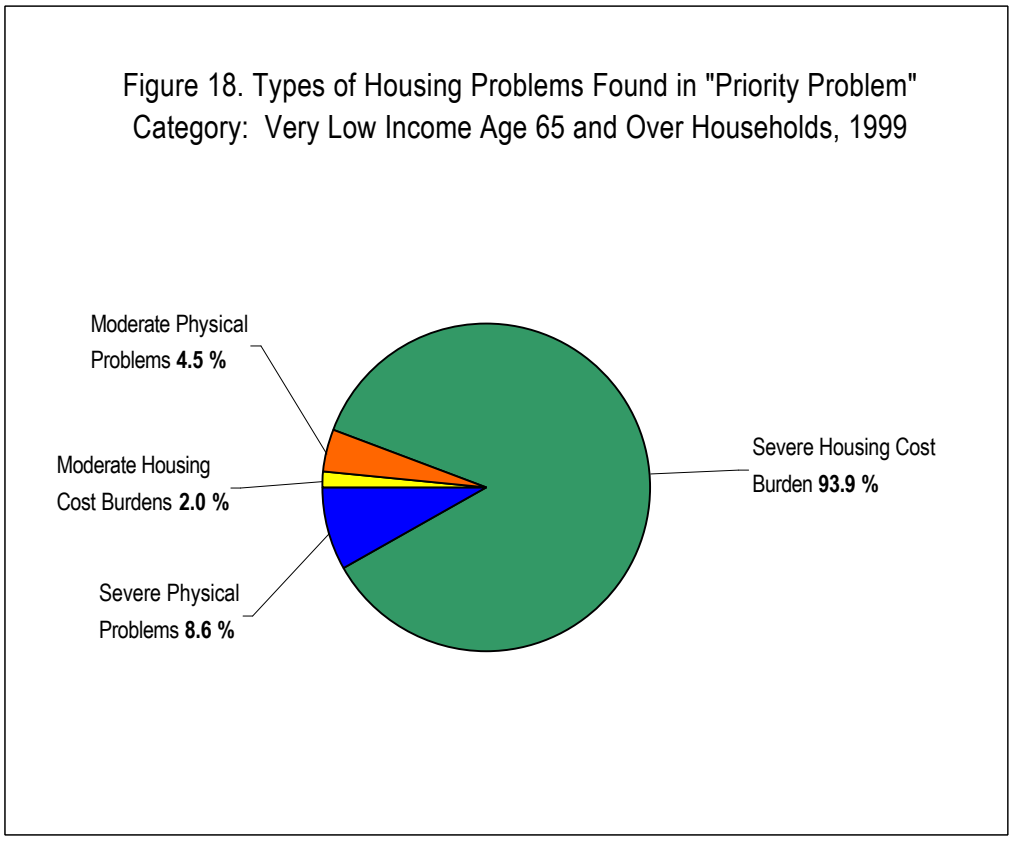
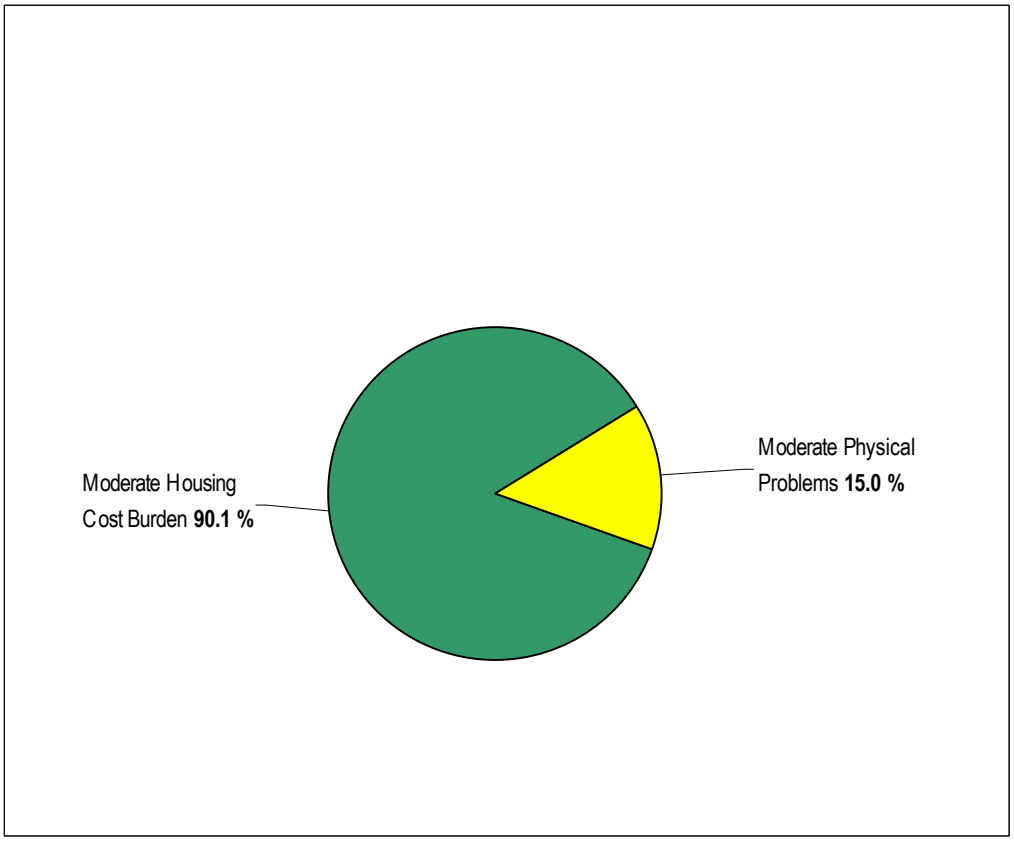


Figure 19. Types of Housing Problems Found in "Less Serious" Problem" Category: Very Low-income Age 65 and Over Households, 1999



FINDINGS

Any assessment of the number and the prevalence of older households with housing problems depends on answers to the following six interconnected questions:

1. Is the focus to be on both priority and less serious problems, or only on priority problems?
2. Is the focus to be on the housing problems of all low-income (80% and under area median income) households or only on very selective and more narrowly defined categories of low-income households?
3. Is the focus to encompass the housing problems of higher income households (80% and higher area median income limits)?
4. Is the focus to encompass the housing problems of both homeowners and renters?[45]
5. Is the focus to encompass the housing problems of older persons living in the dwellings of younger (under age 65) households?
6. Is the focus to be on specific and especially vulnerable subgroups of low-income older households (such as older persons living alone or on African-American households)?

In the process of considering these questions, certain generalizations are readily apparent:

- Housing problem prevalence rates and the number of problem households will be higher when both priority and less serious problems are measured.

- Housing problem prevalence rates will be higher, but the number of problem households will be lower when the focus is on more narrowly defined groups of very poor households.
- Both housing problem prevalence rates and the number of problem households will be lower when the focus includes higher income older households.
- The number of problem households will be much higher when the focus includes both homeowners and renters.
- The number of problem households will be much higher when the focus includes older persons living in younger households.
- Housing problem prevalence rates will be higher, but the number of problem households will be lower, when the focus is on the more vulnerable low-income demographic groups.

Housing Problem Prevalence Rates

Older households will differ considerably as to their likelihood of having priority or less serious housing problems depending on their income level and demographic attributes. Some of the key findings (Figures 20 and 21):

- The priority problem prevalence rates are typically much higher for renters than owners and range from just under 44% for very low-income older renters to just over 2% for higher income older homeowners.

- The combined priority and less serious prevalence rates range from just over 72% for very low-income older renters to 9% for higher income older homeowners.

The prevalence of priority problems is similar for very low-income older persons living in different types of households (Figures 22 and 23). This is a somewhat unexpected finding, because older persons living alone are usually shown to have more dwelling problems than married couples. This is also true here, if older persons living alone and married are compared without considering their income differences. This analysis, however, controls for income, that is, it focuses only on alone and married older households, both groups of which have low incomes. This helps explain why extremely low-income married couples are *more* likely than older persons living alone to have priority problems (owners—46% vs. 41%; renters—61% vs. 53%).

and good quality as inseparable domains.
2 This decision was driven by the availability of household projections for this household group and the importance of being able to compare the findings of this report with most other scientific and public policy analyses.
3U.S. Census Bureau. Current Housing Reports, Series H150/99, American Housing Survey for the United States: 1999. Washington, DC: U.S. Government Printing Office.
4 The Survey of Income and Program Participation (SIPP). The data were based on the SIPP 1996 panel, topical module 3, 5 and core 5. Information about household composition was taken from a topical module of Wave 3. Disability information was taken from a topical module of Wave 5. All other information (i.e., on personal characteristics) was taken from the Core module of Wave 5.
5 Joint Center for Housing Studies of Harvard University. 2001. The State of the Nation's Housing, 2001. Cambridge, MA: The Joint Center for Housing Studies of Harvard University; Masnick, George S. and Zhu X. Di. 2000. Updating and Extending the Joint Center Household Projections Using New Census Bureau Population Projections. Cambridge, MA: Harvard, Joint Center for Housing Studies.
6 U.S. Census Bureau, Population Projections Program. 2000. (NP-D1-A) Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin, 1999 to 2100. Washington, DC: U.S. Census Bureau, Department of Commerce.
7 When speaking of current or today's housing arrangements, the report usually is focusing on conditions in 1999.
8 The accommodations in congregate or assisted living facilities, and most certainly in nursing homes are typically not considered dwelling units. To compute the overall "housing type" distribution of older households, however, even the beds in nursing homes are treated as one-person households.
9 Joint Center for Housing Studies of Harvard University. 2001. The State of the Nation's Housing, 2001. Cambridge, MA: The Joint Center for Housing Studies of Harvard University; Masnick, George S. and Zhu X. Di. 2000. Updating and Extending the Joint Center Household Projections Using New Census Bureau Population Projections. Cambridge, MA: Harvard, Joint Center for Housing Studies.
10 George, Lance and Christopher Holden. Why Housing Matters: HAC's 2000 Report on the State of the Nation's Rural Housing. Washington, DC: Housing Assistance Council; Joint Center for Housing Studies of Harvard University. 2001. The State of the Nation's Housing, 2001. Cambridge, MA: The Joint Center for Housing Studies of Harvard University; and U.S. Department of Housing and Urban Development. 1999. Waiting in Vain: An Update on America's Rental Housing Crisis. Washington, DC: U.S. Department of Housing and Urban Development.
11 These estimates are based on the most recent decennial census and then are adjusted each year by HUD.
12 HUD income limits measures are from Department of Housing and Urban Development Office of Policy Development and Research, FY 1999 HUD Income Limits Briefing Material.
13 The Quality and Housing Work Responsibility Act replaced the previous system of Federal preferences for rent-assisted housing occupancy with minimum Federal thresholds for targeting. The law established that at least 40% of all public housing and project-based Section units that become available for rent in any given year and at least 75% of new vouchers must be provided to families with income at or below the 30% AMI income limit standard.
14 The "80% percent of median" limits for each area cannot exceed the 1999 national median of $47,800, unless justified by unusually high housing costs in the local area.
15 The main exceptions are the Section 235 and Section 221(d)(3) programs.
16 The 150% poverty threshold level corresponds to the eligibility cutoff for the U.S. Department of Agriculture Food Stamp program.
17The poverty thresholds are updated every year to reflect changes in the Consumer Price Index. The poverty status indicator distinguishing the incomes of physically limited older persons is based on respondent self-reported household incomes from the SIPP database. This report, at various times, also refers to the poverty levels of households in owned and rented dwellings. These data are drawn from U.S. Census

Bureau. Current Housing Reports, Series H150/99, American Housing Survey for the United States: 1999. Washington, DC: U.S. Government Printing Office.

18 Dalaker, Joseph. 2001. U.S. Census Bureau, Current Population Reports, Series P60-214, Poverty in the United States: 2000. Washington, DC: U.S. Government Printing Office; U.S. Census Bureau. 2000. Current Population Reports, Series P60-209, Money Income in the United States, 1999 . Washington, DC: U.S. Government Printing Office; Friedland, Robert B. and Laura summer. 1999. Demography Is Not Destiny. Washington, DC: National Academy on an Aging Society, Gerontological Society of America; Joint Center for Housing Studies of Harvard University. 2000. Housing America's Seniors. Cambridge, MA: The Joint Center for Housing Studies of Harvard University.

19 Porter, Kathryn, Wendell E. Primus, Lynette Rawlings, and Esther Rosenbaum. Strengths of the Safety Net. Washington, DC: Center on Budget and Policy Priorities. It constitutes an average of 38% of the income of all older people's sources of income.

20 Dalaker, Joseph. 2001. U.S. Census Bureau, Current Population Reports, Series P60-214, Poverty in the United States: 2000. Washington, DC: U.S. Government Printing Office; U.S. Census Bureau. 2000. Current Population Reports, Series P60-209, Money Income in the United States, 1999. Washington, DC: U.S. Government Printing Office; Friedland, Robert B. and Laura summer. 1999 Demography Is Not Destiny. Washington, DC: National Academy on an Aging Society, Gerontological Society of America.

21 Rank, Mark R. and Thomas A. Hirschl. 1999. "Estimating the Proportion of Americans Ever Experiencing Poverty During the Elderly Years." Journal of Gerontology: Social Sciences 54B(4):S184-S193

22 Rank, Mark R. and Thomas A. Hirschl. 1999. "Estimating the Proportion of Americans Ever Experiencing Poverty During the Elderly Years." Journal of Gerontology: Social Sciences 54B(4):S184-S193.

23 Rubin, Rose M., Shelley I. White-Means, and Luojia M. Daniel. 2000. "Income Distribution of Older Americans." Monthly Labor Review (November):19-30. This can be illustrated by considering one older married household and one older single-person household. The two married persons have an income putting them above the poverty level threshold; the single-person has an income below the poverty threshold. Using "individual" units, the poverty rate of this older group is 33%; using household units, the poverty rate of this older group is 50%.

24 Rubin, Rose M., Shelley I. White-Means, and Luojia M. Daniel. 2000. "Income Distribution of Older Americans." Monthly Labor Review (November):19-30.

25 U.S. Census Bureau. 2000. Current Population Reports, Series P60-209, Money Income in the United States, 1999 . Washington, DC: U.S. Government Printing Office.

26 Rubin, Rose M., Shelley I. White-Means, and Luojia M. Daniel. 2000. "Income Distribution of Older Americans." Monthly Labor Review (November), p. 23.

27 Income figures represent the amount of income before any deductions such as taxes, Social Security, and insurance. It also excludes inheritances, tax refunds, accrued interest on uncashed savings bonds, and "in kind" income such as food stamps.

28 These numbers will differ somewhat from those reported in HUD's "worst case" housing needs reports. HUD assigns many of the households reporting zero or negative income to a middle-income category. In the analyses for this report, these households are categorized as having "extremely low" incomes (30% and under area median) .

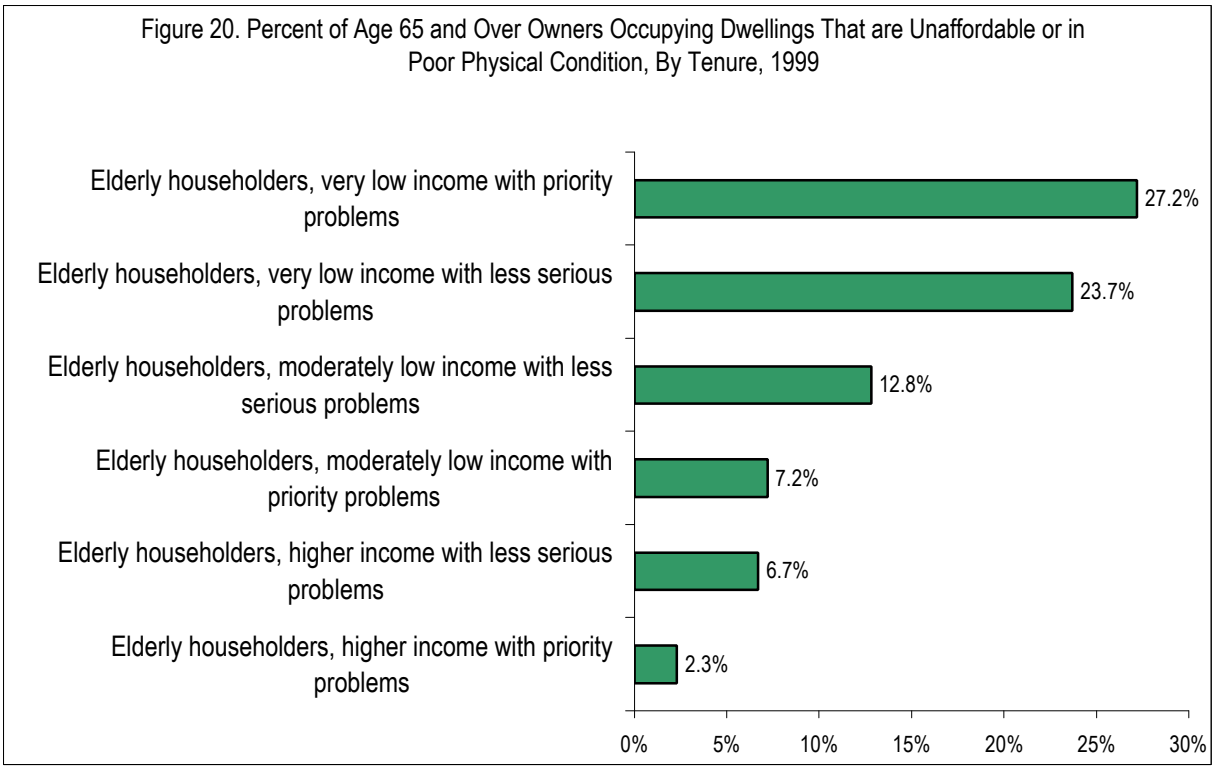
29 This definition differs from its original formulation by Lane, T. S. and J. D. Fines. 1985. "Are the Elderly Overhoused? Definitions of Space Utilization and Policy Implications." The Gerontologist 25:243-50.

30 Davern, Michael E. and Patricia J. Fisher. 2001. U.S. Census Bureau, Current Population Reports, Household Economic Studies, Series P70-71, Household Net Worth and Asset Ownership, 1995. Washington, DC: U.S. Government Printing Office.

31 The average equity value was a higher $92,729 reflecting the skewed influence of a small share of very expensive houses.

32 More sophisticated analyses would undoubtedly fine-tune these numbers. On the one-hand, more households would be included in this economically vulnerable group who have unpaid mortgages (thus lower

home equities than home values); on the other hand, fewer households would be included in this vulnerable group who have substantial financial assets other than their owned home.
33 U.S. Department of Health and Human Services, Administration on Aging. 2001. A Profile of Older Americans: 2001. Washington, DC: U.S. Department of Health and Human Services, Administration on Aging.
34 Friedland, Robert B. and Laura Summer. 1999. Demography Is Not Destiny. Washington, DC: National Academy on an Aging Society, Gerontological Society of America, p. 35.
35 Friedland, Robert B. and Laura Summer. 1999. Demography Is Not Destiny. Washington, DC: National Academy on an Aging Society, Gerontological Society of America.
36 The major difference is that the problem categories may be associated with households at various income levels and not limited to "very low income" (50% AMI limit) households. This report's focus is also broader and assesses the unmet housing needs of older homeowners. Unlike HUD analyses, housing problems are summarized for both unassisted and assisted rental housing.
37 U.S. Department of Housing and Urban Development. 2000. Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs. Washington: U.S. Department of Housing and Urban Development.
38 Housing costs for renters include contract rent, utilities, property insurance, and mobile home park fees. Housing costs for owners include payments for mortgages or installment loans or contracts, real estate taxes, property insurance, homeowner association fees, cooperative or condominium fees, and utilities. Dwelling costs, however, do not measure costs for maintenance and repairs.
39 HUD reports refer to this category as "other problems".
40 Households with negative or zero income are not considered as housing cost burdened. Housing costs are compared with the household's previous year's income. Households that reported their monthly costs as 100% or more of their past year's income were included in the "serious cost burden" category.
41 A very small percentage of households (0.1%) occupy overcrowded units (l.01 or more persons per room).
42 The distribution of affordability and physical condition problems is similar for all income groups. A higher share of extremely low-income" older households, however, have a severe cost burden.
43 A very small percentage of households (0.2%) occupy overcrowded units (l.01 or more persons per room).
44 These percentages will not add up, because some of the households with moderate cost burdens also have moderate physical problems—that is, they are in both categories.
45 Most U.S. analyses of worst-case housing needs focus only on renters.



Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.

Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

Very low income: 50% and under of area median income (AMI)

Moderately low income: 51% to 80% of area median income (AMI)

Higher income: 81%+ of area median income (AMI)

Figure 21. Percent of Age 65 and Over Renters Occupying Dwellings That are Unaffordable or in Poor Physical Condition, By Tenure, 1999

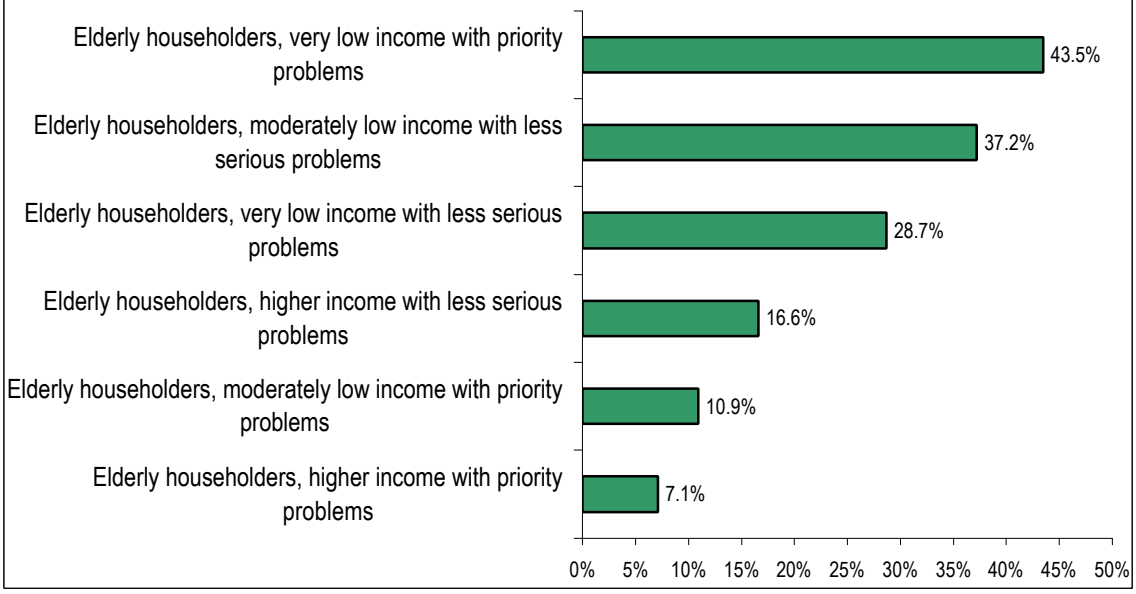


Figure 22. Percent of Very Low Income Types of Households Age 65 and Over Households Occupying Dwellings with Priority Problems, By Tenure, 1999

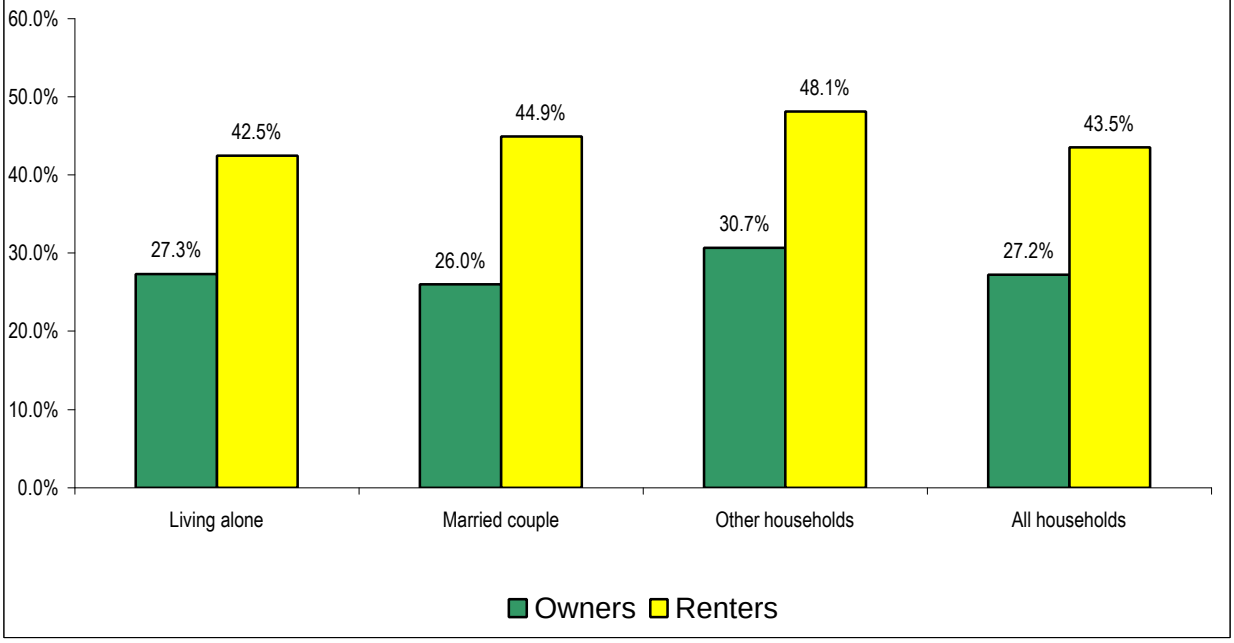
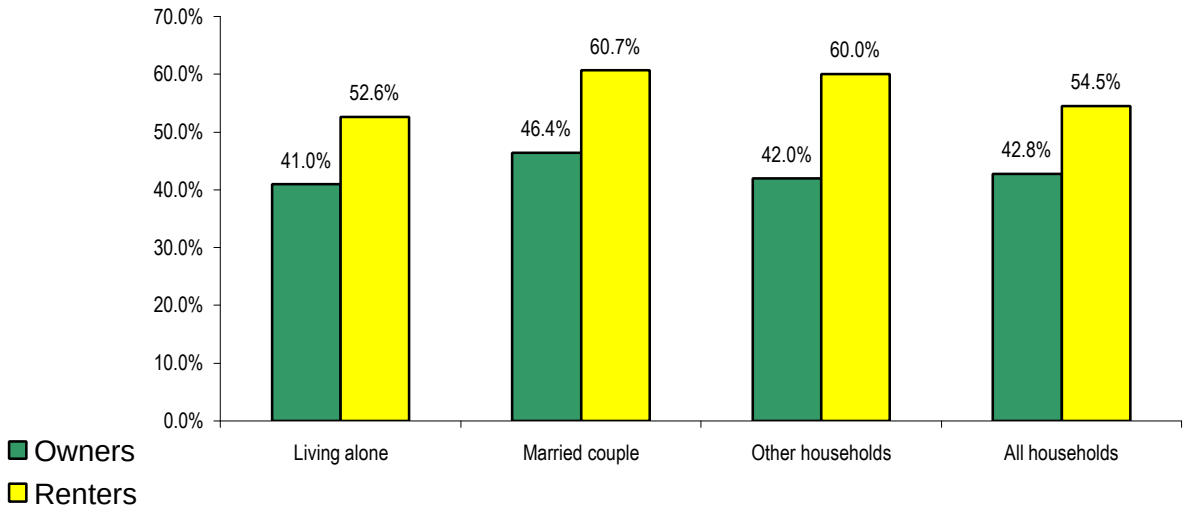


Figure 23. Percent of Extremely Low Income Types of Households Age 65 and Over Households Occupying Dwellings with Priority Problems, By Tenure, 1999



- The varying prevalence of priority problems among very low-income older households differentiated by race or ethnic background again offers some surprises (Figures 24 and 25). Very low-income older Hispanics are the most likely to live in dwellings with priority problems, but problem prevalence differences between very low-income black and white elderly households are small. Once again, this finding is accounted for by the focus on white and black elderly with similarly low incomes. Without controlling for income, black elderly households are more likely to live in dwellings with priority or less serious problems than white elderly households.

Figure 24. Percent of Very Low Income Racial and Ethnic Households Age 65 and Over Households Occupying Dwellings with Priority Problems, By Tenure, 1999

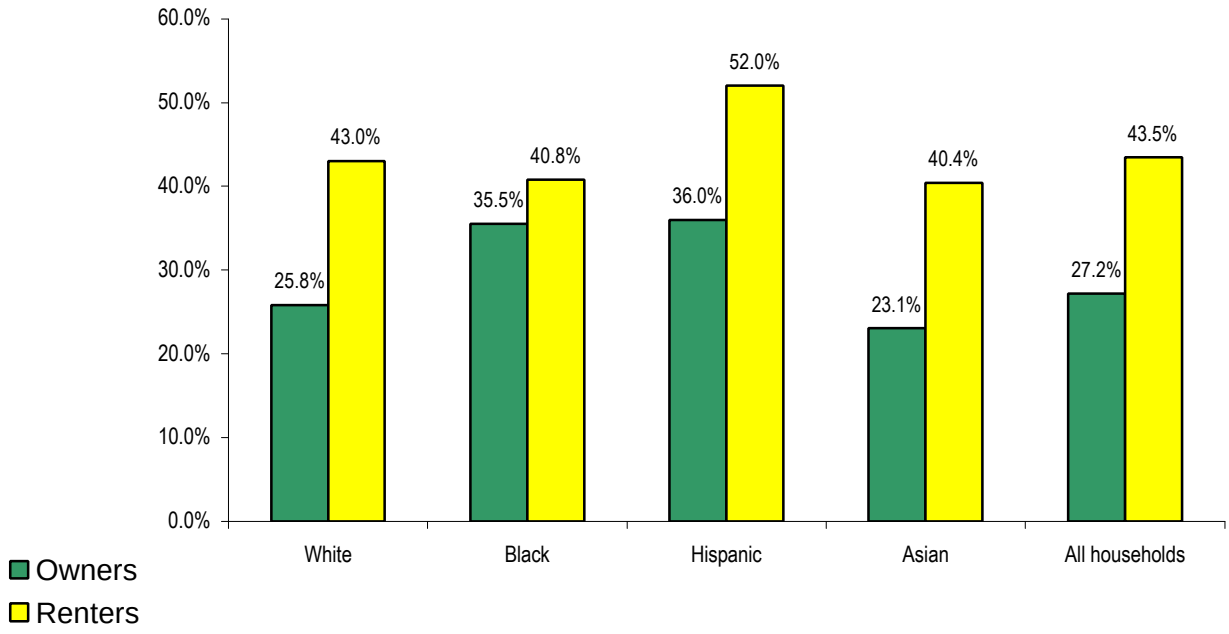
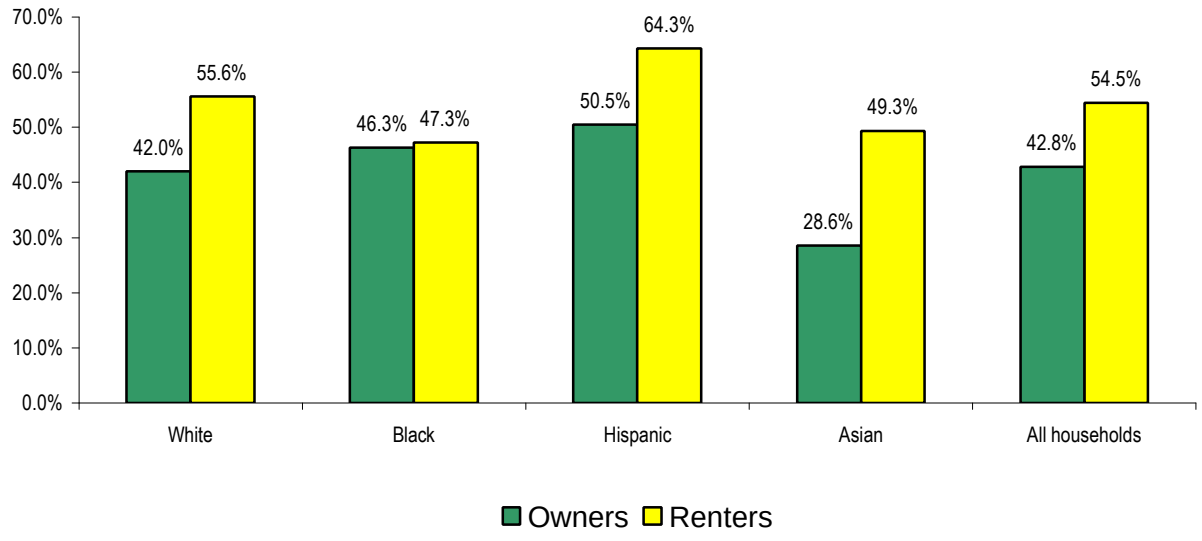
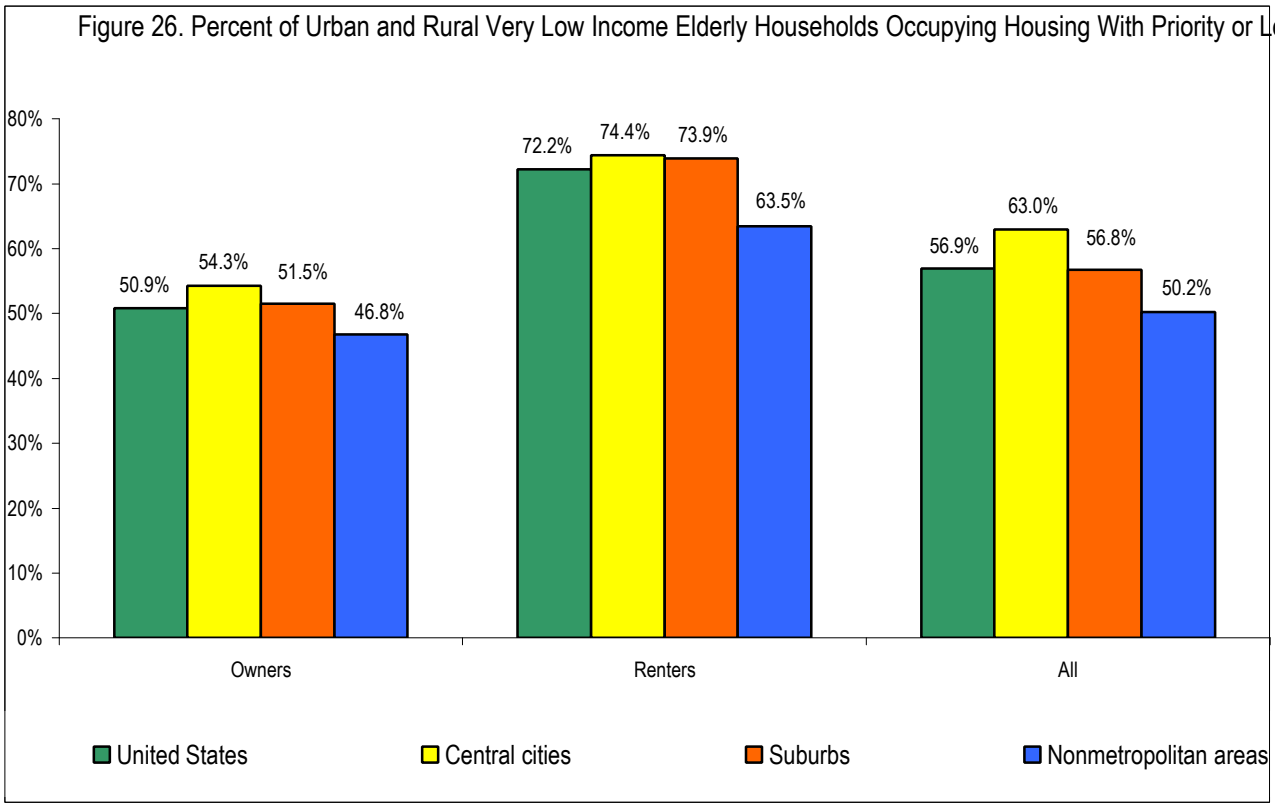


Figure 25. Percent of Extremely Low Income Racial and Ethnic Households Age 65 and Over Households Occupying Dwellings with Priority Problems, By Tenure, 1999



- The priority or less serious problems of very low-income older households who lived in central city, suburban, and nonmetropolitan locations also did not differ as expected.[1] Predictably, the problems were more likely to occur in central cities; however, the differences in the prevalence rates in the three locations were not large. Furthermore, very low-income suburban elderly households (both owners and renters) were actually more likely to have priority or less serious problems than very low-income nonmetropolitan elderly households (Figure 26). As emphasized, the priority problem indicator primarily reflects affordability problems and once controlling for the area median income level of households (that is, focusing only very low-income households), the usual "problem" differences observed between urban and rural America disappear. This is explained partly by the generally lower housing costs found in nonmetropolitan areas. A later analysis focusing only on the prevalence of severe or moderate physical problems will yield different findings.



- Very low-income owners with priority or less serious dwelling problems present a starkly different profile from higher income owners (with incomes 81% or more of their area median) without dwelling problems. The householders in the former group are more likely to be overhoused, are less likely to have moved in the past 5 years, are less likely to have graduated from high school, are more likely to own a dwelling valued under $40,000, are more likely to live in a house built 1949 or

earlier, are more likely to be old-old, are more likely to live alone, and are more likely to be African-American or Hispanic.

- Very low-income renters with priority or less serious dwelling problems present a starkly different profile from higher income renters (with incomes 80% or more of their area median) without dwelling problems. The householders in the former group are less likely to have graduated from high school, are more likely to live in an apartment structure built 1949 or earlier, are more likely to be old-old, are more likely to live alone, and are more likely to be African-American or Hispanic.

Number of Older Households with Housing Problems

The number of older households experiencing either priority or less serious housing problems varies greatly depending on the specification of income level limits. The key findings (Figures 27 to 29, Tables 8 and 9):

Figure 27. Number and Distribution of All Low Income Age 65 and Over Householders Living In Unaffordable Dwellings with Poor Physical Conditions, 1999

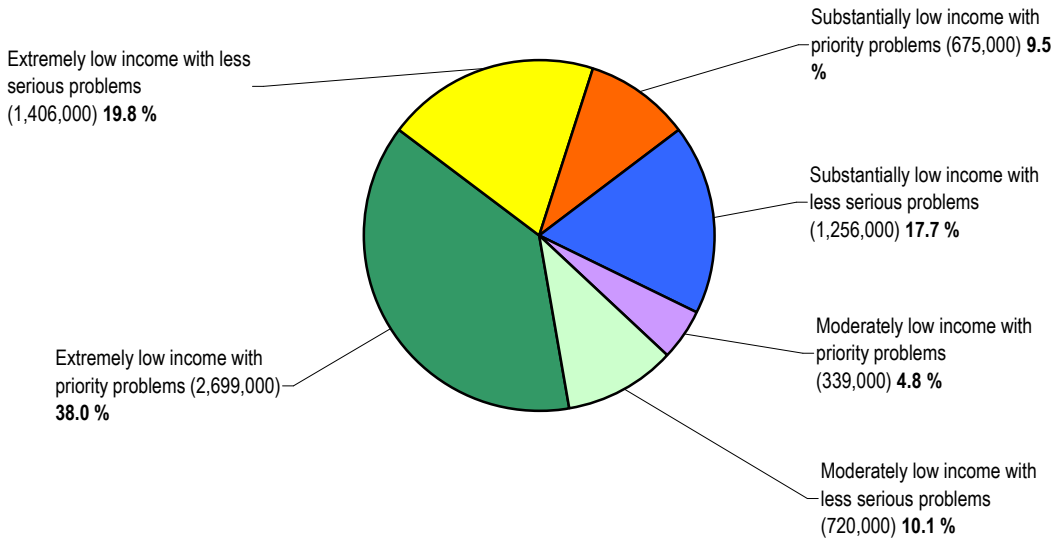


Figure 28. Number and Distribution of Low Income Age 65 and Over Homeowners Living In Unaffordable Dwellings with Poor Physical Conditions, 1999

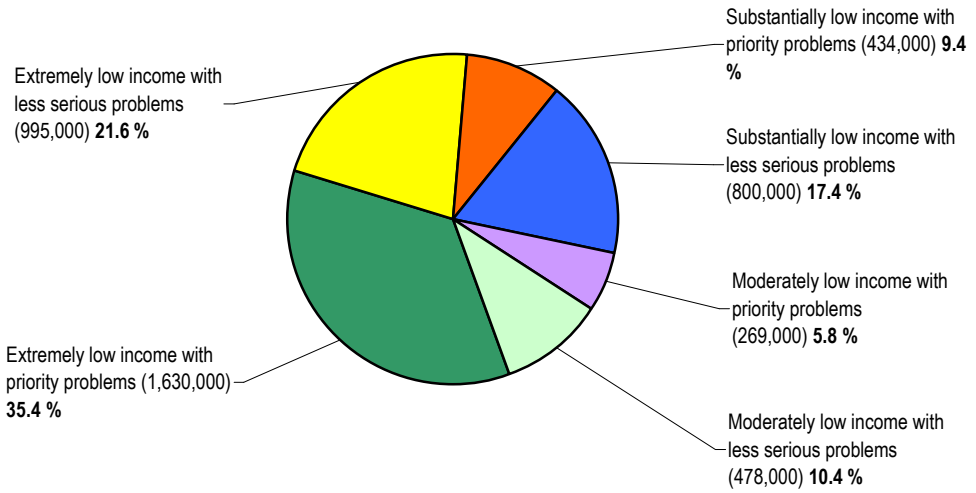


Figure 29. Number and Distribution of Low Income Age 65 and Over Renters Living In Unaffordable Dwellings with Poor Physical Conditions, 1999

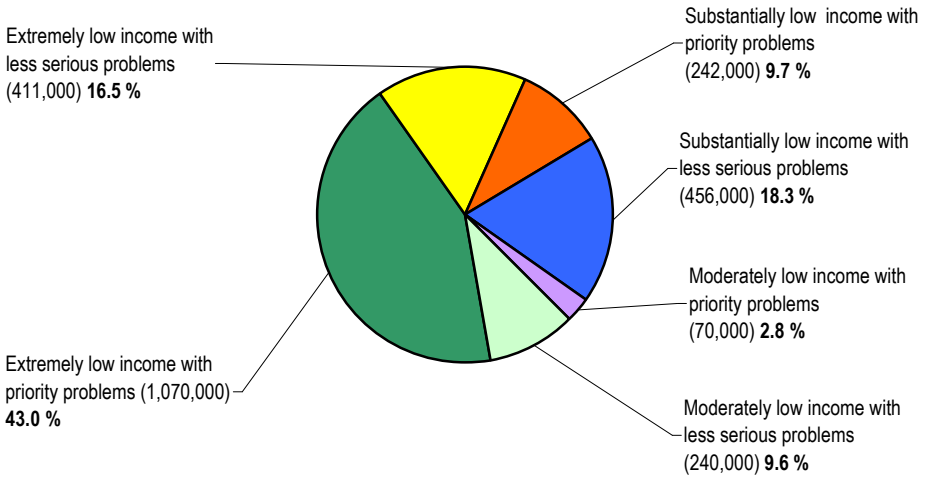


Table 8. Current and Projected Number of Low and Higher Income Age 65 and Over Households in Unaffordable or Poor Quality Dwellings, By Housing Tenure, 1999 to 2020

Income Group	1999			2010			2020		
	Total	Owners	Renters	Total	Owners	Renters	Total	Owners	Renters
All Income Levels									
With priority problems	3,890,000	2,468,000	1,422,000	4,630,636	3,046,823	1,583,813	6,099,070	4,205,761	1,893,309
With less serious problems	3,868,000	2,667,000	1,201,000	4,627,811	3,291,260	1,336,551	6,140,905	4,543,177	1,597,729
With all problems	7,758,000	5,135,000	2,623,000	9,258,447	6,338,084	2,920,363	12,239,976	8,748,938	3,491,038
Extremely Low Income									
Under 30% AMI with priority problems	2,699,000	1,630,000	1,070,000	3,204,044	2,012,286	1,191,758	4,202,353	2,777,711	1,424,642
Under 30% AMI with less serious problems	1,406,000	995,000	411,000	1,686,127	1,228,359	457,769	2,242,819	1,695,597	547,222
Under 30% AMI with all problems	4,105,000	2,625,000	1,481,000	4,890,171	3,240,645	1,649,526	6,445,171	4,473,308	1,971,864
Very Low Income									
Under 50% AMI with priority problems	3,375,000	2,064,000	1,311,000	4,008,254	2,548,073	1,460,182	5,262,817	3,517,298	1,745,519
Under 50% AMI with less serious problems	2,662,000	1,795,000	867,000	3,181,642	2,215,984	965,658	4,213,250	3,058,890	1,154,359
Under 50% AMI with all problems	6,037,000	3,859,000	2,178,000	7,189,896	4,764,056	2,425,840	9,476,066	6,576,188	2,899,878
Low Income									
Under 80% AMI with priority problems	3,713,000	2,331,000	1,382,000	4,416,953	2,877,692	1,539,261	5,812,348	3,972,297	1,840,051
Under 80% AMI with less serious problems	3,382,000	2,274,000	1,107,000	4,040,292	2,807,324	1,232,968	5,349,067	3,875,163	1,473,905
Under 80% AMI with all problems	7,095,000	4,605,000	2,489,000	8,457,246	5,685,017	2,772,229	11,161,416	7,847,460	3,313,956
Higher Income									
81% and over AMI with priority problems	177,000	137,000	40,000	213,682	169,131	44,552	286,722	233,464	53,258
81% and over AMI with less serious problems	486,000	392,000	93,000	587,519	483,936	103,583	791,838	668,014	123,824
81% and over AMI with all problems	663,000	529,000	133,000	801,201	653,067	148,134	1,078,560	901,478	177,082

Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.
Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

Table 9. Current Number of Low and Higher Income Age 62 to 64 Householders in Unaffordable or Poor Quality Dwellings, By Housing Tenure, 1999

Income Group	1999		
	Total	Owners	Renters
All Income Levels			
With priority problems	566,000	414,000	152,000
With less serious problems	568,000	418,000	149,000
With all problems	1,133,000	832,000	301,000

Extremely Low Income			
Under 30% AMI with priority problems	375,000	258,000	117,000
Under 30% AMI with less serious problems	123,000	90,000	33,000
Under 30% AMI with all problems	498,000	348,000	150,000
Very Low Income			
Under 50% AMI with priority problems	453,000	314,000	139,000
Under 50% AMI with less serious problems	314,000	209,000	105,000
Under 50% AMI with all problems	767,000	523,000	244,000
Low Income			
Under 80% AMI with priority problems	498,000	357,000	141,000
Under 80% AMI with less serious problems	432,000	293,000	139,000
Under 80% AMI with all problems	930,000	650,000	280,000
Higher Income			
81% and over AMI with priority problems	68,000	57,000	11,000
81% and over AMI with less serious problems	135,000	125,000	10,000
81% and over AMI with all problems	203,000	182,000	21,000

Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.

Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

- The number of older (age 62 and over) households living in dwellings that are unaffordable or in poor physical condition is extraordinarily high. This generalization holds true for each of the housing problem indicators, all definitions of poorness, and whether the focus is on renters or owners,

- The largest share of age 65 and over households with priority or less serious problems have extremely low incomes (30% and under of area median). This includes over 4.1 million households (1.5 million of whom are renters) or close to 58% of low-income (80% and under AMI) households. Almost 2.7 million of these households have priority problems; just over 1.4 million of these households have less serious problems.

- Almost 500,000 age 62 to 64 households (150,000 of whom are renters) with extremely low incomes have priority or less serious problems.

- If the definition of poorness is broadened to include very low-income (50% and under of area median income) age 65 and over households, the number of households with priority or less serious problems increases by almost 50%. This includes over 6 million age 65 and over households (almost 2.2 million of whom are renters) or about 85% of low-income (80% and under area median income) households. Almost 3.4 million of these households have priority problems; just over 2.6 million of these households have less serious problems.

- Over three quarters of a million (767,000) age 62 to 64 households (244,000 of whom are renters) with very low incomes have priority or less serious problems (Table 9).

- An additional 1 million age 65 and over households (310,000 of whom are renters) with incomes between 51% and 80% of area median income (at the income margins of HUD's low-income definition) have priority or less serious problems. An additional 163,000 age 62 to 64 households are also in this category.

The Especially Vulnerable Group of Older Homeowners

Poor age 65 and over homeowners occupying unaffordable dwellings have the option of trying to secure a reverse mortgage (see page 46) as a way to generate cash income. Alternatively, they can sell their dwellings and occupy a less expensive dwelling. Older homeowners occupying low-valued dwellings are considered less attractive reverse mortgage loan candidates. There were 725,000 age 65 and older homeowners with low incomes (80% and under of area median) who not only had priority or serious dwelling problems, but they also lived in dwellings valued under $40,000. Almost 2.5 million low-income older homeowners with priority or serious problems lived in dwellings valued under $100,000 (Table 10).

Table 10. Current and Projected Number of Low-income Age 65 and Over Homeowners in Unaffordable or Poor Quality Dwellings, By Dwelling Value, 1999 to 2020

Income Group	1999	2010	2020	1999	2010	20
	All Homeowners			All Homeowners in Dwellings Un $40,000		
Extremely Low Income						
Under 30% AMI with priority problems	1,630,000	2,012,286	2,777,711	265,000	327,151	451
Under 30% AMI with less serious problems	995,000	1,228,359	1,695,597	232,000	286,411	395
Under 30% AMI with all problems	2,625,000	3,240,645	4,473,308	497,000	613,562	846
Very Low Income						
Under 50% AMI with priority problems	2,064,000	2,548,073	3,517,298	303,000	374,063	516
Under 50% AMI with less serious problems	1,795,000	2,215,984	3,058,890	369,000	455,542	628
Under 50% AMI with all problems	3,859,000	4,764,056	6,576,188	672,000	829,605	1,14
Low Income						
Under 80% AMI with priority problems	2,331,000	2,877,692	3,972,297	317,000	391,346	540
Under 80% AMI with less serious problems	2,274,000	2,807,324	3,875,163	408,000	503,689	695
Under 80% AMI with all problems	4,605,000	5,685,017	7,847,460	725,000	895,035	1,23

Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physica problems.

Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

Irrespective of their house values, there were 2,890,000 low-income age 65 and over homeowners earning less than $25,000 annually living in dwellings with priority or less serious problems who reported having either no savings or investments (1,818,000) or savings and investments of less than $25,000 (1,072,000).[2]

Invisible Groups of Elderly with Dwelling Problems

There are two groups of elderly "households" whose dwelling-related problems are almost never enumerated (at least, not designated in the "elderly" household category) in needs assessment analyses. The first of these groups are age 65 and over persons who are living in the households headed by younger persons. This report earlier identified 2,166,000 of these younger households occupied by over 2.3 million seniors. Some 548,000 of these low-income younger households are living in dwellings that have either priority or less severe housing problems (Table 11). It is unclear how dwellings that are unaffordable by their nonelderly owners or renters or that have physical deficiencies will affect the quality of lives of these elderly occupants. Nonetheless, there is good reason to speculate the effects will be similar to those instances where seniors themselves own or rent unaffordable dwellings with physical deficiencies.

Table 11. Current and Projected Number of Low-income Under Age 65 Households in Unaffordable or Poor Quality Dwellings that are Occupied by Age 65 and Over Persons, 1999 to 2020

Income Group	1999			2010			2020		
	Total	Owners	Renters	Total	Owners	Renters	Total	Owners	Renters
All Income Levels									
With priority problems	311,000	232,000	79,000	352,111	269,615	82,496	367,607	284,740	82,868
With less serious problems	403,000	287,000	116,000	454,666	333,532	121,134	473,922	352,242	121,679
With all problems	714,000	519,000	195,000	806,777	603,146	203,630	841,529	636,982	204,547
Extremely Low Income									
Under 30% AMI with priority problems	173,000	119,000	54,000	194,684	138,294	56,390	202,696	146,052	56,644
Under 30% AMI with less serious problems	45,000	28,000	17,000	50,292	32,540	17,752	52,197	34,365	17,832
Under 30% AMI with all problems	218,000	147,000	71,000	244,976	170,833	74,142	254,893	180,417	74,476
Very Low Income									
Under 50% AMI with priority problems	230,000	159,000	71,000	258,921	184,779	74,142	269,621	195,145	74,476
Under 50% AMI with less serious problems	156,000	86,000	70,000	173,041	99,943	73,098	178,977	105,550	73,427
Under 50% AMI with all	386,000	245,000	141,000	431,963	284,722	147,240	448,598	300,695	147,903

problems									
Low Income									
Under 80% AMI with priority problems	279,000	201,000	78,000	315,041	233,588	81,452	328,511	246,692	81,819
Under 80% AMI with less serious problems	269,000	171,000	98,000	301,062	198,725	102,337	312,671	209,873	102,798
Under 80% AMI with all problems	548,000	372,000	176,000	616,102	432,313	183,789	641,182	456,565	184,617
Higher Income									
81% and over AMI with priority problems	32,000	31,000	1,000	37,070	36,026	1,044	39,096	38,047	1,049
81% and over AMI with less serious problems	134,000	116,000	18,000	153,604	134,807	18,797	161,251	142,370	18,881
81% and over AMI with all problems	166,000	147,000	19,000	190,674	170,833	19,841	200,347	180,417	19,930

Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.
Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

Older households with higher incomes (81% and over area median limit), but who also have priority or less serious dwelling problems constitute a second undocumented group. Most of these households probably have incomes in the 81% to 100% area median income range,[3] but this cannot be confirmed. What is unequivocal is that 663,000 of these older households are living in dwellings (529,000 owners and 133,000 renters) with either priority or less serious problems. An additional 203,000 age 62 to 64 householders are also in this category (Tables 8 and 9).

Overview

Four major groups of older (age 62 and over) households can be distinguished based on the degree of urgency of their housing problems (Table 12). "Urgency" in this classification depends on both the income level and degree of housing problem severity of households. Households, for example, with *extremely urgent unmet needs* have both extremely low incomes (30% and under area median limit) and priority housing problems. Households with *very urgent unmet needs* have extremely low incomes but with less serious housing problems. This latter grouping can also include, however, households with substantially low incomes (31% to 50% of area median limit) but with priority housing problems. The rationale for this classification is that households with lower levels of income combined with the presence of priority problems demand greater attention than do households with higher levels of income and less serious housing problems.

Table 12. Older Households and Older Persons in Younger Households with Urgent Unmet Housing Needs, 1999

Degree of Urgency of Unmet Needs	Age Group							
	Age 65 and over		Age 62 to 64		Age 62 and over		Age 65 and over Persons in Under Age 65 Households	
	Number	%	Number	%	Number	%	Number	%

Extremely Urgent Unmet Needs:	**2,699,000**	**12.6**	**375,000**	**11.1**	**3,074,000**	**12.4**	**173,000**	**8.0**
Extremely low-income households with priority housing problems	2,699,000	12.6	375,000	11.1	3,074,000	12.4	173,000	8.0
Very Urgent Unmet Needs	**2,081,000**	**9.7**	**201,000**	**6.0**	**2,282,000**	**9.2**	**102,000**	**4.7**
Extremely low-income households with less serious problems	1,406,000	6.6	123,000	3.6	1,529,000	6.2	45,000	2.1
Substantially low-income households with priority housing problems	675,000	3.2	78,000	2.3	753,000	3.0	57,000	2.6
Moderately Urgent Unmet Needs	**1,595,000**	**7.4**	**236,000**	**7.0**	**1,831,000**	**7.4**	**160,000**	**7.4**
Substantially low-income households with less serious housing problems	1,256,000	5.9	191,000	5.7	1,447,000	5.8	111,000	5.1
Moderately low-income households with priority housing problems	339,000	1.6	45,000	1.3	384,000	1.5	49,000	2.3
Somewhat Urgent Unmet Needs	**1,382,000**	**6.5**	**321,000**	**9.5**	**1,703,000**	**6.9**	**279,000**	**12.9**
Moderately low-income households with less serious housing problems	720,000	3.4	118,000	3.5	838,000	3.4	113,000	5.2
Higher income households with any housing problems	662,000	3.1	203,000	6.0	865,000	3.5	166,000	7.7
All Unmet Needs	**7,757,000**	**36.2**	**1,133,000**	**33.6**	**8,890,000**	**35.9**	**714,000**	**33.0**
ALL HOUSEHOLDS	**21,423,000**	**100.0**	**3,372,000**	**100.0**	**24,795,000**	**100.0**	**2,166,000**	**100.0**

Extremely low income: 30% and under of Area Median Income (AMI).
Substantially low income: 31% to 50% of Area Median Income (AMI).
Moderately low income: 51% to 80% Area Median Income (AMI) .

Higher income: 81% and over Area Median Income (AMI).

By this classification, almost 5.4 million age 62 and over households (or almost 4.8 million age 65 and over households) have extremely or very urgent unmet housing needs. The inclusion of older persons living in younger households adds another 275,000 households. Over 3.5 million age 62 and over households (or almost 3 million age 65 and over households) will have moderately or somewhat urgent unmet housing needs.

The Future Number of Age 65 and over Households Living in Dwellings with Priority or Less Serious Problems

Between 1999 and 2020, the number of age 65 and over homeowners is projected to increase by over 70% and the number of age 65 and over renters by 33%.[4] If it is assumed that the income distributions of these groups will not substantially change and if there is no major deviation from the current housing policy response pattern, the number of future older owners and renters with dwelling problems will be driven primarily by these projected demographics. As large is the current number of seniors living in unaffordable or poor quality dwellings, tomorrow's numbers of seniors living in such inadequate housing will be staggering. Tables 8, 10, and 11 show these future numbers. Using the above classification approach, by the year 2020, over 7.5 million age 65 and over households will have extremely or very urgent unmet housing needs. Over 4.7 million age 65 and over households will have moderately or somewhat urgent unmet housing needs (Table 13).

Table 13. Projected Number of Older Households and Older Persons in Younger Households with Urgent Unmet Housing Needs, 2020

Degree of Urgency of Unmet Needs	Age Group		
	65 and over	Age 65 and over Persons in Under Age 65 Households	Total
Extremely Urgent Unmet Needs:	**4,202,353**	**202,696**	**4,405,049**
Extremely low-income households with priority housing problems	4,202,353	202,696	4,405,049
Very Urgent Unmet Needs	**3,303,283**	**119,122**	**3,422,405**
Extremely low-income households with less serious problems	2,242,819	52,197	2,295,016
Substantially low-income households with priority housing problems	1,060,464	66,925	1,127,389
Moderately Urgent Unmet Needs	**2,519,962**	**185,670**	**2,705,632**
Substantially low-income households with less serious housing problems	1,970,431	126,780	2,097,211
Moderately low-income households with priority housing problems	549,531	58,890	608,421
Somewhat Urgent Unmet Needs	**2,214,377**	**334,041**	**2,548,418**
Moderately low-income households with less serious housing problems	1,135,817	133,694	1,269,511
Higher income households with any housing problems	1,078,560	200,347	1,278,907
All Unmet Needs	**12,239,975**	**841,529**	**########**

Extremely low income: 30% and under of Area Median Income (AMI)
Substantially low income: 31% to 50% of Area Median Income (AMI)
Moderately low income: 51% to 80% Area Median Income (AMI)
Higher income: 81% and over Area Median Income (AMI)

Older Households Occupying Conventional Housing in Poor Physical Condition

A small subset of the older households with priority or less serious problems are specifically occupying dwellings in poor physical condition.[5] The physical problems in these dwellings may affect not only the personal well-being of the older occupants, but also the social and economic viability of their neighborhoods.

About 809,000 or 5% of older owners and 447,000 or 11% of older renters occupied dwellings with either severe or moderate physical problems (Table 14). These dwellings were more likely found in the central cities of metropolitan areas and in rural or nonmetropolitan areas, especially in southern United States (Figures 30 and 31). Extremely low-income (8%) and very low-income homeowners (7%) and extremely low

(13%) and very low-income renters (11%) were especially likely to occupy housing in poor physical condition.

Figure 30. Urban-Rural Differences in the Percent of Dwellings in Poor Physical Condition Occupied by Age 65 and Over Households, 1999

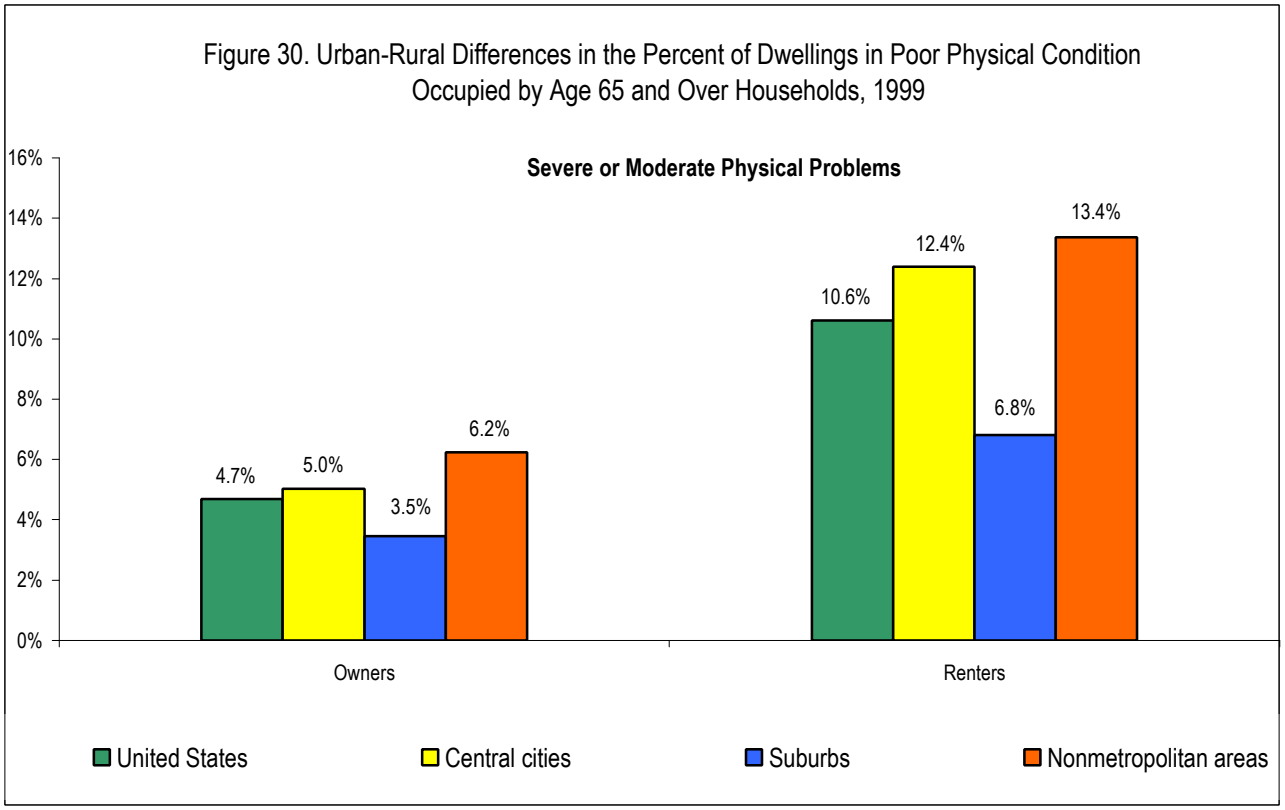
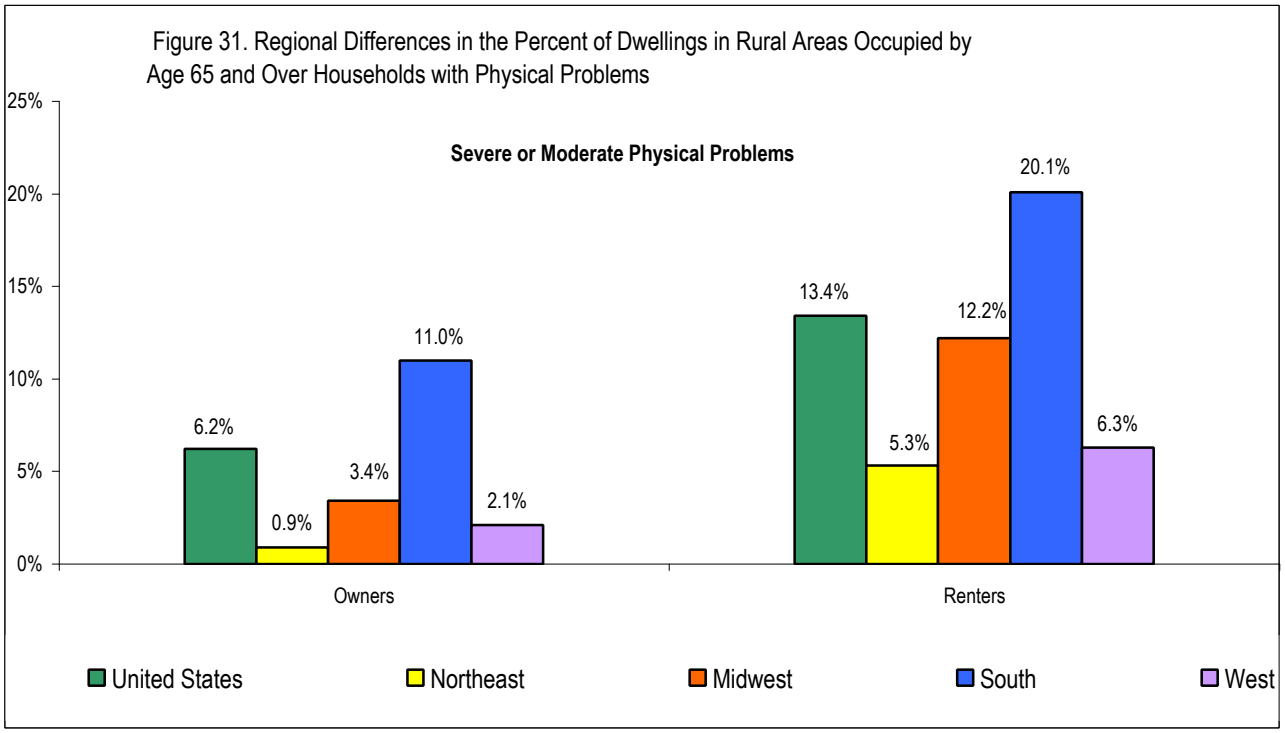


Figure 31. Regional Differences in the Percent of Dwellings in Rural Areas Occupied by Age 65 and Over Households with Physical Problems



Severe or Moderate Physical Problems: as defined by 1999 American Survey Housing

Table 14. Number and Percent of Low and Higher Income Elderly Households Living In Dwellings in Poor Physical Condition, 1999

Income Group	Number of Households				Percent of Income Group		
	Age 65 and Over Households	Severe Physical Problems	Moderate Physical Problems	All Physical Problems	Percent with Severe Physical Problems	Percent with Moderate Physical Problems	Percent with All Problems
OWNERS							
All Incomes	17,197,000	281,000	528,000	809,000	1.6	3.1	4.7
Extremely Low income	3,806,000	111,000	200,000	311,000	2.9	5.3	8.2
Very Low Income	7,585,000	174,000	334,000	508,000	2.3	4.4	6.7
Low Income	11,319,000	223,000	433,000	656,000	2.0	3.8	5.8
Higher Income	5,878,000	58,000	95,000	153,000	1.0	1.6	2.6
RENTERS							
All Incomes	4,228,000	151,000	296,000	447,000	3.6	7.0	10.6
Extremely Low income	1,964,000	98,000	155,000	253,000	5.0	7.9	12.9
Very Low Income	3,019,000	117,000	217,000	334,000	3.9	7.2	11.1
Low Income	3,666,000	132,000	261,000	393,000	3.6	7.1	10.7
Higher Income	562,000	19,000	35,000	54,000	3.4	6.2	9.6
ALL HOUSEHOLDS							
All Incomes	21,423,000	432,000	821,000	1,253,000	2.0	3.8	5.8
Extremely Low income	5,770,000	209,000	355,000	564,000	3.6	6.2	9.8
Very Low Income	10,604,000	291,000	551,000	842,000	2.7	5.2	7.9
Low Income	14,985,000	355,000	694,000	1,049,000	2.4	4.6	7.0
Higher Income	6,440,000	77,000	130,000	207,000	1.2	2.0	3.2

Extremely low income: 30% and under of Area Median Income (AMI).
Very low income: 50% and under of Area Median Income (AMI).
Low Income: 80% and under of Area Median Income (AMI).
Higher Income: 81% and over of Area Median Income (AMI).

