Testimony of

Ramsey Alwin

President & CEO

National Council on Aging

Submitted to

Committee on Health, Education, Labor & Pensions

U.S. Senate

The Older Americans Act: Supporting Efforts to Meet the Needs of Seniors

March 7, 2024

For more information, please contact:

Howard Bedlin

howard.bedlin@ncoa.org

INTRODUCTION

Chairman Sanders, Ranking Member Cassidy, and members of the Senate Committee, thank you for the opportunity to speak with you today about the vital need to reauthorize, modernize, and fund the Older Americans Act (OAA) to support the needs of older adults.

I am Ramsey Alwin, President and CEO of the National Council on Aging (NCOA), the nation's oldest organization focused on serving older adults. For nearly 75 years, we have worked to improve the lives of older Americans, especially vulnerable and underserved populations. From advocating for passage of the original Older Americans Act, Medicare, and Medicaid, to helping end mandatory retirement, NCOA has operated under the principle that aging well in America should be a right for all, not a privilege for a few.

NCOA's goal is to improve the health and economic security of 40 million older adults by 2030, especially women, people of color, LGBTQ+, low-income, and rural individuals. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. Every day, our team works to help individuals secure job training and placement, enroll in programs that help with the cost of food and medicine, better manage their chronic conditions like diabetes and hypertension, and prevent falls. All our insights from our direct service delivery inform our reauthorization recommendations.

The OAA is integral to achieving NCOA's vision of a just and caring society in which each of us, as we age, lives with dignity, purpose, and security. First enacted in 1965, the OAA establishes priorities and operations for key programs and services that help keep our nation's adults ages 60 and older healthy and independent.

The OAA is the designated vehicle to plan for and provide professional assistance to older Americans and their families, providing the many nonmedical care services that older adults often need and complementing the support provided by Medicare, Medicaid, and Social Security. The Act provides the blueprint that encompasses the full range of services and supports that address vital social determinants of health and allow all of us to age well in community and at home as desired. Further, OAA-funded services and supports have been shown to reduce health care costs and delay nursing

home placement.[1] Given that greater than 90% of older adults live in communities,[2] we must recognize the OAA's critical role in supporting family caregivers who are the backbone of long-term care for older adults.

Reauthorization of the OAA provides a critical opportunity to strengthen and revitalize its many important provisions. Previous bipartisan reauthorization efforts have created innovative new programs that have significantly improved the lives of older adults, their caregivers, and the Aging Network. For example:

- The Supporting Older Americans Act of 2020 created a **Research, Demonstration and Evaluation Center for the Aging Network.** The purpose of the Center is to coordinate research, evaluation, and demonstration projects and increase the repository of information on evidence-based programs and interventions available to the Aging Network.[3] This work will help us understand how the Aging Network can improve the lives of older adults and do its part in slowing the growth in expenditures of programs like Medicare and Medicaid.
- The OAA Amendments Act of 2006 created the **National Center for Benefits Outreach and Enrollment**. The Center supports a network of community-based organizations that find and enroll low-income beneficiaries—generally with annual incomes below $22,000—in benefits programs they are eligible for. Thanks to this work, from 2022-2023, 9.3 million low-income older adults and individuals with disabilities were connected to benefits[4] that enable them to afford prescription drugs and other needed health care, as well as food and energy assistance.
- The 2000 OAA reauthorization created the **National Family Caregiver Support Program**, which provides grants to states and territories to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. Grantees provide information to caregivers about available services, individual counseling, support groups, caregiver training, and respite care.

---

[1] https://www.liebertpub.com/doi/10.1089/pop.2017.0199
[2] https://aspe.hhs.gov/reports/understanding-characteristics-older-adults-different-residential-settings-data-sources-trends-0#exhibit2
[3] https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2021/05/Policy-Spotlight-OAA-Research-FINAL-508.pdf
[4] https://www.ncoa.org/article/helping-lower-income-adults-afford-medicare

ncoa national council on aging

Today's realities demand that we examine the OAA with fresh eyes and with innovation at the forefront. The OAA must be modernized to better address the needs of the diverse and growing older adult population, which includes not only the Silent Generation and Baby Boomers, but also Generation X, whose members start to turn 60 in 2025.

