96TH CONGRESS } SENATE { REPORT
1st Session } { No. 96-55

PART 1

DEVELOPMENTS IN AGING: 1978

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 375, MARCH 6, 1978, AND
S. RES. 376, MARCH 6, 1978

Resolutions Authorizing a Study of the Problems of the Aged and Aging

TOGETHER WITH

ADDITIONAL VIEWS

MARCH 30, 1979.—Ordered to be printed

Filed, under authority of the order of the Senate of March 29, 1979

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U.S. GOVERNMENT PRINTING OFFICE
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SPECIAL COMMITTEE ON AGING [1]

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[1] Amendment No. 23 to S. Res. 4, Reorganization of the Senate Committee System, agreed to Feb. 1, 1977, established the Special Committee on Aging as a permanent, nonlegislative committee under the rules of the Senate. Membership was reduced from 23 to 14 for the 95th Congress and by attrition must begin the 96th Congress with no more than 9 members. S. Res. 21, Jan. 23, 1979, increased the membership on the committee to 10. S. Res. 101, Mar. 13, 1979, increased the membership on the committee to 12.

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., March 29, 1979.

Hon. WALTER F. MONDALE,
President, U.S. Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolutions 375 and 376, agreed to March 6, 1978, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1978, Part 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

LAWTON CHILES, *Chairman.*

SENATE RESOLUTION 375, 95TH CONGRESS, 2D SESSION [1]

Resolved, That the Special Committee on Aging, established by section 104 of Senate Resolution 4, 95th Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from March 1, 1978, through February 28, 1979, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

SEC. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from March 1, 1978, through February 28, 1979, to expend $321,000 from the contingent fund of the Senate, of which amount (1) not to exceed $25,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such act).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 28, 1979.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at annual rate.

SENATE RESOLUTION 376, 95TH CONGRESS, 2D SESSION [1]

To make sections 133(g), 134, and 202 of the Legislative Reorganization Act of 1946 applicable to the Special Committee on Aging.

Resolved, That section 104(a)(2) of Senate Resolution 4, 95th Congress, agreed to February 4 (legislative day, February 1), 1977, is amended by inserting "and for purposes of sections 133(g), 134, and 202 of the Legislative Reorganization Act of 1946," before "the special committee".

[1] Agreed to Mar. 6, 1978.

PREFACE

Almost 3 years remain before the next White House Conference on Aging is held. This provides an excellent opportunity for the administration and Congress to pull together the information needed for an effective conference, preceded by useful forums and State conferences. It also provides a means to take stock of what has and has not been accomplished since 3,400 delegates made a stirring call for action at the last White House Conference on Aging in 1971. Much progress, to be sure, has been made since the early 1970's. Social security benefits have been improved considerably. A supplemental security income program has been established to provide more adequate income for the aged, blind, and disabled. The mandatory retirement age for most workers in the private sector has been raised from 65 to 70, and the Federal Government banned mandatory retirement for practically all of its employees last fall. A national nutrition program for older Americans is now operating in every single State and provides more than 500,000 nutritious meals in a wide range of settings for older Americans 5 days a week.

However, major challenges exist in fashioning a national policy on aging. One good example is that our health care system is crisis oriented with a heavy institutional bias. Only a small portion of medicare, medicaid, and other Federal health expenditures are directed at home health care. Formidable barriers now make it difficult for many older Americans to receive home health care under medicare. Recently, Senators Chiles, Church, Burdick, Percy, Heinz, Cohen, and Kassebaum joined Senator Domenici in sponsoring a comprehensive home health package (S. 489). This bill includes several important features to make home health benefits more accessible, including the removal of the 3-day prior hospitalization requirement to qualify under part A (hospital insurance) of medicare, elimination of the 100-visit ceiling under both part A and part B (supplementary medical insurance), and making occupational therapy a primary service for a home health patient instead of a secondary service.

Another essential challenge is to control inflation, which not only erodes the purchasing power of the elderly but also threatens to undercut the integrity of public and private retirement systems. More and more now, older Americans are telling the Committee on Aging that a comfortable income a few years ago no longer stretches as far today. For millions of elderly persons, inflation is their number one problem. Rapidly rising prices have already had an enormous impact on social security, the civil service retirement system, and other income maintenance programs. Social security's recent need for additional financing—especially over the short range—was caused in large part by inflation. From July 1975 to December 1978, rising prices increased social security's outlays by an estimated $27.9 billion above and beyond what was initially forecast by Government experts in late 1973.

The Senate Committee on Aging will continue to focus on these challenges and other vital issues facing older Americans. The committee will attempt to gather facts upon which intelligent policy decisions can be made for older Americans today and tomorrow. Important spadework has already been performed in the overall hearings on retirement and work. One common theme has clearly emerged: The United States has no rational retirement policy today. Existing pension systems oftentimes operate as if they were in a vacuum. Private pension plans may be closely connected with social security; others are loosely related; and some have no relationship whatsoever. And, confusion often abounds for those planning for their retirement.

The committee will examine another closely related question: What should be the appropriate mix for the various components of what might be termed our loosely knit retirement policies? At present, our income maintenance system can be analogized to a three-legged stool. The first leg is the social security system which provides partial replacement for lost earnings because of retirement in old age, death, or disability. In one form or another, it affects almost every American family. About 110 million persons pay into social security as employees or self-employed persons. Nearly 95 percent of all individuals now reaching age 65 are eligible for social security. For most older Americans, social security is their economic mainstay—accounting for more than half the income for about 7 out of 10 aged beneficiaries and 1 out of 2 elderly couple beneficiaries.

Private efforts, such as pensions, insurance, and savings, represent the second leg in the three-legged income maintenance stool. Nearly half of private-sector wage earners—or 48 million in all—work in jobs covered by private pension plans. More than 650,000 Keogh plans for self-employed people and 1,500,000 individual retirement arrangements for wage earners have been established. However, most older Americans today do not have a pension. Those fortunate enough to qualify frequently receive small benefits. In fact, only about 20 percent of all people 65 or older now receive a private pension. An additional 9 percent receive a government pension.

The third leg is means-tested assistance programs, such as supplemental security income, for persons with incomes insufficient to meet basic needs. About 2 million persons 65 or older receive SSI benefits. They are now assured a minimum monthly income of $189.40 for individuals and $284.10 for couples.

Several fundamental—and at times controversial—questions arise in any objective examination of our existing retirement system, including:

—What is the appropriate role for private efforts, social security, and SSI?

—Should any or all of these systems be revamped, restructured, or perhaps replaced?

—Should social security be a universal system so that employees of Federal, State, and local governments would be covered under the program?

—Should the social security payroll tax be the only source of financing for the cash benefits program or should some other source be used to pay some of the costs?

These questions are being addressed in one way or another by several distinguished advisory groups, including the Social Security Advisory Council, the National Commission on Social Security, the Universal Coverage Study Panel, and the President's Retirement Policy Commission. The committee will follow closely the deliberations of these groups and their recommendations.

The inquiry into neighborhoods represents another effort by the committee to provide an umbrella context for related questions which are often considered individually. National attention was directed at neighborhood-related issues when elderly residents of a San Francisco hotel were forcibly evicted in 1977. Subsequent committee on-site investigations and hearings have revealed that many aged are in a desperate situation in finding decent and affordable housing. In addition, Federal urban renewal policies frequently have destructive results for older Americans. These problems may intensify as a part of a massive shift in urban dynamics occurring throughout our Nation. However, the committee is encouraged by many constructive, cost-effective, and nonbureaucratic efforts at the local level to revitalize cities with minimum disruption for the neighborhood inhabitants. Older Americans—perhaps more so than other groups in our society—have the greatest need for strong and stable neighborhoods. They are likely to be the chief victims if they are forced to reside in rundown neighborhoods with substandard housing and inadequate public services.

Waste and fraud in government, always intolerable, is even more so when this Nation must face up to the need for reduced deficits and greater budgetary responsibility. Preliminary hearings on State antifraud units suggest that much more must be learned about the proper Federal-State "mix" of responsibility in combating fraud and abuse. The personal losses which fraud can cause should not be overlooked. Last year, the committee focused special attention on unethical and unscrupulous practices in the sale of "medi-gap" policies. Most agents who sell supplementary medical policies to older Americans are decent, hard working, and honest. However, there will always be "opportunists" who will attempt to take advantage of the unsophisticated or unsuspecting. These hearings helped provide the framework for the introduction of a Medicare Supplemental Health Insurance Information Disclosure and Protection Act. Strong bipartisan support has already been expressed for this proposal. A coalition for action, involving private insurers as well as State and Federal agencies, is now underway. The committee will keep close watch of its progress.

Self-evident as it may seem, it is not always realized that national goals for retirement income adequacy must consider health care costs in the equation. Medicare provides valuable protection, but it only does part of the job. In some respects, it is like a leaky umbrella. Much of medicare's reimbursement is targeted toward acute care when greater attention to chronic care may be more appropriate—especially as our "older" aged population continues to increase rapidly. A clear-cut and sound policy on alternatives in long-term care is needed now.

These challenges take on added importance as we move toward the next White House Conference because our society is becoming older. Today, one out of nine Americans is 65 years or older. In 50 years from now, about one out of every five or six persons will be an older American, or 55 million in all. In terms of sheer numbers, we, as as a Nation, have a vital stake in these demographic changes which are becoming more apparent and will accelerate in the years ahead.

LAWTON CHILES,
Chairman.
PETE V. DOMENICI,
Ranking Minority Member.

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EVERY NINTH AMERICAN [1]

When we declared our independence, every 50th American was a so-called older person (aged 65-plus). They came to some 50,000 out of an estimated total population of 2.5 million or 2 percent.

By the beginning of this century, the numbers of older persons had increased more rapidly than the young and represented every 25th American.

At the beginning of 1979, the estimated 24.4 million older Americans made up just over 11 percent of the population—"Every Ninth American."

But something quite different with new potentials for study and concern is also becoming evident. In the past, since the proportion of older persons in the population grew somewhat faster than did the other age groups, we had a growing total population, including the aged. The recent trends, however, have been different. The fertility rates since the end of the postwar baby boom have actually been below zero population growth so that continuation and the passage of time will bring us an aging society with an increasing median age.

Even cursory consideration indicates the implications for shifting of product markets, clothing styles, social and recreational facilities, types of housing, health care facilities, entertainment, et cetera.

STATE HIGHLIGHTS

In mid-1978, the largest concentrations of older persons—13 percent or more of a State's population—occurred in five States: Florida (17.6), Arkansas (13.4), Iowa (13.1), and Missouri and South Dakota (both at 13 percent).

California and New York each had more than 2 million older people while Florida, Pennsylvania, Texas, Illinois, and Ohio each had more than 1 million.

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Florida). Adding five more States (Pennsylvania, Texas, Illinois, Ohio, and Michigan) brings the eight-State total to almost half the older population of the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, North Carolina, Wisconsin, Tennessee, Georgia, Virginia, Minnesota, and Alabama) or a total of 19 to account for just under three-quarters of the older population. It requires an additional 11 States, or a total of 30, to include 90 percent. The remaining 10 percent of the 65-plus population lives in the remaining 21 States and the District of Columbia. (See exhibit A, page XXV, for a more detailed analysis of recent State trends.)

What is the older population like, and how does it change?

[1] Prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former assistant to the Commissioner on Aging, Department of Health, Education, and Welfare.

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold. The 65-plus population continues to grow faster than the under-65 portion; between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with a large number of in-migrants. These five States also had the fastest growth rates in 1970–78. Florida still has the highest proportion of older people—17.6 percent in 1978 (14.5 in 1970). Alaska, with just over 2 percent, remains the State with smallest number and smallest proportion of older persons (10,000 or 2.5 percent in 1978).

TURNOVER

The older population is not a homogeneous group nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,500 persons aged 65-plus die. The *net* increase is about 1,500 a day, or a half million a year, but the 5,000 "newcomers" each day are quite different from and have lived through a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1978, most older Americans were under 75 (62.1 percent); over half were under 73; and more than a third (35.6 percent) were under 70. Over 2.2 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available, but about 10,690 persons (end of 1976) are receiving cash social security benefits after producing some "proof of age" that shows ages of 100 or more. (See Projections, page XXIII, for changes in age distribution in the future.)

PERSONAL INCOME

Older economic units continue to have half the income of their younger counterparts. In 1977, half of the families headed by an older person had incomes of less than $9,110 as compared with $17,203 for families with under-65 heads; the median income of older persons living alone or with nonrelatives was $3,829 compared with $7,674 for under-65 unrelated individuals.

Some 3.2 million or a seventh of the elderly had incomes below the official poverty thresholds ($3,637 for older couples and $2,895 for older individuals). This is a significant improvement over the 4.7 million or quarter of the elderly who lived in "poor" households in 1970 and results primarily from the increases in social security benefits.

Women and minority aged are heavily overrepresented among the aged poor. Many of the aged poor became poor after reaching these ages because of the half to two-thirds cut in income that results from retirement from the labor force.

The theoretic retired couple budget prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living came to $7,198 in autumn 1977. A lower budget came to $5,031; a higher came to $10,711.

INCOME SOURCES AND FINANCIAL STATUS

The Bureau of Labor Statistics' Consumer Expenditure Survey for 1972 and 1973 also collected data on income, taxes, and value of and net change in assets. For the purpose of the survey, "family" includes both a group of persons related by blood or marriage living in a single household and unrelated individuals living alone or with nonrelatives (see exhibit B, page XXX, for more detailed data and for information on the characteristics of the "families").

A summary of the highlight shows the following by age of family head:

Category	Average annual		
		65-plus	
	Under 65	Amount	Index: Under 65 equals 100
Money income before taxes	$12,702	$6,292	50
Wages and salaries	10,294	1,524	15
Self-employment	994	402	40
Social security and railroad retirement	201	2,085	1,040
Government retirement, veterans, unemployment	253	450	178
Income from assets investments, etc	383	1,134	296
Other, including welfare, contributions, pensions, etc	577	697	121
Personal taxes	1,978	528	27
Income after taxes	10,728	5,764	54
Other money receipts	227	188	82
Goods and services received	149	68	46
Mortgage principal paid	−358	−76	21
Net increase in assets	942	353	38
Market value of financial assets	5,490	13,511	246

The older units had about half the income of the younger, primarily because the larger amounts from retirement benefits and income from investments for the older families did not balance out the loss of earnings from employment. As is to be expected, the financial assets of older families was greater than for the younger. Not as expected was the net increase in assets held by the elderly albeit at a lower figure than for the younger units; this is a result of the fact that older persons not only add less new assets but tend to avoid new liabilities completely.

EXPENDITURES

Older Americans spend proportionately more of their income on gifts and contributions, food, housing, and health and personal care and less on other items in a pattern generally similar to that of other low income groups. Persons living on fixed incomes are hit hard by price inflation and the elderly command little potential for personal

improvement of income. Even formulas that adjust retirement payments for changes in price indices are of only partial assistance since, at best, they provide only for a restoration of the previous living standard, they provide the "catch-up" well after the fact, and older people have little in easily available savings to carry them over.

The BLS survey (see exhibit B) shows the following by age of family head:

Category	Average annual			Distribution		
		65-plus			65-plus	
	Under 65	Amount	Index[1]	Under 65	Percent	Index[1]
Total	$10,059	$5,400	54	100.0	100.0	100
Insurance and pension	874	176	20	8.7	3.3	38
Gifts and contributions	410	490	120	4.1	9.1	222
Other consumption	8,775	4,734	54	87.2	87.7	101
Food	1,831	1,155	63	18.2	21.4	118
Alcoholic beverages	86	30	35	.9	.6	67
Tobacco products	146	60	41	1.4	1.1	79
Housing	2,619	1,559	60	26.0	28.9	111
House furnishings and equipment	438	174	40	4.4	3.2	73
Clothing	737	290	39	7.3	5.4	74
Transportation (excluding trips)	1,801	689	38	17.9	12.8	72
Health care (out of pocket)	480	448	94	4.8	8.3	173
Personal care	105	82	78	1.0	1.5	150
Recreation	712	336	47	7.1	6.2	87

[1] Index: Under 65 equals 100.

INCOME MAINTENANCE

Old Age, Survivors, and Disability Insurance

In September 1978, the Social Security Administration paid cash benefits to 34.4 million persons of all ages for a total of $7,829 million. Subtracting the 4.9 million under-65 disabled workers and their dependents (paid benefits from the disability insurance trust fund) there remains 29.9 million persons and $6,839 million in payments.

For retired workers and their dependents, the average monthly payment to the retired worker was $261.51; to their wives and husbands, $132.01; and to their children, $103.83. Almost 60 percent of all retired workers are receiving "reduced benefits," having started to draw benefits before attaining age 65.

For survivors of deceased workers, the average monthly payment to widowed mothers or fathers with children was $188.26; to the children, $180.59; to older and disabled widows and widowers, $238.27; and to parents, $213.09.

Special age-72 beneficiaries receive $82.93 plus 50 percent more for a wife.

Of the total 34.4 million beneficiaries in September 1978, 22.3 million or about 65 percent were aged 65 plus, as follows: 16.3 million retired workers, 5.9 million survivors and dependents, and 139,000 special age-72 beneficiaries.

Supplementary Security Income

In September 1978, the Social Security Administration sent checks to 1,993,000 65-plus persons eligible because of age and need, totalling $200.8 million. Of this amount, $147 million was State supplements administered by the Federal agency for the 27 States that have made such an arrangement. Two States pay no State supplement and 22 pay supplements (totalling $15 million) directly to their own eligible aged residents under the State law.

In addition, it is estimated, about 23,000 65-plus persons received SSI payments as "blind" and 260,000 as "disabled" beneficiaries with higher payments.

HEALTH

Total Health Costs

The total health bill in the United States rose from $38.9 billion in 1965, when it amounted to 5.9 percent of the gross national product, to $162.6 billion in 1977, 8.8 percent of the GNP. This more than tripling of the costs of health care results from vast technical changes, very rapid price increases, the "aging" of the population, and the increased utilization made possible by the provision of increased resources, especially through public programs.

In this period, hospital care costs rose most rapidly, proportionately from 34 percent of total costs to 40 percent; nursing home costs rose from 3 percent to 8 percent of the total; the other components increased in amounts but decreased proportionately.

Personal Health Care Expenditures

These expenditures (which exclude costs of research, construction, and certain public health activities like control of contagious diseases) rose from $33.5 billion in 1965 to $142.6 billion in 1977.

Per capita health care costs in 1977 for an older American came to $1,745, 3.4 times the $514 spent for each under-65 person. $769 or 44 percent of the $1,745 went for hospital care, $446 or about 26 percent for nursing home care, $302 or 17 percent for physician services, $121 or 7 percent for drugs, $43 or almost 3 percent for dentists' services, and the small remainder for all other items.

Older people represent 11 percent of the total population but account for 29 percent of total personal health care expenditures ($41.3 billion out of a $142.6 billion).

Of the $41.3 billion total personal health care expenditure for older persons in 1977, only $13.6 billion or 33 percent came from private sources; of the $27.6 billion or 67 percent paid for from public sources, $18.3 billion or 44.3 percent came from medicare, $6.9 billion or 16.7 percent came from medicaid, and the remaining $2.5 billion or 6 percent came from a variety of smaller programs.

Comparison of levels and sources of payments on a per capita basis over the last 11 years shows the following:

Age and year	Total	Direct out of pocket	3d-party payments: Total	3d-party payments: Government	3d-party payments: Private health insurance	3d-party payments: Philanthropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1977	514	164	350	150	187	13
65-plus:						
1966	445	237	209	133	71	5
1977	1,745	463	1,282	1,169	101	13
Distribution (percent):						
Under 65:						
1966	100.0	51.1	48.9	19.4	27.3	2.2
1977	100.0	31.9	68.1	29.1	36.4	2.6
65-plus:						
1966	100.0	53.2	46.8	29.8	15.9	1.
1977	100.0	26.5	73.5	67.0	5.8	0.

It should be noted that the above comparison shows a significant increase in the utilization of health care in addition to a doubling of health care prices, with a pronounced shift toward third-party payments, especially public programs.

Health Status

In a recent household interview survey of a sample of the noninstitutional population, over two-thirds (69 percent) of the older persons reported their health as good or excellent as compared with others of their own age. Almost 22 percent reported their health as fair and 9 percent as poor. Minority group members, residents of the South, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.

Counting older people in institutions as, by definition, in poor health, a total of 14 percent of all older people consider themselves in poor health.

The most frequently reported chronic conditions are: Arthritis (44 percent), hearing impairments (29 percent), and vision impairments, hypertension, and heart conditions (each about 20 percent).

While over 80 percent of the noninstitutional older population reported some chronic condition, less than 18 percent said that it limited their mobility. Some 5 percent were confined to the house (but only slightly over 1 percent were bedridden); almost 7 percent needed help in getting around (less than 2 percent needed the help of another person and less than 5 percent needed an aid like a cane, walker, or wheelchair); and almost 6 percent could move around alone, but with some difficulty.

Utilization

Older people are subject to more disability, see physicians about 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 82 percent reported no hospitalization in the previous year.

Based on data for 1974, on the average, a person aged 55–64 spends 2 days per year in a short-stay hospital. This increases to an average of 3.3 days for persons aged 65–74 and to 5.6 days for those 75 plus.

On the average, a person aged 55–64 spends a fraction of a day per year in a nursing home, with a jump to 4.4 days for persons aged 65–74, 21.5 days for those aged 75–84, and 86.4 days for those 85 plus.

Of the 1.1 million older people in nursing homes at the time of a 1977 study, 19 percent were aged 65–74, 41 percent were 75–84, and 40 percent were 85 plus; in the total older population, the comparable percentages were 62, 29, and 9. In the nursing home population, 74 percent were women (60 in the total), 69 percent were widowed, 14 percent were single, and 12 percent married; 93 percent were white. Of every 100 admissions to nursing homes in 1973–74 almost 40 came from their own private residences (only 13 had been living alone), 36 came from general hospitals, 14 from other nursing homes or related facilities, and the rest came primarily from mental institutions and boarding homes.

Death Rates

In the period between 1965 and 1976, annual death rates for older persons dropped about 11 percent from 6.1 per 100 to 5.4 per 100. Within the older population, there were these variations: The rate for persons 65–74 dropped 18 percent from 3.8 to 3.1 per 100; the rate for those 75–84 declined 11 percent from 8.2 to 7.3 per 100; while the rate for the 85-plus dropped 23 percent from 20.2 to 15.5.

The rate for deaths of older persons from heart disease dropped 14 percent, from 2.8 to 2.4 per 100 per year and the rate for deaths from stroke dropped 22 percent, from 0.9 to 0.7 per 100. On the other hand, the rate for deaths from cancer increased 11 percent, from 0.9 to 1.0. Still, these three causes of death accounted for three-quarters of the deaths of older people in both 1965 and 1976.

LIFE EXPECTANCY

Based on death rates in 1976, average life expectancy at birth was 72.8, 69.0 years for males but almost 8 years longer or 76.7 for females. At age 65, average remaining years of life were 16.0, 13.7 for men but more than 4 years longer or 18.0 for women. The 25-year increase in life expectancy at birth since 1900 results from the wiping out of most of the killers of infants and of the young—much smaller improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. Many more people now reach age 65 (about 75 percent versus 40 percent in 1900) but, once there, they live only 4.1 years longer than did their ancestors who reached that age in the past. Should recent decreases in death rates continue among older persons, especially from cardiovascular conditions, life expectancy in the later years may increase further.

SEX RATIOS

As a result of the yet unexplained longer life expectancy for families, most older persons are women—13.9 million as compared with 9.6

million men in mid-1977. Between ages 65 and 74, there are 130 women per 100 men; after 74, there are 176. In the 85-plus group, there are 217 women for every 100 men. The average for the total 65-plus population is 146 women per 100 men. (See also, "Projections," below.)

MARITAL STATUS

In 1978, most older men were married (7.1 million or 78 percent) but most older women were widows (6.9 million or 52 percent). There are 5.3 times as many older widows or widowers. Among 75-plus women, almost 70 percent were widows. About 35 percent of the married 65-plus men have under-65 wives. In 1976, among the 2.2 million marriages of persons of all ages, there were about 20,800 brides and 39,800 grooms aged 65-plus. For about 1,200 of these older brides and 2,000 older grooms, it was a first marriage. For the remainder, it was a remarriage, mostly after widowhood rather than divorce. Marriage rates for older men were seven times those for older women for marriages in 1976; for first marriages, the rates for older men were 2.5 times those for older women; for remarriages, the rate for men was 8.8 times that for women.

EDUCATIONAL ATTAINMENT

In 1978, almost half (46 percent) of the older Americans had not completed one year of high school; the median for the 25–64 age group was high school graduation. About 2.2 million or 10 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates.

LIVING ARRANGEMENTS

In 1978, more than 8 of every 10 older men, but less than 6 of every 10 older women, lived in family settings; the others lived alone or with nonrelatives except for the 1 in 20 who lived in an institution (1 in 5 in the 85-plus age group). About three-quarters of the older men lived in families that included the wife but only one-third of the older women lived in families that included the husband. Four of every 10 older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1978, a slightly smaller proportion of older than of younger persons lived in metropolitan areas (62 versus 67 percent). Within the metropolitan areas, however, about half of the older people lived in the central city but almost 60 percent of the under-65 lived in the suburbs. The inevitable aging of the residents of the suburbs which began their rapid expansion in the post-World War II period will soon bring a reversal of proportions and the development of the same problems, lacks, and barriers faced by the inner city aged.

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes. Some 62

percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than women voted, but the women still outnumbered the men voters. Voter participation falls off sharply after age 75.

MOBILITY

In the March 1978 household survey 13.7 percent or 3.1 million of the persons then aged 65-plus reported that they had moved from one residence to another in the 3-year period since March 1975. In a pattern that has remained consistent for a long period of time, remembering that most moves are made for occupational reasons, some 8.4 percent of the elderly moved within the same county, 2.9 percent moved to a different county within the same State, and only 2.3 percent moved across a State line. The impression that there is more extensive interstate migration of older people arises from the very visible flow but only toward a very few States—Florida, Arizona, and Nevada.

EMPLOYMENT

In 1978, just over 20 percent of 65-plus men (1.9 million) and 8 percent of 65-plus women (1.1 million) were in the labor force with concentrations in three low-earnings categories: Part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that in a period of sizable unemployment discouraged older workers stop seeking jobs and are not counted as being in the labor force at all. For those remaining actively in the labor force and counted as unemployed, the average duration of unemployment was longer than for younger workers.

AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but at least part of the difference depends on income level rather than age, health, or choice. A 1974 Census Bureau survey shows that 62 percent of older households owned at least one car as compared with 86 percent of younger households. However, there is a strong relationship between automobile ownership and income level at all ages and a much higher proportion of low-income households among the elderly—thus accounting, in part, for the lower ownership in older households.

PROJECTIONS

The "safest" Census Bureau population projections of the size and composition through 2050 are the so-called "series II" which are based on an ultimate cohort fertility rate of 2.1 (an ultimate level of 2.1 children per woman or eventual zero population growth), small improvements in life expectancy including that for older persons, narrowing of the gap between white and black rates, constant 400,000 net immigration, and no new major medical "cures" of chronic diseases.

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65 PLUS BY SEX, 1977-2050

[Numbers in thousands]

Year	All ages	65-plus				
		Both sexes		Male	Female	
		Number	Percent of all ages		Number	Per 100 men
1977	216,745	23,431	10.8	9,545	13,885	145
1980	222,159	24,927	11.2	10,108	14,819	147
1985	232,880	27,305	11.7	11,012	16,293	148
1990	243,513	29,824	12.3	11,999	17,824	149
1995	252,750	31,401	12.4	12,602	18,799	149
2000	260,378	31,822	12.2	12,717	19,105	150
2005	267,603	32,436	12.1	12,924	19,512	151
2010	275,335	34,837	12.7	13,978	20,858	149
2015	283,164	39,519	14.0	16,063	23,456	146
2020	290,115	45,102	15.6	18,468	26,634	144
2025	295,742	50,920	17.2	20,861	30,059	144
2030	300,349	55,024	18.3	22,399	32,624	146
2035	304,486	55,805	18.3	22,434	33,371	149
2040	308,400	54,925	17.8	21,816	33,108	152
2045	312,054	54,009	17.3	21,335	32,674	153
2050	315,622	55,494	17.6	22,055	33,439	152

If the present fertility rate of approximately 1.8 should continue at this low level rather than the 2.1 rate assumed above, the size of the total population would be smaller and the *proportion* of older people would be larger. The increasing number and proportion of older persons reflects both the impact of longer life expectancy and the movement of the post-World War II baby boom through the population pyramid. Projections based on lower fertility rates also shows a much slower rate of growth of the older population after 2030 when today's babies and youngsters start reaching age 65.

The above projections represent averages. Important differences by sex and age group within the 65-plus are shown as follows:

POPULATION PROJECTIONS, TRENDS WITHIN THE 65-PLUS AGE GROUP, 1977-2050

[Percent change]

Sex	1977-2000	2000-25	2025-50
Both sexes, 65 plus	+35.8	+60.0	+9.0
65 to 74	+19.6	+77.5	-6.7
75 to 84	+56.0	+41.1	+14.0
85 plus	+84.1	+32.4	+91.6
Male, 65 plus	+33.2	+64.0	+5.7
65 to 74	+21.3	+79.1	-6.3
75 to 84	+54.7	+44.1	+13.5
85 plus	+64.4	+29.9	+92.9
Female, 65 plus	+37.6	+57.3	+11.2
65 to 74	+18.3	+76.2	-7.1
75 to 84	+56.8	+39.4	+14.3
85 plus	+93.2	+33.4	+91.1

Thus, comparison of the 25-year time spans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the post-war babies reach their later years, and a sharp deceleration as the current low birth rates are reflected in older people. Significantly, the traditionally more rapid growth of the older women is reversed in the 2000

to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025, and return to the current trend after 2025.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young and the old are dependent on the middle group, the so-called productive-age population, tends to show a reasonable "burden" on the middle group under reasonable economic and labor force assumptions, as follows:

Year	Number aged under 18 per 100 aged 18 to 64	Number aged 65-plus per 100 aged 18 to 64	Total
1970	61.1	17.6	78.7
1977	49.7	18.2	67.9
2000	43.2	20.0	63.2
2025	42.1	29.6	71.7
2050	41.7	30.2	71.9

Exhibit A

Recent State Trends in the Older Population, 1970–78

Between 1970 and 1978, the Nation's older population (65-plus) increased from 20 million to 24.1 million at a rate faster than did the under-65 population as has been true for most of the twentieth century. These national trends, however, represent the averaging out of a variety of separate State trends. Details are presented in the tables and analyses that follow.

PROPORTION OF POPULATION AGED 65 PLUS

For the Nation as a whole (50 States and District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 11 percent in 1978. In Wyoming, the under-65 population grew faster and the proportion aged 65-plus actually dropped from 9.1 percent in 1970 to 8.4 percent in 1978. In four other States (Alaska, Colorado, Illinois, and Utah), the increase in the proportion of the State's population aged 65-plus was 0.5 percent or less in the 8-year period. The remaining States had larger increases.

SUMMARY: PERCENT OF STATE'S POPULATION AGED 65-PLUS, 1978

Under 8.0 (3)—Alaska, Hawaii, Utah.