The oldest built dwellings, those built 1949 or earlier and at greatest risk of requiring rehabilitation, were especially likely to have these physical deficiencies. Almost 29% of the owned dwellings and 28% of the rented dwellings occupied by age 65 and over households were built 1949 or earlier (Figure 32). Very low-income, the old-old, one-person, and African American households are especially likely to occupy this oldest housing stock. Predictably, these very early built units are disproportionately found in central cities and in nonmetropolitan areas (Figure 33). Of low-income (80% and under of area median limits) age 65 and over households living in this oldest housing stock, 337,000 or just over 9% of the owners and 269,000 or almost 16% of the renters were in dwellings that had severe or moderate physical problems. The older dwellings occupied by extremely low-income older households were even more likely to have physical problems.

Figure 32. Number and Distribution of Dwellings Occupied By Age 65 and Over Householders, According to Year Built by Tenure, 1999

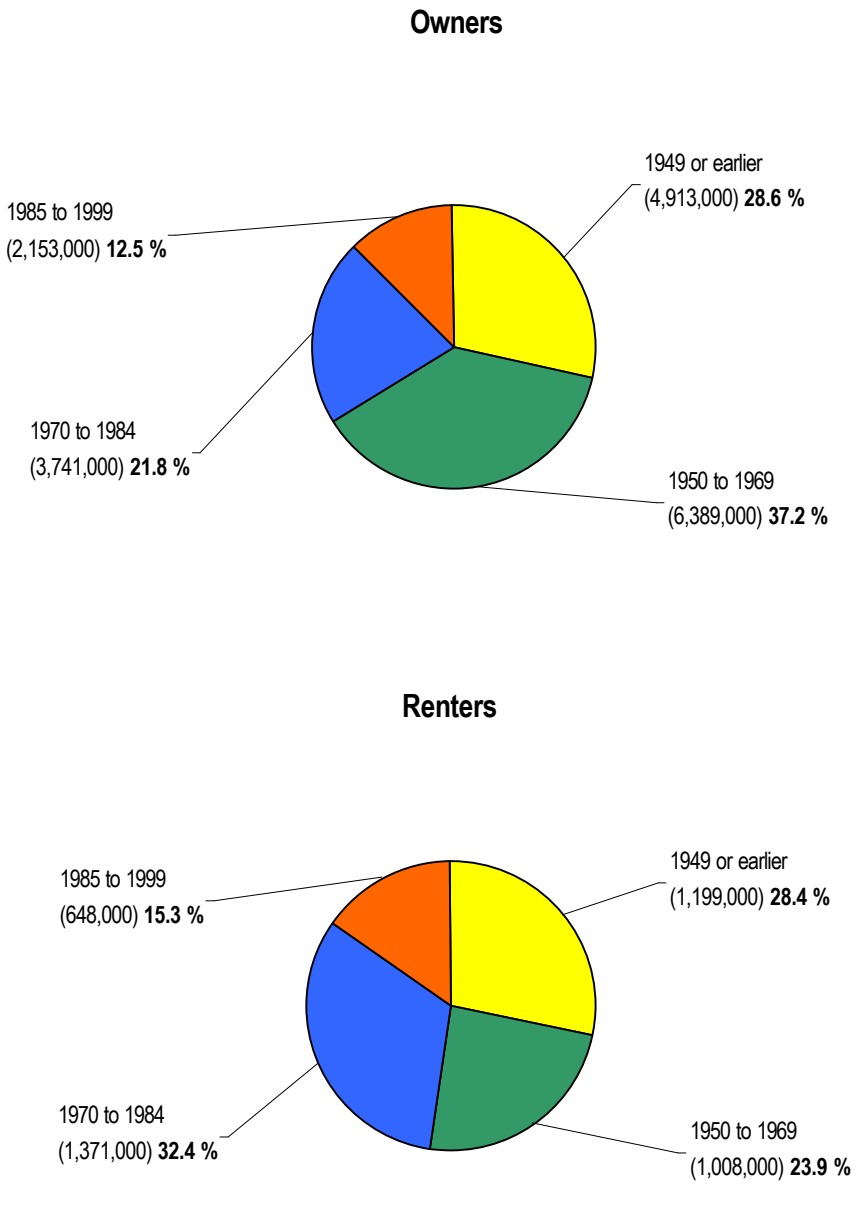
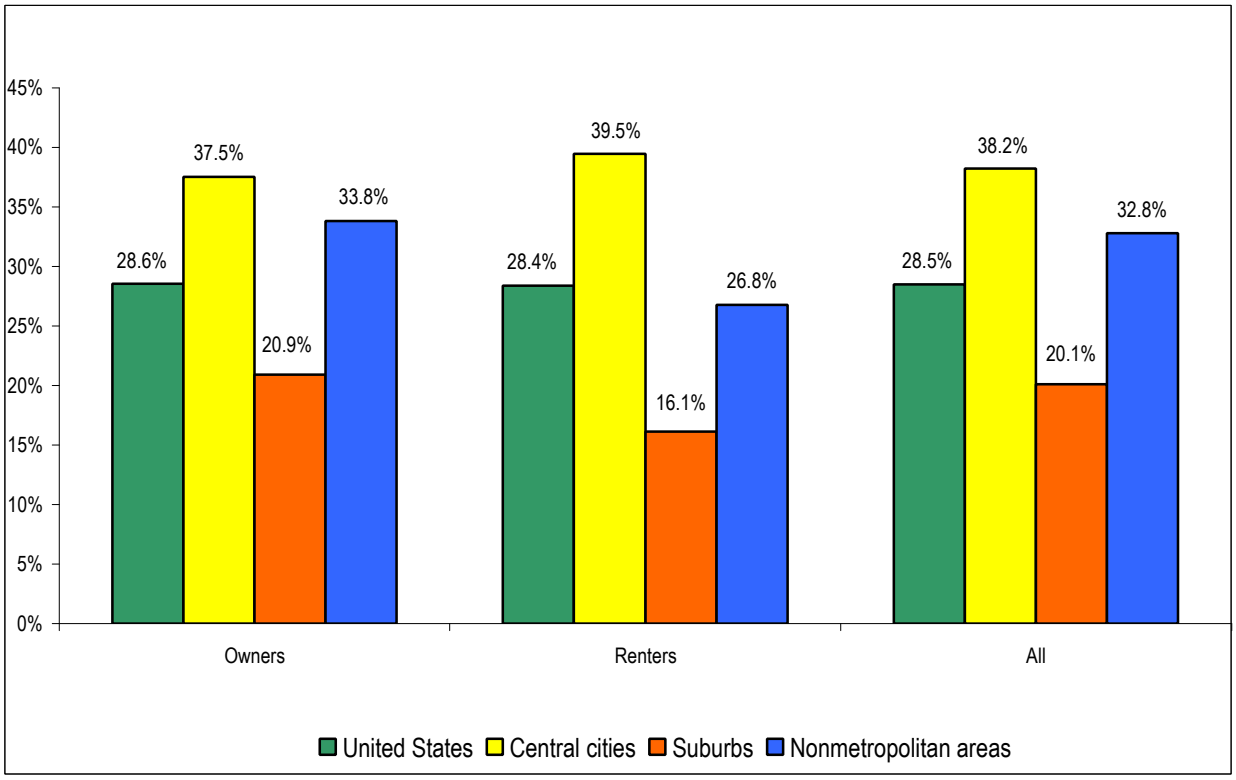


Figure 33



Much past research has documented that older dwellings are not only more likely to have severe or moderate problems that demand repairs.[6] They are also more likely to have architectural design features that create more difficult to use or unsafe environments, especially when their occupants also suffer from physical limitations. These older buildings tend also to suffer from technological obsolescence and have outmoded, inefficient, or dangerous lighting, electrical, air and heating systems that not only threaten the physical safety of their older occupants but may also be very expensive to replace. Altogether, the poor physical conditions of these older settings may also have a negative psychological impact on their occupants. Older homeowners or renters may start to feel that their living situations are outside of their control and may experience a sense of helplessness and despair.[7]

Older dwellings in need of physical repair, upkeep, and renovation not only contribute to a lower quality of life of their older occupants and help depress their property values. When these inadequately maintained dwellings are concentrated in the same location, entire neighborhoods may become physically distressed. Lower property values, higher rates of property depreciation, and lower property tax revenues are a strong possibility.[8] Community efforts to revitalize these neighborhoods may be more difficult to achieve.[9]

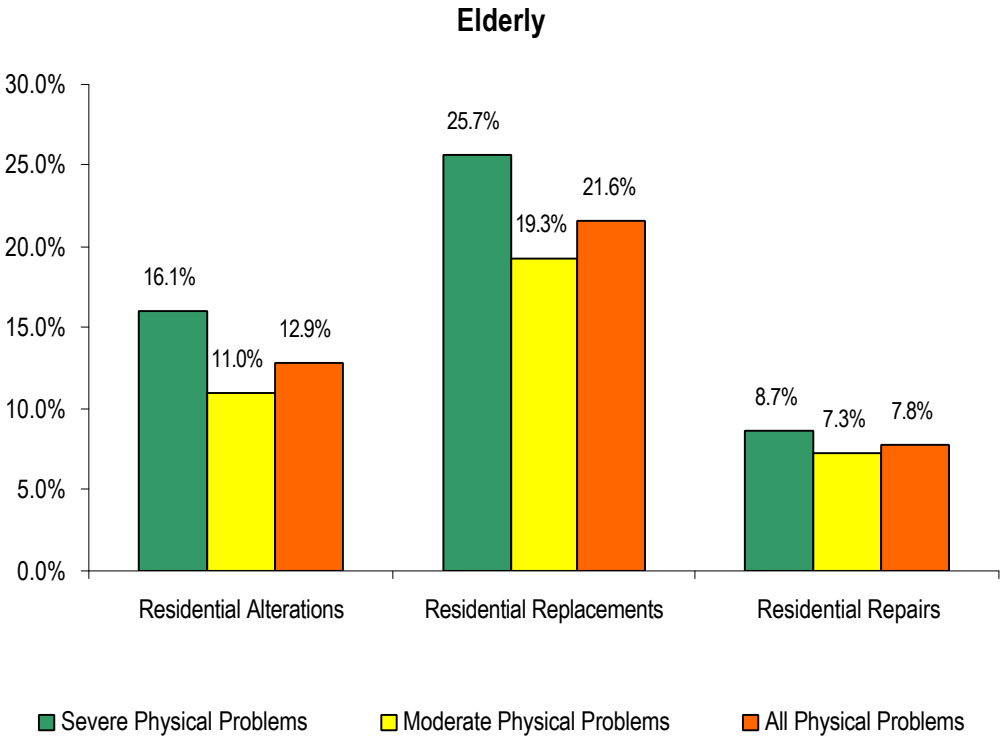
The following assessment is informative:

> *Mature suburbs can be blinded by what they used to be: new, popular, problem-free places to live and do business—resulting in resistance to the fact they have aged, are being left or avoided for new places 20 miles farther out, and are beginning to have the same problems that used to be strictly urban. Facing the new reality requires a fundamental shift in attitude and outlook. Governing and managing a suburb whose real estate is aging and on the downside is a very different role than when it was new. It is a challenge for those involved to recognize that the magnitude of the forces undermining their community makes their situation a life-or-death battle.*[10]

Improvement and Repair Activities by Older Homeowners

Although older dwellings are at a greater risk of experiencing these physical declines, upgrading and maintenance can help forestall their occurrence. Three categories of responses are possible: (1) physical alterations within the dwelling (e.g., creation of a room from previously unfinished space; total or simple improvement of existing finished space), (2) maintenance, repairs, and other work (e.g., installing siding, interior water pipes, insulation, fuse boxes, finished flooring, ceiling tiles, or furnace parts); and (3) major replacements (e.g., replacing a total roof, all siding, all interior water pipes, all electrical wiring, all plumbing fixtures, and installing central air). Based on a 1995 survey,[11] however, only small percentages of elderly homeowners occupying dwellings with serious or moderate physical problems undertook any of these three activities over a 2-year period. About 13% of the elderly households made internal residential alterations 22% made physical replacements to their dwelling, and 8% initiated maintenance or repair activities (Figure 34). On a positive note, older homeowners were more likely to make these residential changes when they occupied dwellings with more severe physical problems. When compared with younger homeowners, however, older residents were much less likely to engage in these upgrading and maintenance activities. Moreover, younger were more likely than older homeowners to perform all three of these improvement and repair tasks themselves rather than to hire professional help. [12] These findings are consistent with earlier research showing a strong inverse relationship between dwelling upkeep and age of household. The dollar amount spent on home upkeep was about $14 to $17 lower for every additional year of a person's age.[13] One explanation: as the chronological age of persons increase, they perceive an increasingly shorter period of time over which to reap the benefits of their upkeep and upgrading adjustments.[14]

Figure 34. Percent of Age 65 and Over Homeowners Making Residential Alterations Replacements, and Repairs in Previous Two Years, By Condition of Dwelling, 1955



(1) Alterations within residential structures: creation of a room from previously unfinished space; total remodeling of existing finished space; simple improvement of existing finishing space.

(2) Maintenance, repairs, and other work: e.g., siding, interior water pipes, insulation, fuse boxes, finished flooring, ceiling tiles, furnace parts.

(3) Major replacements: total roof, all siding, all interior water pipes, all electrical wiring, central air, plumbing fixtures, furnace, dishwasher, garbage disposal, doors or windows, water heater.

Source: U.S. Census Bureau. 2001. *Current Housing Reports, Series H151/95-1, Supplement to the American Housing Survey for the United States in 1995.* Washington, DC: U.S. Government Printing Office.

The Availability of Government-Subsidized Rental Facilities

THE RENT-ASSISTED HOUSING STOCK

To help address these housing problems, the Federal government offers three basic types of rental housing assistance to income-eligible households. The oldest program, Public Housing, consists of project-based units that are owned and operated by local public housing agencies (PHAs). A second category, project-based assisted housing includes units that are built or rehabilitated by for-profit and nonprofit sponsors. The most important programs include the Section 221 (d) (3), Section 236, Section 8, Section 202, Section 515 of Rural Housing Service, Low-Income Housing Tax Credits, and the HOME programs. A third category, tenant-based assisted housing, provides direct financial assistance to profit and nonprofit landlords in the private market allowing them to rent their units to households who would otherwise find their units to expensive. These

[1] The pattern is very similar when focusing separately on priority and less serious problems.
[2] The American Housing Survey database only identifies the amount of savings for households with annual incomes of under $25,000. Almost 92% of low-income age 65 and over homeowners with priority or less serious problems have annual incomes of under $25,000.
[3] This analysis did not break down area median income limits after the 80% threshold.
[4] Joint Center for Housing Studies of Harvard University. 2001. *The State of the Nation's Housing, 2001*. Cambridge, MA: The Joint Center for Housing Studies of Harvard University.
[5] These households may also be experiencing affordability problems.
[6] Golant, Stephen M. and Anthony J. LaGreca. 1994. "Housing Quality of U.S. Elderly Households: Does Aging in Place Matter?" *The Gerontologist* 34(6):803-14.
[7] Golant, Stephen M. 1998. "Changing an Older Person's Shelter and Care Setting: A Model to Explain Personal and Environmental Outcomes." Pp. 34-60 in *Environment and Aging Theory: A Focus on Housing*, Eds. Paul G. Windley and Rich J. Scheidt. New York: Greenwood Press.
[8] Burkhauser, Richard V., Barbara A. Butrica, and Michael J. Wasylenko. 1995. "Mobility Patterns of Older Homeowners: Are Older Homeowners Trapped in Distressed Neighborhoods." *Research on Aging* 17(4):363-84;
Krause, Neal. 1998. "Neighborhood Deterioration, Religious Coping, and Changes in Health During Late Life." *The Gerontologist* 38(6):653-64; Margulis, Harry L. 1993. "Neighborhood Aging and Housing Deterioration: Predicting Elderly Housing Distress in Cleveland and Its Suburbs." *Urban Geography* 14(1):30-47; Quercia, Roberto G. and William M. Rohe. 1992. "Housing Adjustments Among Older Home Owners." *Urban Affairs Quarterly* 28(1):104-25.
[9] Newman, Sandra J. and Kirsten Envall. 1995. *The Effects of Supports on Sustaining Older Disabled Persons in the Community*. Washington, DC: AARP.
[10] Bier, Thomas. 2001. *Moving Up, Filtering Down: Metropolitan Housing Dynamics and Public Policy*. Washington, DC: Brookings Institution, Center on Urban and Metropolitan Policy, p. 11.
[11] U.S. Census Bureau. 2001. Current Housing Reports, Series H151/95-1, *Supplement to the American Housing Survey for the United States in 1995*.Washington, DC: U.S. Government Printing Office.
[12] Struyk, Raymond J. and Beth J. Soldo. 1980. *Improving the Elderly's Housing*. Cambridge, Mass.: Ballinger Pub. Co.
[13] Newman, Sandra J. and Kirsten Envall. 1995. *The Effects of Supports on Sustaining Older Disabled Persons in the Community*. Washington, DC: AARP.
[14] Burns, Leland S. and Leo Grebler. 1986. *The Future of Housing Markets*. New York: Plenum.

Section 8 Certificates and Vouchers (and now, only Vouchers) cover the difference between the tenant contribution and the local HUD-calculated fair market rent.[1]

In 1999, there were over 5.1 million federally subsidized rent-assisted units of which 1.7 million, or about one-third, were occupied by age 62 and over tenants (Table 15).[2] Somewhat confusingly, this estimate does not agree with data from the 1999 American Housing Survey (AHS), the database on which this report primarily relies. A possible explanation is that the AHS database depends on household self-reports that is more subject to response error. In 1999, the AHS database enumerated a total of 6.2 million rent-assisted units in the United States of which just under 1.4 million units or 22% were occupied by age 62 and over households. A smaller number, 1.2 million rent-assisted units or 20%, were occupied by age 65 and over households. This report will primarily rely on these AHS estimates when assessing the government response to the unmet housing needs of U.S. older households.

Table 15. Government-Assisted Rental Housing Programs in the United States, 1999

	Total	Age 62+
HUD Programs		
Public Housing	1,120,000	358,400
Section 202	319,502	319,502
Section 221(d)(3)	109,861	21,437
Section 236	429,567	146,053
Section 8 new/rehab	744,889	343,673
Tenant Based Section 8	1,420,000	213,000
Rural Housing Service		
Section 515	453,275	190,829
Federal Incentives via State Agencies		
Low-Income Housing Tax Credit (w/out other Federal subsidy)*	433,427	108,357
HOME	125,100	20,016
Total	**5,155,621**	**1,721,266**

** - In addition, approximately 290,000 low-income housing tax credit units are also subsidized through Section 8 or Section 515. Around 72,000 of those units are occupied by older persons.*

PPI estimates based on HUD, Recent Research Results: New Facts About Households Assisted by HUD's Housing Programs (October 2000); HUD Office of Budget Production Report; AARP 1999 National Survey of Section 202 Housing for the Elderly; HUD, A Picture of Subsidized Households (1998); Rural Housing Service, FY 1999 Multifamily Housing Occupancy Survey; HUD's Low-Income Housing Tax Credit Database; National Council of State Housing Agencies; GAO Survey of Tax Credit Units (as published in letter B-248332); Cummings and DiPasquale, "The Low-Income Housing Tax Credit: An Analysis of the First Ten Years,Housing Policy Debate, 1999; HUD, HOME Program Data, Q4 1999.

Source: Andrew Kochera (2001). *A Summary of Federal Rental Housing Programs, Fact Sheet* #85. Washington, DC: AARP, p. 4.

The rent-assisted units produced under these programs are far from uniform products. They have different building characteristics (size, when built, type of structure), different types and amount of common area footage (e.g., presence of communal recreational, dining room and clinic-adapted spaces), different degree and types of design features responsive to older persons with physical disabilities (e.g., grab-bars in bathrooms). Very different types of for profit, nonprofit, and public organizations also own and operate them. Their subsidies are also often financed very differently and this results in their somewhat different income eligibility limits. While most programs allow households to have "low incomes" as high as 80% of their area median limits, in practice, most tenants have "very low incomes" that do not exceed 50% of their local area's median limits. Facilities built under some older HUD programs have shallower subsidies, such as the Section 236 or 221 (d) (3) facilities without Section 8 subsidies, because they were made affordable by mortgage interest reductions, and tenants with higher incomes can qualify as tenants.[3]

Seniors who occupy the facilities produced under these various programs may be in primarily seniors' buildings or in mixed age facilities. They are usually likely to be in mixed aged buildings when funded under the tenant-based section 8 programs. Only HUD's Section 202 facilities expressly target older tenants. Nonprofit, usually community- or faith based, sponsors, exclusively develop these facilities. This program well illustrates the difficulties of making program-specific generalizations. The funding approaches, operational requirements, and physical plant requirements have changed various times throughout the history of the 202 program. Thus, depending on when Section 202 facilities were built, they differ according to the income distributions of their older tenants, the financial basis of their subsidies, the size of their buildings, and the extent to which their physical plant (e.g., presence of congregate spaces) are especially geared to the more frail older tenant.[4]

THE RESPONSE BY THE FEDERAL GOVERNMENT TO THE POOR HOUSING CONDITIONS OF LOW-INCOME AMERICANS

The Department of Housing and Urban Development (HUD) is the dominant Federal agency responding to the poor housing conditions and affordability problems of low-income Americans.[5] It alone accounts for 95% of the housing assistance outlays that are targeted to this group.[6] The housing assistance provided by other Federal agencies, most notably by the Rural Housing Service, is very small by comparison.

While Federal housing assistance financial outlays (from all Federal agencies) have grown substantially over the past two decades, they nonetheless constitute a small proportion of all Federal

expenditures. In 1999, the 28 billion dollars[7] spent on housing assistance programs in this country represented only l.6% of total Federal outlays, targeted to low-income households.[8] This compared with 6.3% for Medicaid, 1.0% for social services, 1.9% for food and nutrition, and 4.5% for other income security programs.[9] Historically, HUD's overall budget is dramatically below previous levels and has declined by $39 billion from 1976 to 2001.[10]

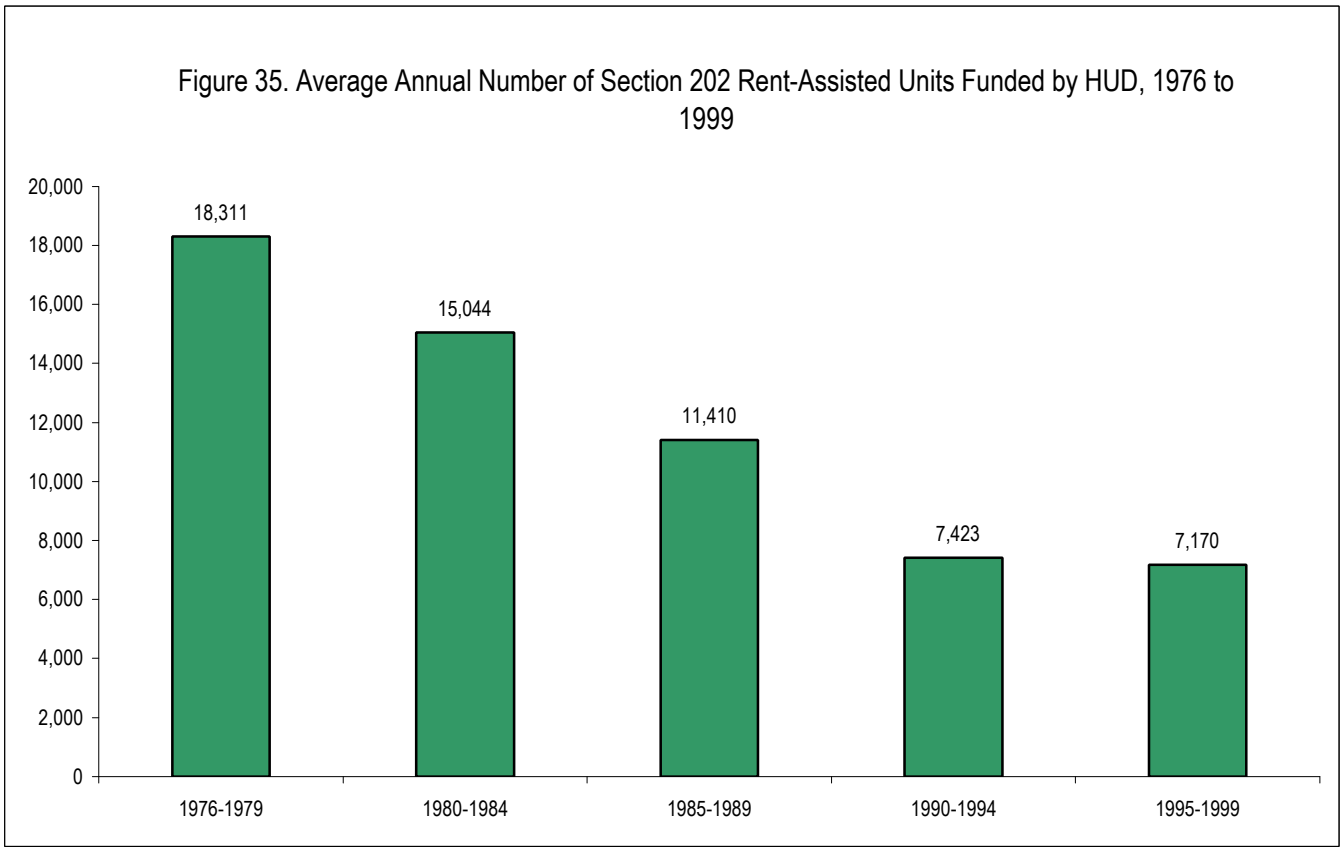
The 1990s was an especially difficult decade as measured by the number of annual incremental units of Section 8 Tenant-Based Rental Assistance (vouchers). Voucher-assistance is one of the most important categories of HUD assistance used to provide affordable housing. Housing vouchers are especially targeted to extremely low-income households and they often make possible the affordable units produced under the Low Income Housing Tax Credit and HOME programs. From 1990 through to 1998, Congressional funding appropriations resulted in a steady decline in the annual number of new housing vouchers.[11] Between 1995 and 1998, Federal appropriations for rental assistance vouchers were eliminated altogether.[12] As a result, the number of HUD-assisted units actually dropped by 65,000 over this period.[13] Only in 1999 did this funding pattern reverse itself and Congress funded 50,000 vouchers followed by 60,000 new vouchers in 2000. In 2001, funding supported 87,000 vouchers, but dropped sharply to 25,900 in 2002.[14]

The growth of the rent-subsidized housing stock has not kept pace with the needs of a growing elderly population. This is well-illustrated by considering the history of the Section 202 program, considered by advocates and experts to be one of HUD's most successful housing production programs. While the number of units produced under this program has increased over the past several years, the current annual production of just over 7,000 units pales in comparison with previous production levels. The average annual number of Section 202 units was 18,000 in the 1970s, over 15,000 in the first half of the 1980s, and over 11,000 in the second half of the 1980s. Funding for this program has declined from $l.2 billion in fiscal year 1995 to under $700 million, currently.[15]

As another indicator of the programmatic failure to address unmet housing needs, in Fiscal year 2001, HUD rejected half of Section 202 production applications because of insufficient funding. In the recent past funding is provided for only 30% to 40% of eligible Section 202 applications.[16] As an example of the competitiveness of the program, the Washington, DC metropolitan area typically receives an allocation to fund only 70 to 80 units per year.[17] If waiting lists are a reasonable gauge of unmet demand, these production levels are not coming close to meeting the unmet affordable rental housing needs of older households. The waiting lists for the Section 202 program are long and increasing. Nine applicants were waiting for each Section 202 unit in 1999 compared to eight applicants per vacancy in 1988.[18]

The loss of subsidized rental units because of expiring Section 8 project-based rental assistance contracts has further exacerbated the effects of producing an inadequate number of new rent-assisted units for older persons. Starting in 1975 HUD signed 20-year contracts with private owners to provide project-based Section 8 subsidies to their properties. These contracts started to expire in 1996. Research estimates that 2,800 elderly-occupied rent-assisted units, primarily in elderly projects, opted out between 1996 and 1998. Another 152,000 units in "elderly" properties are at risk of opting out through 2004. An unknown number of units will be lost from mixed-aged occupancy rent-assisted facilities in the program.[19] Adding to their difficulties, when older tenants

leave these buildings, they often find it is difficult to secure affordable accommodations in buildings with the special design features that were found in their earlier occupied facilities and that helped them to compensate for their physical limitations.



Source: Tabulations provided by the American Association of Homes and Services for the Aging (AAHSA).

THE REPRESENTATION OF LOW-INCOME OLDER HOUSEHOLDS IN RENT-ASSISTED HOUSING

Older households in all income categories are under-represented in rent-assisted housing. Only 5.5% of age 62 and over households that live in conventional housing now occupy rent-subsidized facilities. This compares with 6.2% of age 61 and under households. Higher shares of low-income (7.9%) and extremely low-income (13.7%) age 62 and over households are found in rent-subsidized facilities, but these percentages are also lower than the comparable shares of younger households found in these affordable units (12.7 and 23.0%, respectively).[20]

National assessments of the need for affordable housing sometime falsely give the impression that the current occupants of rent-assisted facilities always have relocated from other rental facilities.[21] As emphasized, however, the problems of affordability and poor quality housing are hardly restricted to older renters. Skeptics counter that while homeowners may be living in unaffordable housing and may be cash-poor, they have considerable asset wealth because of their dwellings' equity. As will be emphasized later in this report, however, older homeowners are often reluctant to "touch" their home's equity. In any case, HUD's income eligibility rules allowing admittance into its rent-assisted programs does not prohibit older people from owning some

specified value of assets. HUD treat assets (such as home equity) as primarily a potential source of income. It requests that applicants compute only an imputed interest rate (now at 2%) on their currently owned dwelling's value or to count the income interest generated after they sell their dwellings and invest the proceeds. The following scenarios in a "higher cost" MSA help to clarify:

> *In the year 2001, the 80% area median income limit for eligibility is $28,050 for couples in the Punta Gorda MSA and $24,550 for single persons. A couple has a home worth $150,000 dollars with no remaining mortgage. They make $1,100 and $675 respectively per month from Social Security. This is their only source of income. Consequently, their annual income is $21,300, which qualifies them for residency. They are living with relatives and their house is for sale but it is not being rented out. HUD says to impute income on an asset (only when real income is not being made) at 2% per year. Therefore, Couple #1 is considered in receipt of $3,000 additional annual income for a total of $24,300. They still qualify.*
>
> *A widow has a home worth $150,000 dollars with no remaining mortgage. She makes $1,200 a month from Social Security or $14,400 annually. However, while living with relatives, she is renting out her house for $570 per month. Thus, she is receiving an additional $6,840 per year income for a total annual income of $21,240. She still qualifies.*
>
> *A widow has a home worth $110,000 dollars with no remaining mortgage. She makes $1,000 a month from Social Security or $12,000 annually. She sells her house and clears $105,000. She has a 3% passbook bank account from which she makes $3,150 annually. Thus, her total annual income is $15,150. She is still eligible not only at the 80% but also at the very low-income (50% area median) limit ($15,350 for one person).*

Thus, it is very possible for cash-poor homeowners (e.g., dependent on Social Security or Supplemental Security Income) who occupy relatively high valued dwellings to qualify for admittance to HUD rent-assisted housing. This is especially true in the current economic environment because interest rate returns on most savings and investments are very low. Since the group of older homeowners is so large, even small percentages of occupants with housing cost burdens and physical quality deficits will constitute a very large latent demand for rent-assisted facilities. Over a 1-year period, 29% of the older occupants that entered rent-assisted housing were previously homeowners.[22]

OLDER RENT-ASSISTED OCCUPANTS: AN INCOME AND DEMOGRAPHIC PROFILE

Just over 97% of age 65 and over households in rent-assisted units have low-incomes (80% and under of area median). This includes 90% with very low incomes and 66% with extremely low incomes (Figure 37). Using another income indicator, just over 72% of older rent-assisted occupants are below the 150% poverty level threshold (Figure 37). Rent-assisted older occupants tend to have lower incomes than the elderly households in unassisted rental units.

Figure 36. Area Median Income Distributions of Age 65 and Over Occupants in Rental Units, 1999

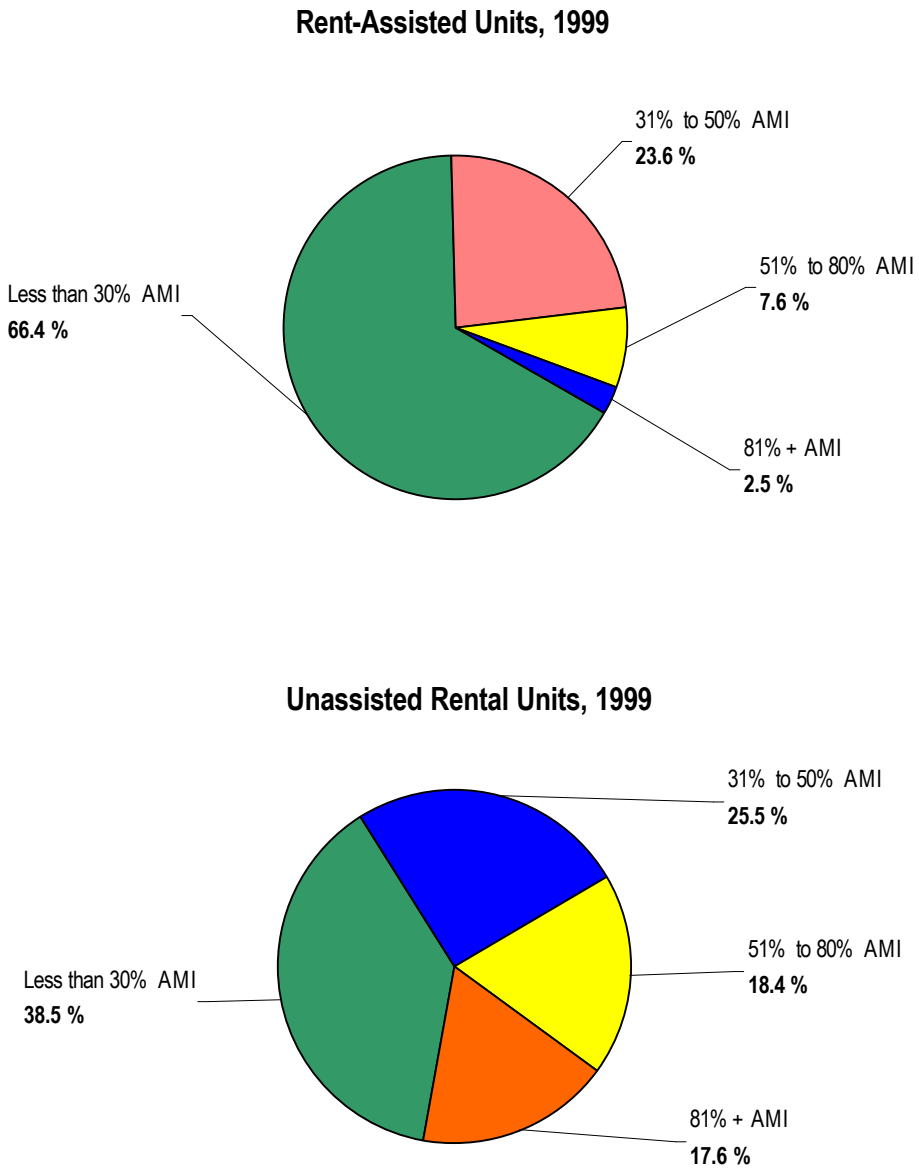


FIGURE 37. Income Distributions of Age 65 and Over Occupants in Rent-Assisted and Unassisted Rental Units, 1999

Income Level	Rent-Assisted	Unassisted Rental	Rent-Assisted	Unassisted Rental	All Rental
Less than 30% AMI	66.4	38.5	806	1157	1963
31% to 50% AMI	23.6	25.5	286	768	1054
51% to 80% AMI	7.6	18.4	92	553	645
81%+ AMI	2.5	17.6	30	531	561
			1214	**3009**	**4223**
Below 100% poverty level	43.5	25.4	530	765	1295
100% to 149% poverty level	28.5	19.0	347	572	919
150%+ poverty level	27.9	55.5	340	1669	2009
			1217	**3006**	**4223**

Extremely low income: 30% and under of Area Median Income (AMI).
Substantially low income: 31% to 50% of Area Median Income (AMI).
Moderately low income: 51% to 80% Area Median Income (AMI).
Higher income: 81% and over of Area Median Income (AMI).

The 100% 1999 poverty threshold (100%) for a one-person householder age 65 and over was $8,241.

The 100% 1999 poverty threshold (100%) for a two-person householder age 65 and over was $11,060.

When compared with unassisted older renters, older rent-assisted tenants are more likely to be African-American, Hispanic, and Asian and to live alone (Table 16). In contrast, age 75 and over households are somewhat under-represented, suggesting that rent-assisted facilities are either unwilling or unable to tolerate this more vulnerable group or that this old-old household group is discouraged from seeking admittance. The disability patterns of this population will later in this report suggest that the former explanation is more likely.

Table 16. Demographic Differences Between Low-Income Age 65 and over Rent-Assisted and Rent-Unassisted Populations, 1999

Household Group	Older Rental Population, All Incomes	Older Very Low-income Unassisted Rental Population	Older Very Low-income Rent-Assisted Population	Older Extremely Low-income Unassisted Rental Population	Older Extremely Low-income Rent-Assisted Population
% White	72.8	71.0	63.6	67.0	60.8
% Black	15.0	16.3	20.9	18.8	23.4
% Hispanic	8.4	9.2	11.4	9.6	10.9
% Asian	3.8	2.4	4.1	3.0	4.2
% Age 75 and over	54.8	57.8	55.4	57.0	53.8
% Married	18.6	17.5	10.3	16.2	8.6
% Living Alone	70.0	71.2	81.0	71.6	83.5
% Other Relationships	11.4	11.3	8.7	12.2	7.9

Extremely low income: 30% and under of area median income (AMI).
Very low income: 50% and under of area median income (AMI).

The rent-subsidized units occupied by older households are not equally found in central cities, the suburbs, and nonmetropolitan areas. Central cities have a higher share of senior-occupied rent-assisted units than would be predicted on the basis of where older households with low incomes and housing problems are located. In contrast, nonmetropolitan areas and the metropolitan suburbs are under-supplied. Whereas 28% of all low-income age 65 and over households and 32% of all low-income renters with priority or less serious problems are found in central cities, over 47% of the rent-assisted units occupied by low-income older households are located in central cities. Whereas 27% of all low-income age 65 and over households and 23% of all low-income older households with priority or less serious problems are located in nonmetropolitan areas, 20% of all low-income rent-assisted units are located in nonmetropolitan areas. Similarly, 45% of all low-income age 65 and over households and 45% of all low-income older households with priority or less serious problems are located in the metropolitan area suburbs, but only 33% of all low-income rent-assisted units accommodating older households are found here. Thus, not only are certain household types and racial and ethnic groups unequally served. There are also locational inequities in the availability of these rent-assisted units.[23]

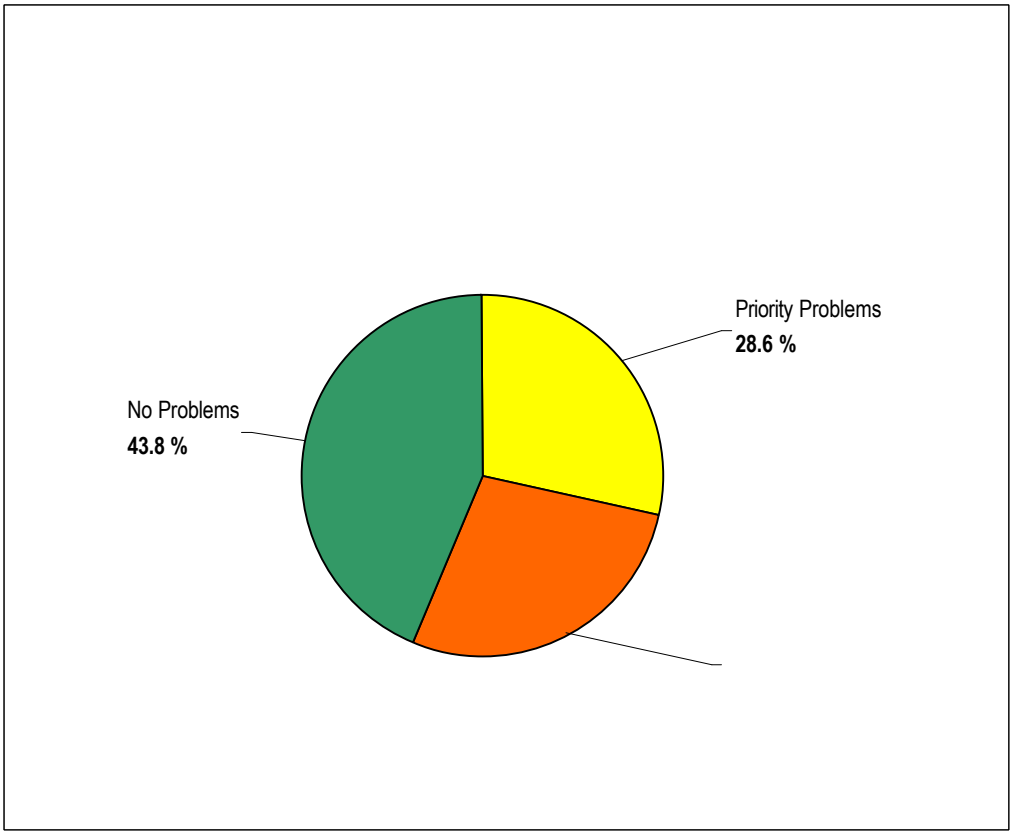
THE RENT-ASSISTED SOLUTION IS PART OF THE PROBLEM

Rent-assisted facilities are designed to eliminate dwelling cost burdens and to provide housing that is in good physical condition. Thus, it is surprising to find that almost 29% of the l.2 million age 65 and over rent-assisted households have priority problems, while another 28% have less serious problems. Additionally, almost 22.4% of the 152,000 age 62 to 64 households have priority problems, while another 33% have less serious problems. Thus, a total of 683,000 age 65 and over and 84,000 age 62 to 64 rent-assisted households have dwelling problems that presumably should not be found in government-subsidized facilities. The vast majority of these problems involve households with an excessive rent burden, while a smaller share consist of households in dwellings with severe or moderate physical deficiencies. Certain groups of elderly tenants are more likely than others to have these problems, most notably, extremely low-income, African-American and Hispanic households.

HUD has recognized the troubling presence of these problem-afflicted households for many years.[24] In a recent HUD report these problems were attributed to survey response error,[25] a result of tenants under-reporting their incomes and over-reporting their gross rents. Methodological artifact is not the only explanation, however. In several of the Federal and State rent-assisted programs, it is possible for tenants to be paying over 30% of their income on their rent.[26] Two recent analyses support this argument. A convenience sample of 39 properties in the Low Income Tax Credit Program (LIHTC) found that 50% of the households (elderly and nonelderly) paid over 30% of their gross household income on rent and utilities and 13% paid over 50% of their income. A study of the HOME program found that 41% of the tenants (elderly and nonelderly) had rent burdens of 30% to 50% and 19% had rent burdens over 50%.[27] The significant percentage of rent-assisted units with physical deficiencies is also more difficult to explain away. HUD is aware that these deficiencies exist and both Public Housing Agencies and private owners of multifamily rent-assisted units are required to inspect and maintain their properties. Still, according to HUD's fiscal year 2002 "Annual Performance Plan", in the year 2000, only 70% of the stock of public housing

units (elderly and nonelderly) was located in developments that met HUD's physical condition standards; and only 86% of the units in multifamily housing stock met these standards.[28]

Unfortunately, there is no simple way to identify what share of these problems is real as opposed to methodologically created. HUD's conclusion still applies: *"Since there is no way to satisfactorily adjust the data for all of the possible problems, the distributions must be used with caution and with full awareness of their limitations and biases."*[29] This creates an analytical quandary because all the previously reported tabulations of priority and less serious problems have included the problems found in the rent-assisted housing stock. The researcher faces an uncomfortable reality: it is irresponsible not to count them and irresponsible to count them. Moreover, it is not difficult to argue that older households in rent-assisted units experiencing these problems are in some ways more worse off than those found in the unassisted rental stock. They run the risk of not having their problems counted or addressed because advocates presume their current accommodations are problem-free.



Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.

Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

HOW MANY RENT-ASSISTED UNITS ARE WE CURRENTLY SHORT?

A conundrum arises when attempting to estimate the number of rent-assisted units needed to accommodate older households with priority or less serious problems. The difficulty arises because, as emphasized above, of the 7,758,000 age 65 and older households identified as having these problems, some 683,000 of them are already occupying rent-assisted facilities. Yet, when strictly interpreted as "problem" households, they would be considered *in need of* rent-subsidized units. At the same, some proportion of these "problem" households is probably methodological in origin. To address this issue, this report takes the position that the problem-afflicted low-income older households in rent-assisted facilities should be treated as a special category of need for which a solution must be found. However, for the purposes of estimating the current shortfall of rent-assisted units, these households will not be counted.

Currently, 1,216,000 rent-assisted units (AHS definition) occupied by age 65 and over households are serving an at-risk population of 7,075,000 *unassisted* renters and owners identified as having priority or less serious housing problems (Table 17). This translates into 5.82 *unassisted* older households for every one existing rent-subsidized unit now occupied by an older household. Obviously, to the extent that this at-risk older population is reduced to reflect the number of households with the most urgent needs, than both the shortfall and the ratio of 5.82 will become smaller. For example, advocates believing that only 2,699,000 older households with extremely urgent unmet needs (actually 2,699,000 less the 309,000 in rent-assisted units or 2,390,000) should be considered the at-risk population would identify a smaller shortfall and a smaller ratio of 1.97 at-risk older households for every one existing rent-subsidized unit).[30]

Subsidized Housing Projections - Table 17

Current Status and Projection Assumptions	Total Households	Total Unassisted Owned and Rented Households	Total Number of Owner-Occupied Households with Any Problems	Total Number of Unassisted Rental Households with Any Problems	Total Number of Owned and Unassisted Rental Households with Any Problems	Number of Rent-Assisted Households	1999-2020 Rent-Assisted Households Projected Growth Rate	Ratio of Unassisted Households with Problems to Rent-Assisted Households
Number of Age 65 and Over Households, 1999								
Current Status, 1999	21,423,000	20,207,000	5,135,000	1,940,000	7,075,000	**1,216,000**		**5.82**
Projected Number of Age 65 and Over Households and Rent-Assisted Units in 2020								
Rent-Assisted Unit Projection Scenarios								
(1) U.S. Census/Harvard Projected Household Growth Trends, 1999-2020	34,932,000	33,312,968	8,750,642	2,582,995	11,333,637	**1,619,032**	**33.1**	**7.00**
(2) Maintain 1999 Ratio of	34,932,000	32,984,331	8,750,642	2,582,995	11,333,637	**1,947,669**	**60.2**	**5.82**

Households with Problems to Rent-Assisted Units								
(3) Maintain 1999 Owner and Renter Household Distributions, 1999	34,932,000	32,949,210	8,750,642	2,582,995	11,333,637	**1,982,790**	**63.1**	**5.72**
(4) Proposed New Ratio of Unassisted Households with Problems to Rent-Assisted Households	34,932,000	32,665,273	8,750,642	2,582,995	11,333,637	**2,266,727**	**86.4**	**5.00**

Notes: Unlike previous household tabulations, these include older households at all income levels.
The growth of all household categories, regardless of rent-assisted unit projection assumption, is based on the U.S. Census/ Harvard projected household growth rates.

To estimate the number of rent-assisted units that will be needed to accommodate future at-risk low-income older households (in the year 2020), the analysis makes two general assumptions. First, the projections will be based on the number of rent-assisted units necessary to accommodate the growth of all the current age 65 and older *unassisted* owners and renters with priority or less serious problems (of all urgencies), a total of 7,075,000. Second, it will assume that these owner and renter groups of households will grow at the same rate as projected for all older owners and renters.[31]

Once making these assumptions, this report proposes four possible rent-assisted unit growth scenarios (Table 17):

Scenario One: The number of rent-assisted units for older households grows at the same rate between 1999 and 2020 as that projected for older renters generally (33.1%). This would result in a need for 1,619,032 rent-assisted units in 2020 and an estimated (and higher) 7.00 unassisted older households with a priority or less serious need for every one rent-assisted unit.

Scenario Two: The number of rent-assisted units for older household grows at a rate that maintains the same 1999 ratio of unassisted older households with problems to rent-assisted units, that is, 5.82. This would result in a need for **1,947,669** rent-assisted units and a 1999-2020 growth rate of 60.2%

Scenario Three: In 1999, all older households (of all incomes) in conventional dwellings can be divided into three groups based on their housing tenure status: 80.3% were homeowners, 14.1% were unassisted renters, and 5.7% were rent-assisted occupants. If the older households in 2020 maintain this same tenure distribution, then there would be a need for 1,982,790 rent-assisted units. This would result in 5.72 unassisted older households with a priority or less serious needs for every one rent-assisted unit and a 1999-2020 growth rate of 60.2%.

Scenario Four: In 2020, advocate for a ratio of unassisted older households with problems to rent-assisted units of 5.00. This lower ratio would result in a need for **2,266,727** rent-assisted units or a growth rate of 86.4%.[32]

The number of rent-assisted units needed under Scenario One is very much driven by 1999 to 2020 demographic projections for older households generally. Over this 21-year period, older homeowners are projected to grow in number at a faster rate than older renters. This accounts for

the relatively low growth rate of rent-assisted units. Scenario Two seeks to maintain the status quo with respect to the current (1999) ratio of unassisted older households with problems to rent-assisted units. Thus, to achieve this ratio given the relatively large projected growth of homeowners, requires that rent-assisted units grow close to the 1999-2000 rate projected for all households (63%). This consequently results in a relatively large number of "needed" rent-assisted units. Scenario Three seeks to insure that the share of rent-assisted units relative to owned and unassisted rental units remains the same. Once again to make this happen, assisted rental units must grow at a faster (overall household) rate than would be predicted by the demographic projections for older renter households generally. Thus, this scenario produces a similar need for rent-assisted units as Scenario Two. Scenario Four's estimate of rent-assisted unit need is strictly based on an advocacy position. The relatively large size of needed rent-assisted units is driven by the proposal to reduce the current (1999) ratio of unassisted older households with problems to rent-assisted units from 5.82 to 5.00. There is no scientific basis for this projection other than the obvious: if a higher share of future older households are to be served than currently, then the number of needed rent-assisted units will have to grow at a disproportionately large rate. Obviously, too, higher or lower ratios can be proposed as solutions.

It is important to recognize why projecting the need for rent-assisted units is so very different from private rental housing market demand studies. Most importantly, the usual consumer demand or supply influences are simply ineffectual predictors of market response. The major stakeholders involved in the production of housing often have few automatic economic incentives to respond to the affordable housing needs of low-income older Americans. Thus, neither the production, current availability, or pricing of affordable rent-subsidized units may bear any orderly relationship to the usual market demand and supply forces. Long-term imbalances between demand and supply are therefore not surprising and public policy responses usually offer the only remedy. Unfortunately, as already argued, government responses to consumer-housing mismatches experienced by older persons often are slow to occur and then they are inadequate. The most blatant example occurred during the four year period of the 1990s when the Federal government simply stopped funding tenant-based subsidies or vouchers that would have increased the supply of affordable rental units. The failure of the Section 202 program to produce units that merely keep up with the demographics of older household growth is yet another. Thus, projections of the future unmet need for affordable and good quality housing has more to do the influence of advocacy groups. What is unequivocal is that the gap exists today, is large, and remains unaddressed. The above four scenarios offer alternative explanations for why this future gap will remain constant, increase, or decrease in size.

Responding Specifically to the Affordability Needs of Older Homeowners

Older homeowners agree that they want to stay in their current residences even as they have very low incomes (cash-poor) and often confront burdensome property taxes, insurance, and upkeep expenses.[33] Although selling their dwellings would offer financial relief to many older persons, they usually are averse to this alternative. Two important government programs have helped to alleviate the financial plight of this group: The federally insured Home Equity Conversion Program (HECP) and State-administered tax relief programs.

THE HECM PROGRAM

The Home Equity Conversion Mortgage (HECM) insurance program[34] was created by the 1987 National Housing Act and made it possible for older households (age 62 and over) to obtain a federally insured reverse mortgage.[35] This is a financial instrument designed to allow older homeowners with lower incomes (cash-poor), but who occupy relatively high valued homes (house-rich), to borrow against the equity in their dwelling and receive tax-free cash payments, either advanced in one or more lump sums, in a steady stream of monthly income payments, in the form of a purchased annuity, or some combination of these payment types. This group would otherwise have difficulty obtaining conventional forward mortgages or home equity lines of credit because of their low incomes.[36] Older households can use these funds for any purpose, whether for a vacation or to pay for health care costs. Borrowers do not have to pay back their loans (and the imputed interest) until they die, sell, or permanently move out of their homes.

These mortgage instruments differ in various ways: by their term length, the length of the period over which the homeowner can receive advance cash payments, the circumstances under which the loan is repaid, and by how the cash value of the dwelling is received.[37] The costs for originating a HECM include the origination fee, a 2% mortgage insurance premium and closing costs. The present value of future monthly serving fees is also subtracted from the amount. Because these fees are included (that is, financed) as part of the loan, the total closing costs are typically about $10,000 or easily about 15% to 20% of the total amount borrowed. The Federal Housing Administration (FHA) insures HECM loans originated by FHA-approved lenders to protect the lenders against loss if the cash advances exceed equity when the older occupants or their family members sell the property.[38]

In light of the financial attributes of this loan instrument, older homeowners most likely to benefit will have certain predictable characteristics: they will be older, living alone, very poor, and will live in higher valued dwellings (that is, house-rich and cash-poor). The ideal applicants will also have no immediate plans to leave their houses in the short-term. Otherwise loan costs will be exorbitantly high relative to the overall size of the loan itself. Thus, the typical demographic and housing characteristics of loan participants are predictable.[39] Forty-nine percent of the borrowers are age group, 75 and over, 28% age 70-74, 17% age 65 to 69, and only 6% age 62 to 64. Most loan participants (just over 70%) lived alone. The race/ethnicity profile is very similar to the overall profile of elderly homeowners and 86% are non Hispanic whites, 9% are African-Americans, 3% are Hispanics and 1% are from other races. The median property value of HECM borrowers was $107,000 at the time of application, but two-thirds had properties valued over $87,000. Most HECM participants chose the line of credit reverse mortgage, or this option in combination with the fixed term option, whereby monthly payments are provided to borrowers over a specified time period.[40]

There is consensus that the widespread adoption of this mortgage instrument would lead to a significant point decline in the percentage of low-income older homeowners below the poverty level.[41] Advocates are also increasingly viewing it as a financial tool that not only allows older homeowners to maintain their immediately past consumption patterns, but also to pay for new long-term care costs. These could include: financing of long-term care insurance, retrofitting of homes

for disabled elderly, paying for private home and community based care, and respite care for the adult children of an ailing parent.[42]

While the growth of mortgages processed by HECM along with the other private sector programs has steadily grown,[43] nonetheless, through 2001, only 50,000 reverse mortgages had been insured under this program (plus another 10,000 private sector products).[44] Moreover, the annual number of originating mortgages has never exceeded 10,000.[45] Thus, this program addresses the needs of an extraordinarily small percentage of older homeowners.

Experts explain this low demand by several factors. Central is the reluctance of older homeowners to borrow on their home's equity because they see it as a last resort security blanket. Economic theorists further argue that older homeowners are unlikely to behave as predicted by the life-cycle hypothesis of consumption, proposing that consumers as they became older would draw down their housing equity to obtain greater liquid consumer income. Rather, research shows that even when homeowners move, a large share does not reduce their home equity values.[46] The reluctance to participate in this type program may also be linked to the desire of older homeowners to leave their wealth to their children and their reluctance to take on any forms of new debt. Older persons may be further motivated by the many income or medical assistance programs that do not count the home as an asset when considering eligibility.[47] They also may perceive these instruments as too complex or be dissuaded by their relatively high up-front loan costs (these can easily represent as high as 15% to 20% of the loan's principal) or the limits on the size of the HECM loan. It is also the case that the older homeowner who needs the most assistance often lives in a very low-valued home and most lenders appear reluctant to give a reverse mortgage to those owning homes valued at less than $40,000.[48]

Lenders, themselves, consider the HECM loans excessively time consuming and complex to implement and fear that elderly homeowners may let their homes fall into serious disrepair, thus violating the loan requirements. The estimation of the size of the older household market for reverse mortgages varies tremendously depending on assumptions regarding the demographics, income levels, household composition, and house values of the targeted market.[49] They have ranged from a low of 800,000 to a high of 6.7 million older households.[50]

This report also estimates the potential size of eligible older (age 62 and over) homeowner group. Several assumptions were made. First, the potential market for reverse mortgages includes households with low-incomes (income under 80% area median income).[51] Second, the mortgage transaction costs would likely make this financial instrument unattractive for households occupying dwellings valued under $40,000. As a corollary to this assumption, there is also reason to expect that dwellings at these lower values would also be less attractive to mortgage lenders because of a greater risk of depreciation and under-maintenance. Third, it was assumed that households eligible for these loans had no mortgage on their dwellings (they owned their units free and clear). Fourth, it was *not* assumed that there was an upward limit on the value of the dwellings occupied by households likely to demand the product. Fifth, it was assumed that older households most likely to entertain obtaining this type of mortgage would already be experiencing difficulties meeting their consumer needs. To operationalize this assumption, it was assumed that only older households that were currently (as defined by the 1999 American Housing Survey) experiencing either a severe or moderate housing burden or were living in dwellings that had unmet severe or moderate physical

deficiencies would be included as potential consumers of this mortgage instrument. Households living in dwellings in poor physical condition are included because of the legitimate argument that affordability problems are worsened by the potential expense of having to make repairs and renovations.[52] Thus, the market for this mortgage alternative included only low-income households with either (or both) priority or less serious housing problems, who owned dwelling valued over $40,000 and did not have a current mortgage. Based on these assumptions, the potential number of low-income elderly homeowners who would seek this lending instrument can range from 1.9 million to just over 2.8 million households depending on what subgroups of low-income households are targeted. If, for example, only extremely low-income households with priority problems, are considered the primary market, the demand for this mortgage instrument demand is likely to be just over 1 million older households.

STATE-ADMINISTERED PROPERTY TAX RELIEF PROGRAMS

State governments have attempted to reduce the property tax burden of older homeowners (and renters) in several ways. [53] Tax relief instruments have included the following. *Homestead exemptions* lower the assessed value of the property subject to taxation. *Homestead credit programs* typically offer direct rebates either as a percentage of taxes or as a fixed credit to qualifying owners, such as elderly homeowners. *Circuit breaker programs* provide a direct tax credit on the property tax bill that is typically larger for lower income households. A fourth approach, *property tax deferral programs*, allows older homeowners to defer payment of property taxes until they sell the home or die. Deferred property taxes become a lien against the value of the taxpayer's home and have similar financial properties as reverse mortgages.

Every State provides some type of property tax relief program, but the size of the benefits vary greatly. Most States favor targeting relief to low-income elderly households and forty-four States and the District of Columbia have at least one property tax relief program that treats elderly homeowners more generously than nonelderly homeowners.[54] An AARP investigation found that older homeowners were more aware of and were more likely to apply for homestead exemption programs. [55] In contrast, seniors were less likely to be aware of or to use circuit breaker and homestead credit programs. They most infrequently used property tax deferral programs. Over 40% of the study's participants reported that they did not apply for these programs because they did not need assistance. However, about 33% of this group indicated that with more information or with help filling out the applications, they would apply. Another 25% reported that they were unaware of these tax relief options, while 14% did not think they would qualify. The report indicated that further outreach efforts would likely to be effective for all types of property tax relief programs.

Despite these programs, property tax burdens remain high for many low-income elderly homeowners, because eligibility is often restricted to homeowners who have very low levels of income or assets and because the participation rate by elderly homeowners in these relief programs is often low.[56]

Unmet Supportive Service Needs of Elderly in Conventional Unassisted Housing Units

THE INDEPENDENT LIVING PROBLEM

Older persons experience another very different category of housing-related problems when they have physical or cognitive limitations that make it difficult for them to conduct their usual life styles, take care of themselves, or maintain their dwellings without the help of others. Depending on the types and seriousness of their impairments, they may have to adopt one or more of the following options: secure help from family members or move into a family member's home; obtain homemaker assistance, help with personal care, or nursing services from professional paid providers, home-based services, or community care providers, or relocate to a supportive seniors housing option. Older persons that are more at risk of having these limitations and having the fewest options will have one or more the following risk factors: they will be chronologically very old, will be poor, alone, unable to secure any type of assistance from family, less educated, or belong to a racial or ethnic minority.[57]

Older persons may find that they have significantly less disposable income if they incur out of pocket costs for home- and community-based care and health care expenses, in particular prescription medicine costs. Those on fixed incomes may particularly find that paying for these expenses results in their once tolerable housing costs becoming a new burden, and in the case of older homeowners, make it difficult for them to afford their dwelling's maintenance, upkeep, and upgrading costs.

The physical environment of the dwelling has the potential for worsening the affects of these physical and cognitive limitations. The design features and overall physical condition of a dwelling and its location relative to everyday needs may offer new obstacles or even an unsafe environment for impaired older persons to conduct their accustomed life-styles. Among the possible consequences: a car or a bus route may become unusable and accessing everyday community needs may become very difficult, an upstairs of a dwelling may suddenly become inaccessible, throw rugs may become a walking hazard, using a stove may become unsafe, or a bathroom's shower or toilet may be difficult or impossible to use.

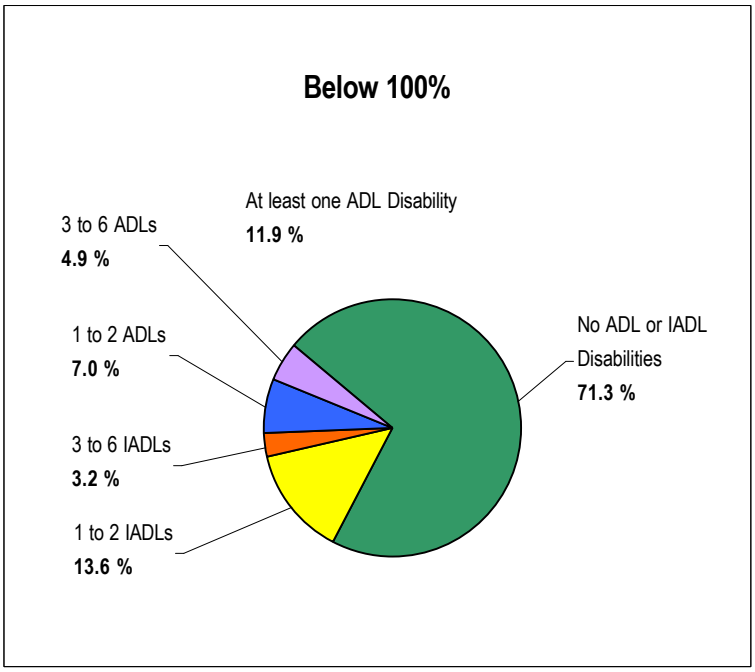
Older persons with unavailable family supports and with the lowest incomes represent the greatest potential demand on their State and locality's government-subsidized long-term care resources. Thus, these limitations are not just a personal affair, they become the "problems" of stakeholders in the public sector.

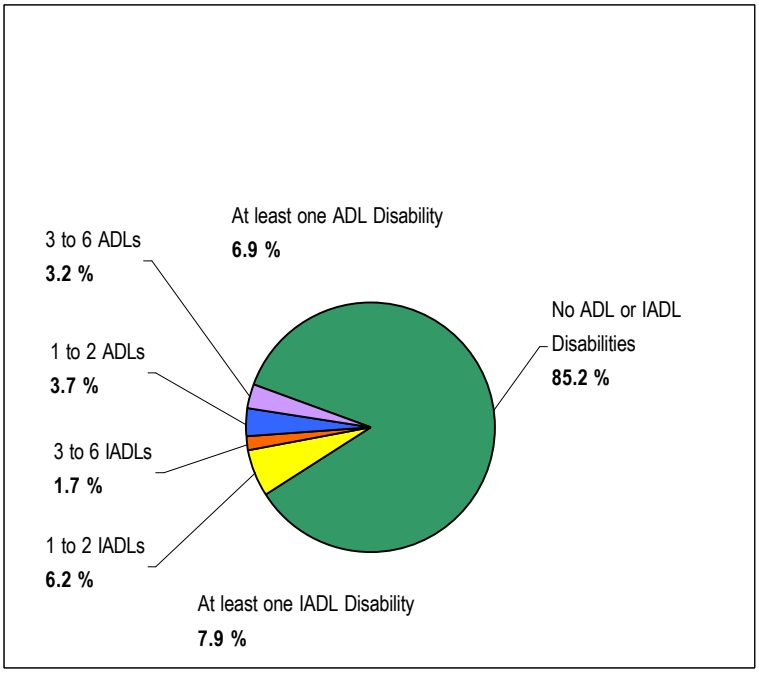
THE OVERALL MAGNITUDE OF THE CURRENT DISABILITY PROBLEM

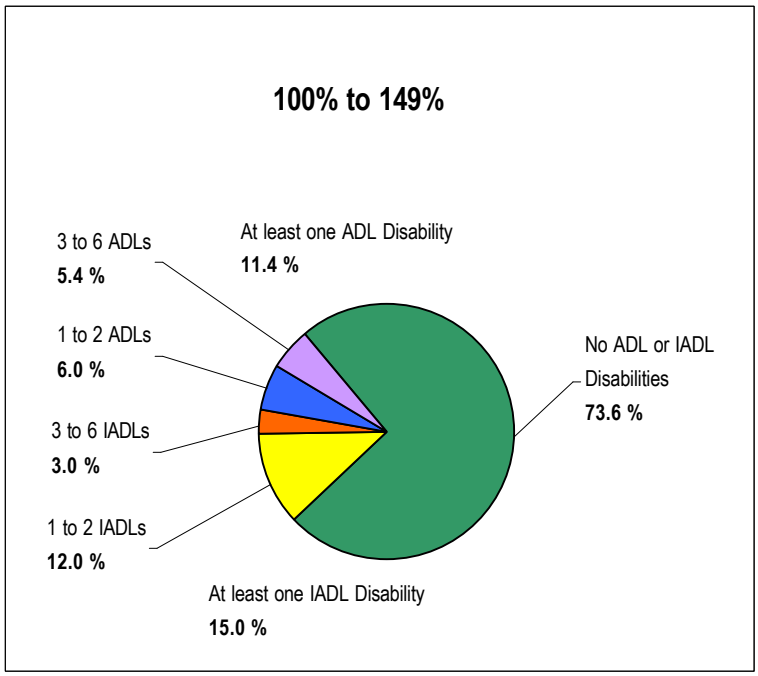
In 1996, over 5.79 million or 18% of older persons aged 65 and over, who did not occupy institutions such as nursing homes, had difficulty performing without assistance either their everyday activities of daily living (ADLs) or their instrumental activities of daily living (IADLs) (Figure 39). They included about 3.18 million or 10% of older persons with at least one IADL limitation involving the following activities: preparing meals, doing light housework, taking right amount of medicine, keeping track of money, or bills, and going outside the home. They also included about 2.61 million or 8% of older persons with at least one ADL limitation involving the following activities: getting in and out of bed or a chair, taking a bath or shower, dressing, walking, eating, and using or getting to a toilet. A smaller share of these older persons, 1.19 million or 3.7%, were especially impaired because they had limitations in three or more ADLs (Figure 39). Just more than 2.6 million or 8% of older persons had a mental disability (based on five different indicators,

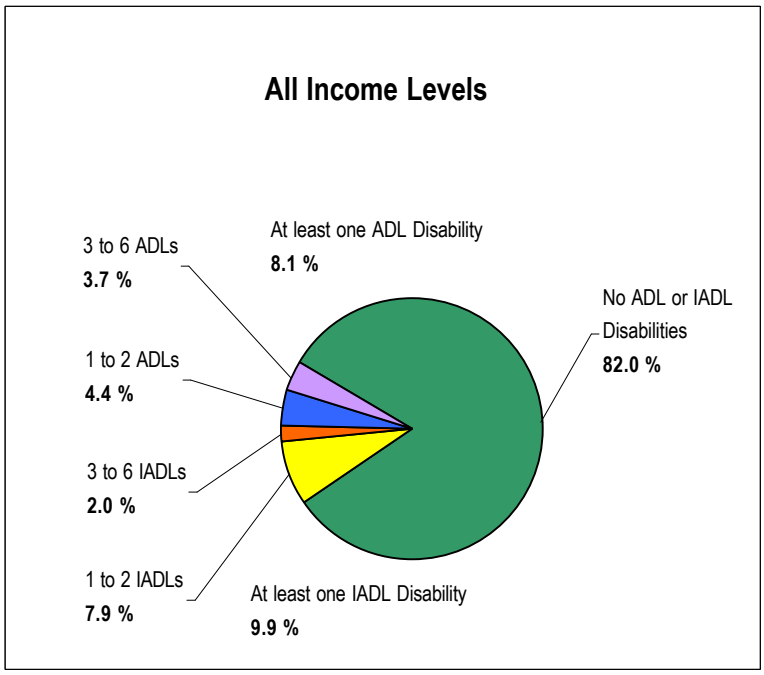
see Attachment I) that seriously interfered with their everyday activities (Figure 40). Predictably, chronologically older persons are more likely to suffer from these limitations. Just over 15% of old-old (age 75 and over) persons have IADL impairments, almost 13% have ADL impairments, and just under 12% had a mental disability interfering with everyday activities.