According to the U.S. Census Bureau, from 2010 to 2020, the 65-plus population experienced its largest-ever percentage-point increase—from 13.0% to 16.8% of the total population. Before 2010, it took 50 years—from 1960 to 2010—for the older population's share of the total population to grow by the same number of percentage points.[5]

The older population is also increasingly diverse. In 2020, 24% of individuals ages 65 and older were members of racial or ethnic minority populations. Over the next two decades, the white (non-Hispanic) older population is expected to grow by 26%, while older racial and ethnic minority populations are expected to increase by 105%, as the younger more racially and ethnically diverse generation ages.[6]

While demand for OAA services is growing and diversifying, OAA funding is not keeping pace. This financial reality has made it increasingly difficult for the Aging Network to maintain existing services, let alone expand. The supplemental funding Congress provided to the Aging Network during the COVID-19 pandemic was critical to helping older adults most at-risk and in greatest need. But today, the demand for these services continues, while the relief funds are running out. The pandemic sharply underscored the value of and critical need for additional investment in OAA programs.

NCOA PRIORITIES

As the leading advocate on behalf of older adults and the Aging Network, NCOA has several priorities that we believe should be included in this year's OAA Reauthorization. Our priorities focus broadly on senior centers, healthy aging, and economic security.

---

[5] https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

[6] https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf

ncoa
national council on aging

Senior Centers

For more than 80 years, senior centers have provided access to support services and opportunities for healthy aging in a highly social setting in towns and neighborhoods across the nation. The OAA has recognized their importance for 50 years—by including multi-purpose senior centers in 1973 and by establishing the senior nutrition program. In the establishment of the Aging Network, senior centers were to be given special consideration as community focal points to deliver OAA services on a local level. Today, an estimated 11,000 senior centers operate locally, sometimes hyper locally, as gathering places for generations of older adults to stay active, healthy, and connected.

Research shows that older adults who participate in senior center programs experience better mental health across several measures compared to non-participants, including perceived social and health benefits,[7] depression,[8] friendship,[9] and stress levels.[10] Compared to their peers, senior center participants have higher levels of health, social interaction, and life satisfaction.

Senior centers are a time-tested model to deliver on the promise of the Older Americans Act. They provide for the "maximum co-location of services," which differentiates them from other community-based organizations. A visitor to a senior center can come to exercise and also get screened for benefits, take an art class and get a hot meal, or learn a new language and find purpose through volunteering. At their core, senior centers are places that foster social connection and belonging, addressing the epidemic of loneliness[11] identified by the U.S. Surgeon General.

Senior centers also serve as critical lifelines for many older adults in the community. This was never more evident as during the pandemic that brought a disproportionately harsh impact on older adults. Senior centers across the country sprang into action, ensuring that older adults, especially the most vulnerable, had credible information; access to nutrition through meal delivery, grab-and-go meals, and grocery shopping services; and social engagement through online programs, parking

[7] Gitelson, R., McCabe, J., Fitzpatrick, T., & Case, A. (2005). Factors that influence perceived social and health benefits of attendance at senior centers. Activities, Adaptation & Aging, 30, 23-45.
[8] Choi, N., & McDougall, G. (2007). Comparison of depressive symptoms between homebound older adults and ambulatory older adults. Aging Mental Health, 11, 310-322.
[9] Aday, R., Kehoe, G., & Farney, L. (2006). The impact of senior center friendships on aging women who live alone. Journal of Women & Aging, 18, 57-73.
[10] Farone, D., Fitzpatrick, T., & Tran, T. (2005). Use of senior centers as a moderator of stress-related distress among Latino elders. Journal of Gerontological Social Work, 46, 65-83.
[11] https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

lot parties, drive-through programs, and thousands upon thousands of phone calls. With deep knowledge of their communities, senior centers creatively pivoted to meet ever-changing needs. Many moved programs from in-person to virtual. Today, their in-person participation is rebounding, and those with capacity continue to offer virtual options for older adults who cannot attend the center due to transportation or health issues. When vaccines became available, senior centers stepped in to facilitate appointments, provide transportation, and host clinics.

Senior centers are also an integral part of the OAA senior nutrition program. The OAA created two delivery systems for nutrition—congregate meals (Title III-C1) and, for those unable to access a congregate meal, home-delivered meals (Title III-C2). The pandemic demonstrated the importance of elevating both home-delivered meals and congregate meals as equally important vehicles for fighting senior hunger and addressing social isolation. These proven and effective community-based programs have more than 50 years of experience, expertise, and trust to serve those in greatest need. However, with rising costs and increasing demand, merely maintaining current funding levels is not enough. We need to increase the authorization level and provide greater parity to support both approaches at scale.