8.0–8.9 (6)—Colorado, Maryland, Nevada, New Mexico, South Carolina, Wyoming.

9.0–9.9 (8)—Delaware, Georgia, Idaho, Louisiana, Michigan, North Carolina, Texas, Virginia.

10.0–10.9 (9)—Alabama, California, District of Columbia, Illinois, Indiana, Montana, New York, Ohio, Washington.

11.0–11.9 (11)—Arizona, Connecticut, Kentucky, Minnesota, Mississippi, New Hampshire, New Jersey, Oregon, Tennessee, Vermont, Wisconsin.

12.0–12.9 (9)—Kansas, Maine, Massachusetts, Nebraska, North Dakota, Oklahoma, Pennsylvania, Rhode Island, West Virginia.
13.0–13.9 (4)—Arkansas, Iowa, Missouri, South Dakota.
Over 17.0 (1)—Florida.

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same general pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the accompanying table by State rank order, at the points where the States in the total population column and the 65-plus population column match exactly, the percentages are as follows:

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.3	10.3	9.4	9.4
New York	8.2	18.5	8.8	18.2
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.5	48.0	30.8	49.0
New Jersey	3.4	51.4	3.4	52.4
Massachusetts	2.6	54.0	2.9	55.3
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, Louisiana, Washington, Alabama, Kentucky, Connecticut, South Carolina, Iowa, Oklahoma, Colorado, Oregon, Mississippi, Arizona, Kansas, Arkansas	38.6	92.6	37.8	93.1
West Virginia	.9	93.5	.9	94.0
Nebraska	.7	94.2	.8	94.8
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.7
Hawaii, Idaho, New Hampshire, Montana, South Dakota, District of Columbia, Nevada	2.5	98.8	2.3	99.0
North Dakota, Delaware, Vermont	.8	99.6	.8	99.8
Wyoming, Alaska	.4	100.0	.2	100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1978

State	Number		Percent increase		Percent of all ages		State rank[2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1978	1960–70	1970–78	1970	1978	1970	1978	1960–70	1970–78	1970	1978
Total, 51 States	19,972,330	24,053,950	21.1	20.4	9.8	11.0						
Alabama	324,263	408,377	24.7	25.9	9.4	10.9	21	19	16	16	30	27
Alaska	6,800	9,964	27.9	26.5	2.3	2.5	51	51	11	6	51	51
Arizona	160,881	268,713	79.0	67.0	9.1	11.4	35	31	1	2	34	19
Arkansas	236,700	293,191	22.0	23.9	12.3	13.4	28	28	21	22	3	2
California	1,791,615	2,242,727	30.9	25.2	9.0	10.1	2	1	9	17	36	34
Colorado	187,014	232,173	18.8	24.1	8.5	8.7	33	33	24	20	38	45
Connecticut	287,520	347,499	19.1	20.9	9.5	11.2	26	26	23	26	27	22
Delaware	43,649	55,071	22.6	26.2	8.0	9.5	48	48	20	15	42	38
District of Columbia	70,318	72,633	2.4	3.3	9.3	10.8	41	45	51	51	32	28
Florida	985,266	1,509,809	78.2	53.2	14.5	17.6	7	3	2	3	1	1
Georgia	365,326	472,528	26.4	29.3	8.0	9.3	17	16	15	11	42	40
Hawaii	43,983	66,336	51.3	50.8	5.7	7.4	47	46	4	4	50	50
Idaho	67,417	87,295	16.3	29.5	9.5	9.9	44	42	29	10	27	35
Illinois	1,088,744	1,206,332	12.2	10.8	9.8	10.7	4	6	40	46	24	29
Indiana	491,659	563,577	10.8	14.6	9.5	10.5	12	12	45	40	27	31
Iowa	349,213	378,146	6.9	8.3	12.4	13.1	19	22	49	49	2	3
Kansas	265,329	296,907	10.8	11.9	11.8	12.6	27	27	45	44	7	8
Kentucky	335,919	388,018	15.1	15.5	10.4	11.1	20	21	35	37	21	24
Louisiana	305,009	370,434	27.0	21.5	8.4	9.3	23	23	12	25	39	40
Maine	114,134	132,718	7.6	16.3	11.5	12.2	36	36	48	32	9	11
Maryland	298,212	369,718	32.3	24.0	7.6	8.9	25	24	8	21	45	43
Massachusetts	633,384	699,997	11.3	10.5	11.1	12.1	10	10	43	48	10	12
Michigan	749,081	867,027	18.0	15.7	8.4	9.4	8	8	25	36	39	39
Minnesota	407,456	463,320	15.4	13.7	10.7	11.6	15	18	33	41	14	18
Mississippi	221,133	268,995	17.0	21.6	10.0	11.2	30	30	27	24	22	22
Missouri	558,374	629,412	11.4	12.7	11.9	13.0	11	11	42	43	6	4
Montana	68,479	81,171	5.1	18.5	9.9	10.3	43	43	50	29	23	33
Nebraska	182,625	202,302	11.8	10.8	12.3	12.9	34	35	41	46	3	6
Nevada	30,780	55,231	70.4	79.4	6.3	8.4	49	47	3	1	49	47
New Hampshire	78,084	95,852	15.8	22.8	10.6	11.0	39	40	31	23	19	25

See footnotes at end of table.

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1978—Continued

State	Number		Percent increase		Percent of all ages		State rank[2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1978	1960–70	1970–78	1970	1978	1970	1978	1960–70	1970–78	1970	1978
New Jersey	693,503	824,489	24.4	18.9	9.7	11.3	9	9	17	28	25	20
New Mexico	70,205	103,605	37.7	47.6	6.9	8.5	42	38	5	5	48	46
New York	1,951,331	2,094,681	15.8	7.3	10.7	11.8	1	2	31	50	14	15
North Carolina	411,880	550,280	32.7	33.6	8.1	9.9	14	13	7	8	41	35
North Dakota	66,159	78,226	13.3	18.2	10.7	12.0	45	44	36	31	14	13
Ohio	993,119	1,124,794	11.2	13.3	9.3	10.5	5	7	44	42	32	31
Oklahoma	298,674	356,988	20.1	19.5	11.7	12.4	24	25	22	27	8	9
Oregon	225,756	285,462	23.5	26.4	10.8	11.7	29	29	19	14	13	16
Pennsylvania	1,266,508	1,460,554	12.7	15.3	10.7	12.4	3	4	37	38	14	9
Rhode Island	103,836	120,464	16.1	16.0	10.9	12.9	37	37	30	34	12	6
South Carolina	189,842	257,895	26.8	35.8	7.3	8.8	32	32	13	7	46	44
South Dakota	80,274	89,370	12.5	11.3	12.1	13.0	38	41	38	45	5	4
Tennessee	382,021	477,892	24.0	25.1	9.7	11.0	15	15	18	18	25	25
Texas	987,505	1,264,444	32.9	28.0	8.8	9.7	6	5	6	13	37	37
Utah	77,047	101,911	29.4	32.3	7.3	7.8	40	39	10	9	46	49
Vermont	47,326	54,943	8.6	16.1	10.6	11.3	46	49	47	33	19	20
Virginia	364,156	467,789	26.6	28.5	7.8	9.1	18	17	14	12	44	42
Washington	320,394	300,664	15.4	25.1	9.4	10.6	22	20	33	18	30	30
West Virginia	193,717	222,661	12.5	14.9	11.1	12.0	31	34	38	39	10	13
Wisconsin	470,634	545,787	17.4	16.0	10.7	11.7	13	14	26	34	14	16
Wyoming	30,076	35,578	16.6	18.3	9.1	8.4	50	50	28	30	34	47

[1] Corrected for errors in numbers of centenarians.
[2] States ranked in decreasing order; State with largest quantity is ranked 1.

Source of data: Bureau of the Census (published and unpublished). Estimates and computations supplied.

XXIX

RESIDENT POPULATION, TOTAL OF AGE 65-PLUS, STATES IN RANK NUMBER ORDER, 1978

Rank	Total, all ages: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	65-plus: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	Rank
1	California	22,294	10.3	10.3	California	2,243	9.4	9.4	1
2	New York	17,748	8.2	18.5	New York	2,095	8.8	18.2	2
3	Texas	13,014	6.0	24.5	Florida	1,510	6.3	24.5	3
4	Pennsylvania	11,750	5.4	29.9	Pennsylvania	1,461	6.1	30.6	4
5	Illinois	11,243	5.2	35.1	Texas	1,264	5.3	35.9	5
6	Ohio	10,749	4.9	40.0	Illinois	1,206	5.1	41.0	6
7	Michigan	9,189	4.2	44.2	Ohio	1,125	4.7	45.7	7
8	Florida	8,594	3.9	48.1	Michigan	867	3.6	49.3	8
9	New Jersey	7,327	3.4	51.5	New Jersey	824	3.4	52.7	9
10	Massachusetts	5,774	2.6	54.1	Massachusetts	700	2.9	55.6	10
11	North Carolina	5,577	2.6	56.7	Missouri	629	2.6	58.2	11
12	Indiana	5,374	2.5	59.2	Indiana	564	2.3	60.5	12
13	Virginia	5,148	2.4	61.6	North Carolina	550	2.3	62.8	13
14	Georgia	5,084	2.3	63.9	Wisconsin	546	2.3	65.1	14
15	Missouri	4,860	2.2	66.1	Tennessee	478	2.0	67.1	15
16	Wisconsin	4,679	2.1	68.2	Georgia	473	2.0	69.1	16
17	Tennessee	4,357	2.0	70.2	Virginia	468	1.9	71.0	17
18	Maryland	4,143	1.9	72.1	Minnesota	463	1.9	72.9	18
19	Minnesota	4,008	1.8	73.9	Alabama	408	1.7	74.6	19
20	Louisiana	3,966	1.8	75.7	Washington	401	1.7	76.3	20
21	Washington	3,774	1.7	77.4	Kentucky	388	1.6	77.9	21
22	Alabama	3,742	1.7	79.1	Iowa	378	1.6	79.5	22
23	Kentucky	3,498	1.6	80.7	Louisiana	370	1.5	81.0	23
24	Connecticut	3,099	1.4	82.1	Maryland	370	1.5	82.5	24
25	South Carolina	2,918	1.3	83.4	Oklahoma	357	1.5	84.0	25
26	Iowa	2,896	1.3	84.7	Connecticut	347	1.4	85.4	26
27	Oklahoma	2,880	1.3	86.0	Kansas	297	1.2	86.6	27
28	Colorado	2,670	1.2	87.2	Arkansas	293	1.2	87.8	28
29	Oregon	2,444	1.1	88.3	Oregon	285	1.2	89.0	29
30	Mississippi	2,404	1.1	89.4	Mississippi	269	1.1	90.1	30
31	Arizona	2,354	1.1	90.5	Arizona	269	1.1	91.2	31
32	Kansas	2,348	1.1	91.6	South Carolina	258	1.1	92.3	32
33	Arkansas	2,186	1.0	92.6	Colorado	232	1.0	93.3	33
34	West Virginia	1,860	0.9	93.5	West Virginia	223	0.9	94.2	34
35	Nebraska	1,565	0.7	94.2	Nebraska	202	0.8	95.0	35
36	Utah	1,307	0.6	94.8	Maine	133	0.6	95.6	36
37	New Mexico	1,212	0.6	95.4	Rhode Island	120	0.5	96.1	37
38	Maine	1,091	0.5	95.9	New Mexico	104	0.4	96.5	38
39	Rhode Island	935	0.4	96.3	Utah	102	0.4	96.9	39
40	Hawaii	897	0.4	96.7	New Hampshire	96	0.4	97.3	40
41	Idaho	878	0.4	97.1	South Dakota	89	0.4	97.7	41
42	New Hampshire	871	0.4	97.5	Idaho	87	0.4	98.1	42
43	Montana	785	0.4	97.9	Montana	81	0.3	98.4	43
44	South Dakota	690	0.3	98.2	North Dakota	78	0.3	98.7	44
45	Dist. of Columbia	674	0.3	98.4	Dist. of Columbia	73	0.3	99.0	45
46	Nevada	660	0.3	98.8	Hawaii	66	0.3	99.3	46
47	North Dakota	652	0.3	99.1	Nevada	55	0.2	99.5	47
48	Delaware	583	0.3	99.4	Delaware	55	0.2	99.7	48
49	Vermont	487	0.2	99.6	Vermont	55	0.2	99.9	49
50	Wyoming	424	0.2	99.8	Wyoming	36	0.1	100.0	50
51	Alaska	403	0.2	100.0	Alaska	10	....	100.0	51

Source of data: Bureau of Census (published and unpublished). Computations supplied.

Exhibit B

Income and Expenditures, 1972–73

Approximately every 10 years, the Bureau of Labor Statistics collects detailed data on income and expenditures from a national sample of economic units (families and unrelated individuals) based in part on "diaries" and in part on household interviews. While the original purpose is to examine the validity of the consumption patterns and weights used in the Consumer Price Index computations, the surveys provide extremely significant data on a national basis of the sources and amounts of income, the holdings and returns on financial assets, and expenditures for consumption and other purposes. Further, the data may be cross-classified by the characteristics of the units in the sample.

The following, analytical tables show the data (annual averages for 1972–73) classified by the age of the family head (all ages, under 65, and 65-plus) with the term "family" applied to both kinds of economic units, the members of a traditional family living in a household and an unrelated individual living alone or with nonrelatives. Part A shows the characteristics of these "families." Parts B and C show the detailed data on income and expenditures summarized in the earlier text but also shows the proportion of "families" reporting such an income or expenditure item.

Most of the data are from published sources but the computation of the under-65 columns, the distributions, and the indices (the "percent of under 65" column is an index based on "under-65=100" were supplied by the author.

FAMILY INCOME AND EXPENDITURES, BY AGE OF HEAD CONSUMER EXPENDITURE INTERVIEW SURVEY, 1972–73

A. FAMILY CHARACTERISTICS

Item	All ages	Under 65	65-plus	
			Annual average	Percent of under 65
Number of families (thousands)	71,220	56,970	14,250	25
1-person families	16,761	10,218	6,543	64
Percent of total families	24	18	46	256
FAMILY CHARACTERISTICS				
Average:				
Size	2.9	3.2	1.7	53
Income before taxes	$11,419	$12,701	$6,292	50
Income after taxes	$9,731	$10,728	$5,764	54
Age of head	48	42	73	194
Children under 18	1.0	1.2	0.1	8
Persons 65 plus	0.3	(1)	1.3	(2)
Automobiles owned	1.3	1.4	0.8	57
Percent distribution by:				
Housing tenure:				
Owners	59	57	66	116
Renters	37	38	32	84
Not reported	4	5	2	40
Race of head:				
White	89	89	91	102
Black	10	10	8	80
Other	1	1	1	100
Education of head:				
1 to 9 years of schooling	21	15	46	307
9 to 12 years	43	46	30	65
12 plus years	29	32	16	50
None or not reported	6	6	8	133
Automobile ownership: Own 1 plus	80	86	58	67

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

B. INCOME, BY SOURCE, TAXES, ASSETS, AND LIABILITIES

Item	Percent reporting			Average annual amount			
						65-plus	
	All ages	Under 65	65-plus	All ages	Under 65	Amount	Percent of under 65
Money income before taxes	98.1	98.1	98.0	$11,419.16	$12,701.73	$6,291.60	50
Wages and salaries, total	78.1	89.7	31.6	8,539.60	10,294.41	1,524.05	15
Money, wages and salaries, civilians	74.8	89.7	27.3	8,475.92	10,214.25	1,526.24	15
Union dues paid	17.2	20.0	3.0	−17.53	−21,29	−2.50	12
Other occupational expenses paid	21.2	24.8	6.9	−33.57	−38.86	−12.43	32
Rent received as pay	.9	1.0	.4	9.78	10.95	5.12	47
Meals received as pay	8.6	9.9	3.5	18.82	21.80	6.90	32
Money wages and salaries, armed forces	.9	1.1	.1	70.86	88.40	.72	1
Quarters and subsistence	1.0	1.0	(1)	15.32	19.15	(1)	(2)
Self-employment income, total	12.9	13.5	10.4	875.24	993.63	401.93	40
Net income from own business	8.9	9.8	5.3	613.59	715.17	207.50	29
Net income from own farm	4.5	4.3	5.5	261.64	278.45	194.43	70
Social security and railraod income	25.0	9.5	87.0	577.61	200.56	2,085.02	1,040
Government retirement, veteran's payments, and unemployment compensation	15.2	14.4	18.6	292.65	253.19	450.40	178
Estates, trust, dividends, interest, rental income, royalties, and income from roomers and boarders, total	64.6	64.2	66.4	533.25	383.09	1,133.58	296
Rental income, royalties, income from roomers and boarders	8.6	7.6	12.7	120.87	100.90	200.71	199
Income from interest, dividends, estates, and trusts	62.7	62.6	63.3	412.38	282.19	932.87	331
Incomes from all other sources, total	68.0	72.5	50.0	600.81	576.84	696.63	121
Welfare and public assistance	6.4	5.8	9.0	107.30	108.87	100.63	92
Private pensions	5.7	2.1	20.2	129.00	48.77	449.77	922
Regular contributions for support	4.0	4.5	2.0	70.38	82.23	23.01	28
Other, including worker's compensation	61.8	69.5	31.0	294.12	336.87	123.21	37
Personal taxes, total	80.6	89.5	44.9	−1,687.93	−1,978.19	−527.51	27
Federal income taxes	75.0	85.9	31.3	−1,399.11	−1,644.64	−447.50	25
State and local income taxes	59.6	68.6	23.7	−234.05	−275.90	−66.75	24
Personal property and other personal taxes	25.6	26.5	22.1	−54.77	−57.65	−43.26	75
Other money receipts	14.0	15.0	10.2	219.41	227.38	187.56	82
Net change in assets and liabilities, total	85.5	90.6	65.1	824.23	942.02	353.31	38
Net change in assets	73.6	77.4	58.5	1,463.88	1,730.93	395.24	23
Net change in liabilities	64.4	74.9	22.5	−639.65	−788.91	−42.92	5
Goods and services received without direct expense	64.6	67.3	53.9	132.45	148.51	68.25	46
Market value of financial assets	76.0	78.0	70.9	7,094.67	5,479.73	13,611.04	246
Mortage principal paid on owned property	35.6	42.2	9.1	−301.46	−357.85	−76.02	21

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

Source: Bureau of Labor Statistics.

C. CONSUMER EXPENDITURES

Item	Percent reporting			Average annual amount				Percent distribution			
						65–plus				65–plus	
	All ages	Under 65	65–plus	All ages	Under 65	Amount	Percent of Under 65	All ages	Under 65	Percent	Percent of under 65
Consumpton expenses, total	100.0	100.0	100.0	$9,126.73	$10,058.90	$5,400.03	54	100.0	100.0	100.0	100
Personal insurance and pensions, total	86.7	93.4	60.1	734.18	873.77	176.13	20	8.0	8.7	3.3	38
Life, endowment, annuities, income	70.9	75.7	51.9	249.11	287.19	96.88	34	2.7	2.9	1.8	62
Other personal	10.7	11.3	8.4	7.72	8.46	4.76	56	.1	.1	.1	100
Retirement and pensions	70.8	83.2	21.2	477.35	578.12	74.49	13	5.2	5.7	1.4	25
Gifts and contributions	86.6	87.3	83.9	425.70	409.69	489.72	120	4.7	4.1	9.1	222
Consumption expense, excluding personal insurance, gifts, and contributions, total	100.0	100.0	100.0	7,966.85	8,775.44	4,734.18	54	87.3	87.2	87.7	101
Food, total	99.7	99.8	99.4	1,695.56	1,830.85	1,154.67	63	18.6	18.2	21.4	118
Food at home	99.1	99.2	98.8	1,307.62	1,388.71	983.45	71	14.3	13.8	18.2	132
Food away from home, excluding trips	87.3	92.3	67.2	369.11	420.33	164.33	39	4.0	4.2	3.0	71
Meals as pay	8.6	9.9	3.5	18.82	21.80	6.90	32	.2	.2	.1	50
Alcoholic beverages	62.7	69.2	36.9	74.80	85.98	30.12	35	.8	.9	.6	67
Tobacco products	56.5	62.0	34.4	128.50	145.71	59.70	41	1.4	1.4	1.1	79
Housing, total	99.7	99.8	99.5	2,406.95	2,619.16	1,558.56	60	26.4	26.0	28.9	111
Shelter, total	97.6	98.1	95.5	1,311.24	1,440.22	795.61	55	14.4	14.3	14.7	103
Rented dwellings	39.0	41.2	30.1	571.90	626.56	353.36	56	6.3	6.2	6.5	105
Owned dwellings	63.6	62.7	67.1	718.51	788.77	437.63	55	7.9	7.8	8.1	104
Other lodging, excluding trips	7.7	8.7	3.6	20.83	24.88	4.62	19	.2	.2	.1	50
Fuel and utilities, total	90.3	90.5	89.6	409.01	425.71	342.25	80	4.5	4.2	6.3	150
Gas, total	54.6	54.6	54.5	92.86	95.18	83.57	88	1.0	.9	1.5	167
Delivered in mains	45.2	45.5	43.9	77.64	80.37	66.71	83	.9	.8	1.2	150
Bottled or tank	10.4	10.2	11.2	15.22	14.81	16.86	114	.2	.1	.3	300
Electricity	76.1	76.3	75.3	156.80	167.39	114.45	68	1.7	1.7	2.1	124
Gas and electricity combined	13.4	13.6	12.8	40.47	42.90	30.76	72	.4	.4	.6	150
Fuel oil and kerosene	20.1	19.6	22.3	51.19	50.01	55.91	112	.6	.5	1.0	200
Other fuel, coal and wood	9.1	9.2	8.9	4.97	4.22	7.95	188	.1	([1])	.1	------------
Water, trash, sewerage	62.3	62.6	61.1	62.73	66.01	49.60	75	.7	.7	.9	129
Housing experiences, total	93.6	93.7	93.3	301.16	314.90	246.21	78	3.3	3.1	4.6	148
Telephone, excluding coin phones	89.5	89.9	87.9	173.10	186.11	121.10	65	1.9	1.9	2.2	116
Other, including domestic services	68.8	68.6	69.5	128.06	128.80	125.11	97	1.4	1.3	2.3	177
House furnishings and equipment, total	88.5	91.2	77.7	385.54	438.33	174.49	40	4.2	4.4	3.2	73
Household textiles	74.3	77.9	59.9	50.82	56.05	29.90	53	.6	.6	.6	100
Furniture	41.6	46.8	20.8	131.73	153.72	43.83	29	1.4	1.5	.8	53
Floor coverings	20.8	22.9	12.3	42.21	47.12	22.58	48	.5	.5	.4	80
Major appliances	31.6	34.8	18.7	89.48	100.62	44.96	45	1.0	1.0	.8	80
Small appliances	31.6	34.9	18.4	9.77	10.88	5.34	49	.1	.1	.1	100

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Housewares	25.6	28.9	12.5	9.29	10.83	3.12	29	.1	.1	.1	100
Miscellaneous	49.8	54.5	31.0	52.23	59.10	24.77	42	.6	.6	.5	83
Clothing, total	99.3	99.6	98.0	647.37	736.81	289.81	39	7.1	7.3	5.4	74
Clothing, male, age 2 plus	79.5	85.5	55.5	216.09	253.20	67.72	27	2.4	2.5	1.3	52
Clothing, female, age 2 plus	88.8	90.2	83.1	308.08	345.21	159.64	46	3.4	3.4	3.0	88
Clothing, children under 2	13.6	16.6	1.7	14.47	17.57	2.08	12	.2	.2	(1)	----------
Dry cleaning and laundry	80.9	82.8	73.2	81.98	90.58	47.59	53	.9	.9	.9	100
Materials and services	62.4	65.8	49.0	26.74	30.23	12.77	42	.3	.3	.2	67
Transportation, excluding trips, total	92.5	96.1	78.1	1,578.50	1,800.83	689.43	38	17.3	17.9	12.8	72
Vehicle purchases (net outlay)	30.4	35.6	9.8	704.55	819.92	243.30	30	7.7	8.2	4.5	55
Vehicle finance charges	29.4	35.4	5.5	79.65	90.16	37.65	42	.9	.9	.7	78
Vehicle operation, total	84.5	90.2	61.9	739.34	831.94	369.17	44	8.1	8.3	6.8	82
Gasoline	83.0	88.6	60.7	347.24	395.47	154.43	39	3.8	3.9	2.9	74
Other	82.8	88.5	60.0	392.10	436.46	214.74	49	4.3	4.3	4.0	93
Other transportation	24.3	24.1	25.3	54.97	58.90	39.30	67	.6	.6	.7	117
Health care, total	96.2	95.8	97.1	473.28	479.51	448.37	94	5.2	4.8	8.3	173
Health insurance, excluding employer share	91.1	90.8	92.4	195.81	195.63	196.54	100	2.1	1.9	3.6	189
Expenses not covered by insurance	86.2	86.3	85.8	277.47	283.88	251.83	89	3.0	2.8	4.7	168
Personal care (selected)	84.2	85.7	78.4	100.22	104.78	82.00	78	1.1	1.0	1.5	150
Recreation, total	92.5	95.6	80.1	636.33	711.50	335.79	47	7.0	7.1	6.2	87
Owned vacation home	2.7	2.8	2.4	9.96	10.55	7.60	72	.1	.1	.1	100
Vacation, pleasure trips, total	62.5	67.2	43.9	249.93	263.92	193.99	74	2.7	2.6	3.6	138
Food	53.9	58.7	34.7	57.32	62.84	35.25	56	.6	.6	.7	117
Alcoholic beverages	24.7	28.3	10.3	6.96	7.95	3.01	38	.1	.1	.1	100
Lodging	35.7	39.6	20.1	41.15	41.55	39.54	95	.5	.4	.7	175
Transportation, total	60.0	64.8	40.7	86.50	91.97	64.62	70	.9	.9	1.2	133
Gasoline	53.1	58.9	30.1	32.03	36.07	15.88	44	.4	.4	.3	75
Other transportation	39.0	41.8	28.0	54.47	55.90	48.74	87	.6	.6	.9	150
All expense tours	7.7	8.0	6.7	35.08	33.61	40.96	122	.4	.3	.8	267
Other vacation expenses	38.9	43.7	19.7	22.92	26.00	10.60	41	.3	.3	.2	67
Boats, aircraft, and wheel goods	15.3	18.2	3.8	83.59	99.59	19.61	20	.9	1.0	.4	40
Other recreation, total	90.4	94.2	75.1	292.86	337.45	114.59	34	3.2	3.4	2.1	62
Television	15.8	17.5	8.9	46.54	51.24	27.73	54	.5	.5	.5	100
Other	89.7	93.7	73.7	246.31	286.19	86.86	30	2.7	2.8	1.6	57
Reading materials	84.0	86.0	76.2	47.72	51.98	30.68	59	.5	.5	.6	120
Education, total	24.2	29.3	3.9	102.53	124.65	14.10	11	1.1	1.2	.3	25
Private	10.4	12.6	1.6	62.05	75.49	8.31	11	.7	.8	.2	25
Public	16.7	20.2	2.6	40.48	49.16	5.79	12	.4	.5	.1	20
Miscellaneous	67.7	71.1	54.3	75.08	83.62	40.95	49	.8	.8	.8	100

[1] Less than half the smallest quantity that can be shown.

Source: Bureau of Labor Statistics.

96TH CONGRESS *1st Session* } SENATE { REPORT No. 96-55

PART 1

DEVELOPMENTS IN AGING: 1978

MARCH 30, 1979.—Ordered to be printed
Filed under authority of the order of the Senate of March 29, 1979

Mr. CHILES, from the Special Committee on Aging, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[Pursuant to S. Res. 375, and S. Res. 376, 95th Cong.]

CHAPTER I

ADJUSTING TO AN "AGING POPULATION"

Challenges to current practices, attitudes, and public policies related to this Nation's work and retirement patterns intensified during 1978.

A successful legislative effort[1] which, in effect, raised mandatory retirement age from 65 to 70 and abolished it completely for most Federal employees served notice that a push for total abolition is likely to continue.

Governmental and other studies were directed more and more at probable trends, problems, or opportunities which could accompany

[1] Public Law 95-256—the Age Discrimination in Employment Amendments of 1978—makes other potentially far-reaching changes affecting older workers. See part F, section VIII, of this report for additional details.

the mounting average age of our population, culminating in what the Secretary of Health, Education, and Welfare describes as the probable reappearance of this century's postwar "baby boom" as a "senior boom" early in the 21st century.[2]

The Senate Committee on Aging held theme-setting hearings on "Retirement, Work, and Lifelong Learning" [3] in July 1978. At a later hearing,[4] Chairman Frank Church identified several recurring themes advanced by witnesses and said they should be considered simultaneously, rather than separately:

> We hear a great deal, for example, about pension problems, but very little is done in the way of relating them to work force issues.
>
> Another example, this committee has given a great deal of attention over the years to older worker problems, and we have been concerned about educational opportunity during the later years, but we haven't usually thought of these subjects together, and we should.[5]

Senator Pete Domenici, ranking minority member of the committee, said:

> Our ability to look at the "big picture" regarding employment, retirement, and continuing education should enable us to develop a hearing record that will benefit other committees, executive agencies, State and local governments, as well as the private sector. America will meet and overcome these challenges, which is the mark of a great civilization.[6]

Among the recurring themes from the first round of hearings were:

> We are ill-prepared, in terms of public policy and private sector response, for the vast changes that can be expected with the increase in the proportions of older persons in our population along with a decrease in the percentage of younger persons within labor force limits.
>
> We have no real national retirement policy; we have many sources of income for life in the later years, but none—including social security—generally does the entire job. We have to think more clearly about the appropriate "mix" of social security and other sources of retirement income.
>
> We fail to recognize fully the economic and social consequences of earlier and earlier retirement, now and even more so in the future.
>
> That the probable, forthcoming total abolition of mandatory retirement will cause stubborn, work-related questions—such as retraining to combat job skill obsolescence—to emerge with new clarity and urgency.
>
> Finally, the challenges ahead, while at times boggling, are nevertheless rich in promise of success, if we keep our heads and if we also question past habits of thought and action.[7]

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[2] In testimony before this committee at hearing on July 17, 1978, in Washington, D.C. Hearing was printed after this report was prepared, therefore no page numbers are available.
[3] July 17, 18, 19, 1978, Washington, D.C.
[4] Sept. 8, 1978, Washington, D.C.
[5] Opening statement, July 17, 1978.
[6] Opening statement, July 17, 1978.
[7] From Senator Church's opening statement, Sept. 8, 1978.