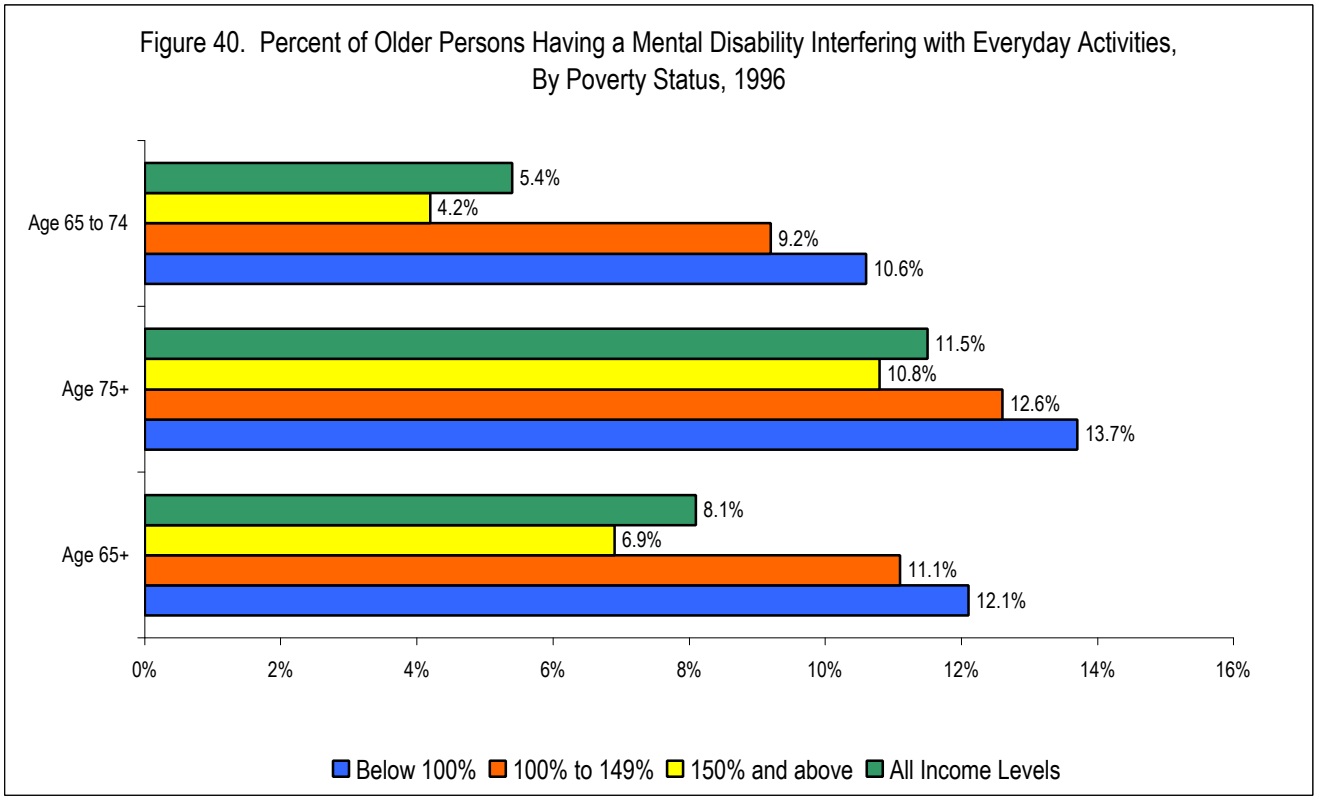
Figure 39





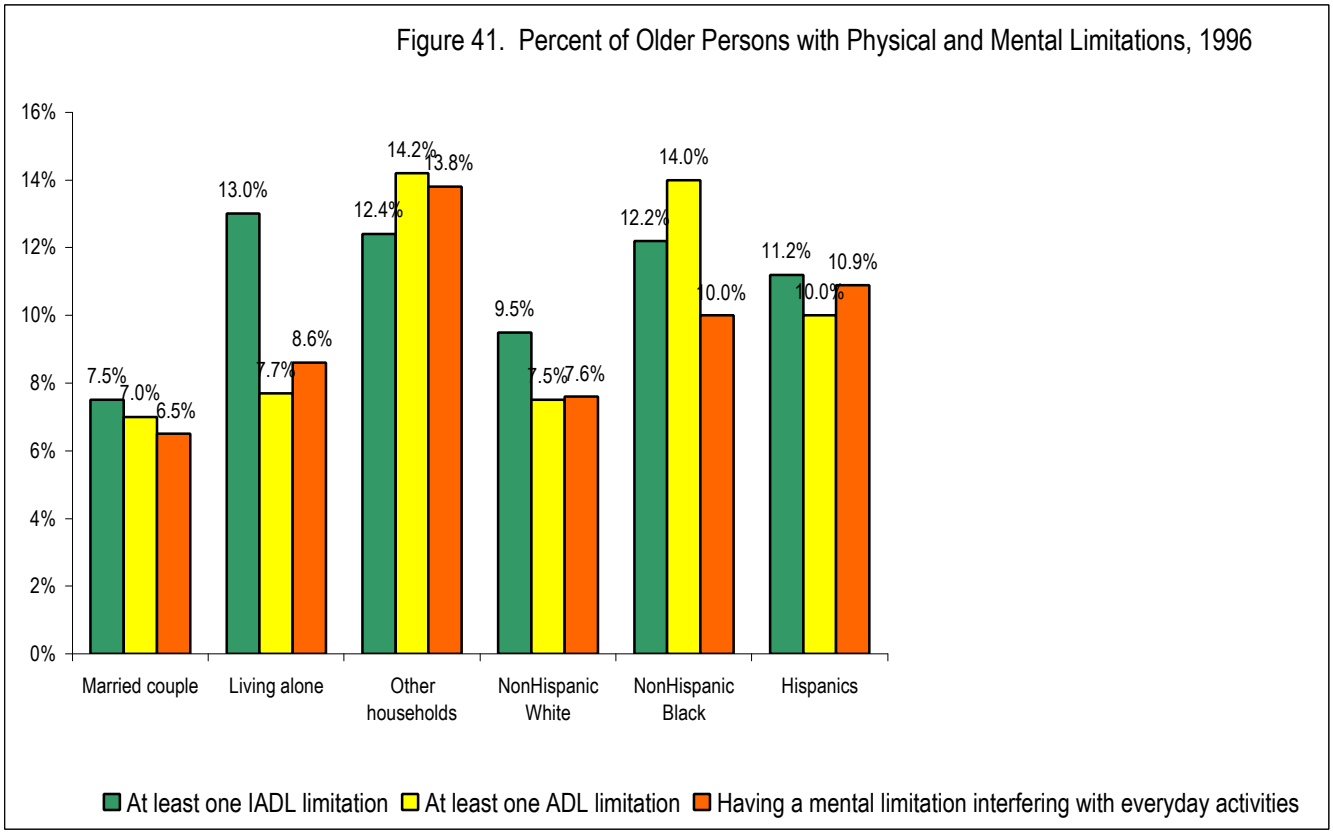

100% to 149%
3 to 6 ADLs
5.4 %
At least one ADL Disability
11.4 %
1 to 2 ADLs
6.0 %
No ADL or IADL
Disabilities
73.6 %
3 to 6 IADLs
3.0 %
1 to 2 IADLs
12.0 %
At least one IADL Disability
15.0 %


All Income Levels
3 to 6 ADLs
3.7 %
At least one ADL Disability
8.1 %
No ADL or IADL
Disabilities
82.0 %
1 to 2 ADLs
4.4 %
3 to 6 IADLs
2.0 %
1 to 2 IADLs
7.9 %
At least one IADL Disability
9.9 %



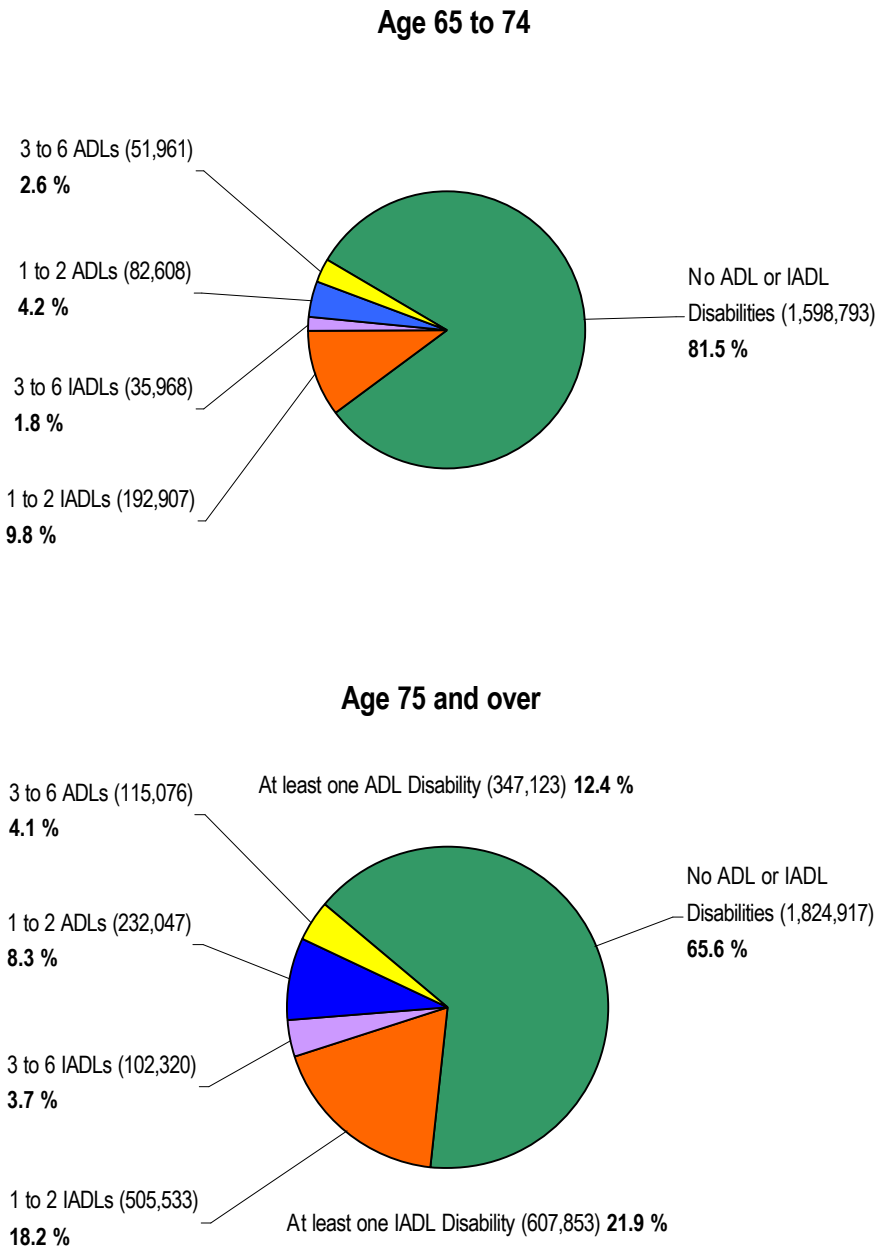
Income level is an important predictor of whether older persons are more likely to have ADL or IADL limitations (Figure 39). Older persons with incomes above the 150% poverty threshold are about 50% less likely to suffer from an IADL limitation, 59% less likely to suffer from an ADL limitation, and 60% less likely to have a mental disability than are older persons below the 100% poverty level.[58] The prevalence of these limitations was also much higher for older African Americans and Hispanics, groups more likely to have lower incomes, than nonHispanic white seniors (Figure 41).

Type of household arrangements is also an important basis for predicting older persons' risk of having physical and cognitive limitations. Persons who live alone and who are in "other household" arrangements have substantially higher limitation rates than married couples (Figure 41). Older persons in other household arrangements are especially likely to have IADL (12%), ADL (14%), and cognitive (14%) limitations. It is likely that these higher levels of impairment were one of the main reasons for why these unmarried older persons (mostly women) are living with a family member or an unrelated person.



Older persons who are in more than one of the above "higher risk" groups are especially likely to be vulnerable (Figure 42). Almost 1 million age 75 and over persons, below the 150% poverty income level, and living alone, had difficulty performing without assistance either their everyday activities of daily living (ADLs) or their instrumental activities of daily living (IADLs). This group included almost 22% or 608,000 older persons who had difficulty performing without assistance at least one IADL and over 347,000 or over 12% of older persons who had difficulty performing without assistance at least one ADL. A smaller number of these older persons, over 115,000 or over 4% were especially impaired because they had limitations in three or more ADLs. Over 322,000 or 12% of these older persons had a mental disability that seriously interfered with their everyday activities (Figure 40).

Figure 42. The Number and Distribution of Physical Limitations Among Low-Income (Below 150% poverty level) Older Persons Living Alone, By Age, 1996

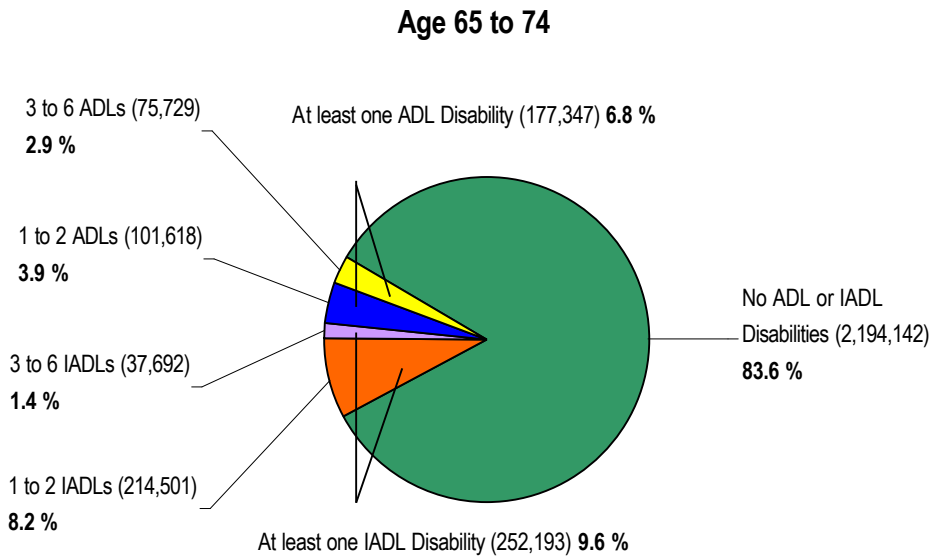


THE MAGNITUDE OF THE DISABILITY PROBLEM FOR OLDER PERSONS IN DIFFERENT TYPES OF CONVENTIONAL HOUSING

Older renters (outside of government-subsidized rental facilities) are more likely to report having physical limitations than older homeowners, even after considering the age and income differences that also differentiate these two groups (Figures 43 and 44).[59] The differences between poor (under

150% poverty level) old-old owners and old-old unassisted renters are especially notable (Figure 44). Two examples are illustrative: (1) About 18% of poor age 75 and over homeowners compared with 27% of the comparable age group of renters reported at least one IADL deficiency; and (2) 6.3% of poor age 75 and over homeowners had 3 or more ADL deficiencies compared with 8.4% of the comparable age group of renters. Even though the likelihood of having IADL or ADL limitations is greater among poor older renters, when even a small percentage of poor older homeowners have these limitations, their numbers are very large. Thus, over 1.3 million poor older homeowners have at least one ADL or IADL limitation compared with just under 600,000 poor older unassisted renters.

Figure 43. The Number and Distribution of Physical Limitations Among Low-Income (Below 150% poverty level) Older Homeowners, By Age, 1996



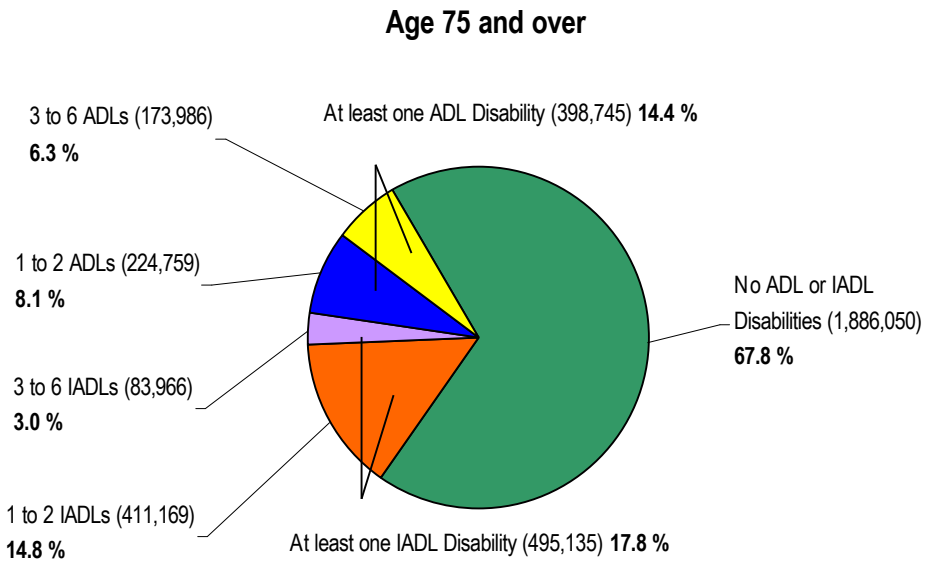
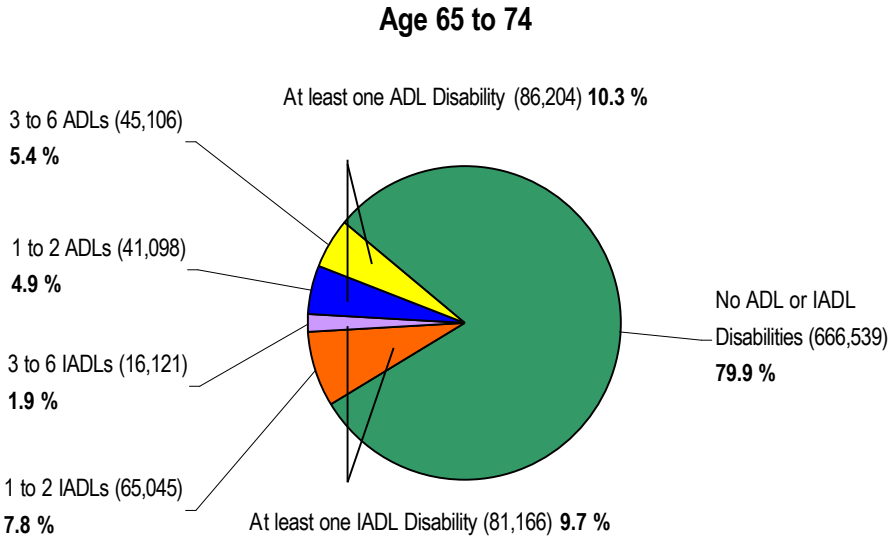
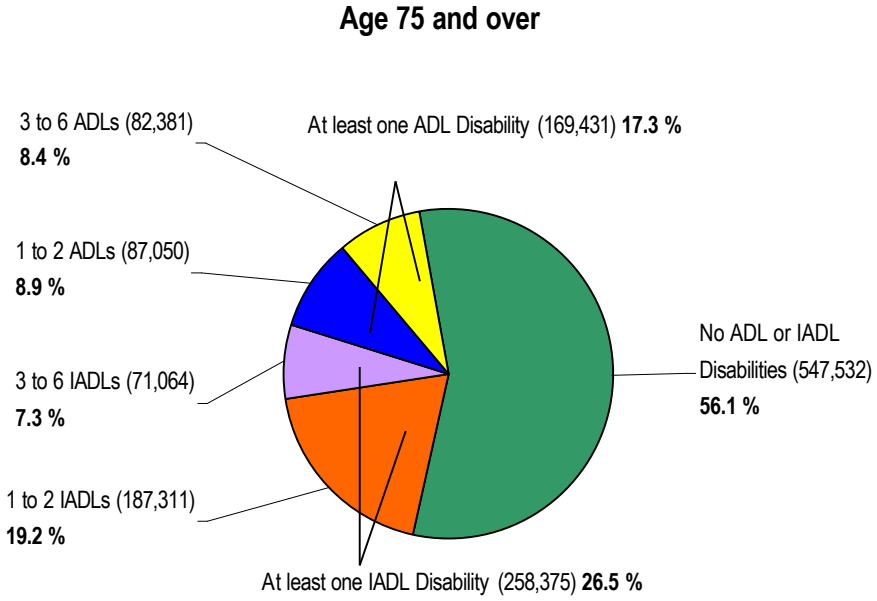


Figure 44. The Number and Distribution of Physical Limitations Among Low-Income (Below 150% poverty level) Unassisted Renters, By Age, 1996





Even these disability patterns tell an incomplete story. The prevalence of physical limitations differs greatly between poor (under 150% poverty level) older homeowners living in low-valued dwellings and higher-income older homeowners living in higher-valued dwellings (Figures 45 and 46). This is important because poor older persons in lower valued dwellings are less able to draw on the equity in their dwellings as a source of cash income. The over 440,000 homeowners who are both cash-poor and house-poor and who have at least one IADL or ADL limitation constitute an especially vulnerable group without the financial wherewithal to take care of themselves or their dwellings.

Figure 45. The Number and Distribution of Physical Limitations Among Low-Income (Below 150% poverty level) Age 65 and Over Persons in Dwellings Valued at $40,000 or Lower, 1996

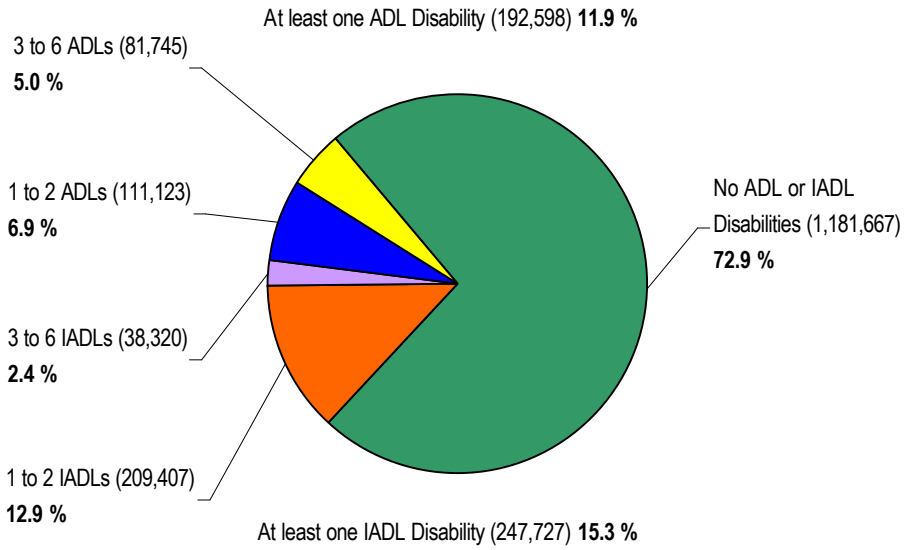
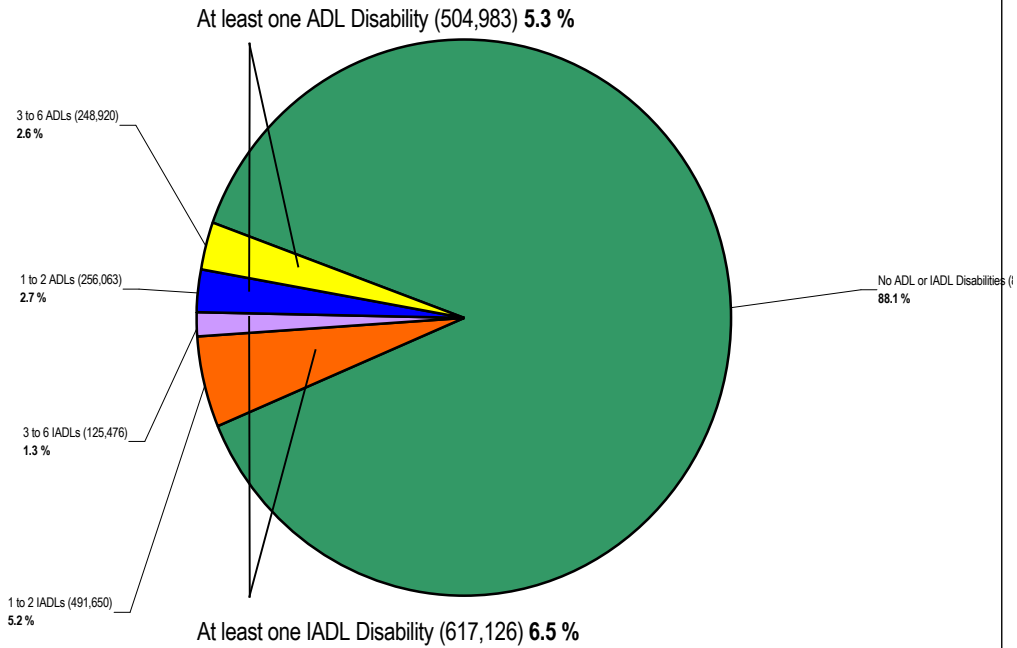


Figure 46. The Number and Distribution of Higher Income (Above 150% Poverty Level) Age 65 and Over Persons In Dwellings Valued at $100,000 and Above



THE UNMET DWELLING MODIFICATION NEEDS OF OLDER PERSONS WITH ADL AND IADL LIMITATIONS

When older persons are afflicted with physical or cognitive limitations, they may find it more difficult and unsafe to occupy their unit. This occurs even in dwellings that are in relatively good physical condition, that is, do not have the more serious HUD-defined severe or moderate physical deficiencies. Rather, dwellings simply have features that are incompatible with their frail occupants because they were not designed with the needs of an aging person in mind. Perhaps in the future, "designing in a way that makes housing work better for all people of all ages"—what is known as "universal design" will become a reality.[60]

Most professionals argue that the home can be physically modified in ways that will enhance the independence of older Americans.[61] If there are appropriate home environmental interventions, it may even be possible to slow the rate of functional decline and reduce the costs of in-home personnel.[62] Home modifications are likely to have the greatest positive effect on that very large group of older persons with fewer and less severe limitations.[63] Other investigations have argued that older persons living alone will benefit the most.[64] On the other hand, at least one contrarian investigation showed that nonsyncopal falls (those not caused by blacking out or losing consciousness) were not consistently related to the typical home environmental hazards.[65]

Estimates as to what percentage of older Americans has modified their dwellings to accommodate their frailties vary greatly.[66] The most recent and optimistic analysis found that in 1995 only 45% of elderly households with activity limitations (42% of homeowners and 55% of renters) in need of home modifications had actually made some adjustments.[67] The most common modifications by elderly homeowners included handrails or grab bars by about 27.6% of this group. The next most frequent modifications were specially equipped telephones (7.2%), easy-access bathrooms (7.1%), widened doors or hallways (5.9%), easy-access kitchens (5.0%), and door handles instead of knobs (3.8%).

Elderly persons report that their most needed home modifications include handrails or grab bars (401,000 households or 8.4% of households with activity limitations), ramps (311,000 households or 6.5%), easy-access bathrooms (268,000 households or 5.6%), specially equipped telephones (185,000 households or 3.9%0, easy access kitchens (144,000 households or 3.0%), elevators or stair lifts (140,000 households or 2.9%), widened doors or hallways (138,000 households or 2.9%), and modified sink faucets or cabinets (105,000 households or 2.2%).[68] These relatively small percentages should be interpreted cautiously. A great many older persons are probably unaware of their home's hazards or are unaware that solutions exist. Thus, older persons who fail to report a need for home modification could very well benefit greatly if they were introduced into their homes.[69]

Older persons with more severe disabilities and health problems were more likely to make home modifications.[70] These included older persons with diseases such as diabetes and stroke, who had a fall or specifically a hip fracture, or a joint replacement.[71] Many older persons, however, are discouraged from making home modifications because of the many obstacles linked with implementation. This is especially true for less educated seniors because of the complexities of the application process for financial resources to carry out such work.[72] Home modifications are also

less likely by households with incomes below the poverty level, who own low valued homes,[73] and are Hispanic or African American. Seniors, generally fear dealing with contractors or home repair personnel because they often overcharge or do inadequate work. Both consumers and professionals, including home builders, remodelers, and human service professionals have inadequate knowledge of the physical attributes of the home that would benefit from modification. The older dwellings occupied by today's older adults only compound an already difficult situation because they often only deal only with the most serious maintenance needs, while they neglect the less visible home hazards needing modification.[74] What does not matter is also important. Seniors who made home modifications had the same or greater availability of informal supports as those without modifications. In short, dwelling physical modifications did not substitute for personal care and households with more modifications actually had more helpers.[75]

GOVERNMENT RESPONSES TO THE UNMET HOME MODIFICATION AND REPAIR NEEDS OF OLDER AMERICANS

Most studies conclude that older persons would be more likely to physically modify their dwellings if government programs were more available and effective. The most important Federal programs that now fund home modification and repair services are the block grant programs sponsored by the U.S. Department of Housing and Urban Development (Community Development Block Grant) and the Department of Health and Human Services' Social Services Block Grants and Title III of the Older Americans Act. The Rural Housing Services, Section 504 home repair loan and grant program, and the Section 533 Housing Preservation Grant program (HPG) also provide grants to nonprofit organizations for the rehabilitation of homes.[76] Weatherization adaptations are funded under the Department of Energy's Low-Income Home Energy Assistance Program (LIHEAP) and the Weatherization Assistance Program. State-sponsored programs are also increasingly important funding sources. Outside of the government, foundations and charitable organizations are also key sources of funds. For most organizations that offer modification and repair services, however, this activity is very small.

Advocates argue that along with these programs' insufficient budgetary allocations, they are less effective than they could be for the following reasons:[77]

- There is poor coordination and communication among the numerous organizations and agencies that provide in-home services to older persons—personal care, homemaker care, home repair, modification, and weatherization activities.
- Home modification and repair needs are often not appropriately assessed and thus more education and training is required for those interfacing with the older client.
- A single State or county organization is often absent that is willing to assess and advocate for consumer needs, identify current weaknesses in the delivery of home modifications services, and better organize these efforts.[78]
- Care managers and human service providers insufficiently inform older persons about the importance of making these repairs and modifications.
- Program funds are disproportionately spent on repairs as opposed to home modifications, driven in considerable part by the program mandates of funding sources such as the Community Development Block Grant program.

- The funding provided by Medicare and Medicaid programs do not sufficiently cover the costs of items such as assistive devices, home modifications, and occupational therapist visits.

THE PROJECTED MAGNITUDE OF THE DISABILITY PROBLEM TOMORROW

Researchers examining different data sets agree that between the early 1980s and the late 1990s older Americans were less likely to report having physical or cognitive disabilities.[79,80] The most influential work, by Manton, shows how both the prevalence in both ADL and IADL limitations, and especially the latter, declined between 1982 and 1999.[81] This trend is usually linked to the higher education levels of successive generations of older persons and in turn to their adoption of healthier life-styles. Since higher educational levels is also linked to higher incomes, it is also speculated that better educated older persons have had better access to health care and have been more able and motivated to comply with treatment regimens. Building on these past trends, most researchers speculate that these disability rates will continue to decline in the future as these past antecedents continue to operate.[82]

When predicting the future number of older persons (age 65 and older) who will suffer from physical and cognitive limitations, this report also assumes a declining annual disability rate. It also assumes that the older population will grow at an intermediate rate (as opposed to very high or very low) according to population projections of the U.S. Census.[83] Based on these assumptions, it is projected that by the year 2020 there will be 4.31 million older persons with IADL limitations, 3.62 million older persons with ADL limitations, and 3.58 million older persons with mental disabilities (Table 18). Most of this future group of older persons with these physical and cognitive limitations will be homeowners. The 26% to 28% projected growth rates of these disabled older populations between 2000 and 2020 will be lower than the projected overall growth rate of the older population, because of the assumed declining disability rates of the future elderly population. The over 3 million of this future older population expected to be frail will be especially disadvantaged because of their low incomes (under 150% of the poverty level) (Table 19).

Table 18. Change in the Size of the Age 65 and Over Noninstitutional Population with a Functional or Mental Health Disability, By Age and Housing Tenure, 1996 to 2020

Dwelling Tenure and Type of Disability	Number of Persons				Growth Rates			
	1996	2000	2010	2020	1996 to 2000	2000 to 2010	2010 to 2020	2000 to 2020
Total Owners	**26,202,110**	**27,158,000**	**30,399,000**	**41,232,000**	**3.6**	**11.9**	**35.6**	**51.8**
No ADL or IADL Disabilities	21,921,872	22,581,000	25,639,000	35,429,000	3.0	13.5	38.2	56.9
At least one IADL Disability	2,329,497	2,469,000	2,562,000	3,140,000	6.0	3.8	22.6	27.2
At least one ADL Disability	1,950,741	2,109,000	2,198,000	2,662,000	8.1	4.2	21.1	26.2
With a mental disability	1,944,134	2,055,000	2,134,000	2,635,000	5.7	3.8	23.5	28.2
Total Unsubsidized Renters	**4,536,431**	**4,858,000**	**5,610,000**	**7,692,000**	**7.1**	**15.5**	**37.1**	**58.3**
No ADL or IADL Disabilities	3,460,783	3,670,000	4,327,000	6,151,000	6.0	17.9	42.2	67.6
At least one IADL Disability	577,902	629,000	671,000	804,000	8.8	6.7	19.8	27.8
At least one ADL Disability	497,746	549,000	611,000	737,000	10.3	11.3	20.6	34.2
With a mental disability	492,137	528,000	580,000	715,000	7.3	9.8	23.3	35.4

Total Rent-Assisted	**1,320,098**	**1,397,000**	**1,610,000**	**2,235,000**	**5.8**	**15.2**	**38.8**	**60.0**
No ADL or IADL Disabilities	885,161	929,000	1,111,000	1,641,000	5.0	19.6	47.7	76.6
At least one IADL Disability	273,011	290,000	307,000	370,000	6.2	5.9	20.5	27.6
At least one ADL Disability	161,926	177,000	192,000	225,000	9.3	8.5	17.2	27.1
With a mental disability	156,815	163,000	181,000	226,000	3.9	11.0	24.9	38.7
All Age 65 and over persons	**32,058,639**	**33,328,000**	**37,619,000**	**51,159,000**	**4.0**	**12.9**	**36.0**	**53.5**
No ADL or IADL Disabilities	26,267,816	27,130,000	31,077,000	43,221,000	3.3	14.5	39.1	59.3
At least one IADL Disability	3,180,410	3,372,000	3,540,000	4,314,000	6.0	5.0	21.9	27.9
At least one ADL Disability	2,610,413	2,826,000	3,001,000	3,624,000	8.3	6.2	20.8	28.2
With a mental disability	2,593,086	2,742,000	2,896,000	3,575,000	5.7	5.6	23.4	30.4

Source: Projections were computed by The Lewin Group. Note: Several important assumptions underlie the above projections. First, it is assumed that both the ADL and IADL disability rates will start to decline in the period 1997-2000 at an annual rate of 1.00%. This rate of annual decline is projected to decrease by 0.1% every five years through 2020. The annual rates of decline are as follows: 2000-2005, 0.90%; 2005-2010, 0.80%, 2010-2015, 0.70%, 2015-2020, 0.60%. It is also estimated that the relative size of the older homeowner population will slowly decline through 2020. That is, it is estimated that the older renter population will grow faster than the older homeowner population.

Table 19. Number and Growth of Age 65 and Over Low-Income Persons Having Physical or Mental Disabilities, 1996 to 2020

Type of Disability	1996	2000	2010	2020	1996 to 2000	2000 to 2010	2010 to 2020	2000 to 2020
No ADL or IADL disabilities	5,993,167	6,189,880	7,090,412	9,861,142	3.3	14.5	39.1	59.3
At Least one IADL disability	1,293,889	1,371,834	1,440,181	1,755,068	6.0	5.0	21.9	27.9
At least one ADL disability	962,396	1,041,878	1,106,396	1,336,081	8.3	6.2	20.8	28.2
	8,249,452	8,603,591	9,636,990	12,952,292	4.3	12.0	34.4	50.5
With a mental disability	948,517	1,002,988	1,059,319	1,307,688	5.7	5.6	23.4	30.4

Source: Projections were computed by The Lewin Group. Note: Several important assumptions underlie the above projections. First, it is assumed that both the ADL and IADL disability rates will start to decline in the period 1997-2000 at an annual rate of 1.00%. This rate of annual decline is projected to decrease by 0.1% every five years through 2020. The annual rates of decline are as follows: 2000-2005, 0.90%; 2005-2010, 0.80%, 2010-2015, 0.70%, 2015-2020, 0.60%. It is also estimated that the relative size of the older homeowner population will slowly decline through 2020. That is, it is estimated that the older renter population will grow faster than the older homeowner population. It also assumes that the older population subgroups with incomes under the 150% poverty level will grow at the same rate as the older population overall.

THE CHALLENGES OF ADDRESSING THE CURRENT AND FUTURE NEEDS OF THE PHYSICALLY AND COGNITIVELY VULNERABLE OLD

The prospect of a large future population of elderly having difficulty taking care of themselves or maintaining their dwellings does not in itself translate into a major societal problem. Physical or cognitive limitations do not automatically result in older persons having unmet needs. These occur when other conditions exist: when family members, especially a spouse, are unable to provide care, when professional care is unaffordable or unreliable, when the costs of personal and medical care tax those on fixed budgets, when the occupied dwellings are in poor physical condition or are insensitively designed, when high-end assisted living facilities are priced beyond the income means of most elderly persons needing them, when lower-cost housing is not available that is organizationally linked with supportive services, and when older persons are forced to occupy a more restrictive care setting such as a nursing home.

Thus, forecasts of the future unmet housing-related needs of the disabled older population must attempt to predict the likelihood of these concurrent conditions. A major challenge is to predict the resources older persons will have available to address their long-term care needs. Currently, about 70% of older persons with either ADL or IADL limitations are found outside of institutions. What this percentage will look like two decades from now is dependent on a host of difficult-to-predict factors.

Foremost will be the extent to which family members will be able to shoulder the caregiving burden. Currently, about 57% of older persons outside of nursing homes will receive care only from unpaid providers (primarily family members), 7% from paid providers only, and 36% from both paid and unpaid providers.[84] Unpaid care is variously provided by spouses (24%), adult children (41%), other relatives (26%), and nonrelatives (9%). Women represent seven out of ten unpaid caregivers.[85] Predicting the future role of the unpaid caregiver turns out to be an extraordinarily difficult task despite the frequency of predictions to the contrary. This is because the relevant influences are both difficult to predict and contradictory. Among the uncertain indicators: the extent to which caregivers are geographically separated from older family members, the effects of smaller families, the higher percentage of childless women, the higher earlier divorce rate of potential caregivers, the higher workforce participation rates of potential female caregivers, and the higher percentage of older persons with ethnic and racial backgrounds (and different attitudes toward caregiving and institutionalization). A full examination of how these factors will influence the availability of unpaid professional care in the next twenty years itself constitutes a major study.[86]

The extent to which older persons living in conventional dwellings will be able to afford the cost of long-term care services will be a crucial factor. In the year 2000, the Congressional Budget Office estimated that older persons paid out-of-pocket $8.5 billion or 23% of the $37.2 billion for all community-based long-term care costs, that is, for services delivered to older persons outside of institutions. These services included post-acute care, personal care, and supportive services, such as homemaker services. Medicare picked up $17.1 billion or 46% of the costs, and Medicaid covered $7.1 billion or 19% of the costs. Other smaller program, payer, and long-term care insurance sources covered the remaining $4.5 billion or 12% of the costs.[87]

In 2020, the Congressional Budget Office has estimated that the total costs for long-term care services provided outside of institutions would rise to $68.6 billion. Elderly out-of-pockets costs are predicted to represent a smaller share, $7.3 billion, or 11% of year 2000 dollars. Medicaid is predicted to account for a larger share, $17.7 billion, or 26% of these costs along with private long-term care insurance, $10.2 billion, or 15% of the costs. Medicare is expected to pay 45% or $31.0 billion of the costs with other payers covering 3% or $2.4 billion. Currently, less than 10% of the elderly and a small percentage of the near elderly population have purchased long-term care insurance.[88]

In 1997, noninstitutionalized Medicare beneficiaries were projected to spend an average of $2,149 on out-of-pocket health care payments, excluding the costs of home care and nursing facility services. Of this amount, 49% was for direct payment for health services, 31% for private insurance or HMO premiums, and 20% for Medicare Part B premiums. Almost 20 of these out-of-pocket costs alone were for prescription drugs. These out-of-pocket costs consumed an average of 21% of the

monthly income of these Medicare beneficiaries but the burden was especially high for Medicare beneficiaries with incomes below the Federal poverty level, but who did not receive Medicaid assistance. They spent about half their income, on average, on out-of-pocket spending (whether or not they were enrolled in managed care).[89]

Predictions regarding the future out-of-pocket costs that seniors not in institutions will have to pay for their long-term care and health expenditures and the extent to which they will be an excessive economic burden are nonetheless plagued with uncertainties. Among the difficult-to-predict variables:

- The disposable income and savings of seniors.
- The extent to which caregiving will be offered by unpaid caregivers, predominantly family members.
- The growth of funding availability for Medicaid and Medicare programs.
- The overall relative importance and coverage policies of Medicaid and Medicare as payers of care.
- The growth rate and coverage flexibility of Medicare home health care spending.
- The growth rate and flexibility of coverage of home and community based services covered under the Medicaid Waiver program.
- The share and availability of Medicaid expenses paid for by State governments.
- The extent to which some share of long-term care expenses will covered by other government programs, such as the Older Americans Act, the Social Services Block Grant program, and the Department of Veterans Affairs.
- The relative importance of long-term care insurance as a payer of care.
- The extent of the out-of-pocket expenditure burden of prescription drugs.
- The extent to which the estate recovery laws will discourage the use of the Medicaid program to subsidize nursing home occupancy by seniors.

Future predictions are also made difficult because of the blurring distinctions between traditional shelter and long-term care settings. The affordability of long-term care cannot be easily separated from the usual costs of shelter. Thus, to the extent that the usual costs of occupying conventional housing settings or the shelter component consumes an increasingly larger share of the older persons monthly budget, then long-term care costs become increasingly unaffordable. This also influences the long-term care policies of State governments because the allocation of Medicaid Waiver funding to shelter and care facilities, for example, assumes that the shelter costs can be adequately covered by other government programs, such as State supplements to Supplemental Security Incomes or by consumers, providers, family members, or by other government programs. To the extent that shelter costs become a more expensive component in the shelter and care setting, this assumption may have to be revisited and may hamper the ability of State governments to maintain their current long-term care subsidization practices.[90]

The role nursing homes will play in the future long-term care network will be crucial but very unclear. It will depend not only on the changing economic costs of providing nursing home care but also the competitive influences of shelter and care alternatives, such as assisted living facilities, continuing care retirement communities, and rent-assisted facilities that can be linked with affordable supportive personal care and health services.

Most expect that the nursing home will become increasingly reserved for only the most frail. Certainly, this reflects past trends. Over the past two decades, the nursing home population in the United States became older, more functionally disabled, and more racially diverse.[91] In one representative period, between 1984 and 1994, the disability profile of older people in nursing homes changed significantly, with sharp declines in the relative size of older occupants with only IADL and 1-2 ADL impairments.[92] Yet, there are countervailing trends. Many nursing homes have been transforming themselves "from organizations focused only on serving long-stay institutional care to organizations providing care to all segments of the LTC market—subacute care, assisted living, home care, and adult day care."[93] Thus, over the next two decades, what we now consider familiar long-term care categories could become indistinguishable and merged into new hybrid forms.[94]

Like the nursing home population, the disability profile of older users of long-term care who have remained in their own dwellings has also changed over time. A higher share of this group is now more physically and cognitively impaired at least partly because of the greater availability of government-supported home and community based care.[95] A changed and more favorable regulatory environment was central, as both Medicare and Medicaid-funded home-based care became both more available to consumers and provider-friendly. Thus, between 1990 and 1997 the average annual growth rate of Medicare home health care spending was 25%, more than three times the growth rate of the total Medicare program. Warning again about the dangers of straight-line predictions, however, legislation in 1997 effectively slowed down this growth. The new interim home health care payment system in 1997, a prelude to the case-mix adjusted prospective payment system, lead to a drop of 40% in home health care visits between 1997 and 1998.[96] Yet, even in the very same period, the use of Medicaid long-term care spending varied tremendously by States, yet another source of uncertainty when predicting the future use of long-term care.[97] Thus, the future is difficult to predict and the only certainty will be the twists and turns of regulatory incentives and constraints over the next two decades.

The role of the court system may also be influential as exemplified by the 1999 Supreme Court Decision, *Olmstead v. L.C.* The court ruled that title II of the Americans with Disabilities Act (ADA) prohibited States from unnecessarily institutionalizing persons with disabilities (old and young) and from failing to serve them in the most integrated setting in light of their disabilities. Thus States are obligated to provide such services and programs so along as it does not represent a fundamental alteration of their public programs and constitutes a reasonable accommodation to their needs. The ruling—which is still being played out in uncertain ways—has particular relevance for the use of the Medicaid program to pay for long-term care. States traditionally have used Medicaid funding to subsidize the costs of nursing home care but a growing proportion of the past decade's Medicaid long-term care expenses have funded home and community based care for low-income older persons. The *Olmstead* ruling suggests that a State's failure to adequately fund home and community based waivers (e.g., for persons on a waiting list) would be in violation. Thus, arbitrary expenditure caps that could be shown to result in institutionalization or reinstitutionalization would seemingly violate the ADA. Still, the full implications of the *Olmstead* decision for State programs is unknown. As a U.S. General Accounting Office report summarized[98]:

> *While the Supreme Court held in Olmstead that institutionalization of people with disabilities is discrimination under the ADA under certain circumstances, it also recognized that there are limits to what States can do, given available resources and the obligation to provide a range of services for people with disabilities. Most States are responding to the decision by developing plans for how they will serve people with disabilities in less restrictive settings. These plans are works in progress, however, and it is too soon to tell how and when they may be implemented. State responses will also be shaped over time by the resolution of the many pending lawsuits and formal complaints that have been filed against them and others.*

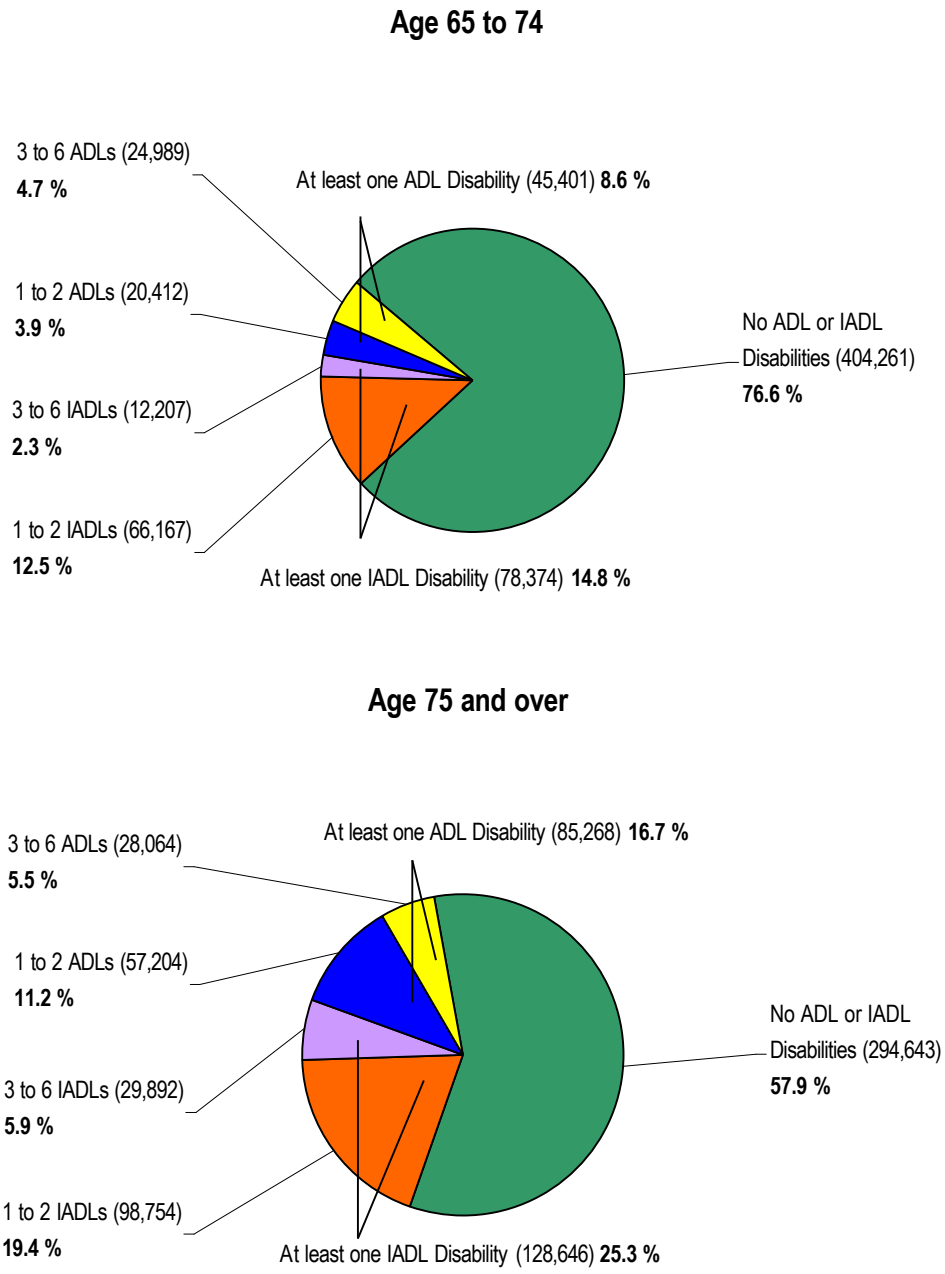
Unmet Supportive Service Needs of Low-Income Older Households in Conventional Government-Subsidized Rental Units

THE PROFILE OF A VULNERABLE GROUP

A substantial share of the older tenants in government-subsidized or rent-assisted housing has physical or cognitive limitations. Overall, about 33% of age 65 and over tenants required assistance with at least one IADL or ADL. This included almost 21% who had at least one IADL limitation and just over 12% who had at least one ADL limitation. Almost 5% of age 65 and over tenants had a level of disability characteristic of the occupants of assisted living facilities or nursing homes because they needed assistance with three or more of their activities of daily living. Some 12% of rent-assisted elderly tenants had a mental disability that seriously interfered with their everyday activities.

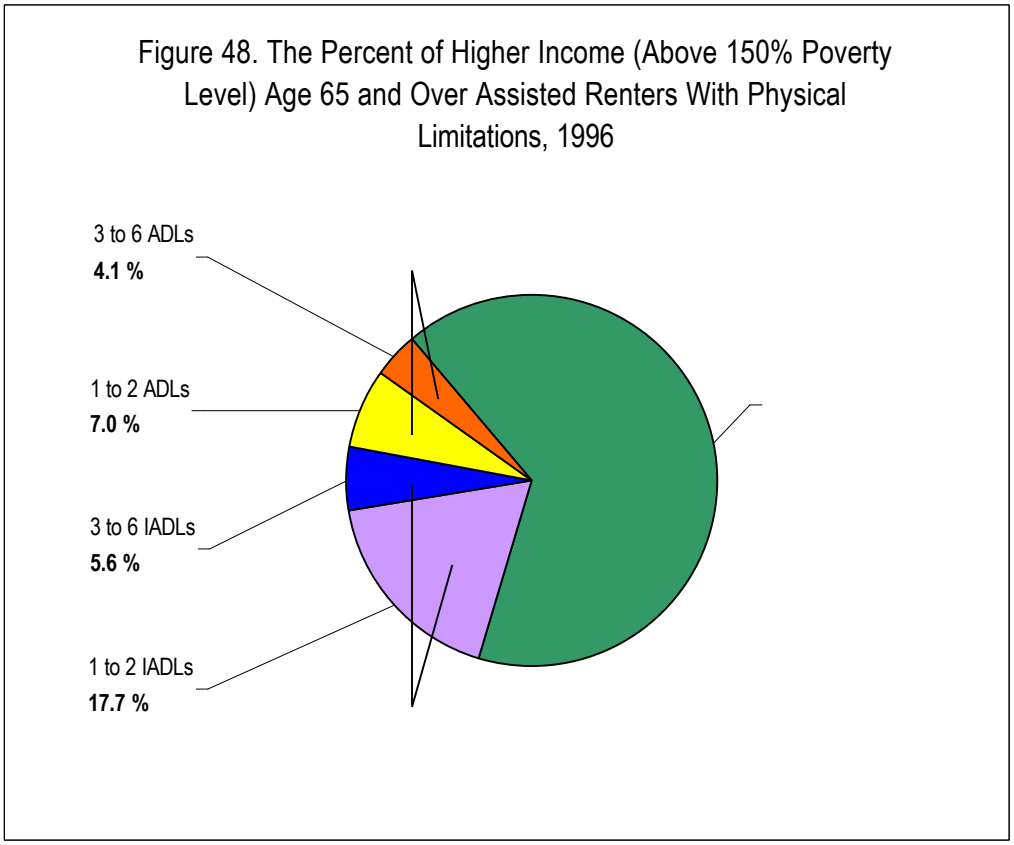
The oldest tenants in these housing developments (the old-old or age 75 and over), are especially likely to have physical and cognitive limitations. Overall, 36% of this group required assistance with at least one IADL or ADL limitation and 11% had a mental disability that seriously interfered with their everyday activities. The poorest members of this group, with incomes under the 150% poverty level, were especially vulnerable. Almost 214,000 or over 42% had at least one ADL or IADL limitation. Just less than 6% (29,892) of this group had three or more IADL deficiencies and just under 6% (28,064) had three or more ADL deficiencies, a level of impairment characteristic of the occupants in assisted living facilities or nursing homes (Figure 47).

Figure 47. The Number and Distribution of Physical Limitations Among Low-Income (Below 150% poverty level) Older Persons in Rent-Assisted Facilities, By Age, 1996



Perhaps surprisingly, the frailty profile differences between older rent-assisted tenants and unassisted renters who are both poor are not remarkable. While age 65 and over tenants in rent-assisted housing are slightly more likely to have IADL limitations, they are less likely to have either ADL limitations or a mental disability. A plausible interpretation is that the more vulnerable tenants in rent-assisted facilities also have the most difficulty taking care of themselves and maintaining

their apartments and thus are more likely to seek more supportive housing arrangements elsewhere. Alternatively, they are not admitted into rent-assisted facilities in the first place or as "difficulty" occupants are encouraged to leave. This would account for why poor age 75 and over rent-assisted tenants are 50% less likely to have mental disabilities than the comparable group living in unassisted rental buildings. Past research has also shown that of the two types of disability, rent-assisted managements are less able to tolerate older persons with cognitive impairments. Another somewhat incongruent finding is presented by the relatively high percentage of both young-old and old-old higher-income tenants (with incomes above 150% of the poverty level) with ADL and IADL limitations (Figure 48). For example, over 24% of the age 75 and over tenants have at least one IADL limitation and over 17% have at least one ADL limitation. Moreover, almost 7% of these old-old tenants have three or more ADL limitations. The strong inference is that the occupancy of rent-subsidized facilities by this higher income group of older persons has been motivated by their need for a somewhat more supportive shelter and care setting with the rent-assisted alternative constituting the most attractive and affordable choice.[99]



While poor older occupants of government-subsidized rental facilities and unassisted rental facilities have similar impairment levels, the former group is more vulnerable:

- They are more likely to be extremely poor.
- They are more likely to live alone (mostly women) and thus are unable to rely on a spouse as a caregiver.

- They are less educated and thus are often unsure about their eligibility for government-sponsored programs, are afraid of and inexperienced in dealing with " system," and lack the sophistication to judge accurately the quality of their assistance. They have difficulty accessing a bureaucratic system presenting very different application procedures and eligibility requirements and are more apt to confront bureaucratic snafus and infringements on their individual rights.
- They are more likely to be members of racial and ethnic minorities and thus confront cultural and language barriers when accessing needed supportive services.
- They generally have fewer affordable supportive service options and are more dependent on government-financed supportive services.

If trends observed in the Section 202 facility program are indicative of what is occurring in rent-assisted facilities sponsored by other government programs, the old-old rent-assisted tenant will have a greater presence. Nationally, in the facilities sponsored under this program, the average age of residents increased from 72 years in 1983 to 75 years in 1999. In some of the older 202 facilities, the average age of tenants is now over 78.[100] The impairment characteristics of this future elderly tenant population, however, will depend less on overall demographic trends then on how programmatic responses deal with the needs of this vulnerable tenant group.

Table 20. Number and Percent of Low-income (150% and Under Poverty Level) Age 65 and Older Persons With Three or More Activities of Daily Living Limitations With Medicaid Coverage, 1996

Housing Category	Number with 3 or more ADL Limitations	Number of Persons With 3+ ADL Limitations With Medicaid	Percent of Persons With 3+ ADL Limitations Having Medicaid Coverage
All Owners	249,715	63,729	25.5
Units valued under $40,000	81,475	36,567	44.9
Units valued between $40,000 and $99,000	116,402	21,661	18.6
Units valued $100,000 or more	46,498	3,547	7.6
Unassisted Renters	127,487	84,915	66.6
Assisted Renters	53,053	38,297	72.2
All Persons	430,255	186,941	43.4
Married couple	134,514	39,766	29.6
Living alone	167,037	63,723	38.1
Other households	128,704	83,452	64.8
All persons	430,255	186,941	43.4

Table 21. Number and Percent of All Age 65 and Older Persons With Three or More Activities of Daily Living Limitations With Medicaid Coverage, 1996

Housing Category	Number with 3 or more ADL Limitations	Number of Persons With 3+ ADL Limitations With Medicaid	Percent of Persons With 3+ ADL Limitations Having Medicaid Coverage

All Owners	920,236	147,367	16.0
Units valued under $40,000	207,551	56,959	27.4
Units valued between $40,000 and $99,000	394,543	42,532	10.8
Units valued $100,000 or more	295,418	43,397	14.7
Unassisted Renters	209,407	118,504	56.6
Assisted Renters	64,580	47,922	74.2
All Persons	1,194,223	313,793	26.3
Married couple	610,052	100,604	16.5
Living alone	267,919	78,102	29.2
Other households	316,252	135,087	42.7
All persons	1,194,223	313,793	26.3

THE SERVICES THEY NEED

The services most needed by these older tenants are indicated by the responses of a sample of 573 elder tenants living in eight different HUD privately owned multifamily facilities in Florida. When asked which services they now often needed, the following percentages of elders identified the following as most important: hand-rails or grab-bars in their bathroom (26%); transportation to and from a doctor's appointment (15%); transportation to and from a store (14%); help with their housekeeping chores (11%); emergency button to push or string to pull in their apartment (4%); and hot meals delivered to their apartment (4%). When asked if they had a problem getting affordable transportation to places (not within walking distance) when they needed it, over 25% of the elders had a problem always or most of the time, 15% some of the time, 51% seldom or never, and 8% responded they did not need to go to places. Over 8% of the elders reported they were so sick during the previous 6 months that were unable to carry on their usual activities for at least a month, and another 12% reported such incapacity for more than a week (but less than a month). Almost 47% of elder tenants reported that they hardly ever worried about things, but 18% reported that they worry about things very often and 36%, fairly often.

These elder tenants also reported difficulty coping with their health and disability-related problems. When asked on whom they could rely on in the event they were sick or disabled over 34% of the tenants felt they had no person on which to rely and 16% could rely on someone only now and then. Only 37% felt they could rely on someone as long as needed, while 6% could rely on someone for a few weeks or months and 7% for a week or less. When asked where they would relocate if they could no longer live on their own in their apartment because of a health or disability problem, 34% said they did not know, while about 27% said they would move into the residence of a family member, 19% to a group home for the aged, 16% to a nursing home, 1% to a friend, and 4% to a variety of other choices. Two obvious observations: it is unclear whether family members would accommodate those elders seeking assistance, and it is rather frightening that over a third of these residents had no idea how they would cope with the onset of serious frailty.

The Recognition of Need by Political and Professional Stakeholders

Problem recognition is a fundamental prerequisite to any programmatic response. Four political and professional stakeholders who are likely to be instrumental in initiating change have recognized that

the seniors in rent-subsidized housing now have unmet needs. These include: (1) the major advocacy groups; (2) owners, sponsors, and administrators of government-subsidized rental facilities; (3) the Federal government; and (4) State and local governments. The positions held by each follow below.

ADVOCACY GROUPS

The Elderly Housing Coalition, comprised of national organizations, agencies, and individuals who work together to influence Federal policies concluded as follows:

> *Persons who are frail and elderly, especially those who participate in federally assisted housing programs, are among the most vulnerable in the nation. They face the triple jeopardy of poverty, declining health and living alone. As they grow older in residences designed for independent living, they are high risk of being forced into unneeded institutional nursing home care or having their needs go unmet.*[101]

> *Many national and State programs have successfully demonstrated that frail low-income residents of federally assisted housing can be helped to age in place through the integration of housing and services. We believe that by making available a continuum of accessible and affordable services, residents will enjoy a better quality of life and will be able to postpone or prevent the need for high cost institutional care.*[102]

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

The public policy position of this major Federal agency is also sympathetic. It concluded in a report to Congress that the housing occupied by older Americans must not only be affordable and in good condition, it must be also be "appropriate:"

> *As a Nation we are committed to ensuring that our elders are able to age in place in a setting that gives them maximum independence and dignity, while safeguarding their safety and welfare. This means that elderly households must have access to flexible packages of housing and supportive services that are integrated and delivered in ways that have the most potential to meet their desire to age in place.*[103]

OWNERS, SPONSORS, AND MANAGEMENTS OF GOVERNMENT-SUBSIDIZED RENTAL HOUSING

The group most directly involved in coping with the needs of frail tenants is also acutely aware of their older tenants' changing profile. The majority (61%) of a national sample of managers of subsidized housing facilities was strongly interested in pursuing onsite and/or near-site health care programs for their residents.[104] A representative sample of rent-assisted administrators in Florida identified three distinctive categories of serious management problems. First, they reported problems dealing with lifestyles linked with the traumas of getting old. Most notably, they had to deal with tenants who were mentally confused or felt very alone. Also topping their list of difficulties was securing transportation for tenants and dealing with those who had drinking problems or were abusive. Second, they had concerns about how they should deal with the practical manifestations of having physically frail elder tenants, especially those who had housekeeping

problems and who had temporary illnesses or self-care problems. Third, they had serious management problems resulting from their relationships with service providers. These encompassed a variety of disagreeable tasks, such as dealing with social service agencies, arranging for home care, and filtering out the inappropriate requests by tenants for assistance.[105]

STATE AND LOCAL GOVERNMENTS

State and local governments express at least three rationales for targeting and providing affordable supportive services to this group:

- To make the delivery of home- and community-based services more administratively timely, efficient and cost-effective. When human service agencies target several facilities in proximate locations that are occupied by relatively larger numbers or concentrations of senior tenants, the following outcomes are more likely to be achieved: lower service unit delivery costs, more effective service targeting, more effective packaging of service modules, more efficient use of staff time to deliver services, more fiscal and organizational incentives to deliver services, better quality control in the assessment of service need and in the monitoring of service and client outcomes.

- To reduce unscheduled tenant-management crises requiring expensive service calls from fire, medical, and human service provider departments/agencies. In the long-term, it is less expensive to deal with the supportive service needs of a frail tenant population when well-established programs and policies are in place.

- To delay the relocation of frail seniors into shelter and care accommodations requiring State expenditures. Frail seniors who can age in place in their current rent-subsidized facilities stand a better chance of delaying their relocation to State-subsidized board and care facilities and nursing home beds.

Facility-Based Responses to the Unmet Needs of Frail Older Tenants

Numerous case studies of rent-assisted facilities have described successful approaches to providing frail seniors with strong supportive service environments.[106] A Florida study, for example, found that just over 30% of a representative sample of HUD multifamily privately owned subsidized facilities were offering relatively strong supportive environments to their low-income frail elderly tenants. [107] Another comprehensive examination of the largest Public Housing Authorities in the country reported that about one-fourth to one-third of the elder tenants in these facilities received social, recreational and transportation services, while 15% to 25% received congregate meals, homemaker services, visiting nurses, health screening, friendly visitors and counseling.[108] The following facility-based strategies are representative of the most successful efforts. A caveat: careful evaluations of the achieved outcomes of these efforts are usually lacking.[109]

- The facility's sponsor or owner has a long-term commitment to managing the housing development and thus has a long-term perspective on helping older tenants to age in place and address their service needs.

- The facility has a dedicated, full-time on-site manager (and support staff) who ensures that residents are living as independently as possible.

- The facility has one or more staff members who can communicate with tenants who speak little or no English.

- A sufficiently large number of elder tenants occupy the facility, thus allowing management to realize economies of scale when contracting, purchasing, and delivering supportive services.

- The housing facility makes physical design modifications to make it safer and easier for older persons to accomplish everyday tasks. These often include the following structural modifications: adding ramps; converting an apartment to a clinic; modifying the position of kitchen cabinets; adding assistance devices (e.g., grab bars, lifts, toileting aids); improving building design (e.g., lighting, flooring, smoke alarms, emergency egress); and adding security systems (e.g., dwelling/building locks and alarms).

- The facility has a communication system that alerts management when elder tenants become incapacitated as a result of an accident or a medical emergency.

- The facility is located within walking distance of grocery stores, restaurants, bus transportation, and a variety store. Alternatively, the facility offers personalized transportation to these places.

- The facility is located in a community with a well-developed service infrastructure that provides a range of community-based (senior centers, congregate meal sites, adult day care, health screening clinics) and in-home services (homemaker, meals on wheels, personal assistance, door-to-door transportation).

- The facility has an active and involved elder tenant group, often organized by facility staff that advises management about tenants' unmet needs and offers feedback about building activities.

- The facility helps organize elderly volunteers and draws frequently on their assistance. These volunteers counsel and assist elder tenants and help management deliver supportive services offered by the facility provides directly or by community-based organizations (e.g., senior volunteer picks up hot meals and delivers them to the tenants).

- The facility has divided its management functions and staff assignments into at least two categories: those who are primarily responsible for traditional bricks and mortar building administrative tasks and those who monitor the needs of older tenants and help coordinate, access, and secure supportive services for them.

- The facility has assigned its own staff resources to provide several of the supportive services needed by its more frail elder tenants.

- Elder residents pay a share of the cost of needed services based on a sliding scale linked to their incomes.