Senior centers are the most common site for congregate meals. During the pandemic, we saw innovation in meal delivery such as grab-and-go meals and virtual options for dining with friends. The flexibility to implement innovative solutions should be maintained and encouraged, as should local flexibility, with limits, to shift funds to the most-needed services. However, the OAA should continue to recognize and prioritize them as distinct programs and fund them equally and adequately. Sharing a meal is one of the most treasured traditions of social connection. We must support the modernization of the congregate meal, in conjunction with senior centers, to ensure current and future generations of older adults have this opportunity.

While they provide these critical services, senior centers, in general, are chronically underfunded. They rely on municipal dollars, philanthropy, and fundraising. While some are operated by Area Agencies on Aging (AAAs), especially when the AAA is part of county government, most are not. They are part of municipal government or nonprofit community-based organizations. In 1978's Older Americans Act Reauthorization, senior centers were placed in the consolidated Title III-B, Support Services and Senior Centers. In the allocation of scarce resources and without a requirement that any percentage of the appropriation for III-B be directed to senior centers, senior

centers generally are not funded by the OAA. They might get funding on a service unit reimbursement rate (e.g., for meal delivery) but not for general programs, operations, or facility needs.

Senior centers that received investments from the American Rescue Plan (ARPA) saw innovations that were not possible before. ARPA was an infusion of funding that supported innovations like grab-and-go meals, allowed communities to make renovations or purchase equipment (for exercise, technology, kitchens, etc.), and shored up the senior nutrition program. ARPA showed us what was possible with better support. However, once ARPA funds are expended, those innovations will not likely be funded, and the programs that were supported will, again, face budget shortfalls.

NCOA has been the national voice for senior centers for more than 50 years. We have over 2,300 senior centers in our affiliate network and, through a three-year cooperative agreement with the U.S. Administration for Community Living (ACL), we have established a Resource Center for the modernization of senior centers. Through this work, we see some senior centers that are modernizing and thriving with new or renovated facilities that support today's technological needs, fitness programs, evidence-based programs, meal options, and services to address complex issues like homelessness and behavioral health. These centers also provide support for economic security through information and referral and benefits enrollment. They have collaborative partnerships with organizations and businesses in their communities, with aging network partners like AAAs, and with community partners like libraries, parks and recreation, and public health. New models of senior centers, including public/private partnerships, wellness centers, and intergenerational centers have been developed.

But not all senior centers are thriving. NCOA conducted an environmental scan, which identified the successes and challenges of senior centers today. Inadequate support, both in recognition of their value and in the allocation of resources, is at the top of the list of challenges.[12] Centers do not have the funding and direction needed to upgrade their facilities, to access technology, and to ensure a skilled workforce. The centers that struggle the most are those in areas of greatest need.

[12] https://www.ncoa.org/article/the-state-of-todays-senior-centers-successes-challenges-and-opportunities

Through OAA Reauthorization, Congress has an opportunity and obligation to provide the focus and funding that will ensure that a modern senior center—one that addresses the needs of current and future generations of older adults in a way that is culturally meaningful—is available in every ZIP code.

OAA Reauthorization should:

- Address lessons learned from the pandemic related to promoting equitable access to senior center services, addressing diverse needs, and pursuing innovation in nutrition programs.
- Ensure strong congregate settings in the community by reinstating a separate title for senior centers and updated language that retains the "special consideration" of senior centers as designated focal points and by strengthening support for multipurpose senior center infrastructure and services, while allowing for the flexibility capacity for virtual connections.
- Strengthen the authorization for modernizing senior centers.
- Increase the authorization level of senior nutrition programs to allow for greater parity for both home-delivered meals and congregate meals approaches to be equally funded at scale.

Healthy Aging

Title III-D Health Promotion

Chronic conditions are the leading cause of frailty, disability, and death in the United States. They lead to declining activities of daily living (ADLs), causing affected individuals to lose their independence, require help from family and/or paid caregivers, and need long-term services and supports. Yet, there are evidence-based health promotion and disease prevention programs that we know can help and work.

NCOA has been a leader in expanding access to health promotion and disease prevention programs, many of which have been shown through research to reduce or delay expensive hospital or nursing home admissions. Through education, outreach, and community programs, NCOA provides older Americans with the tools and resources they need to age well—physically, cognitively, and mentally. Through our ACL-funded National Chronic Disease Self-Management Education and Falls

Prevention Resource Centers, NCOA provides broad support and technical assistance to state agencies and community-based organizations delivering these programs.