The Inflation Factor

Another theme expressed with some frequency was the harsh impact of inflation, not only on individual persons and their families, but upon retirement income systems. A national organization for older persons summed it up:

> Elevated rates of persistent inflation hold the gravest consequences for the elderly. Not only do their personal financial arrangements suffer, but the income maintenance and income support arrangements of the Federal, State, and local governments are forced to meet with increasingly severe problems in funding the payments, which must be indexed to offset higher prices. These financing problems are often partly met by throwing the losses of inflation on pensioners. This may be done by ignoring inflation, by partially ignoring inflation in making only partial pension adjustments that do not offset fully the effect of inflation—a common practice at the State and local level—or by making adjustment for inflation long after the fact. The private sector follows suit; ad hoc adjustment in pension payments are made irregularly, if at all. Most employers make no provision out of current expenses for meeting the future costs of making such adjustments in pension payments largely because there is no way that the size and cost of those adjustments can be known in advance.[8]

[*For additional discussion of inflation and retirement income, see chapter II.*]

I. THE TRENDS

Demographers can anticipate a "senior boom" early in the next century because all of those who will reach age 65 then have been born; their actuarial future can be forecast with reasonable accuracy. But overall proportions of "young" and "old" can fluctuate markedly if (1) the birth rate pattern of today, far lower than it was in the two decades after World War II, rises significantly or if (2) longevity for older persons increases by even a few years. Nevertheless, the most commonly accepted assumptions held today foresee a dramatic increase in the proportion of elderly and an equally striking reduction in the proportion of young.

One observer has described this graying process as "an upheaval comparable to the immigrant tide in the late 19th and early 20th centuries and the migration of blacks to the North after World War II."

A. The Statistical Underpinnings

Bureau of the Census Chief Statistician Jacob Siegel recently gave a fresh reappraisal[9] of census studies on prospective changes in the size and structure of the elderly population.

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[8] From statement by National Retired Teachers Association/American Association of Retired Persons submitted for Sept. 8, 1978, hearing.

[9] "Consequences of Changing U.S. Population, Demographics of Aging," May 24, 1978, at a joint hearing before the Select Committee on Population and the Select Committee on Aging of the U.S. House of Representatives (pp. 76–121). For a more comprehensive treatment, see U.S. Bureau of the Census, "Democraphic Aspects of Aging and the Older Population in the United States," by Mr. Siegel, Current Population Reports, Series P–23, No. 59 (rev.), May 1976.

Warning against assumptions that people become members of a "homogeneous" group upon reaching age 65,[10] Mr. Siegel made these points:

Population 65 and over is expected to grow at only about half the rate of the past quarter century, but this growth will still be considerable:

	Percent increase			
	65 and over	65–74	75–84	85 and over
Period:				
1950–76	85	67	104	233
1976–2000	39	23	57	91
2000–20	42	61	15	27

The 65-plus numerical increase will be from 23 million in 1976 to 32 million in 2000 and 45 million by 2020, as indicated in detail in table 1:

TABLE 1.—PERCENT OF THE TOTAL POPULATION AT THE OLDER AGES, BY SEX: 1950 TO 2020

[Estimates and projections as of July 1. Based on totals including Armed Forces overseas. See text for explanation of Series I, II, and III]

Age and sex	1950	1960	1970	1976	Projections[1] 1980 II	1980 Range I–III	2000 II	2000 Range I–III	2020 II	2020 Range I–III
ALL RACES										
Both sexes:										
60 years and over	12.1	13.2	14.1	15.0	15.6	15.5–15.7	16.1	14.8–17.1	21.8	17.9–25.0
65 years and over	8.1	9.3	9.9	10.7	11.2	11.1–11.3	12.2	11.3–12.9	15.5	12.7–17.8
70 years and over	4.8	5.8	6.4	6.8	7.3	7.2–7.4	8.7	8.0–9.2	10.0	8.2–10.2
75 years and over	2.6	3.1	3.7	4.1	4.2	4.2–4.3	5.5	5.1–5.9	5.9	4.8–6.7
85 years and over	0.4	0.5	0.7	0.9	1.0	1.0–1.0	1.4	1.3–1.5	1.6	1.3–1.7
Male:										
60 years and over	11.8	12.4	12.6	13.1	13.6	13.5–13.7	13.8	12.7–14.7	19.3	15.7–22.3
65 years and over	7.7	8.5	8.5	9.0	9.3	9.3–9.4	10.0	9.2–10.7	13.2	10.7–15.2
70 years and over	4.5	5.2	5.3	5.5	5.8	5.7–5.8	6.8	6.2–7.2	8.0	6.5–9.2
75 years and over	2.3	2.7	3.0	3.1	3.1	3.1–3.2	4.0	3.7–4.2	4.3	3.4–4.9
85 years and over	0.3	0.4	0.5	0.6	0.7	0.6–0.7	0.8	0.8–0.9	0.9	0.8–1.1
Female:										
60 years and over	12.5	14.1	15.6	16.8	17.6	17.4–17.7	18.3	16.9–19.3	24.1	20.0–27.5
65 years and over	8.6	10.0	11.2	12.3	13.0	12.9–13.1	14.3	13.2–15.1	17.8	14.7–20.3
70 years and over	5.2	6.3	7.5	8.1	8.8	8.7–8.8	10.5	9.7–11.1	12.0	9.9–13.6
75 years and over	2.8	3.5	4.4	5.0	5.3	5.3–5.3	7.0	6.5–7.4	7.4	6.1–8.4
85 years and over	0.5	0.6	0.9	1.2	1.4	1.4–1.4	2.0	1.9–2.1	2.3	1.9–2.6

[1] Base date of projections is July 1, 1976.

Source: U.S. Bureau of the Census, "Current Population Reports," Series P–25, Nos. 311, 519, 614, 643, and 704.

[10] Herman Brotman, consultant to this committee for the "Retirement, Work, and Lifelong Learning" hearings and other matters, also makes that point: "The older population is not a homogeneous group, nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,600 persons aged 65-plus die. The net increase is about 1,400 a day, or half a million a year, but the 5,000 'newcomers' each day are quite different from and have lived through a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War." (From "Developments in Aging: 1977," p. XVI, Senate Committee on Aging, April 1978.)

Difficult as it is to project proportions of 65-plus persons to overall population because of possible fertility fluctuations, the following provides a reasonable picture of future possibilities:

Year:	Percent
1976	10.7.
1980	11.2 (11.1–11.3).[1]
1990	12.2 (11.7–12.6).
2000	12.2 (11.3–12.9).
2010	12.7 (11.1–13.9).
2020	15.5 (12.7–17.8).
2030	18.3 (14.0–22.1).
2040	17.8 (12.5–22.8).

[1] On Bureau of Census fertility tables to come.

The proportion of those 75 years and older as part of the 65-plus group was about 38 percent in 1976 and will probably be 45 percent in 2000, and may fall back to about 38 percent again as larger cohorts born in the high fertility period following World War II enter the younger segment of the group (65 to 74). Rates of increase for women in the 75-plus group will be greater than for men in the same group, but the tremendous differences in the growth rates of the sexes seen in the last decades will not be repeated:

Sex and period	Percent increase			
	65 and over	65–74	75–84	85 and over
Male:				
1950–76	60	51	69	159
1976–2000	36	24	55	69
2000–20	45	63	17	25
Female:				
1950–76	108	82	135	286
1976–2000	41	22	58	101
2000–20	39	60	14	28

Note: For each sex for the 1976–2000 period, growth rates progress upward with increasing age.

THE SECRETARY'S APPRAISAL

Health, Education, and Welfare Secretary Joseph Califano, leadoff witness at this committee's July 17 hearing, linked such projections with what he called four dramatic and seemingly inevitable trends about the aging of America.

First:

> Life expectancy has increased almost 10 years since 1940. In 1940, the average life expectancy at birth was about 63½ years, lower than social security's retirement age of 65. Today, life expectancy is 69 for men, 77 for women. Three-quarters of the population now reaches age 65; once there, they live on the average for another 16 years, to age 81. As we contemplate the year 2050, we are told that life expectancy will increase only another 3 years for men and 4 for women. *And we must remember that biomedical advances have consistently ren-*

> *dered recent projections of life expectancy too low.* [Emphasis added.]

Second: Predicting the transformation of the baby-boom group of this century to the senior-boom people of the next, the Secretary said:

> In 1940, roughly 7 percent of the total population was 65 and over; today, the proportion is 11 percent—more than 24 million people. After 2010, the elderly percentage will not just increase: it will soar . . .
>
> By the year 2030, nearly 1 in 5 Americans—55 million citizens—will be 65 or older. And the composition of the older population is changing also. In 1940, only 30 percent of older citizens were 75 or older; by the year 2000 they will comprise 45 percent of the elderly—more than 14 million people.

Third:

> Ironically, while people are living longer, they are retiring earlier. Thirty years ago, nearly one-half of all men 65 and over remained in the work force. Today, among people 65 and over, only 1 man in 5, and 1 woman in 12, are in the work force. *There is no indication that this trend to earlier retirement will cease.* This confronts us with some serious questions concerning not only the cost of providing retirement income, but the quality of life for many citizens who may spend 20 years, or even longer, in retirement. [Emphasis added.]

Fourth:

> The ratio of active workers to retired citizens will change dramatically over the future: from 6 to 1 today to only 3 to 1 in 2030. This ratio is important because it suggests how many active workers are available to support programs for the elderly. We can estimate this ratio by comparing the number of citizens 65 and over to those 20–64. This is rather crude, since some persons over 65 are not retired, and many people age 20 to 64 are not workers. But the historical changes in this ratio are extraordinary nonetheless: In 1940, there were 9 citizens age 20 to 64 for every citizen 65 or over; today, it is 6 to 1; by 2030 it will be only 3 to 1.

B. Questions About the "Dependency Ratio"

As acknowledged by Secretary Califano, the so-called dependency ratio—or proportion of workers to nonworkers—can be challenged on a number of grounds: it provides only a "crude" indicator of potential proportions.

Another witness, Dr. Harold Sheppard,[11] said that conventional dependency ratios use an arbitrary and imprecise definition of "working age" population, assuming that all persons 20 or 21 to 59 years

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[11] Dr. Sheppard, senior research fellow at the American Institutes for Research since March 1975, and director of the Center of Work on Aging, is coauthor (with Sara E. Rix) of "The Graying of Working America: The Coming Crisis of Retirement-Age Policy" (1977). He is consultant to this committee on the "Retirement, Work, and Lifelong Learning" study and on other matters. The above excerpts are from his testimony at the July 17, 1978, hearing.

old are actually working as a support base for the nonworking young and old, and that they are all working full time.

He added:

> Another problem with using simply a dependency ratio approach is that it tells us nothing about costs, which, after all, is what this fuss is all about. It is quite possible to find, for example, that a dependency ratio might go up—more nonworking persons per 100 workers over time—but costs could nevertheless go down. The dependency ratio might remain the same over the next four or five decades, but costs could go up. In other words, the sample arithmetical body-count approach tells us nothing about costs.

THE BIOMEDICAL DIMENSION

Sheppard described recent biomedical developments as "the new feature in the story." As recently as 1970, demographers and biostatisticians were expecting about 6 million persons of age 80 and over by the year 2000. But recent projections, reflecting improvements in mortality rates of older adult groups now put that total at close to 8 million. Sheppard added:

> If we continue to pursue the goal of improving the health conditions of preelderly Americans—and no one, I hope, can challenge that goal—we must be prepared to cope with the full consequences of successful outcomes. And one of those outcomes is an increase in life expectancy among older adult men and women, which results in greater increases in the numbers of persons becoming 80 and older.

Focus on the Family: As did Secretary Califano, Sheppard said that persons of 80 and over are more likely to require care of one or more chronic illnesses than others in the 65-plus group. He agreed with the Secretary's emphasis on helping families to provide care when appropriate. But he asked whether the children of the very old, over the next few decades, can be expected to provide direct services to their elderly relatives or pay directly for those services. He provided the following "quantitative clues" as to the human side of the emerging problems:

> Back in 1960, I first became interested in how large a percentage of Americans 60–64 had parents still alive, as one indication of the responsibilities of those on the verge of retirement, or already in their early retirement years. The most convenient way of estimating that percentage is to take the total population 80 and over, and divide that by the size of the population 60 to 64 years old—as a rough approximation of the number of very old parents and relatives that the young-old have. In 1960, according to such an approach, there were 34 very old persons for every 100 persons 60–64. By 1970, this ratio had increased to 46. By 1980, it will probably be 52. By the end of the next decade—by 1990—we

> can expect to find 63 very old persons for every 100 60–64, and by the end of the century, the proportion will rise to 79.
>
> Keep in mind that in 1970, the proportion was only 46. Compare that proportion to the one expected by the year 2000—79—assuming, of course, that no further reduction in the mortality rates of older adult Americans takes place. Further reductions mean a higher proportion of the young-old with very old family members.

Such statistics raise what Sheppard described as a number of critical policy questions:

> For example, can we really expect an increasing proportion of Americans in their early sixties to take care of their elderly relatives, especially if they themselves are retired? They might have more time to provide such care, but what about the expenses involved, particularly in relation to retirement income? If we do witness an increase or stabilization of the labor force participation rate of persons 60–64, will they, because of the time factor, be able directly to provide those services?
>
> Finally, assuming that much of the support costs for this population of persons 80 and older—nearly 80 million by the year 2000—will be borne by the total working population, might this not constitute a motive on the part of the under-60 working population to keep older workers in the labor force longer than is currently the case as one way of distributing over a wide population and sharing the collective expenditures?
>
> My concern over the past several years is that, as a Nation, we can assure our very old fellow citizens—those about 80 or older—of a quality of retirement life that will not put them or the Nation to shame. But that goal requires a strong economic base which implies a large enough working population. I am suggesting here that we need now to consider the need to include in that working population substantial proportions of those age groups that are now defined as "retirable," or of pensionable age.

II. THE RETIREMENT POLICY THICKET

Four major concerns related to current retirement practices emerged at the hearings:

—The lack of a national policy in the face of helter-skelter costly retirement income systems.

—Very uneven distribution of economic protection for older persons who have left the work force, with special reference to the need for establishing sensible relationships between social security retirement benefits and other forms of income in later life.

—Problems of minority groups.

—A clearcut and perhaps accelerating trend toward earlier and earlier retirement at just the time that demographic and economic pressures appear to push in a contrary direction.

A. In Search of a National Policy

Congress, in its debates about amendments which changed current mandatory retirement practices, dealt only tangentially with the overall retirement policy of this Nation.

The debate, triggered by the 1978 amendments to the Age Discrimination in Employment Act (*For additional discussion of Public Law 95–256, the Age Discrimination in Employment Amendments of 1978, see chapter XI, part VIII*, focused attention on the growing commitment to retirement income expenditures and what is generally regarded as the inadequate factual and conceptual base needed to understand present realities and future implications.

Senators and witnesses at the July and September hearings criticized present policy gaps and contradictions. Secretary of Labor Ray Marshall, for example, called for a review of the entire income support system for the elderly:

> The role of the private pension system and its relation to social security should be studied with the aim of providing more adequate income support to the retired. Special attention must be given to the effects of inflation on private pension benefits. The soundness of the government-financed programs also should be carefully examined.[12]

A New York Times article reached a similar conclusion:

> . . . overall, the steps that have been taken to correct shortcomings and abuses in both the private pension and the social security systems are generally conceded to be no more than aspirins to relieve the immediate symptoms of a much deeper affliction: the lack of a national retirement policy. In fact, nobody seems to know how the various plans affect one another or how the system as a whole affects the economy.[13]

THE SOCIAL SECURITY SHARE

Social security was described by Secretary Califano as dominating the pension landscape—not simply in size, but in reliability. He also said: "It is, quite simply, probably the grandest and most successful social experiment of our age." The National Council of Senior Citizens, critical of what they call "alarms and scare stories, questioning the financial soundness of the social security system," added:

> Given all the uncertain guesses which prophets use to foretell the future, the anticipated problems may be exaggerated. But again, the social security system is not the problem; it is the answer! Those persons born during this baby-boom period will be with us early in the next century and they will be in need of a system of income maintenance when they reach retirement age. Obviously, though it sometimes seems to be overlooked, they would be here with their needs even if we did not have a social security system.[14]

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[12] In testimony on July 18 at hearings cited in footnote 3.
[13] "Life in a Rose-Covered Cottage Isn't Rosy on $2,485 a Year," by Philip Shabecoff, June 25, 1978.
[14] From hearing cited in footnote 4.

The "old age" portion of OASDHI (the formal name for social security is old-age, survivors, disability, and health insurance) was operating on the following scale in 1978, according to SSA reports:

BENEFICIARIES (FEBRUARY 1978)

Retired workers	17,928,926
Wives and husbands	2,965,932
Children	668,340
Total retired workers and dependents (out of a total of 34,137,276 for all of OASDHI)	21,563,198

SOCIAL SECURITY MONTHLY RETIREMENT BENEFITS

(July 1978, including 6.5 cost-of-living adjustment)

Maximum benefit for worker retiring in 1978 at age 65	$489.70
Maximum benefit for worker retiring in 1978 at age 65 with spouse 65 years old	734.60
Minimum benefit for worker retiring at age 65	121.80
Minimum benefit for worker retiring at age 65 with spouse 65 years old	182.70
Average benefit, retired worker alone	254.00
Average benefit, retired couple both receiving benefits	432.00
Average benefit, aged widow	239.00

Approximately 110 million persons paid contributions, or payroll taxes, to social security in 1978. In 1982 the total will be 122 million. The following table gives estimated outlays for cash benefits of OASDI for the next decade:

Calendar year	Income	Disbursements	Net increase in funds	Funds at end of year	Funds at beginning of year as a percentage of disbursements during year
1977 [1]	82.0	87.3	−5.3	35.9	47
1978	91.8	97.1	−5.2	30.6	37
1979	105.8	107.8	−2.0	28.6	28
1980	118.6	119.3	−.7	27.9	24
1981	138.5	131.1	7.4	35.3	21
1982	154.5	143.6	10.9	46.2	25
1983	169.1	156.0	13.0	59.2	30
1984	181.9	168.9	13.0	72.2	35
1985	205.3	181.9	23.4	95.7	40
1986	222.0	195.4	26.6	122.2	49
1987	237.9	209.8	28.2	150.4	58
1988	255.6	225.1	30.5	180.9	67

[1] Figures for 1977 represent actual experience.

Note: Totals do not necessarily equal the sum of rounded components.

The 1978 Board of Trustees report gives this assessment of the status of old-age, survivors, and disability trust funds over the next few years:

> The Social Security Amendments of 1977 have restored the financial soundness of the cash benefit program over the short- and medium-range periods, beginning in 1981 and greatly improved the long-range actuarial status. The additional financing provided by the 1977 amendments in calendar years 1978–80 prevents the assets of the combined trust funds from falling below 21 percent of expenditures—for the equivalent of about 2½ months of expenditures—at the beginning

of 1981 under the intermediate assumptions. The recently appointed Advisory Council on Social Security is studying the long-range financial status of the social security program and will report their findings and recommendations in 1979. In view of these considerations, and the short time that has elapsed since the enactment of the 1977 amendments, the Board recommends that no action be taken to change the financial arrangements of the social security system at this time. The Board believes that there is ample time to await the Advisory Council's report before making any proposals to change the financing provisions in present law. Nonetheless, the Board also recommends that the likelihood of significant long-range deficits be recognized in all current planning and in all proposals that would modify the system.

THE OTHER SOURCES

Important as social security is, it does not work in isolation. Secretary Califano listed other sources:

—The supplemental security income program reached about 23 million aged beneficiaries, about 70 percent of whom also received social security.

—About $50 billion is paid out in benefits each year by "68 different retirement plans in the Federal Government, more than 6,000 State and local pension plans, and thousands of private plans." The Secretary added: "Of all new social security retirees, fully half have other pension income."

—Help is also provided through tax expenditures: tax breaks accorded to pension plans and social security income, and for elderly taxpayers, will total more than $19 billion in fiscal 1978.

—Finally, there are private savings, which provide an estimated $15 to $20 billion in income to retirees.

Secretary Marshall, discussing the growth of private pension plans, said: [15]

> In 1960, $1.7 billion in private retirement benefits were paid to about 1.8 million beneficiaries; by 1975, $14.8 billion were paid to 7 million beneficiaries. An estimated 47 percent of wage and salary workers in the private sector are currently participating in retirement plans.

[15] Secretaries Califano and Marshall appear to differ about the financial status of private pensions. The HEW Secretary, saying that the "integrity of employer pension plans is open to serious question," asserted that unfunded liabilities for private plans is roughly $200 billion. He added: "Ten of the largest industrial corporations in America have unfunded pension liabilities equal to a third or more of their net worth; seven of them have unfunded liabilities which exceed the aggregate market value of the common stock." Asked by Senator Pete Domenici what he meant by the use of the word "unfunded," Secretary Califano replied: "I use the term 'unfunded' to mean funds that are not here today to cover all the liabilities that those systems have incurred. The Secretary also said: "Obviously, they all represent conscious decisions to rely on current income from various sources. I do think these numbers raise very serious questions about the extent to which this committee should look at the need for legislation to assure that individuals who are relying on those unfunded pension plans for their retirement years will indeed be placing their reliance with security." Asked on the following day for comment on the degree to which private pension funds are fully funded, Secretary Marshall said: "We have just completed a special study of it because using different actuarial methods you can reach totally different conclusions about whether or not the pension funds are fully funded. There is no question that it is a serious problem, but I think it requires very careful thought and it is easy to exaggerate it; it is easy to use some actuarial methods that make it look like the funds are not as sound as they really are in terms of being able to be paid off."

The Labor Secretary also identified several groups of workers whose retirement income falls below a Bureau of Labor Statistics budget standard for living costs in urban areas:

> First, many persons do not qualify for a private pension. Such pension plan coverage generally is concentrated on those persons with higher than average wages during their working lives. As a result, those workers who are forced to rely solely on social security benefits tend to be low- and moderate-wage workers. Moreover, *most private pension plans lack protection against inflation.* [Emphasis added.]
>
> Second, some of those who file for reduced benefits before 65 are in effect forced to do so. It is more difficult for a person in their 60's to find another job once they become unemployed. A Social Security Administration study of persons filing for reduced benefits at age 62 *found that one-fifth of the men and one-third of the women had been unemployed more than 12 months prior to applying.* [Emphasis added.]

QUESTIONS ABOUT THE MIX

Senate Committee on Aging members, after analysis of testimony and studies, will decide in 1979 on issues which will receive special attention in its study of "Retirement, Work, and Lifelong Learnings."

Among the issues posed by witnesses about the relationship of social security payments to other forms of retirement income, were several by Secretary Califano:

—A basic question is what the ratio should be between income earned before retirement and income thereafter.

—[For new social security retirees aged 65, this ratio today stands at about 47 percent.] Questions exist about those at the "top" and the "bottom" of the social security scale. "Today," said the Secretary, "social security benefits are wholly exempt from taxes. It seems at least open to discussion whether a wealthy lawyer, doctor, or business executive with a $40,000 pension should receive tax-free social security benefits." Turning to the low-income social security beneficiaries, the Secretary said that their ratio between contributions and benefits is not fixed, and now stands at 61 percent to help make benefits more adequate; whereas for high-income recipients it falls to 35 percent. He asked whether we wish a broadening of the supplemental security income which focuses income only on the low end of the income scale.

—As to private pensions, he asked whether we wish to continue to encourage "the creation of this layer on top of social security by providing substantial tax benefits for contributions to pension plans, and he asked whether "we are comfortable with a system in which some retirees pile up the maximum social security benefits on top of generous pensions, while other retirees have no pension income and find social security barely enough to get by on."

—And finallv, should social security coverage be extended to all employees, including public and nonprofit workers? He added: "Income maintenance policy should not be a game with complex

rules, winners who get windfalls and losers who get nothing; it should be a rational system meeting definable human needs."

Additional questions or proposals made during the hearings for modifications of the present social security-private pension relationship:

"The Federal Government should define the minimum—and perhaps maximum—parameters of what constitutes a suitable retirement benefit and how it will be funded and made available, as well as control of abuses and policing of implementation."

—Stanley Babson,[16]
Financial consultant.

"A special consumer price index for the elderly should be constructed; cost-of-living adjustments under social security should be given twice a year instead of once."

—National Council of Senior Citizens.

"The social security system . . . should be transformed into a national pension program which has earnings replacement as its dominant purpose. The minimum floor-of-income function would be the responsibility of a revamped SSI program." Other features would include the introduction of actuarially increased benefits for those electing to work after age 65 and postpone applying for benefits—a fixed 3 percent annual increase, which becomes effective in 1982, is already in law—and "pay-as-you-go" financing from payroll taxes with an additional general revenue mechanism to act as economic safety nets protecting the program from high rates of inflation and unemployment; and elimination of the social security earnings test, "a severe work disincentive." [17]

—National Retired Teachers Association/American Association of Retired Persons.

"Almost unanimously, witnesses asked for broadening of work opportunities for older employees in order to reduce claims for early retirement benefits under social security or to postpone such payments after age 65. Typical was this statement: 'Clearly, there needs to be a stronger Federal commitment to promoting employment opportunities for middle-aged and older workers.'"

—National Council on the Aging.[18]

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[16] Mr. Babson, who testified on July 19, is a former senior vice president of finance and administration for the Technicon Corp. He is author of "Fringe Benefits: The Depreciation, Obsolescence, and Transcience of Man" (1974).

[17] The social security "earnings limitation" or "retirement test" sets an amount of $4,500 yearly in 1979 to beneficiaries 65 to 71 years old ($3,480 for those under 65) of earnings possible without any loss of social security benefits. NRTA–AARP disputes arguments that elimination of the retirement test would be costly and would benefit high-income beneficiaries, in particular. "We firmly believe," says the NRTA–AARP statement, "that as an economic matter, the earnings test already costs society more than its worth and will cost even more in the future. In addition, the elderly detest it." Their estimates of "cost" are based on "lost production or of the costs to the government in foregone income and social security taxes" that would be paid if older persons were not discouraged from working by the reduction in social security benefits. The NCSC statement takes an opposing view: "The National Council of Senior Citizens is opposed to abolishing the retirement test completely on the grounds that to do so would be financially irresponsible and severely inequitable to most beneficiaries." The NCSC position is spelled out in a booklet called "The Retirement Test in Social Security," issued in May 1976 and written by Nelson H. Cruikshank, then NCSC president.

[18] In Statement at hearing cited in footnote 4

B. The Trend to Early Retirement

Secretary of Labor Marshall reported that there is a decided downturn in the age at which Americans are retiring. In 1950, 46 percent of men aged 65 and over were in the labor force. In 1965, it was 28 percent. And today, it stands at 20 percent. Lower participation rates are also evident for the 55–65 age groups, as indicated in the following table:

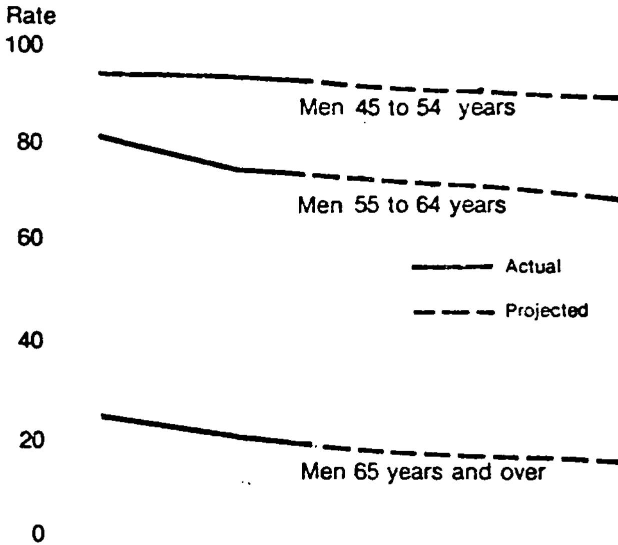
LABOR FORCE PARTICIPATION RATES FOR OLDER AGE GROUPS, BY SEX, SELECTED YEARS, 1950–78

Age group and year	Men	Women
50 to 54 years:		
1950	90.5	30.8
1960	92.0	45.9
1970	91.5	52.4
1978	89.7	54.5
55 to 59 years:		
1950	86.7	25.9
1960	87.7	39.7
1970	86.8	47.6
1978	82.9	48.6
60 to 64 years:		
1950	79.4	20.6
1960	77.8	29.4
1970	73.2	36.4
1978	62.0	33.1
65 to 69 years:		
1950	59.7	12.0
1960	44.0	16.5
1970	39.3	17.2
1978	30.1	14.9

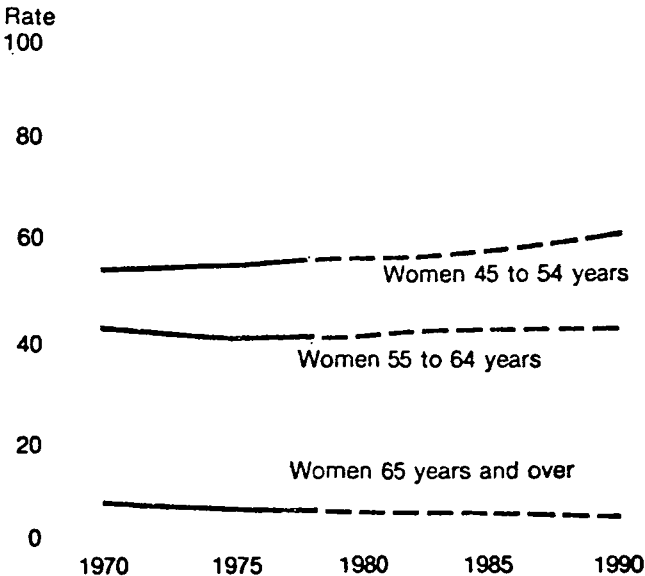
Source: Bureau of the Census, 1970 Census of Population, Employment Status and Work Experience, table 2 for 1950, 1960, and 1970 data. The 1978 data are from the Bureau of Labor Statistics annual averages from the 1978 Current Population Survey.

The labor force participation rate for women 50 to 59 years old has increased steadily since 1950, although more moderately since 1970. However, for women 60 or older, the rate has declined since 1970, after rising steadily during the two preceding decades.

The downward trend in middle-aged and older men's labor force participation is expected to continue...



...while women's participation will rise until age 65 and then drop moderately.



Source: U.S. Department of Labor.

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A PROBLEM OR AN ACHIEVEMENT?

"Until fairly recently, 'early retirement'—before age 65—has been a symbol of social progress, especially when it offers a release with dignity from many years in undesirable working conditions, or when the worker's health is failing."

—Page 97, Employment and Training Report of the President, 1978.

As Secretary Califano observed, the traditional concept of retirement was support for workers who have reached old age and can no longer work. But a new view of retirement sees it as "a reward not necessarily related to old age; simply a reward for a certain period of work—typically 20 to 30 years." But this approach to retirement, said the Secretary, is expensive: "It is born of the rich choices that affluence, without inflation, seemed to offer in the past years."

Similar concerns about the present and future costliness of retirement below the traditional age of 65 were voiced by other witnesses.

Charles Merin, representing the National Association of Retired Federal Employees, asked at the September 8 hearing:

> Can we afford early retirement? The inactive or retired population is growing at a significantly faster rate than the active or working population and by the year 2020 45 percent of the population will be either under 18 or over 65 and, given the present configuration of laws, who is going to produce the gross national product of this country?