- Management uses a percent of its residual receipts, budget-based debt increases, special rent adjustments, PRAC (Project Rental Assistance Contract) or has secured funding from non-Federal funding sources (e.g., State housing finance agencies, local governments, foundations, charitable organizations) to pay for needed supportive services, in particular, the hiring of a service coordinator.

- The facility has loaned or rented physical space (vacant apartment, office, common room, or a complete floor) to an outside vendor or community service provider, who in turn offers on-site services to the building's tenants.

- The facility has affiliated with a nonprofit or for profit organization that offers home-and community-based services to frail older adults living in the community at large. Thus, the facility's tenants become identified as an additional targeted group.

- The managements of two or more rent-assisted facilities have entered into cooperative arrangements to share information, staff, or services (e.g., 50% sharing of a service coordinator staff position).

- The facility is actively engaged in grant writing and other fund-raising activities to finance the delivery of services to its more frail senior tenants. Private businesses, foundations, and Federal, State, county, or municipal governments will variously offer such funding.

- The facility negotiates below-market prices from service vendors for goods or services (e.g., food and transportation).

- The facility relies extensively on community-based charitable and religious organizations, and on community volunteer groups to help assess and respond to the multiple supportive services required by its elder tenant population.

- The building initiates contracts, partnerships, or other special arrangements with community or home-based senior organizations and human service agencies, managed care providers, other housing sponsors, or with nurses, social workers, or volunteer groups to ensure more regular and timely delivery of supportive services. These may be simple arrangements that facilitate the delivery of a single service or more complex programs combining several different funding sources, as exemplified by the On Lok or PACE programs examined below.

Community-Based Organizational Strategies

A central feature of these organizational strategies is their fostering of low-income residents' independence through a "one-stop shopping" service package funded by a capitation approach that offers frail seniors living in the community a full complement of supportive services, provided

either on the housing site or at a nearby adult day center.[110] The two most important exemplars are the On Lok and the PACE programs.

Since 1983, the On Lok program has targeted very impaired and low-income elderly persons living in the community who required ongoing preventive, long-term and acute care services, were dually eligible for Medicare and Medicaid, and were at risk of having to enter a nursing home. A substantial share of lower-income older persons is potentially eligible for this type of program (Tables 20 and 21). Currently, the program operates six adult day care center locations throughout San Francisco. Most participants come several times a week to the site's adult day care center where they can receive services from a multidisciplinary team consisting of physicians, nurses, occupational and physical therapists, and social workers. These professionals directly assess participants' needs, formulate care plans, and directly provide most personal assistance and nursing services, including primary care. They manage the care given by contracted providers, monitor treatment results, and continuously adjust the care plan. Seniors who are unable to attend the center can receive home care. The program is financed by capitated (per person) payments from Medicare, Medicaid, and from the clients themselves.[111]

The more widely known and available PACE model (Program of All-Inclusive Care) was designed to replicate the On Lok program and was first authorized as a demonstration in 1983 (though it began operating in 1990). The Balanced Budget Act of 1997 made it a permanent provider under Medicare and a State option under Medicaid.[112] It also is financed using a capitated approach that pools Medicaid and Medicare funds and gives the PACE provider a fixed monthly fee for each individual in the program. A multidisciplinary team of health professionals similarly offer a full range of acute and long-term care services and the program cannot disqualify individuals when their health condition changes.[113] A typical PACE program is divided into sites that each serves 120 to 150 participants.[114] It is distinguished from the original On Lok program in that not all PACE providers also offer affordable housing accommodations for their enrollees.[115] Professionals, however, may evaluate the adequacy of the enrollees' housing and assist them in acquiring appropriate accommodations.[116] The effectiveness of this programmatic model is still under review. It represents, however, the best effort yet to eliminate the typical organizational barriers now plaguing many shelter and care approaches directed towards low-income frail seniors. Twenty-five fully capitated PACE sites now exist and there are ten pre-PACE sites. An additional twenty programs each year will be authorized by The Centers on Medicare and Medicaid.[117]

Federally Sponsored Supportive Service Programs

The Department of Housing and Urban Development (HUD) has funded various types of programs designed to assist low-income and frail older persons to secure needed supportive services. Evaluations and surveys of varying methodological sophistication have considered the effectiveness and degree of success of these responses. The most important programs, either because of the size of their fiscal commitments or because of the larger scope of their offered services, have included the following: (1) the Section 202 Program, (2) the Service Coordinator Program, (3) the Congregate Housing Services Program (CHSP), and (4) the HOPE for Elderly Independence Demonstration Program (HOPE IV),

SECTION 202 RENT-ASSISTED FACILITIES

The facilities produced under the Section 202 program are more likely than those developed under other of HUD's privately-owned multifamily subsidized programs to accommodate successfully the supportive housing needs of their frail older tenants.[118] The 202 program is also the first that turned to nonprofit organizations as project sponsors. Recent legislation will make it easier to develop Section 202 facilities. Nonprofit sponsors will be able to form limited partnerships with for-profit entities to compete for low-income housing tax credits and give sponsors greater discretion in how they use funds to meet the needs of elderly (and disabled) households.[119]

A Florida study comparing project-based HUD multifamily privately owned subsidized properties showed that supportive environment management styles were especially prevalent in Section 202 facilities. Almost 40% of Section 202 facilities offered relatively strong supportive environments and they were more likely to provide supportive services directly with their own staff, as opposed to relying on the service delivery efforts of outside agencies.[120] Many, though not all, of the Section 202 facilities have six relative advantages over other programs:[121]

- They were among the first to incorporate physical infrastructure (e.g., common dining room, spaces for services) in their rental buildings, thus creating the opportunity to deliver on-site supportive services, such as meals.
- They were among the first to be awarded funding under the Federal Service Coordinator Program.
- They were more likely to be beneficiaries of the Congregate Housing Services Program.
- Since 1990, newer Section 202/PRAC (Project Rental Assistance Contract) facilities can pay for up to $15/unit/month to cover the cost of meals and/or supportive services as part of their operating budget.[122]
- They are more likely to secure independent grant support and to implement more frequent and creative supportive housing environment approaches.
- The nonprofit, often faith-based, sponsors of 202 facilities are more likely to operate human service programs that address the needs of seniors in the community-at-large.

A 1999 national investigation of 202 facilities confirmed some of the successes enjoyed by this program.[123] Some of the key findings:

- Over 37% of the facilities had professional service coordinators.
- Managers with service coordinators reported that the experience was overwhelmingly positive for both residents and management.
- Most facilities had some support and accessible design features in place (e.g., grab rails, entrance ramps, call buttons).
- Most facilities had at least one disabled-accessible unit.
- Just over one-fourth of the facilities reported having 24-hour on-site personnel.
- Over 90% of facilities had community space for social and recreational facilities; about half the facilities had spaces for congregate dining and visiting services.
- About 23% of the facilities had on-site meal programs.
- Just over 26% offered housekeeping services provided by either the facility's staff or from an outside human service agency.

- Over 12% of the facilities had staff who offered social work or counseling services.
- About 5% of the facilities provided "assisted living" like services to their tenants.[124]

THE SERVICE COORDINATOR PROGRAM

Service coordinators are hired either on a full- or part-time basis to help senior tenants access and secure needed home- and community-based services, help monitor their outcomes, counsel them, and serve as their confidants. Service coordinators were first funded under the Congregate Housing Service Program (began as demonstration in 1978). Later, under the 1990 National Affordable Housing Act, service coordinators became an eligible expense in Section 202 housing developments or facilities operated by Public Housing Agencies. Their hiring by facilities greatly eased some of the difficulties senior tenants were confronting in their efforts to retain their independent life-styles and manage their own self-care. With the passage of the Housing and Community Development Act of 1992, the cost of providing service coordinators was authorized as an eligible expense for all federally subsidized housing programs serving older persons.[125]

Several studies have shown the success of service coordinators to help rent-assisted older tenants maintain their independent living arrangements. Testimony to the many advantages resulting from this staff position is the efforts by rent-assisted facilities to secure a service coordinator, even without financial assistance from the federally funded service coordinator program. Thus, while the Federal program has funded about 1,100 service coordinator positions, facilities are themselves paying for these staff persons by drawing on their facility's residual receipts, budget-based debt increases, special rent adjustments, PRAC (Project Rental Assistance Contract) operating budgets, or through non-Federal funding sources (e.g., State housing finance agencies, local governments, foundations, charitable organizations). An unofficial estimate is that over 4,000 service coordinators are now working in HUD, Public Housing, and Rural Housing Service facilities and are assisting an estimated 600,000 older persons.[126] Studies have identified the following ways in which managers and residents benefit:[127]

- Residents obtain more health, personal care, homemaking and other supportive services and navigate the human system better.
- Premature institutionalization is avoided because residents have more services available to them to maintain their independence.
- The needs of at-risk and frail residents are more quickly recognized, thereby resulting in more timely service delivery.
- Older residents feel empowered through education to meet their own needs. Thus, they are better able to identify and access needed services.
- Residents feel an increased sense of community and can draw on more informal help from other tenants.
- Residents are living more comfortably and express greater residential satisfaction.
- There are fewer conflicts between older residents and between older residents and management.
- Building managements are relieved of time-consuming and stressful responsibilities having to do with their residents' requests for supportive services. In turn, they have better relationships with both elderly residents and service providers.
- Administrators spend more time on traditional building management roles.

THE CONGREGATE HOUSING SERVICES PROGRAM (CHSP) AND THE HOPE FOR ELDERLY INDEPENDENCE DEMONSTRATION PROGRAM (HOPE IV)

The now inactive Congregate Housing Services Program (CHSP) was a very small project-based supportive-service and case management program (just over 100 facilities are still receiving funding under this program). It was originally authorized under Title IV of the Housing and Community Development Act of 1978 and was designed to help frail elderly tenants,[128] mostly women living alone, age in place. In the last version of this program, services were tailored to individual needs through the use of a Professional Assessment Committee. HUD and the Rural Housing Service[129] provided funds of up to 40% for the cost of nonmedical supportive services, such as transportation, personal assistance, housekeeping, meals, and the support of a service coordinator. The housing sponsor could collect up to 10% of service delivery costs from the residents, but had to find funding from other sources for up to 50% of the remaining costs.[130]

A similarly small and now inactive HOPE IV (Elderly Independence) program was also designed to assist low-income frail elderly. The funding formula was the same as the CHSP and funds were awarded to 16 public housing agencies in 1993 to cover both supportive services and rental assistance (with Section 8 vouchers). It also provided many of the same services, offered service coordination, and was also designed to help seniors live independently. The major difference was that HOPE IV was tenant-based, whereas CHSP was project-based. While the CHSP was provided in HUD-assisted congregate housing, HOPE IV was offered to older persons who lived in unassisted housing units throughout the grantee's service area.[131]

Evaluations were conducted of both the Congregate Housing Services Program and the HOPE for Elderly Independence Demonstration Program (HOPE IV) to assess their effectiveness of providing supportive services to low-income frail elderly *persons.*[132] Facility managements were very satisfied with both programs. Both fostered the development of partnerships with other service delivery agencies in the community that helped meet tenant needs. Elderly residents in the HOPE IV program were compared with a similarly frail elderly group who received Section 8 rental assistance but were not enrolled in the HOPE IV program. The HOPE IV enrollees received a significantly higher level of supportive services than the comparison group and this disparity in service access increased over time. HOPE IV enrollees also scored higher on several mental health evaluations. There were no differences, however, in rates of nursing home placement, mortality, or exiting Sections 8 for other reasons. More CHSP than HOPE IV elderly participants moved to a nursing home, group home, or other higher levels of care, even though their frailty levels were comparable. Moreover, even with the greater service availability, the turnover of participants was substantial (approximately 40% left their respective housing and service programs during the two year period). Thus, as the report concluded:

> *This high exit rate suggests that the presence of ADL limitations beyond certain levels, even with a viable service component, may preclude participation in tenant-based Section 8 or congregate housing for both current tenants or residents, and new applicants.*[133]

The authors of the evaluation, however, warn against judging the merit of the program on the basis of only these outcomes:[134]

> *Systemic change often requires the presence of a key individual to increase awareness among staff and promote policy and program initiatives, in this case to respond to the complex needs of a frail elderly population. The evaluations showed that prior to HOPE IV and CHSP, existing policies and procedures often discouraged application and participation in HUD housing assistance programs by eligible frail elderly persons. In-person application requirements, the need for assistance in locating accessible rental housing for elderly persons with functional limitations, the absence of linkages with service providers, and the steering of older applicants with service needs to other, restrictive options, often excluded frail elderly persons from HUD housing assistance programs altogether, especially tenant-based Section 8. These barriers adversely affected not only new frail elderly applicants, but also existing tenants and residents who had aged in place. The HOPE IV and CHSP Service Coordinators played an important role in changing this restrictive orientation by educating existing PHA Section 8 staff and building managers, by developing linkages with other community agencies, and by providing case management services to individual.*

Partnerships of the Federal Government with the Private and Public Sector

Three specific Federal programs dependent on the joint participation of both the private and public sectors have helped to increase the availability of affordable supportive service accommodations. These have included: (a) Section 8 Vouchers subsidizing the shelter component costs of privately-owned assisted living facilities, (b) Medicaid Waivers subsidizing the care component of assisted living facilities owned by for-profit entities, and (c) the assisted living conversion program, whereby the Federal government funds the re-design of the physical plant of the facility. The first two subsidization approaches involve organizational partnerships with the owners of privately-developed assisted living facilities; the third approach organizationally links federally subsidized rental facilities and State governments.

THE CURRENT PRIVATE SECTOR ASSISTED LIVING FACILITY MODEL

The private sector developed assisted living facility (ALF)—built both by for-profits and nonprofits—is by many measures, one of the most prominent, fastest growing, and successful shelter and care alternatives for frail older persons. It formally emerged in the United States in the mid-1980s,[135] inspired by models in Oregon and the east coast. As one prominent consultant sums up, it was *"a reaction against premature institutionalization…. Nursing homes, by then called skilled or intermediate care facilities were said to be too medical, too regulated, too stifling to the human spirit of those who worked and lived in them."*[136] This alternative has grown considerably in the past decade, with the number of beds or units increasing by almost 115% between 1991 and 1998. A recent national survey estimated that about 95% are owned by for-profit entities (either privately or publicly held) and 5% are owned by not-for-profits.[137] The typical assisted living facility older resident is a woman in her early 80s. She will require assistance with an average of 2.3 activities of daily living. In contrast, average nursing home resident needs assistance with 3.8 activities of daily living.[138] The estimated percentage of residents with cognitive impairments varies according to research source, and estimates range from 24% to 45%.

This alternative has primarily catered to the middle-income and above elder consumers willing to pay out of their own pocket for this alternative. An industry rule of thumb has been that that this option was affordable to older persons with incomes of $25,000 or more. This dollar benchmark has recently come scrutiny, however. A national survey found that 69%[139] of the elderly residents reported their income (including, savings, interest, dividends, and social security) as less than $25,000, even as the median cost of these units was **$22,523**.[140] Researchers speculated that a significant percentage of seniors in these for-profit assisted living facilities were spending down their assets and relying on financial help from their families.[141]

Ideally, the best designed and operated assisted living facilities can accommodate older persons with physical and cognitive deficits who require a protective environment, regular and unscheduled assistance with activities of daily living, and some nursing care. Such facilities provide residents with a "social" or "residential" model of shelter and care that recognizes the importance of maintaining their dignity, independence, control, individuality, and privacy. The architectural setting and organizational environment of this model more closely resembles a residence, an inn, or a hotel than a hospital or nursing home. Unlike more medically-oriented long-term care settings, or very small, house-like traditional board and care facilities, residents do not have to share their dwellings, but rather have their own apartments, can lock their doors, and have their own bathroom and kitchen facilities. They have much more say about how they conduct everyday activities, such as when they eat or recreate. Most importantly, they play a more active role in deciding what services they receive and when they receive them. Care and services, rather than delivered as a one size fits all, is individually tailored to meet the specific needs of seniors and the preferences of their families. Quality of care is judged less on its staff resources, physical plant, and organizational practices and standards than on resident care outcomes. Terms such as residents, units, and services, rather than patients, beds, and care are used to describe this long-term care option.[142]

To achieve this greater amount of individual autonomy and rights, and a more generally flexible setting administrative environment, residents or family members must acknowledge that they will tolerate facility practices that allow residents to take risks they usually would not be taken in a more regulated care setting and that might increase the likelihood of accidents or medical mishaps. These situations arise, for example, when seniors or their family members prefer not to adhere to a physician-recommended diet regime, when seniors decline to use a walker, or when they request not to be supervised when they take their medicines or bathe or shower. Facilities attempt to reduce their legal exposure by having residents sign a negotiated or shared risk agreement (also called "managed risk agreements")[143] whereupon they accept responsibility for any risks inherent in their care choices. While these agreements cannot be used "to authorize violation of regulatory requirements or the prevailing standard of care," they are designed to "cover issues not clearly addressed (or prohibited) by State law but that may create risks beyond which the residence is normally willing to allow."[144]

In practice, some assisted living facilities fall short of this ideal. This variability in large part results from the assisted living facility option being primarily a creation of State governments and their idiosyncratic influence on its regulatory environment, and how it looks and operates. Even as the terminology of assisted living is now used in the regulations or statutes of 29 States, the types and level of care offered by ALFs vary greatly. Despite the increased prevalence of the "assisted living" terminology, like alternatives are still known by a confusing array of other names, including

residential care, personal care, basic care, domiciliary care, housing with services, and board and care.[145] These various labels are symptomatic of the many different versions of this housing product. Thus, the alternatives that identify themselves as assisted living often present very different physical or architectural styles, offer varied types of care and services, and use different organizational strategies to deliver care.

Sometimes, however, the boundaries between alternatives are blurred, as is sometimes true for assisted living and board and care facilities. Lower-income seniors primarily occupy these latter very affordable facilities that are usually funded through State supplements to the funds that their seniors receive from the Supplemental Security Income program. Although they lack the design features and amenities of high-end assisted living facilities, these "single-family dwelling" facilities are small in scale, have a homelike ambience, and often tailor their care to meet the individual needs of their residents.[146] They are operated by middle-aged women or married couples who live on the premises as opposed to the corporations that own and manage assisted living facilities. Although many of these facilities are well run, States have often been embarrassed by widely publicized reports of poor-quality care and resident abuses.[147]

States with the assisted living alternative (or closely named options) most fundamentally differ with respect to the level of tenant impairment they will tolerate (that is, limitations in activities of daily living, and medical/cognitive needs), and the types and duration of personal assistance and skilled nursing services they allow. Regulations in some States, for example, allow only meals, housekeeping, and limited personal assistance, while in other States, assisted living facilities can provide a level of skilled care compatible with that found in traditional Intermediate Care nursing homes.[148] In some States, but not in others, nursing services can be delegated to nonlicensed personnel, as along as they were earlier instructed on these tasks by a nurse.[149]

Labeling and regulation, aside, many advocates and critics are increasingly questioning whether current assisted living facilities are meeting their "ideal" goals and offering older persons a good quality shelter and care environment. The year 2001 will probably set a record for the large number of influential critical news stories in major newspapers and magazines that pointed to the many failings of this alternative.[150] Earlier, a 1999 U.S. General Accounting Office study of assisted living facilities in four States (California, Florida, Ohio, and Oregon) found that more than a quarter of the facilities had been cited by State oversight agencies or ombudsmen "for 5 or more quality of care or consumer protection related problems."[151] In contrast, a far more upbeat assessment is offered by the 1999 ALFA National Satisfaction Study.[152] It reported that about 85% of the residents in both freestanding and multilevel (assisted living) *facilities "say that their expectations have been met or exceeded for their community."*[153] More recent facility surveys offer troubling statistics about whether current assisted living facilities conform to the ideal model. They raise doubts about whether ALFs do always offer privacy, a homelike environment, emphasize consumer dignity and choice, and even offer a real alternative to the nursing home. For example, a significant percentage of ALFs include units that accommodate three or more unrelated persons and do not have a sink. Other evidence points to facilities that lack appropriate nursing personnel and that do not retain residents if they need help with locomotion.[154] Assisted living owners and managements themselves are troubled by the difficulty they have in hiring and keeping qualified staff.[155] Inadequate pay scales are undoubtedly partly responsible, but may be difficult to improve given the financial realities of operating these facilities.[156]

The latest investigation of a nationally representative sample of residents and staff in ALFs[157] was more positive. It focused on ALFs classified as providing relatively high services or offering a high privacy environment.[158] It concluded that:

> *Assisted living appears to offer an important type of residential long-term care setting for persons with mild or moderate disabilities who cannot safely or securely live alone but do not need the level of care provided in a nursing home. Further, the high privacy or high service ALFs provide this care in a setting that has many components valued by consumers, particularly in terms of privacy and environmental autonomy.*

Residents give staff high satisfaction ratings for treating them with dignity and respect (79%) and caring and affection (61%)—key goals of assisted living. At the same time, only 42% of the residents reported that an adequate number of staff was always available and only 28% said that their facility was very successful in retaining good staff. Resident perceptions of training excellence and of staff attentiveness were mixed (52%). The most equivocal finding was whether an ALF could substitute for a nursing home, because the residents in the ALFs did not have the same impairment severity as found in nursing homes and because staffing levels were considered inadequate in a significant percentage of facilities.

THE FUTURE AVAILABILITY OF THE PRIVATE SECTOR MODEL

Estimating the growth and number of assisted living facilities in the year 2020 is also a difficult task. The clientele of assisted living facilities can conceivably be seniors who would otherwise deal with their impairments in their conventional dwellings or those who would otherwise occupy nursing homes. Thus, the future demand for the assisted living facility alternative also depends on other projections—the future number and share of older persons who will enter nursing homes as those who will cope with their needs in their own homes. Making both these future estimates are challenging tasks in their own rights.

Accurate predictions are also required of the number of seniors who will be income- and asset-qualified to enter these facilities.[159] This, in turn, requires predictions of the income distributions of the future elderly and of the future cost of this alternative.[160] Additionally, corollary estimates must be made of the number of income nonqualified seniors who will be able to pay for this alternative by way of intergenerational transfer payments from their children.

The future supply of this alternative will also depend on State policies that regulate both the supply of nursing homes, the care requirements in assisted living facilities, the availability of affordable home and community based care. Currently, many States have placed caps on their nursing home expansion. This suggests that institutional care alternatives will receive an increasingly smaller share of the long-term care dollar as States seek to accommodate their frail seniors less expensively by their home and community based care alternatives and by their subsidizing the cost of assisted living facilities.

The recent policy enactments of two States, Michigan and Texas, reflect this trend and are giving older persons and their family members more flexibility in making choices regarding where

to receive long-term care. They are making it more possible for their very frail seniors to remain in assisted living facilities even as they require more care than current regulations allow. Michigan, for example, recently passed a law that gave residents in their "homes for the aged"[161] more say in whether they wish to remain in assisted living facilities even as their health and limitation problems increase. An elderly person who would otherwise be too frail to remain in a State licensed facility according to current regulations can have that option if the resident, the resident's family, the resident's physician, and the owner, operator, and governing body of the home for the aged consent to the resident's continued stay. The owner, operator, and governing body of the home for the aged must also assure that the resident receives the necessary additional services.[162] A similar bill was passed in Texas.[163]

A countervailing trend, however, is the call for increased regulation of the assisted living alternative by various consumer groups convinced that the quality of care in these facilities would be helped by greater State oversight. This might dampen both the demand for these facilities and developer incentives to build them. Another reason to lower future supply estimates comes from a recent survey of financial institutions by the National Investment Center. It reported that low-acuity projects, such as congregate housing and independent living facilities, accounted for more than half of the investment activity in 2001. In contrast, financiers had concerns about market saturation in some assisted living markets and the uncertainty of this option's future liability insurance costs.[164] Thus, the financing these facilities has become more restrictive and expensive even as this past decade has witnessed a large increase in and greater diversity of capital sources for financing this housing product.[165]

Providers of assisted living facilities, themselves, have not been accurate forecasters. The industry itself badly misjudged the demand for the current supply of assisted living facilities. In many regions of the county, markets are now overbuilt and oversaturated and have relatively low occupancy rates.[166] Thus, most of the major corporations have postponed their often ambitious expansion plans. There have been several bankruptcies, and several company consolidations. Increasingly, a smaller group of corporations is controlling a larger share of ALF units throughout the country. Consolidations have not only occurred in the ownership of these facilities, but also in their managements. A typical practice is for assisted living corporations to develop new facilities, sell them but retain a minority ownership interest, and then establish a long-term operating/management contracts with the new owners. Thus, a large corporate developer of assisted living facilities, such as Sunrise Assisted Living, manages many more facilities than it owns outright.

Predicting the future is also plagued by the same mentality that led to the downfall of most analysts who predicted the future of dot-com securities. The demand for any innovation is often very large as the first and substantial wave of new adopters "jump on the bandwagon." As is true for any innovation, however, subsequent demand often shrinks substantially and warns of the dangers of predictions based on straight-line projections. This may be especially applicable when predicting the growth of assisted living facilities because the future demand for this alternative will in part be served by the current supply, itself. There are now over 500,000 ALF units in operation and their annual resident median turnover is over 56%.[167] Thus, in any given year, some 280,000 existing units will accommodate new consumer demand without any increase in new units.

There are also three important senior consumer trends that suggest a dampening of demand for this alternative. The first is the aforementioned expected decline in the disability rate of the next generation of seniors with the obvious implications for future demand. The second is the projected higher share of seniors who will be homeowners and the stronger attraction of the conventional dwelling, as a place to accommodate their care needs. The third is the predicted slower growth of the age 75 and over age group (and the 85 and over group) in each of the next two decades (2000-2010 and 2010-2020) than was the case in the 1990s.

Two projection scenarios are offered to predict the number of assisted living facilities in 2020. A third set of projection scenarios are also reviewed from the National Investment Center.

Scenario One

This scenario is organized around the following four assumptions:[168]

1. The growth of the elderly population (age groups 65-74, 75-84, 85+) between 2000 and 2020 will be consistent with the U.S. Census middle series projections.[169]
2. Between 1999 and 2000, the percentage of age 65 and over persons that occupy nursing homes will remain unchanged.
3. Between 2010 and 2020 (but not between 2000 and 2010), the expected decline in the disability rate of older persons will depress the growth of older persons occupying nursing homes with the result that a smaller percentage of this group will occupy this institutional alternative in 2020.
4. Between 1999 and 2020, the ratio of assisted living units to nursing home beds occupied by older persons will remain unchanged.[170]

The 1,539,000 nursing home beds occupied by older persons in 1999 are projected to grow to 2,161,660 beds by 2020, an almost 41% increase. In 1999, there were about 2.9 elderly-occupied nursing home beds for every elderly-occupied assisted living unit. Maintaining this ratio (and growth rate) would result in the number of *elderly-occupied*[171] assisted living units increasing from 507,414 units to 712,707 units between 1999 and 2020 (Table 22).

Table 22. Alternative Assisted Living Facility Projection Scenarios of Number of Units Occupied by Age 65 and Over Persons in the United States, 1999 to 2020: Alternative Scenarios

Assisted Living Projection Scenarios	Number of Units[a]		
	1999[c]	2020	% Growth Rate
ASSISTED LIVING FACILITY PROJECTION SCENARIO ONE	507,414	712,707	40.5
ASSISTED LIVING FACILITY PROJECTION SCENARIO TWO	507,414	755,302	48.9
NICb Conservative	511,163	673,911	31.8
NIC Base	511,163	720,299	40.9
NIC Optimistic	511,163	874,585	71.1

[a]*Numbers all refer to units except for skilled nursing that is reported in beds and that are treated as one-person households. See notes in Table xx for assumptions used to compute 1999 totals.*

[b]*NIC demand models are focused on "individuals" rather than "units" and thus will produce artificially higher estimates than the first two scenarios. They also only include private pay residents.*

[c]*NIC numbers are for the year 2000.*
NIC projections estimates from: National Investment Conference. 2001. *The Case for Investing in Seniors Housing and Long Term Care Properties.* Annapolis, Maryland: National Investment Conference for the Senior Housing &Care Industries.

Scenario Two

This scenario is organized around the following three assumptions:[172]

1. The growth of the elderly population (age groups 65-74, 75-84, 85+) between 2000 and 2020 will be consistent with the U.S. Census middle series projections.[173]
2. In 1999, the age distribution of the assisted living population was as follows: 3% under age 65, 8.7% age 65 to 74, and 88.3% age 75 and over. The number of persons in each of these age groups are projected to grow in size to 2020 in accordance the U.S. Census middle series projections and the Harvard household projections
3. Between 1999 and 2020, the disability rate of the older population will remain constant.

Using this methodology, the 507,414 units of assisted living occupied by age 65 and over persons in 1999 will grow to 755,302 or by 49% in 2020 (Table 22).

The NIC Assisted Living Facility Projection Scenarios

The National Investment Center (NIC) makes three alternative projections of the number of elderly persons likely to demand assisted living in 2020. These are referred to as conservative, base, and optimistic estimates.[174] The lowest number of elderly persons[175] occupying assisted living is predicted by the "conservative" projection and the highest by the "optimistic" projection." All the residents are estimated to be private pay. The optimistic differs from the conservative demand model in that it assumes constant homeownership rates through 2010 and then somewhat *declining* homeownership rates; and it assumes fairly constant ADL deficiency rates between 2000 and 2010 and then a slow *decline* in these ADL deficiencies through 2020. An important new assumption of all three alternative projections is that the income-eligible elderly persons may have annual incomes as low as $15,000 and even lower than $15,000, if they have assets greater than $50,000 (because they are capable of spending down these assets). The optimistic model assumes that between 2000 and 2020, there will be gradual increases in the percentage of seniors with incomes greater than $15,000 or having net worth of over $50,000. Based on these assumptions, the NIC estimates that from 673,911 to 874,585 older persons will demand assisted living facilities in 2020, resulting in growth rates that range from 32% to 71% (Table 22).

MAKING THE ASSISTED LIVING MODEL AFFORDABLE TO LOW-INCOME FRAIL OLDER PERSONS

The many desirable social and economic features of the assisted living alternative are currently unaffordable to most low-income frail seniors. Both Federal and State governments have initiated programs designed to remove these financial barriers. Two of these, Section 8 Vouchers and

Medicaid Waivers, expand current government subsidy programs to make the private sector assisted living facility alternative affordable. The third, seeks to convert an already affordable rent-assisted shelter alternative into an affordable shelter *and* care alternative.[176]

Section 8 Vouchers to Subsidize the Rents of Assisted Living Facilities

Public Housing Authorities may now provide tenant-based voucher assistance (part of Housing Choice Vouchers program) for families who live in an assisted living facility.[177] This is an attempt to make private-market assisted living facilities – that now primarily cater to frail upper-income seniors – affordable to low-income seniors. One important downside is that these section 8 subsidies are available only to fund the shelter rent portion of an assisted living facility's costs. Thus, the service costs must be funded by other sources, usually the State's allocated Medicaid Waivers[178] (see below). Furthermore, the Section 8 vouchers are not specifically designated for ALF facility units. Thus, their use for the ALF alternative must compete with their use to subsidize traditional rent-assisted units. Only a small number of units are currently funded under this program.

The Assisted Living Conversion Program

This program initiated in fiscal year 2000 is the most recent effort by HUD to add residential units that can accommodate low-income frail seniors.[179] It provides funding to sponsors of Section 202 facilities who seek to modify physical infrastructure of a building—its units and common spaces—so that it can be licensed by their State as an assisted living facility.[180] They may convert one or two floors or the whole building. The grant covers items such as: retrofitting a regular apartment to make it accessible for a person with disabilities; retrofitting common spaces to make them accessible for persons with disabilities; introducing new or modifying existing common spaces such as kitchen, nurse's station, staff spaces; and modifying building infrastructure such as air conditioning, lighting, plumbing, alarm systems, and sprinkling systems. The funding is only available to change the physical infrastructure or introducing physical design features. The facility's sponsor must guarantee the availability of service delivery financing from third party sources and secure regulatory approval from its State's, assisted living (or similarly named) program. At least ten Section 202 developments are expected to complete conversion of their units to assisted living by fiscal year 2003.[181] There are two possible downsides of this approach. First, both the application and implementation process is exceptionally complex. Second, the viability of this program depends on the availability of State-administered Medicaid Waivers. And, third, and largely unstudied, is the possibly high cost of producing these affordable assisted living units, because of the sometimes high award rehab funding amount allocated per converted rent-assisted unit.[182]

Medicaid Waivers

As of April 2000, 38 States were able to use their Medicaid waiver programs to subsidize the personal care and nursing services provided in assisted living facilities.[183] States use Medicaid in one of three ways to pay for the service component of the assisted living facility: (1) through their Medicaid State plans; (2) home and community based services (HCBS) 1915(c) Waivers; and (3) through Section 1115 Waivers. Most use the HCBS 1915 (c) Waiver program. This program is serving over 60,000 older persons, an increase of 50% over the previous two-year 40,000 total.

Only a few States, however, are especially active under this program. In Florida, for example, there are only about 2,050 ALF waiver clients representing about 2.6% of the State's 80,000 ALF beds. In other States, Medicaid participation rates are especially high, such as Colorado (20%), Idaho (14%), Maine (48%) and North Carolina (48%), Oregon (18%) and Washington (13%) among others.[184] A new Medicaid rule (Section 1902 (r) (2), May 11, 2001) reduces the institutional bias towards nursing homes. It allows States to disregard income that the person may need to pay for rent, utilities, food, and other costs before determining the excess income or spend-down obligation.[185]

State governments must find alternative funding sources to subsidize the shelter cost component of the assisted living facility. Typically, this is made possible by Medicaid beneficiaries paying for the housing or shelter cost component through some combination of their Supplemental Security Income (SSI) payments, State supplements to SSI, and where allowed, financial contributions from family members. States differ as to how they decide the mix of these funding sources and their reimbursement levels.[186]

There are several possible downsides to this funding approach. First, by necessity, the ALF alternative must compete with nursing homes and home and community based care for the allocation of a State's limited Medicaid waiver funding. This forces State legislators to make a difficult choice between two equally important long-term care approaches. Second, the Medicaid reimbursements and State supplements to the SSI Program must be sufficiently large to attract assisted living providers. The more a State's reimbursement level deviates from the private market rental fee of the ALF, the more facilities will be less favorably disposed to participating and the result will be fewer shelter and care choices for low-income frail older persons. Critics argue that the current subsidization approach does not adequately cover the ALF's real shelter (as opposed to care) costs and encourages them to double up Medicaid clients in a single unit.[187] Third, and more perversely, the reimbursement value of the Medicaid waiver, in combination with other State supplements may not encourage the quality of care found in private-pay facilities. Critics have argued that nursing homes funded by Medicaid are prime examples. A recent study, for example, concluded that the Medicaid program was reimbursing seniors' long-term care facilities at levels that were substantially less than the acknowledged cost of care.[188]. Fourth, although studies have yet to be conducted on this issue, a strong possibility exists that the use of Medicaid Waivers results in an ALF facility that is excessively regulated and thus inconsistent with the residential or social model of ALF care. Thus, critics argue that Medicaid funding invites more rather than less regulation. Fifth, to subsidize both the shelter and the care components, the assisted living facility's owners must draw on at least two funding sources and thereby invite cumbersome paperwork and bureaucratic hurdles.[189] Sixth, one analysis of this Medicaid funding approach cautions that diverting Medicaid recipients from nursing homes to the presumably less expensive to operate assisted living facility will not necessarily save States money. Obviously, a single day of care by an *individual* in an assisted living facility costs less than a single day in a nursing facility. The issue, however, is whether programmatic costs will decline when assisted living facilities are subsidized with Medicaid Waivers. That the answer is not clear-cut is suggested by the following arguments.[190]

> *That Medicaid-eligible people who try to stay of out nursing facilities will be attracted to assisted living. But the aggregate cost to Medicaid could rise if total use increases as people who would not otherwise enter a facility opt to go into assisted living if it is available.*

> *Similarly, the number of Medicaid recipients (and aggregate Medicaid spending) can increase if those with moderate incomes exhaust their resources on costly assisted living and then become Medicaid recipients.*
>
> *Second, officials worry about what will happen to Medicaid nursing home rates as poor people with the least needs ("low case mix") are diverted or transferred from nursing facilities to assisted living. More than half the States now pay nursing facilities Medicaid rates that are tied to resident acuity. In these States, as average case mix in nursing facilities increases (i.e., as residents have greater needs), Medicaid costs rise….Assuming that the total number of days paid for by Medicaid stays the same, total Medicaid costs could, in theory, be held constant. But Medicaid officials find it difficult to make the tradeoffs work in such a way that the State can save money or just hold payments constant.*

Not all experts agree that States will be unable to control the long-term care costs associated with this "woodwork effect," an issue to be subsequently addressed in more detail (see subsequent section on "Barriers to Successful Supportive Housing Solutions"). They argue that the expenditure growth trend line can be lowered by holding the supply of institutional facilities constant or by reducing nursing home occupancy rates while expanding the availability of alternatives such as subsidized assisted living.[191]

The Number of Low-Income Elderly Assisted by Subsidized Private Sector Assisted Living Units

Few studies have attempted to measure the extent to which government subsidies, such as Medicaid Waivers and States supplements to the cash payments of the Supplemental Security Program, are making the for-profit assisted living facility affordable to low-income older persons. The most relied on estimate is from a 1999 study by the Assisted Living Facility Association (ALFA). It found that 10.3% of the residents in a survey of 373 properties (26,742 residents) received assistance from State Medicaid waiver programs, Supplemental Security Insurance, or other State assistance programs.[192] Based on the estimated number of 644,815 older persons in assisted living facilities in 1999 (Table 1), 66,415 of this group would receive subsidies.

Future Accommodation of Low-Income Elderly Persons in Subsidized Assisted Living Facilities

The number of projected assisted living facility *units* in 2020 ranged from 712,707 to 755,302.[193] ALFA has estimated that in 1999, 10.3% of the residents in assisted living facilities received subsidies. Assuming there are l.27 older residents per unit,[194] then the 2020 estimates range from 905,137 to 959,234 older persons. If the current estimated proportion of subsidized residents remains constant through 2020, then assisted living facilities in 2020 will have to accommodate from 93,229 to 98,801 "subsidized" older persons. This, of course, is a very speculative estimate given the uncertain future role of Medicaid waivers in the subsidization of assisted living facilities. It is also, of course, dependent on the correctness of the estimated number of assisted living facility units likely to be available in 2020.

Barriers to Successful Affordable Supportive Housing Solutions

The above summarized programmatic strategies that offer affordable shelter and care solutions to frail low-income older tenants give considerable credibility to the conclusion reached by the aforementioned Elderly Housing Coalition report:

> *We know who needs care; we know where they prefer to receive support; we know what services are needed; and we know how to provide care in an integrated, comprehensive, affordable system.*[195]

Thus, the large presence of low-income frail seniors who still have difficulty finding affordable supportive settings in which to maintain their independence is not because we are lacking for solutions. Rather, it is much more about politics, acceptance, and implementation.[196] Consensus simply does not exist among the major stakeholders as to whom should assume responsibility for this vulnerable group of seniors or what public policy responses are desirable, acceptable, and achievable. Furthermore, certain obstacles to linking shelter and care are ingrained in our current shelter and care policies. It is possible to identify four categories of barriers.

AMBIGUOUS MISSION STATEMENT

The first obstacle is the lack of consensus over whether HUD's mandate or mission should extend to providing supportive services to assist vulnerable tenants. Traditionally, the major purpose of rent-assisted housing was to guarantee the occupancy of affordable housing in good condition. As the rent-subsidized housing stock has become increasingly occupied by older persons who are having difficulty taking care of both themselves and their apartments, government agencies charged with providing affordable housing must consider whether affordable housing must satisfy yet another major goal. Many government administrators strongly believe that HUD should not deviate far from its "bricks and mortar" traditions. Many housing facility owners, sponsors, and management firms similarly argue that addressing the supportive housing environment needs of their elderly tenants is not in their job description.

The bricks and mortar orientation has dominated the Federal housing response to seniors' housing needs. Housing legislation and budgets have traditionally emphasized the financing of new construction, the availability of a satisfactory physical plant, and the subsidization of a building's rent. In the early 1960s, when elderly persons became a notable constituency of public housing, developments were oriented to those who were active and well. At most, the special features in these facilities included emergency-call buttons and common recreational spaces, but few services. Similarly, the nonprofit sponsored Section 202 program for the elderly and handicapped funded the construction of facilities that were geared to the more active and ambulatory tenants. Their special needs were acknowledged only by the provision of design features to minimize accidents and facilitate mobility and by allowing the physical infrastructure to include common space (e.g., dining rooms, office, clinics) to offer the services. Even as the buildings under this program increasingly catered to frail seniors and it was recognized that a supportive physical infrastructure by itself did not guarantee the availability of human services, the financing of the service component was left to the initiatives of the facility's sponsors, third party providers, or the voluntary contributions of residents. At the same time, housing providers operating under other HUD assisted housing programs were discouraged from providing supportive services because their buildings did not have the common spaces that would facilitate their delivery.[197]

This fiscal funding firewall between physical infrastructure and service provision still persists. The third party emphasis on providing services in the Assisted Living Conversion Program is a recent example. Altogether, these policies have left the funding of supportive services to State and local agencies, to programs under the Department of Health and Human Services and to nongovernmental sources. At the same time, HUD regulations have variously restricted privately-owned multifamily housing sponsors or Public Housing Agencies from spending project operating funds, reserve funds, or residual rental receipt income on supportive housing services.

FEARS THAT FACILITIES WILL BECOME NURSING HOMES

A second barrier is linked to the fears of affordable housing providers that by providing supportive services in traditional shelter accommodations, their facilities will unattractively and unrealistically assume the appearance and functions of a nursing home or an assisted living facility. They question whether they have the competence to administer this type of housing, whether they will incur the wrath of the facility's more healthy tenants, or if they will violate State regulations. They worry that the psychological well being of their well elder tenants will suffer and that their facility will project an image of being the home of very frail elders to the outside community.[198] The fundamental question becomes whether there is *"an upper limit in the volume, variety, intensity and continuity of services that can be integrated" without a facility becoming an "institution*."[199] This is a question without an easy answer because housing providers, managements, Public Housing Agencies, and boards of directors hold very different opinions on this issue and because States differ considerably as to the frailty level thresholds that come under their regulatory purview.[200] HUD's position is suggested by examining its "Challenge of Housing Security" report where it is concluded that "*there is mounting evidence that many of their increasingly frail residents have more comprehensive assistance needs that demand supportive environments such as those offered by assisted living."*[201]

UNCERTAINTY AS TO HOW THE SUCCESS OF PROGRAMMATIC EFFORTS SHOULD BE MEASURED

A third barrier results from the lack of consensus as to what exactly supportive services should accomplish when they are delivered to rent-subsidized housing facilities. It is possible to distinguish three broad categories of successful outcomes. Advocates argue that improving the quality of life of older persons is sufficient reason to provide assistance. Helping them to remain in safe and comfortable quarters and minimizing problems they confront in taking care of themselves and their apartments is reason enough for public policy intervention. They argue that older persons should be able to exercise consumer choice even when they occupy government-subsidized housing.

A second position is held by advocates who argue that if the owners and managements of rent-assisted housing address the needs of their frail tenants, they benefit in the following important ways:[202]

- Lower apartment turnover and vacancy rates
- Fewer housekeeping and repair crises
- Lower incidence of fires and accidents

- Decrease in legal fees/evictions/time in court
- Fewer crisis situations, especially in off-hours
- Better bricks & mortar building management
- Greater marketability of units
- Fewer unscheduled visits from human service professionals
- Fewer off-hour emergency calls to management and local paramedics
- Fewer failed unit inspections
- Reduced time pressures on administrators
- Better tenant-housing management relations
- Increase in both tenant and management morale
- Greater peace of mind for family members

A third, and probably the most frequently cited basis for success, is that subsidized supportive services delay or prevent premature and more costly nursing home admission and thus allow Federal and State governments to realize long-term care cost savings. Unfortunately, this is also the most difficult position to justify as already suggested in reference to the subsidized assisted living facility alternative.

It is a difficult position to take for several reasons.[203] First, as revealed by the evaluations of the HOPE IV and Congregate Services Housing Programs, it is difficult to show that the introduction of supportive services lowers nursing home use, hospital admission rates, costs, mortality rates, or results in gains in individual physical functioning.[204] Thus, it is often difficult to turn aside arguments that, *"for many … residents whose physical functioning or mental health prevents them from living independently, entering a nursing home may be the most appropriate placement and ultimately may not be preventable."*[205]

Second, programmatic comparisons that purport to show savings often are seriously flawed by their failure to consider all the costs incurred by the supportive services program. As one example, recent testimony by a well-intended administrator of a rent-assisted housing facility with supportive services concluded that an individual moving from a for-profit assisted living facility to his facility experienced considerable cost savings. Certainly, rent and service costs to the residents were in fact less expensive than what she was spending in the assisted living facility. What was left out of the analysis was telling: the government costs of subsidizing the rental costs of his facility, the salary of the service coordinator, the below-cost meals received, plus the "reduced" costs of various other services. Furthermore, the assisted living facility, itself, was undoubtedly providing services not offered by the rent-assisted facility—whether the resident used them or not—that were legitimate expenditures.

Third, the mindset of housing advocates is often focused on the benefits and costs accruing to an *individual*. It can be relatively easily shown how a *given* individual with physical and cognitive impairments with supportive services needs can be maintained in a conventional setting at a cost that is less than that for a person residing in an assisted living facility or a Medicaid-funded nursing home. However, a program or group of programs designed to delay institutionalization must be directed to a *population* of potential beneficiaries. Herein lie the challenges of establishing favorable outcomes. Such a program runs the risk of delivering services to older persons who

would in any case not enter a nursing home or other more expensive supportive housing alternatives. Two analysts, Weissert and Kemper, have best articulated this "woodwork" effect:[206]

> *Savings produced on reduced nursing home use can be used to offset costs of the new home and community care services. But if patients serviced would not have gone to a nursing home anyway, or if [those] gone would have stayed only a short time, costs must go up because nursing home use is not being avoided but new services are being used.*
>
> *Small reductions in nursing home costs for some people are more than offset by the increased costs of providing expanded services to others who would remain at home even without expanded services…This is because it is difficult to serve only those at high risk of nursing home placement, difficult to effect large relative reductions in placement rates, and costly to provide the level of community care that many feel is appropriate.*

Not all experts necessarily share this pessimistic view. Cost savings and delay of nursing home admission may be achieved when the following conditions are met:

- If the most impaired elders are targeted and eligibility limited to those who are at high risk of nursing home placement
- If there is a proper mix of targeted services
- If there is a careful capping of per capita service costs
- If average benefit levels are kept low and in particular if case-management spending is constrained
- If older persons targeted have access to informal supports (in order to keep per capita benefits lower)

Many, though certainly not all, experts are optimistic about the results obtained from analyses of Arizona's Long-Term Care System which appears to have operated cost-effectively while offering an expanded home care option.[207]

In summary, those advocates seeking to justify the offering of supportive services on the basis of so-called commonsense arguments such as cost-savings and nursing home curtailment should be forewarned that this is a highly complicated and difficulty strategy to justify policy implementation. There are many "ifs" that must be satisfied. It is possible to come to a "desirable" conclusion, but it will not be easy, will more often fail than succeed, and may be an unnecessarily lofty result for which to argue.

CONNECTIVITY BARRIERS

A fourth category of "obstacles" can be understood by referring to an analogy from living systems theory. Individuals who have healthy hearts and lungs may still constitute high mortality risks if their arteries connecting these vital organs are narrowed and clogged with fatty deposits. This category thereby recognizes that the problem of providing supportive services to low-income frail seniors may have less to do with the availability of a community's resources, than about how to package, link, and deliver them. Three types of connectivity problems can be distinguished: (1) organizational and administrative, (2) transportation and geographical, and (3) information, digital,

and telecommunication. Ideally, the tightest integration of tenant needs and service resources requires the elimination of all three categories of connectivity problems.

Organizational and Administrative Connectivity

Program evaluations and expert testimonies frequently identify the administrative or organizational barriers that make it difficult to link together the benefits and services needed by low-income older persons that are offered under very different government programs, levels of government, different types of providers (e.g., nonprofit vs. for profits), and involve very different funding streams. The blurring boundaries between the service and housing domains accentuate these difficulties. Older persons often suffer from multiple ailments that require multiple treatment approaches and individually tailored benefit packages. For example, an older person recovering from a stroke may need rehabilitation therapy and assistance with meal preparation, personal care, home upkeep, transportation, and have design modifications made to their dwelling. These services are often subsidized by different governmental programs at the Federal, State, and local levels, and delivered by different agencies in different geographic locations. These programs differ with respect to their coverage, regulations, and eligibility requirements, the types of services they cover, the minimum income and assets they require for qualification, the priority they give to specific subgroups, the types, severity, and duration of their covered physical ailments and disabilities, the proportion of the service cost they subsidize, the length of time of the subsidy, and where the services must be delivered.[208]

Governmental agencies charged with providing social and health care services often fail to coordinate their efforts with agencies or providers charged with providing affordable housing. A number of barriers discourage housing-service integration: very different congressional or legislative committees and governmental agencies have responsibility for providing affordable human services at both the Federal and State levels; different and inconsistent geographical boundaries are attached to administrative oversight; and different and complex eligibility rules and funding approaches exist for program participation.[209]

Nationally, the Department of Housing and Urban Development and the Department of Health and Human Services have forged few formal linkages. Awareness is not the issue. Interviewed by *Older Americans Report*,[210] Assistant Secretary for Aging, Josephina Carbonell, promised to address a related issue. In her words: *"Information and referral, and the location of support services will be critical to bringing that message clearly to people in a language and manner they can understand.* She noted *"both President Bush and Secretary Thompson have made it a priority to look at barriers that keep people from accessing appropriate services, or having to go to half dozen places to access information."*

Moreover, even the Federal funds available from HUD alone are fragmented into separate programs and funding streams (e.g., Community Development Block Grant funds, HOME program, Service Coordinator funds, PRAC operating funds). Given these connectivity problems, even housing providers or managements receptive to the provision of a more supportive environment, often lack the know-how or experience to package program modules and are turned off by the many obstacles that make it difficult to secure uninterrupted funding from outside sources. Housing

sponsors are continually trying to get around the artificial barriers between the shelter and care domains.

At the State or local level, no single agency usually coordinates Federal, State, and local housing programs on the one hand, and supportive service programs on the other. Without such a dedicated local unit, the housing sponsor or provider must assume a much greater "service packaging" burden. One research effort showed that most lead agencies funded under the Older American's Act who coordinate the services for their planning areas, have little knowledge of HUD policies and few organized service delivery strategies targeted at the senior occupants of rent-subsidized facilities.[211] Another earlier study of the supportive services available to older persons in larger public housing facilities also concluded:

> *Service providers appear to overestimate the extent of service available to elder residents direction from the Public Housing Authority. This perception might lead providers to do less outreach in public housing than they would do otherwise, thinking that their services are not as much needed as they actually are.*[212]

Newman points to another related key obstacle:[213]

> *Substantively, health and housing professionals and policy makers have different orientations and types of expertise. It is rare to find individuals knowledgeable in both areas….*

The net result of these connectivity lapses is that to older persons, especially who are less educated and knowledgeable about "how the system works," a locality's shelter and care resources can appear very remote from the ways they think of their needs and problems. As early observed by Alfred Kahn, a noted American social worker:

> *People and their problems simply do not divide up as do agency functions and professional specializations. People can be fitted, consequently, into patterns of service involving variously established boundaries. But the initial fitting is no guarantee that the decision is strategic or that the various relevant components receive needed attention.*[214]

A similar conclusion was reached by the Elderly Housing Coalition:

> *An older person eligible for Medicare, Medicaid, Older Americans Act programs, and subsidized housing is treated by the government as four different entities…we see fragmented services, with one provider of services neither knowing what services are being delivered, nor informed about whether and how needs are being met. This leads to duplication, major gaps in services, and an inefficient use of resources.*[215]

It is not just the elder consumer who suffers. Well-intended housing providers seeking to offer subsidized supportive services to their low-income elderly tenants frequently confront incoherent programs where features that should fit together are artificially separated. The Section 202 program offers a physical plant and an organizational infrastructure to provide supportive services, but the housing sponsor must shoulder the burden of funding service delivery. The CHSP

program created an organizational infrastructure to offer meals and supportive services to frail tenants but HUD was willing to pay for only 40% of the cost. This discouraged, frustrated, and outright prevented many sponsors from participating in this program.[216] The recently funded Assisted Living Conversion Program is consistent with this fragmented perspective. Once a facility is physically transformed to accommodate the needs of frail elderly tenants, service delivery and administrative responsibility are shifted to other State and local government agencies charged with regulating licensed assisted living facilities and funding supportive services (such as through Medicaid Waivers).

The breakdown in cooperation between organizations, however, is not limited to the shelter-service interface. Builders and developers of affordable housing themselves continually confront obstacles as a result of local zoning and State environmental laws. When they propose a new project and participate in a public hearing, they often encounter opposition from neighbors and elected officials motivated by NIMBY (not in my back yard) concerns.[217] This often occurs when they are seeking to develop facilities that serve frail or disabled older persons. They still confront opposition despite recent rulings on the Fair Housing Amendments Act of 1988 that often justify their activities.[218] Even with regulatory permission to build, their development efforts may be thwarted by unrealistically demanding licensing standards, building codes and regulations, or design expectations that make it prohibitively expensive for them to proceed with their proposed development.[219]

Transportation and Geographical Connectivity

Most older persons are living in dwelling locations that require them to rely on vehicular transportation to reach family members, caregivers, human service providers, establishments, activities, and organizations. Overcoming such physical distances is obviously of paramount importance. The ability of older persons to easily access everything from a grocery store to a medical clinic obviously will influence whether they can continue to live independently in their current homes. Case studies, scientific research, and Congressional testimony abound with the horror stories of older persons who have been isolated in their dwellings and unable to secure the most essential of goods and services. Overcoming these geographic barriers can be accomplished via three substitutable delivery modes: (1) by older persons using traditional transportation modes such as private cars or vans, fixed route public transit, and walking to reach their destinations; (2) by older persons availing themselves of demand-responsive transportation services that offer more flexible, sometime door to door transportation, as exemplified by subscription bus services, shared-ride taxis, carpooling, vanpooling, and jitney services; and (3) by co-locating the goods and services on the same physical site where older persons live. Each of these delivery mode approaches is briefly examined below.

Traditional transportation modes. Researchers and advocates have focused the most on the affordability and usability difficulties experienced by older people when they use traditional transportation modes to reach desired destinations. Given that automobile travel accounts for over 90% of their everyday trips, it is not surprising that most attention has been placed on the advantages and disadvantages of older people continuing to drive even as they experience diminished locomotor and cognitive limitations that increase their risks of accident and death.[220] This is a complex topic having major consequences for older persons, other drivers, and the service

delivery system itself. Suffice to observe that most analysts agree that without automobile transportation, a great many older persons would suddenly find it difficult to remain in their current residential locations where they can usually access needed destinations only by automobile. This is especially the case for older persons with multiple impairments who live in low-density suburbs and rural areas.[221] While transit and walking are possible alternatives in the largest metropolitan areas, their well-documented limitations result in a far less flexible modes of transportation. This helps explain why only about 11% of older persons use public transit services.[222]

Demand-responsive transportation services. This has become an increasingly important way in which seniors are accessing desired destinations. In particular, some health and service providers and establishments (e.g., hospitals, clinics, adult day care centers) used frequently by seniors often provide their own specialized supplemental transportation services. Elders report that these services have made a tremendously positive impact on their lives giving them otherwise nonexistent mobility.[223] The vast majority of programs are operated by nonprofit organizations (82%) with only 2% provided by for profits with the remainder tending to be operated by combinations of these.[224] The programs are typically supported by government agencies (62%),[225] nonprofits (45%), churches (29%), and businesses (12%). These transportation alternatives, however, still fall short of meeting the needs of those older rural Americans who require long-distance travel to specialized medical services such as dialysis and chemotherapy.[226] Figure 49 offers a useful framework for evaluating how well a community is addressing the mobility needs of their older residents.[227]

Organizational and administrative connectivity barriers also plague the delivery of transportation services. Often, in the very same community, multiple public, for-profit, and nonprofit service providers are variously providing demand-responsive transportation services to older persons. Among the providers: Departments of Social Services providing Medicaid-funded transportation, Department of Health and Mental Health providing medical trips, Area Agencies on Aging, transporting clients to senior centers and other service destinations, Departments of Employment serving individuals moving from welfare to work, private nonprofit organizations, such as the American Red Cross and faith-based organizations providing transportation to various types of services. As Burkhardt summarizes[228]:

> *This human service transportation "system" has resulted in a multiplicity of local services targeted to particular populations for specific (and often limited) purposes. Transportation resources are often not coordinated and frequently duplicate expenditures and service efforts. They lack cooperation and communication, provide inadequate levels of service, vary in service quality, provide inadequate and unreliable information about services and costs, and have no comprehensive plan for meeting service needs. The fragmented system confuses consumers and fails to address the needs of many individuals who do not meet specific agency or program eligibility requirements.*

Several communities in Florida, Virginia, Oregon, Pennsylvania, South Carolina, and Wyoming, however, have attempted to improve transportation coordination and these efforts have resulted in a higher quality and more cost-effective services.[229] Furthermore, Federal agencies have demonstrated a commitment to encourage and support the coordination of community transportation resources. As one indicator, the U.S. Department of Health and Human Services and the U.S. Department of Transportation have agreed to support State and local efforts to coordinate

transportation services by providing technical assistance and guidance to their grantees. This commitment is manifested by the two agencies' efforts on the Coordinating Council for Access and Mobility designed to encourage and support the coordination of community transportation resources.[230]

Co-locating the goods and services on the same physical site as residence. The private sector has most frequently offered older persons the option of living in a residential site that also contains a variety of needed services. The two best and very different exemplars include: (1) the Del Webb's, active adult requirement communities, in which a plethora of everyday needs are located within walking or at least golf cart distance, and (2) the full-service, higher end, continuing care retirement community whose services can incongruously range from snack bars, library, post office, bank, to personal assistance services and skilled nursing care. Both these shelter-care examples, however, are primarily available only to higher-income seniors. In contrast, comparable shelter-care site examples targeted to lower income seniors are far less available. While food services are often found at affordable housing sites, only sporadic affordable housing site examples exist where an on-site clinic offers personal or health care. The previously examined On Lok program and to lesser extent, its successor, the PACE program present perhaps the best closest examples of the integration of services with affordable housing accommodations.

Information, Digital, and Telecommunication Connectivity

It is increasingly possible for older persons to obtain needed services through the use of less traditional modes of delivery, such as information transfer strategies including email, teleconferencing, videoconferencing, and other digital transfer strategies. Undoubtedly, some of the most innovative and helpful future service delivery strategies will be discovered in this domain and will benefit low-income and high-income frail elders alike.[231] Some predictions appear highly futuristic. One example is an electrode-studded cap that picks up brain waves, delivers them to an EEG machine, from which software instructions can maneuver the person's wheel chair or type text.[232] Figure 50 offers examples of current innovations in this area. The introduction of these innovative connectivity approaches will undoubtedly eliminate many of the transportation barriers that now prevent older consumers from accessing needed supportive services.

CONCLUSIONS

This report on the unmet housing needs of older Americans distinguishes itself from similar efforts in the following five ways:

First, its analysis of the unmet needs is not limited to assessments based on the traditional indicators of housing quality, the physical condition and affordability of the dwelling. Additionally, it examines the extent to which older Americans are in residential settings that link them to needed supportive services—ranging from social relationships, homemaker assistance, personal care, nursing services, and medical services—yet allow them to preserve the autonomy and normalcy of their past life-styles. This dual focus is necessitated by the new shelter and care reality in which the boundaries between conventional housing settings and long-term care environments are increasingly becoming blurred and less meaningful.

Second, its analysis is not restricted to the problems experienced by older renters, but additionally focus on the unmet needs older homeowners. Older homeowners not only comprise the largest single group of dwelling occupants, but also the fastest growing.

Third, it identifies seniors usually ignored by housing elderly research. They occupy the dwellings that are owned and rented by younger householders. The housing problems of this group is generally lost in tabulations summarizing the quality and affordability difficulties of their younger householders.

Fourth, in light of the new shelter and care reality, it examines the availability and desirability of the assisted living facility, perhaps the most visible, fastest growing, and the most promising alternative designed to accommodate frail older persons in an noninstitutional environment.

Fifth, while its focus is on the unmet housing needs of all older Americans, this report is especially concerned with identifying the problems confronted by low-income older households, as occupants of traditional shelter arrangements, but also as potential consumers of affordable noninstitutional shelter and care alternatives.

Sixth, while it thoroughly examines the unmet housing needs of the current population of older Americans, its mandate is to project how these needs will manifest themselves over the next 20 years. This recognizes that the demands and challenges of the forthcoming explosive growth of the baby boomer population are uncomfortably close.

The report's major findings included the following:

- Estimates of the number of older persons who are poor that are based on official poverty threshold standards substantially underestimate the number of older households who are unable to afford the costs of living in their particular metropolitan areas and nonmetropolitan counties. Over 5.7 million or 27% of older households have "extremely low" incomes that are 30% or less than their area's median; an additional 4.8 million or 23% of older households have substantially low incomes that are between 31% and 50% of their area's median. Altogether, over 10.6 million or 49% of this country's seniors have "very low incomes" (50% and under of area median income). Certain groups of older households are more likely than others to have very low incomes: the old-old (age 75 and over), those living alone, the less educated, African Americans, and Hispanics. Older households who are "overhoused," that is who live in excessively large dwellings are also more likely to have lower incomes. These over 3.8 million households are at greater risk of living in unaffordable housing and being unable to pay for their out-of-pocket medical and home care costs because they are burdened with the upkeep and maintenance of unused dwelling space even as they have very low incomes. A well-defined group of older homeowners is also economically disadvantaged. As many as 5 million or just over 29% of elderly homeowners are both cash-poor (they have low incomes) and house-poor (their homes are of low value).

- Over 3 million age 62 and older households now have extremely urgent unmet housing needs. In combination with their extremely low incomes, they occupy dwellings with

"priority" problems. That is, they pay over 50% of their monthly income on their housing costs (they have a serious housing cost burden) or they occupy dwellings with severe physical deficiencies. Another 2.3 million older households have very urgent unmet housing needs. They have extremely or substantially low incomes (under 50% of their area's median) and either have priority or less serious housing problems. Households with *less serious* housing problems include households who pay 30% to 49% of their monthly incomes on their housing costs (they have a moderate cost burden) or that occupy dwellings with moderate physical problems.

- Certain groups of older homeowners living in unaffordable or poor quality housing are especially vulnerable. There were 725,000 age 65 and older homeowners with low incomes (80% and under of area median) who not only had priority or less serious dwelling problems, but they also lived in dwellings valued under $40,000. Almost 2.5 million older homeowners with low incomes and living in dwellings with priority or serious problems lived in dwellings valued under $100,000. Irrespective of their house values, there were 2,890,000 low income age 65 and over homeowners earning less than $25,000 annually living in dwellings with priority or less serious problems who reported having either no savings or investments (1,818,000) or savings and investments of less than $25,000 (1,072,000).

- Certain groups of older homeowners living in unaffordable or poor quality housing are especially vulnerable. There were 725,000 age 65 and older homeowners with low incomes (80% and under of area median) who not only had priority or less serious dwelling problems, but they also lived in dwellings valued under $40,000. Almost 2.5 million older homeowners with low incomes and living in dwellings with priority or serious problems lived in dwellings valued under $100,000. Irrespective of their house values, there were 2,890,000 low income age 65 and over homeowners earning less than $25,000 annually living in dwellings with priority or less serious problems who reported having either no savings or investments (1,818,000) or savings and investments of less than $25,000 (1,072,000).

- As large is the current number of seniors living in unaffordable or poor quality dwellings, the future numbers seniors living in such inadequate housing will be staggering. By the year 2020, over 7.5 million age 65 and over households are projected to have extremely or very urgent unmet housing needs. Over 4.7 million age 65 and over households will have moderately or somewhat urgent unmet housing needs.

- A small subset of the older households with priority or less serious problems are specifically occupying dwellings in poor physical condition. The physical problems in these dwellings may not only affect the personal well-being of the older occupants, but also the social and economic viability of their neighborhoods. About 809,000 or 5% of age 65 and older owners and 447,000 or 11% of older renters occupied dwellings with either severe or moderate physical problems. These dwellings were more likely to be found in the central cities of metropolitan areas and in rural or nonmetropolitan areas, especially in southern United States. The oldest dwellings, those built 1949 or earlier and at greatest risk of requiring rehabilitation, were especially likely to have these physical deficiencies.

- Government-subsidized rental units mostly produced under the auspices of the Department of Housing and Urban Development are the most important public response to older households living in unaffordable or poor quality dwellings. The growth of the rent-subsidized housing stock, however, has not kept pace with the needs of a growing elderly population. This is well-illustrated by considering the history of the Section 202 program, considered by advocates and experts to be one of HUD's most successful housing production programs. While the number of units produced under this program has increased over the past several years, the current annual production of just over 7,000 units pales in comparison with historical production levels. The average annual number of Section 202 units was 18,000 in the 1970s, over 15,000 in the first half of the 1980s, and over 11,000 in the second half of the 1980s. Funding for this program has declined from $l.2 billion in fiscal year 1995 to under $700 million, currently.

- Older households in all income categories are under-represented in rent-assisted housing. Only 5.5% of age 62 and over households that live in conventional housing now occupy rent-subsidized facilities. This compares with 6.2% of age 61 and under households.

- Government-subsidized or rent-assisted facilities that are designed to eliminate dwelling cost burdens and to provide housing that is in good physical condition are themselves sources of problems. Almost 29% of the l.2 million age 65 and over rent-assisted households have priority problems, while another 28% have less serious problems. Additionally, almost 22.4% of the 152,000 age 62 to 64 households have priority problems, while another 33% have less serious problems. Thus, a total of 683,000 age 65 and over and 84,000 age 62 to 64 rent-assisted households have dwelling problems that presumably should not be found in government-subsidized facilities.

- Currently, 1,216,000 rent-assisted units (American Housing Survey database definition) occupied by age 65 and over households are serving an at-risk population of 7,075,000 *unassisted* renters and owners identified as having priority or less serious housing problems. This translates into 5.82 *unassisted* older households with dwelling problems for each existing rent-subsidized unit now occupied by an older household. Projections of the estimated future need for rent-subsidized units in 2020 range in number from 1.6 to 2.3 million. This would result in rent-assisted household projected growth rates that would range from 33.1% to 86.4%.

- Older persons experience another very different category of housing-related problems when they have physical or cognitive limitations that make it difficult for them to conduct their usual life styles, take care of themselves, or maintain their dwellings without the help of others. Older persons may find that they have significantly less disposable income if they incur out of pocket costs for home- and community-based care and health care expenses, in particular prescription medicine costs. Those on fixed incomes may find that paying for these expenses results in their once tolerable housing costs becoming a new burden, and in the case of older homeowners, make it difficult for them to afford their dwelling's maintenance, upkeep, and upgrading costs. Older persons with unavailable family supports and with the lowest incomes pose the greatest potential demand on their State and locality's

government-subsidized long-term care resources. Thus, physical and cognitive limitations of older persons are not just a personal affair, they become the "problems" of stakeholders in the public sector.

- In 1996, over 5.79 million or 18% of older persons aged 65 and over, who were not in institutions such as nursing homes, had difficulty performing without assistance either their everyday activities of daily living (ADLs) or their instrumental activities of daily living (IADLs). They included about 3.18 million or 10% of older persons with at least one IADL limitation involving the following activities: preparing meals, doing light housework, taking right amount of medicine, keeping track of money, or bills, and going outside the home. They also included about 2.61 million or 8% of older persons with at least one ADL limitation involving the following activities: getting in and out of bed or a chair, taking a bath or shower, dressing, walking, eating, and using or getting to a toilet. A smaller share of these older persons, 1.19 million or 3.7%, were especially impaired because they had limitations in three or more ADLs.

- Those seniors more at risk of experiencing these limitations and with the fewest options to address them will have one or more the following risk factors: they will be chronologically very old, poor, alone, unable to secure any type of assistance from family, less educated, or belong to a racial or ethnic minority.