These health promotion and disease prevention programs result in positive health outcomes related to managing chronic disease, preventing falls, increasing physical activity, and reducing symptoms of depression and social isolation. These well-researched programs have resulted in health care cost savings for participants:[13]

- A Matter of Balance, a falls prevention program, reduces total annual medical costs by $938 per participant.
- The Otago Exercise Program reduces falls by 35%, resulting in net savings of $429 per participant.
- The Community Aging in Place Advancing Better Living for Elders Program (CAPABLE) provides home modifications to reduce falls risks resulting in more than $30,000 in medical costs savings.
- The Chronic Disease Self-Management Program (CDSMP) shows participants saved $714 in emergency department visits and hospital utilization. If 10% of Americans with one or more chronic conditions were reached by CDSMP, there's potential for $6.6 billion in savings.[14]

Given that 80% of older adults experience two or more chronic conditions, NCOA believes CDSMP should be offered in every ZIP code across the U.S. in an effort to save lives and decrease health care costs. CDSMP is a workshop for adults with at least one chronic health condition, which may include diabetes, heart disease, or arthritis. Given that chronic conditions are the primary drivers of health care costs and disability, as well as declines in quality of life, we must ensure that anyone with a chronic illness has access to this program. CDSMP focuses on critical disease management skills, including decision making, problem-solving, and action planning. The program increases confidence, physical and psychological well-being, knowledge of ways to manage chronic conditions, and motivation to manage challenges associated with chronic diseases. Interactive

[13] https://www.ncoa.org/article/falls-prevention-programs-saving-lives-saving-money-infographic
[14] Lorig K, Ritter P, Stewart AL, et al. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. *Medical Care*. 2001;39:1217–1223.

educational activities include peer discussions, brainstorming, action-planning and feedback, behavior modeling, problem-solving techniques, and decision making. The program also results in behavior change, such as more exercise and relaxation, better communication with health care providers, healthy eating, medication management, and better management of fatigue.

The delivery of these programs to older adults is funded by OAA Title III-D. Funding amounted to $26.3 million in the FY23 federal budget; this funding is shared across all states, territories, and the District of Columbia. Beginning in 2012, ACL required that programs funded by Title III-D meet strict evidence-based criteria defined as proven effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults; *and* proven effective with older adult population, using experimental or quasi-experimental design; *and* results published in a peer-review journal; *and* fully translated in one or more community site(s); *and* includes developed dissemination products that are available to the public.

However, not all these programs are reaching older adults in need, especially in rural and diverse communities. This lack of access is due in part to inadequate funding under OAA Title III-D, which has not kept pace with growing needs and costs to deliver evidence-based programs. Congress and the Administration must address lessons learned from the pandemic related to promoting equitable access to services, addressing diverse needs, and expanding healthy aging programs that are offered both in-person and virtually. For example, the costs associated with delivery of virtual programs are significantly higher in most cases than in-person programs due to greater technology and staffing needs.

NCOA recognizes that evidence-based programs have some implementation challenges and inequities. Most have not been tested with a full diversity of populations, communities, or contexts. Some communities struggle to implement them as designed. Therefore, we advocate for expanding the continuum of programs funded under the OAA to include those that are "evidence-informed," defined as an approach in which "practitioners are encouraged to be knowledgeable about findings coming from all types of studies and to use them in an integrative manner, taking into consideration

experience with a program or intervention and judgment, clients' preferences and values, and context of the interventions."[15]

NCOA is proud to be leading the Innovation Lab through funding from ACL's Center for Performance and Evaluation. We are partnering with researchers to take a "core-components" approach to identify what is truly necessary to achieve the ultimate goal—better outcomes for people and communities. This broader approach gives communities the flexibility to deliver programs that match their capacity and meet the needs of their culturally diverse populations. This core components methodology is being applied to falls prevention interventions, and we believe it has significant potential across other areas of aging services such as nutrition and chronic disease management.

OAA Reauthorization should:

- Double authorized funding levels for OAA Title III-D to support the licensing, training, technology, and other costs required for implementation of evidence-based programs.
- Expand the continuum of programs funded under the OAA to include those that are "evidence-informed."

Jane's Story

One of our participants, a 76-year-old woman, initially relied on a walker for mobility. However, as she diligently engaged in the exercises taught in our sessions, her progress was remarkable. By the third session, she entered class confidently using only her cane, brimming with pride at her newfound ability. Her excitement was palpable as she shared how these exercises had significantly improved her mobility and daily activities. Her husband, who accompanied her to class, echoed her joy, thrilled to engage in activities together that had been out of reach for a while.