The National Council on the Aging, in a statement submitted by Robert Ahrens of the Chicago Mayor's Office for Senior Citizens and Handicapped, stated:

> The economic effects of early retirement can be devastating. . . . It is true that many workers look forward to retirement and appreciate company policies that allow early retirement at minimally reduced pension benefit levels. But, it is not true that all older workers enjoy being "put out to pasture," nor should they. Consider the fact that, on the average, a man reaching his 65th birthday could expect to live 13.4 years longer; a woman, 17.5 years.
>
> Over the years, those who retired on seemingly adequate pension and social security benefits will see their purchasing power diminish as the cost of living climbs.[19]

In addition, Mr. Ahrens said, those who are forced to retire early often do so under the worst of circumstances:

> Work-related problems often become more severe for older adults because of the age discrimination inherent in American society. The recent economic recession severely affected the employment status of older workers; the unemployment rate for those over 55 more than doubled during 1974 and has only very slowly begun to decrease. Once out

[19] The statement added: "The overwhelming majority of private pension plans pay fixed retirement benefits, with no provision for adjustment due to inflation. If inflation averages 7 percent a year, the purchasing power of fixed pensions will be reduced by 50 percent in 10 years. For example, a fixed retirement income of $200 a month will be worth about $100 a month in 10 years and about $50 a month in 20 years if inflation is 7 percent a year."

of a job, the older worker traditionally has a more difficult time in finding a new one. Too often, he is forced into early retirement after months and sometimes years of "job searching."

Former Bureau of Labor Statistics Commissioner Ewan Clague [20] described early retirement as causing two inflationary pressures:

> One is the shortened duration of contributions; perhaps 30 years of work to age 50, plus a lengthened duration of benefits, age 50 to age 80. The other is the combination of full-time earnings and early retirement benefits (when the "retiree" begins a new career after a pension begins). Furthermore, the new earnings may produce a second retirement benefit.

Dr. Sheppard, Director of the Center on Work and Aging of the American Institutes of Research, said:

> . . . early retirement costs the general economy something, and the benefits, such as the alleged increase in job opportunities for the younger population, might not exceed those costs. Indeed, the real resource costs involved—including the reduction of an economy's potential output due to early retirement patterns—must be reckoned with. It is even possible that the standard of living of the remaining working population would have to be lower. After all, the increased cost of early retirement has to be paid from a smaller national product.

A potent trend: Whatever arguments may be raised against it, early retirement nevertheless remains a powerful force in the labor marketplace. A report [21] issued in November 1978 by the Conference Board concluded: "The move toward early retirement is so pronounced that the average retirement age in some firms is now below 60." The survey of 41 personnel officers at major U.S. companies found that the combined total of a company pension and social security payments may make it unattractive for many workers to continue employment, and it adds:

> Virtually all of those surveyed oppose special increases in company pensions or buyouts in order to spur people 65 and over to retire. Generally, it is felt that the natural trend toward early retirement is so strong that it is not needed.

The United Auto Workers reported in November that nearly 45,000 auto workers opted for pensions after 30 years of service from 1971 through 1977. The largest surge came in October 1978, when the benefit level hit $700 a month.[22]

C. Minority Concerns

Dr. Dolores A. Davis, executive director of the National Caucus on the Black Aged, noted at the September 8 hearing that little had

[20] In testimony presented on July 18, 1978.
[21] "The Ban on Mandatory Retirement at 65: Management Responses," information bulletin No. 46, the Conference Board, 845 Third Avenue, New York, N.Y.
[22] Detroit Free Press, Nov. 19, 1978, "Bumper Crop of 30-and-Outers," by Ralph Orr.

been said in July about differing retirement patterns of the older black population.

She said that the greatest fear of national organizations representing the black elderly is that growing concern about the rising costs of retirement in this Nation could produce legislation to raise the age of eligibility for social security benefits. Her statement cited a National Center on Black Aged study which revealed that:

—Black males aged 45 and over suffer from unemployment rates that are nearly twice as high as the rates for their white counterparts.

—Black males aged 45 and over do not participate in the job market as readily as their white counterparts.

—Elderly poverty rates are at least 2½ times as high for elderly blacks than those for whites.

—Older black workers are handicapped in finding jobs because of their substantially lower levels of education than whites.

What is often called "retirement" among older black persons, Dr. Davis added, may often be poor health or economic status or other involuntary pressures. Among Dr. Davis' recommendations was Federal action to reduce differences which characterize black and white unemployment rates.

A National Indian Council on Aging statement,[23] submitted by Larry Curley, noted that of approximately 89,000 Indians who are 60 years or older, nearly 75 percent may have incomes at or below the poverty level. In the year 2000, 25 percent of the total Indian population will be 50 years or older. This will be approximately half a milion—an increase of almost 800 percent:

> Most will be educated at the ninth grade level living on income derived from their past earnings—mostly lower paid employment throughout their earning years, which would not produce the maximum allowable income from the social security programs. Some will benefit from private pension programs, but most will not benefit from these programs since the life expectancy of Indian persons born in 1950 was approximately 50 years of age. . . . Retirement to that group of "eligibles" will mean a time of searching and developing a definition of existence. It will mean a time of isolation since most of the young people will be in the urban areas pursuing their occupations. As a result, the traditional natural system of cooperation and assistance will have eroded to mere romantic reminiscence (this even seems to be the case in 1978).

Carmela G. Lacayo, executive director of the Asociacion Nacional Pro Personas Mayores (National Association for Spanish Speaking Elderly,[24] also looked to the future elderly and asked for action in today's job market:

> . . . according to 1978 census data, almost 42 percent of the Hispanics in the United States are 18 years old or younger. Demographers agree that the highest fertility ages are between the ages of 20 to 29. Since the Hispanic community is just on the threshold of the highest fertility aged period,

[23] Submitted in conjunction with hearing cited in footnote 4.
[24] In a statement submitted in conjunction with the hearing cited in footnote 4.

given Hispanics larger family size, it is clear that the Hispanic community will significantly increase over the next two decades by propagation alone. Thus, the policies and plans formulated today, in anticipation of the aged of tomorrow, must consider a significantly expanded Hispanic elderly population . . . policy does not operate in a vacuum. Government policy on retirement, employment, and lifelong learning will affect all of society's attitudes and opinions about work and growing old in America. Such policies will have a profound effect on all the institutions of society. And unless steps are taken to affect the realities of minority group workers today, the prospects of retirement and lifelong learning will be meaningless for minority group workers tomorrow.

(*For additional discussion of minority issues, see chapter XI, part I.*)

III. POTENTIAL ROLE OF BROADENED WORK OPPORTUNITIES

If early retirement is unwanted—and becomes more so in the future for many older workers because of inflation and other factors—can appropriate work opportunities be developed and made accessible to those who may wish to continue employment?

Secretary Marshall offered this prediction:

> . . . the prospect of an expanding older population with a stable or declining younger population also has its optimistic aspects. As the current low birth rate makes itself felt in the labor markets of the future, the skills and contributions of older workers will be increasingly sought. Employers will find themselves competing for the services of older workers, possibly bidding up wages and accommodating their desires for more flexible work schedules. As employers take a positive approach in which they recognize the worth of their older employees, the ultimate result will be wider opportunities, and more cooperative relations among different age groups.

The Secretary said employers should ideally provide "a full menu of options" for the older employee, including: Continued full-time work, regular part-time, temporary callback, consulting relationships, and community work.

Formidable difficulties, as described in an employment report issued by the Department of Labor in 1978, stand in the way of an improved lot for older workers:

—Emerging industries may recruit or require workers, typically from younger age groups, but more than half of the employed men aged 45 and over in 1970 were concentrated in declining or slow-growth industries.

—Limited educational attainment hampers many older workers.

—Current population survey data for 1976 . . . show that over 60 percent of the 45- to 54-year-old male nonparticipants in the labor force had left their last jobs due to ill health or disability;

less than 15 percent of them reported any intention to seek another job.

—Studies of older worker job performance tend to disapprove the prevailing belief that older people are less effective workers than younger workers, but "there is some truth to the proposition that older workers are more reluctant than younger ones to undergo training for new skills. Frequently, this attitude may be the result of a psychological concern that they may fail."[25]

In addition, there continues to be ample evidence that negative attitudes toward older workers affect acceptance of their skills and services. Dr. Bernard I. Forman, Washington representative of the National Gray Panthers, challenged age-based discrimination:[26]

> We see age-ism as having four basic dimensions: stereotyping, segregation, paternalism, and victim-blaming. They tend to overlap and reinforce each other and provide convenient alibis for social evasions and calloused exploitation. Young and old alike suffer from their common, characteristic failure to recognize that people remain individuals throughout life—and have individual needs, desires, and problems regardless of age. Categorizing people as "too immature," "overqualified," "too impetuous," or "set in their ways" ignores the infinite variety of human nature and human experience.

A. The Positive Side: What Is Already Happening

National organizations which serve as contractors for the senior community service employment program—SCSEP—(formerly title IX, now title V of the Older Americans Act) gave examples of the usefulness and adaptability of this program, which, in 1978, provided part-time work opportunities for 47,500 persons of age 55 or above. (*For additional information about the SCSEP program and older worker problems, see chapter XI, part VIII.*)

Senator Lawton Chiles said he has observed the fulfillment and enthusiasm of participants in such employment program—as well as the Foster Grandparent program—and he added:[27]

> It looks to me that this is one of the most attractive options that we have. We generally, I think, are getting more for our money. We pay these people part-time salaries for their services. They are very satisfied with that; they are looking for part-time income. I don't know of a better return we are getting for our dollar, and I just certainly hope that the Department would continue the broadening of these programs.

Secretary of Labor Marshall said he agreed with Senator Chiles' appraisal of SCSEP and described it as "a very good program from all perspectives."

A new provision of the Comprehensive Employment and Training Act, advanced by Senators Chiles and Domenici, also came under discussion. (See chapter XI, part VIII for details.) Said Senator Chiles

[25] Summarized from pp. 90–97, "Employment and Training Report of the President," transmitted to the Congress in April 1978.
[26] Submitted in conjunction with hearing cited in footnote 4.
[27] At July 18 hearing cited in footnote 3.

in explaining the concern about services for elderly workers under CETA:

> Many of us feel that the older workers are currently underserved by CETA, and I wanted to call that section to your attention.

The Secretary replied:

> We think we need the targeted programs like Green Thumb that you have mentioned, but we also need to encourage CETA to employ older workers. It now provides jobs for about 100,000 older workers in fiscal year 1977, and we think that, as the overall level of unemployment declines, the participation by older workers in the system should and probably will increase.

B. The Private Sector

Secretary Marshall suggested that the Committee on Aging "may wish to consider further hearings to publicize efforts by private employees in offering such [flexible] arrangements, thus encouraging others to follow this example."

Examples of private incentives to encourage older workers were grouped by the NCOA under four headings:

1. *Employers could voluntarily end mandatory retirement:*

Among the already numerous and diverse private and public employers who have ended mandatory retirement are Tektronix, Inc., United States Steel, Hamrick Mills, Gold Kist Agricultural Cooperative, Paddock Publications, Steinway & Sons, the city of Chicago, the State civil service in Maine, Bankers Life & Casualty Co., and most public and private employers in California, where a new State law abolished compulsory retirement last year. Bankers Life has been without mandatory retirement for 40 years and reports that its experience has been "consistently favorable throughout a variety of economic cycles and stages of company growth."

To determine functional capacity to perform work tasks, 4,000 individuals were screened during 1970 to 1975 in a GULHEMP (general physique, upper extremities, lower extremities, hearing, eyesight, mentality, and personality). Findings were matched to minimum job requirements.

"Not one of the employees who were employed after being matched for a specific job was involved in an industrial accident or a workman's compensation case," said the NCOA statement.

The United States Steel non-age-related retirement policy requires employees to pass annual physical examinations closely related to their jobs. Often when a worker seems to be falling short on one job, management joins with the local union to find another more suitable job.

2. *Employers could institute more flexible work arrangements to allow older employees to make a more gradual transition into retirement:*

At the very least, employers should consider systems of phased-in retirement, whereby workers might be encouraged to shift to part-time jobs before entering full retirement.

Senator Charles Percy told Secretary Marshall on July 18:

> My own industrial experience shows that when we introduced a program of compulsory retirement at age 68, we did it on a phased-in basis. We required beginning at age 65 a paid vacation plan plus an extra month the next year, plus 2 months the next year, plus 3 months the next year, so they phased out with a program of 15 weeks of counseling with the families 5 years prior to retirement, on various phases of adjustment to the retirement. . . . I think 15 to 16 other companies followed us later. . . .

Two workers may be able to share a full-time job where part-time work does not contribute to management's goals.

Retired employees could be used as a company's temporary work pool instead of relying on inexperienced outsiders.

The permanent part-time work force of America is now the fastest growing segment of the employed. It has increased in the past 15 years by 40 to 50 percent. The concept of part-time work, which includes job-sharing, has largely been avoided in the general economy because the American system of unemployment insurance excludes those persons from their benefits and because work-sharing is thought to increase employers' costs. However, in the older worker category, work-sharing can become an important alternative to retirement by providing additional income and utilizing talents and skills developed which would be of disservice to the entire society if placed on the shelf.

3. Employers could offer retraining for new careers or encourage continuing education on the part of their employees:

Example: An employment program such as the Erie Guild (Erie, Pa.) combines the flexibility of part-time employment with a new career thrust for skilled retired workers. In this program, begun in 1971, highly skilled sheetmetal workers, drill press operators, and welders were put to work tutoring on a 1-to-1 basis unemployed and unskilled workers to fill the type job that the retiree once held. An agreement was reached with the union leaders whereby trainees (who are paid under CETA) reaching production level would be hired, but not automatically at the level of skill for which they had been trained. After a short period of time, they became members of the union.

C. Federal Government as a Model Employer?

Secretary Marshall recommended that the Federal Government, as a major employer, "should become a leader in offering flexible work schedules and wider career options for older workers." He cited DOL support for "flexitime" and part-time employment in the Federal Government.

(*See chapter XI, part VIII for additional details on enactment of this legislation.*)

Alan K. Campbell, Chairman of what was then the U.S. Civil Service Commission, appeared before the committee on July 19 to discuss, among other things, the implementation in the provision of the Age Discrimination in Employment Act Amendments of 1978 abolishing age 70 for mandatory retirement in the Federal Service. (Over the past few years, the Federal work force has remained relatively static

at about 2.7 million persons; in 1977, only 1,773 were mandatorily retired; the average age of Federal retirees was 58.3.) The CSC (now the Office of Personnel Management and the Merit System Protection the new law, which was described by Campbell as probably having the new law, which was described by Campbell as probabbly having "minimal" impact. He added, however, that the removal of mandatory retirement can be expected to affect performance evaluation programs in at least two ways:

> The first impact is upon the manager who, seeing his staff growing older, begins to interpret the performance evaluation guidelines more strictly in evaluating middle-aged and elderly employees to provide an alternative to mandatory retirement.
> The second impact is upon the employees whose job skills become outdated over time and must be renewed or changed.

To develop a "fair and effective evaluation program for all employees," CSC is developing the following components:
—Positions described by skills and abilities;
—Fair and effective performance appraisals;
—Self-analysis and career planning;
—Modified work arrangements, including part-time, special assignments, voluntary reassignment to lower position and pay.
Mr. Campbell added:

> To retire or terminate an older employee would require evidence that would stand up in court that the employee was not performing properly, so that the employer can demonstrate that the separation was not based on age alone. To obtain this evidence, agencies would have to make their programs for evaluating employees more objective. All ages must be evaluated on the same basis. Evaluating an older employee under more severe standards would amount to age discrimination.

One problem cited by Campbell was the ceilings under which a part-time employee who worked 2 hours a week counted the same as one who worked 39 hours a week. He explained:

> Because of the limited number of ceiling spaces, managers frequently do not want to use their allocation for less than the number of staff hours available. This obviously discourages the hiring of true part-time workers.

Questions about CSC policies: A representative [28] of the National Association of Retired Federal Employees, testifying at the September 9 hearing, challenged Commissioner Campbell's statement that elimination of the age 70 mandatory separation provision would not have a major impact on the Federal civil service:

> Mandatory retirement served as a significant psychological disincentive to performance by older workers. With no hope of remaining on the job past mandatory retirement age, worker self-esteem and productivity most certainly diminished.

[28] Charles L. Merln, then NARFE legislative representative.

The witness also urged the CSC to make a greater effort to provide reliable preretirement counseling:

> Some basic data dramatize the urgency of this problem. In 1965, there were approximately 728,000 Federal annuitants and survivors throughout the United States; today that figure exceeds the 1.5 million mark. With Federal employees retiring at the rate of approximately 80,000 per year, the need for competent and readily accessible preretirement counseling services is clear.

IV. LIFELONG LEARNING

> "... policymakers with a lifelong learning perspective can help to close the gap between the learning and work-lives of individuals by improving the work-related experience available through the educational system, by improving the learning opportunities available at the workplace, and by encouraging linkage between both systems to support continual human development and life transitions."
>
> —"Lifelong Learning and Public Policy," HEW–DOL Report, February 1978, p. vii.

Learning opportunities of all kinds—including those oriented to work, adjustment in retirement, of cultural development—will be needed to help cope with likely demands which will accompany the aging of our population.

This conclusion, gaining widespread concurrence among committee witnesses and others, nevertheless took differing forms and differing priorities.

Education for today's elderly: The National Council of Senior Citizens said that the partially literate elderly are underrepresented in the federally funded adult basic education program.

The NCSC statement added:

> We are particularly concerned that public and privately funded ventures into what is sometimes called citizen education (an effort to provide citizens with the information and skills needed to use our democratic political process to better their lives) tend to overlook the aged and concentrate their attention upon the young and the middle-aged. But the aged—not our members at least—do not retire from citizenship.
>
> It is noteworthy that the National Institute of Education has at this time no program to study the learning needs and wants of the aged.
>
> The blunt truth is that today's aged have financed a vast and expensive publicly funded educational bureaucracy which gives a very low priority to providing appropriate learning opportunities for them.

Another aspect of education was related to what one witness on September 8 called self-improvement activities:

Skills such as managing money, planning adequate diets, knowing appropriate exercise programs, preventive health mechanisms, dealing with bureaucracy, once learned usually are effective throughout the life cycle; once mastered, these skills have lasting power. We need to know something about the transmission of these skills throughout the life cycle and we need also to learn whether and how skills in one area are transferrable to another area.[29]

Education for recycling of skills: A representative of the private sector put the case most directly at committee hearings for more widespread concern about systematic retraining to prevent obsolescence of worker skills.

Stanley M. Babson, Jr., a financial consultant with experience in medium-sized and large firms, said that accountants generally think of workers as a cost—an overhead expense, a charge against operations. He added:

Frequently ignored is the extent of the investments that corporations make in an employee. It costs to attract him, to recruit him, sometimes to relocate him, to train him, and to maximize his productivity and momentum and, finally, to terminate him. All too often, these peripheral costs are lost sight of superficial decisions can be made as to the temporary advantage to the corporation of an employee motivated by cost reduction per se.[30]

Babson suggested that more information be sought about an employee's motives for retirement:

Is he tired? If so, why not scale down by degrees instead of all or nothing? It is certainly a cheaper approach than full-scale retirement. Is he bored? If so, why not a new assignment after a certain number of years? Isn't it conceivable that a person could be recycled into another type of activity entirely? If wage level is a barrier, let the new wage apply and again draw down a supplemental wage from a "semiretirement fund."

NRTA/AARP also emphasized economic functions of lifelong learning:

In the coming year, the Institute of Lifetime Learning will be assessing the work/education field to identify realistic options for the reeducation and retraining of the employed middle-aged and older workers. This option might include job-sharing, job transition, returning to earlier careers, job reclassification, and skill renewal. Once the various options have been assessed, the institute, in cooperation with various educational and corporate institutions, will assist in the development and implementation of training materials and curricula.

Among Dr. Sheppard's recommendations was one calling for the Departments of Labor and Health, Education, and Welfare—along

[29] In statement submitted by Mildred M. Seltzer, president-elect of the Association for Gerontology in Higher Education, in conjunction with hearing cited in footnote 4.
[30] In statement submitted in conjunction with July 19 hearing cited in footnote 3.

with the Congress and the private sector—to take "the appropriate measures to develop expanded programs for midcareer development."

Learning for learning's sake: According to press and official accounts, a large number of older persons are attending courses at universities, evening courses at local schools or colleges, and in other learning environments. A paper prepared for the HEW lifelong learning report gave this account:

> According to a survey by the Academy for Educational Development, one out of three colleges and universities now offers learning opportunities for older persons, and 28 States have passed legislation permitting older students to enroll in regularly scheduled classes free or at reduced tuition rates. A variety of other organizations and institutions—senior centers, community schools, museums, membership groups, and libraries—have also started educational programs for older persons or have encouraged them to participate in ongoing activities. Some 100 museums, for example, now make special efforts to reach older adults.

The paper added, however, that "the elderly remain outside the mainstream of adult education because of relatively low educational attainment, on the average, and other barriers, including transportation problems and an instructional bias in favor of youth."

(*See chapter XI, part VII, for additional information about educational opportunities for older persons.*)

Education about aging: Attitudes toward aging are often shaped by what young persons are taught, or not taught, from the very beginning of their schooling. A representative of the Association for Gerontology in Higher Education asked these questions:

> What can we do in the earlier years of life that will encourage people to view educational organizations as appropriate resources throughout the life cycle and how can educational institutions be changed to accept education as a lifelong actuality?
>
> What are we teaching children in the primary grades about old age and aging?
>
> About work and retirement?
>
> While there are attempts to introduce curriculum content on these topics in the K through 12 grades, how effective have they been?
>
> How can you teach young children about work, retirement, and aging?
>
> Or do you?
>
> Are the curriculum materials being used to reach young children about aging doing an accurate job, or do they provide further reinforcement of existing stereotypes?
>
> How do you teach teachers about aging and the teaching of life cycle approaches?

She added:

> . . . all of these are researchable questions on which, as yet, we have little data. Answers to these questions will give

us some indication about the usefulness of education in achieving attitude changes.

V. THE GRAYING OF THE BUDGET: QUESTIONS

Implicit—or, at times, very explicit—concern was expressed during the Committee on Aging hearings about total Federal allotments for present and future older Americans.

The committee, in future hearings and studies, will focus on the expenditure issues and will seek expert opinions on vital issues related to public allocations related to an "aging" population. Some perspective, however, has already been provided by recent statements.

Secretary Califano, in his testimony, acknowledged the magnitude of present and probable future commitments:

> This year, six major programs for which HEW has responsibility—old age insurance, survivors and disability insurance, medicare, medicaid, supplemental security income, and black lung benefits—will pay out more than $94 billion to persons 65 and over. Another $14 billion will be paid to this group under the civil service, railroad, and military retirement programs. Still another $4 billion will go to the elderly under other programs providing housing subsidies, food stamps, social and employment services.
>
> This adds up to $112 billion—5 percent of the gross national product, and 24 percent of the Federal budget for fiscal year 1978.
>
> This is a whopping increase. Real spending under these programs in 1978 will be four times what it was in 1960, when we spent only 2.5 percent of GNP on programs for the elderly. And from only 13 percent of the Federal budget in 1960, the percentage has nearly doubled—largely due to the enactment of such major programs as medicare and medicaid, real benefit increases in social security, and other program expansions.
>
> These expenditures, large as they are, are expected to grow even more. Under the major programs I have mentioned, estimating benefits only for recipients age 65 or older, we expect real spending to more than triple: to $350 billion by the year 2010. Between 2010 and 2025, when the "baby boom" becomes the "senior boom," real spending will escalate from more than $350 billion to around $635 billion. It will constitute more than 10 percent of GNP; more than 40 percent of total Federal outlays.

The Secretary added:

> The figures, I should emphasize, are subject to the hazards that afflict all estimates. I cite them not to alarm; simply to inform. *What I have just described is a shift in the age of our population; the shift in resources that has followed is both inevitable and natural.* [Emphasis added.]
>
> Indeed, the presence in our society of a growing elderly population is as much a blessing as a cause for concern. It speaks to the success we have had as a nation in improving the health and well-being of all our citizens, in making the

advances of the medical sciences more broadly available, and in being able to respond to the changing needs of citizens of all ages. If we are spending more on behalf of older Americans, that is only as it should be. It is one mark of the respect in which society holds the older generation.

Nor is the effort we make on behalf of the elderly unrelated to our own lives. The taxes that younger workers pay on what they earn today not only assure their own futures, they make possible a better present for all generations. With medicare paying for the medical needs of elderly parents, the earnings of the young can be used for education or the downpayment on a home. We may, as family members, choose to live with different generations under different roofs, but we remain members of our families wherever we may live; the economic choices made by any one generation affect all.

Indeed, "the elderly" are ourselves—and our children. The commitments we make to the elderly of tomorrow are no less than the commitments which we all make to ourselves.

The National Council of Senior Citizens, in a statement submitted at the September 8 hearings, said:

While Government support of the aged has increased over the past 20 years, such expenditures represent only 5 percent of our gross national product. In fact, the growth of categorical programs for the aged in the past decade can be attributed to the low level of support in prior years due to wholesale discrimination against older persons in other government service and employment programs.

Dr. Robert Butler, Director of the National Institute on Aging, also has entered into the discussion of budget commitments for aging,[31] warning against regarding the elderly population as a "burden" or "drain." He asked for a broadening of the discussion to include these dimensions:

1. The costs of a public policy of supporting retirees reflect the public policy of forced or induced retirement. Simply put, the need for all those dollars in retirement systems might be lessened if we did not pressure people to leave the work force while they were able and willing to continue working. This does not mean forcing people not to retire, but rather to remove pressure the other way. Those who wish to claim their social security cash benefits should have no barrier to exercising their rights at any time.

While a policymaker focusing narrowing on the budget impact of all those retirement systems might want to reduce benefit levels now or in the future, a wiser approach might be to consider whether we have not boxed ourselves into a budgetary corner because of nonbudgetary decisions. If

[31] Dr. Butler's article, "The Economics of Aging: We Are Asking the Wrong Questions," appeared in the November 4 issue of the National Journal. It was written partially in response to a Feb. 18, 1978 Journal article, "Busting the U.S. Budget—the Costs of an Aging America." The Journal has since issued other articles exploring aging issues, including a special report, "Growing Old in America," which appeared in its Oct. 28, 1978 issue. In December, the Journal conducted a 3-day conference in Washington, D.C., on the "Economics of Aging."

people were free to decide to continue working after age 65—and they continue to contribute to retirement systems—the budget could become far less menacing and far more manageable.

2. A considerable proportion of the $152.7 billion reflects the existence of illness and disability in the older population. What if the source of that illness and disability were in part related to policies of premature retirement and the stresses they may bring? What if we could identify the biomedical and socioenvironmental factors that produce the sickness and disability that prompt some people to retire? Suppose these illness factors could be minimized in some way: Would we not reduce the great sums being spent through such programs as medicare and medicaid for institutional and other services?

3. . . . while the governmental cost of the medicare program has burgeoned, the elderly now pay as much out of pocket for health care as they did before medicare began. So, the elderly do share the costs of their health services. To what extent is the increasing cost of medicare to be attributed to the elderly? To what extent is it to be attributed to the providers of services?

Cost containment is as much a pertinent issue in the rise of medicare costs as is the growth of the elderly population. The cost containment issue raises questions about social policy: Should we reduce or freeze benefits to accommodate the increased costs? Should we tighten up on cost controls and require providers to justify their spending in the light of community priorities and funding availability?

We all know that health care costs have risen much faster than the Consumer Price Index. And we know, too, that social security benefit levels at the time medicare began did not—and still do not—provide anything approaching a decent standard of living. One may argue that the social security system was not set up to be a guarantor by itself of a decent standard of living in retirement. But we know that relatively few elderly persons have any major pension to rely on, and that to be old often means to be poor. Surely, we must rethink the place of social security in the context of retirement income needs as they exist more than 40 years after the program began.

VI. CONCLUSION

A combination of factors—including inflation, growing recognition of the dramatic changes to be expected in the age structure of our population in the next half century, and growing concern about the cost of Government—have caused the Senate Committee on Aging to begin an inquiry into "Retirement, Work, and Lifelong Learning."

Our preliminary hearings and research have identified a large number of issues and suggested many others. The committee will have to be selective in choosing a manageable, yet broad-based, range of themes and individual subjects to explore and arrange in ways which will throw new light and information on matters of concern to all generations.

This task would be timely even if there were not a White House Conference on Aging scheduled for 1981. The fact that this Conference has been authorized by the Congress and endorsed by the administration lends even greater urgency to the mobilization of facts needed to obtain a proper perspective on policy issues to be decided in the future.

This committee will, therefore, maintain close contact with other factfinding units, including congressional bodies which may have already begun or are considering research of their own, in an effort to arrive at an effective information exchange which will serve several purposes, including development of a data base worthy of the forthcoming White House Conference. We acknowledge help already provided by units of the executive branch toward that end, and we will continue to seek their help.

It is clear that the aging of our population will call for boldness and clarity of thought and action. To view this process simply in terms of causing a "burden" to younger generations is to limit our will and our vision.

We look forward to new information and ideas from all who will help us as we look further into "Retirement, Work, and Lifelong Learning."

CHAPTER II

INFLATION AND RETIREMENT INCOME

Older Americans—perhaps more so than all other Americans—are sensitive to price increases, primarily because they live to a large degree on an essentially fixed income.

Many elderly persons have repeatedly emphasized to the Committee on Aging [1] that coping with the high cost of living is their most important day-to-day problem.

In recent years that struggle has intensified. From December 1958 to December 1968, the average annual increase in prices amounted to 2.3 percent. However, the average yearly inflation rate has nearly quadrupled during the past decade, to 9.1 percent.

DECEMBER TO DECEMBER PERCENTAGE CHANGE IN CONSUMER PRICE INDEX, 1948–78

[Year and percent change]

Year	Percent	Year	Percent
1948	2.7	1964	1.2
1949	1.8	1965	1.9
1950	5.8	1966	3.4
1951	5.9	1967	3.0
1952	.9	1968	4.7
1953	.6	1969	6.1
1954	.5	1970	5.5
1955	.4	1971	3.4
1956	2.9	1972	3.4
1957	3.0	1973	8.8
1958	1.8	1974	12.2
1959	1.5	1975	7.0
1960	1.5	1976	4.8
1961	.7	1977	6.8
1962	.7	1978	9.0
1963	1.6		

Source: Washington Post, Oct. 29, 1978, p. F1.

Ewan Clague, former Commissioner of the Bureau of Labor Statistics, warned in July 1978:

> If the 1968–78 cost-of-living increase continues into the future, the Consumer Price Index at the end of 1990 will be about 400 (double the present) and will be nearing 800 by the year 2001 (doubling again). This is *not* a forecast; it is a pro-

[1] For example, see "Developments in Aging: 1975 and January-May 1976," pt. 1, S. Rept. 94–998, 94th Cong., 2d sess., pp. 20–60.

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jection to show where the economy is going unless steps are taken to correct inflation, whatever may be the cost.[2]

Mr. Clague provided some examples to illustrate the impact of rising prices in the marketplace if these trends should continue:

> . . . In our home a half-gallon of milk now costs 85 cents; in 2001 it would be $3.40. A $100 man's suit would cost $400; the Metro fare in Washington would be $2, or possibly even more, because the fares aren't high enough now to cover expenses.[3]

I. RISES IN COST OF LIVING

Prices continued ominously upward in 1978, rising by 9 percent from December 1977 to December 1978. All Americans felt the impact in one form or another wherever they went: the supermarket, the doctor's office, the department store, the gas station, and elsewhere.