- Older renters (not in government-subsidized rental facilities) are more likely to report having physical limitations than older homeowners, even after controlling for the age and income differences of these two groups. Even though the likelihood of having IADL or ADL limitations is greater among poor older renters, when even a small percentage of poor older homeowners have these limitations, their numbers are very large. Thus, over 1.3 million poor older homeowners have at least one ADL or IADL limitation compared with just under 600,000 poor older unassisted renters. Even these disability patterns tell an incomplete story. The over 440,000 homeowners who are both cash-poor and house-poor and who have at least one IADL or ADL limitation constitute an especially vulnerable group without the financial wherewithal to take care of themselves or their dwellings.

- The physical environment of the dwelling has the potential for worsening the affects of these physical and cognitive limitations. The design features and overall physical condition of a dwelling and its location relative to everyday needs may offer new obstacles or even an unsafe environment for impaired older persons to conduct their accustomed life-styles. Among the possible consequences: a car or a bus route may become unusable and accessing everyday community needs may become very difficult, an upstairs of a dwelling may suddenly become inaccessible, throw rugs may become a walking hazard, using a stove may become unsafe, or a bathroom's shower or toilet may be difficult or impossible to use.

- This report projects that by the year 2020 there will be 4.31 million older persons with IADL limitations, 3.62 million older persons with ADL limitations, and 3.58 million older persons with mental disabilities. Most of this future group of older persons with these physical and cognitive limitations will be homeowners. The 26% to 28% projected growth rates of these disabled older populations between 2000 and 2020 will be lower than the projected overall

growth rate of the older population, because of the assumed declining disability rates of the future elderly population. The over 3 million of this future older population expected to be frail will be especially disadvantaged because of their low incomes (under 150% of the poverty level).

- A major forecasting uncertainty is which options older persons will adopt to address their long-term care needs. They could remain in their conventional dwellings relying on family caregivers or professional workers or alternatively relocate to supportive senior housing facilities, including the nursing home. Currently, about 70% of older persons with either ADL or IADL limitations are found outside of institutions. What this percentage will look like two decades from now is dependent on a host of factors that are difficult to predict.

- A substantial share of the older tenants in government-subsidized or rent-assisted housing has physical or cognitive limitations and is the most at risk of needing supportive services. Overall, about 33% of age 65 and over tenants required assistance with at least one IADL or ADL. This included almost 21% who had at least one IADL limitation and just over 12% who had at least one ADL limitation. Almost 5% of age 65 and over tenants had a level of disability characteristic of the occupants of assisted living facilities or nursing homes because they needed assistance with three or more of their activities of daily living. Some 12% of rent-assisted elderly tenants had a mental disability that seriously interfered with their everyday activities. The oldest tenants in these housing developments (the old-old or age 75 and over), are especially likely to have physical and cognitive limitations.

- The poor older occupants of government-subsidized facilities are especially likely to be vulnerable:

    - They are more likely to be extremely poor.
    - They are more likely to live alone (mostly women) and thus are unable to rely on a spouse as a caregiver.
    - They are less educated and thus are often unsure about their eligibility for government-sponsored programs, are afraid of and inexperienced in dealing with " system," and lack the sophistication to judge accurately the quality of their assistance. They have difficulty accessing a bureaucratic system presenting very different application procedures and eligibility requirements and are more apt to confront bureaucratic snafus and infringements on their individual rights.
    - They are more likely to be members of racial and ethnic minorities and thus confront cultural and language barriers when accessing needed supportive services.
    - They generally have fewer affordable supportive service options and are more dependent on government-financed supportive services.

- Numerous case studies of rent-assisted facilities reveal successful approaches to providing supportive services to this group. Community-based organizational strategies have fostered low-income residents' independence through a "one-stop shopping" service package funded by a capitation approach (usually combining Medicaid and Medicare funding) that offers frail seniors living in the community a full range of acute and long-term care services

provided either at an affordable housing site or at a nearby adult day center. The two most important exemplars are the On Lok and the PACE programs. Rent-assisted facilities built under the Federal (HUD) Section 202 program have sometimes successfully accommodated the supportive service needs of their older tenants. Service coordinators that staff rent-assisted facilities have helped to link older tenants with the community-based services they need to maintain their independent living arrangements. An unofficial estimate is that over 4,000 service coordinators are now working in HUD, Public Housing, and Rural Housing Service facilities and are assisting an estimated 600,000 older persons. Two small programs, The Congregate Housing Services Program (CHSP) And The Hope For Elderly Independence Demonstration Program (HOPE IV) while now inactive, were judged to be very successful programs that offered supportive-service and case management services including service coordination to a very small number of facilities and older tenants.

- The use of Medicaid Waivers to subsidize the care component of assisted living facilities owned by for-profit entities has been the most successful in creating affordable units for low-income frail older persons. Ideally, the best designed and operated assisted living facilities can accommodate older persons with physical and cognitive deficits who require a protective environment, regular and unscheduled assistance with activities of daily living, and some nursing care. Such facilities provide residents with a "social" or "residential" model of shelter and care that recognizes the importance of maintaining their dignity, independence, control, individuality, and privacy. The architectural setting and organizational environment of this model more closely resembles a residence, an inn, or a hotel than a hospital or nursing home. Unlike more medically-oriented long-term care settings, or very small, house-like traditional board and care facilities, residents do not have to share their dwellings, but rather have their own apartments, can lock their doors, and have their own bathroom and kitchen facilities. They have much more say about how they conduct everyday activities, such as when they eat or recreate. Most importantly, they play a more active role in deciding what services they receive and when they receive them. Care and services, rather than delivered as a one size fits all, is individually tailored to meet the specific needs of seniors and the preferences of their families. In practice, some assisted living facilities fall short of this ideal; however, the latest investigation of a nationally representative sample of residents and staff in assisted living facilities offered a generally positive evaluation of this more *residential-like long-term care setting,*

- As of April 2000, 38 States were able to use their Medicaid waiver programs to subsidize the personal care and nursing services provided in assisted living facilities. This program is serving over 60,000 older persons, an increase of 50% over the previous two-year 40,000 total. Although there are several possible downsides to this funding approach, advocates consider it to be one of the most promising strategies to make the assisted living facility alternative affordable.

- This report projects that in 2020 the number assisted living facility *units* will range from 712,707 to 755,302. Currently, it is estimated that 10.3% of the residents in assisted living facilities received subsidies. If this current estimated proportion of subsidized residents remains constant through 2020, then assisted living facilities in 2020 will have to accommodate from 93,229 to 98,801 "subsidized" older persons.

- Despite these successful efforts, barriers to successful affordable supportive housing solutions remain. There still exists a large presence of low-income frail seniors who are having difficulty finding affordable supportive settings in which to maintain their independence. It is not for lack of awareness. The major advocacy groups, the Department of Housing and Urban Development, and State and local governments are aware of the needs of frail older persons in government-subsidized housing.

- It is also not for lack of solutions. Rather, consensus simply does not exist among the major stakeholders as to whom should assume responsibility for this vulnerable group of seniors or what public policy responses are desirable, acceptable, and achievable. It is possible to identify four categories of barriers: (1) a lack of consensus over whether the mandate or mission of the Department of Housing and Urban Development should extend to providing supportive services to assist vulnerable tenants; (2) a fear by affordable housing providers that by providing supportive services in traditional shelter accommodations, their facilities will unattractively and unrealistically assume the appearance and functions of a nursing home or an assisted living facility; (3) a lack of consensus as to what exactly supportive services should accomplish when they are delivered to rent-subsidized housing facilities; and (4) organizational, administrative, transportation, and electronic/digital barriers that impede the packaging, linking, and delivery of the available resources in the community.

ATTACHMENT I.

DATA SOURCE AND DEFINITIONS OF FUNCTIONAL DISABILITIES AND CORRELATES USED IN THIS REPORT

Data Source

Disability measures were computed from the Survey of Income and Program Participation (SIPP). The data were based on the SIPP 1996 panel, topical module 3, 5 and core 5.
Information about household composition was taken from a topical module of Wave 3. Disability information was taken from a topical module of Wave 5. All other information (i.e., on personal characteristics) were taken from the Core module of Wave 5. The file weights from Wave 5 were used

Definitions of Major Disability Indicators

Activity of Daily Living Limitations (ADLs)

A person who answered yes to any of the following six questions was considered to have Activity of Daily Living (ADL) limitation:
EBEDHELP
Need help getting in and out of bed or a chair.
Does the person need the help of another person with getting in and out of bed or a chair? All persons 15+ at the end of the reference period who need the help of another person with getting in and out of bed or a chair. (EPOPSTAT=1, EBEDDIF=1)
-1. Not in universe
1. Yes
2. No

EBATHH
Need help taking a bath or shower.
Does the person need the help of another person with taking a bath or shower?
All persons 15+ at the end of the reference period who need the help of another person with taking a bath or shower. (EPOPSTAT=1, EBATHDIF=1)
-1. Not in universe
1. Yes
2. No

EDRESSH
Need help dressing.
Does the person need the help of another person with dressing?
All persons 15+ at the end of the reference period who need the help of another person with dressing. (EPOPSTAT=1, EDRESSD=1)
-1. Not in universe
1. Yes
2. No

EWALK2H
Need help walking.

Does the person need the help of another person with walking?
All persons 15+ at the end of the reference period who need the help of another person with walking. (EPOPSTAT=1, EWALK2D=1)
-1. Not in universe
1. Yes
2. No

EEATHELP
Need help eating.
Does the person need the help of another person with eating?
All persons 15+ at the end of the reference period who need the help of another person with eating. (EPOPSTAT=1, EEATDIF=1)
-1. Not in universe
1. Yes
2. No

ETOILETH
Need help using or getting to the toilet.
Does the person need the help of another person with using or getting to the toilet?
All persons 15+ at the end of the reference period who need the help of another person with using or getting to the toilet. (EPOPSTAT=1, ETOILETD=1)
-1. Not in universe
1. Yes
2. No

Instrumental Activities of Daily Living (IADLs)

A person who answered yes to any of the following sic questions was considered to have Instrumental Activities of Daily Living (IADL) limitation:

EMEALSH
Need help preparing meals.
Does the person need the help of another person with preparing meals?
All persons 15+ at the end of the reference period who need the help of another person with preparing meals. (EPOPSTAT=1, EINDIF=1)
-1. Not in universe
1. Yes
2. No

EHWORKH
Need help doing light housework.
Does the person need the help of another person with doing light housework such as washing dishes or sweeping a floor?
All persons 15+ at the end of the reference period who need the help of another person with doing light housework such as washing dishes or sweeping a floor. (EPOPSTAT=1, EHWORKD=1)
-1 .Not in universe
1 .Yes
2 .No

EMEDH
Need help taking right amount of medicine.

Does the person need the help of another person with taking the right amount of prescribed medicine at the right time?
All persons 15+ at the end of the reference period who need the help of another person with going outside the home. (EPOPSTAT=1, EOUTDIF=1)
-1. Not in universe
1. Yes
2. No

EMONEYH

Need help keeping track of money and bills.
Does the person need the help of another person with keeping track of money and bills?
All persons 15+ at the end of the reference period who need the help of another person with keeping track of money and bills. (EPOPSTAT=1, EMONEYD=1)
-1. Not in universe
1. Yes
2. No

EOUTHELP
Need help going outside the home.
Does the person need the help of another person with going outside the home, for example, to shop or visit a doctor's office?
All persons 15+ at the end of the reference period who need the help of another person with going outside the home. (EPOPSTAT=1, EOUTDIF=1)
-1. Not in universe
1. Yes
2. No

ETELEC (Ability rather than needs help)
Ability to use a telephone at all.
Is the person able to use an ordinary telephone at all?
All persons 15+ at the end of the reference period who have any difficulty using an ordinary telephone. (EPOPSTAT=1, ETELED=1)
-1. Not in universe
1. Yes
2. No

Mental Disabilities

This was defined by 5 different variables. A person who answered yes to any of the questions was considered to have a mental disability:

EINTRFER
Ability to manage everyday activities.
During the past 12 months, did the problems just mentioned seriously interfere with the person's ability to manage everyday activities?
All persons 15+ at the end of the reference period. (EPOPSTAT=1, EANXIOUS=1 or ESOCIAL=1 or ECTRATE=1 or ECOPE=1)
-1. Not in universe
1. Yes
2. No

EMR
Does the person have mental retardation?
All persons 15+ at the end of the reference period. (EPOPSTAT=1)
-1. Not in universe
1. Yes
2. No

EALZ
Alzheimer's disease.
Does the person have Alzheimer's disease or any other serious problem with confusion or forgetfulness?
All persons 15+ at the end of the reference period. (EPOPSTAT=1)
-1. Not in universe
1. Yes
2. No

EDEVDIS
Developmental disability.
Does the person have a developmental disability such as autism or cerebral palsy?
U All persons 15+ at the end of the reference period. (EPOPSTAT=1)
-1. Not in universe
1. Yes
2. No

EOTHERM
Other mental or emotional condition.
Does the person have any other mental or emotional condition?
All persons 15+ at the end of the reference period. (EPOPSTAT=1)
-1. Not in universe
1. Yes
2. No

Owners and Renters

The household variable (owners vs. renters) was created by combining 3 different variables:

ETENURE
Ownership status of living quarters Are your living quarters, owned or being brought by you or someone in your household, rented for cash or occupied without payment of cash rent?
All persons
1. Owned or being bought by you or someone in your hhld
2. Rented for cash
3. Occupied without payment of cash rent

EPUBSE
Residence in public housing project Is the residence in a public housing project...is it owned by a local housing authority?
All persons residing in a rental unit

ETENURE = 2 or 3

-1. Not in universe
1. Yes
2. No

EGVTRNT
Receipt of Government subsidized rent.
Is the Federal, State or local government paying part of all of the rent for this residence?
All persons residing in a rental unit ETENURE = 2 or 3
-1. Not in universe
1. Yes
2. No
For non-home owners, public housing (EPUBSE=1) or government subsidized rent (EGVTRNT=1) were used to denote rental assistance.

Income and Poverty Indicators

The income and poverty level were created using two different variables.

THTOTINC
Total household income.
Re-aggregated total household income for relevant month of the reference period after top-coding.
All persons
-1500000:1500000 .Dollar amount

THPOV
Low-income cutoff for this household
All persons

1:40000 Dollar amount

The SIPP survey asks a first group of questions that addressed the employment and earnings status. These questions identify characteristics about the employment, self-employment and business that the respondent may own. A second set of questions focuses on income from sources other than the respondent's work situation. Including: Social Security, Food Stamps, retirement/disability/survivors' incomes, unemployment insurance, workers' compensation, severance pay, lump sum payments from pension or retirement plans, child support, and alimony payments.

Attachment II. Major Types of Supportive Senior Housing Units in the United States

Congregate Living Facility or Independent Living Facilities

This is typically a multi-family occupied apartment building with self-contained rental units marketed to a predominantly independent senior population paying a monthly rent or fee. Its supportive services are typically restricted to housekeeping, meals, security, transportation, social activities, recreation, and service and health-need counseling. Personal assistance or health care services by in-house staff are usually not offered except as a home-care delivered option. A variant of this model is the higher-end residential hotel in which seniors occupy rooms rather than apartments. In the past, nonprofit sponsors predominantly owned these facilities, but for-profit sponsors' role is increasing. This housing category may or may not be licensed by the State.

Assisted Living Facilities

This is typically a professionally managed housing facility with self-contained rental units marketed to higher-income seniors. It usually offers all the supportive services of congregate care. It additionally offers personal assistance and nursing services to seniors, who require assistance performing everyday activities; and it often offers some health care services but not 24-hour skilled nursing care. The monthly rent covers the costs of the shelter and some of the services, but also sometimes includes an additional fee for specific personal care/nursing services. Some facilities only house Alzheimer's Disease residents, while others may have part of their facility dedicated to this resident group. This option is primarily owned by for-profits (69%) or are publicly held (26%). About 5% are owned by nonprofit organizations. These facilities are usually regulated by States, although they may or may not be referred to as assisted living facilities. This category also sometimes misleadingly includes "board and care" facilities (see below).

Board and Care Facilities

This is typically a large, conventional "single family" house occupied by three or more, but usually less than twenty unrelated adult persons who pay a monthly fee. These "mom and pop" facilities are usually operated by a married couple or single person who lives on the premises and is responsible for all shelter aspects (e.g., housekeeping, meals, laundry) and the care of their occupants. Seniors, ranging from the relatively independent to the somewhat frail, will occupy a bed sitting room, often with its own bathroom. This room is often shared my two or more seniors. Residents share all other space, such as a common living room, kitchen, and recreation areas. Residents are predominantly lower-income and these facilities are mostly owned by for-profits (80%) as opposed to nonprofits (20%). These facilities may or may not be licensed by the State. This category also includes facilities known as Shared Group Housing. This is also typically a large conventional residential structure (often a single family house) that operates as a single housekeeping unit occupied by three or more, but usually less than twenty unrelated adult persons (e.g., the Abbeyfield houses in Canada). Relatively independent seniors will typically have their own bedsitting room and sometimes their own bathroom, but they will otherwise share the kitchen, living room and other common living areas. They will also share responsibility for the usual residential upkeep and homemaking tasks, although one or more hired persons may do the housekeeping, laundry, home repairs, meal preparation, and provide transportation assistance. A full-time manager often takes care of the facility, and sometimes, but not always, will reside full-time in the house. These facilities are predominantly owned by for-profits and may or may not be licensed by the State.

Continuing Care Retirement Communities (CCRCs)

Most CCRCs (77% in the U.S.) incorporate congregate living, assisted living, and nursing home care within a single building or several buildings on a campus-like site. Other combinations include: assisted living and nursing care, but not congregate care (3%); congregate living and nursing care, but not assisted living (12%); and congregate living and assisted living, but not nursing care (8%). CCRCs usually offer at least a one-year contract that guarantees residents access to all its offered levels of care at specified prices. For this "insurance" residents often pay a one-time "entrance fee" (variously refundable) along with a monthly fee covering shelter and services. Over 90% of CCRCs are owned by nonprofits; the remainder, by for-profits. A facility's levels of shelter and care may be licensed by multiple State/Federal agencies.

Nursing Homes or Care Facilities

Skilled nursing and rehabilitative care and sometimes subacute care are offered in a hospital/institutional-like building to the most physically and cognitively impaired elderly population. About 66% of nursing home facilities are owned by for-profit firms, 26% by nonprofits, and 8% by government agencies. These facilities are usually licensed and regulated by a State.

Sources: American Association of Homes and Services for the Aging. 1999. *Continuing Care Retirement Communities: 1998 Profile.* Washington, D.C.: American Association of Homes and Services for the Aging (AAHSA); American Seniors Housing Association. 2001. *The State of Seniors Housing, 2000*. Washington, DC: American Seniors Housing Association; Anikeeeff, Michael A. and James E. Novitzki. 1998. "Quantifying the Supply of Seniors Housing." Pp. 183-204 in *Seniors Housing*, eds. Michael A. Anikeeff and Glenn R. Mueller. Norwell, Massachusetts: Kluwer Academic Publishers; Golant, Stephen M. 1992. *Housing America's Elderly: Many Possibilities, Few Choices*. Newbury Park, CA: Sage Publications; National Investment Conference. 2001. *The Case for Investing in Seniors Housing and Long Term Care Properties* . Annapolis, Maryland: National Investment Conference for the Senior Housing &Care Industries; Strahan, G. W. *An Overview of Nursing Homes and Their Current Residences: Data From the 1995 National Nursing Home Survey*. Advance Data From Vital and Health Statistics, No. 280. Hyattsville, Maryland: U.S. National Center for Health Statistics.

Attachment III. Indicators of Dwellings in Poor Physical Condition

Dwelling units are distinguished by the American Housing Survey database according to whether they are reported as having severe or moderate physical problems.

Physical problems-severe. A unit has severe physical problems if it has any of the following five problems:

Plumbing. Lacking hot or cold piped water or a flush toilet, or lacking both bathtub and shower, all inside the structure (and for the exclusive use of the unit, unless there are two or more full bathrooms).

Heating. Having been uncomfortably cold last winter for 24 hours or more because the heating equipment broke down, and it broke down at least three times last winter for at least 6 hours each time.

Electric. Having no electricity, or all of the following three electric problems: exposed wiring, a room with no working wall outlet, and three blown fuses or tripped circuit breakers in the last 90 days.

Hallways. Having all of the following four problems in public areas: no working light fixtures, loose or missing steps, loose or missing railings, and no working elevator.

Upkeep. Having any five of the following six maintenance problems: (1) water leaks from the outside, such as from the roof, basement, windows, or doors; (2) leaks from inside structure such as pipes or plumbing fixtures; (3) holes in the floors; (4) holes or open cracks in the walls or ceilings; (5) more than 8 inches by 11 inches of peeling paint or broken plaster; or (6) signs of rats in the last 90 days.

Physical problems-moderate. A unit has moderate physical problems if it has any of the following five problems, but none of the severe problems:

Plumbing. On at least three occasions during the last 3 months, all the flush toilets were broken down at the same time for 6 hours or more.

Heating. Having unvented gas, oil, or kerosene heaters as the primary heating equipment.

Kitchen. Lacking a kitchen sink, refrigerator, or cooking equipment (stove, burners, or microwave oven) inside the structure for the exclusive use of the unit.

Hallways. Having any three of the four problems listed above.

Upkeep. Having any three or four of the six problems listed above in “upkeep.”

Source: U.S. Census Bureau. Current Housing Reports, Series H150/99, *American Housing Survey for the United States: 1999*. Washington, DC: U.S. Government Printing Office.

Attachment IV. Number of Low and Higher Income Age 65 and Over Households in Unaffordable or Poor Quality Dwellings, By Housing Tenure and Rent-Assisted Status, 1999

Income Group	Total	All Owners	All Renters	Unassisted Renters	Assisted Renters	All Households Except Rent-Assisted	Assisted as % of Total Renters	Assisted as % of Total Households
All Incomes	21,423,000	17,196,000	4,227,000	3,011,000	1,216,000	20,207,000	28.8	5.7
All incomes with priority problems	3,891,000	2,468,000	1,422,000	1,074,000	348,000	3,542,000	24.5	8.9
All incomes with less serious problems	3,868,000	2,667,000	1,201,000	866,000	335,000	3,533,000	27.9	8.7
All incomes with all problems	7,759,000	5,135,000	2,623,000	1,940,000	683,000	7,075,000	26.0	8.8
Extremely Low Income	5,770,000	3,806,000	1,964,000	1,156,000	808,000	4,962,000	41.1	14.0
Under 30% AMI with priority problems	2,699,000	1,630,000	1,070,000	761,000	309,000	2,391,000	28.9	11.4
Under 30% AMI with less serious problems	1,406,000	995,000	411,000	208,000	203,000	1,203,000	49.4	14.4
Under 30% AMI with all problems	4,105,000	2,625,000	1,481,000	969,000	512,000	3,594,000	34.6	12.5
Very Low Income	10,604,000	7,585,000	3,019,000	1,925,000	1,094,000	9,510,000	36.2	10.3
Under 50% AMI with priority problems	3,375,000	2,064,000	1,311,000	967,000	344,000	3,031,000	26.2	10.2
Under 50% AMI with less serious problems	2,662,000	1,795,000	867,000	564,000	303,000	2,359,000	34.9	11.4
Under 50% AMI with all problems	6,037,000	3,859,000	2,178,000	1,531,000	647,000	5,390,000	29.7	10.7
Low Income	14,985,000	11,309,000	3,666,000	2,480,000	1,186,000	13,789,000	32.4	7.9
Under 80% AMI with priority problems	3,714,000	2,331,000	1,382,000	1,036,000	346,000	3,367,000	25.0	9.3
Under 80% AMI with less serious problems	3,380,000	2,274,000	1,107,000	775,000	332,000	3,049,000	30.0	9.8
Under 80% AMI with all problems	7,094,000	4,605,000	2,489,000	1,811,000	678,000	6,416,000	27.2	9.6
Higher Income	6,440,000	5,878,000	562,000	532,000	30,000	6,410,000	5.3	0.5
81% and over AMI with priority problems	177,000	137,000	40,000	38,000	2,000	175,000	5.0	1.1
81% and over AMI with less serious problems	485,000	392,000	93,000	90,000	3,000	482,000	3.2	0.6
81% and over AMI with all problems	662,000	529,000	133,000	128,000	5,000	657,000	3.8	0.8

Priority Problems: Refers to households in which the occupants pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.
Less Serious Problems: Refers to households in which the occupants pay between 30% and 49% of their monthly income on their housing costs or that occupy dwellings with moderate physical problems.

[1] The Section 8 Certificate and Voucher programs have been merged into the Housing Choice Voucher program and as before is administered through Public Housing Agencies and other State and local designated entities.
[2] Kochera, Andrew, Don Redfoot, and Jeremy Citro. 2001. *Section 8 Project-Based Rental Assistance: The Potential Loss of Affordable Federally Subsidized Housing Stock*. Washington, DC: AARP.
[3] U.S. Department of Housing and Urban Development. 2000. *Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs*. Washington: U.S. Department of Housing and Urban Development.
[4] Currently, developers of Section 202 facilities receive capital advances to cover construction and development costs that are interest free. These monies do not have to be repaid as long as the housing remains available for the very low-income elderly for a minimum of 40 years. The rent subsidy component is arranged as a Project Rental Assistance contract (PRAC) (rather than as before, Section 8) that covers the property's operating costs (subject to HUD guidelines).
[5] This section draws heavily on Dolbeare, Cushing N. 2001. *Changing Priorities: The Federal Budget and Housing Assistance, 1976-1999*. Washington, DC: National Low Income Housing Coalition; U.S. Department of Housing and Urban Development. 2000. *Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs*. Washington: U.S. Department of Housing and Urban Development; and U.S. Department of Housing and Urban Development 1999. *Waiting in Vain: An Update on America's Rental Housing Crisis*. Washington, DC: U.S. Department of Housing and Urban Development.
[6] These outlays include not only rental subsidies offered in HUD-assisted housing (public housing, vouchers, and project-based properties), but also other assistance, such as, drug elimination grants, public housing revitalization (HOPE VI), homeless assistance grants, and Housing opportunities for persons with AIDs.
[7] Total housing and low-income outlays for HUD in 1999 was $32.8 million expressed in constant year 2000 dollars.
[8] Of course, these expenditures pale in contrast to the $200+ billion spend for Medicare benefits or the $400+ billion for Social Security. These two programs alone account for over 40% of Federal spending.
[9] Including TANF (Temporary Assistance for Needy Families), child care, and Supplemental Security Income.
[10] Dolbeare, Cushing N. 2001. *Changing Priorities: The Federal Budget and Housing Assistance, 1976-1999*. Washington, DC: National Low Income Housing Coalition; Dreier, Peter. 2001. "Putting Housing Back on the Political Agenda." Pp. 43-92 in *Housing Policy in the New Millennium*: Conference Proceedings, Eds. Susan M. Wachter and R. L. Penne. Washington, DC: U.S. Department of Housing and Urban Development.
[11] Sard, Barbara. Director of Housing Policy, Center for Budget and Policy Priorities Before the Senate Committee on Banking, Housing and Urban Affairs, Hearing on Housing and Community Development Needs: The FY 2003 HUD Budget, November 29, 2001.
[12] From 1977 to 1983, the number of new additional HUD-assisted households grew an average of 204,000 units annually; from 1984 to 1994 by an average of 107,000 new additional units annually (U.S. Department of Housing and Urban Development. 2000. *Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs*. Washington: U.S. Department of Housing and Urban Development).
[13] U.S. Department of Housing and Urban Development. 1999. *Waiting in Vain: An Update on America's Rental Housing Crisis*. Washington, DC: U.S. Department of Housing and Urban Development.
[14] Sard, Barbara. Director of Housing Policy, Center for Budget and Policy Priorities Before the Senate Committee on Banking, Housing and Urban Affairs, Hearing on Housing and Community Development

Needs: The FY 2003 HUD Budget, November 29, 2001. According to Sard, this was the lowest number of new vouchers under a Republican President since the first budget of the Reagan Administration..

[15] Based on compilation of historical record of Section 202 production provided by American Association of Homes and Services for the Aging.

[16] Testimony of Thomas Slemmer, President National Church Residences, before the House Financial Services Subcommittee on Housing and Community Opportunity, July 17, 2001.

[17] Howell, Joseph and Elena Yearly. 2001. "Affordable Housing Help." *Assisted Living Today* 8(4):55-57.

[18] Heumann, Leonard, Winter-Nelson, and James R. Anderson. 2001. *The 1999 National Survey of Section 202 Elderly Housing*. Washington, DC: AARP.

[19] Kochera, Andrew, Don Redfoot, and Jeremy Citro. 2001. *Section 8 Project-Based Rental Assistance: The Potential Loss of Affordable Federally Subsidized Housing Stock*. Washington, DC: AARP.

[20] For the representation of age 65 and over households (all income categories) in rent-assisted facilities, see Attachment IV.

[21] U.S. Department of Housing and Urban Development. 1999. *Waiting in Vain: An Update on America's Rental Housing Crisis*. Washington, DC: U.S. Department of Housing and Urban Development.

[22] McGough, Duane T. 1997. *Characteristics of HUD-Assisted Renters and their Units in 1993*. Washington, DC: U.S. Office of Policy Development and Research, Department of Housing and Urban Development.

[23] Golant, Stephen M. 2002. "Geographic Inequalities in the Availability of Government-Subsidized Rental Housing for Low-Income Older Persons in Florida." *The Gerontologist* 42(1):1-9.

[24] Nonetheless, in its usual time series data reporting on trends in worst case housing needs, these problems are lost in the tabulations because rent-assisted housing is treated as a category undifferentiated by the presence of problems.

[25] McGough, Duane T. 1997. *Characteristics of HUD-Assisted Renters and Their Units in 1993*. Washington, DC: U.S. Office of Policy Development and Research, Department of Housing and Urban Development.

[26] U.S. Department of Housing and Urban Development. 2000. *Rental Housing Assistance--The Worsening Crisis: A Report to Congress on Worst Case Housing Needs*. Washington: U.S. Department of Housing and Urban Development.

[27] Buron, Larry, Sandra Nolden, Kathleen Heintzi, and Julie Stewart. 2000. *Assessment of the Economic and Social Characteristics of LIHTC Residents and Neighborhoods, Final Report*. Washington, DC: U.S. Department of Housing and Urban Development.

Herbert, Christopher E. et al. 2001. *Study of the Ongoing Affordability of HOME Program Rents*. Cambridge, MA: Abt Associates, Inc.

[28] U.S. Department of Housing and Urban Development. 2001. *FY 2002 Annual Performance Plan*. Washington, DC: U.S. Department of Housing and Urban Development.

[29] McGough, Duane T. 1997. *Characteristics of HUD-Assisted Renters and Their Units in 1993*. Washington, DC: U.S. Office of Policy Development and Research, Department of Housing and Urban Development, p. 19.

[30] That is, 2,390,000 divided by l,216,000.

[31] Based on the aforementioned U.S. Census population projections and Harvard household projections.

[32] All four scenarios presume a base total of 1,216,032 rent-assisted units in 1999. As indicated earlier, this number is based on American Housing Survey data, which is lower than other published estimates of the current supply of rent-assisted units. With little violation of the projection scenarios, the computed "1999-2020 rent-assisted households projected growth rate" (second column from right in Table 17) can be applied to these other base totals to obtain revised estimates of the number of rent-assisted units needed in 2020.

[33] AARP. 2000. *Fixing to Stay: A National Survey on Housing and Home Modification Issues*. Washington, DC: AARP.

[34] The two major types of reverse mortgages available today are the FHA's HECM reverse mortgage and Fannie Mae's Home Keeper loan. Private reverse mortgages are also offered by the Financial Freedom

Senior Funding Corporation. Reverse mortgages can be privately insured, FHA-insured, or uninsured. We focus primarily on FHA-insured HECM mortgages in this section.

[35] Rodda, David T., Christopher Herbert, and Hin-Kin Lam. 2000. *Evaluation Report of FHA's Home Equity Conversion Mortgage Insurance Demonstration*. Washington, DC: U.S. Housing and Urban Development.

[36] HECM loans are available to all homeowners age 62 and over have low outstanding mortgage balances or own their home free and clear. The interest on this loan is not tax-deductible until the debt is repaid.

[37] In the "tenure plan" reverse mortgage the borrower receives monthly payments from the lender for as long as the borrower lives and continues to occupy the home as a principal residence; in the "term plan" the borrower receives monthly payments for a fixed period of time, after which the borrower may stay in the home and defer payment; in the "line of credit plan" the borrow can make withdrawals up to a maximum amount, at times and in amounts of the borrower's choosing. The borrower could receive a lump sum payment at the time the loan issued. Both term and tenure mortgage plans may be combined with the line of credit option. They are all non-recourse loans, that is, only the value of the home can serve as collateral and other personal assets cannot be seized if the house value is not sufficient to pay back the loan.

[38] In the past 2 years, the number HECM lenders has declined at least in part because of the limitations in the size of the originations fees charged by lenders.

[39] This is based on the July 1999 extract of 30,236 HECM loans reported in Rodda, David T., Christopher Herbert, and Hin-Kin Lam. 2000. *Evaluation Report of FHA's Home Equity Conversion Mortgage Insurance Demonstration*. Washington, DC: U.S. Housing and Urban Development.

[40] Rodda, David T., Christopher Herbert, and Hin-Kin Lam. 2000. *Evaluation Report of FHA's Home Equity Conversion Mortgage Insurance Demonstration*. Washington, DC: U.S. Housing and Urban Development.

[41] Kutty, Nandinee. 1998. "The Scope for Poverty Alleviation Among Elderly Homeowners in the United States Through Reverse Mortgages." *Urban Studies* 35(1):113-29.

[42] Rasmussen, David W., Isaac F. Megbolugbe, and Barbara Morgan. 1997. "The Reverse Mortgage As an Asset Management Tool." *Housing Policy Debate* 8(1):173-94.

[43] Rodda, David T., Christopher Herbert, and Hin-Kin Lam. 2000. *Evaluation Report of FHA's Home Equity Conversion Mortgage Insurance Demonstration*. Washington, DC: U.S. Housing and Urban Development.

[44] Eschtruth, Andrew D. and Long C. Tran. 2001. "A Primer on Reverse Mortgages." *Just the Facts on Retirement Issues* October(3):1-4.

[45] Block, Sandra. 2001. "Reverse Mortgages Offer Many Retirees a Source of Income." *USA Today*, October 16.

[46] Venti, Steven F. and David A. Wise. 1989. "Aging, Moving, and Housing Wealth." *The Economics of Aging, ed. David A. Wise*. Chicago: The University of Chicago Press.

[47] Morgan, Barbara, Isaac F. Megbolugbe, and David W. Rasmussen. 1996. "Reverse Mortgages and the Economic Status of Elderly Women." *The Gerontologist* 36(3):400-405.

[48] Rasmussen, David W., Isaac F. Megbolugbe, and Barbara Morgan. 1995. "Using the 1990 Public Use Microdata Sample to Estimate Potential Demand for Reverse Mortgage Products." *Housing Policy Debate* 6(1):1-23.

[49] Rasmussen, David W., Isaac F. Megbolugbe, and Barbara Morgan. 1995. "Using the 1990 Public Use Microdata Sample to Estimate Potential Demand for Reverse Mortgage Products." *Housing Policy Debate* 6(1):1-23.

[50] Rasmussen, David W., Isaac F. Megbolugbe, and Barbara Morgan. 1995. "Using the 1990 Public Use Microdata Sample to Estimate Potential Demand for Reverse Mortgage Products." *Housing Policy Debate* 6(1):1-23.

[51] Just over 99% of households in this income group have incomes under $25,000.

[52] Listokin, David. 2001. "Housing Rehabilitation and American Cities." Pp. 363-401 in *Housing Policy in the New Millennium: Conference Proceedings*, Eds. Susan M. Wachter and R. L. Penne. Washington, DC: U.S. Department of Housing and Urban Development.

[53] Mackey, Scott and Karen Carter. 1994. *State Tax Policy and Senior Citizens*. Washington, DC: National Conference of State Legislatures.

[54] Mackey, Scott and Karen Carter. 1994. *State Tax Policy and Senior Citizens*. Washington, DC: National Conference of State Legislatures.
[55] Baer, David. 1998. *Awareness and Popularity of Property Tax Relief Programs*. Washington, DC: AARP.
[56] Reschovsky, Andrew. 1994. *Do the Elderly Face High Property Tax Burdens?* Washington, D.C.: American Association of Retired Persons.
[57] Cultural backgrounds or language difficulties may make it more difficult for them to negotiate the human service system to obtain necessary supportive services.
[58] The difference in ADL and IADL limitation prevalence between older persons at 100% and 149% poverty thresholds was very small. The subsequent analyses will focus on the 150% and below poverty threshold.
[59] The one exception: for age 65 to 74 poor older persons, there was no significant difference in the prevalence of IADL limitations.
[60] Connell, Bettye R. and Jon A. Sanford. 1997. "Individualizing Home Modifications and Recommendations to Facilitate Performance of Routine Activities." pp. 143-144 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[61] Mann, W. C., K. J. Ottenbacher, L. Fraas, M. Tomita, and C. V. Granger. 1999. "Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly. A Randomized Controlled Trial." *Archives of Family Medicine* 8(3):210-217.
[62] Mann, W. C., K. J. Ottenbacher, L. Fraas, M. Tomita, and C. V. Granger. 1999. "Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly. A Randomized Controlled Trial." *Archives of Family Medicine* 8(3):210-217.
[63] Manton, Kenneth, Larry Corder, and Eric Stallard. 1993. "Changes in the Use of Personal Assistance and Special Equipment From 1982 to 1989: Results From the 1982 and 1989 NLTCS." *The Gerontologist* 33(2):168-76.
[64] Gilderbloom, John I. and Markham John P. 1996. "Housing Modification Needs of the Disabled Elderly: What Really Matters." *Environment and Behavior* 28(4):512-35.
[65] Gill, Thomas, Christianna S. Williams, and Mary E. Tinetti. 2000. "Environmental Hazards and the Risk of Nonsyncopal Falls in the Homes of Community-Living Older Persons." *Medical Care* 38(12):1-10.
[66] Gill, Thomas, Christianna S. Williams, and Mary E. Tinetti. 2000. "Environmental Hazards and the Risk of Nonsyncopal Falls in the Homes of Community-Living Older Persons." *Medical Care* 38(12):1-10.
[67] This is based on the analysis of the U.S. Census Bureau. 2001. Current Housing Reports, Series H151/95-1, *Supplement to the American Housing Survey for the United States in 1995*. Washington, DC: U.S. Government Printing Office. Older persons with physical limitations were asked if they had housing modifications or if they needed modifications including: ramps, elevators or stair lifts, extra handrails or grab bars, extra wide doors or hallways, door handles instead of knobs, push bars on doors, modified wall sockets or light switches, modified skin faucets or cabinets, bathrooms and kitchens designed for easier accessibility, raised letters or Braille, specially equipped telephones, or flashing lights. The research is summarized in U. S. Department of Housing and Urban Development, Office of Policy Development and Research. 2001. "Home Modifications Among Households With Physical Activity Limitations." *U.S. Housing Market Conditions*, 1st Quarter May:5-12.
[68] These figures are for both owners and renters. Separate figures were not available in the published analysis.
[69] Connell, Bettye R. and Jon A. Sanford. 1997. "Individualizing Home Modifications and Recommendations to Facilitate Performance of Routine Activities." Pp. 113-48 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[70] Mutschler, Phyllis H. 1997. "The Effects of Income on Home Modification: Can They Afford to Stay Put?" Pp. 149-67 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[71] Tabbarah, M., M. Silverstein, and T. Seeman. 2000. "A Health and Demographic Profile of Noninstitutionalized Older Americans Residing in Environments With Home Modifications." *Journal of Aging Health* 12(2):204-28.

[72] Florida Department of Education and Florida Council on Aging. 1994. *The Unfinished Business of Learning*. Tallahassee, FL: Florida Council on Aging.
[73] LaPlante, Mitchell P., Gerry E. Hendershot, and Abigail J. Moss. 1992. "Assistive Technology Devices and Home Accessibility Features: Prevalence, Payment, Need and Trends in National Center for Health Statistics." *Advance Data From Vital and Health Statistics of the Centers for Disease Control*, National Center for Health Statistics 217:1-12; Mutschler, Phyllis H. 1997. "The Effects of Income on Home Modification: Can They Afford to Stay Put?" Pp. 149-67 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[74] Center for Universal Design, North Carolina State University. 1997. *A Blueprint for Action*. Raleigh, NC: Center for Universal Design, North Carolina State University, p. 9.
[75] Mutschler, Phyllis H. 1997. "The Effects of Income on Home Modification: Can They Afford to Stay Put?" Pp. 149-67 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[76] George, Lance and Christopher Holden. Why Housing Matters: *HAC's 2000 Report on the State of the Nation's Rural Housing*. Washington, DC: Housing Assistance Council.
[77] Pynoos, Jon, Phoebe Liebig, Julie Overton, and Emily Calvert. 1997. "The Delivery of Home Modification and Repair Services." Pp. 171-92 in *Staying Put: Adapting the Places Instead of the People*, Eds. Susan Lanspery and Joan Hyde. Amityville, NY: Baywood Publishing Co.
[78] Center for Universal Design, North Carolina State University. 1997. *A Blueprint for Action*. Raleigh, NC: Center for Universal Design, North Carolina State University.
[79] Wolf, Douglas. 2001. "Population Change: Friend or Foe of the Chronic Care System?" *Health Affairs*.
[80] The National Long-Term Care Survey, the Medicare Current Beneficiary Survey, and the National Health Interview Survey.
[81] Manton, Kenneth, Larry Corder, and Eric Stallard. 1993. "Changes in the Use of Personal Assistance and Special Equipment From 1982 to 1989: Results From the 1982 and 1989 NLTCS." *The Gerontologist* 33(2):168-76.
Manton, Kenneth G. and XiLiang Gu. 2001. "Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population Above Age 65 From 1982 to 1999." *Proceedings of the National Academy of Sciences* 98(11):6354-59.
[82] Some researchers suggest that these future predictions may be too optimistic. They argue, for example, that even as disability rates have declined, the prevalence of various chronic conditions such as osteoporosis, cancer, diabetes, heart disease, arthritis, obesity, glaucoma and cataracts have risen. They also argue that antecedents such as improved educational attainment may not continue to have the same effects for next generations of older persons, because there will be smaller proportional increases in the size of older persons who will be better educated and thus smaller marginal increases in desirable healthy behavior. See, in particular, Wolf, Douglas. 2001. "Population Change: Friend or Foe of the Chronic Care System?" *Health Affairs*, November-December.
[83] U.S. Census Bureau, Population Projections Program. 2000. *(NP-D1-A) Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin, 1999 to 2100*. Washington, DC: U.S. Census Bureau, Department of Commerce.
[84] Spector, William D., Liliana E. Pezzin, and Brenda C. Spillman. 2000. *The Characteristics of Long-Term Care Users*. Rockville, MD: Agency for Healthcare Research and Quality.
[85] U.S. General Accounting Office. 2001. *Federal Housing Programs: What They Cost and What They Provide*. Washington, DC: U.S. General Accounting Office.
[86] Wolf, Douglas. 2001. "Population Change: Friend or Foe of the Chronic Care System?" *Health Affairs*.
[87] U.S. Congressional Budget Office. *Projections of Expenditures for Long-Term Care Services for the Elderly: A CBO Memorandum*. Washington, DC: 1999.
[88] U.S. Congressional Budget Office. *Projections of Expenditures for Long-Term Care Services for the Elderly: A CBO Memorandum*. Washington, DC: 1999. This analysis is incomplete to the extent that the costs are not estimated for alternatives such as assisted living facilities.

[89] AARP Public Policy Institute and The Lewin Group. 1997. *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*. Washington, DC: American Association of Retired Persons.
[90] Kane, Rosalie and Keren B. Wilson. 2001. *Assisted Living at the Crossroads: Principles for Its Future.* Portland, OR: The Jessie F. Richardson Foundation.
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[92] Bishop, Christine E. 1999. "Where Are the Missing Elders? The Decline in Nursing Home Use, 1985 and 1995." *Health Affairs* 18(4):146-55.
[93] Spector, W. D. and D. B. Mukamel. 2001. "Nursing Home Administrators' Perceptions of Competition and Strategic Responses." *Long-Term Care Interface* March: p. 40.
[94] Golant, Stephen. M. 1998. "Aging Boomer Communities Will Cover Landscape." *Aging Today* 19(Jan./Feb.).
[95] Spector, William D., Liliana E. Pezzin, and Brenda C. Spillman. 2000. *The Characteristics of Long-Term Care Users*. Rockville, MD: Agency for Healthcare Research and Quality.
[96] U.S. General Accounting Office. 1998. *Long-Term Care, Baby Boom Generation Presents Financing Challenges: Statement of William J. Scanlon, Director, Health Financing and Systems Issues*. Washington, DC: U.s. General Accounting Office.
[97] U.S. General Accounting Office. 2001. *Long-Term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding*. Washington, DC: U.S. General Accounting Office.
[98] U.S. General Accounting Office. 2001. *Long-Term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding*. Washington, DC: U.S. General Accounting Office, p. 14.
[99] Such a conclusion must be made with care because of the small sample sizes upon which these patterns are based.
[100] Heumann, Leonard, Winter-Nelson, and James R. Anderson. 2001. *The 1999 National Survey of Section 202 Elderly Housing*. Washington, DC: AARP.
[101] Elderly Housing Coalition. 2000. *Providing an Affordable Continuum of Care for Low-Income Residents of Senior Housing*. Washington, DC: American Association of Homes and Services for the Aging, p. 5.
[102]Elderly Housing Coalition. 2000. *Providing an Affordable Continuum of Care for Low-Income Residents of Senior Housing*. Washington, DC: American Association of Homes and Services for the Aging, p. 5.
[103] U.S. Department of Housing and Urban Development. 1999. *The Challenge of Housing Security: Report to Congress on the Housing Conditions and Needs of Older Americans*. HUD-9709. Washington: Office of Policy Development and Research.
[104] Schwartz, David C. "Helping Elders to Age in Place Via Onsite and Near-Site Housing-Based Healthcare Programs." Pp. 225-88 in *Housing Policy in the New Millennium Conference, Proceedings,* Susan Wachter and Leo R. Penne. Washington, DC: U.S. Department of Housing and Urban Development.
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[106] Examples include Pynoos, Jon, Susan Lanspery, and Susan Hardwick. 1994. *Linking Housing and Services: Six Case Studies*. Los Angeles, CA: Andrus Gerontology Center, University of Southern California; American Association of Homes and Services for the Aging. 1997. *Affordable Assisted Living: Options for Converting or Expanding Housing to Assisted Living, Four Case Studies*. Washington, DC: American Association of Homes and Services for the Aging; U.S. Department of Housing and Urban Development.1995. *Elderly Housing With Supportive Services*. Washington, DC: U.S. Department of Housing and Urban Development; Warach, B. 1991. "Enriched Housing for the Elderly: The JASA Experience (1968-1990)." Pp. 141-56 in *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*, New York: Haworth Press.
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[109] The following approaches were summarized in Golant, Stephen M. 1999. *The CASERA Project*. Tallahassee, Florida: Stephen M. Golant and Margaret Lynn Duggar & Associates, Inc., pp. 16-17.
[110] Golant, Stephen M. 1999. *The CASERA Project*. Tallahassee, Florida: Stephen M. Golant and Margaret Lynn Duggar & Associates, Inc.
[111]Ansak, Marie-Louise. 1990. "The On Lok Model: Consolidating Care and Financing." *Generations* 14(2):73-74.
[112] Shannon, K. and C. Van Reenen. 1998. "PACE (Program of All-Inclusive Care for the Elderly): Innovative Care for the Frail Elderly. Comprehensive Services Enable Most Participants to Remain at Home." *Health Progress* 79(5):41-5.
[113] Lawler, Kathryn. 2001. *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population*. Cambridge, MA: Harvard Joint Center on Housing Studies.
[114] Shannon, K. and C. Van Reenen. 1998. "PACE (Program of All-Inclusive Care for the Elderly): Innovative Care for the Frail Elderly. Comprehensive Services Enable Most Participants to Remain at Home." *Health Progress* 79(5):41-5.
[115] However, the current On Lok Program also does not specifically include housing as part of its comprehensive package of services, though they offer and manage affordable senior housing at three locations.
[116] Hansen, Jennie C. 1999. "Practical Lessons for Delivering Integrated Services in a Changing Environment: The PACE Model." *Generations* 22(2):22-28.
[117] Lawler, Kathryn. 2001. *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population*. Cambridge, MA: Harvard Joint Center on Housing Studies.
[118] U.S. Select Committee on Aging. 1989. *The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped*. Comm. Pub. No. 101-736. Washington, DC: U.S. Government Printing Office; Heumann, Leonard, Winter-Nelson, and James R. Anderson. 2001. *The 1999 National Survey of Section 202 Elderly Housing*. Washington, DC: AARP.
[119] U.S. Department of Housing and Urban Development. 2001. *FY 2002 Annual Performance Plan*. Washington, DC: U.S. Department of Housing and Urban Development.
[120] This relationship was linked to the greater availability of common areas (e.g., central dining room) in these facilities.
[121] Nachison, Jerold S. 1994. "The Housing Programs of the Department of Housing and Urban Development: Description and Issues." Pp. 83-104 in *Housing and the Aging Population*, eds. W. E. Folts and D. E. Yeatts. New York: Garland; Pynoos, Jon. 1992. "Linking Federally Assisted Housing With Services for Frail Older People." *Journal of Aging and Social Policy* 4(3/4):157-77; Pynoos, Jon and Donald L. Redfoot. 1995. "Housing Frail Elders in the United States." Pp. 187-210 in *Housing Policy for Frail Elders: International Policies, Perspectives and Prospects*, Eds. Jon Pynoos and Phoebe S. Liebig. Baltimore: John Hopkins University Press; Schulman, Abbott J. 1996. "Service Coordination: Program Development and Initial Findings." *Journal of Long-Term Home Health Care* 15(2):5-12; U.S. Select Committee on Aging. 1989. *The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped*. Comm. Pub. No. 101-736. Washington, DC: U.S. Government Printing Office.
[122] HUD policies now allow Public Housing Authorities (PHAs) to use their annual contributions to cover up to 15% of the cost of supportive services.
[123] Heumann, Leonard, Winter-Nelson, and James R. Anderson. 2001. *The 1999 National Survey of Section 202 Elderly Housing*. Washington, DC: AARP.
[124] Providing 24-hour on-site supervision, homemaker services, and personal care services.
[125] The hiring of service coordinators is central to HUD's current "Housing Security Plan" as reported in U.S. Department of Housing and Urban Development. 1999. *The Challenge of Housing Security: Report to Congress on the Housing Conditions and Needs of Older Americans*. HUD-9709. Washington: Office of Policy Development and Research.

[126] Testimony of Janice C. Monks, Executive Director of American Association of Service Coordinators to The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, September 24, 2001.
[127] Lanspery, Susan C. 1998. *A How-to Guide: Service Coordination*. Washington, DC.; Lanspery, Susan C. 1997. *Dying Buildings Come to Life: Coordinating Services in Senior Housing With Flexibility and Creativity*. Washington: American Association of Homes and Services for the Aging; Schulman, Abbott J. 1996. "Service Coordination: Program Development and Initial Findings." *Journal of Long-Term Home Health Care* 15(2):5-12; Sheehan, Nancy W. 1999. "The Resident Services Coordinator Program: Bringing Service Coordination to Federally Assisted Housing." *Journal of Housing for the Elderly* 13(1/2):35-49; and U.S. Department of Housing and Urban Development. 1996. *Evaluation of the Service Coordinator Program* (Vols. 1 and II). Washington, DC: Office Policy Development and Research, U.S. Department of Housing and Urban Development.
[128] Participants needed assistance in three or more activities of daily living.
[129] Formerly Farmers Home Administration of the U.S. Department of Agriculture.
[130] Ficke, Robert C. and Susan G. Berkowitz. 2000. *Report to Congress: Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program*. Washington, DC: U.S. Department of Housing and Urban Development.
[131] Ficke, Robert C. and Susan G. Berkowitz. 2000. *Report to Congress: Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program*. Washington, DC: U.S. Department of Housing and Urban Development.
[132] Ficke, Robert C. and Susan G. Berkowitz. 2000. Report to Congress: *Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program.* Washington, DC: U.S. Department of Housing and Urban Development.
[133] Ficke, Robert C. and Susan G. Berkowitz. 2000. *Report to Congress: Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program.* Washington, DC: U.S. Department of Housing and Urban Development, p. 7-8.
[134] Ficke, Robert C. and Susan G. Berkowitz. 2000. *Report to Congress: Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program.* Washington, DC: U.S. Department of Housing and Urban Development, p. 7-1.
[135] National Center for Assisted Living. 2001. Facts and Trends: *The Assisted Living Sourcebook 2001*. Washington, DC: National Center for Assisted Living, American Health Care Association.
[136] Manard, Barbara B. 1999. "Assisted Living for Changing Needs." *Health Progress* March-April.
[137] American Seniors Housing Association. 2001. *The State of Seniors Housing, 2000*. Washington, DC: American Seniors Housing Association.
[138] National Center for Assisted Living. 2001. *Facts and Trends: The Assisted Living Sourcebook 2001*. Washington, DC: National Center for Assisted Living, American Health Care Association.
[139] Promatura Group, LLC. 1999. *Income Confirmation Study of Assisted Living Residents and the Age 75+ Population* . Annapolis, Maryland: National Investment Conference for the Senior Housing &Care Industries.
[140] National Investment Conference. 1998. *National Survey of Assisted Living Residents: Who Is the Customer?* Annapolis, Maryland: National Investment Conference for the Senior Living and Long Term Care Industries.
[141] National Investment Conference. 1998. *National Survey of Assisted Living Residents: Who Is the Customer?* Annapolis, Maryland: National Investment Conference for the Senior Living and Long Term Care Industries.
[142] An extensive review of the assisted living option can be found in Golant, Stephen M. 1998. "The Promise of Assisted Living As a Shelter and Care Alternative for Frail American Elders: A Cautionary Essay." Pp. 32-59 in *Aging, Autonomy, and Architecture: Advances in Assisted Living*, eds B. Schwarz and R. Brent. Baltimore, MD: John Hopkins Press.

[143] Burgess, Kenneth L. 2000. "Negotiated Risk Agreements Revisited." *Assisted Living Today* 7(2):43-45; Kane, Rosalie and Keren B. Wilson. 2001. *Assisted Living at the Crossroads: Principles for Its Future.* Portland, OR: The Jessie F. Richardson Foundation.
[144] In practice, residents are increasingly asking for variances that violate their state's regulatory requirements and the validity of these agreements remain largely untested in the courts. Consumer groups, moreover, are often at the same time objecting to these agreements even as they seek greater resident autonomy (Burgess, Kenneth L. 2000. "Negotiated Risk Agreements Revisited." *Assisted Living Today* 7(2):43-45.)
[145] Mollica, Robert. 2000. *State Assisted Living Policy: 2000*. Portland, Maine: National Academy for State Health Policy.
[146] Morgan, L. A., J. K. Eckert, and S. M. Lyons. 1995. *Small Board-and-Care Homes: Residential Care in Transition*. Baltimore: Johns Hopkins Press.
[147] U.S. Senate, Special Committee on Aging. 1990. *Board and Care: A Failure in Public Policy*. Washington, DC: Government Printing Office.
[148] Mollica, Robert. 2000. *State Assisted Living Policy: 2000*. Portland, Maine: National Academy for State Health Policy.
[149] Kane, Rosalie and Keren B. Wilson. 2001. *Assisted Living at the Crossroads: Principles for Its Future.* Portland, OR: The Jessie F. Richardson Foundation.
[150] *Time Magazine*, *The Washington Post*, *The New York Times*, *Milwaukee Journal Sentinel*, among others.
[151] U.S. General Accounting Office. 1999. *Assisted Living: Quality-of-Care and Consumer Protection Issues in Four States*. Washington, DC: U.S. General Accounting Office, p. 24.
[152] Assisted Living Federation of America and ServiceTRAC, Inc. 1999. *The 1999 ALFA National Assisted Living Resident Satisfaction Study.* Scottsdale, Arizona: ServiceTRAC, Inc.:4.
[153] In fact, these apparently dissimilar conclusions may actually be very compatible. Several of the press stories focused on very selected case studies of residents that had experienced abuses; similarly, the quality of care violations may be applicable to only a very few residents.
[154] Hawes, Catherine, Miriam Rose, and Charles D. Phillips. 1999. *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*. Washington, D.C.: U.S. Department of Health and Human Services, Office of Disability, Aging, and Long-Term Care Policy.
[155] Kane, Rosalie and Keren B. Wilson. 2001. *Assisted Living at the Crossroads: Principles for Its Future.* Portland, OR: The Jessie F. Richardson Foundation.
[156] As one indicator, a report released by the Hospital Healthcare Compensation Service (2000-2001 Nursing Dept. Report) showed that registered nurses in assisted living facilities are at the bottom of the pay scale for nurses in senior housing settings.
[157] It included about 41% of the places calling themselves assisted living facilities.
[158] Hawes, Catherine and Charles D. Phillips. 2000. *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results From a National Survey*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.
[159] National Investment Conference. 2001. *The Case for Investing in Seniors Housing and Long Term Care Properties* . Annapolis, Maryland: National Investment Conference for the Senior Housing &Care Industries.
[160] Evidence does not exist that the assisted living alternative will become less expensive over the next two decades (National Center for Assisted Living. 2001. *Facts and Trends: The Assisted Living Sourcebook 2001*. Washington, DC: National Center for Assisted Living, American Health Care Association.)
[161] Michigan's category for assisted living facilities that serve 21 or more people.
[162] Michigan House Bill 5689; see miassistedliving.org.
[163] SB527 went into effect September lst, 2001.
[164] National Investment Conference. 2001. *The Investment Case for Senior Living and Long Term Care Properties*. Annapolis, Maryland: National Investment Conference for the Senior Living and Long Term Care Industries.

[165] Mollica, Robert L. 2001. *State Assisted Living Practices and Options: A Guide for State Policy Makers*. Portland: OR.
[166] In the third quarter of 2001, the mean assisted living occupancy rate was 85.5% (Robert Kramer, in an address to the national conference of the National Investment Center in Washington), December 13, 2001. In 1999, the mean occupancy rate was 89.4%.
[167] American Seniors Housing Association. 2001. *The State of Seniors Housing, 2000*. Washington, DC: American Seniors Housing Association.
[168] The first three assumptions underlie the nursing home projections of The Lewin Group for the Seniors Housing Commission.
[169] U.S. Census Bureau, Population Projections Program. 2000. *(NP-D1-A) Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin, 1999 to 2100*. Washington, DC: U.S. Census Bureau, Department of Commerce.
[170] This assumption is made by the author of this report.
[171] Consistent with earlier tabulations, this report is primarily interested in the demand for assisted living units rather than the existing or future supply of assisted living units. For any given year or period, the supply of assisted living units must be reduced by its occupancy rate and the percentage of units occupied by elderly as opposed to nonelderly (Table 1).
[172] The first three assumptions underlie the nursing home projections of The Lewin Group for the Seniors Housing Commission.
[173] U.S. Census Bureau, Population Projections Program. 2000. *(NP-D1-A) Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin, 1999 to 2100*. Washington, DC: U.S. Census Bureau, Department of Commerce.
[174] National Investment Conference. 2001. *The Case for Investing in Seniors Housing and Long Term Care Properties* . Annapolis, Maryland: National Investment Conference for the Senior Housing &Care Industries.
[175] These estimates are expressed in persons as opposed to units. Thus, they should be somewhat larger than this report's projections for that reason alone.
[176] Although this section focuses only on these three major approaches, other innovative financial and administrative strategies are found in other States. One noteworthy example was the 1999 conversion of a traditional Public Housing Facility in Miami, Helen Sawyer Plaza, by the MIA Consulting Group to an affordable licensed assisted living facility by using three funding streams, the U.S. HUD subsidy, Medicaid Waivers, and Florida's, Optional State Supplement. In Massachusetts, the ElderChoice Program operated by the Massachusetts Housing Finance Agency assists developers building assisted living units by simplifying the funding process that draws on Medicaid Waivers and tax exempt bond financing.
[177] Notice PIH 2000-41, Department of Housing and Urban Development, implementing Section 523 of the "Preserving Affordable Housing for Senior Citizens and Families into the 21st Century Act as of September 1, 2000.
[178] Mollica, Robert. 2000. *State Assisted Living Policy: 2000*. Portland, Maine: National Academy for State Health Policy.
[179] U.S Department of Housing and Urban Development. 2000. "Fiscal Year 2000 Funding Availability for the Assisted Living Conversion Program (ALCP) for Section 202 Projects; Notice." *Federal Register*, Friday March 17:14694-705.
[180] In fiscal year 2001, the eligibility of the program has now been expanded to all HUD multifamily projects with project-based Section 8, and also Section 236 and Section 221(d)(3) projects.
[181] U.S. Department of Housing and Urban Development. 2001. *FY 2002 Annual Performance Plan*. Washington, DC: U.S. Department of Housing and Urban Development.
[182] Year 2000 Awardees and Program Descriptions, release from AAHSA, December 6, 2000.
[183] States use Medicaid in one of three ways to pay for the service component of the assisted living facility: (1) Through their Medicaid State plans; (2) home and community based services (HCBS) 1915(c) Waivers; and (3) Section 1115 Waivers. Most use the HCBS 1915 (c) Waiver program.

[184] Mollica, Robert. 2000. *State Assisted Living Policy: 2000*. Portland, Maine: National Academy for State Health Policy.
[185] As summarized by Mollica, Robert. 2001. "Medicaid Waiver Bandwagon Gains Speed." *Assisted Living Today* 8(8):28-30.
[186] Mollica, Robert L. 2001. *State Assisted Living Practices and Options: A Guide for State Policy Makers*. Portland: OR.
[187] Kane, Rosalie and Keren B. Wilson. 2001. *Assisted Living at the Crossroads: Principles for Its Future.* Portland, OR: The Jessie F. Richardson Foundation.
[188] The study documented the 1999 average disparity by State between Medicaid rates and allowable Medicaid per patient day costs. See: BDO Seidman, LLP. 2001. A Briefing Chartbook on Shortfalls in Medicaid Funding For Nursing Home Care. Washington, DC: American Health Care Association.
[189] This is the rationale for the proposal of a "single source funding" financing proposal. Conchy Bretos and Stephen Golant, "Single Source Funding for Assisted Living Facilities," Unpublished paper, 2000. Proposals have also been made to modify Medicaid law to cover room and board in assisted living facilities. A fundamental obstacle is that this proposal would shift costs from the Federal Supplemental Security Income program to State Medicaid programs. See: Mollica, Robert. 2001. "Medicaid Waiver Bandwagon Gains Speed." *Assisted Living Today* 8(8):28-30.
[190] Manard, Barbara B. 1999. "Assisted Living for Changing Needs." *Health Progress* March-April.
[191] Mollica, Robert L. 2001. *State Assisted Living Practices and Options: A Guide for State Policy Makers*. Portland: OR.
[192] Assisted Living Federation of America. 2000. *ALFA's Overview of the Assisted Living Industry*. Fairfax, Virginia: Assisted Living Federation of America.
[193] This excludes the most optimistic NIC scenario of over 874,000 residents in assisted living facilities in 2020.
[194] Promatura Group, LLC. 2000. *NIC National Supply Estimate of Seniors Housing & Care Properties*. Annapolis, Maryland: National Investment Center for the Seniors Housing & Care Industries.
[195] Elderly Housing Coalition. 2000. *Providing an Affordable Continuum of Care for Low-Income Residents of Senior Housing*. Washington, DC: American Association of Homes and Services for the Aging, p. 13.
[196] Newman, Sandra J. 1995. "Housing Policy and Home-Based Care." *The Milbank Quarterly* 73(3):407-41; Pynoos, Jon. 1992. "Linking Federally Assisted Housing With Services for Frail Older People." *Journal of Aging and Social Policy* 4(3/4):157-77; Redfoot, Donald L. and Katrinka S. Sloan. 1991. "Realities of Political Decision-Making on Congregate Housing." Pp. 99-110 in *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*, Eds. Lenard W. Kaye and Abraham Monk. Binghamton, NY: Haworth Press
[197] Bernstein, Judith. 1982. "Who Leaves -- Who Stays: Residency Policy in Housing for the Elderly." The Gerontologist 22(3):305-13; Pynoos, Jon. 1992. "Linking Federally Assisted Housing With Services for Frail Older People." *Journal of Aging and Social Policy* 4(3/4):157-77; Pynoos, Jon and Donald L. Redfoot. 1995. "Housing Frail Elders in the United States." Pp. 187-210 in *Housing Policy for Frail Elders: International Policies, Perspectives and Prospects*, Eds. Jon Pynoos and Phoebe S. Liebig. Baltimore: John Hopkins University Press; Schulman, Abbott J. 1996. "Service Coordination: Program Development and Initial Findings." *Journal of Long-Term Home Health Care* 15(2):5-12.
[198] Bernstein, Judith. 1982. "Who Leaves -- Who Stays: Residency Policy in Housing for the Elderly." *The Gerontologist* 22(3):305-13.
[199] Monk, Abraham and Lenard Kaye. 1991. "Congregate Housing for the Elderly: Its Need, Function, and Perspectives." Pp. 5-19 in *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*, eds. Lenard W. Kaye and Abraham Monk. New York: Haworth Press.
[200] Mollica, Robert. 2000. *State Assisted Living Policy: 2000*. Portland, Maine: National Academy for State Health Policy.

[201] U.S. Department of Housing and Urban Development. 1999. *The Challenge of Housing Security: Report to Congress on the Housing Conditions and Needs of Older Americans*. HUD-9709. Washington: Office of Policy Development and research, p, 48.
[202] Several of these items were drawn from the recent Senior Commission testimony by Janice Monks, September 24, 2001.
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Appendix G-2

Appendix I: Service and Housing Income Eligibility

This appendix discusses the differences between the income estimates of the 1999 American Housing Survey (AHS) and the Current Population Survey (CPS) and the interaction of service and housing eligibility income units.

Under-reporting of Income on the AHS

As the American Housing Survey documentation notes, the 1999 AHS income data reported a higher percentage of households with incomes of less than $5,000 when compared with years prior to 1997 and other data sources.[1] The source of the disparity has not been identified by HUD or the Bureau of the Census.

The income under-reporting on the AHS has a fairly significant effect on the estimates of the percent of households with incomes less than the poverty level and correspondingly for income as a percent of average median income (AMI). The table below provides measures of those differences and indicates that households headed by an individual age 65 and older, under-reported income to a greater degree than younger households.[2]

Comparison of Income Reported in American Housing Survey and Current Population Survey, 1999

	AHS	CPS	Difference
All Households			
Median	$35,961	$40,816	-11.9%
<$15,000	21.0%	16.5%	27.3%
<100% poverty	14.7%	9.3%	58.1%
Age 65+ Householders			
Median	$19,712	$22,812	-13.6%
<$15,000	39.3%	29.8%	31.9%
<100% poverty	19.0%	11.4%	66.7%
<30% AMI	27%	17%	58.8%
<50% AMI	50%	39%	28.2%

Source: The Lewin Group tabulations of the 1999 American Housing Survey and the March 2000 Current Population Survey (which reports 1999 income). Prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, (March 2002).

Income Eligibility Limits for Housing versus Supportive Services

To assess the intersection of public assistance income eligibility used for services and for housing programs, The Lewin Group analyzed data from the March 2000 Current Population Survey (CPS) Income Supplement. The measures assessed included:

- 30%, 50%, 80%, and 120% of area median income (AMI), where the 30% and 50% AMI levels for 1999 were posted under Section 8 income limits and

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1 AHS Documentation Changes, July 9,2001 available at www.huduser.org/datasets/ahs/docchg 1997.pdf.

2 See: American Housing Survey, Appendix C, 10.

matched to the CPS based on Federal Information Processing Standards (FIPS) for county and metropolitan statistical areas (MSA). AMI incorporates an area's cost of living into the eligibility for housing programs.