Direct Care Workforce

[15] Adapted from: Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: towards evidence-informed practice. *British Journal of Social Work*, 41(1), 1–22.

Between 2021 and 2031, the direct care workforce is projected to add more than 1 million new jobs, resulting in a total of 9.3 million direct care jobs need to be filled,[16] according to PHI. Low wages, lack of full-time employment, and the pandemic have caused fewer workers to enter direct care at the exact time the need for their services is growing.

Funded by ACL, the Direct Care Workforce Strategies Center, housed at NCOA, is addressing this challenge by supporting state systems change through the provision of resources, technical assistance, and training to state systems, providers, and stakeholders to improve direct care workforce recruitment, training, and retention.

This Center addresses the charge of OAA and its National Family Caregiver Support Program (enacted as part of the 2000 OAA reauthorization) to build and strengthen the care infrastructure needed to address the pressing challenges that threaten the independence, health, and economic security of older adults who rely on the support of family caregivers.

OAA Reauthorization should:

- Strengthen authorities for sustained funding for the Direct Care Workforce Strategies Center beyond five years to increase dissemination of state technical assistance and training opportunities to ensure an adequate and well-trained direct care workforce.

Economic Security

Older adults are more likely to face economic insecurity as they age. In 2023, poverty among older adults rose for the third consecutive year to 14%.[17] An analysis conducted by NCOA and the LeadingAge LTSS Center at the University of Massachusetts, Boston found that of people age 60 and older, 80% (47 million) do not have the financial resources to cover long-term care services or another financial shock, nearly 20% of older households have no assets to draw upon to withstand a financial shock, and 21-80% of older adults have modest assets but would still be unable to afford more than two years of nursing home care or four years in an assisted living community.[18]

[16] https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/
[17] https://www.ncoa.org/article/older-adult-poverty-continues-upward-trend-reaching-an-unacceptable-14-percent
[18] https://www.ncoa.org/article/80-percent-of-older-americans-cannot-pay-for-long-term-care-or-withstand-a-financial-shock-new-study-shows

An important factor in determining older adults' economic security is the geographic location of their primary residence. Regions such as the Northeast and the West Coast have a higher cost of living compared to states in the Sunbelt region. NCOA urges Congress and the Administration to modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index[19], which is a more accurate measure of the income older adults need to meet their basic needs and age in place with dignity. It includes household size, geographic location, housing, and health status in determining costs of living. The Elder Index is updated annually to include the latest Consumer Price Index data to account for inflation costs. Elder Index data show that nearly half of older adults live alone, and one in five older couples are economically insecure and cannot pay for necessities.[20] The costs of necessities in every state exceeds the federal poverty thresholds used in eligibility requirements for benefits programs.

The Elder Index also shows that the average Social Security benefit does not cover the cost of basic expenses. Researchers from the University of Massachusetts, Boston reported that the average Social Security benefit only covers 68% of the costs for basic necessities for a single person living alone and 81% for couples living together.[21] This gap identifies the reality that many older adults must use other means to cover their basic costs either by working, withdrawing from savings and other retirement accounts, or relying on social safety net programs such as the Supplemental Nutrition Assistance Program (SNAP) or Medicare Savings Programs.

OAA Reauthorization should:

- Modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index to ensure the local cost of living are addressed as future generations are expected to age with limited financial resources.

Christian's Story

[19] https://elderindex.org/

[20] Mutchler, Jan; Su, Yan-Jhu; and Velasco Roldan, Nidya, "Living Below the Line: Economic Insecurity and Older Americans, Insecurity in the States, 2022" (2023). Center for Social and Demographic Research on Aging Publications. 66.

[21] https://kffhealthnews.org/news/article/elder-index-aging-costs-seniors-basic-necessities/.

Christian, 61, lives with disabilities and relies on a fixed income of $1,156 monthly. He relocated to Windsor, VT, to assist his 93-year-old father with his care. Christian previously paid $148.50 for Medicare, along with co-pays for medications, without receiving assistance for food, fuel, or prescriptions. Unfamiliar with available resources in Vermont due to being a non-native, Christian faced financial strain when prescribed a new medication with a $500 co-pay. With the help of a local benefits enrollment center, Senior Solutions, Christian received a tablet for telehealth, facilitating his connection with family in New York and easing access to medical services. Additionally, Christian applied for food benefits, fuel assistance, and pharmacy aid programs, promptly receiving a tablet for telehealth, a SNAP card with $202 for food, $56 for fuel assistance, and relief from his Medicare Part B premium, qualifying him for Medicaid after a $60 spend down. Thrilled by these benefits, Christian anticipates saving for a car, resulting in monthly savings exceeding $500. These supports allow Christian to continue to care for his father and himself, both remaining independent.