Limited retirement income created major problems for the elderly to absorb steep price hikes in everyday necessities. Increasingly, they found themselves confronted with difficult and sometimes impossible choices. Should they buy food for the table or necessary prescriptions to maintain their health? Should they raise the heat at home and risk driving up the utility bill or should they visit a doctor?

Increasingly, older Americans discovered that a seemingly comfortable income a few years ago bought far less in 1978. During the past 5 years (from December 1973 to December 1978) the price of goods and services jumped by nearly 50 percent (46.5 percent).

Ewan Clague noted that an elderly person's purchasing power would be cut in half in 12 years with an annual inflation rate of 6 percent. He added:

> A retired worker drawing benefits of $10,000 a year would have the purchasing power cut in half with a 6-percent inflation rate over a period of 12 years ($5,057). The following table shows the shrinking purchasing power of that pension. For this calculation, the results are rounded to the nearest dollar.

Year:	*Purchasing power*	*Year:*	*Purchasing power*
1	$10,000	7	$6,890
2	9,400	8	6,477
3	8,836	9	6,088
4	8,296	10	5,723
5	7,798	11	5,380
6	7,330	12	5,057

> At the end of 6 years the retiree would lose over one-fourth of the value of his pension ($7,330). In 9 years its purchasing power is almost down to 60 percent of the original benefit.[4]

[2] "Retirement, Work, and Lifelong Learning," hearing before the Senate Special Committee on Aging, Washington, D.C., July 18, 1978. Hearing was printed after this report was prepared, therefore no page numbers are available.

[3] Testimony at hearing cited in footnote 2.

[4] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

He also describes the effect of a 4-percent inflation rate on the purchasing power of an older American:

> At an inflation rate of 4 percent the retiree comes out much better.

Year:	Purchasing power	Year:	Purchasing power
1	$10,000	7	$7,824
2	9,600	8	7,514
3	9,216	9	7,213
4	8,847	10	6,925
5	8,493	11	6,648
6	8,153	12	6,382

> At the end of 6 years the retiree is down about 19 percent ($8,153), and at 9 years about 28 percent ($7,213). In the 12th year the loss has been over 36 percent.[5]

Mr. Clague pointed out that early retirees may be even more vulnerable to inflation, since they will probably live longer in retirement than those waiting until age 65.

> Furthermore, for early retirees 12 years may be far too low an estimate. With increasing longevity, those retiring at 62 have a reasonable prospect of about 16 years. That would result in the following shrinkage of retirement income in a period of 6 percent annual inflation.

Year:	Purchasing power	Year:	Purchasing power
13	$4,754	15	$4,200
14	4,468	16	3,948

> The additional years would bring a shrinkage of purchasing power to less than $4,000 in the 16th year. The retiree would by that time be approaching the poverty level.[6]

II. AREAS OF SPECIAL IMPACT ON THE ELDERLY

Compounding everything else, some of the sharpest price increases have occurred in areas where the elderly's greatest expenditures are concentrated: Housing, food, medical care, and transportation. These four items typically account for more than $4 out of every $5 in an aged family's budget.

During the past 5 years, these basic expenditures have been right at or above—and in some cases substantially above—the increase in the overall Consumer Price Index.

PERCENT OF PRICE INCREASES

	December 1977 to December 1978	December 1973 to December 1978
Consumer Price Index (all items)	9.0	46.5
Food	11.8	45.0
Medical care	8.8	61.1
Transportation	7.7	52.0
Housing	9.9	50.4
Other goods and services	6.4	44.0

Source: Bureau of Labor Statistics, Department of Labor.

[5] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

[6] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

Some components, such as utility charges—which are included in housing—have surged forward at a more accelerated pace—and in some cases more than twice the overall inflation rate for the Consumer Price Index. Natural gas, for example, rose by 109.2 percent during the past 5 years; home heating fuel oil No. 2 by 90 percent; and electricity, by 66.5 percent.

PERCENT INCREASES IN ENERGY COSTS

	December 1977 to December 1978	December 1973 to December 1978
Natural gas	11.2	108.1
Home heating fuel oil No. 2	7.7	82.5
Electricity	7.2	66.5
Other goods and services	7.7	40.4
Consumer Price Index (all items)	8.3	47.1

The 1977 Social Security Amendments [7] authorized a nine-member national Commission to conduct a thorough study of social security, including the need to develop a special Consumer Price Index for the elderly. The Commission is to present a full report to the President and to the Congress within 2 years after a majority of the members have been appointed.

III. IMPACT ON RETIREMENT SYSTEMS

Inflation not only erodes the purchasing power of older Americans, but it also threatens to undercut the actuarial soundness of public and private retirement systems. A seemingly insignificant rise in prices can have an enormous effect on social security, the civil service retirement system, and other income maintenance programs. A 1-percent increase in the inflation rate, for example, adds about $1 billion in benefit payments to social security and more than $100 million to civil service annuities. [The Social Security Administration estimates cash benefit payments in 1978 at about $93 billion. A 1-percent rise in prices increases benefits by almost $1 billion—$93 billion multiplied by 1 percent equals $930 million. Similarly, the civil service retirement program pays between $9 and $10 billion—in round numbers. A 1-percent increase in the inflationary rate boosts annuity payments approximately $100 million ($10 billion multiplied by 1 percent equals $100 million.)]

Social security's recent need for additional financing—especially over the short range—was attributed in large part to accelerated inflation. Rapidly rising prices caused substantially higher benefit payments than initially forecast. The Social Security Administration estimated in late 1973 (using intermediate assumptions),[8] that cost-of-living increases would amount to 3.1 percent in 1973. 3.1 percent in 1976, and 5.8 percent in 1978. But prices leaped forward at an accelerated pace, pushing the cost-of-living increases up to 8 percent in 1975, 6.4 percent in 1976, 5.9 percent in 1977, and 6.5 percent in 1978. The compound effect of these four adjustments amounted to 29.7 percent, compared with the original projection of 12.5 percent. Translated into dol-

[7] Public Law 95–216, approved Dec. 20, 1977.

[8] These estimates were provided to the House Ways and Means Committee during consideration of the two-step, 11-percent social security increase. Public Law 95–233, approved Dec. 31, 1973.

lars and cents, inflation increased social security's benefit payments by about $27.9 billion from July 1975 to December 1978.

IMPACT OF INFLATION UPON SOCIAL SECURITY

Date	1973 cost-of-living assumptions when the House of Representatives considered the 2-step, 11-percent social security increase (percent)	Actual cost-of-living increase (percent)	Additional benefit payments because of higher inflation for the calendar year (in billions of dollars)
July 1975	3.1	8.0	1.6
July 1976	3.1	6.4	4.7
July 1977	0	5.9	9.0
July 1978	5.8	6.5	[1] 12.6
Total			27.9

[1] Estimate.

Source: Social Security Administration.

Inflation has also materially affected the civil service retirement system. From fiscal year 1966 to fiscal year 1977, annuity payments jumped by 516 percent, from $1,322 to $8,143 million—in large part because of inflation, a major increase in the number of retirees, earlier retirement, and other factors.

FEDERAL CIVIL SERVICE RETIREES AND BENEFITS, SELECTED FISCAL YEARS, 1956–76 [1]

Year	Number	Payment (millions)
1966	560,992	$1,322
1968	604,873	1,665
1970	662,223	2,129
1973	843,520	3,762
1974	938,654	4,825
1975	989,786	6,052
1976	1,038,377	7,098
1977	1,096,561	8,143

[1] Testimony by Ewan Clague at hearing cited in footnote 2.

Between 1975 and 1978, the rate of civil service annuity cost-of-living increases averaged 8 percent per year. If the cost-of-living increases had been 6 percent on the average instead of 8 percent, the civil service retirement system would have saved $2.3 billion.

IV. COST-OF-LIVING INCREASES FOR OLDER AMERICANS

Rising prices played havoc with the elderly's budgets throughout 1978. However, cost-of-living mechanisms in Federal income maintenance programs provided some measure of relief.

Nearly 34.5 million social security beneficiaries received a 6.5 percent cost-of-living adjustment on July 3. The increase was based upon the rise in prices from the first quarter—January, February, and March—in 1977 to the first quarter in 1978.

On an individual basis, the cost-of-living adjustment increased average monthly benefits from $407 to $432 for a retired couple, from $239 to $254 for a retired worker, and from $225 to $240 for an aged widow. The minimum monthly benefits for a worker 65 years or older rose

from $114.30 to $121.80. And, the maximum benefit for a worker retiring in 1978 at age 65 increased from $459.80 to $489.70.

MONTHLY SOCIAL SECURITY BENEFITS: IMPACT OF 6.5-PERCENT COST-OF-LIVING INCREASE

	Prior law rate	6.5-percent cost-of-living increase
Maximum benefit for worker retiring in 1978 at age 65	$459.80	$489.70
Minimum benefit for worker retiring at age 65	114.30	121.80
Average benefit, retired worker alone	239.00	254.00
Average benefits, retired couple, both receiving benefits	407.00	432.00
Average benefit, aged widow	225.00	239.00
Average benefit, mother and two children	562.00	598.00
Average benefit, disabled worker with wife and children	532.00	567.00
Average benefit, all disabled workers	268.00	285.00

Other beneficiaries were also helped by cost-of-living adjustments. Nearly 4.3 million aged, blind, and disabled persons received a 6.5 percent cost-of-living adjustment in their supplemental security income payments. Qualifying individuals are now assured a minimum monthly income of at least $189.40, compared with $177.80 under prior law. The minimum monthly income floor for aged couples rose from $266.70 to $284.40.

MONTHLY SUPPLEMENTARY SECURITY INCOME PAYMENT STANDARD (FEDERAL)

	Prior law rate	6.5-percent cost-of-living increase
Qualifying individual	$177.80	$189.40
Qualifying couple	266.70	284.10

More than 1 million railroad retirees and their families were eligible for a cost-of-living adjustment. Retired employees and their spouses were eligible for a 6.5-percent increase on the tier I portion of their railroad retirement annuities. This amount, however, was offset by any social security cost-of-living increase that the annuitant received. Retired railroad employees and their spouses also received a 2.1-percent increase in the tier II portion of their annuities. This represented the second of four annual tier II increases authorized under the 1974 Railroad Retirement Act Amendments.[9] Widows and other survivors received a 6.5-percent cost-of-living increase for both tiers of their annuities. Their tier I annuity increase, though, was reduced by any social security cost-of-living adjustment.

In addition, 1.5 million civil service retirees and survivors received two cost-of-living increases: 2.4 percent in April, and 4.9 percent in October. The April adjustment was based upon the rise in prices for the 6-month period from June 1977 to December 1977, and the October increase reflected the inflation rate from December 1977 to June 1978.

V. MEANING OF THE NEW POVERTY STATISTICS

Our Nation has made considerable progress in reducing poverty among older Americans during the past decade. In 1967, almost 5.4 million persons 65 or older were considered poor under the Govern-

[9] Public Law 93–445, approved Oct. 16, 1974.

ment's definition of poverty. Ten years later this number declined to 3.2 million.[10]

PERSONS 65 YR OR OLDER BELOW THE POVERTY LEVEL: 1967 TO 1977

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
1977	3, 177	14. 1
1976	3, 313	15. 0
1975	3, 317	15. 3
1974 [1]	3, 085	14. 6
1974	3, 308	15. 7
1973	3, 354	16. 3
1972	3, 738	18. 6
1971	4, 273	21. 6
1970	4, 709	24. 5
1969	4, 787	25. 3
1968	4, 632	25. 0
1967	5, 388	29. 5

[1] Based on revised methodology. In 1974, the Bureau of the Census revised the methodology to reduce the nonsampling error (i.e., certain response, enumeration, and processing errors). The differences between the original and revised 1974 estimates are because of changes in the magnitude of the nonsampling error associated with the statistics. The differences result from one or more of the following four factors: (1) Changes in procedures which impute missing responses to the income and work experience questions on the March Current Population Survey (CPS) questionnaire, (2) changes in the March CPS income and work experience questions, (3) changes in the number of detail of tabulated income intervals, and (4) the correction of several small errors found in the processing system. For more information, see "Characteristics of the Population Below the Poverty Level: 1975," series P–60, No. 60, issued June 1977, pp. 6–12. Poverty data for 1975, 1976, and 1977 reflect this revised methodology.

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P–60, No. 116, issued July 1978, p. 21.

During this same period, the total number of older Americans increased by 4.2 million. The net impact is that 19.3 million persons 65 or older do not live in poverty today, or 6.4 million more than in 1967 (12.9 million).

PERSONS 65 YR OR OLDER BELOW AND ABOVE THE POVERTY LEVEL: 1967 AND 1977

[Numbers in thousands]

Year	Total [1]	Number below the poverty level	Number above the poverty level
1977	22, 468	3, 177	19, 291
1967	18, 245	5, 388	12, 857
Difference	+4, 223	−2, 211	+6, 434

[1] The universe for determining poverty does not include the institutionalized aged.

Source: Bureau of the Census.

[10] See following table:

WEIGHTED AVERAGE THRESHOLDS—POVERTY CUTOFFS IN 1977, BY SIZE OF FAMILY AND SEX OF HEAD, BY FARM-NONFARM RESIDENCE

Size of family unit	Total	Nonfarm			Farm		
		Total	Male head	Female Head	Total	Male head	Female head
1 person (unrelated individual)	$3, 067	$3, 705	$3, 214	$2, 969	$2, 588	$2, 672	$2, 498
14 to 64 yr	3, 147	3, 152	3, 267	3, 023	2, 709	2, 776	2, 569
65 yr and over	2, 895	2, 906	2, 936	2, 898	2, 475	2, 495	2, 563
2 persons	3, 928	2, 951	3, 961	3, 907	3, 318	3, 325	3, 176
Head 14 to 64 yr	4, 054	4, 072	4, 095	3, 981	3, 466	3, 474	3, 278
Head 65 yr and over	3, 637	3, 666	3, 670	3, 646	3, 128	3, 131	3, 079

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P–60, No. 116, issued July 1978, p. 20.

The rate of poverty among the elderly has also been slashed substantially, from 29.5 percent in 1967 to 14.1 percent in 1977. Social Security increases, improvements in other income maintenance programs, and the establishment of supplemental security income have all helped to improve the economic well-being of older Americans.

To a very large degree, the reduction in poverty was achieved during the period 1967–74—when the elderly received five across-the-board social security increases aggregating 90.5 percent.[11] Since 1974, the number of older Americans living in poverty has essentially stabilized.

The 1974–75 recession contributed to a 200,000 increase in poverty in 1975. A 1978 advance report from the Census Bureau [12] provides new information about improved economic conditions for many older Americans, although not all groups of elderly—especially members of minority groups. From 1976 to 1977, the number of low-income persons 65 or older declined by 136,000—from 3 ,313,000 to 3,177,000.

However, poverty increased among elderly members of minority groups by 71,000—from 680,000 to 751,000. In addition, the proportion of low-income minority rose from 32.7 percent in 1976 to 34.9 percent in 1977.

The minority aged made rapid economic gains between 1967 and 1973. In 1967, more than one out of every two (51 percent) persons 65 or older who were black or members of other races lived in poverty. By 1973, about 1 out of 3 (35.5 percent) aged members of minority groups were poor. From 1973 to 1977, there has been almost no decline in the poverty rate among the minority aged. On the other hand the poverty rate for elderly whites has declined from 14.4 percent to 11.9 percent in 1977.

PERSONS 65 YR OR OLDER BELOW THE POVERTY LEVEL BY RACE: 1967–77

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
White:		
1977	2,426	11.9
1976	2,633	13.2
1975	2,634	13.4
1974	2,460	12.8
1974	2,642	13.8
1973	2,698	14.4
1972	3,072	16.8
1971	3,605	19.9
1970	3,984	22.5
1969	4,052	23.3
1968	3,939	23.1
1967	4,646	27.7
Black and other races:		
1977	751	34.9
1976	680	32.7
1975	683	34.0
1974	625	32.5
1974	666	34.7
1973	656	35.5

[11] Social security beneficiaries received across-the-board increases of 13 percent in 1968 (effective February 1968), 15 percent in 1970 (effective January 1970), 10 percent in 1971 (effective January 1971), 20 percent in 1972 (effective September 1972), and 11 percent in 1974 (7 percent for March, April, and May 1974), with the full 11 percent payable for months after May 1974). The increases total 69 percent. However, the aggregate benefit boost is 90.5 percent because of the compound effect of adding one increase on top of another.

[12] "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P–60, No. 116, issued July 1978.

PERSONS 65 YR OLD OR OLDER BELOW THE POVERTY LEVEL BY RACE: 1967-77—Continued

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
White:		
1972	666	37.5
1971	668	38.4
1970	725	46.2
1969	735	48.1
1968	693	46.6
1967	742	51.0
Black:		
1977	701	36.3
1976	644	34.8
1975	652	36.3
1974	591	34.3
1974	626	36.4
1973	620	37.1
1972	640	39.9
1971	623	39.3
1970	683	48.0
1969	689	50.2
1968	655	47.7
1967	715	53.3

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P-60, No. 116, issued July 1978, p. 21.

VI. AN END TO POVERTY: HOW NEAR?

Abolition of poverty among older Americans has been a major goal of the Committee on Aging. Considerable progress was made in implementing that goal during the late 1960's and early 1970's (see page 36 for more details). However, much more remains to be done, since 3.2 million older Americans—or about one out of every seven persons 65 or older—lives in poverty.

The committee gave considerable attention to this issue during hearings on "Retirement, Work, and Lifelong Learning." [13] Senator Church, for example, asked HEW Secretary Joseph Califano to estimate the net cost to abolish poverty among older Americans. Secretary Califano provided the following information for the hearing record: [14]

> Under the SSI program, States spend approximately $1.5 billion each fiscal year in supplementation costs. Raising the Federal SSI guarantee to the poverty level would reduce State expenditures by about 70 percent.
>
> The 1978 nonfarm poverty line for a head of household age 65 or older is $3,080. Estimates of the minimum cost—the cost for people already receiving SSI—and the maximum cost—the cost for everyone eligible to receive SSI payments—if the Federal SSI guarantee for an individual were raised to the $3,080 amount for the period July 1, 1977, through June 30, 1978, are shown below:

Minimum estimate:	
Program costs (billion)	$8.3
Beneficiaries (million)	4.2
Maximum estimate:	
Program costs (billion)	12.2
Beneficiaries (million)	9.3

[13] Hearings were held in Washington, D.C., on July 17, 18, and 19 and September 8, 1978.
[14] Response included in July 17, 1978, hearing cited in footnote 2.

Senator Church subsequently asked Secretary Califano in a follow-up letter (July 31, 1978) what would be the most effective approach to abolish poverty for the elderly.[15] Secretary Califano replied:

> There are two conflicting needs that we face in any effort to abolish poverty—that of keeping future costs under control and of increasing benefits for people whose income is inadequate.
>
> The earnings related social security programs should remain the Nation's primary means of providing economic security for older Americans. The system lends itself well to supplementation by private pensions, savings, and other individual and group efforts to provide economic security. We recognize that social insurance cannot provide an adequate income for those who have had little or no earnings during their working years. Thus, an effective means tested program to provide basic income for people with low income is a necessary third ingredient to meet any need for cash income that social security and private resources cannot provide.
>
> The Advisory Council on Social Security that was appointed in February 1978 is currently studying all aspects of the social security program. The Council will be focusing on selected issues dealing with the role of social security in the future, including the issues raised by your questions. In addition, as you know, the Social Security Amendments of 1977 established a National Commission on Social Security, which will be jointly appointed by the President and the Congress, to make a broad-scale comprehensive study of the social security program. Along with the financial status of the social security program, coverage, and benefit adequacy, this Commission may study possible alternatives to the current program, including integration of the current program with private retirement systems.
>
> Further study of this sort will be carried out by the Presidential Commission on Pension Policy. Established under an Executive order, the Commission will examine pension systems around the country in an effort to develop national policies for retirement, survivor, and disability programs that can serve as a guide for public and private programs. The Commission on Pension Policy will coordinate its work of the Advisory Council and the National Commission.[16]

Significance of Veterans' Legislation

Enactment of the Veterans' and Survivors' Pension Improvement Act [17] represented one of the most significant legislative developments in 1978 affecting the economic well-being of the elderly. Public Law 95–588 assures all veteran pensioners an income above the poverty

[15] Senator Church wrote Secretary Califano on July 31, 1978, and posed this question: "If our Nation decides to abolish poverty for older Americans, what would be the most effective way to approach this goal? For example, should the emphasis be on supplemental security income, social security, a combination of these two programs, or some other approach?"

[16] Response included in July 17, 1978, hearing cited in footnote 2.

[17] Public Law 95–588, approved Nov. 4, 1978.

level. The new legislation increases the maximum annual rates effective January 1, 1979 from $2,364 to $3,550 for single veterans and from $2,544 to $4,651 for a veteran with a dependent. These rates are $800 higher for a veteran of World War I. Public Law 95–588 is expected to remove 150,000 to 200,000 veterans from the poverty rolls.

Another major purpose of the act is to assure that VA pensions will never be reduced because of social security cost-of-living increases. Public Law 95–588 automatically indexes pension rates to the Consumer Price Index on the same basis as social security. Thus, when social security benefits are increased, veterans will receive the full cost-of-living adjustment in their pensions as well.[18]

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[18] Example: The maximum annual pension rate for a single veteran is $3,550. Assuming the veteran is receiving $2,500 in social security benefits (or any other source of annuity payments) and $1,050 in VA pension benefits at the time social security benefits are increased, and the social security increase was 6 percent, the maximum support level for pension purposes would be calculated as follows:

Annual social security benefits	$2,500
Cost-of-living social security increase	×.06
Additional social security benefits	$150
Annual VA pension benefits	$1,050
Cost-of-living pension increase	×.06
Additional pension benefits	$63

This would provide an additional $213 annual benefit. The annual maximum income support level would, as a result of the indexing, be raised by 6 percent from $3,550 to $3,763. Thus, the individual receives a full pension increase of 6 percent as well as a full 6 percent increase in social security.

CHAPTER III

HEALTH: HIGH COSTS AND NEW APPROACHES

I. THE INDIVIDUAL BURDEN

The personal share of health care expenditures for the elderly, that which is paid for by the elderly themselves, continues to increase.[1]

The out-of-pocket share of total national health care expenditures for the elderly is the highest it has ever been. During 1977, each older American spent $613 for medical services—35 percent of their total health care bill.[2]

Total per capita personal health care outlays for the elderly during 1977 were $1,745. This is a 15 percent increase over 1976, and an increase of 31 percent in a period of 3 years. (Per capita personal health care expenditures for the elderly were $1,336 in 1975; $1,521 in 1976.)

Most of the public share for national health care expenditures of the elderly comes from medicare and medicaid.

During 1977, medicare paid for about 44 percent of the total health expenditures of the elderly. When medicare's cost-sharing amounts, paid for by beneficiaries themselves, are deducted, medicare actually paid for only 41 percent of the elderly's total health care expenditures nationwide.

State medicaid programs paid for an additional 16.7 percent of the total health care expenditures of the elderly. This is a minimal increase over 1976 payments, when medicaid accounted for 16 percent of the total health care expenditures of the elderly.

The annual rise in out-of-pocket payments for health care services is perhaps most directly evident when medicare's coinsurance charges increase.

The amounts each medicare beneficiary must pay out-of-pocket for medicare's hospital insurance will increase by 11 percent on January 1, 1979. The initial deductible for hospital stays under medicare part A will increase to $160 per benefit period, up from $144 during 1978. When medicare first took effect, in 1966, the in-patient hospital deductible was $40.

The coinsurance charges for long-term hospital and skilled nursing days will also increase 11 percent on Jauuary 1, 1979.[3]

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[1] Statistics from "Age Differences in Health Care Spending, Fiscal Year 1977," Social Security Bulletin, vol. 42, No. 1, January 1979.

[2] Reference cited in footnote 1. The comparable figure published for the year 1976 was $404, which did not include private health insurance premiums or medicare's coinsurance charges paid for by the elderly themselves. The 1977 data includes these charges, which is a more accurate reflection of the out-of-pocket share. (If the coinsurance charges and private health insurance premiums are not included, the 1977 figure is $463, about a 15 percent increase.)

[3] Daily coinsurance charges for the 61st through the 90th day of hospitalization will rise from $36 to $40. From the 91st day through the 150th day, the charge will rise from $72 to $80 per day. The daily charge for skilled nursing days, from the 21st through 100th day, will rise from $18 to $20.

II. ELUSIVE GOAL: HOSPITAL COST CONTAINMENT

Hospital costs continue to rise at least 1½ times the rate of inflation.[4] Congressional efforts to pass legislation which would have placed mandatory cost controls on hospitals failed during 1978. Voluntary efforts initiated by the hospital industry reportedly decreased the rate slightly early last year. However, HEW predicts that if hospital controls are not adopted, then the medicare deductible will climb from its present $160 to $276 by 1983.[5]

A. Costs Continue to Rise

Hospital costs alone account for 40 percent of all health care expenditures.[6] They are the most inflationary element in the health care sector, increasing 15.6 percent in 1977 alone. HEW stated that early estimates for 1978 were already at 13.6 percent.[7] Further, the cost of hospital care was averaging $140 per day—an increase of $22. The average stay of about 7 days costs $1,363.[8]

B. Voluntary Effort

The American Hospital Association, the American Medical Association, and the Federation of American Hospitals announced a voluntary effort to reduce the spiraling inflation rate in hospital costs by 2 percent a year for the next 2 years.

Projections by the Congressional Budget Office estimate that during early 1978, inflation in hospital costs had decreased from 15.6 percent to 13.6 percent.[9]

C. Legislation Fails

House and Senate Health Committees took differing routes to curb inflation in hospital costs.

—In February, the House Ways and Means Health Subcommittee, on a 7-to-6 vote, approved a bill calling for mandatory controls if, after 2 years, voluntary efforts by the hospital industry fail to slow the cost increases.

—During 7 weeks of debate in June and July, the House Interstate and Foreign Commerce Committee considered the bill. The committee defeated Federal controls by a vote of 22 to 21. The committee then approved a substitute bill asking hospitals to cut revenue increases by 2 percent a year. It also proposed a Presidential commission to oversee the effort. In addition, States that initiate their own cost commissions would be given financial assistance.

—Senator Herman Talmadge attached his Medicare and Medicaid

[4] "Hospital Cost Containment," a summary of legislation pending before the Senate of the United States, prepared by the Department of Health, Education, and Welfare, July 1978, p. 2. See also Congressional Budget Office report, "The Voluntary Effort to Control Hospital Costs: A Preliminary Assessment," March 1979.

[5] Washington Post, Dec. 29, 1978.

[6] See report cited in footnote 4, p. 43.

[7] Draft paper from the Congressional Budget Office, March 1979. CBO estimates that because hospital rates increased 2 percent in the last part of 1978, inflation will be higher than last year's rate.

[8] See report cited in footnote 4, p. 2.

[9] See report cited in footnote 7, p. II.

Reimbursement Reform Act[10] to a House-passed tariff measure and sent it to the Senate floor in August. The Talmadge bill did not reach a vote in the final days of the session.

—Senator Edward Kennedy introduced a bill similar to the administration's 1977 Hospital Cost Containment Act.[11] The Senate rejected the mandatory program in favor of a voluntary one introduced by Senator Gaylord Nelson.[12] The Nelson proposal, as passed, was similar to that passed by the House Ways and Means Subcommittee.

—The House adjourned before the measure could be brought up for a vote.

Late in December, the Carter administration asked the Nation's hospitals to hold their 1979 spending to a 9.7-percent increase.[13] The voluntary goal would be a reduction of 25 percent in the present inflation rate and would be part of the President's anti-inflation guidelines.[14]

D. State Initiatives

Most of the hospital cost containment proposals would exempt States that have health care rate setting commissions. Currently, Connecticut, New York, California, and Massachusetts have established hospital costs control commissions and rate-setting boards. An example of one such State commission is in Maryland where the Maryland Health Services Cost Review Commission reports that hospitals had increases of only 9 percent as compared to a nationwide average of 14 percent.[15]

The Indiana Hospital Association and Blue Cross established their own cost-control program under the auspices of a Department of Health, Education, and Welfare grant. The program estimates to have saved health care consumers 10 percent since 1973.[16]

In North Dakota, citizens defeated an initiative on the November ballot that would have regulated all health-care costs.[17]

The Carter administration has set hospital cost containment as a priority in 1979. With voluntary and State efforts being initiated, debate on methods for decreasing the rate of inflation in the hospital sector will continue to be in the national political arena.

III. INCREASING ATTENTION TO "ALTERNATIVES"

HEW Secretary Joseph Califano, testifying before members of this

[10] The Medicare and Medicaid Reimbursement Reform Act would establish a new method of reimbursement for routine hospital operating costs under medicaid and medicare, providing incentive reimbursements for hospitals whose routine costs are below the average and penalties for those with costs exceeding 120 percent of the average. Also see "Developments in Aging: 1977," part 1, pp. 59–60.

[11] See Congressional Record, Oct. 12, 1978, p. S18353. The administration's bill had two major elements to contain costs. They would establish an overall ceiling on total inpatient revenues, limit allowable increases to 9 percent by fiscal year 1981; and second, would set limits on capital expenditures for hospital construction. Also see "Developments in Aging: 1977," part 1, pp. 59–60.

[12] See Congressional Record, Oct. 12, 1978, p. S18353.

[13] Washington Post, Dec. 29, 1978.

[14] The hospital industry announced, as reported, in the Washington Post, Jan. 6, 1979, that they would reject Secretary Califano's 9.7-percent ceiling on increases. The American Hospital Association predicted there would be "extensive rationing of care' if hospitals were forced to keep their expenses from climbing above the 9.7 percent Califano requested.

[15] Washington Star, Dec. 28, 1978, p. Mc1.

[16] Journal of the American Hospital Association, September 1978.

[17] Wall Street Journal, Oct. 31, 1978.

committee, posed what he called a critical question facing our society in the coming years:[18]

> How shall we deliver the services older citizens need—health care and social services—more compassionately and efficiently?

He cited a 40-percent increase in costs in medicare and medicaid between fiscal years 1976 and 1978, with little increase in the covered population and benefits. There will be a tenfold increase in cost of those programs by the year 2025, he said:

> We must be at least equally concerned about the shortcomings of this expensive system. For all the money we spend, major needs remain unmet. As the elderly population increases—especially those 75 and over, who are especially likely to have serious health problems—these needs will increase . . . We must build a rational, comprehensive, efficient, and humane system for delivering health and social services.

Such a system should include:

—Adequate, supervised residential facilities for those who lack families but want to live in their communities.

—Special services for those who live at home but need help from outside: transportation or shopping help, for example, and help with meals and personal care.

—A range of alternatives between the hospital and the nursing home, including a system of home health care.

—Innovative and compassionate ways of caring for the terminally ill outside the traditional hospital or nursing home.

Secretary Califano also directly acknowledged that there is no such system now:

> We have, instead, a confusing and expensive patchwork of financing systems that spawn an even more inadequate delivery system.

Calling home health care a worthwhile alternative to nursing home care for many people, he pointed to what he termed an acute-care bias in medicare and the institutional bias in medicaid, and said we have not yet developed an adequate system of community and home health care.

How can we end the fragmentation of services for the elderly and insure that the needs of the elderly are properly identified? His answer: "We don't know yet."