- 100% and 300% of the Federal Supplemental Security Income (SSI) level, which was $500 per month for single individuals and $731 per month for married couples.
- 100% and 150% of the poverty threshold, where poverty threshold was based on the Bureau of the Census thresholds assessed against family income. This makes these estimates consistent with published Census estimates.[3]

The data indicate that more individuals qualify for housing programs with priority status (less than 30% AMI) than would qualify for Medicaid services, and that among those qualifying for Medicaid services, nearly all would also qualify for housing programs. Also, depending on the Medicaid income criteria used, differing percentages of individuals who qualify for housing programs would qualify for Medicaid services. A common income criteria for Medicaid Home- and Community-Based waivers is 300% of the SSI level. Among those who meet this income criteria, more than three-quarters would also meet housing assistance income levels (50% of AMI), whereas at the 100% poverty level, nearly all would qualify.

Estimates of the Number of Households Headed by an Individual Age 65+ Meeting Alternative Income Eligibility Criteria, 1999 (in thousands)

	Area Median Income					
Income Measure	<30%	<50%	<80%	<120%	>120%	Total
<100% SSI	918	932	934	939	17	957
<100% Poverty	2,240	2,388	2,397	2,406	47	2,454
<150% Poverty	3,596	5,495	5,602	5,623	84	5,708
<300% SSI	3,751	7,923	10,110	10,262	128	10,390
>300% SSI	5	460	3,262	6,708	4,405	11,113
Total	3,756	8,383	13,372	16,970	4,533	21,503
Row Percentages						
<100% SSI	98%	100%	100%	100%	2%	
<100% Poverty	93%	99%	99%	100%	2%	
<150% Poverty	64%	97%	99%	100%	1%	
<300% SSI	36%	77%	98%	100%	1%	
>300% SSI	0%	4%	29%	60%	39%	
Total	17%	39%	62%	79%	21%	
Column Percentages						
<100% SSI	24%	11%	7%	6%	0%	4%
<100% Poverty	60%	28%	18%	14%	1%	11%
<150% Poverty	96%	66%	42%	33%	2%	27%
<300% SSI	100%	95%	76%	60%	3%	48%
>300% SSI	0%	5%	24%	40%	97%	52%

[3] We use the poverty "threshold" because this is what is used in reporting rather than the poverty guidelines.

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Note: Average Median Income levels assessed against household income and poverty level and Supplemental Security Income levels assessed against family income.

Source: The Lewin Group tabulations of the March 2000 Current Population Survey matched to HUD Section 8 income limits from http://www.huduser.org/datasets/il/fmr99rev/index.html for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, (March 2002).

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Appendix II: Supportive Services Need Projections

The Long-Term Care Financing Model (LTCFM) was used to generate support services projections. The LTCFM simulates nursing home and home care use and expenditures for individuals ages 65 and older to the year 2030. It permits analyses of alternative assumptions about the nature of the senior population in the future (e.g., declining disability rates) and policy scenarios (e.g., tax incentives for long-term care insurance or changes to Medicaid eligibility). The model uses microsimulation to project the following:

- Family status (marriage, divorce, children);
- Work history (earnings history for social security and pension accrual);
- Retirement income (social security, pensions, asset income);
- Morbidity and mortality;
- Use of LTC services; and
- Financing of LTC services.

The model is comprised of two major components: 1) the Pension and Retirement Income Simulation Model (PRISM), which projects work and family history, retirement income, disability, and nursing home use; and 2) the Long-Term Care Financing Model, which projects home care use, long-term care financing and policy simulations.

The model permits examination of the implications of a variety of policy issues related to the healthcare use, financing, and delivery system for individuals with disabilities. The Office of the Assistant Secretary for Planning and Evaluation is currently funding a major update of the model's assumptions and an extension of the time horizon to 2050.

The key assumptions for this analysis include:

- Population and mortality growth that are consistent with the Social Security Trustees intermediate assumptions;
- Age/sex disability rates that decline consistent with improvements in mortality (-0.6 percent annually over the long term), resulting in the length of time with a disability remaining similar to today;
- Current age/sex/marital status use of service rates continued into the future; and
- Current law payment policies that remain in effect during the projections period.

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Table 1
Seniors Commission Service Projections
(amounts in millions)

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	2.4	0.8	2.5	3.2
Hours of Care	11,958	5,108	405	643
2005				
Number of Users	2.8	1.0	2.6	3.3
Hours of Care	15,426	6,703	414	665
2010				
Number of Users	3.4	1.2	2.8	3.5
Hours of Care	18,223	7,610	475	748
2020				
Number of Users	3.7	1.4	3.2	4.2
Hours of Care	19,996	9,495	534	867
Annual Percent Change				
Number of Users				
2000-05	3.0%	5.5%	0.6%	0.6%
2005-10	3.5%	2.6%	1.3%	0.9%
2010-20	1.0%	2.1%	1.6%	2.0%
Hours of Care				
2000-05	5.2%	5.6%	0.5%	0.7%
2005-10	3.4%	2.6%	2.8%	2.4%
2010-20	0.9%	2.2%	1.2%	1.5%

Nursing facility and alternative residential facility care assumes 24 hour per day care. For skilled home health, visits assumed to be three hours, while personal care assumed to be four hours, on average.

Source: The Lewin Group analysis of Long Term Care Financing Model supplemented by the National Long Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 2a
Seniors Commission Service Projections
By Primary Source of Payment
(amounts in millions)

Medicare

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	0.9	NA	1.7	0.9
Hours of Care	691	NA	156	208
2005				
Number of Users	0.9	NA	1.8	0.9
Hours of Care	729	NA	160	214
2010				
Number of Users	1.1	NA	1.8	0.9
Hours of Care	786	NA	176	234
2020				
Number of Users	1.2	NA	2.2	1.1
Hours of Care	913	NA	204	272
Annual Percent Change				
Number of Users				
2000-05	0.7%		0.6%	0.6%
2005-10	3.6%		1.0%	1.0%
2010-20	0.8%		1.7%	1.7%
Hours of Care				
2000-05	1.1%		0.5%	0.5%
2005-10	1.5%		1.9%	1.9%
2010-20	1.5%		1.5%	1.5%

Classification of users and their hours of care based on the payment source covering the largest portion of the costs.

Source: The Lewin Group analysis of Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 2b
Seniors Commission Service Projections
By Primary Source of Payment
(amounts in millions)

Medicaid

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	1.0	0.0	0.3	0.6
Hours of Care	7,298	121	103	165
2005				
Number of Users	1.3	0.0	0.3	0.6
Hours of Care	10,500	261	92	147
2010				
Number of Users	1.5	0.1	0.3	0.6
Hours of Care	11,996	502	112	173
2020				
Number of Users	1.8	0.1	0.3	0.7
Hours of Care	13,819	821	117	183
Annual Percent Change				
Number of Users				
2000-05	6.5%	14.0%	-0.4%	-1.0%
2005-10	2.6%	14.0%	2.8%	0.3%
2010-20	1.6%	5.2%	0.9%	1.6%
Hours of Care				
2000-05	7.5%	16.7%	-2.3%	-2.3%
2005-10	2.7%	13.9%	4.0%	3.3%
2010-20	1.4%	5.0%	0.5%	0.5%

* Less than 100,000.

Classification of users and their hours of care based on the payment source covering the largest portion of the costs.

Source: The Lewin Group analysis of Long Term Care Financing Model supplemented by the National Long Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 2c
Seniors Commission Service Projections
By Primary Source of Payment
(amounts in millions)

Private

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	0.6	0.8	0.5	1.7
Hours of Care	3,969	4,987	145	270
2005				
Number of Users	0.6	1.0	0.6	1.8
Hours of Care	4,198	6,441	162	304
2010				
Number of Users	0.8	1.1	0.6	1.9
Hours of Care	5,441	7,108	188	340
2020				
Number of Users	0.8	1.4	0.7	2.4
Hours of Care	5,263	8,674	212	412
Annual Percent Change				
Number of Users				
2000-05	0.3%	5.4%	1.1%	1.3%
2005-10	5.3%	2.2%	1.4%	1.1%
2010-20	-0.2%	2.0%	1.6%	2.2%
Hours of Care				
2000-05	1.1%	5.3%	2.2%	2.4%
2005-10	5.3%	2.0%	2.9%	2.3%
2010-20	-0.3%	2.0%	1.3%	1.9%

Classification of users and their hours of care based on the payment source covering the largest portion of the costs.

Source: The Lewin Group analysis of Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 3a
Seniors Commission Service Projections
By Income as a Percent of the Poverty Level
(amounts in millions)

Less than 150 percent of the poverty level

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	1.2	*	1.3	1.6
Hours of Care	6,122	*	247	369
2005				
Number of Users	1.4	*	1.2	1.5
Hours of Care	8,177	*	229	346
2010				
Number of Users	1.5	*	1.2	1.4
Hours of Care	8,606	*	248	369
2020				
Number of Users	1.2	*	1.1	1.4
Hours of Care	6,611	*	227	343
Annual Percent Change				
Number of Users				
2000-05	3.2%		-0.9%	-0.9%
2005-10	0.8%		-0.5%	-1.1%
2010-20	-2.2%		-0.7%	0.0%
Hours of Care				
2000-05	6.0%		-1.5%	-1.3%
2005-10	1.0%		1.6%	1.3%
2010-20	-2.6%		-0.9%	-0.7%

* Less than 100,000.

Income as a percent of the poverty level is based on an individual or couple's income and does not include the income of other family or household members.

Source: The Lewin Group analysis of Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 3b
Seniors Commission Service Projections
By Income as a Percent of the Poverty Level
(amounts in millions)

150-249 percent of the poverty level

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	0.6	0.1	0.6	0.7
Hours of Care	2,996	836	81	121
2005				
Number of Users	0.6	0.1	0.6	0.8
Hours of Care	3,180	949	87	131
2010				
Number of Users	0.8	0.2	0.8	0.9
Hours of Care	4,377	1,247	121	180
2020				
Number of Users	1.3	0.2	1.1	1.3
Hours of Care	6,861	1,333	159	237
Annual Percent Change				
Number of Users				
2000-05	1.2%	3.5%	0.4%	1.6%
2005-10	6.2%	3.1%	5.7%	4.4%
2010-20	4.2%	0.8%	3.0%	3.0%
Hours of Care				
2000-05	1.2%	2.6%	1.4%	1.5%
2005-10	6.6%	5.6%	6.9%	6.5%
2010-20	4.6%	0.7%	2.8%	2.8%

Income as a percent of the poverty level is based on an individual or couple's income and does not include the income of other family or household members.

Source: The Lewin Group analysis of Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

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Table 3c
Seniors Commission Service Projections
By Income as a Percent of the Poverty Level
(amounts in millions)

250 percent or more of the poverty level

	Nursing Facility	Alternative Residential Care	Skilled Home Care	Personal Care
2000				
Number of Users	0.6	0.7	0.6	0.9
Hours of Care	2,840	4,272	77	152
2005				
Number of Users	0.8	0.9	0.8	1.0
Hours of Care	4,069	5,754	99	187
2010				
Number of Users	1.0	1.0	0.8	1.1
Hours of Care	5,239	6,363	106	199
2020				
Number of Users	1.2	1.3	1.0	1.5
Hours of Care	6,524	8,163	147	287
Annual Percent Change				
Number of Users				
2000-05	4.5%	5.9%	3.4%	2.5%
2005-10	6.0%	2.5%	0.2%	1.0%
2010-20	1.8%	2.4%	3.0%	3.3%
Hours of Care				
2000-05	7.5%	6.1%	5.1%	4.3%
2005-10	5.2%	2.0%	1.5%	1.3%
2010-20	2.2%	2.5%	3.3%	3.7%

Income as a percent of the poverty level is based on an individual or couple's income and does not include the income of other family or household members.

Source: The Lewin Group analysis of Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

PRESERVING AND IMPROVING SUBSIDIZED RENTAL HOUSING STOCK SERVING OLDER PERSONS: RESEARCH AND RECOMMENDATIONS FOR THE COMMISSION ON AFFORDABLE HOUSING AND HEALTH FACILITY NEEDS FOR THE 21ST CENTURY

Michael Bodaken
Kyra Brown

March 1, 2003

Executive Summary

We live in an aging nation. This demographic reality is irrefutable. As we proceed through the first decade of the 21st Century, our nation will be increasingly challenged by problems that confront our current and future elderly households. Safe, accessible, and affordable housing is critical to good health and function at any age. But the relationship between housing and health is, perhaps, more apparent when one is faced with the frailties associated with old age. As we age, more and more health care is provided at our homes. Future demographic drivers call for numerous innovations to meet the affordable housing and supportive services needs of older persons. Much has been written about the *production* of new units to meet these needs. This document, written for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century focuses on *preserving and improving existing* senior affordable housing.[1]

While the goal of preservation may be obvious, it is not always clear how this stock should be recapitalized and improved. Affordable senior housing, like its occupants, is undergoing an "aging process." Most of it was developed through private/public partnerships more than two decades ago and much of the stock is itself in need of updating and repair. Not surprisingly, as the average age of the population in this housing has climbed, so have their needs. The dilemma that confronts us is how to both preserve what we have and, simultaneously, meet the changing needs of those who call it home.

The goal of this study is threefold:

(1) To provide specific data on the existing subsidized elderly rental housing stock in the United States.

(2) To summarize that data in a comprehensive, easy-to-read format for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century and the general public. This report will include information on what properties have already been "converted" to market rate units where the majority of the units are occupied by older persons, the ages and races of the existing occupants, and the number of properties serving primarily the elderly that may be capable of refinancing in the not too distant future.

[1] The National Housing Trust wishes to acknowledge the generous and unstinting assistance of the following individuals in the preparation of this document for Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century: Andrew Kochera, AARP Public Policy Institute; Don Redfoot, Ph.D., Senior Policy Advisor, AARP; Gary Eisenman, Related Capital Companies; and Michael Reardon, Nixon, Peabody, LLC.

(3) To make recommendations on how to preserve and improve existing subsidized elderly homes. Our analysis includes a discussion of new tools approved by HUD to preserve elderly, HUD-insured properties. These include: prepayment of existing Section 202 loans; the use of 501(c)(3) bonds, private activity bonds, and low-income housing tax credits to revitalize this stock; the possible curtailment of debt in Section 202 properties; and policy recommendations to facilitate the conversion of existing subsidized housing serving primarily the elderly to assisted living facilities.

We begin with a general summary of the various federal programs that serve the rental housing needs of older persons. In particular, we focus on those programs that have HUD Section 8 or other types of federal subsidies. The document proceeds to analyze what we have chosen to designate as "primarily elderly" properties, that is, properties where over 50% of the households served are older persons, age 62 or over. In our study, we found that in recent years, more than 250 properties that primarily serve the elderly have prepaid their HUD FHA-insured mortgage or opted out of their Section 8 contracts, in the process releasing over 20,000 apartments from their previously regulated rents. We expect this trend to continue since many properties that primarily serve older persons have high interest rates with current rents below market. At the same time, we believe a good case can be made to current and future owners of this housing that their economic interests and preservation of affordable housing can be readily aligned.

Indeed, signs of hope are emerging. New HUD tools are at our disposal to renovate subsidized, senior housing. Additionally, state and local housing finance agencies, increasingly aware of this housing problem, are providing greater resources for its resolution. Some subsidized housing owners are already converting their facilities to assisted living sites to accommodate the changing needs of their tenant profile. In this study, the Trust explains how an owner of primarily elderly, subsidized housing can use some of these tools to rehabilitate the property without raising the occupants' rents. The Commission should encourage these trends and propose other meaningful, cost-efficient programs to save this unique housing resource.

Moreover, our recommendations recognize the devolution of housing programs and resources to state and local governments. As the Commission will see, a great many states are already devoting considerable resources, including low-income housing tax credit set asides, for the preservation of the primarily elderly, subsidized housing stock. However, much more can be done. The data reveals that this problem will grow in the coming decades. The federal government still has a strong role to play, including encouraging state and local governments to "steer" their resources towards maintaining this unique housing stock. The adoption of the Affordable Housing Preservation Act of 2001 would be a significant step in that direction.

The recommendations that follow flow directly from the Trust's initial analysis of the data and our belief that the federal government cannot abdicate its role to save this housing. No one expects the federal government to do this by itself. But, the federal government can play a significant role by: (1) Setting aside existing resources for preservation; (2) Increasing the flexibility of existing HUD tools for preservation; and (3)

fully funding programs that match state and local efforts to preserve primarily elderly, subsidized housing.

Recommendations

RECOMMENDATION #1: Recommend that an ongoing database be established providing project specific information on primarily elderly, subsidized properties that a) have Section 8 contract rents at or below market and/or b) have loans with significantly high current interest rates. These properties arguably have a high risk of mortgage prepayment and should be placed on an "early warning" list to be shared with state housing finance agencies, HUD, the Rural Housing Service and the general public.

RECOMMENDATION #2: Recommend that state housing finance agencies set aside or prioritize the use of low-income housing tax credits and private activity bonds to preserve and improve affordable, subsidized, primarily elderly housing.

RECOMMENDATION #3: Recommend that Congress strongly encourage HUD to facilitate "Mark Up to Market" Section 8 contract rents for elderly, subsidized properties with current rents below market to prevent Section 8 opt outs by private owners and permit current nonprofit owners the resources needed to meet their ongoing operating costs. Additionally, it is absolutely critical that nonprofit owners of such properties receive distributions from their properties to meet other mission-related activities.

RECOMMENDATION #4: Recommend that useful information be provided to owners of existing HUD-insured, Section 236 properties primarily serving older persons. The distribution of information should include a simple explanation of how the owner can take advantage of HUD's Section 236 "decoupling process" to rehabilitate the property and keep it affordable.

RECOMMENDATION #5: Recommend Congress urge HUD to immediately establish a program for use of the recaptured interest reduction payments that are now in an IRP Pool at HUD. Furthermore, Congress should urge HUD to use at least a third of these for the preservation and improvement of existing HUD-insured, Section 236 properties primarily serving older persons.

RECOMMENDATION #6: Recommend Congress urge HUD to permit subordination of its Section 202 mortgage to new debt brought in with tax credits where the new debt and tax credits actually enhance the property's value and livability.

RECOMMENDATION #7: Recommend Congress encourage HUD to prepare a report to explain to Section 202 owners the comparative costs and benefits of prepaying its current loan with 501(c)(3) bonds or refinance with new debt and low-income housing tax credits.

RECOMMENDATION #8: Recommend that Congress revisit the issue of waiving all or part of the existing debt on Section 202 properties supported by Section 8.

RECOMMENDATION #9: Recommend Congress fund a meaningful study of how to best facilitate conversion, where appropriate, of existing subsidized housing to assisted living facilities. This study should document the costs of such conversion, and in particular, conduct a cost/benefit analysis of such conversion. The study should determine whether conversion to assisted living prevents premature institutionalization, and it should ask practitioners to provide detailed training on how to efficiently undertake these conversions. Congress should allow industry practitioners and others to provide detailed testimony on the recent Senate Bill 1886, the "Assisted Living Tax Credit Act," introduced by Senator Dodd (D-CT), which allows for a business credit for supported elderly housing.

RECOMMENDATION #10: The Commission should urge Congress to immediately consider, amend and adopt Senate Bill 1365, the Affordable Housing Preservation Act of 2001. *The Commission should urge Congress to amend the Senate Bill 1365 to include Section 202 housing as eligible for grants provided pursuant to the Act*. Further, the Commission should recommend that at least $300 million of funds should be devoted to the Affordable Housing Preservation Act of 2001 and that no less than a third of these funds should be devoted to the preservation and improvement of primarily elderly, subsidized housing.

Narrative

A. The Need to Preserve and Improve Affordable Rental Housing for Older Persons

We live in an aging Nation. The demographics are irrefutable:

- Growth in senior households (ages 65 and older) will surge in the coming decades. By 2030, the senior population will double to nearly 70 million, bringing their share of the total U.S. population to 20 percent. The number of those aged 85 and older will nearly quadruple, going from 3.5 million to 14 million by 2030.[1]

- Further, almost a third of the growth between now and 2010 of one-person households will be for those over age 65.[2]

- Assisted communities are home to only 3% of the Nation's senior population.[3] Nevertheless, as elderly households age in place, the need for future *affordable* assisted living increases. The possibility of converting elderly, subsidized dwellings to assisted living facilities is just now being explored.

- 4.6 million elderly households are renters; almost a third of these households–1.5 million–pay more than 50 percent of their incomes for rent and/or are living in substandard housing.

- The median net worth of elderly rental households is less than $7,000 compared with the median net worth of $141,000 for elderly homeowners.[4]

- Older renters in subsidized housing are two to three times as likely to report disabilities than older homeowners.[5]

- Wealth and income disparities will widen, limiting the housing choice of poor elderly households: "[t]he sharp disparity in wealth among baby boomers will carry well into their retirement years, leaving many lower income seniors with few housing and special care options. Elderly renters will face particularly onerous housing cost burdens."[6]

- The number of older persons residing in subsidized housing (over 1.9 million) is actually greater than the number of persons residing in our Nation's nursing homes.[7]

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[1] Joint Center for Housing Studies of Harvard University, *Housing for Seniors,* 2001.

[2] Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2001*, p. 10.

[3] Ibid.

[4] Ibid.

[5] AARP Public Policy Institute, *Adding Assisted Living to Subsidized Housing: Serving Frail Persons with Low Incomes,* Wilden and Redfoot, January 2002.

[6] *Housing forSeniors,* 2001.

[7] National Center for Health Statistics, 2000 and data derived from AARP study, January 2002.

- In recent years, nearly 900,000 unsubsidized, affordable housing units have been lost from the affordable housing stock due to demolition or rising rents; an additional 150,000 subsidized units have been converted to market rate housing.[8] Most subsidized senior housing facilities have long waiting lists. For instance, the AARP study of Section 202 facilities shows there is a Nationwide average of nine older applicants for every vacant Section 202 apartment that becomes available each year. A similar waiting list confronts those who are in line for a low-income housing tax credit unit.[9]

B. Types of Existing Subsidized Rental Housing Primarily Occupied by Older Persons

Over the past 40 years, the Federal government has, through a private/public partnership, produced more than 800,000 apartments specifically designed to provide decent, safe and affordable homes to poorer, older persons. This apartment inventory constitutes the most significant source of affordable housing for our Nation's elderly population. The following describes the programs that produced this important housing resource.

Section 221(d)(3) BMIR and Section 236

The Housing Act of 1961 authorized the Section 221(d)(3) below-market interest rate (BMIR) program. The program insured 40-year mortgages made directly to nonprofit and limited dividend sponsors. Typically, the interest rate was 3 percent. The Housing and Urban Development Act of 1968 added Section 236 to the National Housing Act, which combined 40-year mortgage insurance with subsidized interest payments to the lender for the production of low-cost housing. The interest rate subsidy lowered the effective rate to the owner to 1 percent. Eventually, many of these projects received additional project-based Section 8 assistance to provide additional rental assistance payments to owners on behalf of very low-income (50% median-income or less) tenants.[10] Nearly 1 million apartments were produced under the Section 221(d)(3) BMIR and Section 236 programs. Under both programs, the owner had the "right to prepay" the mortgage after 20 years and end the affordability restrictions.

Some Section 236 projects are nonprofit sponsored developments specifically designed for older persons. Indeed, a flurry of these Section "236/202" elderly developments occurred between 1969 and 1976, in large part due to the moratorium on construction of elderly Section 202 properties between 1969 and 1976.

According to data analyzed by the National Housing Trust for the Commission, 657 properties with 91,956 Section 221(d)(3) BMIR and Section 236 affordable, subsidized

[8] Compilation of data from National Housing Trust and the Joint Center for Housing *Studies' The State of the Nation's Housing: 2001*.

[9] "Serving the Affordable Housing Needs of Older Low Income Renters: A Survey of Low Income Housing Tax Credit Properties" (Executive Summary), Andrew Kochera, AARP Public Policy Institute, January 2002.

[10] Generally rental assistance from the Federal government covers the difference between what the tenant is obligated to contribute towards rent—typically 30% of his/her income—and the rent charged by the landlord. Because tenants' incomes are so low, their payment often does not pay the operating cost of the property. At least 13,686 project-based properties, containing 914,847 Section 8-assisted apartments, will have their Section 8 contracts expire during the next five years.

apartments are primarily (50% or more households in property are 62+) elderly properties. Many more elderly households—163,958 households according to HUD data—reside in 221(d)(3) BMIR and Section 236 apartments in properties that are not primarily elderly.[11]

Section 202 program

Congress enacted the Section 202 elderly housing program in the Housing Act of 1959. The Section 202 program has been successful, producing more than 320,000 apartments, of which approximately 170,000 are also assisted with Section 8 housing subsidies. Since 1959, the Section 202 program has gone through three basic program structural changes. The recent Affordable Housing for Seniors and Families Act has initiated a fourth basic structural change in the program.

Initial Program Structure. When enacted in 1959, the Section 202 program provided direct loans from the Federal government to eligible nonprofit entities. Originally, the loans were typically for a 40-year term at a 3 percent interest rate, although later HUD determined the interest rate based on the cost of government borrowing. The loans could be used to cover the costs of new construction or substantial rehabilitation of rental housing for the elderly and the handicapped and the loans could not be repaid without the approval of the government. The requirements for the operation of the projects were embodied in a Regulatory Agreement that controlled the rent levels to ensure project affordability. However, there was no rental assistance provided to the project owners. Tenant rents were set at the level necessary to cover the cost of repaying the loans and project operations. While much of this stock is in decent physical condition, there has not been sufficient income to allow for major capital improvements.

Introduction of Section 8 Rental Assistance. As the cost of government borrowing increased, the interest rates on Section 202 elderly housing projects rose, making it more difficult to maintain affordability in the projects. In 1975, HUD was authorized to provide Section 8 assistance to Section 202 elderly housing projects. Between 1975 and 1990, HUD provided direct loans to eligible nonprofit borrowers under a 40-year note and mortgage. Simultaneously, HUD provided properties with 20-year Section 8 project-based rental assistance contracts. With the exception of projects that closed between approximately 1977 and 1981, the notes and mortgages on these projects cannot be prepaid without the approval of HUD. Operations of these projects are governed by a Section 202 Regulatory Agreement and Section 8 housing assistance payments contract. Today, the Section 8 contracts are renewed on an annual basis at rents that are the lesser of the existing rent multiplied by the applicable operating cost adjustment factor (OCAF) published by HUD or at a budget-based rent.

Capital Advance Program. In the National Affordable Housing Act of 1990, Congress significantly altered the structure of the Section 202 elderly housing program. First, Congress provided for two separate and distinct programs for older persons and for persons with disabilities. New construction under the Section 202 program is now exclusively for older persons—defined by HUD as persons 62 years of age and older. Second, Congress changed the

[11] U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *A Picture of Subsidized Households in 1998*, August 1998.

program from a loan program to a capital advance program. Under the capital advance program, HUD basically provides a grant to the project that the owner is not required to prepay unless the owner does not operate the project in accordance with the program requirements for the 40-year term of the capital advance. HUD has structured the program so that the obligation of the owner to operate the project in accordance with the Section 202 program requirements is secured by a zero-interest, 40-year note and mortgage, which is not required to be repaid unless the owner is in default. Third, Congress decided that the rental assistance received by Section 202 projects would no longer be provided through the Section 8 housing assistance payments program. Instead, HUD provides a renewable rental assistance contract (PRAC) to Section 202 projects. The operation of the PRAC is essentially the same as the Section 8 housing assistance program, but the appropriations for the rental assistance are provided under the Section 202 program and not under the Section 8 program.

Affordable Housing for Seniors and Families Act. In December of 2000, Congress again made significant changes to the structure of the Section 202 program. First, Congress amended the Act to provide for a change in the nature of eligible ownership entities. Over the years, one of the constants in the Section 202 elderly housing program was the requirement that the project be owned by a nonprofit entity. In the new legislation, Congress amended the eligible owner definition of "private nonprofit organization" to include for-profit limited partnerships, in which the sole general partner is an organization that qualifies as a private nonprofit organization, or corporations that are wholly owned and controlled by a private nonprofit organization. Through this amendment, Congress intends to bring to the Section 202 program additional funding sources that have previously not been available to these projects, including most particularly the possible use of low-income housing tax credits. Second, Congress enacted legislation that requires HUD to approve the prepayment of Section 202 loans with a prepayment plan under which (i) the owner agrees to operate the project under terms at least as advantageous to tenants as required under the original Section 202 program terms or the Section 8 housing assistance payments contract and (ii) the prepayment may involve refinancing of the loan if the refinancing results in a lower interest rate and reductions of debt service. At least 50% of any Section 8 savings resulting from the refinancing shall be made available to the owner for purposes such as increased supportive services, rehabilitation or retrofitting of buildings and units, or the construction of additional facilities for the project which could include facilities such as additional community space or assisted living facilities.

In addition to providing the owner savings resulting from a refinancing, the new law contains other provisions that may be used in the prepayment and refinancing plan, including:

- The law requires the Secretary to make available to the owner funds in the project's residual receipts account (these accounts accrue when the annual income to the owner from tenant payments and HUD rental assistance payments are more than are needed to meet project debt service and operating expenses) and the reserve for replacement accounts. The residual receipts account must be maintained at a minimum of $500 per unit and the reserve for replacement account must be maintained at a minimum of $1,000 per unit.

- The law limits the amount of residual receipts funds made available for supportive services to fifteen percent of the costs of increased services, but does not specify other activities that the owner can undertake with the residual receipts funds made available to the owner. It provides that the reserve for replacement amounts made available may be used for rehabilitation and retrofitting, and the construction of an addition or other facility, including assisted living facilities, at the project or in the community as described above.

Section 202 Refinancing Candidates. The new Section 202 prepayment and refinancing legislation could help preserve some of this valuable housing stock. However, the utility of the prepayment provisions will depend on the individual circumstances of the project, including factors relating to when the project was developed and the willingness of the current owner to "share control" with other partners.

The following table summarizes various types of Section 202 properties and the predicted likelihood that these properties will or will not prepay their current HUD loans and/or pursue now available low-income housing tax credits for rehabilitation or other uses.

	Current Terms of Mortgage/ Rental Assistance	Right to Prepay?	Residual receipts and Replace. Reserves?	Who "owns" the reserves?	Likely to use Section 202 prepay option?	Likely to compete for tax credits?
Initial Section 202 Program	40-50 years at 3%	Only with HUD approval	Not much	Owner	Yes, if HUD will subordinate existing note.	Yes, if can refinance with subordination of existing HUD note
1975-1990 Section 202 Program	40 year market rate mortgage; always with Section 8 contract for only 20 years.	Only with HUD approval unless built b/t 1977-1981. Where HUD approves, must show that tenants are advantaged by the prepayment.	Often substantial	Generally, the owner if notice of selection given before end of 1979	Yes, if current rate is above approximately 9%	Yes, if can work out details on what entity provides tax credit guarantees, etc.
Current Section 202 Capital Advance Program	40 year capital advance-grant	N/A	Yes	HUD	No	Yes, but only if HUD will subordinate its loan to new debt that comes with tax credits.

For those projects that do not have a right to prepay without HUD approval, HUD requires that the owners demonstrate that the proposed prepayment is advantageous to the tenants. Such advantages could include extensive retrofitting and renovation, construction of new, co-located facilities such as a clinic, community space, or assisted living facilities, a rent freeze or rent subsidy for unassisted tenants, or increased supportive services. In addition, HUD requires the owner to execute a Use Agreement in the form established by HUD that requires that the project continue to be operated in accordance with the Section 202 program requirements.

In *Section F, Point 4* below and Tab 8, the Trust and the Related Companies have produced a proforma example of a potential refinancing of a Section 202 property with low-income housing tax credits. While not all Section 202 properties should be refinanced, we do believe the Commission should aggregate better data on the rents and loan balances of

Section 202 properties. Then, we suggest that these owners be contacted about the potential costs and benefits of refinancing with low-income housing tax credits.

Finally, a number of hurdles exist with respect to the development of new projects under this mixed finance development method, particularly when the sponsor plans to use low-income housing tax credits.[12]

Section 515 program

The Section 515 multifamily housing program was authorized in 1962. The Rural Housing Service (RHS) of the U.S. Department of Agriculture currently administers the Section 515 program.[13] The Section 515 program is a direct loan program under which private sponsors receive low-interest rate loans from the Rural Housing Service in return for renting to persons with low and moderate incomes. Unlike the Section 221(d)(3) BMIR and Section 236 programs, Section 515 is still financing the construction of affordable housing though funding cuts in recent years have substantially reduced the number of new units being constructed.

Approximately 67 percent of Section 515 units, mostly those constructed in the 1970s, also receive Section 8 rental assistance or rental assistance under the RHS Section 521 program, whose terms and conditions are quite similar to Section 8. Generally, projects developed before December 15, 1989 may prepay their mortgages after twenty years and end the low-income use restrictions.

According to data published in 2001 by the Rural Housing Service, approximately 177,577, or 41 percent of households residing in Section 515 units are elderly.[14] In the Trust's analysis of HUD-assisted properties, we found that 798 Section 515 properties with 21,571 Section 8 assisted units are primarily (50% or more households in property are 62+) elderly properties.

Section 515 Occupied Units	432,246
Section 515 Units Occupied by Elderly Households	177,577
Section 515 Units with Project-Based Assistance	317,727
Section 515 Units with Project-Based Section 8	50,628
Section 515 Units with Project-Based Section 8 (Primarily Elderly)	21,571

[12] Generally, in order to qualify for 9% tax credits, the Section 202 capital advance funds will need to be made available to the project by way of a loan in order to include these funds in eligible project basis. Another similar issue is the treatment of the PRAC payments that are provided to the project as rental assistance. The Internal Revenue Service has determined that the provision of Section 8 rental assistance, and Section 9 operating subsidy in the context of mixed finance development public housing projects, are not Federal grants that require a reduction in tax credit basis. However, even though for all intents and purposes the PRAC is the same as Section 8 assistance, it is legally authorized under Section 202 and not under Section 8.

[13] This program was once known as the Farmers Home program.

[14] U.S. Department of Agriculture, Rural Housing Service, *Results of Fiscal Year 2001 Fair Housing Occupancy Survey*, 2001.

C. *Overall Data on Senior Households Residing in HUD Subsidized Housing, Section 515 RHS Housing and Housing Developed with Low Income Housing Tax Credits or the HOME Program.*

A Picture of Subsidized Households in 1998, published by HUDUSER in August 1998, enumerates the vast array of Federally subsidized and public housing occupied by older persons.[15]

	Total	Age 62+
HUD Programs		
Public Housing	1,120,000	358,400
Section 202	319,502	319,502
Section 221(d)(3)	109,861	21,437
Section 236	429,567	146,053
Section 8 new/rehab	744,889	343,673
Tenant-based Section 8	1,420,000	213,000
Rural Housing Service		
Section 515	453,275	190,829
Federal Incentives		
Low-Income Housing Tax Credits	433,427	108,357
HOME	125,000	20,016
TOTAL	5,155,621	1,721,266

These numbers produced, in part, from A Picture of Subsidized Households in 1998 show that 1.7 million older persons live in subsidized housing. *However, this number includes all elderly households in properties that may not primarily house elderly households.*

D. The Overall Data for "Primarily Elderly" Subsidized Housing

For purposes of this report, the National Housing Trust generated new information for the Commission that examines subsidized properties that primarily house the elderly. For the Commission to make recommendations, especially recommendations about the preservation of properties that primarily house the elderly, we recommend the Commission first focus on those properties where the majority of the occupants are elderly (50 percent or more households are 62 or over) and/or the client group for the property is classified by HUD as elderly. The subsidized "primarily elderly" rental housing stock currently constitutes more than 10,000 properties with over 800,000 assisted units throughout the United States. The annual median income of residents in subsidized housing is approximately $8,200 (in 1998 dollars). Approximately 21.6 percent of households in primarily elderly properties are minorities and 67.4 percent are female-headed.

[15] The National Housing Trust wishes to thank the AARP Public Policy Institute for its summation of this data, reproduced here from various reports published by the Institute. Attached at Tab 1 is a Summary of Federal Rental Housing Programs produced by the AARP in May 2001.

E. Conversion of Primarily Elderly Subsidized Housing to Market Rate Properties: Opt Out and Prepayment Statistics

The preservation of primarily elderly, subsidized housing becomes increasingly important as one reviews data documenting the conversion of this stock to market rate rentals. Since FY 1996, the number of affordable, subsidized, elderly properties has declined because some of the properties have been converted to market rate rentals. Federally subsidized rental housing enables many poor, older persons to live in affordable housing without having to move or worry about being able to afford the rent. The sense of security provided by this housing is placed at risk where owners decide to convert to market rate housing. The potential loss of this housing places older Americans in competition with others in seeking affordable rents in a market with fewer and fewer choices. This random process, like a game of "musical housing" leaves poor elderly with few options. Owners may convert to market rate rentals by either prepaying their HUD-insured mortgage or "opting out" of their Section 8 contract:

- According to National Housing Trust data, 99 primarily elderly properties with 11,024 apartments have prepaid their HUD-insured mortgages through September 2001, and had their affordability restrictions removed.

- According to data produced for this report, owners have opted out of Section 8 contracts in 155 properties through September 2001, covering 9,040 Section 8-assisted, primarily elderly apartments**. All told, the number of subsidized, primarily elderly apartments converted to market rent in the recent past is more than 20,000 apartments Nationwide.**[16]

This trend will presumably continue as the Trust has determined that at least 4,400 elderly properties consisting of over 324,000 Section 8-assisted apartments have Section 8 contract rents less than market (defined as 110% of FMR) and, for purposes of this report, are defined as "at-risk" of being converted to market rate rentals.[17] Of these, nearly 180,000 apartments have Section 8 rents below 90% of Fair Market Rent.[18]

The conversion from subsidized to market rate properties is particularly difficult for older persons. AARP found in a recent study that:

> "Many residents in these elderly projects are frail and would face substantial difficulties in today's housing market. Due to their limited incomes and incidence of disability, locating alternative affordable housing suitable to their needs would be difficult if owners were to convert their projects to market rate housing. Many of the elderly projects have special design features (such as grab bars and elevators), special services (such as meals or housekeeping), and special staffing (such as service coordinators). When these residents lose their homes in subsidized projects, they are losing more than rental assistance and a community of friends – quite often they are

[16] See Tab 2 for elderly opt outs and mortgage prepayments by State.

[17] See Tab 3 for State by State listing of at-risk properties.

[18] See Tab 4 for 90% FMR Table by State.

losing supportive services and project features that are critical to their continued independence."[19]

Analysis of Primarily Elderly Housing and Units Currently At Risk

Financing Type	Primarily Elderly Properties		Units Lost through FY2001		Units at Risk of Loss (Rents <=110% of FMR)		Ability to Refinance[20]		Ability to Refinance AND at Risk of Loss	
	Prop.	Units	Prop.	Units	Prop.	Units	Prop.	Units	Prop.	Units
202s[21]	4,468	285,356			2,000	125,692	1,674	99,271	358	23,616
236 & 221(d)(3) BMIR	657	91,956	99	11,024	545	52,820	532	51,934	532	51,934
Other Section 8[22]	5,344	425,790	155	9,040	1,864	145,489	375	31,205	80	7,347
TOTAL	10,469	803,102	254	20,064	4,409	324,001	2,581	182,410	970	82,897

More detailed tables with State-by-State information are included in Tabs 2 through 4, which describe the elderly subsidized housing landscape in greater detail. Also included in Tab 9 is an exemplar of a "total State" expiring Section 8 database for primarily elderly properties.

Notably, the more than 800,000 elderly, subsidized housing units tend to have the following characteristics:

- In general, this housing has Section 8 contract rents above the fair market rent, but a majority of the stock is probably below the market rents for the surrounding neighborhood—approximately 45% of the stock have Section 8 rents at or below 110% of the Fair Market Rent.[23]

- A very large percentage of HUD Section 202 loans have high interest rates (above 9%). The Trust found that 1,674 Section 202 properties with 99,271 units have interest rates at or above 9%. This means that, depending on the condition of the

[19] AARP Public Policy Institute, *Adding Assisted Living to Subsidized Housing: Serving Frail Persons with Low Incomes*, Wilden and Redfoot, January 2002.

[20] Ability to refinance is defined any Section 236-insured property with rents at or below market (<=110% FMR) and other non-236 properties with interest rates of 9%.

[21] Prior to 1990, Section 202 financing was available to developers of housing for both elderly and disabled, low-income households. This report focuses only on those properties that are for the elderly, and therefore, the total number of units will be less than the number of units for the Section 202 program as a whole.

[22] Other Section 8 is defined as any Section 8-assisted property that is not insured under the Section 202, Section 236 or Section 221(d)(3) BMIR programs. Some of these properties may not have a HUD-insured mortgage.

[23] Fair Market Rent is not really a proxy for "market" or "street rent." Because Fair Market rent is a derivative of the 40th percentile of rents paid by recent movers, Fair Market Rents are often lower than what is often considered market rent in a neighborhood. As a consequence, HUD housing practitioners often use 110% of FMR as a general proxy for market rent.

property and prevailing interest rates, the refinancing of these loans may well make sense for the property and its nonprofit ownership.[24]

RECOMMENDATION #1: Recommend that an ongoing database be established providing project specific information on primarily elderly, subsidized properties that a) have Section 8 contract rents at or below market and/or b) have loans with significantly high current interest rates. These properties arguably have a high risk of mortgage prepayment and should be placed on an "early warning" list to be shared with State housing finance agencies, HUD, the Rural Housing Service and the general public.

F. Current Federal, State and Local Initiatives to Preserve and Improve Elderly, Subsidized, Rental Housing

1. Increasing Use of Tax Credits to Preserve and Improve Elderly, Subsidized Housing

The Low-Income Housing Tax Credit program is widely regarded as the Nation's most successful and productive affordable housing program. The tax credit program annually produces between 75,000 and 100,000 affordable apartments Nationwide. In 2000, the low-income housing tax credit and private activity bond allocation provided to the States was increased by approximately 50% (25% increase per year over 2 years). To determine the use of such credits, State housing finance agencies hold annual hearings to examine the most important housing needs in their respective jurisdictions.

Again, much has been or is being written about the use of tax credits to produce quality elderly, affordable housing. *For this report, we focused on the use of tax credits to preserve existing primarily affordable housing.* It turns out that allocation of low-income housing tax credits to existing affordable, subsidized, rental properties for the elderly is an increasingly important resource for their preservation in the Nation's affordable housing inventory.

To assess the interest of the various State agencies in preserving subsidized, elderly, rental housing, the National Housing Trust undertook a survey of State housing finance agencies charged with the responsibility of allocating competitive 9% low income housing tax credits for its respective jurisdictions. We asked a set of questions designed to determine the allocation priority, if any, of low-income housing tax credits and private activity bonds to preserve subsidized, elderly, rental housing.

[24] This is not to suggest that residents of Section 202 properties would necessarily be adversely affected by prepayments by their owners. Quite the contrary; as the proforma examples in this paper indicate, refinancing at a lower rate may enable the nonprofit borrower to complete required repairs, increase reserves and maintain rents at current levels.

Here are some of the State Housing Finance Agency survey highlights:

- 38 State housing finance agencies responded to the survey;
- Over half of the respondents, 22 in all, had some form of set aside or priority in their scoring system for allocating scarce 9% low income housing tax credits to creation or preservation of elderly housing;
- 25 of the responding States anticipate the use of non-competitive private activity bonds and 4% credits for the preservation of elderly, rental housing.
- 15 State respondents anticipate that the demand to use private activity bonds and 4% credits to preserve elderly, subsidized, rental housing will increase over the next 5 years.

The results of the survey are included in Tab 5.

RECOMMENDATION #2: Recommend that State housing finance agencies set aside or prioritize the use of low-income housing tax credits and private activity bonds to preserve and improve affordable, subsidized, primarily elderly housing.

2. Prevent Section 8 Opt Outs and Allow Nonprofit Owners a Reasonable Rent to Meet Ongoing Operating Expenses: Encourage HUD to Facilitate Marking Below-Market Section 8 Contract Rents Up to Market:

For approximately 2 years, between 1998 and 2000, a spate of Section 8 contracts was terminated. Notably, some of these properties housed elderly residents. Stories about elderly residents being evicted for failure to pay sky-high, market level rents created a news controversy across the U.S.[25]

These developments prompted a reaction from the Federal government. In 2000, HUD implemented a program to reduce the number of Section 8 contract terminations. Designed to give owners of below-market, Section 8 properties rents that were more equivalent to "street rent," HUD Notice 99-36 permitted owners to "mark up" the property's below-market Section 8 rents to market rents. Importantly, owners were permitted to obtain increased cash flow from the property as well. As noted in the table above, some 4,409 Section 8 primarily elderly properties with 324,001 assisted units currently have Section 8 rents arguably below market.[26] Presumably, if owners of these properties were given an appropriate incentive to keep their properties affordable, they would be less likely to opt out of their Section 8 contracts. There are really two separate issues raised by an opt out of a Section 8 contract, depending on the ownership entity:

[25] Selected stories about the termination of Section 8 contracts for properties that housed elderly residents are attached in Tab 6.

[26] Defined as 110% of Fair Market Rent.

1. A for-profit owner of a primarily elderly, Section 236 property has a duty to its investors to assure reasonable cash flow. The Mark Up to Market procedure, if applied correctly, should permit the owner to increase cash flow, effectively reducing the incentives to opt out.

2. An equally positioned nonprofit owner may not be as likely to opt out, but that same nonprofit owner would want to make sure the operator could meet reasonable expenses. Allowing the nonprofit owner the option of Marking Up to Budget, not to exceed market rents, helps the nonprofit meet its ongoing operational and repair needs. Moreover, many of these nonprofit owners would be willing to take distributions from these "Mark Ups" and, in turn, dedicate these distributions to their mission of saving or producing affordable housing. Therefore, HUD should allow the nonprofit owner to receive distributions for this purpose.

RECOMMENDATION #3: Recommend that Congress encourage HUD to facilitate "Mark Up to Market" Section 8 contract rents for elderly, subsidized properties with current rents below market to prevent Section 8 opt outs by private owners and permit current nonprofit owners the resources needed to meet their ongoing operating costs. Additionally, it is absolutely critical that nonprofit owners of such properties receive distributions from their properties to meet other mission-related activities.

3. Interest Reduction Payment Decoupling of Primarily Elderly Section 236 Properties

Section 236 of the National Housing Act of 1968 authorized below-market interest rate insured loans to private builders who agreed to develop affordable units reserved for low-income families and seniors. The program lowered the loan's interest rate to 1%. The difference between a market rate mortgage and the 1% mortgage is called an "Interest Reduction Payment." (IRP). The entire stream of IRP funds were allocated at the time the mortgage was approved, creating a revenue source available to the project for entire term of the mortgage. *The Trust has determined that 628 Section 236 properties with 88,716 apartments are occupied primarily by older persons. Approximately 85% of these properties, 532 properties with 75,762 apartments (51,934 of these with Section 8 assistance), have Section 8 rents that are presumably below market levels.*

Pursuant to HUD Notice 00-8, an owner of a Section 236 property can refinance the asset through what practitioners refer to as "decoupling the IRP."[27] The key to this concept is that HUD will allow an owner of a Section 236 property to transfer or refinance the property *without loss* of the existing Interest Reduction Payment. This can be a powerful finance tool, depending on the amount of the Interest Reduction Payment and the amount required to reposition the property. The result can be a win-win for both owners and the residents of these properties. The essentials of the program are summarized in the following table.

[27] HUD issued guidelines on decoupling the IRP on May 16, 2000 in HUD Notice 2000-8.

Summary of Section 236 IRP Decoupling Program

Eligibility	Any Section 236 property (including Section 236 elderly properties)
Process	Submit proposal to HUD Multifamily.
Eligible Mortgagee	Any mortgagee may qualify if public agency agrees to monitor use agreement; if no public agency will monitor, then must use FHA insurance from a HUD approved lender and HUD will monitor agreement.
Term and Amount of IRP	In accordance with remainder of the IRP schedule. Owners can also choose to reduce the annual subsidy and extend the IRP schedule.
Rents	Budget based rents allowed to cover operating costs including new debt service. Rents are capped at comparable market rent LESS the IRP. Rent increases may not exceed 10%. If need more than 10% hike, must appeal to HUD Headquarters.
Limit on Distributions	Annual distributions range from 6% to 10% of new tax credit or other equity.
Affordability/ Use Agreement	Maintain Sec.236 occupancy and income restrictions, i.e. occupants must earn less than 80% of median and pay affordable rents until at least 5 years after the original maturity date of the mortgage. No involuntary displacement. If the owner retains project based Section 8, then the Section 8 stays in place for the balance of the use agreement. If the owner opts out of Section 8, tenants are eligible for enhanced vouchers.

A significant number of Section 236 decoupling transactions have already taken place. The National Housing Trust and others have concluded transactions that combine the Section 236 IRP Decoupling concept with private activity bonds and four percent low-income housing tax credits. Maintaining the IRP for the remaining term, typically about 13 years, is a critical funding resource for making the transaction financially feasible. In these transactions, one set of bonds is issued on the revenue stream of the property, and another set is issued on the IRP stream of income. Standard & Poors rates the IRP payments as investment grade, thereby making this debt instrument more attractive to investors. Tenants are protected against a significant rent hike through the continuation of the project-based Section 8 contract or the receipt of enhanced vouchers to eligible residents, which are triggered, as a matter of law, by the prepayment of the Section 236 mortgage.

The benefits of decoupling the IRP in these transactions are substantial. A 25-30-year-old property is rehabilitated and amenities updated in the range of $10,000 to $15,000 per unit. Valuable affordable housing stock is preserved and improved for another 30 years. Because many of these transactions use tax-exempt bonds and tax credits, States—not the Federal government—are choosing which properties to preserve.

SAMPLE PROJECT

To demonstrate the benefits of a sample Section 236 IRP Decoupling transaction for the Commission, the Trust has prepared the following information on a real project located in Anderson, South Carolina. It is a family project, but the financial information is one that could be equally applicable to an elderly Section 236 property.

Background:

- 200 apartments in Anderson, SC
- 100% Section 8 with annual contract renewals
- Property is almost 30 years old
- Section 236 mortgage

Acquisition Plan

- Will perform immediate rehabilitation of $3.77 million ($18,850/unit)
- Seeking Federal and State funding to improve security and eliminate drug trafficking
- Obtain private activity bonds and 4% credits for rehab
- Use IRP decoupling to help fund rehabilitation.

	Cash Flow	Rehab	Fees	Debt
Anderson Gardens (Before)	Di minimis	None	None	$5 M at 7%
Anderson Gardens (After IRP Decoupling and Tax Credit Acquisition by Nonprofit)	$80,000	$18,000/unit	$781,000 split between for profit developer and nonprofit general partner	$5.95 M at variable rate, now at 2%

Not every primarily elderly, Section 236 property can benefit from decoupling the IRP. Another tool, however, is available, which the Commission should strongly urge HUD to employ to save primarily elderly, subsidized housing. In 1998, Congress gave the HUD Secretary the right to retain IRP in a "pool" that could be set aside for rehabilitation of Federally assisted and insured properties.[28] To date, none of these funds have been expended. According to HUD's February 2002 budget submission to Congress, approximately $300 million of these funds are now available. At a time of shrinking resources, it is ironic that HUD has not acted to use these

[28] P.L. 105-65 established new authority for the Secretary to recapture interest reduction payment subsidies from Section 236-insured multifamily properties for purposes of providing rehabilitation grants to properties suffering from deferred maintenance. Section 531 of P.L. 105-65, enacted in 1997, authorized the HUD Secretary to make these grants for the capital costs of rehabilitation to owners who demonstrated need and also had insufficient project income to support such rehabilitation. Section 533 of the HUD FY 2001 Appropriations Act added the amendment that the program be structured as a grant or loan

funds in the manner Congress intended. The Commission should urge HUD to immediately establish a program for use of these funds and, furthermore, seek at least a third of these funds to be used for primarily elderly, subsidized housing stock

RECOMMENDATION #4: Recommend that useful information be provided to owners of existing HUD-insured, Section 236 properties primarily serving older persons. The distribution of information should include a simple explanation of how the owner can take advantage of HUD's Section 236 "decoupling process" to rehabilitate the property and keep it affordable.

RECOMMENDATION #5: Recommend Congress urge HUD to immediately establish a program for use of the recaptured interest reduction payments that are now in an IRP Pool at HUD. Furthermore, Congress should urge HUD to use at least a third of these for the preservation and improvement of existing HUD-insured, Section 236 properties primarily serving older persons.

4. Prepayment of Section 202 Loan with 501(c)(3) Bonds

Where the project's current interest rate is relatively high, where competition for tax credits is significant, and where the repair needs are not considerable, the current nonprofit owner may be wise to establish a 501(c)(3) pool to provide bond financing for senior, subsidized housing.[29]

In order to determine the feasibility of refinancing a Section 202 property with 501(c)(3) Bonds, the Related Company and National Housing Trust have created a sample proforma for the Commission demonstrating how this bond tool could help rehabilitate a property.

We titled the property "**Anytown Apartments."** Anytown is a 180-unit Section 202 property with an original mortgage of $7.4 million. That mortgage has a current interest rate of 9.25% with a 40-year term. The unpaid principal balance is $5.7 million. Current debt service is $702,000 annually. Cash flow is approximately $67,000 annually. The current, stabilized debt and cash flow are included in Tab 7.

We then constructed a scenario in which the current owner prepaid the current loan and refinanced with 501(c)(3) bonds. The results are as follows:

- We reduced the current debt service from $702,000 to $667,000, for a savings of $35,000 annually;
- We provided the operator an additional $3,000/unit that could be used for reconfiguration or rehabilitation of the apartments;

[29] The State of California is considering establishing such a loan pool for Section 202 properties. The term for the Section 8 loan would be approximately 30 years. The loan is sized commensurate with affordable rents at 30% of 50% of adjusted median income (AMI). The California Housing Finance Agency would use HUD Risk Share insurance on the bonds. Excess proceeds would be used for rehabilitation. The second loan is supported by the difference between 30% of 50% of AMI and the Section 8 rent, where the Section 8 contract rent is above 30% of 50% of median income. The second loan is for a shorter term (e.g. 10 or 15 years).

- Cash flow was maintained at current levels;
- The owner and its technical assistance advisor have up to $100,000 to split between them in pursuit of their own missions.

Clearly, this option is generally limited to properties with higher interest rates. Nevertheless, the Trust found that 2,056 primarily elderly properties with 133,743 total units have interest rates at or above 9 percent and may be refinancable using 501(c)(3) bonds.[30]

5. Use of Tax Credits to Refinance Section 202 properties

Using **Anytown Apartments** as our sample property, the Related Companies and the National Housing Trust constructed a proforma in which the current nonprofit owner prepaid the Section 202 loan, refinancing with private activity bonds and 4% low-income housing tax credits. The results of the proforma, included in Tab 8, are as follows:

- The debt service was reduced from $702,000 to $697,000, for a savings of $35,000 annually;
- Rehabilitation assistance of an additional $16,000/unit that could be used for reconfiguration or rehabilitation of the apartments;
- Cash flow was maintained at current levels;
- The owner and the technical assistance advisor have up to $700,000 to split between them in pursuit of their own missions.

Comparative Analysis of "Anytown Apartments"
(Current Operations, Refinancing with 501(c)(3) Bonds
and Refinancing w/ Private Activity Bonds and Tax Credits

	Sole Nonprofit control	Cash Flow	Rehab	Fees	Debt
Current Operating Budget and Stabilized Cash Flows	Yes	$67,000	Replacement reserves. No ability to finance significant rehab	None	$5.7 m. at $702,000 debt service on annual basis.
Refinance with 501(c)(3) Bond	Yes	$67,000	$3,000/unit plus building of reserves.	$100,000 split with advisor	$7.2m at $667,000 debt service on annual basis.
Refinance with Private Activity Bonds And 4% Low Income Housing Tax Credits	Not clear. Must negotiate with private syndicator.	$69,000	$16,000/unit	$700,000 developer fee split between current owner, tax credit consultant and, perhaps for profit partner.	$8.8m at $697,000 debt service on annual basis.

[30] See Tab 10 for HUD-insured elderly properties with interest rates at or above 9%.

The use of low-income housing tax credits as a significant refinancing tool requires that HUD subordinate any remaining existing debt to the new debt brought in by the owner or purchaser. That will allow the property to retain its current Section 202 loan and, perhaps, use the operating cost savings to fund increased services on site**. The Trust makes two suggestions that the Commission might consider in its deliberations concerning the potential use of low-income housing tax credits to preserve and improve Section 202 properties.**

RECOMMENDATION #6: Recommend Congress urge HUD to permit subordination of its Section 202 mortgage to new debt brought in with tax credits where the new debt and tax credits actually enhance the property's value and livability.

RECOMMENDATION #7: Recommend Congress encourage HUD to prepare a report to explain to Section 202 owners the comparative costs and benefits of prepaying its current loan with 501(c)(3) bonds or refinance with new debt and low-income housing tax credits.

5. Debt Forgiveness for Outstanding Section 202 Loans Supported by Section 8

The American Association of Homes and Services for the Aging (AAHSA) has proposed "PRAC Conversion," to convert approximately 260,000 elderly housing units assisted with Section 8 contracts to a project rental assistance contract (PRAC) and would substitute a capital advance for the unpaid principal balance of the Section 202 loan. Henceforth, the property would receive operating assistance under a PRAC, based on the actual property budget. Presumably, the new property would have sufficient equity to refinance the property. Whether HUD would permit the PRAC to be used to pay for debt service associated with this refinancing is not clear.

This approach could have a significant up-front, one-time budget cost.[31] This cost would presumably be offset by the benefits to the occupants and the operators of these properties, as the conversion effectively reduces their reliance on ongoing Section 8 assistance. The Trust has not studied this matter closely, nor do we opine on the wisdom or lack thereof of forgiveness. At the same time, it is plainly obvious that this forgiveness would relieve these properties of enormous subsidies, which could be at risk of loss at some point in the future. Moreover, to the extent that forgiveness of this debt would, in fact, assist nonprofit operators in maintaining the existing Section 202 stock, we believe the Commission could ask Congress to revisit this issue, with a

[31] According to HUD, the one-time cost for this forgiveness depends on the type of "budget scoring" used to determine the impact on HUD's budget. Under the current scoring rules pursuant to the Budget Enforcement Act, the cost of forgiving approximately $7.8 billion would be *either $3.6 or $10.6* billion in both budget authority and outlays in the year in which the debt is forgiven, depending on the scoring rules used. If taken outside of these rules, the cost would be effectively zero since HUD would recover the cost of forgiveness by saving Section 8 subsidy payments equal to the amount of forgiveness. Under current "pay as you go" rules, if the item were legislated by the authorizing committee, it would be a mandatory cost; if legislated as part of the VA/HUD Appropriations process, the discretionary costs would be "scored" against HUD's discretionary budget. See May 19, 2000 letter from HUD to Honorable Alan B. Mollohan, Ranking Minority Member, Subcommittee on VA, HUD and Independent Agencies.

particular focus on the current owners' needs as well as the salvation of the Section 202 inventory.

RECOMMENDATION #8: Recommend that Congress revisit the issue of waiving all or part of the existing debt on Section 202 properties supported by Section 8.

6. Conversion of Subsidized Housing to Assisted Living Facilities

If "aging in place" has any meaning for poorer senior citizens living in subsidized, rental housing, it means that they are able to grow older with dignity. As reported in a recently published study by Harvard University's Joint Center for Housing Studies:

> "There are a significant number of expenses and inefficiencies associated with this separation of health and housing services. ... When seniors, often the most stable forces in the neighborhood, are forced out in search of more adequate and affordable health and housing services, communities suffer."[32]

In part, this means that their present housing can be reconfigured or modified to function as an assisted living facility. Research is currently emerging that indicates that this may be a trend the Commission should recognize.[33] Some research indicates that providing assisted living services to a targeted population in subsidized, elderly projects could reduce costs toward nursing homes. If *premature placement* in nursing homes can actually be reduced, this option should be fully explored.

HUD appropriations for fiscal years 2002 and 2003 included funds to retrofit subsidized elderly housing projects for assisted living. This permits the seniors to remain in the same residential development even if their need for supportive services increases. The program provides funding for the physical reconfiguration of the units, but not for support services. Assisted living was recently authorized as an eligible site for use of HUD rental assistance vouchers. The need for affordable assisted living has also become evident to those who syndicate low-income housing tax credits. Senate Bill1886, introduced in December 2001 by Senator Dodd and titled the "Assisted Living Tax Credit Act," would create a new "supported elderly housing tax credit."

In January 2002, Robert Wilden, past national director of elderly housing at HUD, and Donald L. Redfoot, Senior Policy Advisor at AARP's Public Policy Institute, published a report on converting subsidized housing to assisted living facilities.[34] They note that the number of elderly residents residing in subsidized housing (over 1.9 million) is actually greater than the

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[32] Harvard University Joint Center for Housing Studies, *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population*, October 2001.

[33] "[T]he desire to remain in their current residence for as long as possible becomes more prevalent as age increases." Between 75 and 95% of seniors want to do so, with the number increasing as their age increases. AARP, *Fixing to Stay: A National Survey of Housing and Home Modification Issues*, May 2000.

[34] AARP, *Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes*, January 2002.

number of persons residing in our Nation's nursing homes.[35] The authors analyzed over 20 housing developments that provided assisted living services in subsidized housing. Housing funding sources ranged from public housing funds to low-income housing tax credits.[36] In particular, they noted that a large number of Section 236 developments apparently have occupancy problems because the owners cannot lease up the efficiency apartments. In at least a few of the cases they studied, converting these efficiency units to assisted living apartments actually helped the owner meet its operating expenses.[37]

The authors made clear that this was an exploratory set of case studies. Nevertheless, it provides some very useful, if preliminary, insights:

- The means by which sponsors "converted" subsidized housing to assisted housing facilities varied widely;
- The types of services provided varied considerably.

There clearly is no precise data on the nature or breadth of "premature placement" in nursing homes. But it seems obvious that the time is ripe for a full-blown study of the costs and benefits of funding more assisted living facilities for poorer, older persons.

RECOMMENDATION #9: Recommend Congress fund a meaningful study of how to best facilitate conversion, where appropriate, of existing subsidized housing to assisted living facilities. This study should document the costs of such conversion, and in particular, conduct a cost/benefit analysis of such conversion. The study should determine whether conversion to assisted living prevents premature institutionalization, and it should ask practitioners to provide detailed training on how to efficiently undertake these conversions. Congress should allow industry practitioners and others to provide detailed testimony on the recent Senate Bill 1886, the "Assisted Living Tax Credit Act," introduced by Senator Dodd (D-CT), which allows for a business credit for supported elderly housing.

7. Matching Grants for Preservation of Primarily Elderly, Subsidized Housing

As the authority for housing programs is increasingly delegated to State and local governments, Congress should encourage State and local governments to meet the preservation needs of primarily elderly, subsidized housing. The expansion of housing initiatives at the State and local level has crucial ramifications for Federal housing policy. Indeed, Federal housing policy can be tailored to encourage State and local preservation initiatives. For example, a bill

[35] Data derived from AARP and National Center for Health Statistics, 2000.

[36] For purposes of their report, Wilden and Redfoot defined "assisted living" as support for activity for daily living (ADLs) *and* instrumental activities of daily living (IADLs). ADLs include bathing, dressing, toileting, transferring, and eating. IADLs include escort help for outside appointments, medicating monitoring, bill paying and health status monitoring. Finally, most sponsors surveyed provided 24-hour supervision and medication management. Not all projects provided all of the services defined in this footnote, but all were focused on increasing supportive services for their residents.

[37] Ibid and conversation with Don Redfoot, February 4, 2002.

currently pending in Congress, if amended, could generate hundreds of millions of State and local funds to preserve affordable, primarily senior housing.

The Affordable Housing Preservation Act of 2001 (Senate Bill 1365) is sponsored by Senators Kerry (D-MA), Grossly (R-IA), Dayton (D-MN), Einstein (D-CA), Schemer (D-NY), Sardines (D-MD), Beaux (D-LA), and Wellstone (D-MN). The Act authorizes Federal matching grants for State or local funds committed to preserving and improving affordable housing. Grants may match State or local funds on up to a two-for-one basis. By providing a two-for-one match, the Act essentially triples the amount of State or local funds earmarked for preservation. Where a State has not devoted its own funds for preservation, the Act authorizes that grants be provided at 50% of tax credits, HOME funds and other Federal funds "steered" to the preservation of affordable housing. According to the Act, Section 202 properties are currently not eligible for the preservation matching grants.

RECOMMENDATION #10: The Commission should urge Congress to immediately consider, amend and adopt Senate Bill 1365, the Affordable Housing Preservation Act of 2001. *The Commission should strongly urge Congress to amend Senate Bill 1365 to include Section 202 housing as eligible for grants provided pursuant to the Act.* Further, the Commission should recommend that at least $300 million of funds should be devoted to the Affordable Housing Preservation Act of 2001 and that no less than a third of these funds should be devoted to the preservation and improvement of primarily elderly, subsidized housing.

Conclusion

As the growth of senior households surges in the coming decades, the need for affordable rental housing for seniors will also increase. While production of new units may be necessary to meet this need, the preservation and improvement of existing affordable senior housing is critical. Existing affordable senior housing, like its occupants, continues to age and will require maintenance, modernization, and services in order to meet the needs of the older population. Fortunately, tools are being developed and used that give us hope that this stock can be preserved. This report has documented the uniqueness of this housing inventory and explained how this resource can be preserved and improved.

Elderly Mortgage Prepayments by State

State	Properties	Units
California	46	5,221
Colorado	2	227
Connecticut	1	159
Delaware	1	169
Florida	1	176
Illinois	2	183
Indiana	1	48
Maine	1	200
Massachusetts	3	342
Michigan	3	325
Minnesota	3	474
Mississippi	1	100
Montana	2	124
Nevada	1	112
New Hampshire	1	24
New York	2	623
Ohio	4	754
Oregon	6	205
Pennsylvania	2	436
South Carolina	1	104
Tennessee	1	80
Texas	3	398
Washington	8	361
Wisconsin	3	179
TOTAL	**99**	**11,024**

Data compiled from several HUD sources and not independently verified.

National Housing Trust, 2002.

Elderly Section 8 Opt Outs by State

State	Properties	Contracts	Assisted Units	Total Units
Alabama	2	2	50	146
Arizona	2	2	207	388
Arkansas	3	4	170	296
California	39	39	3,805	3,960
Colorado	3	5	290	409
Connecticut	1	1	50	50
District of Columbia	1	2	65	93
Florida	3	3	43	389
Georgia	1	1	20	94
Idaho	2	2	45	45
Illinois	4	4	202	711
Indiana	2	2	75	75
Iowa	8	8	311	311
Kansas	3	3	109	454
Kentucky	1	1	14	170
Louisiana	1	1	41	56
Maine	1	1	32	32
Maryland	3	3	67	376
Michigan	3	3	171	483
Minnesota	1	2	8	69
Mississippi	2	2	45	116
Missouri	1	1	8	40
Montana	2	2	23	68
Nebraska	1	1	9	52
Nevada	1	2	28	90
New Hampshire	5	5	260	375
New Jersey	1	1	24	24
New York	3	3	258	347
North Carolina	1	1	10	10
North Dakota	3	3	94	94
Ohio	13	13	783	948
Oregon	7	7	148	253
Pennsylvania	1	1	94	101
Puerto Rico	1	1	31	130
South Dakota	2	2	43	52
Tennessee	3	3	87	197
Texas	6	8	543	1,173
Utah	2	2	50	50
Washington	10	10	400	686
West Virginia	1	1	20	200
Wisconsin	3	3	171	171
Wyoming	2	2	136	136
TOTAL	**155**	**163**	**9,040**	**13,920**

Data compiled from several HUD sources and not independently verified.

National Housing Trust, 2002.