Older Workers

For millions of Americans, aging well means having the opportunity to work in the years leading up to and beyond the traditional retirement age. The reasons older adults want or need to work are the same as at any age. Work provides meaning, social connections, and much-needed income to pay for daily needs. As longevity continues to climb and many Americans struggle to save enough for retirement, work is also essential to affording a longer life. This is especially true for older adults of color, who experience higher rates of poverty than white older adults, and among rural and LGBTQ+ older adults who face access barriers and discrimination in employment.

Since 1968, NCOA has served as one of several national administrators for the Senior Community Services Employment Program (SCSEP). Today, we provide SCSEP services in 11 states and Puerto Rico, including Georgia, New York, North Carolina, and Pennsylvania. This work has given us clear insight into the value older workers contribute to our economy.

A Department of Labor program that is authorized and funded under OAA, SCSEP is the only federal job training program focused exclusively on helping older Americans return to the workforce. It prioritizes services to veterans, individuals with disabilities, those living in rural communities, and other most-in-need older adults who have low job prospects and significant barriers to employment. Significant majorities of participants have incomes below the 125% federal poverty

line, are women, and are people of color. The program enables them to develop new skills and add work experience through subsidized community training assignments with local nonprofit organizations.

SCSEP incorporates benefits coordination and access to wraparound services. Older workers—particularly low-income individuals with significant barriers to employment—have traditionally been left behind by public workforce systems and strategies. Many have been out of the workforce due to caregiving responsibilities, health and disability challenges, and age discrimination. For many, the traditional 40-hour week and year-round employment placement envisioned in Workforce Innovation and Opportunity Act (WIOA) and other public workforce programs are not appropriate. These systems lack the targeted, one-on-one counseling and assistance many older workers require for successful training and re-employment.

However, the impact on ageism starts much before age 55. We advocate for lowering SCSEP eligibility to 50, so we can broaden the impact of the program by helping people retool their skill set earlier in life. Similarly, we recommend broadening the income eligibility to at or below 200% of the federal poverty level to recognize that those who are slightly over the current cap still need the help of a program like this. If we focus on younger individuals with slightly more income initially, we will be able to further decrease the curve of individuals falling into a position that requires federal benefits and Medicaid.

OAA Reauthorization should:

- Update SCSEP eligibility to make it available to adults 50 years and older.
- Adjust income eligibly guidelines to allow for individuals with incomes at or below 200% of the federal poverty level to improve access for older workers struggling with financial security and employment.

Susan's Story

At age 75, Susan learned of the NCOA SCSEP program while waiting at her doctor's office. Unsure of what to expect, but in dire need of work, she took a chance and dialed the number listed on the flyer, hoping for assistance. At the Crawford County Read Program, Susan found fulfillment in helping

people of all ages improve their literacy and basic math skills. However, when the program faced closure due to funding issues, Susan feared returning to financial uncertainty.

Thankfully, another opportunity arose swiftly, and Susan embarked on training as a receptionist at an organization dedicated to mental health awareness. As Susan's tenure in the program approached its conclusion, her colleagues recognized her value and advocated for her to join the team permanently. In a remarkable show of support, Susan's coworkers collectively urged management to hire her full-time.

Now secure in her job and an active taxpayer, Susan expresses a newfound sense of relief, stating that she can finally relax knowing she has stable employment. She passionately shares her experience with others, emphasizing the vital role of SCSEP in assisting older adults facing employment obstacles, noting that the program can be a lifeline for many.

CONCLUSION

The OAA provides our nation with a blueprint for ensuring we have the infrastructure in place to support individuals across the full spectrum of domains related to aging in community and at home as we all desire. The various titles of the Act intentionally and thoughtfully support an ecosystem for deploying services and supports that reflect the needs of states and communities, prioritizing the most vulnerable.

With nearly 12,000 people turning 65 each day this year and for the next several years, we applaud ACL's leadership in updating the Act with the recently released OAA regulations, largely building upon lessons of the pandemic, and we also recognize that demographic trends require us to further align federal, state, and local programs with the needs of today and tomorrow. We appreciate this opportunity to offer our priorities to reauthorize, modernize, and fund the Older Americans Act to ensure every American can age well.