Secretary Califano offered three alternatives:

(1) Revising medicare and medicaid to make home health benefits the same in both programs, and relaxing the current restrictions on skilled nursing benefits only, or creating a new financing structure to expand the range of health and social services available to the elderly.[19]

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[18] Secretary of Health, Education, and Welfare Joseph A. Califano, Jr., testimony before the Senate Special Committee on Aging, July 17, 1978.

[19] Testimony cited in footnote 18. Secretary Califano also suggested that this option poses problems of aggravating inflation in health costs, and that questions still remained about the potential for overuse of chronic care services in the same way acute care services are now being overused. He also speculated that such an approach ought not to reduce incentives for families to provide their own care.

(2) Creating special health maintenance organizations for the elderly, providing a broader range of services than conventional HMO's.[20]

(3) Creating a separate financing and delivery system for long-term care, which would integrate current long-term care expenditures from medicare and medicaid (including nursing home and home health care) with a broad new range of support services.

PRESSURES INCREASING

Looking to the future, another administration representative warned Congress and the Nation to brace for significantly increased demands for the homebound and other elderly victims of chronic illness.

Robert Benedict, named as U.S. Commissioner on Aging in 1978, made these predictions:[21]

> As the population ages, more older people will fall into the category that the Federal Council on Aging has called the frail elderly, those elderly people whose ability to function in the ordinary business of daily living has become limited because of the increased infirmities of later life. . . . We can expect that the continuing increase of the very old population will mean a greater incidence of disability and isolation over the years. The population 65+ will increase by about 500,000 persons each year over the next half century. It is estimated that between 80,000 and 100,000 of those persons will need assistance to remain in the community. These facts portend increasing pressures on the family, special living arrangements, community service programs, and nursing homes and other institutions.

There is new urgency in the statistics of the "old old." Dr. Harold Sheppard told the committee that, in 1960, there were 34 persons age 80 and over for every 100 persons age 60 to 64, the "young old." By 1970, the ratio had increased to 46. By 1980, it will probably be 52. By the end of the next decade—by 1990—we can expect to find 63 very old persons for every 100 age 60 to 64. By the end of the century, the proportion will rise to 79.[22]

STATUS OF THE "FRAIL ELDERLY"

The Federal Council on Aging established a task force on the frail elderly in 1975. A seminar was held with national experts to assist the Council develop a targeted focus on the "frail elderly."[23] The Council held several meetings over the next 3 years to develop a public policy report on the frail elderly.

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[20] Secretary Califano noted that the administration had already proposed legislation to permit broadened medicaid and medicare funds to be used to pay for more participation by the elderly in conventional HMO's.

[21] Robert C. Benedict, Commissioner on Aging, Department of Health, Education, and Welfare, in testimony before the Subcommittee on Aging, Senate Committee on Human Resources, U.S. Senate, Apr. 21, 1978.

[22] Dr. Harold L. Sheppard, Center on Work and Aging, American Institutes for Research, in testimony before the Senate Committee on Aging, July 17, 1978. See chapter I of this report for a more detailed discussion of demographic trends.

[23] Defined as the oldest among the elderly, usually age 75 or over, who, because of the accumulation of continuing problems, often require one or several supportive services in order to cope with daily life.

During 1978, Federal Council staff prepared a draft study discussing the status of this group of the "oldest of the old" and made preliminary recommendations:[24]

—The population 75 years of age and older has experienced a 10-fold increase since 1900, and the age group 85 years of age and older has grown by about 17 times. Concurrently, about 40 percent of the elderly population is 75 and over, and this proportion is expected to increase to 45 percent by the year 2000.

—There is sufficient evidence regarding a continuing lessening of physiological and social well-being with increasing age to support, (1) a public policy of social intervention for the frail elderly to provide services not available in the marketplace and (2) provision of social services based on automatic entitlement to assure access to services by all those who become frail.

The staff study recommends:

—Systematizing aid to persons who need direct personal assistance from society on a continuing basis by establishing a freestanding case assessment and case management service as an entitlement of the frail elderly upon reaching a certain age, on a national and voluntary basis. Frail persons below the age could be qualified by some functional eligibility determination.

—Developing a plan of care, by skilled practitioners, in conjunction with the older person and his or her family and/or friends. A priority in the assessment and plan process would be identification of a "significant other" person or persons to help the older person cope with daily needs.

Additional recommendations to further the overall goals of meeting the needs of the frail elderly include:

—Elimination of the current reduction in the supplemental security income benefit of elderly recipients residing in the household of another. This would encourage families and friends to maintain older relatives or friends in their homes as long as possible.

—Development of a long-term care social support system, as a matter of national priority, to complement the national long-term care health system.

STATES SEE GROWING NEED

Preliminary results from a committee survey of State development of alternative programs of community long-term care indicates a growing sense of urgency to find ways to meet the needs of the growing older population with nontraditional ways of providing services.

Many of the States report encountering significant problems.

Alaska.—"Long-term care clients are confronted with an array of services offered by an array of providers. . . . The result is all too frequently inappropriate institutionalization or preventable patient debilitation leading to institutionalization. . . . The overriding obstacle to the creation and continuing operation of institutional alternatives (outreach, counseling, long-term care, respite, rehabilitation, training, screening, and placement) is a reliable and consistent funding source. Continuum of service delivery, both into the home and into

[24] "Public Policy and the Frail Elderly," a staff study. Federal Council on the Aging, Washington, D.C., 1978; in draft form, not yet released.

the alternative residential setting to avoid premature nursing home admission and retention, is desperately needed." [25]

Florida.—"It is important to note that when we speak of a continuum of care, the range of services provided must address the physical, social, emotional, functional, and environmental aspects of an individual's needs. Therefore, the integration of both health and social services into a single service system is perhaps the most problematic area in developing this program. We have, in our efforts to develop this comprehensive system, encountered innumerable barriers created by the categorical arrangement of funding sources." [26]

New Hampshire.—"Despite our efforts as an agency to develop comprehensive services at the local level and to coordinate with other funders . . . we are hampered by the continuing lack of direction at the Federal level. If a truly coordinated service system ever becomes a reality, this will occur when Congress takes the initiative in requiring rather than requesting that this coordination takes place." [27]

Wyoming.—"The numbers of qualified and adequately trained personnel in the rural areas are very limited. Those who are available in the area are grossly overworked. We do not have a demonstrated cost-effective service delivery model in a rural State. Research and demonstration projects are needed in this area." [28]

Nebraska.—"Nebraska is keenly interested in the continuum of care concept and the provision of appropriate services, both institutional and community-based. A number of problems have been encountered in the development of coordinated service delivery, however. Among those which are appropriate for Federal action are review, and possible modification, of eligibility criteria and regulations, standardization of reporting requirements, and legal vesting of authority in one lead agency." [29]

A. The Administration: Behind Schedule

The urgency echoed in Secretary Califano's testimony before the committee in July followed by almost 9 months his designation of the Health Care Financing Administration as the "focal point" for development of long-term care policies within the Department of Health, Education, and Welfare.[30] In October of that year, HCFA Administrator Robert Derzon transmitted to the committee the administration's timetable for long-term care policy development.

By March 1978, the administration would submit to Congress its proposals for national health insurance. The proposal, the timetable said, would include a decision on how long-term care services were to be treated within national health insurance.

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[25] Letter to Senator Frank Church from Helen D. Beirne, commissioner, State of Alaska Department of Health and Social Services, Dec. 13, 1978.

[26] Letter to Senators Church, Chiles, and Domenici from E. Bentley Lipscomb, program staff director, Aging and Adult Services, State of Florida Department of Health and Rehabilitative Services, Dec. 7, 1978.

[27] Letter to Senators Church, Chiles, and Domenici from Claira P. Monier, director, New Hampshire State Council on Aging, Dec. 14, 1978.

[28] Letter to Senators Church, Chiles, and Domenici from James Hammer and Nancy Krois, Office on Aging, Department of Health and Social Services, State of Wyoming, Dec. 12, 1978.

[29] Letter to Senators Church, Chiles, and Domenici from David M. Howard, executive director, Nebraska Commission on Aging, Dec. 13, 1978.

[30] See "Developments in Aging: 1977," part 1, U.S. Senate Special Committee on Aging, p. 65, for discussion of the HEW commitment and other activities during the year. Since that time, Robert Derzon has left HCFA and a new Administrator has been appointed.

In July 1978, the administration announced a set of "principles" to serve as a guide in preparation of national health insurance legislation. They did not address the health problems of older Americans and specifically excluded any discussion of long-term care issues.[31]

By August 1978, the administration was to have transmitted to Congress a report on the results of major research conducted during recent years to assess the feasibility of including such benefits as homemaker and day care services in medicare and medicaid.

No report has yet been transmitted to Congress.[32]

By December 1978, the administration was to have formulated its plans for development and testing of major alternative service delivery and financing methods. Goals were to test models for coordinating services and providing a community-based continuum of care for the chronically ill and disabled to eliminate problems of fragmentation and institutional biases in long-term care.

No plans have yet been transmitted to Congress, and a proposal made by Secretary Califano for $100 million for special demonstration projects in long-term care during fiscal year 1980 was rejected by the Office of Management and Budget.[33]

By December 1978, the administration would transmit to Congress a full report on home health services with recommendations for service availability and provision, program administration, and reimbursement and costs of home health programs under medicare, medicaid, and title XX. The report would also include recommendations for coordination of home health resources among the three programs, service utilization control, and prevention of fraud and abuse.

The report has not yet been made public.[34]

SETBACKS IN THE FISCAL YEAR 1980 BUDGET PROPOSAL

In order to implement the Department's long-range goals of testing and demonstrating major new delivery systems for alternative forms of long-term care, an early HEW budget memorandum for fiscal year 1980 included a special request for $100 million for demonstrations of effective methods of organizing and delivering long-term care services.[35] The major portion was to be for the development of specialized long-term care agencies which would perform a central role of assessing a patient's service needs, make the appropriate services available to the patient, and coordinate and integrate existing mental health, health, and social services to meet individual needs.

This initiative, however, did not appear in the final version of the administration's budget request to Congress for fiscal year 1980.[36]

The highly successful home health demonstration program was also severely cut in the fiscal year 1980 budget request.[37] The budget proposed a cut from $6 million (the fiscal year 1979 funding level) to $804,000, to phase the program out during the year.

[31] See p. 60 of this report for a discussion of national health insurance proposals.

[32] See next page for a discussion of initial findings from the section 222 demonstrations. The full report, which is to include recommendations, has not yet been released.

[33] See next page for further details on the original HEW proposal and p. 52, following, for discussion of similar legislative authority.

[34] HEW's final report, with recommendations, was expected to be made available to Congress by April 1979.

[35] Memorandum from HEW Secretary Joseph Califano to HEW staff, Oct. 2, 1978.

[36] "The Budget of the U.S. Government, fiscal year 1980."

[37] Document cited in footnote 36. See p. 52, following, for program history and congressional action to reauthorize the program through fiscal year 1981.

WHAT DO WE KNOW? THE SECTION 222 DEMONSTRATIONS

The 1972 amendments to the Social Security Act mandated an evaluation of the feasibility of including geriatric day care and homemaker services as a benefit in medicare and medicaid programs.[38]

Six demonstration projects were established, helped by special waivers for payment of homemaker and day care services for a period of 1 year. Most of the participants in the demonstration programs were over the age of 75, female, and widowed.[39]

In an early report of the findings of the experiments, HEW researchers found that the new services offered substantial benefits to participants:[40]

—Participants, particularly those who received homemaker services, experienced lower death rates.

—Increased physical dependency was postponed or entirely avoided through the use of day care services.

—Contentment was sustained or increased, particularly for patients who had access to both homemaker and day care services.

—Day care services increased mental functioning and social activity levels.

—Day care services substantially reduced the likelihood of a patient entering a skilled nursing facility or a hospital. Day care services also reduced average hospital days used.

—The number of skilled home health visits needed by participants using day care services or day care and homemaker services together was significantly reduced.

—The cost to medicare for hospital days, skilled nursing day, and home health visits was reduced. Costs for the new services of day care and homemaker, however, offset these reductions.

WHERE DO WE STAND? THE HOME HEALTH DEMONSTRATIONS

A special demonstration program for the development and expansion of home health agencies, first authorized in 1975, has completed 3 years of operation.[41]

The program's goal was to encourage the development of home health services in underserved areas. Grants were made to finance the initial costs of establishing and operating new home health agencies

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[38] Section 222 of Public Law 92-603.

[39] Mean age for demonstration participants was 75.6 years; over 60 percent were women; about 50 percent were widowed. About one-third of the experimental population were classified as "severely dependent." The waivers allowed medicare and medicaid payments to be made for the services received. Day care and homemaker services are not covered by medicare and are only covered by medicaid in some States.

[40] "Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment," Department of Health, Education, and Welfare, National Center for Health Services Research, Jan. 19, 1979.

[41] The Home Health Extension Act was first authorized for fiscal year 1976 by an amendment, offered by Senator Frank Church, to the Health Revenue Sharing and Health Services Act, Public Law 94-66, enacted July 29, 1975; $8 million was authorized for demonstration and expansion grants. The program was extended through fiscal year 1977 as part of the Health Maintenance Organization Amendments of 1976, Public Law 94-640, with authorizations of $8 million for demonstration and expansion grants and $4 million for training of home health agency personnel. An additional $2 million for expansion grants and $1 million for training for the fiscal year 1976 transition quarter was also authorized by this measure. The program was extended for a third year, fiscal year 1978, as part of the Health Assistance Programs Extension Act of 1977. Authorizations for fiscal year 1978 were $8 million for expansion grants and $4 million for training. See p. 52, following, for further authorizations through fiscal year 1981.

until they could become self-sufficient, and to enable existing home health agencies, primarily those equipped to provide only a limited service, to expand their home service capabilities. A typical expansion made possible by a program grant was addition of homemaker services to skilled nursing and therapy services. The grants were targeted to areas of the country with limited, or no, home health services.[42]

Recognizing that there were few people adequately trained to provide home health services, the legislation made a separate authorization for grants to be used to train home health agency personnel.[43]

Grants totaling $11 million have been awarded to more than 200 agencies to develop home health services where none were previously available, and to provide an opportunity to expand the services of existing agencies. In addition, $1 million has been awarded to 21 programs to provide special training for about 3,000 home health aides.

Prior to the home health demonstrations program, 788 counties in the country were without the services of a medicare-certified home health agency; 135 of these counties now have a medicare-certified home health agency, serving almost 2 million people who did not have access to home health services before. Home health services have been expanded in an additional 446 counties. All of the 112 home health agencies awarded grants in 1976 and 1977 are now self-sustaining.

The Department of Health, Education, and Welfare is now evaluating the results of the startup and expansion grants authorized under the Home Health Extension Act, and a final report on program operations is expected at the end of March 1979.[44]

Three areas of program operation will be reported: (1) an evaluation of whether the specific legislative objectives of capacity-building and program expansion can be effectively met through such a grant program; (2) an evaluation of the program's ability to affect the distribution of trained home health personnel; and (3) an analysis of the costs of home health visits and the factors which contribute to utilization of home health services.

NEW ATTENTION TO HOSPICE SERVICES

The concept of "hospice" services, to help terminally ill patients remain as physically and emotionally comfortable as possible, has received extensive and favorable attention.[45]

Currently, hospice care in the United States is delivered in a number of settings: through specially designed programs of home care, through institutional hospices serving only dying patients, and through specially trained teams of hospice workers working within acute-care hospitals.

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[42] Hearings conducted by the Committee on Aging had documented that the need for home care was particularly acute in rural areas where institutional facilities are limited or nonexistent. Many rural areas, however, had no home health agencies. Those which did often provided only the minimum limited service required to be eligible for medicare reimbursement—skilled nursing plus one other service, usually physical therapy.

[43] During the program's first 2 years of operation, grants were made for agency startup and service expansion only. No appropriations for training were made available until fiscal year 1978, the third year of operation.

[44] The evaluation is being conducted by the Center for Health Services Research, University of Colorado Medical Center, Denver, Colo., under a contract with the Department of Health, Education, and Welfare, Health Services Administration, Office of Planning, Evaluation, and Legislation, contract HSA 240–77–0148.

[45] See "Death With Dignity: An Inquiry Into Related Public Issues," hearings before the Senate Special Committee on Aging, U.S. Senate, Washington, D.C., Aug. 7, 8, and 9, 1972, for an early exploration of the hospice concept and other issues related to care of the terminally ill.

The major goals of hospice care focus on the needs of the dying patient and his family, including relief from pain through the use of drugs and psychological therapy in preparation for death.

The National Hospice Organization[46] held its first annual meeting in Washington, D.C., in October. Featuring keynote addresses by Secretary of Health, Education, and Welfare Joseph Califano and Senator Edward Kennedy, the conference also heard reports on the origins of the hospice care concept and discussed current issues in hospice care delivery.

Secretary Califano announced that a National Conference on the Care of Dying Patients would be convened next year to further refine these issues and explore approaches to private sector funding.

A special task force to examine current hospice activities within and outside the Federal Government has been formed by the Department of Health, Education, and Welfare. The task force will also make recommendations about the appropriate Federal role in hospice development.[47]

HEW's Health Care Financing Administration, which administers medicare and medicaid, has invited agencies providing hospice-oriented home care and in-hospital hospice care to submit proposals for special demonstration projects. State medicaid agencies were also invited to conduct special hospice demonstration projects.[48] The projects were solicited by HCFA to evaluate factors related to provision of hospice services in various settings in order to make long-range recommendations for medicare and medicaid coverage of specific hospice service components.

B. Legislative Efforts

Home health demonstration continued.—In recognition of the success of the home health demonstration program, Congress reauthorized the program for an additional 3 years, through fiscal year 1981.[49] Fund authorizations were increased: $11 million is authorized for start-up and expansion grants for fiscal year 1979, $12 million for fiscal year 1980, and $13 million for fiscal year 1981. Training grants are authorized at $1.5 million for fiscal year 1979, $2 million for fiscal year 1980, and $2.5 million for fiscal year 1981.

Congress had not passed a new appropriations bill by the end of the year, however, and the program entered 1979 under a continuing resolution at the fiscal year 1978 funding level of $5 million for startup and expansion grants, and $1 million for training.

Special HCFA demonstrations.—An amendment sponsored by Senator Lawton Chiles to provide an additional $5 million to the Health Care Financing Administration for special long-term care demon-

[46] NHO is the national hospice advocate group. Hospice, Inc., of New Haven, Conn., recently assigned its hospice service mark to NHO in order to allow for eventual control of the use of the word "hospice" by organizations. NHO estimates that there are approximately 200 groups in the country in various stages of developing hospice services. About 75 of these are actually delivering hospice care.

[47] A number of Members of Congress have also expressed interest in hospice, and an informal congressional working group has been participating in task force activities.

[48] 43 CFR, Oct. 27, 1978. pp. 50376–50378. The projects are to be conducted under the authority of section 402 of the Social Security Amendments of 1967, as amended by sec. 222(b) of Public Law 92–603, and sec. 1115 of the Social Security Act.

[49] Public Law 95–626, the Health Services and Centers Amendments of 1978. See p. 50 of this report for discussion of program performance during the past 3 years.

strations was included in the fiscal year 1979 Labor-HEW appropriations bill.[50]

The additional funding is to be used for: [51]

—Development of community organizations to perform assessment of care needs, prescription of services, monitoring and reassessment of service needs, and quality assurance.

—Provision of a broad range of services, health and social, based on the needs of individuals rather than forcing people to fit into narrowly defined categories.

—Testing of various methods of financing long-term care services, such as fixed budgets, capitation, and sliding fee scales, to determine the effect on costs, utilization, and quality of care.

The Health Care Financing Administration is now reviewing a number of proposals for special projects. Announcements of grant awards will be made early during 1979.

Medicare home health benefits.—Even though both the House and the Senate passed bills which would have expanded medicare's home health benefits, final agreement was not reached.

A House-passed bill would have removed the 100-visit limitation for home health services under medicare parts A and B, eliminated the requirement for a prior 3 days of hospitalization under medicare part A, eliminated the $60 deductible for home health services under part B, and eliminated the present medicare requirement that proprietary home health agencies be licensed by a State before becoming eligible for medicare reimbursement.

In addition, the HEW Secretary would have been required to establish additional standards for home health agencies participating in medicare, and to establish regional intermediaries for home health agencies. The bill also required training programs for home health aides, and would have barred a physician who certifies eligibility for home health services from having a substantial financial relationship with the agency providing home health services.[52]

The Senate-passed bill would also have repealed the requirement for a prior stay of 3 days in a hospital to be eligible for home health services under medicare part A and removed all limitations on the number of home health visits allowed under medicare parts A and B.[53]

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[50] Public Law 95–480, signed Oct. 18, 1978.

[51] Letter to Senator Warren Magnuson, chairman, Subcommittee on Labor-HEW Appropriations, from Senator Lawton Chiles, May 12, 1978. See following section on similar legislation advanced by Senator Chiles and others in the Older Americans Act Amendments of 1978. The intent of advancing similar demonstration programs in two agencies, the Health Care Financing Administration and the Administration on Aging, was to encourage joint activities and coordination between the two agencies. HCFA staff and AOA staff serve together on joint reviews of demonstration proposals made to both agencies. The joint activities are meant to encourage both agencies to bring to bear their own special expertise in demonstrating programs which can answer questions of both service delivery efficiency and cost effectiveness.

[52] H.R. 13097, the Medicare Amendments of 1978. The bill also contained amendments to expand medicare payments for services provided by community mental health centers and inpatient services of licensed clinical psychologists, as well as chiropractic services. For a full discussion of proposals considered by the House see "Proposed Amendments to the Medicare Program." Committee Print No. 95–92, Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, Aug. 4, 1978.

[53] H.R. 5285, the Medicare-Medicaid Administrative and Reimbursement Reform Act. The Senate bill would also have allowed small hospitals with 50 beds or fewer to use empty acute-care beds for long-term care needs without requiring a hospital to establish a separate section for this purpose. The bill also contained measures to encourage more physicians to accept assignment on medicare claims through administrative improvements in the billing and payment process and would have required the adoption of a uniform claims form for medicare and medicaid.

Agreement on the two bills, however, was not reached. It is expected that a number of these provisions will be reconsidered during the 96th Congress.[54]

C. The Older Americans Act Breakthrough

The Comprehensive Older Americans Act Amendments of 1978 contain a number of provisions stressing a much broader commitment by the network of State and area agencies on aging to the development of community-based systems of long-term care.[55]

Senators Lawton Chiles and Pete Domenici, members of this committee, introduced bills early in the year to strengthen the act's commitment to long-term care services development.[56]

After a series of hearings on the "alternatives" issue,[57] Senator Chiles stressed the important role already played by Older Americans Act programs in the development of community-based long-term care services. At the same time, however, he emphasized that medicare, medicaid, and title XX programs must all be drawn upon to fashion the flexible programs which are needed to respond to changing needs.

> The Older Americans Act could perform a vital role in what could become a transition period leading to lessened dependence upon institutional care and the development of genuine, community-based care and support systems . . . Many experiments along these lines are already taking place under the Older Americans Act, sometimes tapping other funding sources. If all these pilot efforts are to lead anywhere, we have to think more clearly in terms of national strategies for national purposes. At a minimum, a deeper involvement by all of the aging network in speeding up this process is called for. . . .[58]

In introducing S. 2609, Senator Domenici stressed:

> This legislation will grant AoA the authority to create a number of model long-term care centers. These centers will be located within selected AAA's that can demonstrate that they have the ability to assume these additional functions: Assess an individual's need; develop a plan of care; arrange for the necessary and appropriate services; monitor, evaluate, and reassess the situation as circumstances change; maintain rec-

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[54] The large number of bills which had to be considered by both the House and the Senate in the last days of the 95th Congress, and major differences between the House and Senate versions of the medicare amendments made it impossible to reconcile the two bills before the 95th Congress adjourned. The Senate-passed bill contained a controversial hospital cost-containment measure which had not been passed by the House. (See p. 43 of this report for a discussion of this legislation.) The House-passed bill contained a number of medicare liberalizations which had not been passed by the Senate.

[55] Public Law 95-478. See chapter XII of this report for additional discussion of the 1978 Amendments to the Older Americans Act.

[56] S. 2967, introduced by Senator Chiles on Apr. 20, 1978. S. 2969, introduced by Senator Church on Apr. 20, 1978, contained similar provisions. S. 2609, introduced by Senators Domenici, Percy, Brooke, Dole, and Schmitt on Feb. 28, 1978.

[57] "Health Care for Older Americans: The 'Alternatives' Issue," parts 1 through 8, hearings before the Senate Special Committee on Aging, U.S. Senate. Senator Lawton Chiles chaired hearings in Washington, D.C., on May 16 and 17, 1977, June 15, 1977, and Sept. 21, 1977, and a hearing in Tallahassee, Fla. on Nov. 23, 1977; Senator John Glenn chaired a hearing in Cleveland, Ohio, on July 6, 1977; Senator Edward Brooke chaired a hearing in Holyoke, Mass., on Oct. 12, 1977; Senator Pete Domenici chaired a hearing in Washington, D.C., on Apr. 17, 1978.

[58] Statement, Senator Lawton Chiles, Congressional Record, U.S. Senate, Mar. 1, 1978.

ords; and assist in Outreach. The model project approach should enable us to determine, over the next few years, the validity and viability of the long-term care center concept.[59]

SPECIAL PROJECTS IN COMPREHENSIVE LONG-TERM CARE

Under the 1978 Older Americans Act Amendments, grants are authorized to State and area agencies on aging, institutions of higher education, and other public and private, nonprofit organizations to develop comprehensive, coordinated systems of community long-term care. Special emphasis is to be on services designed to support alternatives to institutional living, and the assessment of need, development of a plan of care, and referral of individuals to long-term care services where appropriate.

Grant funds may be used to help support services as necessary parts of a comprehensive system, but the law stipulates that no grant funds may be used to pay for direct services which are eligible for reimbursement through medicare, medicaid, or title XX. Grant funds may also be used for training.

The law requires the Commissioner to give preference to States which have developed standards for the services to be provided and have involved either the State medicaid or title XX agency, or both, in program operation. The law also requires the Commissioner on Aging to coordinate grant activities at the Federal level with other departments and agencies involved in the development of long-term care services development.

No funds had been appropriated for the special projects by the end of the year. Public Law 95–482, however, continues funding for the Administration on Aging's research and demonstration projects at the fiscal year 1978 funding level of $15 million. A portion of these funds may be used to initiate projects similar to those authorized under this special section.

OTHER PROVISIONS

The 1978 amendments also require the Commissioner on Aging to develop planning linkages with local health systems agencies. This provision was adopted in recognition of the unique opportunities which exist for area agencies on aging and health systems agencies to work closely together in the development of area plans for long-term care services.

The Commissioner on Aging is required to assess the Nation's future personnel needs for both institutional and noninstitutional long-term care and evaluate the adequacy of existing programs. The law also states the desire of Congress to have the Commissioner on Aging review and comment on all HEW activities concerning institutional and noninstitutional long-term care services development.

IV. VISION CARE AND A GRAYING POPULATION

More Americans are encountering vision loss simply because they are living longer. A soon-to-be-released study by the American Foun-

[59] Statement, Senator Pete V. Domenici, Congressional Record, Feb. 28, 1978.

dation for the Blind states that by the year 2000 there will be 1.5 million older Americans with severe vision problems, a one-third increase due in just over 20 years.

This projection, coupled with an existing blindness service delivery system described by authorities in aging and blindness as ill-prepared to serve older clients, prompted the Senate Committee on Aging to hold an August 3, 1978 hearing on "Vision Impairment Among Older Americans."

The hearing focused on several issues, including:

—Legislation intended to help visually impaired older persons to better cope with everyday life.

—The role of vision impairment of the 1981 White House Conference on Aging.

Senator Frank Church stated in his opening remarks:

> We must gear up—far better than we are now doing—to meet the special needs of those whose sight becomes less dependable with passing years, even to the extent of total blindness.

Ranking minority Member Senator Pete V. Domenici said:

> . . . with an increasing visually impaired population, we need to examine how we can strengthen existing legislation to assist visually impaired Americans to remain functionally independent.

Principal points made at the hearing were:

—The so-called "blindness system" is a fragmented structure made up of more than 700 public and private agencies, few of them operating with agreed upon goals.

—Both medicare and medicaid provide some acute care medical services to the elderly blind but practically no rehabilitation service is available.

—Rehabilitation agencies, hampered by State and Federal regulations providing for rehabilitation for employable younger persons, offer little long-term help for older persons suffering a vision loss.

—Dramatic breakthroughs in treatment have great potential for restoring low vision but, since the leading causes of blindness among the elderly often accompany the aging process, prevention of blindness and vision loss remains an elusive goal.

—Promising rehabilitation techniques for older persons exist and may become more widespread with the passage of the 1978 amendments to the Rehabilitation Act calling for support for the unique rehabilitation needs of older persons.

V. MENTAL HEALTH: NEW REPORTS, SETBACKS, AND NEW POSSIBILITIES

High priorities for meeting mental health needs of older Americans were set in three reports issued during 1978.

However, legislation to broaden medicare for such services failed to emerge from the Senate after having passed in the House.

Another bill, the Community Mental Health Act of 1978, became law and continued that program for 1 more year. But it delayed the implementation of a provision requiring special programs for older persons at community mental health centers.

An omnibus reform bill, possibly centered on recommendations from a Presidential commission, may be offered in 1979.

A. The Studies

Three major studies considering the mental health of older Americans were released during 1978.

The President's Commission on Mental Health [60] found:

> . . . depression escalates decade by decade; 25 percent of all the suicides are committed by people over 65 years of age; we face the devastating organic brain syndrome; we face all the same crises in everyday problems that people of all ages do . . . Yet, less than 3 percent of the budget of the National Institute of Mental Health has been devoted to the totality of services, training, and research on the plight of the older Americans.[61]

The Secretary's Committee on Mental Health and Illness of the Elderly [62] documents the fragmentation of services to the senior citizen:

> Although the past two decades have brought about significant actions on behalf of many of the Nations' long ignored minority groups, including the elderly, and have witnessed the enactment of several major pieces of legislation—medicare, the Older Americans Act, Community Mental Health Center legislation with specialized services for the elderly, and the establishment of an Administration on Aging, a National Institute on Aging, and a Federal Council on Aging—untold numbers of older people are essentially untouched by them, and untold more still have problems and needs to which there has been no adequate response. The mental health needs of the Nation's elderly in particular continue to remain largely ignored.[63]

The conclusions reached by both studies are similar. As summarized, they recommend:

—Preventive services to relieve human and financial costs.

—Programs to provide the elderly with opportunity to continue in community roles.

—Education and research initiatives.

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[60] The Commission was established by Executive Order No. 11973 signed Feb. 1, 1977, to identify mental health needs of the Nation and submit recommendations on how needs can be met. Also see "Developments in Aging: 1977," pp. 76–77.

[61] Task panel reports submitted to the President's Commission on Mental Health, p. 1119. See footnote 60.

[62] The committee was established through an amendment to Public Law 94-63 sponsored by Edmund Muskie, signed into law on July 29, 1975, and extended through fiscal year 1977 by Muskie amendment to Public Law 94-640 signed into law Oct. 8, 1976. The committee was charged with making recommendations to meet the future services, manpower, training and research needs in mental health programs for the elderly. Also see "Developments in Aging: 1977," pp. 77–78.