Total and At-Risk Elderly Properties with Project-based Section 8

	ALL CONTRACTS			RENTS <= 110% OF FMR		
State	Properties	Assisted Units	Average Percent Rent to FMR	Properties	Assisted Units	Percent of All Contracts
Alaska	18	502	89.9%	10	186	37.1%
Alabama	149	9,076	125.8%	47	2,730	30.1%
Arkansas	151	5,549	123.8%	61	1,736	31.3%
Arizona	85	5,754	104.8%	45	3,313	57.6%
California	692	54,944	92.8%	456	37,356	68.0%
Colorado	168	10,377	101.4%	110	7,648	73.7%
Connecticut	201	15,536	104.2%	99	5,938	38.2%
District of Columbia	23	2,593	74.0%	19	2,142	82.6%
Delaware	26	2,441	104.5%	14	1,239	50.8%
Florida	287	25,497	97.9%	181	16,427	64.4%
Georgia	158	13,512	103.0%	93	9,022	66.8%
Guam	1	49	0.0%	1	49	100.0%
Hawaii	37	2,341	100.8%	21	1,585	67.7%
Iowa	188	9,116	116.9%	51	2,317	25.4%
Idaho	70	2,495	144.7%	15	446	17.9%
Illinois	352	31,772	127.3%	106	9,757	30.7%
Indiana	219	15,597	122.5%	66	4,642	29.8%
Kansas	146	7,222	117.3%	48	2,751	38.1%
Kentucky	216	13,691	130.6%	66	4,032	29.5%
Louisiana	104	9,054	118.6%	31	2,082	23.0%
Massachusetts	402	37,616	102.3%	239	21,648	57.5%
Maryland	153	14,482	108.1%	77	6,788	46.9%
Maine	174	5,909	158.2%	22	822	13.9%
Michigan	363	37,149	107.3%	193	19,492	52.5%
Minnesota	332	16,620	115.0%	146	8,779	52.8%
Missouri	245	16,062	116.6%	95	7,149	44.5%
Mississippi	153	7,517	123.7%	53	2,651	35.3%
Montana	61	2,666	120.5%	27	1,140	42.8%
North Carolina	252	12,641	103.7%	127	6,310	49.9%
North Dakota	86	1,952	118.5%	24	582	29.8%
Nebraska	144	4,627	113.7%	53	1,580	34.1%
New Hampshire	114	4,655	131.8%	24	956	20.5%
New Jersey	264	31,177	106.7%	114	11,093	35.6%
New Mexico	41	2,412	111.6%	22	1,044	43.3%
Nevada	21	1,606	91.0%	14	1,173	73.0%
New York	655	54,913	108.9%	300	25,330	46.1%
Ohio	556	41,248	117.8%	225	18,448	44.7%
Oklahoma	92	5,089	136.2%	23	1,442	28.3%
Oregon	152	6,740	113.6%	66	3,109	46.1%
Pennsylvania	503	40,951	134.7%	145	11,788	28.8%
Puerto Rico	77	6,242	143.5%	14	1,441	23.1%
Rhode Island	128	12,022	130.8%	21	1,384	11.5%
South Carolina	107	6,983	118.0%	46	3,249	46.5%
South Dakota	109	2,876	127.5%	30	912	31.7%
Tennessee	231	17,594	114.9%	102	8,605	48.9%
Texas	285	19,966	105.7%	149	10,889	54.5%
Utah	48	2,511	101.3%	31	1,841	73.3%
Virginia	147	13,912	101.0%	83	7,642	54.9%
Virgin Islands	3	153	0.0%	3	153	100.0%
Vermont	84	2,458	145.1%	8	228	9.3%
Washington	248	11,814	94.3%	179	8,693	73.6%
Wisconsin	430	24,122	114.2%	185	11,137	46.2%
West Virginia	95	6,995	147.5%	16	710	10.2%
Wyoming	31	1,031	118.3%	13	395	38.3%
TOTAL	**10,077**	**711,829**		**4,409**	**324,001**	**45.5%**

Data compiled from several HUD sources and not independently verified.

National Housing Trust, 2002.

Elderly Properties with Project-based Section 8 (rents <=90% of FMR)

	RENTS <= 90% OF FMR		
State	Properties	Assisted Units	Percent of All Contracts
Alaska	9	167	33.3%
Alabama	27	1,539	17.0%
Arkansas	34	834	15.0%
Arizona	30	1,959	34.0%
California	324	27,274	49.6%
Colorado	57	4,256	41.0%
Connecticut	69	4,218	27.1%
District of Columbia	11	708	27.3%
Delaware	8	825	33.8%
Florida	101	9,343	36.6%
Georgia	60	5,603	41.5%
Guam	1	49	100.0%
Hawaii	12	505	21.6%
Iowa	32	1,595	17.5%
Idaho	11	318	12.7%
Illinois	64	5,324	16.8%
Indiana	31	1,391	8.9%
Kansas	22	945	13.1%
Kentucky	34	1,979	14.5%
Louisiana	22	1,539	17.0%
Massachusetts	144	11,412	30.3%
Maryland	43	3,191	22.0%
Maine	10	380	6.4%
Michigan	105	8,898	24.0%
Minnesota	78	4,460	26.8%
Missouri	54	3,587	22.3%
Mississippi	34	1,599	21.3%
Montana	6	229	8.6%
North Carolina	76	3,481	27.5%
North Dakota	17	335	17.2%
Nebraska	26	854	18.5%
New Hampshire	16	620	13.3%
New Jersey	79	6,120	19.6%
New Mexico	13	670	27.8%
Nevada	7	664	41.3%
New York	209	15,392	28.0%
Ohio	129	9,854	23.9%
Oklahoma	13	872	17.1%
Oregon	34	1,823	27.0%
Pennsylvania	85	6,793	16.6%
Puerto Rico	9	754	12.1%
Rhode Island	12	627	5.2%
South Carolina	14	960	13.7%
South Dakota	12	355	12.3%
Tennessee	60	4,313	24.5%
Texas	89	6,111	30.6%
Utah	17	850	33.9%
Virginia	46	3,230	23.2%
Virgin Islands	3	153	100.0%
Vermont	2	64	2.6%
Washington	93	4,444	37.6%
Wisconsin	71	3,024	12.5%
West Virginia	11	482	6.9%
Wyoming	7	236	22.9%
TOTAL	**2,583**	**177,208**	**24.9%**

Data compiled from several HUD sources and not independently verified.

Anytown Apartments

NHT / Enterprise Preservation Corporation

SCENARIO

Prepay a Sec. 202 mortgage, and refinance with 501(c)(3) bonds.

PROPERTY PROFILE

Number of Units:	180	Current Financing:	0	Asking Price:	-
Type:	0	Loan Balance:	5,699,411	Offer Price:	5,700,000
Section 8 Units:	0	Interest Rate - First Trust:	9.25%	NHT/E Valuation:	
Section 8 Expires:	1/0/2000	Reserve Balances:	-		

UNIT MIX AND RENTS

UNIT TYPE	CURRENT # OF UNITS	# OF UNITS PROPOSED	CURRENT RENTS	FMR RENTS	STREET RENTS	50% TAX CREDITS	60% TAX CREDITS	PRO-FORMA YEAR 1	PRO-FORMA YEAR 2	PRO-FORMA YEAR 3
Efficiency	60	60	0	0	675	0	0	675	689	703
1 Bedroom	120	120			765			765	780	796
Total Units	180	180								

DEVELOPMENT BUDGET

ITEM		TOTAL AMOUNT	PER UNIT
Uses of Funds			
Acquisition		5,700,000	31,667
Rehabilitation		554,400	3,080
Replacement Reserve Capitalization		77,400	430
Owner & TA Consultant Fees		100,000	556
Estimated Financing Costs		162,586	903
Other		980,580	5,448
Debt Service Reserve Funds		-	-
TOTAL USES OF FUNDS:		7,574,966	42,083
Sources of Funds			
1st Trust		6,327,600	35,153
2nd Trust		996,900	5,538
3rd Trust		-	-
Equity/Gap		-	-
Non-Loan Equity	Residual Receipts, Rep. Reserve Fund	250,466	1,391
Tax Credits		-	-
TOTAL SOURCES OF FUNDS:		7,574,966	42,083

KEY ASSUMPTIONS

FINANCING SOURCES & TERMS

Bridge Financing:	0		
Interest Rate	0.000%	Term (in years)	-
Permanent Financing Features		501(c)(3) Bonds	
		Senior/Subordinate Debt Structure	
1st Trust	Sr. Rated & Insured Bond		
2nd Trust	Jr. Rated, Uninsured Bond		
3rd Trust			
Equity/Gap			
Non-Loan Equity	Residual Receipts, Rep. Reserve Fund		
LIHTax Credit Rate:	NA	Price:	NA
Historic Rehab Rate:	NA	Price:	NA

	1st	2nd	3rd
Interest Rate	7.200%	9.000%	
Amort. Term in Years	30	10	
Loan to Value	86%	100%	
Debt Coverage Ratio	142%	110%	

OPERATING BUDGET

Stabilized Year: 1

ITEM		TOTAL AMOUNT	PER UNIT
Administrative Expenses		43,460	241
Management Fee		64,800	360
Utilities		152,460	847
Repairs & Maintenance		146,262	813
Payroll*		176,784	982
Real Estate Taxes		108,000	600
Insurance, Other Taxes & Miscellaneous		19,800	110
Total Operating Expenses:		711,566	3,953
Contribution to the Replacement Reserve		54,000	300
Financing Costs:		13,656	76
Total Expenses and Reserves:		779,222	4,329
Property Taxes Reduced:	0%		

CASH FLOW PROJECTION:

		Year 1	Year 2	Year 3
Rental Income		1,587,600	1,619,280	1,652,400
Interest Income including DSR Interest		-	-	-
Laundry Income		11,700	11,934	12,173
Other Income		3,240	3,305	3,371
Gross Income:		1,602,540	1,634,519	1,667,944
LESS: Vacancy	5.55%	(88,969)	(90,745)	(92,600)
LESS: Expenses		(725,222)	(746,569)	(768,556)
LESS: Reserve Contributions		(54,000)	(54,000)	(54,000)
Net Operating Income:		734,349	743,205	752,787
1st Trust Debt Service		(516,060)	(516,060)	(516,060)
Mortgage Insurance Premium		0	0	0
Second Trust Debt Service		(151,540)	(151,540)	(151,540)
Third Trust Debt Service		0	0	0
Return on Equity		0	0	0
Other Ongoing Financing Costs		0	0	0
Cash Flow to Borrower:		66,749	75,605	85,187
Per Unit Per Month:		31	35	39

Development Budget
Anytown Apartments

Prepay a Sec. 202 mortgage, and refinance with 501(c)(3) bonds.

ITEM	TOTAL AMOUNT	CALCULATIONS: UNIT PRICE	UNIT OF MEASURE	QUANTITY	NOTES
HARD COSTS:					
Acquisition - Land	$ 855,000	15%		5,700,000	
Acquisition - Building	$ 4,845,000	85%		5,700,000	
Rehabilitation-Hard Cost	$ 504,000	$ 504,000	Lump Sum	1	
Rehabilitation-Gen. Requirements	$ -	0.00%	% of	$ 504,000	
Rehabilitation-Profit	$ -	0.00%	% of	$ 504,000	
Rehabilitation-Contingency	$ 50,400	10.00%	% of	$ 504,000	
		Total Rehab:	$ 554,400	3,080	per unit
TOTAL HARD COST BUDGET:	$ 6,254,400				
SOFT COSTS:					
CLOSING					
Survey	$ 12,600	$840	building	15	
Title Search & Examination Fee	$ 4,000	$4,000	lump sum	1	
Title Policy	$ -	*included in title search & exam.*			
Recording Fees	$ 21,974	0.30%	of mortgages	$ 7,324,500	
Transfer Fees	$ -	*included in recording fees above.*			
ARCHITECTS & ENGINEERS					
Architect/Engineering Design & Project Supervision	$ 37,500	7.44%	Construction Budget	$ 504,000	
Environmental Assessment	$ 7,000	$7,000	Lump Sum	1	
Construction Lender Rehab Inspection Fee	$ -	$500	visit		
LEGAL					
Legal - Preparation of TPA	$ -	$20,000	Lump Sum		
Legal - Purchaser	$ 191,530	$191,530	Lump Sum	1	
Legal - Seller	$ -	*Costs borne by Seller*			
Legal - HUD	$ -	*Costs borne by HUD*			
LOAN RELATED COSTS					
TOTAL LOAN COSTS INCLUDING:	$ 162,586	2.22%	of mortgages	$ 7,324,500	
Underwriter's Fee					
Legal					
Appraisal					
Market Study					
Origination Fee					
Prepaid Mortgage Insurance	$ -	0.00%	of 1st trust	$ 6,327,600	
LOC enhance bonds during construction	$ -	0.00%	Bond Issue X Constr. Period	$ -	
DEVELOPMENT					
Builder's Risk Insurance	$ -	0.00%	Constr. Budg.	$ 554,400	5 basis points of Constr. Budg.
Owner Refinancing Fee	$ 100,000	1.37%	Dev'l Budg.	$ 7,301,774	Cash out to the owner
Technical Assistance Dev. Consultant	$ 77,000		Lump Sum	$ 1	Fee to Refinance consultant
Relocation/Misc.	$ -	0	Lump Sum	$ -	

Development Budget
Anytown Apartments

Prepay a Sec. 202 mortgage, and refinance with 501(c)(3) bonds.

ITEM	TOTAL AMOUNT	CALCULATIONS: UNIT PRICE	UNIT OF MEASURE	QUANTITY	NOTES
OTHER					
Prepaid Property/Hazard Insurance	$ 21,200				
Furniture, Fixtures & Equipment	$ 20,000				
Transition Reserve	$ 348,464			$59,297	
Marketing	$ -		Lump Sum		
Audit	$ -		Lump Sum		
Tax Credit Consultant	$ -		Lump Sum		
Tax Credit Fees	$ -		Lump Sum		
Miscellaneous/Contingency	$ 178,877	**29.00%**	other soft costs	$ 616,816	
Start-up Working Capital	$ 60,435	**1**	1 mth operate	$ 60,435	
Initial Deposit to Replacement Reserve	$ 77,400	**430**	unit	180	HUD requires 1,000/unit
Funded Operating Deficit *(Don't rename this line item)*	$ -	**0**	Vac Apt Months	$ -	

TOTAL SOFT COST BUDGET:	$ 1,320,566	**17.43%**	of total development budget	
		21.11%	of hard costs	
SUBTOTAL:	$ 7,574,966			
Debt Service Reserve Fund	$ -	**0**	months	$ -
		2.22%	**=Cost of Issuance on 1st Trust**	**$ 162,586**
TOTAL DEV. COST	$ 7,574,966	**2.0%**	**=Maximum Allowed on TE Bonds**	**$ 146,490**
			Amt. Included in Taxable Tail	**$ 16,096**

Total Rehab as % of dep. basis	9.82%
First trust as % of dep. Basis plus land	97.31%
Dev. Fees as % of TDC:	2.36%

		Actual		
Hard Costs		6,254,400		
Soft cost 1: All Except Dev. Fees Below		826,854	$ -	
Working cap thru end		137,835	0	
		7,219,089	0	
Contingency-% of soft cost 1		82,685	10.00%	
TDC Subtotal:		7,301,774		
Development Fees				
Development Oversight		100,000	1.37%	
Development Consultant		77,000		
Tax Credit Consultant		0		
Development Fee Subtotal:		177,000		
Contingency-% of Dev. Fees		17,700	10.00%	
TDC Total:		7,496,474		
Max. Development Fees:	**15%**	1,124,471	of TDC	

Anytown Apartments

NHT / Enterprise Preservation Corporation

SCENARIO

Prepay a Sec. 202 mortgage, and refinance using Private Activity Bonds and LIHTC.

PROPERTY PROFILE

Number of Units:	180	Current Financing:	0	Asking Price:	-
Type:	0	Loan Balance:	5,699,411	Offer Price:	5,700,000
Section 8 Units:	0	Interest Rate - First Trust:	9.25%	NHT/E Valuation:	
Section 8 Expires:	1/0/2000	Reserve Balances:	-		

UNIT MIX AND RENTS

UNIT TYPE	CURRENT # OF UNITS	# OF UNITS PROPOSED	CURRENT RENTS	FMR RENTS	STREET RENTS	50% TAX CREDITS	60% TAX CREDITS	PRO-FORMA YEAR 1	PRO-FORMA YEAR 2	PRO-FORMA YEAR 3
Efficiency	60	60	0	0	675	0	0	675	689	703
1 Bedroom	120	120			765			765	780	796
Total Units	180	180								

DEVELOPMENT BUDGET

ITEM		TOTAL AMOUNT	PER UNIT
Uses of Funds			
Acquisition		5,700,000	31,667
Rehabilitation		2,901,600	16,120
Replacement Reserve Capitalization		61,200	340
Developer Fee		700,000	3,889
Estimated Financing Costs		267,611	1,487
Other		1,182,666	6,570
Debt Service Reserve Funds		670,846	3,727
TOTAL USES OF FUNDS:		11,483,923	63,800
Sources of Funds			
1st Trust		7,734,000	42,967
2nd Trust		984,400	5,469
3rd Trust		-	-
Equity/Gap		-	-
Non-Loan Equity	Residual Receipts, Rep. Reserve Fund	249,987	1,389
Tax Credits		2,515,536	13,975
TOTAL SOURCES OF FUNDS:		11,483,923	63,800

KEY ASSUMPTIONS

FINANCING SOURCES & TERMS

Bridge Financing:	0		
Interest Rate	0.000%	Term (in years)	-
Permanent Financing Features		Private Activity Bonds	
		Senior/Subordinate Debt Structure	
1st Trust	Sr. Rated & Insured Bond		
2nd Trust	Jr. Rated, Uninsured Bond		
3rd Trust			
Equity/Gap			
Non-Loan Equity	Residual Receipts, Rep. Reserve Fund		
LIHTax Credit Rate:	3.66%	Price:	0.8000
Historic Rehab Rate:	NA	Price:	NA

	1st	2nd	3rd
Interest Rate	6.250%	9.000%	
Amort. Term in Years	35	10	
Loan to Value	91%	102%	
Debt Coverage Ratio	140%	110%	

OPERATING BUDGET

Stabilized Year: 1

ITEM	TOTAL AMOUNT	PER UNIT
Administrative Expenses	33,588	187
Management Fee	64,800	360
Utilities	144,837	805
Repairs & Maintenance	136,080	756
Payroll*	168,883	938
Real Estate Taxes	108,000	600
Insurance, Other Taxes & Miscellaneous	19,800	110
Total Operating Expenses:	675,988	3,755
Contribution to the Replacement Reserve	54,000	300
Financing Costs:	15,398	86
Total Expenses and Reserves:	745,386	4,141

Property Taxes Reduced: 0%

CASH FLOW PROJECTION:

		Year 1	Year 2	Year 3
Rental Income		1,587,600	1,619,280	1,652,400
Interest Income including DSR Interest		-	-	-
Laundry Income		11,700	11,934	12,173
Other Income		3,240	3,305	3,371
Gross Income:		1,602,540	1,634,519	1,667,944
LESS: Vacancy	5.55%	(88,969)	(90,745)	(92,600)
LESS: Expenses		(691,386)	(711,665)	(732,553)
LESS: Reserve Contributions		(54,000)	(54,000)	(54,000)
Net Operating Income:		768,185	778,109	788,790
1st Trust Debt Service		(548,706)	(548,706)	(548,706)
Mortgage Insurance Premium		0	0	0
Second Trust Debt Service		(149,640)	(149,640)	(149,640)
Third Trust Debt Service		0	0	0
Return on Equity		0	0	0
Other Ongoing Financing Costs		0	0	0
Cash Flow to Borrower:		69,839	79,764	90,445
Per Unit Per Month:		32	37	42

Development Budget
Anytown Apartments

Prepay a Sec. 202 mortgage, and refinance using Private Activity Bonds and LIHTC.

ITEM	TOTAL AMOUNT	CALCULATIONS: UNIT PRICE	UNIT OF MEASURE	QUANTITY	NOTES
HARD COSTS:					
Acquisition - Land	$ 855,000	15%		5,700,000	
Acquisition - Building	$ 4,845,000	85%		5,700,000	
Rehabilitation-Hard Cost	$ 2,340,000	$ 2,340,000	Lump Sum	1	
Rehabilitation-Gen. Requirements	$ 187,200	8.00%	% of	$ 2,340,000	
Rehabilitation-Profit	$ 140,400	6.00%	% of	$ 2,340,000	
Rehabilitation-Contingency	$ 234,000	10.00%	% of	$ 2,340,000	
		Total Rehab:	$ 2,901,600	16,120	per unit
TOTAL HARD COST BUDGET:	$ 8,601,600				
SOFT COSTS:					
CLOSING					
Survey	$ 12,600	$840	building	15	
Title Search & Examination Fee	$ 10,000	$10,000	lump sum	1	
Title Policy	$ -	*included in title search & exam.*			
Recording Fees	$ 26,155	0.30%	of mortgages	$ 8,718,400	
Transfer Fees	$ -	*included in recording fees above.*			
ARCHITECTS & ENGINEERS					
Architect/Engineering Design & Project Supervision	$ 37,500	1.60%	Construction Budget	$ 2,340,000	
Environmental Assessment	$ 8,000	$8,000	Lump Sum	1	
Construction Lender Rehab Inspection Fee	$ -	$500	visit		
LEGAL					
Legal - Preparation of TPA	$ -	$20,000	Lump Sum		
Legal - Purchaser	$ 213,487	$213,487	Lump Sum	1	
Legal - Seller	$ -	*Costs borne by Seller*			
Legal - HUD	$ -	*Costs borne by HUD*			
LOAN RELATED COSTS					
TOTAL LOAN COSTS INCLUDING:	$ 267,611	3.07%	of mortgages	$ 8,718,400	
Underwriter's Fee					
Legal					
Appraisal					
Market Study					
Origination Fee					
Prepaid Mortgage Insurance	$ -	0.00%	of 1st trust	$ 7,734,000	
LOC enhance bonds during constructio	$ -	0.00%	Bond Issue X Constr. Period	$ -	
DEVELOPMENT					
Owner Refinancing Fee	$ 100,000	0.00%		$ 2,901,600	Cash out to the owner
Dev. Fee	$ 700,000	7.05%	Dev'l Budg.	$ 9,924,384	
Technical Assistance Dev. Consultant	$ 77,000		Lump Sum	$ 1	Fee to the Refinance consultant
Relocation/Misc.	$ 2,000	2000	Lump Sum	$ -	

Development Budget
Anytown Apartments

Prepay a Sec. 202 mortgage, and refinance using Private Activity Bonds and LIHTC.

ITEM	TOTAL AMOUNT	CALCULATIONS: UNIT PRICE	UNIT OF MEASURE	QUANTITY	NOTES
OTHER					
Prepaid Property/Hazard Insurance	$ 21,200				
Furniture, Fixtures & Equipment	$ 20,000				
Transition Reserve	$ 348,464			$56,332	
Marketing	$ 27,500	27500	Lump Sum		
Audit	$ -		Lump Sum		
Tax Credit Consultant	$ -		Lump Sum		
Tax Credit Fees	$ -	17,750.00	Lump Sum		
Miscellaneous/Contingency	$ 221,145	15.00%	other soft costs	$ 1,474,298	
Start-up Working Capital	$ 57,615	1	1 mth operate	$ 57,615	
Initial Deposit to Replacement Reserve	$ 61,200	340	unit	180	HUD requires 1,000/unit
Funded Operating Deficit *(Don't rename this line item)*	$ -	0	Vac Apt Months	$ -	

TOTAL SOFT COST BUDGET:	$ 2,211,477	**19.26%** of total development budget			
		25.71% of hard costs			
SUBTOTAL:	$ 10,813,077				
Capitalized Interest Reserve	$ 670,846	0	months	$ -	
		3.07%	**=Cost of Issuance on 1st Trust**	**$**	**267,611**
TOTAL DEV. COST	$ 11,483,923	**2.0%**	**=Maximum Allowed on TE Bonds**	**$**	**174,368**
			Amt. Included in Taxable Tail	**$**	**93,243**

Total Rehab as % of dep. basis	33.77%
First trust as % of dep. Basis plus land	81.87%
Dev. Fees as % of TDC:	7.21%

		Actual		
Hard Costs		8,601,600		
Soft cost 1: All Except Dev. Fees Below		1,094,517	$ -	
Working cap thru end		118,815	0	
		9,814,932	0	
Contingency-% of soft cost 1		109,452	10.00%	
TDC Subtotal:		9,924,384		
Development Fees				
Development Oversight		700,000	7.05%	
Development Consultant		77,000		
Tax Credit Consultant		0		
Development Fee Subtotal:		777,000		
Contingency-% of Dev. Fees		77,700	10.00%	
TDC Total:		10,779,084		
Max. Development Fees:	**15%**	1,616,863	of TDC	

Elderly Properties with HUD-Insured Mortgages (Interest Rates of 9% or Above)

State	Properties	Section 8 Units	Total Units
Alabama	40	2,434	2,441
Arizona	31	1,563	1,574
Arkansas	47	1,410	1,428
California	156	11,889	12,355
Colorado	50	2,588	2,592
Connecticut	34	2,340	2,627
Delaware	5	482	487
District of Columbia	6	737	741
Florida	66	5,835	5,872
Georgia	33	2,479	2,485
Hawaii	4	110	113
Idaho	6	293	296
Illinois	58	4,475	4,643
Indiana	43	2,349	2,355
Iowa	28	1,452	1,459
Kansas	18	713	723
Kentucky	61	3,416	3,429
Louisiana	30	2,470	2,483
Maine	27	769	774
Maryland	25	2,116	2,124
Massachusetts	55	4,283	5,347
Michigan	70	5,489	5,679
Minnesota	41	1,796	1,798
Mississippi	46	2,181	2,189
Missouri	55	3,413	3,507
Montana	5	283	322
Nebraska	14	586	587
Nevada	8	464	482
New Hampshire	9	297	299
New Jersey	40	4,201	4,573
New Mexico	7	366	367
New York	170	13,357	13,519
North Carolina	85	3,456	3,466
North Dakota	2	63	63
Ohio	129	7,660	7,735
Oklahoma	35	1,524	1,535
Oregon	17	774	783
Pennsylvania	107	7,174	7,239
Puerto Rico	36	2,608	2,610
Rhode Island	10	852	855
South Carolina	28	1,707	1,715
South Dakota	1	0	31
Tennessee	53	3,001	3,041
Texas	86	5,167	5,196
Utah	13	492	493
Vermont	7	167	169
Virgin Islands	1	56	56
Virginia	33	2,852	2,879
Washington	39	1,671	1,696
West Virginia	20	1,400	1,420
Wisconsin	60	2,823	2,861
Wyoming	6	230	230
TOTAL	**2,056**	**130,313**	**133,743**

Data compiled from several HUD sources and not independently verified.

National Housing Trust, 2002.

Appendix G-4

"INTERGENERATIONAL LEARNING AND CARE CENTERS"

A REPORT FROM GENERATIONS UNITED TO

THE COMMISSION ON AFFORDABLE HOUSING AND HEALTH FACILITY NEEDS FOR SENIORS IN THE 21ST CENTURY

MANDATE

Examine how to establish intergenerational learning and care centers and living arrangements, in particular to facilitate appropriate environments for families consisting only of children and a grandparent or grandparents who are the head of the household.

OVERVIEW

Definition and Background

Intergenerational learning and care centers and living arrangements are environments where "multiple generations receive ongoing services and/or programming at the same site, and generally interact through planned and/or informal intergenerational activities."[1] These environments are commonly referred to as intergenerational shared sites and include programs like a continuing care retirement community with on-site child care; co-located adult day services and early childhood programs; and housing for grandparents raising grandchildren.

Intergenerational shared sites provide new environments where children, youth, and older adults share space, interact, and learn and grow together. They provide opportunities for organizations serving children and those serving older adults to work together to enhance services and expand and fully use resources.

Intergenerational shared-site programs have emerged and grown progressively over the past 15 years. A wide variety of creative models have incepted at the grassroots level according to the resources and needs in each community. These cutting-edge programs are opening in urban, suburban, and rural settings. A 1995 AARP study found more than 400 organizations across the country that were currently operating or planning to open an intergenerational shared site.[2] These programs vary in style and scope but all provide ongoing services to multiple generations. Many of these programs are models in their state or locality, but are isolated from others doing similar work.

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[1] Goyer, A. and R. Zuses (1998). *Intergenerational Shared-Site Project, A Study of Co-located Programs and Services for children, youth, and Older Adults: Final Report.* Washington, DC: AARP. p.V.

[2] *Ibid.*

One of the types of shared sites concerns housing for grandparents raising grandchildren. Before addressing the housing needs of these families, some brief background information about them will be explored.

Large Number of Children Being Raised By Relatives

More than 2 million grandparents are raising 4.5 million children, and other relatives are raising an additional 1.5 million children whose parents are unable or unwilling to do so.[3] The number of grandparents and other relatives raising children has increased recently, including a 53 percent increase from 1990 to 1998 in the number of "skipped generation" households in which neither parent is present.[4] Of the 6 million children currently being raised by grandparents and other relatives, 145,150 of them are in the formal foster care system.[5] The 145,150 children make up more than a fourth of the entire foster care population of 588,000 children.[6] Grandparents and other relatives caring for the millions of children outside of the system often do not have access to services, including affordable housing, which are essential to their care of the children. If less than 20 percent of the children living in grandparent-maintained homes outside of the foster care system, or about 1 million children, were to enter the system, it would cost taxpayers an estimated $4.5 billion a year and completely overwhelm it.[7] Improving relative caregivers' access to services, such as affordable housing, is one important way to ensure that these relative caregivers are appropriately supported and do not need to look to the foster care system as the only viable alternative.

Several Factors Causing Increase and Diversity of Families

Factors causing the increase in the number of grandparents and other relatives raising children include parental drug and alcohol abuse, incarceration, death, teenage pregnancy, poverty, mental illness and HIV/AIDS. Because these factors are present throughout society, anyone can find him or herself raising related children. U.S. Census Bureau statistics prove the geographic and ethnic diversity of these families. Many grandparent families live in the South and in non-metropolitan areas.[8] Fifty-one percent of the grandparents raising grandchildren are married couples.[9] 44 percent of

[3] U.S. Bureau of the Census, Census 2000, Summary File 1, Detailed Table P28.
[4] Fuller-Thomson, E., Minkler, M. & Driver, D. (1997) "A Profile of Grandparents Raising Grandchildren in the United States." *The Gerontologist* 37: 406-11.
[5] U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children, Youth and Families. *The AFCARS Report: Current Estimates as of April 2001*. Washington, D.C.: Author.
[6] *Ibid.*
[7] This number was calculated by Generations United based on a $373 monthly payment, which was the 1996 national average for basic maintenance payments to foster parents for a nine-year old.
[8] Bryson, K. & Casper, L. (1999). *Coresident grandparents and grandchildren: Grandparent maintained families.* Population Division Working Paper No. 26. Washington, D.C.: U.S. Census Bureau.
[9] *Ibid.*

the grandchildren are white, 35 percent are black, and 18 percent are Hispanic.[10] 65 percent of the grandparents are between ages 45-64, whereas 21 percent are over age 65, and 15 percent are under 45.[11]

The statistics concerning these diverse families also show that they need help. More than one out of ten grandparent caregivers live in poverty.[12] One in three children in homes maintained by their grandparents has no health insurance, whereas one in five in parent-maintained homes lacks health insurance.[13]

Many Caregivers are "Informal"

Many of these caregivers are raising children informally, meaning outside of the formal foster care system and without a legal relationship, like legal custody. They may not want to sue their adult children or other relatives, the parents, for a legal relationship. To do so, the relative caregivers must prove that the parents are unfit, which often tears families apart, rather than keeping them together. In order to adopt, parental rights and responsibilities must be severed and the relative becomes the parent in the eyes of the law. Even if a relative chooses to seek a legal relationship, the financial cost of hiring an attorney and pursuing these options can be prohibitive. Another possible option is to become part of the formal foster care system. If the child is in the system, the state has legal custody while the grandparent or other relative is responsible for the day-to-day care. The concern with this option for some caregivers is that the state may remove and place the child elsewhere at any time. Although some of these "formal" options are not attractive to caregivers, access to services can be severely limited for "informal" caregivers.

Need for Intergenerational Learning and Care Centers and Living Arrangements and Appropriate Environments for Grandparents Raising Children

Older adults are living longer, increasing in number, and are generally healthier than ever before. With changing patterns of retirement, many older adults find themselves spending a longer period of time in retirement and want new options for living environments. Eighty-three percent of older adults report that volunteering and community service play or will play a role in their plans for retirement.[14] Intergenerational shared sites provide opportunities, for even the frailest older people, to continue to learn and become involved and connected with others. Older adults in

[10] *U.S. Bureau of the Census, Current Population Reports (P20-514), Marital status and living arrangements: March 1998 (Update).* Washington, D.C.: Author.

[11] Bryson, K. & Casper, L. (1999). *Coresident grandparents and grandchildren: Grandparent maintained families.* Population Division Working Paper No. 26. Washington, D.C.: U.S. Census Bureau.

[12] *Ibid.*

[13] *Ibid.*

[14] Hart, P (1999, September). *The New Face of Retirement: Older Americans, Civic Engagement, and the Longevity Revolution.* San Francisco: Civic Ventures.

intergenerational shared-site settings are less likely to feel isolated, but instead feel more valued and invested in their communities and hopeful for the future.

As the size of the older population is projected to grow rapidly over the next 30 years, increased demand for resources and services will require creative solutions. Intergenerational shared-site programs expand the use of resources in the communities by tapping into existing resources and sharing space with other vital community services. For example, to address issues of staffing shortages in long-term care settings, some facilities have begun offering on-site childcare, HeadStart and/or before- and after-school programs in the same building or campus as the older adult care facility. In addition to offering an employee benefit, these programs can experience cost-savings by sharing resources such as transportation, copy machines, and cleaning services. At the same time, they connect with other groups in the community and develop a wider base of support for the program.

Housing Challenges Faced by Families

Many grandparent-headed families need help with affordable housing. Drs. Esme Fuller-Thomson and Meredith Minkler received clearance from the U.S. Census Bureau to analyze the Census 2000 Supplementary Survey data. Their study shows that of the more than 2 million grandparent caregivers in the United States, over 26 percent were renters. Almost a third of these renters spent 30 percent or more of their income on rent, and for over 17 percent, at least half of their income was spent on rent. The Doctors further examined gross rent, which included estimated costs of utilities and fuel paid by renters. 48 percent of grandparent renters spent 30 percent or more of their household income on gross rent and a quarter spent 50 percent or more.[15]

For grandparent caregivers below the poverty line, the numbers were worse. 237,516 grandparent caregivers lived below the poverty line, which was $17,603/year for a family of four. Of these, over 40 percent spent at least half of their household income on rent. In gross rent, 83.5 percent spent more than 30 percent of their household income and 57.2 percent spent at least half.[16]

Sixty percent of grandparent caregiver renters who were living below the poverty line were not receiving any housing subsidy from the federal government.[17] This significant percentage is likely due to a number of factors. One is the misperception among U.S. Department of Housing and Urban Development (HUD) employees that grandparents must have legal custody in order to be eligible for housing subsidies.[18] Although the Fair Housing Act does not allow discrimination on the basis of familial

[15] Fuller-Thomson, E. & Minkler, M. (2002). *Housing issues and realities facing grandparent caregivers who are renters.* Unpublished paper.
[16] *Ibid.*
[17] *Ibid.*
[18] Sand, P. (2001). *Generations united under one roof: A briefing paper on housing barriers for grandparents raising grandchildren.* Unpublished paper.

status, local housing workers are often misinformed about the legal requirements and in turn disseminate incorrect information to the public.[19] Furthermore, according to focus groups conducted by the Urban Institute, grandparent caregivers often avoid approaching public agencies for the appearance of a "handout." They may fear that if they approach an agency, it might place their grandchildren in unrelated foster care. Many also do not know that they are eligible for public programs and are confused by their eligibility requirements.[20]

Overcrowded housing conditions are another problem faced by grandparent caregivers. According to both the Census definition of overcrowding (more than one person per room) or the HUD definition (more than two persons per bedroom), more than a quarter of grandparent caregivers are living in overcrowded quarters.[21] Obvious reasons explain why overcrowding can occur in grandparent households. Grandparents, having planned for retirement, may live in residences that are too small to accommodate the children. Grandparents may violate their private lease agreements due to the presence of additional people or they may be living in senior housing where children are disallowed. The receipt of housing subsidies improves the overcrowding these families face. According to Drs. Fuller-Thomson and Minkler, of those grandparents that receive housing subsidies, only 19.8 percent lived in overcrowded quarters (Census definition) in contrast to 36.9 percent of those without subsidies.[22]

There is only one housing project in the country specifically designed for grandparent-headed families: GrandFamilies House in Dorchester, Massachusetts. It will be discussed later in this Report. GrandFamilies has addressed a need in its community and ten jurisdictions around the country are planning to or are in the process of replicating it: Baltimore, Maryland; Buffalo, New York; Chicago, Illinois; Cleveland, Ohio; Detroit, Michigan; Minneapolis, Minnesota; Nashville, Tennessee; New Haven, Connecticut; New York City; and Philadelphia, Pennsylvania. Grandparent caregivers, however, are in need of affordable housing throughout the country and a federal response is warranted.

Benefits

Intergenerational shared sites have been shown to benefit older adult participants in a variety of ways. Participants' experience: improved physical and mental health; enhanced socialization through regular opportunities to have contact with children and other participants; improved sense of self-worth; increased personal independence;

[19] *Ibid.*
[20] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2001) *On their own terms: supporting kinship care outside of TANF and foster care.*
[21] Fuller-Thomson, E. & Minkler, M. (2002*). Housing issues and realities facing grandparent caregivers who are renters.* Unpublished paper.
[22] *Ibid.*

lowered levels of agitation for participants with dementia; improved attitudes about other generations;[23] and delayed entrance into nursing homes.[24]

Furthermore, intergenerational experiences in shared-site settings also benefit children. They have been associated with enhanced social skills, lower levels of aggressive behavior, decreased drug use,[25] increased stability,[26] and improved academic performance.[27]

Intergenerational shared-site programs have been shown to benefit the organization and the community. A 1995 DHHS study of co-located intergenerational activities revealed reports from intergenerational officials stating that "co-located programs encourage efficiency [and] better utilization of space . . . savings resulting from combining facilities and programs could be used to increase the level and quality of services."[28] The study showed that sharing facilities resulted in decreases in total expenditures for equipment, administrative costs and overhead. In addition to these benefits, programs have experienced increased productivity; increased employee job satisfaction; improved community views of the program since a wider range of community needs are met; improved public relations and marketing opportunities; and increased community involvement in the program as volunteers are attracted to the intergenerational approach.[29]

Barriers to Development and Expansion

Regulatory Conflicts

- ***Federal***

Like other programs that serve younger and older people, intergenerational shared-site programs and facilities must abide by regulations at the federal, state and local levels. The 1995 DHHS study of co-located intergenerational activities revealed that regulations by the Administration on Aging (AoA) and the Administration on Children and Families (ACF) sometimes conflict. The study revealed differences in fire safety codes, immunization requirements, facility sanitation standards, nutritional requirements, and licensing standards regarding staff/participant ratios and staff

[23] Goyer A. (2001). Intergenerational Shared Sites and Resource Programs: Current Models. Washington, DC: Generations United

[24] Department of Health and Human Services. *Co-located intergenerational activities in Department of Health and Human Services' Programs.* Washington, DC: Office of the Inspector General, ADF-IM-92-

[25] Public/Private Ventures (2000*). Making a Difference: An Impact Study of Big Brothers Big Sisters.* New York: Public/Private Ventures.

[26] Larkin, E. (1999). *The Intergenerational Response to Childcare and Afterschool Care.* San Francisco: Journal of the American Society on Aging, 4, 33-36

[27] Strom, R and Strom, S. (1999). *Establishing School Volunteer Programs. In Intergenerational Programs: Understanding What We Have Created.* Binghamton: Haworth Press.

[28] *Ibid.*, p. ii

[29] Goyer A. (2001). Intergenerational Shared Sites and Resource Programs: Current Models. Washington, DC: Generations United

certifications. Individuals interviewed in this study suggested, "coordinated policy guidance and standards to resolve potential regulatory conflict would be useful in implementing intergenerational centers."[30]

There is a precedent for collaborative efforts between AoA and ACF, including work on several intergenerational demonstrations. Early indications of the success and cost-effectiveness of these programs led AoA and ACF to enter into an interagency agreement to continue to explore the long-term benefits of intergenerational activities. In 1990 ACF and AoA funded intergenerational demonstration projects in 10 communities to provide intergenerational volunteer opportunities and bring together older adults and Head Start children.[31] AoA also awarded a 1-year grant to Generations United to develop a book and data-base of intergenerational child care programs.

While these demonstrations, book, and data-bases have led the way for many similar programs, multiple policy barriers continue to limit other groups interested in developing new programs, especially those seeking cutting edge, innovative models to complement the growing and changing environments for seniors in the 21st century.

- ***State and Local***

Many of the regulatory barriers also come at the state and local level. In order to operate an intergenerational share site, programs or facilities must receive all state-required licenses for the children and senior components of their services. Licensure requirements vary considerably by state. All states, for example, require the licensure of childcare facilities, but manage it in different ways. On the other hand, only 22 states require licensure for adult day care, and regulations vary considerably for those that do require a license.[32] The variation of requirements makes it difficult for a group interested in developing a shared site in one state to take guidance from a model program in another state. Furthermore, interpretations of the same regulations may even vary by locality within the same state.

While geographical and population variations may direct the need for some differences in state requirements, the issuance of coordinated policy guidance and standards from a federal level could help resolve potential regulatory conflicts. Furthermore, additional federal efforts to support the compilation of a nationwide, accessible database of programs could help connect programs operating under similar regulatory requirements and would increase and improve replication efforts.

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[30] Department of Health and Human Services. *Co-located intergenerational activities in Department of Health and Human Services' Programs.* Washington, DC: Office of the Inspector General, ADF-IM-92-12. p. 15.

[31] *Ibid.*

[32] Peterson, J. and Butts, D. (2001). *Intergenerational Shared Sites and Shared Resources: Public Policy Barriers and Opportunities.* Washington, DC: Generations United.

Lack of Training and Awareness

One of the largest barriers to increasing the numbers of intergenerational shared-site programs appears to be people's lack of knowledge about the models and benefits. Another is the ability to connect the methodology to furthering their own agency's local mission. National leaders can do a tremendous service by reviewing their own mission, vision, value statements and directives to ensure that intergenerational terminology is clearly articulated thereby encouraging local affiliates to do the same.

Recently the Administration on Aging added the promotion of intergenerational programming to its organizational goals. The next step will be to encourage intergenerational shared sites through AoA's guidance to the states. While creative, quality intergenerational programs exist around the country, they are more widely replicated only when they are held up as models within the larger systems in which they operate. Many organizations may have interest in developing an intergenerational shared-site program, but do not know how to access information about program development. Federal decision makers can promote these programs by championing intergenerational shared-site programs and supporting efforts to improve and maintain an accessible database of promising practice models and a directory of existing programs.

For grandparents and other older relatives who are raising children and living in or seeking government-assisted housing, there may be multiple barriers. While there is no federal law that requires grandparents or other relatives to have legal custody of the children they care for in order to qualify for assisted housing, many local housing authorities impose this restriction due to insufficient or inaccurate knowledge. For those who do qualify, there is often a lack of affordable units with three or more bedrooms to adequately accommodate families.[33]

Liability Issues

Currently available data provide mixed information on liability issues for intergenerational shared sites. While the 1995 DHHS report cited insurance costs as one of the ways shared facilities save in overhead costs,[34] other reports from intergenerational shared-site programs named the cost of insurance coverage as a barrier.[35]

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[33] Sand, P. (2001). *Generations united under one roof: A briefing paper on housing barriers for grandparents raising grandchildren.* Unpublished paper.

[34] Department of Health and Human Services. *Co-located intergenerational activities in Department of Health and Human Services' Programs.* Washington, DC: Office of the Inspector General, ADF-IM-92-12.

[35] Peterson, J. and Butts, D. (2001*). Intergenerational Shared Sites and Shared Resources: Public Policy Barriers and Opportunities.* Washington, DC: Generations United.

Like all service facilities and programs, intergenerational shared-site programs provide services that hold them liable for a wide range of issues. Since the cost of liability insurance is often linked to age-specific risk determiners, programs serving both the young and old are usually subject to especially high rates. The high cost of coverage may leave some programs to operate assuming substantial risks. Other children or older adult programs interested in starting a shared site are inhibited by the overwhelming additional cost for liability insurance. Still other programs may be prepared to take on the additional insurance costs, but find that sufficient liability coverage is not available.

Zoning and the Physical Environment

According to the 1995 DHHS report, many officials of intergenerational shared sites identified the lack of flexibility in "build versus lease" options for facility space as a hindrance to implementing intergenerational shared-site facilities. Many areas lack existing buildings that are adequate for the relocation of Head Start programs or senior centers. In some cases, the cost of renovating an inadequate existing facility to accommodate both children and older adults would be more expensive than purchasing or constructing a new facility. Officials recommended that "more flexibility in Head Start and senior center regulations would help eliminate the lack of adequate facilities."[36]

Zoning regulations vary considerably among localities, but many public regulations could restrict the development and operation of intergenerational shared-site programs. Due to the broad variation in local regulations, successful models are needed in a variety of settings in order to promote replication. For example, public zoning regulations that restrict commercial facilities in residential areas may limit plans for a childcare center on the site of a naturally occurring retirement community. Some areas may have zoning regulations that restrict congregate housing. This may limit opportunities to build a continuing care retirement community in an area where there are more likely to be families with children and a need for local children's programs.

Lack of Research and Empirical Data

In addition to the need for research about zoning and liability issues for intergenerational shared sites, further empirical research on these programs is needed to identify best practices and to be used as a basis for program standards. A comprehensive search of intergenerational program literature reveals less than one dozen research studies of intergenerational shared-site programs.

With the exception of the paper by Fuller-Thomson and Minkler there is no current, available research specifically on housing for grandparents and other relatives raising children. The Fuller-Thomson and Minkler paper provides information based on

[36] Department of Health and Human Services. *Co-located intergenerational activities in Department of Health and Human Services' Programs.* Washington, DC: Office of the Inspector General, ADF-IM-92-12, p. 16.

extrapolated data from the Census 2000 Supplementary Survey, but is limited in its scope because the data was not specifically gathered to investigate the housing needs of these caregivers. For example, there is currently no available data on the quality of housing units currently occupied by this population or the number of these families that qualify, but are not receiving housing subsidies, due to lack of availability.

Funding

Intergenerational shared sites and resources have the potential to open the door for expanded funding options. Not only have these programs demonstrated cost-containment and savings while maintaining steady or increasing productivity, they can also be funded creatively by co-mingling funds and drawing from multiple streams such as traditional children, youth and senior sources. This can limit the drain on some already overburdened funding sources.

While there may be enhanced funding opportunities, there are also barriers that need to be addressed. There is no central source of funding information for intergenerational shared-site programs and there is a lack of explicit intergenerational language in Requests for Proposals and funding guidelines. This can limit grant-seekers who may not be familiar with this approach or overburdened providers who might not have time to think outside of the box.

Categorical funding addresses the clear need to assure resources to address specific needs of populations; however, programs that are funded to serve a specific age group can limit creativity and the further development of intergenerational shared sites.

Despite the breadth of federal funding opportunities, there are few dollars available for demonstration programs. Furthermore, no federal funds are currently available to document and disseminate promising practices. Interviews with facility officials in older adult and children's programs revealed wide interest in participating in demonstration projects.[37]

Model Programs and Responses

Despite the multiple barriers to the development of intergenerational shared-site programs, many persistent pioneers have overcome these obstacles and are currently operating innovative model intergenerational shared-site programs. The following are three examples of the many successful model intergenerational shared-site programs around the country.

> Hope Meadows is the first "planned neighborhood" of Generations of Hope, a non-profit, licensed foster care and adoption agency headquartered in Rantoul,

[37] Department of Health and Human Services. *Co-located intergenerational activities in Department of Health and Human Services' Programs.* Washington, DC: Office of the Inspector General, ADF-IM-92-12.

Illinois. Living side by side on a decommissioned military base, lower income senior residents live in reduced-rent housing in exchange for providing a minimum of eight hours of support to children and their foster parents living in the community each week. Most contribute far more. The senior residents interact with the children in a variety of ways, like through mentoring and tutoring relationships or acting as crossing guards or day care aids. The housing community provides a safe and loving environment where children who have been shuttled through the foster-care system live and interact with senior citizens. Ninety-eight percent of seniors at Hope Meadows reported improvement or no change in health status during their time at Hope, while the adoption/permanency rate is more than 3 times the average for the state.[38]

The Chicago Housing Authority Intergenerational Computer Learning Center is a collaborative project between residents of Chicago Housing Authority's (CHA) Senior Housing and Chicago Public Schools. When residents of CHA's Senior housing came together to create a computer-learning center to meet the needs of the surrounding community, they elected to share their resource with local school children. Participants found that the technological expertise of the children surpassed the skills of the seniors, while the children lacked perspective on how to use the information and craved attention, which the adults were able to provide. Now, older and younger participants mutually benefit from one another's perspective, skills and expertise, while sharing a valuable resource.

GrandFamilies House is the nation's first specially designed housing program for grandparents raising grandchildren. GrandFamilies is located in Dorchester, Massachusetts, and was developed by two local non-profit organizations, Boston Aging Concerns Young & Old United, Inc. (BAC-YOU) and the Women's Institute for Housing and Economic Development. These non-profits used a mix of local, state and national public and private financing. They obtained federal "HOME" housing program funds, in addition to 50 section 8 vouchers from the Boston Housing Authority and another 50 from the Massachusetts Department of Housing and Community Development. The Section 8 vouchers were targeted to families with heads of households 62 years old or older. Households headed by the near elderly were given second priority.

GrandFamilies House consists of 26 two-, three-, and four-bedroom apartments. Each apartment has specially designed safety features for both the grandchildren and grandparents. The House, which is managed by BAC-YOU,

[38] Generations of Hope. *Hope for the Future: A Campaign to Support a Successful Alternative to Traditional Foster Care by Creating Nurturing Intergenerational Communities for Every Child.* Rantoul: Generations of Hope.

also has extensive communal program space and services on-site. It provides an on-site resident services coordinator, a live-in house manager, educational services, and assistance with accessing outside services. In addition, YWCA-Boston offers its on-site program called Generations Learning Together.

RECOMMENDATIONS

Collaboration Among Agencies and Organizations to Address Regulatory Conflicts

As discussed earlier, regulations by the Administration on Aging and the Administration on Children and Families sometimes conflict in areas such as fire safety codes, immunizations requirements, facility sanitation standards, and licensing standards. Coordinated policy guidance and standards could resolve potential regulatory conflicts to remove barriers for the development of intergenerational learning and care centers. An interagency summit between key federal and non-governmental organizations could be conducted. It would provide an opportunity to develop coordinated policy guidance and discuss other ways to overcome policy barriers related to intergenerational learning and care centers. The summit could further discuss the benefits and contributions of shared sites and ways to develop and promote them.

Education and Training

While there is nationwide interest in developing intergenerational learning and care centers, many groups are unaware of model programs around the country. Creating a comprehensive national database of information on intergenerational facilities and programs would help provide useful information to help promote more intergenerational programs across the country.

Federal agency web sites could provide information about the benefits of intergenerational programming and include intergenerational as a key search word on their sites. In addition, these agencies could provide guidance to states and grant-seekers that encourages the use of existing opportunities in current legislation for intergenerational programs.

Many regional and federal workers may not be promoting intergenerational learning and care centers because they are not familiar with the benefits of intergenerational programs. Including information about program options and benefits could help encourage their development.

There are two significant education and training programs that could be used to raise awareness about grandparents and other relatives raising children and assist them in obtaining existing affordable housing opportunities. One would be to conduct

education and training of housing workers through the Fair Housing Initiatives Program (FHIP). Additional FHIP funds could be appropriated to conduct education concerning these families or existing FHIP training could be expanded to include this component.

FHIP is designed to promote fair housing laws and equal housing opportunity awareness. The FHIP Education and Outreach Initiative funds nonprofit organizations to educate the general public and key housing market actors about what equal opportunity in housing means and what is required in the sale, rental and financing of housing. FHIP activities can be national, regional, local or community-based, making them well suited to the type of educational activities that need to occur at so many different levels.

A training component through HUD would also be of great benefit to assist grandparent caregivers. HUD has funding for training relating to public and assisted-housing issues. Congress could require HUD to issue a directive that its own personnel, who work in a wide variety of program areas, receive training on the special circumstances that may impact grandparents raising grandchildren in subsidized housing.

Research and Empirical Data

Initial research indicates potential barriers to the development of intergenerational learning and care centers and living arrangements based on regulatory conflicts, zoning issues and liability issues. Additional research is needed to determine the nature of the barriers and the degree to which current programs are encountering them.

There is also a dearth of research evaluating current model programs. Evaluative research should be conducted, encouraged and supported. Further research should assess the quality of current modes; develop intergenerational shared-site “best practices;” and quantify and qualify the reduction of costs and increases in levels of productivity. The long-term effects of the programs on participants should be studied in the following areas: physical and mental health; delay of nursing home placement for older adults; attitudes and learning opportunities for all ages; and educational benefits.

A national study that builds on the data analyzed by Drs. Minkler and Fuller-Thomson is needed. It is recommended that HUD work with Census sampling to do a national study of housing needs of grandparents raising grandchildren. Possible responses to this need may also be examined. For example, HUD could examine whether the Section 202 program regulations should be changed to allow for some units larger than two bedrooms, which would accommodate grandparent-headed households.

Public Policies and Funding Opportunities for Intergenerational Learning and Care Centers and Living Arrangements

Policy makers can include explicit intergenerational language in public policies to promote the intentional development of intergenerational learning and care centers. For example, 21st Century Community Learning Centers provide opportunities that benefit the educational, health, social services, cultural, and recreational needs of all ages in the community. Including intergenerational programs as one of the allowable activities would encourage grant-seekers to pursue intergenerational learning and care-center arrangements. Demonstration programs and conducting joint ventures among federal agencies can also provide opportunities for creative intergenerational programs in a variety of ways. In addition, AoA can encourage intergenerational shared sites by including these programs in their guidance to states.

National demonstration programs based on GrandFamilies House are recommended. GrandFamilies House was completed with a mix of local, state and national public and private funds and, because of its funding, it is a unique project that others cannot replicate exactly. National demonstration projects could establish a blueprint that others could follow with greater ease. Demonstration projects are recommended using both the Section 202 and Section 8 programs. For Section 202, a small separate building could be attached to an existing or new development. This building would include units for families, giving preference to grandparent-headed families. The creation of a "grandfamily annex" would allow the grandparents to access the senior services they may need at the same time that it creates a family-friendly environment for the children. Outdoor play space could be created away from the senior-only units. This set-up might make it more attractive for grandchildren of residents in the senior-only portion to visit their grandparents, in addition to creating a supportive environment for grandparent-headed families. A national Section 8 demonstration program could also test the feasibility of replicating GrandFamilies House on a larger scale. These demonstration programs should also include social service components to facilitate access to other services that may be needed by the families.

Finally, an expansion of existing definitions for housing programs to include grandparent- and relative-headed households is needed. Both the Section 8 Family Unification Program (FUP) and ECHO Housing Program could be used to reach this population. For FUP, grandparents raising grandchildren should be treated as families, not “interim families.” A more inclusion definition would encompass those grandparent-headed households at risk of losing custody of their grandchildren because of their housing situation. By allowing grandparents to use these vouchers, the program would continue to meet its goal of preventing children from entering foster care due to the housing conditions of a family member.

An adaptation of the HOME program's Elder Cottage Housing Opportunity (ECHO) program represents another existing program that could be used to provide affordable housing opportunities to grandparent caregivers. A modification of the ECHO program would allow grandparents in single-family homes to stay in homes that would

otherwise be too small due to the arrival of their grandchildren. The proposed national study could include as one of its components an examination of how many grandparent caregivers throughout the U.S. would be interested in this type of housing. It is suspected that many would be, and the ECHO program can respond to this need. As the ECHO program is currently configured, HOME funds can be used for the initial purchase and placement costs of ECHO units. These units must be small, free-standing and barrier free. The aim of the program is to allow older persons to live near their relatives. An adaptation of this program would be the addition of bedrooms for the grandchildren.

Manufactured Housing
And
Its Impact on Seniors

Prepared for

The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century

By

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Executive Summary

Manufactured housing is the big secret of the housing production system in this country. Over 8 million families are housed in manufactured homes. Between 2.5 and 3 million are households headed by a person over 60 years of age. That represents significantly more senior households than are housed in all of the U.S. Department of Housing and Urban Development's subsidized programs put together. While not subsidized, manufactured housing serves many low- and moderate-income households because it is less expensive than any other home ownership option. Manufactured housing represents over twenty percent of the annual housing starts. Yet many do not understand what manufactured housing is, or how it differs from other types of housing.

Manufactured housing differs from all other housing in that it is built to the HUD code, a national performance code that supercedes all state and local codes. Manufactured housing evolved from trailers and mobile homes, and while still stigmatized by its background, now results in products that look and function much like site-built housing, even though it is less expensive on a per-square foot basis than site-built housing. Even though the industry is currently in recession, it continues to produce hundreds of thousands of homes each year and offers Americans their most affordable homeownership option.

Residents of manufactured housing average 52.6 years old. Most are high school graduates or have some college education, have a median income of $26,900, and a median net worth of $59,000. The average household size is 2.4 persons. Thirty-six percent of such residents are in households headed by a person over age 60. Two-thirds of the households reside in single-section homes. Slightly more than one-third of the households reside in a manufactured housing park, where site rents average $220 per month. Median year of purchase is 1992. Median market value of the home is $17,000. Approximately 8.5 percent of the households living in manufactured homes headed by a person over 60 years of age have a member with a self-care or mobility limitation.

Manufactured housing has a substantial impact on the elderly. While most manufactured housing parks tend to serve the young-old, they are experiencing aging in place and will soon find themselves in a situation not unlike that of owners of HUD subsidized projects for the elderly, who are currently facing the issue of how to deal with aging in place. Manufactured housing parks and HUD subsidized projects have certain characteristics in common: (1) they tend to serve low- to moderate-income households; (2) they have common areas that can be used to provide services; (3) they have a "critical mass" of persons aging in place so that services can be provided efficiently and effectively. HUD subsidized projects for the elderly are somewhat further along in addressing aging-in-place issues, and their experience can be useful to park owners. Park owners are well positioned to help improve the extent and quality of home and community based services including health care services because of the large number of sites they control and the network that exists among such owners. As a result, they can have significant influence on state legislatures and local governments.

Two-thirds of the households used financing to purchase their homes. While there are three kinds of financing used in the purchase of manufactured homes, personal property loans are still the most common type, rather than mortgage loans or hybrid loans. While personal property loans have higher interest rates and shorter terms than mortgage loans, the lower loan amounts (they cover the home only, not the land on which it is located) often result in both modest down payments and modest monthly payments. Financing is less of an issue for seniors because, based on data from the Manufactured Housing Institute, approximately two-thirds of seniors purchase their manufactured homes with cash from the sale of a previous home.

While there are consumer issues needing to be resolved, they are best addressed by engaging the manufactured housing industry rather than ignoring it.

Manufactured housing is an important element in any strategy of serving the affordable housing and health facility needs of seniors for three reasons. First, 2.5 to 3 million seniors are already living in manufactured housing. Second, it is the most affordable form of homeownership available. As a result, nonprofit developers and others need to consider manufactured housing in their development plans. Third, it offers the opportunity to bring services to the residents, both because there is a "critical mass" of seniors living in manufactured housing parks, and because in many cases the home is movable and could be relocated in a park providing assisted living services.

The task before the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century is twofold: (1) Bridge the perception gap by the various housing trade associations regarding manufactured housing and its role in serving the housing and service needs of seniors who are aging in place; and (2) Create networking opportunities between park owners and owners of HUD subsidized housing for seniors. By taking on these tasks, the Commission can help expand the reach of manufactured housing, so that more seniors and others can benefit from its affordability, and at the same time facilitate the delivery of services to seniors already residing in manufactured housing.

I. What Is Manufactured Housing

Introduction

Manufactured housing is the big secret of the housing production system in this country. Over 8 million families are housed in manufactured housing. Between 2.5 and 3 million are households headed by a person over 60 years of age. That represents significantly more seniors than all of those served by all of HUD's assisted housing programs, including Public Housing, Section 202, Section 236 and Section 8. While manufactured housing is not subsidized by the government and does not have income limits for residents, it serves many lower income households because it costs less than any other homeownership option. Manufactured housing represents over twenty percent of the annual housing starts. Yet many if not most people do not understand what manufactured housing is, or how it differs from other types of housing.

The HUD Code

One distinctive feature of manufactured housing is that it is built to the HUD code. The HUD code, created in 1974 by Congress, is the only national housing code in this country. It is also unique in that the code preempts all state and local codes. In doing so, it makes it possible for manufacturers of HUD code housing to ship to different states and not be concerned about different requirements in different local housing codes. As a result, a few manufacturers with many plants ship homes to virtually every state. There are currently nearly 300 plants producing manufactured housing.

The HUD code is administered by the U.S. Department of Housing and Urban Development, which contracts with the National Conference of States on Building Codes and Standards, which carries out plant inspections to assure that homes are built in conformance with the HUD code. The HUD code, while having similar electrical and plumbing standards, differs from state and local codes in significant ways. The main difference is that it is a performance code rather than a prescriptive code. For example, it does not require the use of a certain grade of two-by-four no more than twenty four inches apart on center in walls. Rather the code requires that a wall be capable of bearing certain loads, but does not set forth what materials are to be used to meet the requirement. The HUD code covers only the production of the home in the plant, not the installation of the home on site.

State and Local Codes

In contrast to manufactured housing, modular and site built housing are subject to state and local codes. This feature has limited the reach of modular housing in that plants building such housing have to meet the code standards of the locality in which their homes will be sited. As a result, modular producers tend to be more localized, primarily working in one or two states. Modular housing tends to be located in the Northeast and provides far fewer housing starts than manufactured housing. According to the HUD publication entitled, "Factory and Site-Built Housing – A Comparative Analysis", published October 1998, estimates of modular production

vary widely, from 25,000 to 100,000 homes per year. By comparison, manufactured housing consistently exceeds 200,000 homes per year, with 300,000 to 400,000 homes in many years.

Differences in Delivery System

Manufactured housing is subject to a delivery system that is unique in the housing field. It is built in a manufacturing plant that typically does not deal in the retail market, but sells its homes to independent retailers. The retailers operate much like retail automobile dealers, who market their product directly to their customers. The retailer frequently provides one-stop shopping - finding a lender, arranging for property insurance, and arranging for the installation of the home on the purchaser's site. This delivery system has the advantage of simplifying the home purchase process, making it much more like purchasing a car rather than purchasing a home. It also creates some unique problems for the consumer, which will be addressed later in this paper. Although there are no precise data on the number of retailers in operation, the general estimate is that about 7,000 currently are in operation.

Differences in Appearance

Manufactured homes have evolved from the mobile home and tend to have certain distinctive features. They tend to be long and narrow, or square in the case of a two-section home. They tend to have a lower pitch to the roof because they are built in the factory and towed over the highway to the retailer's lot and again to their final site location. As a result, they must be low enough to clear highway bridges. They tend to have little or no roof overhangs because of limitations on the width due to being towed on highways. They also tend to be smaller than site-built housing due to the hauling requirements.

While most manufactured housing can be distinguished from site-built or modular housing, the evolution of the manufactured housing industry is breaking down these differences. For example, multi-section homes are being produced in greater numbers today than in the past. Manufacturers are also using siding and roofing materials that are the same as those used on other types of housing. Manufacturers have developed hinged roofs, so that they can be delivered flat and pitched up on site, with a normal roof pitch and normal roof overhangs. They can also be set on permanent foundations, and avoid the skirting that is usually associated with manufactured housing.

Differences in Cost

Manufactured housing tends to be less expensive than either modular or site-built housing. This is not simply a function of size, because manufactured housing costs less than either modular or site built housing on a square foot basis, including the cost of installation. An average manufactured home on a permanent foundation costs $22.41 per square foot compared to $32.78 per square foot for a modular home and $38.57 for a site-built home. There are several reasons why manufactured housing is less expensive. One is that manufacturers use unskilled labor and tend to locate their plants in areas with lower wage rates. Another is that they are able to obtain substantial discounts on the cost of materials because they purchase large quantities. A third

reason is that the homes are built indoors, and are not subject to the problems of poor weather and vandalism that site-built housing faces.

The significant differences in cost for manufactured housing compared to modular or site built housing mark the most important feature of manufactured housing – its affordability. In a housing market where subsidies are limited, the importance of affordability takes on special meaning in any national strategy for providing housing for low- and moderate-income persons.

Two-thirds of the households used financing to purchase their homes. While there are three kinds of financing used in the purchase of manufactured homes, personal property loans are still the most common type, rather than mortgage loans or hybrid loans. While personal property loans have higher interest rates and shorter terms than mortgage loans, the lower loan amounts (they cover the home only, not the land on which it is located) often result in both modest down payments and modest monthly payments. Financing is less of an issue for seniors because, based on data from the Manufactured Housing Institute, approximately two-thirds of seniors purchase their manufactured homes with cash from the sale of a previous home.

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II. Who Owns Manufactured Housing

Resident Profile

The Foremost Insurance Group of Companies conducts a national study of owners of manufactured homes every three years. The most recent study was in 1999. Based on this study, which included 22,723 respondents, the following profile emerges:

Age

Age 60-69	17%
Age 70+	19%
Retired	29%

Average age – 52.6 years

Education

Grade school	3%
Some high school	13%
High school graduate	36%
Some college (no degree)	29%
Associate's degree (2 yrs)	8%
Bachelor's degree (4 yrs)	7%
Post graduate degree	3%

Median income - $26,900

Median net worth – $59,000

Average household size – 2.4 persons

Characteristics of Manufactured Home

Single-section home	68%
Multi-section home	32%

Moved home from one location to another in last three years	6%
Median years of residence in manufactured home	12 years
Home located in park (homeowner on leased land)	36%
Median park rent	$220 per month
Home located on owner's private property	46%

Median year home purchased	1992
Median market value of home	$17,000
Financed home at time of purchase	65%

Demographic Data

The data used below is from three sources: The1990 Census; the 1995 American Housing Survey; and the 2000 Census. The 1990 Census was used because it had more information about

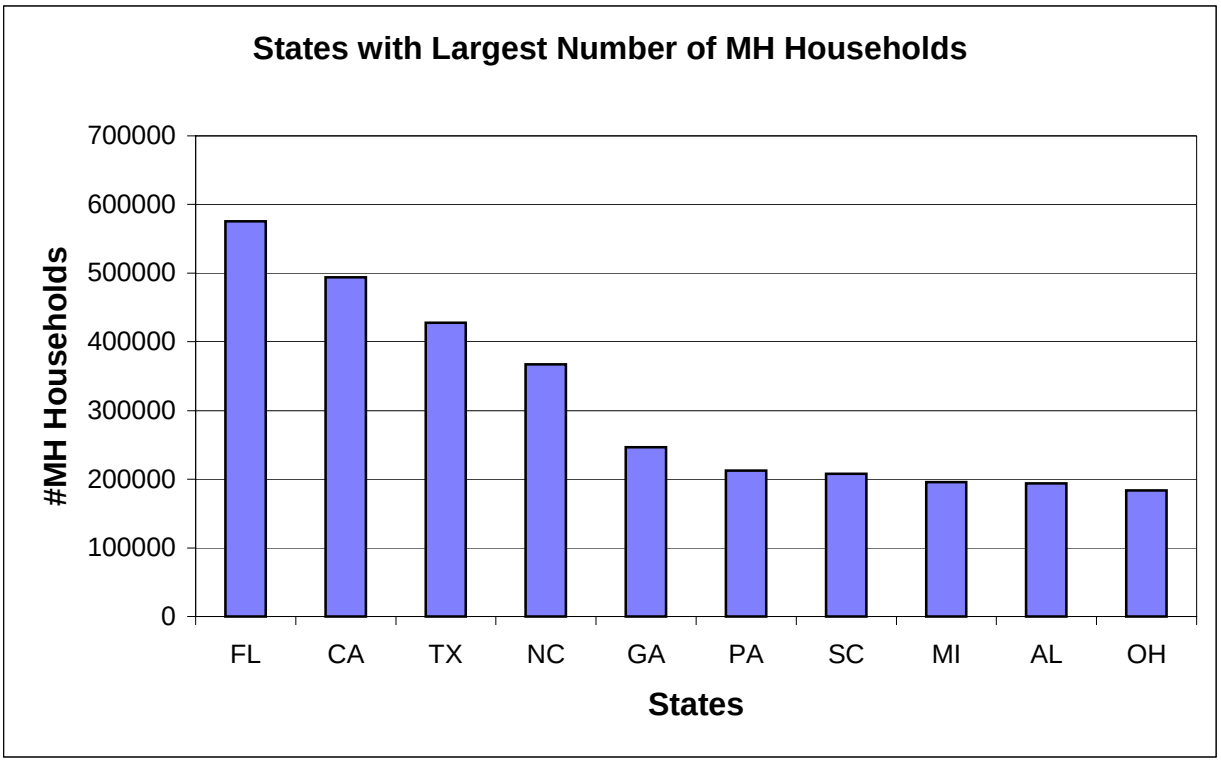
disabled persons living in manufactured housing. The 1995 American Housing Survey was used because of the limited information currently available from the 2000 Census.