[63] Report of the Secretary's Committee on Mental Health and Illness of the Elderly, p. 1. See footnote 62.

—Access by older persons to community services.
—Linkages between social support systems and general physical and mental health delivery systems.[64]

Medicare financing was recommended for more mental health services, but few other program recommendations were offered in regard to the elderly.[65]

The third report that addresed the mental health problems of the aged was the age discrimination study issued by the U.S. Commission on Civil Rights.[66] The Commission found low participation in community mental health programs by the over-65 population. "Older persons accounted for 10 percent of the service area population, but represented only 4 percent of the participant population." [67]

A reason for this discrepancy is lack of adequate outreach efforts on the part of community mental health centers.

> Older persons are put at a severe disadvantage when centers fail to work with agencies concerned primarily with their needs: (1) Older persons do not have the opportunity to learn what preventive measures they can take to maintain good mental health; (2) older persons are less likely to learn about services available to them when they do encounter problems; and (3) agencies concerned with older persons do not obtain the information and guidance necessary for them to provide appropriate and adequate assistance to older persons who may have mental health problems.[68]

B. Legislative Action

H.R. 13097, as passed in the House, would have allowed medicare beneficiaries to seek mental health outpatient and partial hospitalization services through community mental health centers.[69]

The Senate Finance's Health Subcommittee held hearings in August to consider expanding medicare and medicaid payments to cover mental health services. Senator Herman Talmadge opened the Senate Finance Committee hearing by asking:

> There is no question that Congress is willing to provide proper coverage for necessary mental care.
>
> The question to which we hope to get answers today is—what is proper mental care?
>
> To what extent would Congress be inviting erroneous and costly new expansion in areas where in part, an individual practitioner can define an almost infinite need for care.
>
> This is an area where there are often no objective parameters. We have limited resources available for health care financing.[70]

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[64] See President's Commission Report pp. 1119–1141; and Committee on Mental Health and Illness of the Elderly, pp. IX–X.

[65] The President's report recommended the expansion of financing for mental health services by using medicare. See later discussion on attempts in the 95th Congress to liberalize funding.

[66] The Age Discrimination Study, a report of the U.S. Commission on Civil Rights, December 1977. Also see *Developings in Aging: 1977,"* pp. 161–172 and chapter XI of this volume.

[67] See report cited in footnote 66, p. 12.

[68] See report cited in footnote 66, p. 13.

[69] Section 7 of the bill. Amendments of the Social Security Act, section 1812(a). Passed the House, Sept. 18, 1978, 398 to 2. Referred to Senate Finance Committee, Sept. 21, 1978.

[70] "Proposals to Expand Coverage of Mental Health Under Medicare-Medicaid," hearing of the Subcommittee on Health of Committee on Finance, 95th Congress, Aug. 18, 1978.

The Finance Committee did not, following the hearing, meet to consider the House-passed bill.

The Community Mental Health Amendments of 1978 [71] delayed the implementation of provisions of the 1975 amendments [72] which required federally funded centers to have programs for the elderly. The combination of the delay and the 1-year authorization may discourage the development of mental health programs for the aged.[73]

The Community Mental Health Act was extended for only 1 year. Senator Harrison Williams explained:

> . . . the complexities of current law have created problems for those administering the programs at the local, State, regional, and Federal levels. And difficult questions have been raised regarding the structure and financing of the centers, as well as the range and quality of delivered services. . . . Such an extension would take fully into account the important recommendations recently made to the President by his Commission on Mental Health.[74]

C. Possibilities for 1979

President Carter will probably send a mental health reform bill to Congress early in 1979. The legislation may follow the lines recommended in the report of the President's Commission on Mental Health.[75] Seven goals are stated in an early discussion of the bill:

—Assuring accessibility for the general population to appropriate and effective mental health services which are acceptable quality and provided in an efficient manner.

—Assuring the availability and accessibility of community based mental health services for those most in need and assisting these persons in obtaining other health, rehabilitative, residential, legal, social and supportive services as they may require.

—Assuring that service systems give priority to the developments of appropriate services in unserved or underserved and inappropriately served populations.

—Minimizing unnecessary or inappropriate hospitalization of persons with mental disorders.

—Assuring that persons requiring long-term residential care due to mental illness or disability receive such care in the least restrictive and most "normal" setting possible.

—Assuring that the basic rights of current and potential patients/clients in all mental health systems are protected through internal advocacy efforts.

—Improving the capacity of the mental health system and of society generally to promote mental health, prevent mental illness and to minimize the consequences of mental illness when it does occur.[76]

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[71] Public Law 95–622, signed by the President Nov. 9, 1978. See Congressional Record, Oct. 14, 1978, pp. S19291–19300.

[72] Public Law 94–63, 94th Congress, July 29, 1975.

[73] S2450, section 104(a)(1)(B)(iii).

[74] Senator Harrison Williams, Congressional Record, June 26, 1978, pp. S9716–9717.

[75] See report sited in footnote 61, pp. 12–55.

[76] Detailed specifications for the Community Mental Health Systems Act, Draft, Dec. 15, 1978.

D. NIMH–AoA Joint Session

The National Institute of Mental Health and the Administration on Aging held a joint training session late in 1978 to bring the aging and mental health networks together to work on common problems. The goals of the session were:

—Improve cooperation and coordination between the two networks.

—Provide information on the interactive role of mental health services and other social health services.

—Provide information on models of coordination between the Community Mental Health Centers and the aging network in order to develop a continuum of care.

—Provide a forum for Federal, State, and local officials to meet and discuss the organization and delivery of mental health and related services.

—Identify gaps in services between the mental health and aging systems.[77]

More than 50 people attended the first session in suburban Washington. NIMH and AoA plan to have additional sessions during 1979 by region throughout the country to encourage dialog between local providers of mental health and aging services.

VI. NATIONAL HEALTH INSURANCE AND THE ELDERLY

A new round in the efforts to provide a comprehensive national health program to all Americans was set in motion during 1978. The Carter administration announced a set of principles [78] in July to guide it in preparing a bill for introduction in 1979. Senator Edward Kennedy and the committee for a national health insurance (a coalition of labor, consumer, and religious organizations) put forward their own outline for a national health insurance plan in early October,[79] but no bill is expected until the 96th Congress.

Neither the administration's principles nor the Kennedy proposal would incorporate a long-term care policy for the eldery, which would remain in modified versions of medicare-medicaid.

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[77] National Institute on Aging and the Administration on Aging conference invitation. Information memorandum AoA–IM–79–2, Oct. 16, 1978. p. 1.

[78] Presidential directive/DPS–3 to the Secretary of HEW, July 29, 1978: (1) The plan should insure that all Americans have comprehensive health care coverage, including protestion against catastrophic medical expenses. (2) The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care. (3) The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems. (4) The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector. (5) The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system. (6) The plan will involve no additional Federal spending until fiscal year 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other Government programs, in which expenditures far exceed initial projections, must not be repeated. (7) The plan should be financed through multiple sources, including Government funding and contributions from employers and employees. Careful consideration should be given to the other demands on Government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care. (8) The plan should include a significant role for the private insurance industry, with appropriate Government regulation. (9) The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans. (10) The plan should assure consumer representing throughout its operation.

[79] 124 Congressional Record 16813 (Oct. 2, 1978).

A. Extent of the Problem

The administration and the Committee for National Health Insurance agree that the country needs a national health program, a position which several national organizations on aging have also strongly supported.

Among the arguments advanced for a NHI plan are:

—Twenty-four million Americans have no public or private health insurance whatsoever.

—Eight million of these have incomes below the poverty line.

—At least 88 million Americans have no insurance protection against catastrophic medical expenses.

—Medicare and medicaid do not reach all older Americans or the poor, nor pay for all needed services.

—More than 49 million Americans live in medically underserved areas.

—There are too many unnecessary hospital beds, and too few physicians delivering primary care.

—The health care industry is inefficient and anticompetitive.

—The poor and elderly often receive "substandard" care in our two-class delivery system.[80] (See following illustrations.)

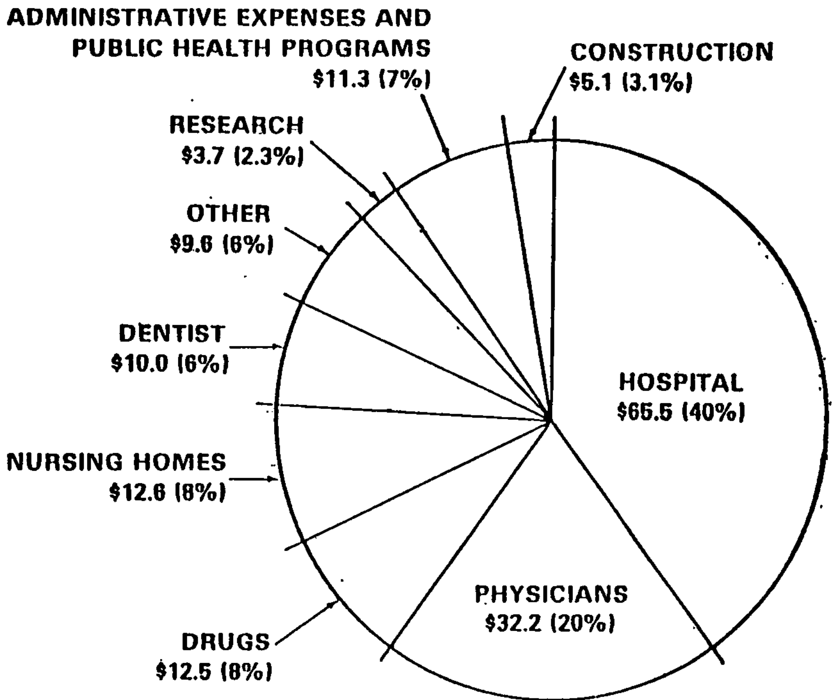
B. What Is To Be Done?

The administration position was presented by HEW Secretary Joseph Califano on July 29, 1978, after 1½ years of study.[81]

[80] Materials distributed by Secretary Califano July 29, 1978.

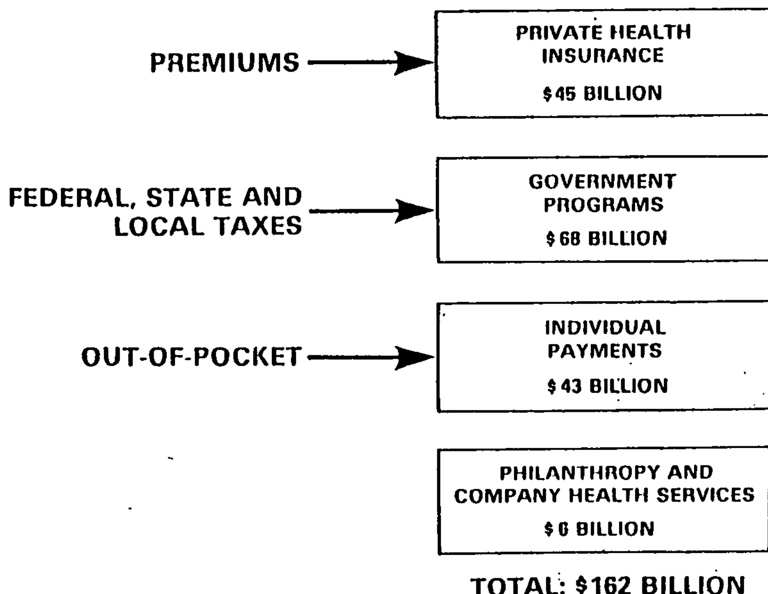
[81] In April 1977, HEW formed a 29-member public Advisory Committee on National Health Insurance issues. For the next 11 months the committee conducted site visits to various communities in this country and Canada to get a better feel for the health care financing and delivery system. A series of NHI briefing papers were prepared by HEW staff and presented to the committee. The committee adjourned in February 1978 without making any recommendations about the direction of NHI. The briefing papers included the following topics: Overview of NHI issues, discussion paper on benefits, discussion paper on Government delivery of health services, discussion paper on cost-sharing and national health insurance, discussion paper on reimbursement issues, discussion paper on national health insurance cost estimation methodology, discussion paper on administration of NHI, discussion paper on financing national health insurance, discussion paper on delivery system reform under NHI, and four prototype plans discussed by the committee: quasi-public corporation target plan, consumer choice health plan and publicly guaranteed health protection. These are available through the Government Printing Office.

THE HEALTH CARE INDUSTRY: WHO RECEIVES THE PAYMENTS (FY 77)



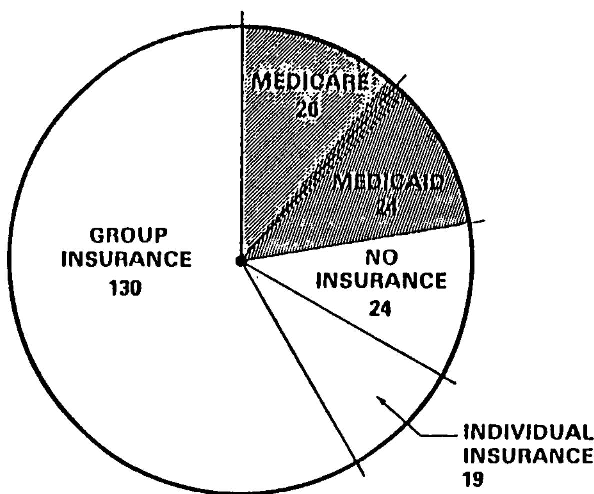
TOTAL: $162.2 BILLION

THE HEALTH CARE INDUSTRY: THE NATION'S HEALTH BILL IS PAID FOUR WAYS



TOTAL: $162 BILLION

CURRENT INSURANCE COVERAGE:* PUBLIC AND PRIVATE (Millions of Persons: FY 78 Projections)



*ANY COVERAGE -- EVEN VERY LIMITED AND INADEQUATE

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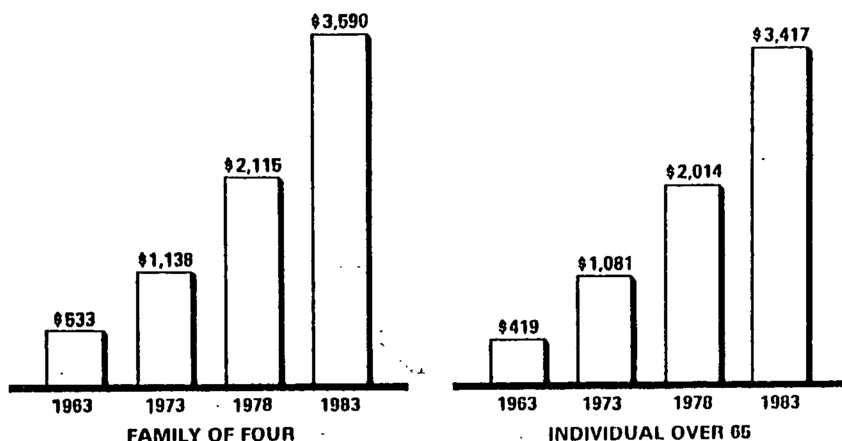
Problem --
RISING HEALTH CARE COSTS: INDIVIDUAL PERSPECTIVE



AVERAGE COSTS OF HEALTH CARE

The administration's principles speak to comprehensive, quality of care for all Americans; freedom of choice of provider; strong cost controls and greater efficiency in phasing in benefits and population groups over a period of time; employer-employee contributions; Government funding and cost-sharing by patients; a role for the private insurance industry; delivery system reform; and consumer representation. The pivotal principles are:

> The plan will involve no additional Federal spending until fiscal year 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other Government programs, in which expenditures far exceed initial projections, must not be repeated.[82]

This reportedly represents a compromise. The President's economic advisers argued that the Federal Government could only afford a program for the poor and those with catastrophic illnesses; HEW and the domestic policy staff, however, argued that a broad program which insures basic benefits to all Americans is the only effective lever on runaway health costs.[83]

On October 2, 1978, Senator Kennedy unveiled the proposal of the Committee for a National Health Insurance,[84] which would impose

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[82] See footnote 78.
[83] 124 Congressional Record 16813 (Oct. 2, 1978).
[84] Inglehart, John K., "National Health Insurance—Carter's Conflicting Promises," National Journal, 1212, July 29, 1978.

immediate cost controls on the hospital industry when enacted and would extend basic benefits to everyone 2 years after enactment.

Under the President's principles phasing in of benefits and/or population groups would occur only if certain economic conditions were met and might require congressional action on each occasion.

Under the Kennedy proposal, every U.S. resident would be issued a health insurance card entitling that person to basic benefits: preventive care, inpatient hospital services, physician services, home health services, X-ray and lab services, and full coverage for catastrophic illness costs. Older Americans would have essential prescription drugs reimbursed by medicare.

However, long-term care services, including nursing home care, would not be included in the basic benefit package. Instead, these services would be the responsibility of each State.

Provider discrimination against patients on the basis of source of payment, race, or national origin would be prohibited.

C. Paying for National Health Insurance

The Kennedy proposal relies on the following:

—*For the employed and self-employed.* The mandated benefits would be financed through employer and employee private health insurance premium contributions. This is generally the case now. Under this plan the private insurers would be subject to stringent Federal regulations.

—*For the elderly.* The benefits would be paid for by social security payroll taxes that now finance medicare part A. This would be supplemented by Federal revenues.

—*For the poor and unemployed.* The Federal Government would pick up the costs.

—The medicaid program would be "federalized" for the services mandated in the national insurance package, thus relieving the States of the financial burden.

The Carter plan.—At this time, the Carter proposal does not have a specific financing mechanism, although one of the principles does discuss a mixture of public and private financing. Costs would also be offset by aggressive cost containment and control of inflation in the health care sectors.

D. Implications for Older Americans

Neither the Carter administration's principles nor the Kennedy plan endorse special services for older Americans. Both indicate that medicare and medicaid would continue somewhat in their present fashion. The Kennedy proposal does do away with the coinsurance and deductible segments which have long been a burden to older Americans in the medicare program. Further, plans call for coverage of catastrophic medical expenses, which would be beneficial for the aged since they tend to spend more days in the hospital than other segments of the population. Coverage of all prescription drugs in the Committee for National Health Insurance's plan would be of special importance to the elderly.

As discussed earlier, long-term care is not included in either proposal. The Kennedy supporters indicate that nursing home, adult day

care, and other forms of long-term care would still be available through the States such as are now available in the medicaid programs. Moneys for long-term care would be available at the same match as States now have under the medicaid program, with a requirement that services currently offered could not be reduced. States would have an incentive to continue and perhaps expand the long-term care programs since total State expenditures would be reduced with the federalization of the mandated national health care package.

The exclusion of nursing home services may be attributed to the large expense. Currently, 38 percent of medicaid expenditures go for nursing home care.

E. Strong Support From Organizations

Both the National Council of Senior Citizens and the American Association of Retired Persons/National Retired Persons Association support the principles put forward by Senator Kennedy.

William Hutton, NCSC executive director said:

> . . . There is no dollar amount that accurately reflects the sense of security an older person gains as a result of knowing that if he or she should become ill, the money will be there to pay for it . . .[85]

Cyril Brickfield, AARP/NRTA executive director said:

> . . . The fact is that through its encouragement of competition among providers of health care, your proposal is far more uniquely American and far more consistent with free enterprise than our present system of "monopolized medicine" . . . Another reason to consider NHI is the failure of medicare to adequately meet the needs of older Americans . . .[86]

NCSC and AARP/NRTA said they will work with Senator Kennedy and his subcommittee on health to get legislation through Congress during the next session.

F. Health Subcommittee Hearings

Hearings on national health insurance began on October 9, 1978, in Washington. Subsequent hearings have been held in Detroit, California, Illinois, West Virginia, and Denver. Comparisons at the Detroit and Washington, D.C., hearings indicated that in Canada, which has a publicly financed health plan, all medically incurred expenses were covered while people with similar problems in this country were without adequate resources.

On the basis of the hearings, as well as other public discussion, a national health insurance bill will probably be introduced during the 96th Congress. The Kennedy and Carter proposals are not the only ones being discussed. Representative Ron Dellums of California has called for a national health service program which would change the financing and method of delivering health care to all Americans. The

[85] Testimony before the Senate Committee on Human Resources Subcommittee on Health and Scientific Research on The National Health Insurance Act of 1979. For the National Council of Senior Citizens, Oct. 10, 1978.

[86] In support of the National Health Insurance Act of 1979. For the National Retired Teachers Association and the American Association of Retired Persons, Oct. 10, 1978.

Dellums proposal would establish a publicly controlled health service—financed primarily by Federal income taxes—that employs health workers on a salaried basis to provide comprehensive health services. Advocates of a national health service argue that a national health insurance program would only make things worse than they already are, since it would put money into an existing health care delivery system without making fundamental changes necessary to assure equal access to quality care.

The American Medical Association has indicated that they may develop a plan of their own.

> At the 1978 interim meeting the house of delegates adopted a resolution calling on the board to sponsor, if necessary, legislation to require minimum standards of adequate benefits for health insurance policies, with deductible and coinsurance; to include a system of uniform Federal, State, and local government benefits for those who cannot provide for their own medical care; to make catastrophic insurance coverage by the private insurance industry available through a nationwide program; and to provide for administration at the State level with national standardization through Federal guidelines.[87]

All of the proposals are likely to be discussed during the next year as health care costs continue to rise.[88]

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[87] American Medical Association statement on national health insurance, interim statement, Jan. 22, 1979.

[88] Senator Russell Long introduced several catastrophic health insurance bills early in 1979. Consideration of these bills and those proposed by the American Medical Association, the Carter administration, the Kennedy Health Subcommittee, and any other similar bills will be considered during the 96th Congress.

CHAPTER IV

FRAUD AND ABUSE: HOW MUCH?

Mounting evidence of repeated patterns of fraud and widespread prevalent mismanagement in key health care programs for older Americans produced several actions by the Congress and the executive branch during 1978:

—The Senate Committee on Aging heard witnesses urge a substantially strengthened effort to aid the establishment and operation of the State fraud control units called for by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. A legislative effort in this direction fell short of final legislative action during the close of the 95th Congress.

—Patterns of medicare and medicaid provider ownership subterfuge resulting in inflated medicare and medicaid reimbursement had resulted in 1977 legislation authorizing stringent ownership disclosure. The Department of Health, Education, and Welfare produced draft regulations in late 1978 to implement these requirements.

—The Inspector General of the Department of Health, Education, and Welfare called for new initiatives to strengthen detection, investigation, and prosecution of fraud and abuse in health care delivery; he also set goals for the tightening of the management of Federal- and State-controlled health care reimbursement practices. Toward that end, Secretary Joseph A. Califano convened the first National Conference on Fraud, Abuse, and Error in HEW, calling for a sharpening of estimates of these losses along with more precise targeting of Federal and State resources to reduce fraud and mismanagement.

President Carter, in his address to more than 1,000 State and local officials at the December 13 and 14 Conference on Fraud, Abuse, and Error, said that Secretary Califano had pledged to save $1 billion during the current fiscal year by eliminating waste and fraud.

Singling out "senior citizens deprived of medical services" among those who are victimized by waste in HEW programs, President Carter called for overhauls in the management of these programs, including a directive to OMB Director James McIntyre and HEW Secretary Joseph A. Califano, Jr., to streamline Federal eligibility programs for public assistance programs.

The General Accounting Office determined that the medicaid management information system (MMIS), a medicaid management tool, falls well below the performance standards required by law. Thus lowering a medicaid detection of fraud and abuse by providers and recipients.

I. THE ESTIMATES

Losses due to fraud, abuse, and waste in the Federal share of medicaid, possibly running as high as 27 percent of the Federal expenditures in this program, are the single largest loss in HEW programs. Medicare losses are the second largest.

In fiscal year 1977, as much as $2.6 billion of the total Federal medicaid expenditures of $9.8 billion were lost through errors, faulty management systems, and fraud. Losses because of these same problems run as much as $2.2 billion of the total medicare expenditures of $21.9 billion in fiscal year 1977.

These losses were reported in the March 31, 1978, First Annual Report of the Department of Health, Education, and Welfare's Inspector General. The Inspector General's self-described "best estimates" of these losses are based on an inventory of information revealed in GAO and HEW audits, HEW quality control surveys, and congressional hearings—including Senate Committee on Aging hearings on fraud and abuse.

The report stresses that the summary is based on incomplete inventories of these programs and that it is virtually impossible to distinguish sharply between fraud, abuse, and waste since each category of loss may involve all three problems.

However, the Inspector General concludes that, in spite of these limitations, the data are reasonable estimates and may well be conservative measures of the total loss.

A. Medicaid Losses

HEW analysis of the $2.6 billion Federal share loss attributed to medicaid shows estimates ranging from $855 million to nearly $1.2 billion, due to error and faulty management systems, such as payments to ineligible beneficiaries, overpayments, and failure to collect third party payments.

The second largest loss, pegged at $802 million, results from unnecessary surgery and hospitalization, excessive hospital bed capacity, excessive physician costs, and unnecessary X-rays.

Outright fraud costs the Federal share of the medicaid program as much as $653 million. "Medicaid mill" operations and abusive clinical laboratory practices—both documented by investigations conducted by this committee—account for the chief losses in this category.

Losses attributable to fraud are probably understated since, according to the Inspector General, no analysis was made of the operations of pharmacists, home health agencies, and other health care providers. In addition, the report contends that some of the losses carried under the category of unnecessary costs may, upon further analysis, be the result of fraudulent or abusive practices of health care providers.

B. Medicare Losses

Over $2.2 billion of the $21.9 billion estimated fiscal year 1977 medicare expenditures was reportedly due to error, faulty management, and chiefly to support excess hospital bed capacity.

While the $15 million loss estimate from fraud and abuse is the smallest category of medicare loss, it is, according to the Inspector

General, attributable entirely to fraudulent and abusive practices by some providers in the nursing home industry: primarily kickbacks to suppliers, deceptive real estate practices, and the filing of false cost reports.

Here too, the losses may be understated because no analysis is made of medicare providers other than hospitals, nursing homes, and physicians.

FRAUD, ABUSE, AND WASTE—THE IMPORTANT DISTINCTION

With evidence of such substantial losses of tax dollars in these programs, this committee expanded its series of hearings on long-term care issues to include a focus on national and State efforts to curb fraud and abuse in health care programs for older Americans.

Expert witnesses have emphasized that fraudulent practices are often undertaken in the absence of the effective management necessary to detect the willful misrepresentation involved in fraud. Time after time, this committee has been told that effective management systems and aggressive prosecution are essential deterrents to these operations and that proper attention to the distinctions involved in fraud, abuse, and waste is necessary for the proper targeting of these resources.

For the purpose of rough definition of these practices, the Inspector General's report makes these distinctions:

—*Fraud* is defined as the obtaining of something of value, unlawfully, through willful misrepresentation.

—*Abuse* covers a wide variety of excessive services or program violations, and improper practices not involving prosecutable fraud.

—*Waste* is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.[1]

II. THE STATE FRAUD CONTROL UNITS

This committee has closely monitored the progress of the State fraud control units called for in the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

Section 17 of this law provides 90 percent Federal matching in fiscal years 1978 through 1980 for the costs incurred in the establishment and operation of these units.

On July 25, Senate Committee on Aging Chairman Frank Church conducted a hearing to review the implementation of section 17 fraud control units. The major questions before this inquiry were:

—The rate of progress in the creation of these units.

—The steps being taken by HEW to encourage the formation of the units.

—The status of the units after October 1, 1980, when the Federal share of funding expires.

Frank S. Beal, Deputy Administrator for Operations of the Health Care Financing Administration, told the committee:

> . . . section 17 is one of the most important provisions of Public Law 95-142. This section, which provides an incen-

[1] Department of Health, Education, and Welfare, Office of the Inspector General, "Annual Report," March 31, 1978, p. 1.

> tive of 90 percent, Federal matching funds to States that establish independent medicaid fraud control units, recognizes that the State is the most appropriate investigator and prosecutor of medicaid fraud.[2]

In reviewing the current status of applications for the program Mr. Beal stated:

> At the present time, there are nine certified State fraud control units, located in Louisiana, Alabama, Michigan, New Mexico, Connecticut, Rhode Island, New Jersey, Washington State, and Colorado.
>
> In addition, we have received applications from 11 other States and anticipate receiving many more this year. The 20 States whose units have been certified or whose applications are being reviewed for certification, account for 72 percent of medicaid expenditures. We expect 35 units to be certified by the end of the year covering nearly 85 percent of medicaid expenditures.[3]

However, as of December 1978 only an additional 10 States—Idaho, Massachusetts, New York, Pennsylvania, Wisconsin, California, Hawaii, Vermont, Ohio, and Nebraska—were certified making a total of 19 participants in the program.

Noting the problems in the certification process, Mr. Beal told the committee:

> . . . our most frequent problem has been in reaching agreement with States on the level of funding. Some States have had great difficulty supporting their funding requests, and the resulting need to negotiate has delayed the certification of some fraud units.[4]

The committee called on Charles J. Hynes, New York's special prosecutor for nursing homes, health, and social services, to testify on New York's pioneering efforts as a prototype fraud control unit. During the July 25 hearing, Hynes stated:

> With respect to my own State's application, after the promulgation of the regulations and the clarifying of various jurisdictional concerns, New York submitted its application to the Department of Health, Education, and Welfare almost 3 months ago. Having been cited by Congress as the "model agency" for these units, we had hoped for a rapid and affirmative response. This response has not been forthcoming.[5]

In view of certification delays and the October 1, 1980, expiration date for the Federal share of funding, Chairman Church asked whether these units would have the full 3 years of operation intended by Congress. Charles J. Hynes replied:

> Given the difficulties in establishing or maintaining medicaid fraud control units, it appears that the investigations will actually be funded, then, for a period of 2 years, and not the

[2] "Medicaid Antifraud Programs: The Role of State Fraud Control Units," statement of Frank S. Beal before the U.S. Senate Special Committee on Aging, July 25, 1978.
[3] Ibid.
[4] Ibid.
[5] Testimony of Charles J. Hynes, July 25 hearing.

3 as was the original intent. This is not satisfactory, Mr. Chairman, when one considers the kind of investigations to which I have been referring.

They are long; they are tedious; and they are difficult.[6]

In view of these problems, Senator Church introduced legislation calling for the period of Federal funding for the units to extend to October 1, 1982, to insure that States making a good faith effort toward certification would have the full 3 years of funding necessary to test this concept.

The Church amendment was made part of a package of health care amendments which failed to pass in the final days of the 95th Congress because the House refused to agree to the measure's hospital cost containment provisions.

The Church amendment, possibly in modified form, will be reintroduced during the first session of the 96th Congress.

III. MEDICARE-MEDICAID PROVIDER OWNERSHIP DISCLOSURE

Testimony before this committee documented complex interweaving of relationships among many medicare providers and subcontractors, ancillary service providers, and other health care facilities often resulting in substantial overreimbursement by medicare and medicaid.

These hearings and investigations helped make the case for congressional approval of the provider ownership disclosure requirements under the Medicare-Medicaid Anti-Fraud and Abuse Amendments.