It is worth noting that a significant increase in the number of households living in manufactured housing occurred during the 1990s. Based on the 1990 Census, a total of 6,133,367 households reside in manufactured housing. Twenty nine percent, or 1,758,539 households, are sixty or older. Nine percent, or 546,794 households, are seventy-five or older.

Based on the 1995 American Housing Survey, 6,164,000 households resided in manufactured housing. This represents a very modest increase since 1990. Slightly over 2 million residents of manufactured housing were over 55 in 1995. However, the 2000 Census estimates that 8.6 million households reside in manufactured housing, an increase of nearly 40 percent since 1995. The number of seniors living in manufactured housing can be presumed to have increased as well.

Manufactured home owners tend to be concentrated in certain states. Chart 1 is from the 1990 Census and shows the number of households in manufactured housing by state for the ten states with the highest manufactured housing population. These ten states have a population of households in manufactured housing of 3,105,588. This represents 50.6 percent of the total population of households in manufactured housing nationwide. The three states of Florida, California and Texas contain 24.6 percent or approximately one-quarter of such households.

Chart 1



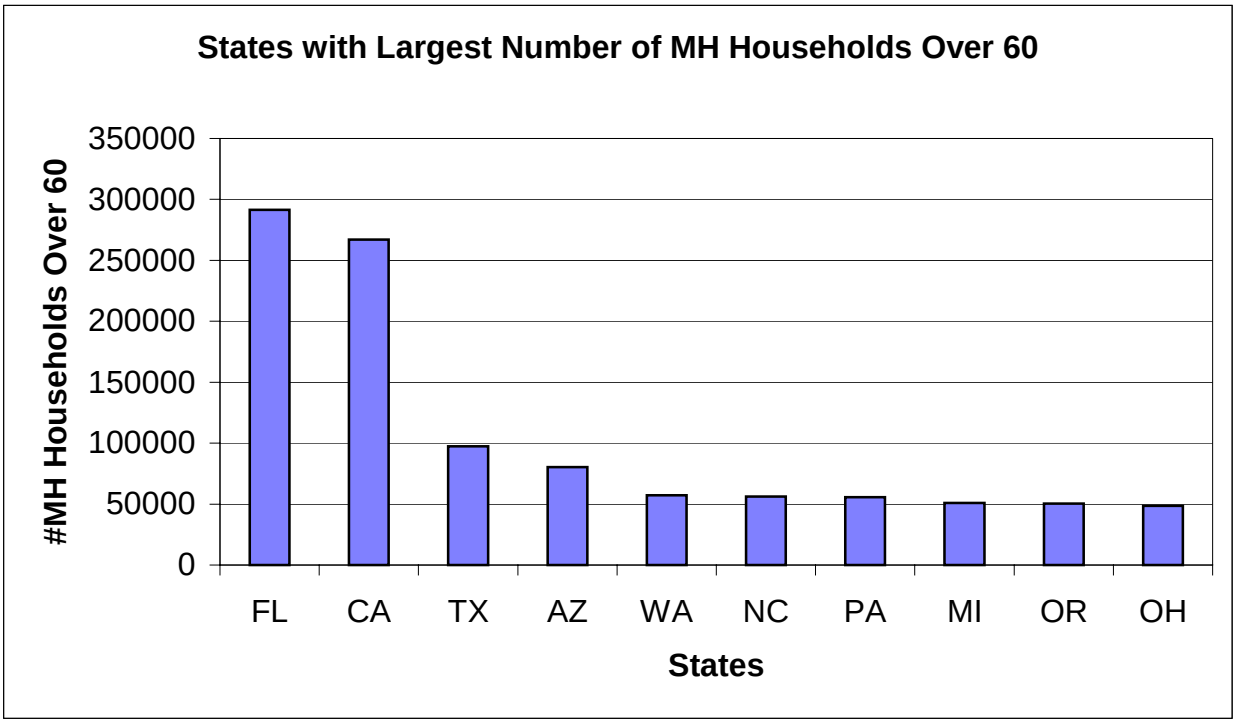
Households living in manufactured housing tend to be concentrated in rural areas rather than major urban areas. Approximately half of all such homeowners are located in twelve states composing the south and southeast portions of the country. Table 1 shows the regional distribution of manufactured housing compared to all types of housing based on the 1995 American Housing Survey.

Table 1

Region Distribution of Housing Stock and New Units by Type, 1995				
	Total Stock		New Construction	
Region	All Types	Manufactured	All Types	Manufactured
Northeast	19.6	8.5	8.7	4.7
Midwest	23.8	18	21.4	18
South	35.8	53.6	45.4	63.8
West	20.8	20	24.5	13.5
Total	100	100	100	100
Total Housing Units	109,457,000	7,647,000	1,354,100	310,700

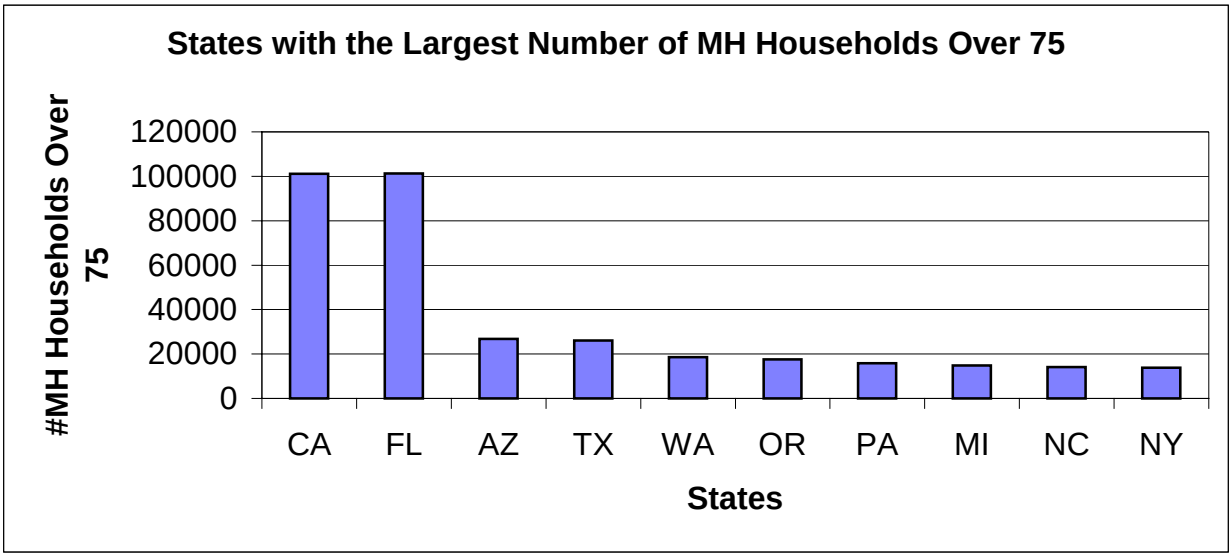
Twenty-nine percent of manufactured home owners are households headed by persons 60 years of age or older, based on the 1990 Census. Chart 2 shows the number of households over 60 living in manufactured housing in the ten states with the largest such populations. These ten states contain sixty percent of such households nationwide. California and Florida alone house 31 percent or nearly one-third of the manufactured home owners nationwide, who are over 60. California, Florida and Texas together house over 37 percent of the manufactured home owners over 60 nationwide.

Chart 2



Based on the 1990 Census, a breakdown of manufactured home owners over 60 by age reveals that 69% fall within the ages of 60 and 74, whereas 31% are over 75. This suggests that manufactured housing serves a wide spectrum of the elderly, mostly concentrated in the young-old. It is worth noting that the concentration of those over 75 is not the same as for those over 60. The ten states with the largest concentration of households in manufactured housing over 75 are shown in Chart 3. These ten states house 64.1 percent of all such households nationwide. It is noteworthy that Arizona, which is not in the top ten states in overall manufactured housing totals, is among the top four states in the categories of households in manufactured housing over 60 and over 75. Similarly, the states of Washington and Oregon make the top ten list for the over 60 and over 75 categories, although they do not make the top ten in overall manufactured housing population.

Chart 3



There is a significant discrepancy between the 1990 Census data and the 1999 Foremost study with regard to the percentage of manufactured home households over 60 years of age. The Census shows those over 60 as 29% of all manufactured home households. The Foremost study shows a total of 36% being over 60. This difference can be accounted for in two ways. First, the Census data is far more comprehensive, whereas the Foremost study is based on a sample of 22,723 households. However, the second and more likely reason is that the Census is based on 1990 data whereas the Foremost study is based on 1999 data. It is reasonable to assume that there has been aging in place during that nine-year period. There is evidence that the average age has increased over time. According to data from the Manufactured Housing Institute, the average age of manufactured housing residents in 1987 was 47 years, and by 1990 it had increased to 50 years. According to the Foremost study, the average age was 52.6 in 1999. The increase in average age suggests that there has been a significant increase in the number of seniors living in manufactured housing since 1990. The pattern of increases in the average age since 1987 suggests that the number of seniors living in manufactured housing is likely to continue to increase in coming years.

It is difficult to know precisely how many seniors reside in manufactured housing. If one assumes that the 40 percent increase in the number of households living in manufactured housing between 1990 and 2000 holds true for seniors, then approximately 2.5 million senior households resided in manufactured housing in 2000. If one accepts the Foremost estimate that 36 percent of manufactured home households are elderly, then 3.1 million households are elderly.

Data on Households with Disabilities

A special tabulation by the Census provides information on households with disabilities. There are two categories in the 1990 Census that relate to disability. The first is “mobility limitation status.” The data on “mobility limitation” status were derived from answers to a question asked

of a sample of persons 15 years old or older. The definition of "mobility limitation" is as follows:

> "Persons were identified as having a mobility limitation if they had a health condition that had lasted 6 or more months and which made it difficult to go outside the home alone. Examples of outside activities on the questionnaire included shopping and visiting the doctor's office. The term "health condition" referred to both physical and mental conditions. A temporary health problem, such as a broken bone that was expected to heal normally, was not considered a health condition."

The second condition is "self-care limitation status." The data on "self-care limitation status" were also derived from answers to a question asked of a sample of persons 15 years of age or older. The definition of "self-care limitation status" is as follows:

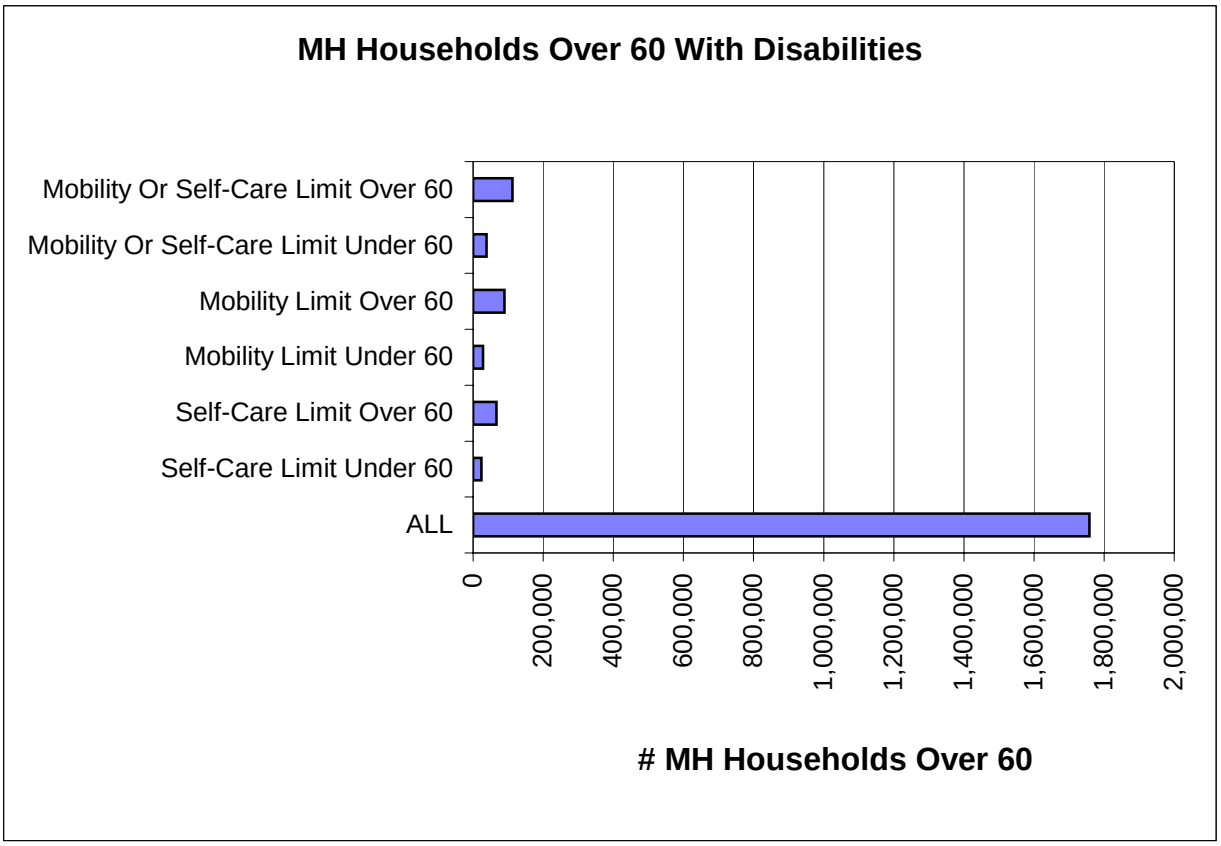
> "Persons were identified as having a self-care limitation if they had a health condition that had lasted 6 or more months and which made it difficult to take care of their own personal needs, such as dressing, bathing, or getting around inside the home. The term "health condition" referred to both physical and mental conditions. A temporary health problem, such as a broken bone that was expected to heal normally, was not considered a health condition."

Under the "mobility limitation status" for manufactured home owners where the head of household is over 60 years of age, a total of 28,051 households have one or more persons under 60 who have a mobility limitation. For those households where the head of household is over 60, a total of 89,060 households have one or more persons over 60 years of age with a mobility limitation.

Under the "self-care limitation status" a total of 24,040 households headed by a person over 60 have one or more individuals under age 60 who have such a limitation. A total of 67,015 households headed by a person over 60 have one or more persons over 60 who have such a limitation.

Among the households of owners of manufactured homes where the head of household is over 60, a total of 38,636 households have one or more persons under 60 with either a mobility or self-care limitation. Among that same universe of households a total of 112,584 have one or more persons over 60 years of age who have a mobility or self-care limitation. There may be some overlap in households with persons under 60 with a mobility or self-care limitation, and households with persons over 60 with a mobility or self-care limitation. Assuming the overlap is small it is apparent that about 150,000 households headed by a person over 60 have at least one person with a mobility or self-care limitation. Stated another way, approximately 8.5 percent of manufactured home households headed by a person over 60 have at least one disabled member. Chart 4 displays the relationships between the universe of over 60 households in manufactured housing and those households with mobility or self-care limitations.

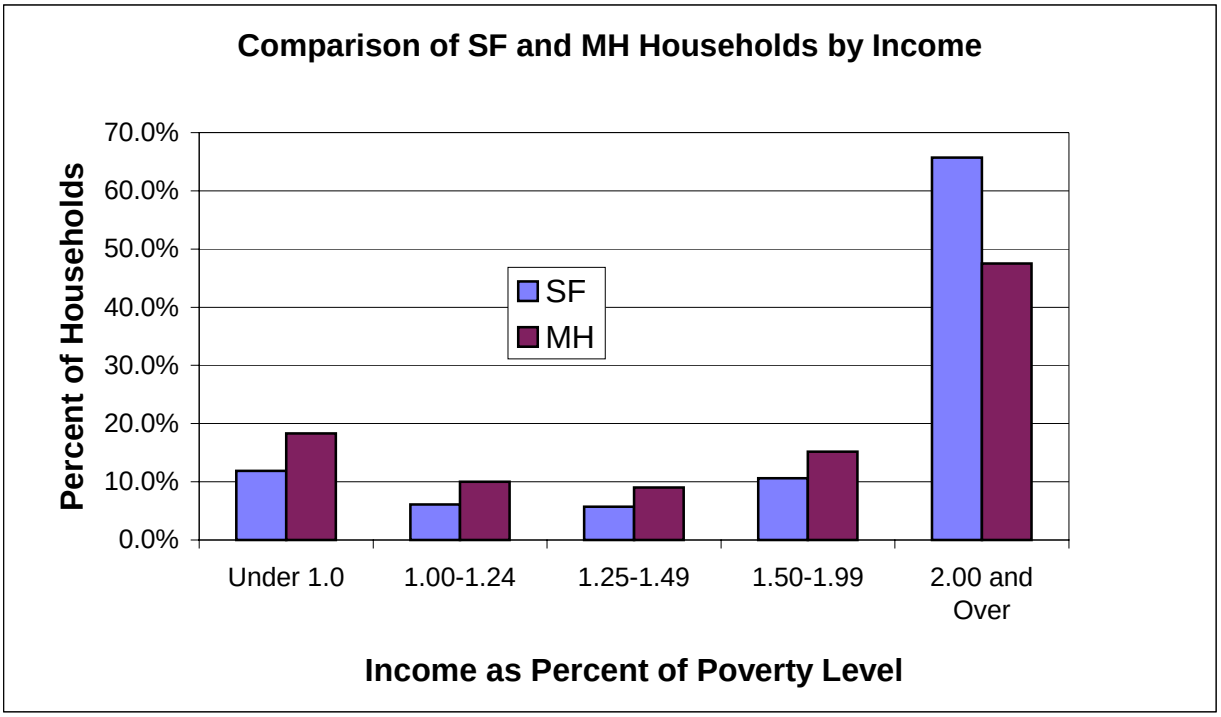
Chart 4



Data on Income

A special tabulation of the 1990 Census contains information with regard to incomes of households headed by a person 60 or older. Chart 5 compares households over 60 living in single family housing to those over 60 living in manufactured housing by income category. The Census information is broken down by multiples of the poverty level, which currently is $11,610 for a two-person household. While the poverty level was lower in 1990, the relationships between the incomes of those in single-family housing and those in manufactured housing is assumed to be relatively unchanged. The incomes of those in manufactured housing tend to fall below those of households in single-family housing. For example, 18.3% of manufactured housing households had income below the poverty level, whereas only 11.9% of residents of single-family housing fell below the poverty level. Similarly, 65.7% of single-family households had incomes above twice the poverty level, whereas only 47.5% of households in manufactured housing had incomes at that level. One would expect that households in manufactured housing would have average incomes below that of households in single-family housing based on the different costs of each type of housing. While that is the case, it is noteworthy that most households in manufactured housing are not poor, with well over half of them having incomes above 1.5 times the poverty level.

Chart 5



Data on Housing Stock

Since manufactured housing is a relatively recent phenomenon, the inventory of manufactured housing tends to be newer than all other housing types. Table 2 shows the year of construction of year-round occupied housing units by type as of 1995. Very few manufactured housing units were built before 1960. A little over one-third of the manufactured housing units were built prior to the enactment of the HUD Code in 1974. Some of these homes were built prior to the imposition of building code requirements. In 1963, the American National Standards Institute (ANSI) published a standard on plumbing, heating and electrical installations for manufactured housing. By 1969, the ANSI standard had been expanded to cover body and frame construction. The older homes, which would be characterized as "house trailers," no doubt vary considerably in quality of construction and current condition.

Table 2

Year of Construction of Year-Round Occupied Housing Units by Type 1995				
	Manufactured Homes		All Other Housing Units	
Year of Construction	Number	Percent of Total	Number	Percent of Total
1995 (Part Year)	136,000	2.2	674,000	0.7
1990-94	1,183,000	19.2	5,795,000	6.3
1985-89	852,000	13.8	7,266,000	7.9

1980-84	811,000	13.2	6,484,000	7.1
1975-79	1,054,000	17.1	10,054,000	11
1970-74	1,184,000	19.1	8,741,000	9.5
1960-69	809,000	13.1	13,458,000	14.7
Pre-1960	134,000	2.1	39,059,000	42.7
Total Units	6,164,000	100%	91,531,000	100%
Median Year	1980		1965	

III. How Manufactured Housing Impacts the Elderly

Introduction

Manufactured housing has a very significant impact on seniors. According to the 1990 Census data, 1,758,539 households in manufactured housing are headed by a person over 60 years of age. That figure has likely increased during the decade of the 1990s, since the average age of manufactured housing residents has gone from 50 in 1990 to 52.6 in 1999. The 2000 census estimate is that 8.6 million households reside in manufactured housing. If we accept the Foremost estimate that 36 percent were headed by households over 60 years of age (data from Foremost study noted earlier), then over 3 million elderly households are residing in manufactured housing.

Manufactured Housing Parks

Manufactured housing parks merit special attention, since 36% of the residents lived in parks in 1999. Using the 2000 census data, which estimates that 8.6 million households reside in manufactured housing, the estimate of the number of households in parks is about 3.1 million. The Foremost study shows 36% of manufactured housing households as headed by a person 60 or older. Applying that figure to the 3.1 million results in an estimate of about 1.1 million senior households residing in parks.

Manufactured housing parks are a unique feature in the American housing system. The resident typically owns the manufactured home but leases the ground on which it sits. The closest parallel is a condominium, in which the resident owns the air space but not the ground under or around it. However, the condominium owner is represented in the condominium association, whereas the manufactured home owner is in a landlord tenant relationship with the park owner. While the manufactured housing owner is subject to rent increases, the condominium owner is subject to increases in the association fees. Being a park resident has both advantages and disadvantages. One advantage is that the resident can own the home with a lower down-payment than under virtually any other housing alternative because the cost of land is not included in the transaction. The resident can also benefit from appreciation provided the home is well maintained in a well-located and maintained park. One disadvantage is that most residents are on relatively short-term leases, and are vulnerable to substantial rent increases. If the resident is unable to pay the increased rent, then he or she may have to sell the home or locate another site to which it could be moved. Another disadvantage is that the manufactured home may actually

depreciate in value if it is an older model or in a poorly located and maintained park. Some parks have converted to cooperatives in which the shares are owned by the residents. A change of use, in which the land is converted to another use and the residents are required to move, is fairly rare because the rate of return on parks is generally higher than that afforded by other uses. A more common situation, in strong markets, is that the park owner decides to upgrade the park and substantially increase rents, forcing lower income residents to sell or move their home to another location.

The author recently attended a networking conference in Chicago for park owners. While at the conference he conducted a brief survey of owners regarding the facilities and services they provide in their parks which are restricted to residents over 55 years of age. The questionnaire used is included in Appendix 1. There were a total of 14 responses by owners who cumulatively owned 460 parks including 123,830 home sites. Six of the respondents owned no parks restricted to seniors over 55 years of age.

Physical Features

The eight respondents who own parks restricted to seniors over 55 years of age reported that they owned 143 such parks with 40,280 home sites. The responses on physical features of the parks were as follows:

Swimming Pools:

Six respondents reported that all of their projects have swimming pools. Two respondents reported that some of its projects have swimming pools. Five respondents reported that the pools are wheelchair accessible; two reported that they are not accessible. One did not indicate whether or not they are accessible.

Health Clubs:

Two respondents reported that all of their parks have health clubs. Four respondents indicated that some of their parks have health clubs. Two respondents indicated that none of their parks have health clubs. Five of the six respondents with health clubs reported that they are wheelchair accessible.

Common Areas:

All eight respondents reported that all of their parks have common areas and seven of the eight reported that such areas are wheelchair accessible.

Central Dining Room:

One respondent indicated that all parks have a central dining room. One respondent said that some of its parks have a central dining room. Six respondents said none of their parks have dining rooms. The two respondents with dining rooms indicated that they are all wheelchair accessible.

Offices for Service Providers:

Two respondents stated that all of their parks have offices for service providers. Three respondents said that some of their parks have offices for service providers. Three respondents stated that none of their parks have offices for service providers. Four of the five respondents with offices for service providers stated that they were wheelchair accessible.

Service Features

The eight respondents with parks restricted to seniors were also asked about the service features of their parks. The responses were as follows:

Meals Program:

Two of the respondents stated that some of their parks have meals programs. No information was provided regarding the number of meals per day. Six respondents said none of their parks have meals programs.

Housekeeping Services:

One respondent said all of its parks have housekeeping services. One respondent said some of its parks have housekeeping services. Six respondents said none of their parks have housekeeping services.

Services Coordinator:

One respondent said all of its parks have a services coordinator. Two respondents said that some of their parks have a services coordinator. Five respondents said none of their parks have a services coordinator.

Preventive Health Services:

Two of the respondents said some of their parks have preventive health services. Six respondents said none of their parks have preventive health services.

Owner Interest in Aging in Place

Considerable interest was evident at the Chicago networking conference in the aging-in-place issue and its potential impact on manufactured housing parks in the coming years.
While current information is very limited and suggests that few services are offered to seniors in seniors-oriented parks, one promising feature is that all eight of the park owners with seniors-oriented parks reported that their parks have common areas and seven of the eight stated that these areas are wheel chair accessible. Common areas offer networking opportunities to the residents as well as potential space for meals programs and preventive health care programs. Informal discussion with owners suggested that they are quite interested in ways to respond as

their residents become older and more needy. They are strongly motivated by profit, and it is quite conceivable that over the next few years they may face a trade-off between providing services in order to keep their occupancy up and their turnover down on the one hand, or facing more move outs as residents become more feeble and require services that are not available in the park.

Parallels Between Manufactured Housing Parks and HUD Subsidized Projects for the Elderly

When assessing the potential for providing service coordination, meals programs, housekeeping assistance, and personal care services in manufactured housing parks, there is a certain parallel to the issue faced by HUD subsidized projects for the elderly that are experiencing aging in place and lack financial resources to provide the needed services. Because manufactured housing is virtually all one story, the provision of a ramp would in most cases be sufficient for a person with a mobility impairment. Most subsidized elderly projects and most manufactured housing parks appear to have common areas that are wheelchair accessible. Both types of facilities appear to have sufficient residents to create a "critical mass" as their residents age, thereby creating efficiency in the provision of services. Both types of facilities are independent living facilities and in most cases the residents are going to want to keep that image rather than become an assisted living type of facility. If the goal is to give residents the option to remain in their home as long as possible by providing a level of service that preserves their independence, then the issues faced by both types of facilities are similar.

Practical Steps in Providing Services in Manufactured Housing Parks

The provision of a services coordinator is the first practical step in providing assistance to seniors living in senior housing communities. While HUD provides a mechanism to pay for such services in subsidized projects for the elderly, there is no such mechanism for manufactured housing parks. Based on the above survey, it appears that some parks oriented to seniors provide service coordinators. Since owners have to pay such staff, they will have to make a judgment as to whether it is cost effective. Providing a services coordinator could reduce turnover and vacancies in some cases sufficient to cover the cost of the coordinator.

Provision of meals programs is another way of assisting those who are aging in place. A one meal per day program could make a major difference to those who are finding meals preparation a difficult task. Common areas could in many cases be adapted to provide the space for such a program. Meals could be prepared off-site and delivered to the dining room in situations where there is no central kitchen. Cost effective meals programs that have a sufficient number of recipients can be self-sustaining without outside subsidies.

Provision of housekeeping services can also be an effective way to serve those aging in place. The advantage to park owners is that these services need not be provided directly by them and need not be subsidized. A communication network among the residents can go a long way in making these services available by publicizing the names of individuals who will provide housekeeping services and providing both an evaluation and referral service for the residents. Housekeeping services can be cost effective if sufficient residents retain such services since the

service provider need not spend a lot of time traveling between jobs. In some cases, park residents may choose to provide such services at a modest price.

Provision of personal care services is another way of assisting those who are aging in place. This is likely to be the most difficult area for park owners in that it is the area that they are likely to know least about, and they may fear that providing such services will change the character of the project and become a deterrent to potential residents who are able to live independently and do not want to be in a facility that has any of the characteristics of an assisted living facility.

In this area, the experience of subsidized elderly projects may be relevant. New Jersey has developed a special program for subsidized elderly projects. Under this program, such a facility need not be licensed for assisted living. Instead, the facility can contract with a service provider whose assisted living program is licensed by the state. In this way, subsidized facilities for the elderly can provide assisted living services without the facility itself having to be licensed as an assisted living facility. One large facility has a contract with the Visiting Nurses Association of New Jersey in which nurses dressed as civilians and carrying medications in a briefcase deliver personal care services to about ten percent of the residents of a large subsidized project. The New Jersey law requires that persons be served where they live and not be required to move to a dedicated section of the building. Because they are scattered throughout the building, they draw little attention from other residents, particularly since nursing services are delivered in a business-like rather than medical environment. Nurses are able to bill in increments of as little as 15 minutes because there are sufficient persons needing their services in the building to reduce travel time to a minimum. For more information on the New Jersey experience, see "Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons With Low Incomes" by Robert Wilden and Donald L. Redfoot (published by the AARP Public Policy Institute in January, 2002).

IV. Home and Community Based Services Including Health Care Services for Elderly Residents of Manufactured Housing

The availability of home and community-based services varies widely from state to state and from community to community within states. The typical resident of a manufactured home faces the same situation as the typical resident of a single family home in that each will need to seek out appropriate services within the community. Fortunately, many communities offer a variety of services, some of which may be free of cost to the resident. For example, transportation may be worked out with the local transit authority or the Area Agencies on Aging (AAAs) depending on the funding source. Meals programs are generally provided under the Older Americans Act (OAA) through AAAs. A senior center might be located in the community. Many hospitals have outreach programs whereby services can be provided to residents in their homes or on an out-patient basis.

Home modification programs using Community Development Block Grants or HOME funds may be available to make modifications necessary to accommodate disabilities. Manufactured homes offer certain advantages since they are virtually all single-level homes and their elevation

is such that placing a ramp for wheelchair access is neither difficult nor expensive. However, older homes, particularly single-section homes, may lack hallways and door openings sufficient to accommodate a wheel chair.

While individual homeowners face the task of seeking out services in the community, those living in manufactured housing parks could benefit from programs brought in by the park owner. While there is not much evidence of activity on the part of the park owners, parks offer similar possibilities to subsidized housing projects because of the presence of community space. Like subsidized projects, parks for the elderly may have the "critical mass" of persons needing services to make the provision of services both efficient and cost effective.

One unusual feature of manufactured housing, particularly single-section units, is their ability to be moved from one site to another. If a particular park offered an array of services, persons living in other parks might feasibly move their home to the park offering the services that they need.

While it is not realistic to assume that park owners are prepared to spend their own money on services for residents, they could benefit from the experience of some of the subsidized project owners who have not had funds available to invest in services. They have searched out their communities for free or modestly priced services. Most residents of subsidized housing who benefit from services are required to pay some portion of the cost of the services. Manufactured housing residents, whose incomes are generally somewhat higher than those of subsidized housing residents, could be expected to do the same.

Preiss-Steele Place, a 102 unit project for older persons and persons with disabilities located in Durham, NC, offers one model for obtaining services for residents without the expenditure of owner funds. Common areas include an examination room for visiting nurses and an office for use by a county social worker for one-half day each week. The project benefits from a meals-on-wheels program for one meal on weekdays. There is also a meals program provided by the county. An optician provides eyeglass repairs on site to the residents at no charge. The juvenile court refers young people to the project to do clerical work and help residents with their groceries. The local hospital participates in health fairs held at the site. Because the sponsor of Preiss-Steele Place has been resourceful in bringing in services at no cost to the sponsorship and little or no cast to the residents, the residents can age-in-place and expect to receive the services they need on an a la-carte basis until such time as they require skilled nursing care.

The presence of a services coordinator, while not essential in obtaining services for residents, can be both cost effective and helpful. Such persons are trained to know and link the resources of the community to the needs of the residents.

Park owners are well equipped to lobby states and localities that do not provide adequate services to their residents. Park owners often control hundreds if not thousands of spaces and are well organized in the sense that they have an identifiable network of such owners. As a result, they could exert influence on their communities and states to improve both the quality and the delivery of state and community programs.

Clearly, more research is needed at the local level to determine where there are gaps in the provision of services to those aging in place. The objective both in manufactured housing parks and in subsidized housing projects for the elderly is to make available to residents the services they need in order to retain as much independence as possible and live in their own homes as long as possible.

V. How Manufactured Housing Is Financed

Introduction

When the purchase of manufactured housing is financed, it usually occurs in one of three ways. The most typical is use of a personal loan on the home. Next, is standard mortgage financing, covering both the cost of land and the cost of the home. Third, is a relatively new hybrid loan that has some of the features of a mortgage loan but is secured by the home and not the underlying land.

Personal Property Loans

Historically, manufactured housing has been financed with personal property loans since the housing was perceived to be mobile and not permanently attached to a given site. This type of financing has continued to be widely used, even when the home is located on property owned by the homebuyer. There are several reasons for this. First, the retailer through whom the purchaser typically buys the home typically provides one stop service for the purchaser, including arranging for financing and insurance. The financing offered by the retailer is usually a personal property loan. Second, the application process and the loan closing are quicker and simpler using personal property loans as compared to real estate mortgages. Third, while interest rates are higher and loan terms are shorter on such loans as compared to real estate mortgages, the lower costs of manufactured housing plus the fact that the loan does not cover land makes the down payment low and the monthly payments relatively modest. This is true even though the personal property loan has a higher percentage down payment, an interest rate that is two to three percentage points higher than a mortgage loan, and has a shorter term, ranging from 5 to 15 years.

Real Estate Mortgages

The second type of financing used by purchasers of manufactured housing is the standard real estate mortgage. Mortgage financing is restricted to homes that have permanent foundations and are on land owned or being purchased by the buyer. Such loans are not available to home owners whose homes are located on leased land, such as in manufactured housing parks. The advantage of mortgage financing is that it is widely available because of the large secondary market through which such loans are purchased from the originating lender, has a low down payment requirement, low interest rate, and 30-year financing.

Hybrid Loans

Freddie Mac has recently come out with a hybrid type of financing that is somewhere between the personal property loan and a real estate mortgage. It has many of the features of a mortgage, including a similar interest rate and term, but does not cover the cost of the land underlying the structure. Therefore, the loan can be used by residents of manufactured home parks under certain situations. Lenders are willing to make these loans because of the secondary market through Freddie Mac. Key requirements by Freddie Mac are that the home must be permanently affixed to the land, must be taxed and legally defined as real estate, and must have a lease that is at least five years longer than the term of the mortgage. This type of financing is not yet widely in use because the program is relatively new and not many lenders are acquainted with the Freddie Mac requirements. However, this type of loan gives those residents living in manufactured housing parks an attractive alternative to personal property loans. According to the most recent survey (1999) by Foremost Insurance, based on 22,703 respondents, 36 percent of manufactured home owners live in parks where they do not own the land, so this continues to be a very large market.

Cash Transactions

While one of the above three types of financing comes into play in most purchase transactions, a significant number of purchasers are able to purchase their home without outside financing. Sixty-five percent of the respondents to the Foremost survey noted above financed at the time they purchased their manufactured home. Over one-third of the purchasers paid cash. Among the elderly, the number of cash transactions may even be greater. Dr. James Clifton, Vice-President of Economics and Housing Finance for the Manufactured Housing Institute (MHI), claims that about two-thirds of seniors paid cash. This figure comes from a survey that MHI conducted last year of recent purchasers of manufactured homes in age-restricted communities. Many seniors are able to pay cash for their manufactured homes because they have cash from the sale of their previous home.

Relative Costs of Different Financing Options

There has been considerable discussion within the industry regarding the relative cost of personal property financing versus real estate financing. Many variables come into play. Personal property financing may require a higher down payment, a higher interest rate, and a shorter term than mortgage financing. However, personal property loans tend to be for much smaller amounts than mortgages because no land cost is built in and the housing itself is less expensive. Table 3 comes from “Factory and Site-Built Housing, A Comparative Analysis” issued by HUD in October 1998. The chart shows a comparison of financing of “identical” homes. The six homes compared are a site-built home, a modular home, and manufactured housing in four different situations. In one situation, the manufactured home is located on land already owned by the purchaser, so no land costs are included. In the second situation, the manufactured home is located in a private subdivision. The third and fourth situations involve manufactured homes located in parks on leased land. The third situation involves a double section home of 2,000 square feet, which is the same size as the site-built and modular homes. The fourth situation involves a single-section home that is 1,215 square feet, and thereby smaller than all of the other homes in the comparison.

Table 3

Comparison of Financing of "Identical" Homes (2,000 square feet)

	Site-Built	Modular	Manufactured Homes			
	Private Land		Private Land		Landlease Community	
			Individual Lot	Subdivision	Double-Section	Single-Section*
Construction Costs	$77,140	$65,560	$47,277	$47,277	$47,277	$26,350
Overhead and Financing	$32,274	$28,950	$15,254	$24,083	$15,554	$8,575
Land Costs	$35,314	$35,314	pre-owned	$35,314	$1,201	$1,000
Delivery and Set Up	--	included	$1,500	$1,500	$1,500	$750
Total Sales Price	**$144,728**	**$129,824**	**$64,031**	**$108,173**	**$65,532**	**$36,675**
Type of Loan	real property	real property	real property	real property	personal property	personal property
Interest Rate	8%	8%	8%	8%	10%	10%
Term	30 years	30 years	20 years	30 years	15 years	15 years
Percent Down Payment	10%	10%	land in lieu	10%	10%	10%
Initial Cash Outlays	**$21,709**	**$19,474**	**$4,364**	**$17,389**	**$11,283**	**$6,389**
Down Payment Price	$14,473	$12,982	--	$10,817	$6,553	$3,668
Closing Costs	$7,236	$6,491	$3,127	$5,334	$3,142	$1,746
Sales Tax (3%)	--	--	$1,238	$1,238	$1,238	$626
Security Deposit	--	--	--	--	$350	$350
Loan Amount	**$130,255**	**$116,841**	**$64,031**	**$97,356**	**$58,979**	**$33,008**
Monthly Loan Payment	**$956**	**$858**	**$535**	**$715**	**$634**	**$355**
Monthly Land Rent	--	--	--	--	$250	$200
Total Monthly Payments	**$956**	**$858**	**$535**	**$715**	**$884**	**$555**

* Square footage is 2,000 in all cases except that the single-section home in a land-lease community is 1,215 square feet.

As can be seen in the analysis, manufactured housing is less expensive on a square-foot basis and that translates into lower selling costs and lower amounts financed. On a monthly payment basis, the lowest payment is for the manufactured home located on private land that is already owned. This lower payment reflects the fact that the land is free and clear and not included in the financing. The next lowest monthly payment is for the single-wide home located in a park. The lower cost is a reflection of the smaller, less costly home and a modest lease rent of $200 per month. Even with the higher cost of personal property financing this option is still less expensive than the manufactured home located in a subdivision. The benefit of mortgage financing over personal property financing is best reflected in a comparison of the identical manufactured home located in a subdivision versus in a park. The thirty-year eight percent financing brings the monthly payment down below that required of the unit in a park that gets fifteen-year ten percent financing. The park rent plus the loan payment on the personal property loan is significantly more than the mortgage payment on the sub-division home. However, the down payment is lower for the unit in the park.

While there continue to be issues in the area of financing manufactured housing, these issues seem less serious for seniors, due to the large number that are able and choose to pay cash for their homes. Those seniors living in parks who need financing are still subject to personal property loans, unless they are able to obtain the Freddie Mac hybrid loan. As the Freddie Mac hybrid financing program becomes better known and more widely offered by mortgage lenders, those who need financing, including seniors, should benefit as well. The author does not agree with the Manufactured Housing Institute that HUD's Title I program should be revitalized for manufactured housing. One reason is that HUD was badly burned by this program several years ago, and is unlikely to respond positively to such a recommendation. The second, and more important reason, is that the future lies with programs such as the Freddie Mac hybrid loans.

They not only provide lower down payments and longer term lower interest rate financing, they also by requiring a long-term lease provide the borrower with predictable lease payments far into the future. This is a protection that seniors and others need in order to avoid the situation of having to move because the rents have suddenly been increased to an amount they cannot afford.

VI. Current Trends in Manufactured Housing

Blurring of Distinction Between Manufactured and Site–Built Housing

Trends in the manufactured housing industry are beginning to blur the distinctions between manufactured housing and other housing. More production is being devoted to multi-section homes, and less to single-section homes. The Final Report of the National Commission on Manufactured Housing states that in 1983, 37% of the new homes sold were multi-section homes. By 1993, 47% of the new homes sold were multi-section homes. According to the HUD study "Factory and Site-Built Housing," in 1996 over half of the new manufactured homes were multi-section homes. More homes are being placed on permanent foundations. A number of manufacturers have built homes with three or more sections, and have developed hinged roofs so that after the house is set up on site it is indistinguishable from site-built or modular housing. Furthermore, a number of manufacturers have expanded into the retail business themselves, cutting back on their dependence on the independent retailer network. In this way, they have more control over the set up of the home and the purchaser is less likely to have problems with the manufacturer and retailer blaming each other when a problem arises with the home.

Manufactured Housing Subdivisions

Another significant change, which is blurring the distinction between manufactured and site-built housing, is that traditional site-built home developers are beginning to develop subdivisions using manufactured homes. For example, the Pulte Home Corporation, a very large site-built developer, in 1993 substituted manufactured homes for site-built homes in its subdivision development in Apex, North Carolina. The subdivision is located just outside Raleigh and includes seventy-seven lots. The homes are double or triple-section homes with garages and porches. The initial homes ranged from 1,815 to 2,166 square feet and were located on lots averaging 10,000 square feet. Some smaller models were added later. The homes have roof pitches that are typical of site-built housing in the area, and the appearance of the subdivision is such that one could not tell it was manufactured housing if one did not know that already. The cost savings achieved by using manufactured housing meant that Pulte was able to offer the homes at a cost below site-built comparable units. Initially homes sold so fast that the developer raised prices in order to bring purchases more in line with the production schedule.

In order to facilitate more such developments, the U.S. Department of Housing and Urban Development published in May 2000 two new guides called, "Manufactured Home Producer's Guide to the Site-Built Market" and "Home Builder's Guide to Manufactured Housing." The Pulte project is described in more detail in the first of the two guides.

The use of manufactured housing in subdivisions offers an avenue to nonprofit developers who wish to provide homeownership opportunities to moderate-income households. Such

developments have all the advantages of a single-family subdivision (long-term, low-cost financing; real estate appreciation) and at the same time offer the substantial cost savings of manufactured housing. Richard Genz, in his article, "Why Advocates Need to Rethink Manufactured Housing" in Fannie Mae's Housing Policy Debate, Volume 12, Issue 2, points out the potential role for nonprofit developers to offer buyers real value, not just low prices by undertaking such developments.

Rental Versus Ownership

While most manufactured homes are owned by the resident, there are situations in which manufactured housing is occupied by renters. Owners of farms sometimes utilized manufactured housing to serve their farm workers. Park owners may own a few of the units in their parks, which they rent out on either a temporary or permanent basis. In localities that permit the placement of "granny flats" on a lot with a single-family house, some homeowners may utilize manufactured housing to house elderly parents or in-laws. Nonprofit developers could also utilize manufactured housing to develop multifamily housing projects for seniors by combining homes into duplex or four-plex units. Unfortunately, no data exists which quantifies the number of manufactured housing rental units; so additional research is appropriate in this area.

Perception Versus Reality

Perceptions of manufactured housing and its residents are every bit as important as the reality of manufactured housing because perceptions determine how the product is accepted and where it is able to be located. An enlightening article on this subject is "Not a Trailer Anymore: Perceptions of Manufactured Housing" by Julia O. Beamish, Rosemary C. Goss, Jorge H. Atiles, and Youngjoo Kim, published in Fannie Mae's Housing Policy Debate, Volume 12, Issue 2. The authors conducted two surveys in eight rural counties in Virginia. They examined the attitudes of manufactured housing residents and nonresidents in the same community. They also examined attitudes about single-section and double-section manufactured homes. Table 4 compares community and manufactured housing resident perceptions with actual residents in the single-section sample. Table 5 compares community and manufactured housing resident perceptions with actual residents in the double-section sample.

Table 4

Comparison of Community and Manufactured Housing Resident Perceptions with Actual Residents: Single-Section Sample

Characteristic	Actual Characteristics Single-Section Sample (%)	Perceived Characteristics: Manufactured Housing Resident Sample (%)	Perceived Characteristics: Community Resident Sample (%)
Education			
High school/GED	44	51	52
Some college/vocational	31	15	8
Income	43 < $20,000	63 low-income	74 low-income
Employment			
Full-time	56	80	79
Retired	21	3	3
Race (white)	91	76	82
Household type			
Small, two-parent families	35	55	58
Couples	21	9	9
Tenure			
Own home and land	73	42	25
Own home/rent land	23	42	48
Foundation			
Blocked and skirted	83	64	67
Permanent	14	13	14
Neighborhood			
Park	15	56	67
Subdivision	9	2	5
Open farm	76	10	10

Table 5

Comparison of Community and Manufactured Housing Resident Perceptions with Actual Residents: Double-Section Sample

Characteristic	Actual Characteristics Double-Section Sample (%)	Perceived Characteristics: Manufactured Housing Resident Sample (%)	Perceived Characteristics: Community Resident Sample (%)
Education			
High school/GED	34	51	58
Some college/vocational	55	34	18
Income	27 < $20,000	16 low-income	74 low-income
Employment			
Full-time	64	87	86
Retired	15	8	2
Race (white)	90	81	76
Household type			
Small, two-parent families	51	66	64
Couples	28	2	9
Tenure			
Own home and land	93	93	74
Own home/rent land	4	4	13
Foundation			
Blocked and skirted	31	31	41
Permanent	68	60	37
Neighborhood			
Park	1	2	22
Subdivision	13	5	8
Open farm	86	18	29

Table 4 displays a discrepancy between the perception of both manufactured housing residents and community residents of the single-section residents in the sample. The reality was that single-section residents had higher incomes and more education than perceived by either group. Far more owned their home and land than were perceived by either group. Far less were located in parks and more on open farms than perceived by either group.

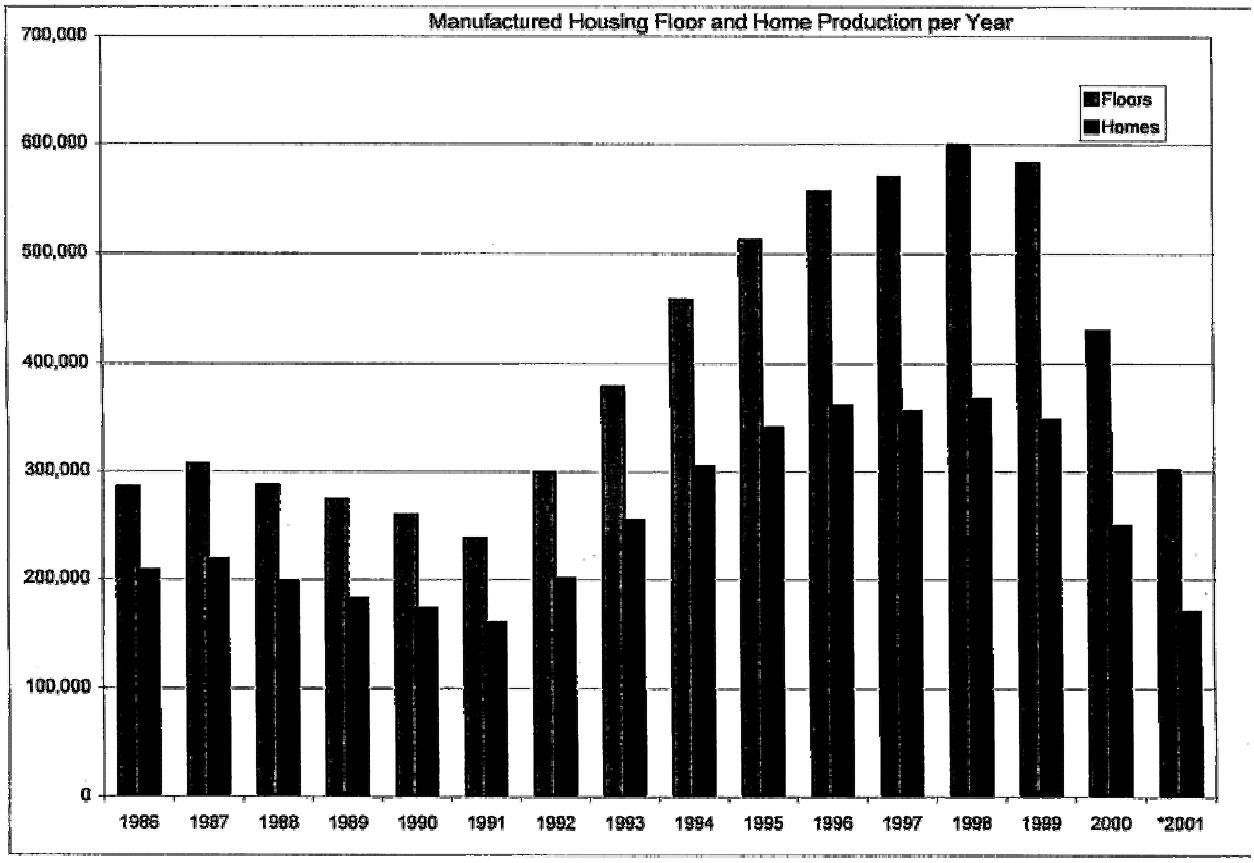
Table 5 displays a similar pattern. The residents of double-section manufactured homes had more education, income, ownership of the land as well as the home, and lived on open farm land in greater numbers than were perceived by either manufactured housing residents or community residents.

The two samples were also asked about the impact of manufactured housing on the neighborhood. Community residents were consistently more negative than manufactured home residents regarding the impact of manufactured housing on the neighborhood. Community residents "think of it as old, having a fairly bad appearance, and housing low-income people who exhibit bad social behavior." Community residents had perceptions of double-section homes that were both unfavorable and inaccurate. The authors state, "It is ironic that homes that could improve the image of manufactured housing might blend into the community so well that any positive influence on perception is negated because people do not recognize them for what they are."

Industry Currently in Recession

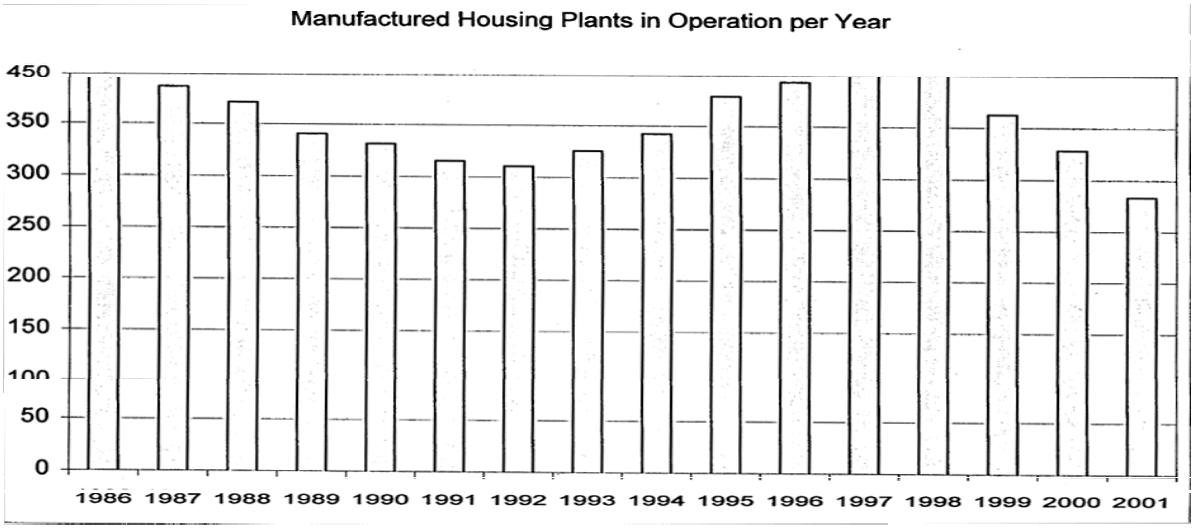
Industry production has been falling for two straight years. Furthermore, there is a glut of new homes unsold that are either in the manufacturers' or the retailers' inventory. There are also a significant number of used homes that are not occupied. These trends suggest that production levels will continue to fall over the next couple of years. Manufacturers count production in two ways. One way is the number of floors (sections) produced. The other way is the number of homes produced. Each floor (section) is required to receive a HUD label before it is shipped from the factory. A single-section home consists of one floor. Multi-section homes can have two or more floors, typically all one level. Housing and Building Technology (HBT), a division of the National Conference on Building Codes and Standards, is the HUD contractor that oversees plant production on behalf of HUD. Chart 6 was provided by HBT, and shows both the number of floors and the number of homes produced each year since 1986. The production number for 2001 is an estimate. Production in 1998 reached nearly 400,000 homes, whereas production estimated for 2001 falls below 200,000 homes.

Chart 6



The drop in production is also reflected in the number of manufacturing plants in operation. Chart 7, which was also provided by HBT, shows the number of plants in operation each year from 1986 through 2001. In 1998 there were over 400 plants in operation whereas in 2001 there are less than 300 plants in operation.

Chart 7



While the industry is currently experiencing economic problems, it continues to provide home ownership opportunities to those who either choose manufactured housing over site-built homes or are unable to afford site-built housing.

VII. Consumer Issues

The National Commission on Manufactured Housing

Congress created the Commission in 1990 with a charge to "develop an action plan containing specific recommendations for legislative and regulatory revisions to the present law." Congress created the Commission to develop recommendations that would resolve issues on which there was disagreement between the industry and its consumers. Among the issues to be addressed were updating of the HUD Code, which was created in 1974 and had subsequently grown out of date, and protections for consumers, some of whom experienced serious structural problems with their homes and were unable to get satisfaction either from the manufacturer or the retailer.

The Commission was composed of representatives of the industry, including manufacturers and retailers, government officials, and consumer advocates. The Commission achieved a broad consensus on the major issues in February, 1993 and issued an interim report to Congress that among other things recommended that a consensus committee representing all affected interests be formed to make recommendations to HUD for updating the HUD code and also recommended the establishment of a five-year structural warranty covering manufacture, transportation, and set up of the home. Manufacturers and retailers would be required to issue the warranty, with each taking responsibility for its actions. Transportation is handled in some cases by the manufacturer and in some cases by the retailer. The retailer typically is responsible for the installation of the home on site, either by doing so directly or by contracting out the installation. Each party would be responsible for warranting its portion of the work. The Commission believed that warranty protections would be more effective than a regulatory structure, in part because HUD is ill-equipped to carry out regulatory functions. The HUD code does not cover installation of the home, although each manufacturer issues its own installation manual.

Unfortunately, when the industry representatives on the Commission went out to gain the approval of industry leaders of the Commission's recommendations, they encountered considerable resistance on the part of retailers. Manufacturers generally issue a one-year warranty, and seemed willing to go along with the five-year structural warranty. However, the retailers, who typically do not issue any warranty covering transportation or installation of the home, refused to participate in a five-year structural warranty. As a result, the manufacturers, not wanting to split the industry, backed away from the agreement and when the Commissioners representing the industry reported back to the Commission, they took a united position against the compromise reflected in the interim report to Congress. As a result, the Commission's final report reflected the split between the industry and the rest of the Commission. Although legislative language had been prepared to implement the recommendations contained in the interim report to Congress, the Congress chose not to act on the matter. For more information on the interaction between consumers and public officials on the one hand, and industry representatives on the other hand, see "Manufactured Housing: A Study in Power and Reform in

Industry Regulation" by Robert W. Wilden in the Fannie Mae publication "Housing Policy Debate", Volume 6, Issue 2 published in 1995.

AARP National Survey of Manufactured Home Owners

AARP was an active participant in the National Commission on Manufactured Housing, with its representative serving as Commission Chairperson. AARP has a significant interest in manufactured housing because a substantial number of the elderly live in manufactured housing. AARP commissioned a survey of manufactured housing homeowners in 1999 to "document the extent to which home owners have experienced problems with the construction and/or installation of their mobile homes, and to explore how they dealt with and/or resolved these problems."

The reason AARP commissioned its survey was that the manufactured housing industry was lobbying Congress for changes favorable to the industry and when AARP raised concerns about consumers, the industry position was that there were no significant problems being experienced by consumers. In order to get factual information, AARP commissioned this survey.

Since the AARP study consistently refers to "manufactured housing" as "mobile homes," this section will use the term "mobile home" although the rest of the paper does not because the amended legislation now refers to "manufactured housing" rather than "mobile homes". The AARP sample consisted of 933 respondents.

The key findings of the AARP survey are as follows:

(1) Problems Reported with Homes

+ Seventy-seven percent of mobile home owners reported at least one problem with the construction, installation, systems, or appliances of their homes. Those who paid under $35,000 for their homes generally reported more problems than those with more expensive homes.

+ The most frequently mentioned problems home owners had with their homes were: interior fit or finish, such as cabinets, etc. (37%); improper fit (or leaks) in doors or windows (35%); and problems with actual construction such as cracks or separation of walls (31%).

+ Six in ten (61%) of the problems of greatest concern occurred during the first year of ownership, while another 14% occurred during the second year, and 14% during years three through five.

(2) Installation of Homes

+ Over eight in ten mobile homes (81%) were installed on blocks or piers with

anchors or tie-downs. Fifteen percent said they experienced problems with set-up or installation of the home. This type of problem was more frequent in newer and more costly homes. Other problems resulting from faulty installation accounted for one-fifth of the problems of most trouble or concern for the home owner.

(3) Resolution of Problems

+ About half (54%) of the problems of most concern to home owners entailed out-of-pocket repair costs for home owners averaging $1,140 per problem. Average out-of-pocket repairs ranged from a low of $420 to a high of $2,240, depending on the type of problem.

+ In 40% of attempts to use warranties to resolve problems, home owners were unsuccessful.

+ For all problems of top concern for home owners, about one-third (35%) were repaired under warranty. For 31% of the problems, the home owner fixed it at his/her expense, and for another 30% of the problems, nothing was done at all (problem still exists).

+ The reasons most often given for unsuccessful attempts to use the warranty were that respondents did not get a response to their calls, or the dealer would not honor the warranty (21%), the problem recurred or was not fixed properly the first time (17%), the warranty had expired (17%), or they were told the problems were not covered under the warranty (16%)

(4) Satisfaction Levels

+ Home owners' satisfaction with the quality of construction of their homes averages 4.0 (on a five-point scale where "1" is very dissatisfied and "5" is very satisfied). However, these average ratings vary significantly by whether or not a problem is reported, and by the type of problem reported.

+ About half (49%) of the total problems reported had a less than satisfactory outcome in attempts to resolve them. Problems reported by those with only a one-year warranty had less than satisfactory resolutions more often than those of homes with longer warranties.

This survey suggests that the warranty problems that the Commission on Manufactured Housing tried to address are a persistent unresolved issue for the manufacturers, retailers and home owners.

The Manufactured Housing Improvement Act of 2000

The industry has continued to lobby Congress on establishing a consensus committee to make recommendations to HUD on changes to the HUD code. AARP also testified before Congress in 1999, supporting: (1) A more balanced consensus committee for making recommendations to the Secretary of HUD to periodically update standards under the 1974 Act. A reformulated committee would reflect a better balance between consumer and industry views on enforceable national construction and safety standards than is currently proposed; (2) Federal minimum level requirements for a manufacturer's warranty, and for a state recovery fund; and (3) a nationally mandated, performance-based installation standard.

Congress enacted changes in 2000. The Act provides for a consensus committee to make recommendations to HUD for improvement to the HUD code. The Act also provides for a five-year period beginning with the date of enactment in order for HUD to establish installation standards and a dispute resolution process. These standards would apply in those states that have not developed their own installation standards and dispute resolution process that meet the requirements of the Act. Once the dispute resolution process is in place, consumers will be able to use it to resolve disagreements between the manufacturer, the retailer and the homeowner regarding installation problems during the one-year warranty period. The Act does not extend the period of the manufacturer's warranty or require a warranty of the installation. It also does not address the need for state recovery funds.

Concerns of Consumers Including Seniors

The success of the manufacturing housing industry in lobbying Congress, along with the relative weakness of the manufactured home owners' association in representing their interests to Congress results in a situation in which consumers are not well served. This is evident in two areas.

Warranty Protection

Most manufacturers provide a one-year warranty and most retailers provide no warranty. The result, as is evident in the AARP survey, is that consumers whose homes develop structural problems as a result of damage received during transportation or an improper installation continue to have difficulty in getting resolution to their problems. Some manufacturers and retailers are sufficiently concerned about their customers that they will work to resolve such problems. The difficulty is that the regulatory system may not require them to do so, and the lack of sufficient warranties gives them cover when they choose not to fix the problem.

Related to the need for warranty protections is the need for recovery funds. Some states, such as Arkansas, have such funds, whereas many others do not. Recovery funds are necessary to protect consumers when manufacturers or retailers go bankrupt or go out of business, leaving no other recourse for repairing defects in the home.

Industry Regulation

Manufactured housing is unique in that it is subject only to the HUD code, which preempts all state and local codes. Manufacturers are required to hire HUD-approved inspection agencies that

conduct in plant inspections under the supervision of HUD's agent, Housing and Building Technology. The HUD regulations require that each floor in production be inspected during at least one stage of construction in order to be eligible to receive a HUD label. Each plant is required to have a quality control manual and the inspection agency is required to check to be sure that the quality control manual is being followed on the production line. The inspections required are less stringent than those that apply to site-built and modular housing, where local inspectors are involved in every stage of construction. While the industry benefits from what amounts to minimal regulation, the industry associations continue to maintain in their dealings with Congress that the industry is over-regulated. HUD has fewer staff currently to oversee the program than in the past, yet the industry continues to lobby for reductions in the HUD budget.

The regulatory system allows states to enact enforcement standards covering the production, distribution, installation, and sale or resale of manufactured housing. The State of Oregon has developed comprehensive legislation giving it the authority to regulate the construction of homes (the state is the inspection agency which conducts in-plant inspections), the installation of homes (the state has an installation standard and requires the licensing of installers), and manufactured housing parks (the state conducts inspections and has dispute resolution requirements). Oregon also functions as the State Administrative Agency (SAA) and handles consumer complaints. Anecdotal information suggests that residents of manufactured housing in Oregon generally receive satisfaction of their complaints. Most states do not take as active a part in regulating manufactured housing as does Oregon. Some states take a minimal role, leaving the SAA process to HUD Headquarters. Residents of such states are not well served, since HUD is neither staffed nor set up to perform regulatory functions.

Given the situation at both the federal and state level, there is a risk that the regulatory system will break down to the detriment of consumers if sufficient resources and staff are not dedicated to this program at both the federal and state level.

VIII. Identification of Policy Issues for Discussion by Commission

Introduction

There are two issues regarding manufactured housing that should be addressed by the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century. The first issue has to do with bridging the gap in perception between manufactured housing and all other housing. The second is to create networking opportunities that will link manufactured housing park owners to owners of subsidized elderly projects so that both can benefit from the efforts and experience of each to deal with issues related to aging in place.

Bridging the Perception Gap

It is tragic that manufactured housing, which houses more elderly persons (mostly of modest income) than all of the HUD subsidized housing programs, is rarely on the radar scope of housing advocates other than the manufactured housing industry associations, such as the

Manufactured Housing Institute. The Commission needs to use its prestige and resources to introduce manufactured housing to other housing advocacy groups, such as the Low Income Housing Coalition, the National Housing Conference, the National Association of Housing and Redevelopment Officials (NAHRO), the American Association of Homes and Services for the Aging (AAHSA), the National Council of State Agencies, the National Association of Home Builders (NAHB), and the Mortgage Bankers Association (MBA). It is not that these organizations have never heard of manufactured housing, but rather they have tended to view it as the black sheep of the housing industry, have not looked at its current or potential impact on homeownership for lower income and elderly persons, and have behaved as though it doesn't exist. Given the affordable housing needs of this country, and the limited public resources available to directly subsidize such housing to make it affordable to low income persons, any national housing strategy must include manufactured housing as a major component. Manufactured housing needs to be viewed as a legitimate player in the moderate-income housing field. One of the benefits of engaging the manufactured housing industry rather than ignoring it is that it then becomes possible to influence the industry, hopefully in a way that will improve the weak regulatory system and provide better protection for consumers.

The Commission can have an impact in this area by including manufactured housing as both legitimate and needed in addressing the affordable housing needs of the elderly and by communicating its action to the various organizations listed above. Those organizations need to support manufactured housing as a component of a national affordable housing strategy that meets the homeownership needs of a major segment of the population that is either unable or chooses not to incur the expense of purchasing a site-built home. In addition to telephone and mail contact with the above organizations, the Commission might consider devoting a special session at which representatives of the above organizations were invited to discuss manufactured housing and provide materials that offer an objective view of its role in providing affordable housing

The Commission can also include and legitimize manufactured housing in its dealings with Congress and HUD. Both Congress and HUD tend to overlook manufactured housing when they develop strategies to house lower income persons including seniors.

Creating Networking Opportunities

The second issue relates to creating networking opportunities between owners of manufactured housing parks and owners of subsidized housing for the elderly. The entry point into the network of park owners is George Allen. George is a Certified Property Manager of the Institute of Real Estate Management who has worked for many years to professionalize the management of manufactured housing parks. He has put together a network of over 700 park owners that own thousands of parks housing nearly a million households. His newsletters are widely circulated among such owners. He is himself a park owner, and has displayed great interest in the aging-in-place issue and the work of this Commission in particular. The common interest in figuring out how to deal with aging-in-place issues creates the opportunity to link this network with the network of owners represented by AAHSA. The recently published AARP issue paper entitled, "Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes" should be of interest to both groups. While the owners of subsidized housing for the

elderly may be a bit further along in dealing with the aging-in-place issues, both groups are at the early stages of addressing this problem and each could benefit from the experience of the other.

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Exhibits

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TO: Owner/Operators of Senior Oriented Communities

FROM: Robert W. Wilden
Consultant to Commission on Affordable Housing and Health Facilities Needs for Seniors in the 21st Century

SUBJECT: Information on How Communities Are Responding to Aging In Place

The information requested below includes questions both on your total inventory of communities and on how many of those communities serve primarily those over 55 years of age. Specific information (other than inventory numbers) is requested only on the communities primarily serving those over 55 years of age.
This information is for use by the Commission on Affordable Housing and Health Facility Needs for Senior in the 21st Century. The Commission was created by Congress, and is interested in manufactured housing as it relates to the elderly and aging in place. Individual questionnaires become the property of the Commission and are confidential. DEADLINE FOR SUBMISSION IS DECEMBER 15, 2001.

Questions

1. Name of Ownership Entity _____

2. Name of Contact Person _____ Telephone Number _____

3. How many parks/sites (both elderly and non-elderly) do you have in inventory?

   _____ Parks _____ Sites

4. How many parks/sites are restricted to households with a member over 55 years of age?

   _____Parks _____Sites

   a. Physical Features

   Wheelchair accessible?

   Swimming pool _____all parks _____ some parks ____no parks ___yes ___no

   Health club _____all parks _____some parks _____no parks ____yes ___no

   Common areas ____all parks ____some parks _____no parks ____yes ___no

   Central dining room ____all parks ____some parks ____no parks ____yes ___no

   Offices for service providers ___all parks ___some parks ___no parks ___yes ___no

   Other (describe) _____

   _____ ____all parks ____some parks ____no parks ____yes ___no

   b. Service Features

   Average # meals

   Meals program ____all parks ____some parks ____no parks ___per day ___days per week

(OVER)

Housekeeping services ____all parks ____some parks ____no parks

Services coordinator _____all parks ____some parks ____no parks

Preventive health care services ____all parks ____some parks ____no parks

Other (describe) _____

_____ ____all parks ____some parks ____no parks

PLEASE RETURN COMPLETED QUESTIONNAIRE BY DECEMBER 15 TO:

Robert Wilden
Fax (703) 534-4504