The Health Care Financing Administration published draft regulations implementing these requirements on August 4, 1978. Secretary Joseph Califano commented:

> These rules would give us an important new tool with which to ferret out evidence of fraud and abuse in those important programs and prosecute offenders. They will help us identify situations in which self-dealing, interlocking directorates, or other arrangements allow providers to make excessive profits. In addition, the existence of this requirement will serve as a deterrent to those who would use obscure business arrangements to defraud taxpayers.[7]

Committee Chairman Frank Church and ranking minority member Pete V. Domenici wrote to Secretary Califano expressing reservations about the draft regulations. Foremost among the problems addressed by the Senators is the fact that the draft regulations require routine disclosure of facility ownership while not applying the same standard to business relationships with subcontractors, ancillary services, and interests in other health-related facilities.

IV. ADMINISTRATION INITIATIVES

In addition to offering its inventory of fraud and other program losses, as described in the beginning of this section, the first annual

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[6] Ibid.

[7] HEW news release for Monday, Sept. 11, 1978.

report of the HEW Inspector General, dated March 31, 1978, also discussed activities underway or recommended to combat these losses.

Among the programs now operating are:

1. Project Integrity—a computer-based effort to detect abuses by physicians and pharmacists in every medicaid State and the District of Columbia. Special scrutiny is directed toward false claims for services not rendered, inflated billings, substitution of generic for brand name drugs, and overbillings for laboratory services as well as simply erroneous billing. The next series of Project Integrity initiatives will involve an intensive effort, in selected States, to examine the practices of dental service providers and clinical laboratories.

2. Audit Agency reports will concentrate on HEW principal operating components in order to analyze the implementation of audit recommendations for more effective program management.

The audit agency's fiscal year 1979 work plan allocates one-third of the staff resources of the Office of the Inspector General to audits of programs in the health services field with known or potential patterns of fraud and abuse or management problems.

The Inspector General also recommended a 100-percent increase in the staffing of the office of investigations in order to deal with the steadily increasing workload. The September 14, 1978, memorandum of understanding between the office of program integrity and the Inspector General, makes the office of investigation chiefly responsible for criminal fraud investigation within HEW programs.

Criminal Fraud Investigations and the Department of Justice

Section 4(c) of the two Medicare-Medicaid Anti-Fraud and Abuse Amendments requires that the Inspector General, as part of his annual report to Congress, provide an analysis of medicare and medicaid criminal fraud cases referred to the Department of Justice. One element of the 1978 report anticipates a sharp increase in the number of referrals:

> . . . the results of Project Integrity and additional initiatives of a similar nature will fall, in part, into the hands of the U.S. attorneys. There is little question that the U.S. attorneys have evinced considerable interest in medicare and medicaid fraud prosecutions, and the stress on white-collar crime being placed by the Attorney General should insure that that interest does not flag. It is crucial, however, that there be continued emphasis on the training of younger assistant U.S. attorneys in the investigation and prosecution of program fraud.[8]

Research Needs

The Inspector General has also outlined long-range research initiatives in the health care field which are particularly noteworthy in view of the known patterns of fraud and abuse.

In 1979 and 1980, the concentration of Project Integrity initiatives are scheduled to focus on home health care agencies, nursing homes, and hospitals.

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[8] Office of the Inspector General, annual report, p. 31.

Nursing Homes

Approximately 38 percent of medicaid expenditures are devoted to long-term care for older Americans. Three specific antifraud and abuse projects will be undertaken in this area:

—In accordance with section 1905(a) of the Social Security Act, an onsite audit of each participating provider must be conducted over the next 3 years.

—Under the disclosure requirements of Public Law 95–142, the Inspector General's office will begin to develop a data base of provider ownership.

—Research audits are now underway in a selected number of nursing homes which show high cost patterns as a further means of perfecting techniques for identifying problem areas.

Home Health Care

The most significant recent growth area in medicaid expenditures is for services rendered by home health care agencies. The first annual report of the Inspector General and investigations and hearings before this committee have surfaced a number of operational patterns indicating opportunities for fraud and abuse. Public Law 95–142 mandates that the Secretary of Health, Education, and Welfare report to Congress on the growing problems within this industry. The Office of the Inspector General is participating in this study by identifying methods to detect fraud, abuse, and waste.

Hospitals

The second largest category of medicaid expenditures go for payments to hospitals. The Inspector General is now developing a national initiative to study patterns of payments within the hospital system. In preparation, HEW has contracted for a 2-year study with the office of the New York State Special Prosecutor for Nursing Homes, Health, and Social Services to analyze and investigate 25 New York hospitals. The project is scheduled for completion in October 1979. The Inspector General's report notes:

> This effort is off to an excellent start and the first indictment in Suffolk County has just occurred involving alleged kickbacks from suppliers and alleged theft of funds by the principal owner.[9]

The provider recently entered a guilty plea to the indictments and is now making restitution of about $1.2 million.

V. THE GAO ASSESSMENT(S): THE SECRETARY'S CONFERENCE ON FRAUD, ABUSE, AND ERROR[10]

A 1978 General Accounting Office report, requested by the Permanent Subcommittee on Investigations of the Senate Committee on

[9] Ibid., p. 39.

[10] Report of the Comptroller General of the United States, "Attainable Benefits of the Medicaid Management Information System Are Not Being Realized," U.S. General Accounting Office, Sept. 26, 1978.

Governmental Affairs, concludes that the surveillance and utilization review systems of medicaid management information system (MMIS) designed to detect potentially fraudulent activities, in Michigan, Ohio—both ranking in the top 10 of medicaid spenders—and Washington, are not effective.

While the surveillance and utilization review system of MMIS does not stand alone in determining medicaid utilization, it is a key element in the effective use of other methods of review used to detect potential fraud and abuse in the medicaid financed health care system. At this time 17 States have certified MMIS operations.

The GAO report criticizes HEW's system design and approval process for MMIS pointing out that, in the present state of development, this key subsystem is ineffective in identifying potential fraudulent or abusive patterns.

CHAPTER V

NEW DIRECTIONS IN NURSING HOME CARE?

"For too long we have focussed on procedures and neglected concern for the patient."

—Robert Butler, Director,
National Institute on Aging.[1]

National concern about nursing home care is often centered on costs. The Congressional Budget Office estimates total Federal, State, and local expenditures for such care are $7.2 billion, or 59 percent of the total $12.6 billion cost.[2]

This committee continues to be concerned about how public and private dollars are being spent, particularly in terms of the quality of care provided.[3]

These two concerns—the high cost of long-term care, as well as the quality of care provided—remained in the forefront in 1978. Among the key developments:

—Several States and the Federal Trade Commission have begun investigations into such issues as patients' rights, full disclosure of nursing home charges, and eviction of patients when public support is withdrawn.

—A coalition of private citizens reported that nurses aides in long-term care facilities are overworked and undertrained.

I. THE HEW REVIEW AND HEARINGS

A long-sought initiative was begun on June 8, 1968, by the Health Care Financing Administration of HEW. At that time, HCFA announced that it would review and invite public comments on regulations that skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) must meet to participate in the medicare and medicaid programs.

—The Department of Health, Education, and Welfare invited and received far-ranging criticisms of current regulations under which skilled nursing home and intermediate care facilities provide care through medicare and medicaid. Repeated pleas were made for sensible, enforceable rules focused more directly on patient care.

—Senate hearings produced new complaints about shortcomings in Federal-State rule enforcement, with special emphasis on quality of care.

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[1] "Long-Term Care," Oct. 20, 1978, vol. 7, No. 42, p. 4.

[2] "Long-Term Care: Actuarial Cost Estimates," a CBO technical analysis paper, August 1977.

[3] A preface to "Nursing Home Care in the United States: Failure in Public Policy" said, for example, in November 1974: "Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars. What is the Nation receiving for this money?" The report was issued by the Subcommittee on Long-Term Care, Senate Special Committee on Aging.

An HCFA report said:

> These regulations have been in effect for over 4 years. There is a need to simplify regulations to focus on patient care, to control the cost of care, and to achieve more effective compliance with the standards.[4]

At the hearings in five cities,[5] HCFA was praised for seeking opinions and criticized for current enforcement problems. An HCFA report summarized:

> ... there were recurrent complaints: too much paperwork, regulations either too specific or so vague as to be unenforceable, sanctions too limited and too drastic, failure to back up regulations with adequate reimbursement for required services. *Everyone agreed that the new regulations should shift the focus of the Government's attention from the physical characteristics of facilities to the quality of care actually given to the residents.* [Emphasis added.] [6]

A. The "Specifications"

HCFA based its hearings on "specifications" outlining issues of concern:

(1) What minimum qualifications should be established for professional personnel who work in or with a certified skilled nursing or intermediate care facility?

(2) Should medications be administered by unlicensed and untrained personnel? Should medication aides be required to satisfactorily complete a State-approved training program? If trained medication aides are to be permitted, which agency or body in the State should approve the training program and provide overall supervision?

(3) Does the medical direction requirement insure that patients receive adequate and appropriate medical and other services on a timely basis? If not, how can the requirement be improved to be made more effective?

(4) In order to obtain adequate physician supervision of SNF patients, should we continue to require physicians to visit their patients every 30 days for the first 90 days and no less than every 60 days thereafter?

(5) Should physician extenders be utilized in SNF's and/or ICF's? These include nurse practitioners and physicians' assistants.

(6) Should SNF's and/or ICF's be required to provide or make arrangements for respiratory services for the provision of inhalation therapy?

(7) Should the facility be permitted to use nursing staff manpower pools?

(8) Should the Secretary seek statutory authority to specify which edition of the life safety code issued by the National Fire Protection Association should apply to currently certified SNF's and the SNF's initially applying for participation in medicare or medicaid?

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[4] In its report, "New Directions for Skilled Nursing and Intermediate Care Facilities," summaries of public hearings, June–August 1978. Also see 43 FR 24873, June 8, 1978.

[5] Rockville, Md., June 27–28; Chicago, Ill., July 11–13; Washington, D.C., July 18–20; Atlanta, Ga., July 25–27; and San Francisco, Calif., Aug. 7–10.

[6] P. II of report cited in footnote 3.

Two additional considerations were suggested: (1) Revision of current procedures to require facilities to perform self-survey and submit plans for correction; and (2) extension of provider agreements from 12 to 24 months or longer.

HCFA officials provided this rationale for the proposed reliance on self-surveys:

> . . . the self-survey would be a means for getting the facility more involved in the evaluation, for having the staff and administration of the facility evaluate themselves, for reducing the survey time spent on things that do not change from one year to the next (e.g., width of halls) and for giving the staff better understanding of the standards they are expected to comply with. . . .[7]

B. Public Comments

HEW received more than 600 statements from witnesses representing providers, professional organizations, consumers, and government officials:

Self-surveys.—Individual providers support the idea of self-surveys" . . . as an excellent vehicle for improving the quality of your own employees. . . ." Consumers and the national provider organizations did not support self-surveys.

Extension of the provider agreement.—The American Health Care Association and the National Council of Health Care Services agreed that the provider agreement should be extended for those facilities that are in "substantial compliance." However, the American Association of Homes for the Aged and consumers stated that lengthening "hardly reinforces the public trust essential for insuring quality services to the elderly . . . is not warranted by conditions in all but a handful of homes across the country."

Medical direction and physician involvement.—HCFA suggested the possibility of eliminating a requirement that each nursing home employ a medical director. The American College of Nursing Home Administrators concurred saying a nurse could fulfill the role of the medical director. Consumer groups, on the other hand, want to keep the medical director.

A second concern is the frequency of physician visits. Again the providers supported the HCFA position that visits should occur at least quarterly and perhaps more frequently.

Specialized services.—The provision of physical therapy, occupational therapy, respiration therapy, dental services, and other rehabilitation services in nursing homes is often not an integral part of the regular daily activities offered to patients. Consumers and professional organizations, such as the American Dietetic Association, the National Association of Social Workers, the American Dental Association, and the American Speech and Hearing Association, argued for more specific requirements in this area.

Patients' rights.—The National Senior Citizens Law Center (NSCLC) suggested that HCFA "absolutely prohibit" nursing homes from transferring residents who exhaust their personal funds and become eligible for medicaid. Consumer groups recommended very strong

[7] Report cited in footnote 3.

patients' rights provisions, but provider groups believe that they are too difficult to administer.[8]

Several other witnesses commented on patients' rights, including Robert Benedict, Administration on Aging Commissioner Benedict asked HCFA to require a staffing ratio in facilities of nurses and nurses' aides to patients. A second issue Benedict addressed was the abolition of the "arbitrary and artificial distinction between skilled and intermediate care." [9]

NEXT STEPS

As 1978 ended, HCFA was preparing new regulations based upon the hearings and other agency analyses. At least a 90-day comment period is to follow publication of the proposed rules early in 1979. Final regulations will be published late in the year. Implementation of the new regulations may take an additional 6 months in order to allow development of instruments to measure quality of care and train the inspectors.

C. New Fire Regulations

Fire prevention in nursing homes was not considered in the "specifications" by HEW, which advanced a separate set of proposed regulations for that purpose in December.[10] The fire safety provisions will become a part of the requirements for nursing homes participating in medicare and medicaid.

Five alternative proposals to the current standards are being offered:

Requiring all participating long-term care facilities to have automatic fire extinguishers.

Requiring automatic extinguishers in newly constructed or recently converted facilities.

Requiring extinguishers in all new or recently converted facilities unless the buildings are of fire-resistant construction.

Retaining the present requirements which require SNF's to meet the 1973 life safety code of the National Fire Protection Association and ICF's to meet the 1967 code.

Requiring facilities to have other measures, such as smoke detectors, special patient evacuation plans, staff emergency training or higher staff-patient ratios.

Comments on the fire safety regulations are due in early January 1979.

II. HEARINGS FOCUS ON QUALITY OF CARE

Senate hearings were called in 1978 to investigate charges of inadequate enforcement of Government regulations and lack of sufficient attention to the quality of nursing home patient care.

A. Chicago Testimony

Senator Charles Percy conducted a hearing in Chicago on August 30, 1978, after receiving allegations from the Better Government Association and Television Station WLS-TV (an ABC affiliate) that poor conditions persisted in Chicago area nursing homes despite repeated inquiries and complaints.

[8] D-12-13, report cited in footnote 4. Also see "Long-Term Care," Oct. 20, 1978.
[9] "Long-Term Care," Oct. 20, 1978.
[10] P. 57166, Federal Register, Dec. 6, 1978.

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Witnesses were called to testify on two subjects: (1) The apparent lack of coordination among Federal, State, and local regulations to insure quality patient care; and (2) the need to develop and fund alternatives to nursing homes in order to assure the most appropriate level of care.

BGA and WLS–TV representatives asserted that no real changes had occurred in the quality of care in nursing homes since their last investigations in 1975 and 1971. They concluded:

> . . . the major causes of failure in nursing home reforms are the lack of enforcement of existing regulations, the Federal Government's failure to develop meaningful guidelines for quality patient care, and a reimbursement system which encourages financial abuses and cost cutting at the expense of patient's needs.[11]

Nursing home administrators and State officials claimed that abuses in nursing homes and poor patient care were found in only a few homes. Additionally, they claimed that most homes were providing acceptable care. The Illinois Health Care Association, represented by Lynn May, criticized the BGA investigation:

> . . . we found a pattern in the nature of the BGA allegations, we think, that largely, although not all, many of them were based on hearsay or incomplete exposition of actual facts.[12]

Suzanne Weiss of the Accom-o-Day Adult Day Center discussed the lack of funding available in the State of Illinois for alternatives to institutional care. She described her frustrations in attempting to fund the center. Ed Stec, an HEW regional office representative, and Art Quern, director of the Illinois Department of Public Aid, agreed that regulations needed to focus more on patient care. Both felt that closing nursing homes as an answer to enforcement was too drastic a measure. Stec commended the current HEW efforts to draft new regulations. Quern pointed to efforts in Illinois to streamline the regulatory process.

Dean Jost, of Uptown Legal Services, representing nursing home patients, saw a specific Federal role to improve quality care:

> The Federal Government needs legislation requiring States which participate in the medicaid program to tie reimbursement to quality care. A certification system needs to be developed which would make it possible to rank homes by quality of care so the private consumer market would decide on what care it wanted.[13]

Four themes emerged from the Chicago hearing:

—A need for greater coordination among the regulators of long-term care facilities.

—A need for a quality measurement of patient care.

—A need for community groups or advocates to visit nursing homes.

—A need for the availability of alternatives to institutionalization.[14]

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[11] "The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and 'Alternatives,'" Chicago, Ill., Aug. 30, 1978.

[12] See footnote 11.

[13] See footnote 11.

[14] See footnote 11. Also see "Growing Old in America," Chicago Tribune, parts 2 and 3, discussion on nursing home abuses.

B. Washington Hearing

The Senate Subcommittee of Federal Spending Practices of the Governmental Affairs Committee also conducted hearings in July and November. Senator John Heinz, who chaired the hearings, said:

> Changing the standards as well as the enforcement procedures will not be easy, but it is necessary and vital, absolutely vital . . . if we are to improve . . . the quality of nursing home care. It may be that we need to take a fundamentally different approach to the regulation of nursing homes. At some point, if the system doesn't work, we need to stop tinkering and build a new and better model.[15]

Harold Gordon of the Maryland State Department of Health and Mental Hygiene summarized many of the witnesses' statements:

> We have fully occupied ourselves with the monitoring of conditions surrounding the physical plant, the life safety code, equipment, construction, and other tangible aspects of the nursing home industry while avoiding the main issue: patient care.[16]

The National Citizens Coalition for Nursing Home Reform and the National Senior Citizens Law Center presented testimony asking that the patients rights and regulations be given Federal attention. According to the coalition:

> The existing patients' rights regulations do not include provisions for implementation and enforcement. States such as Texas, New York, and Connecticut have dealt with the problems with State regulations.[17]

Representatives of the nursing home industry pointed out that the requirements for documentation of compliance with Federal regulations often take time away from patient care.

Roger Lipitz of the American Health Care Association and Jack MacDonald of the National Council of Health Care Services said:

> The documentation process itself is counterproductive to the work that needs to be done in nursing homes. They agreed with other witnesses who said patient care and patient satisfaction should be the major criteria for measuring home effectiveness.

III. FEDERAL TRADE COMMISSION INVESTIGATES NURSING HOME PRACTICES

The Federal Trade Commission is considering the possibility of proposing a trade rule[18] dealing with such issues as: disclosure of nursing home charges, refund policies, transfer and discharge policies, itemization of monthly bills, prohibitions against waivers of liability, and freedom of choice in the selection of pharmacies.

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[15] "Problems in the Procedures Now Used for the Medicare and Medicaid Certification of Skilled Nursing Facilities and Intermediate Care Facilities," Subcommittee on Federal Spending Practices.

[16] See footnote 15.

[17] See footnote 15.

[18] A trade rule is the means by which the FTC recommends action. The staff may recommend the drafting of a rule, additional work with other administrative agencies such as HEW, or make other recommendations to be considered by the Commissioners. If the FTC Commissioners decide that a rule is needed, they will initiate the process by printing the proposed rule and asking for comments. The whole process, if initiated, may take as long as 2 years before the final rule would go into effect.

The FTC rules would apply to all nursing homes, not only medicare and medicaid certified homes; the FTC act authorizes civil penalties up to $10,000 per violation.

FTC investigators interviewed consumers, regulators, and the nursing home industry around the country during 1978 in order to determine the extent of the problems faced by nursing home residents. In a speech before the Indiana Governor's Conference on Aging in October, FTC Commissioner Elizabeth Dole stated:

> . . . several disclosure rules for the $14 billion-a-year industry are under active consideration. These would include disclosure, in nursing home contracts, of refund and eviction policies and of services that aren't included in the basic fee.

Ms. Dole went on to describe the practices attributed to some nursing home providers:

> . . . Patients sometimes are charged for such items as aspirin, soap, bed bars, and crutches that are presumed to be included in the daily rate. . . . FTC staff's preliminary investigations have found instances which a nursing home was charging drug prices 24 percent higher than those of independent pharmacies. In other cases, patients have been evicted from homes when their private moneys are expended and the individual becomes financially eligible for medicaid. . . .[19]

The FTC plans to continue its investigations into nursing home practices during the next few months.

IV. QUALITY OF CARE: STUDIES AND ACTION

Consumer advocacy organizations, ombudsman, and State and private investigative efforts are developing methods to assure better care in long-term care facilities. Legislation at the State and Federal level is, more and more, calling for improvement in the care offered older Americans.

A. The National Citizens' Coalition for Nursing Home Reform

The coalition is a group of 30 advocacy groups from around the country which are working at the local and State levels on nursing home reform issues. Additional groups are in the initial organizing stages from California to Maine.

Members of the coalition met in Washington in January and again in June of 1978 to set priorities, elect a board, and share information and skills with member organizations.

The coalition developed a paper, entitled "The Plight of the Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents," which stated:

> Upgrading the working conditions of aides would directly benefit patients, for they depend almost entirely on the aides. Aides can only provide proper, tender care when their situation allows them to give each patient time and individual service. Aides need to understand patients' problems and to

[19] "An Investigation Into the Business of Caring for the Elderly," 1978 Indiana Governor's Conference on Aging, Oct. 24, 1978.

develop the skills to determine and provide appropriate remedies. Turnover of aides prohibits development of close, caring relationships. High turnover and the lack of training can result in treatment of the patient as an object rather than a person. In large part, the mental and physical well-being of patients depends on the ability of aides to care for them well.[20]

ACTION/VISTA gave the coalition a model grant in late 1978 to do local organizing throughout the country on improving patient care. The National Citizens' Coalition will receive 30 VISTA volunteers to work with member organizations in Oregon, Washington, Massachusetts, Tennessee, New York, North Carolina, Missouri, Wyoming, Minnesota, Wisconsin, Mississippi, Colorado, and Washington, D.C.

B. Ombudsman Directors Coalesce

The State ombudsman directors throughout the country have formed an organization to foster communication among State advocates. The ombudsman programs are funded by the Administration on Aging through the State offices on aging to provide advocates for the institutionalized elderly. During a training session held in Washington, D.C., in January 1978, the ombudsman directors expressed the need for ongoing training and working relationships among the States. Many of the quality of care problems which each of the States might have with nursing homes has similar ramifications in the other States.

The reauthorization of the Older Americans' Act during 1978 gave the ombudsman statutory authority. Their responsibilities include the following:

(1) Investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare, and rights of such residents.

(2) Monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities in that State.

(3) Provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities.

(4) Provide for training volunteers and promote the development of citizen organizations to participate in the ombudsman program.

(5) Carry out such other activities as the Commissioner deems appropriate.[21]

In addition to these five functions, States must develop: (1) Procedures for appropriate access by the ombudsman to long-term care facilities and to patients' records; (2) a statewide uniform reporting system to collect and analyze data relating to complaints and conditions; and (3) a procedure to assure that the ombudsman's files are kept confidential.

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[20] "The Plight of Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents," National Citizens Coalition for Nursing Home Reform, February 1978, p. 2. Papers are available from the Coalition at 2000 P Street NW., Washington, D.C. 20036.

[21] Comprehensive Older Americans Act Amendments of 1978, Public Law 95-478, section 307(a)(12)(A)(i)-(v).

C. Investigations

Virginia, Kentucky, Ohio, California, and New Jersey have released State investigative reports on the current problems in nursing homes. All of the studies found that poor patient care was a major problem and that care was not at all related to the amount homes were being paid.[22]

Virginia's Joint Legislative Audit and Review Commission makes the following suggestions:

> . . . limited number of nursing homes may be providing only marginally acceptable care. The State can initiate several actions to upgrade the quality of care provided in these homes. Foremost among these actions could be the development of intermediate sanctions to insure timely compliance with standards, and the establishment of a better system of processing patient complaints. Furthermore, medicaid reimbursement rates could be more closely linked to the quality of care to insure that a high level of quality is maintained.
>
> A need also exists for more specific State standards dealing with the qualifications and size of nursing home staff. The number of staff is the most important factor in explaining the high cost of some nursing home care. At the same time, however, too few or poorly trained staff can result in inadequate patient services. . . .[23]

Ohio found similar conditions:

> . . . we believe that our observation of poor care in many other homes shows that there is no guarantee that adequate quality of care is routinely and uniformly delivered to every nursing home resident in Ohio. Until such guarantee of adequate care exists, quality of life remains a phantom issue. The very fact of uneven care, excellent in some homes and terrible in others, is a sure sign of the nursing home program's failure.[24]

New Jersey reported that many of the items reimbursed by medicaid had nothing to do with direct patient care costs but were being billed for that purpose.[25]

D. Community Involvement

The State of Maryland's Nursing Home Advocate Office on Aging, the Urban Institute, and Citizens for Better Care Institute with the Michigan State Office on Aging have been examining the role of the community in assuring quality care.

The Maryland Nursing Home Advocate researched and then developed methods for encouraging nursing home residents to partici-

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[22] Cost-related reimbursement (see "Developments in Aging: 1977," pp. 91–92) does not require that costs be related to quality of care. A few States have included an element of directly relating quality care to the reimbursement formula. Although HEW is considering new regulations on cost-related reimbursement in 1979, they do not relate quality to costs.

[23] "Long-Term Care in Virginia," Joint Legislative Audit and Review Commission, Mar. 28, 1978, p. 70.

[24] "A Program in Crisis," the Ohio General Assembly Nursing Home Commission, June 1978, p. 7.

[25] New Jersey State Nursing Home Study Commission report on long-term care, "An Analysis of Medicaid Nursing Home Reimbursement: A Special Study," 1978, attached appendixes.

pate, assist, and to exercise their rights as patients and as citizens. Patients' councils, organized in several Maryland nursing homes, encourage patients to take an active role in daily decisions.[26]

The Urban Institute developed information booklets intended to help consumers decide what homes provide the types of services and quality of care that their family or friends might need.[27]

The Kellogg Foundation funded a joint project by the Citizens for Better Care Institute and the Michigan Office on Aging project to develop a rating system for nursing homes. The rating system will take into account the deficiencies found by licensing inspectors and complaint information on the home. Findings will be available through computer terminals in local department of social services offices. The Michigan system is designed to help consumers understand the range of services available in the community.

E. Legislation

Several States have introduced model legislation to deal with quality of care issues. Michigan has recently been successful in passing major nursing home reforms which drew much criticism from the provider industry. The law:

—Limits payments to homes that provide poor quality care.
—Requires safeguards for patients personal belongings.
—Requires a licensed nurse 24 hours per day.
—Allows the family of a terminally ill patient to stay in the nursing home with the patient.
—Guarantees access to families and consumer groups.
—Requires homes to report abuses to patients.
—Forbids involuntary transfers of patients, while saying that when transfers do take place they must be planned.
—Allows receivers to be appointed when homes are providing poor care and requires the owner to pay penalties at the time the receiver is appointed.[28]

Two areas which have been of Federal concern which Michigan now deals with are: (1) A requirement that homes certified for either medicare or medicaid must be certified for both programs,[29] and (2) a specific prohibition on providers receiving kickbacks.[30]

Federal legislative efforts to address quality of care have been limited largely to reimbursement issues and enforcement of regulations. Alone, these reforms have not been totally effective.

Senator Frank Church proposed an amendment during the closing days of the 95th Congress. It would have required States that pay a profit to nursing homes as an incentive for efficiency to also provide quality care. However, no final action was taken on the amendment by the Senate. Senator Church is studying similar legislation for the 96th Congress.

[26] "How To Establish a Nursing Home Resident Council," Maryland Office on Aging.
[27] Urban Institute, 2100 M Street NW., Washington, D.C.
[28] Michigan Public Law 493.
[29] Medicaid/Medicare Reimbursement Reform Act as H.R. 5285 as amended by the Senate Finance Committee contained a provision that would have required the concurrent certification of nursing homes for medicaid and medicare. Senator Gaylord Nelson has asked HEW to study whether such a requirement would increase access to nursing homes.
[30] See "Developments in Aging: 1977". Kick-backs were prohibited by the medicare and meidcaid anti-fraud and abuse bill of 1977, Public Law 95–142.

V. FAMILY RESPONSIBILITY

Cost containment concern has triggered a widespread attempt by States to make families more responsible for a significant part of the expenses of relatives in nursing homes. One such method has been used during 1978, while another has been proposed. Massachusetts hopes to initiate a family responsibility clause for those with incomes over $23,000 a year. Other States have spouse responsibility, while some States have been using a prohibition of transfer of any major assets. "Spouse deeming" has, however, recently been ruled unconstitutional in California.

A. Massachusetts

Massachusetts has received a waiver from the U.S. Department of Health, Education, and Welfare, to allow the assessment of charges to the families of nursing home patients. The State Department of Public Welfare has submitted a bill to the State legislature to set up a pilot program to test the family responsibility concept in the State's medicaid program. A similar bill was approved by a Joint Committee on Health Care, but was not considered in either of the two Houses of the legislature.

The family responsibility plan would have a progressive scale which would make children of nursing home patients with at least $23,000 income responsible for contributing $50 per month to their care. The range would be up to $300 per month for those families with incomes up to $50,000 a year. Families with higher incomes would pay for the entire nursing home care of their parents.

Massachusetts officials see the program as accomplishing additional purposes by giving families more of a role in caring for their parents. There is some indication that families might be encouraged to visit more and take a more active interest in what happens in the nursing home. The State hopes to strike a balance between family and government responsibility. In some cases, it is argued, families may be encouraged to keep their parents out of institutions and find services in the community.

Other States are considering similar types of assessment programs.

B. Prohibiting the Transfer of Assets

The U.S. Senate Finance Committee put forward a proposal during the 95th Congress that would have made ineligible for at least 1 year a person who had transferred a house or other significant asset for less than market value as a condition of becoming eligible for medicaid nursing home services.[31] The measure was reported and passed the Senate but no companion legislation existed in the House.

Many States have had prohibition on the transfer of assets as conditions for medicaid eligibility for some time. The length of time that a person would be ineligible varies by State. These usually involve the transfer of a house to a family member.

[31] Section 21 of H.R. 5285 as passed by the Senate Oct. 14, 1978. Resources of medicaid applicant to include certain assets previously disposed of for substantially less than market value.

C. Gray Panthers Win Suit on Spouse Deeming

States which have medicaid eligibility that differs from the Federal SSI standard have been using income from noninstitutionalized spouses as a contribution to pay for the spouse living in the nursing home. The Gray Panthers found that using income from one spouse without regard for the amount or duration of the contribution left the noninstitutionalized spouse without any income to pay for housing, food, fuel, or transportation.

On December 8, 1978, Federal District Judge Ritchie ruled in the District of Columbia that States could not continue to use spouse income without regard to the needs of the noninstitutionalized spouse. The Gray Panthers do not want to say that spouses do not have some responsibility, rather the needs of the person outside the home must be considered.

Other States use spouse income, but after 6 months the noninstitutionalized spouse is not required to contribute.

Judge Ritchie ordered that HEW demand States to pass laws, propose and publish regulations before they determine what is "actually available" income to help pay for the institutionalized spouse.[32]

[32] *Gray Panthers* v. *Secretary, Department of Health, Education, and Welfare*, U.S. District Court, District of Columbia, Civ. No. 78–0061, Dec. 8, 1978. See Commerce Clearing House Medicare-Medicaid Guide No. 29426.

CHAPTER VI

MEDI-GAP, OTHER CONSUMER ISSUES

Medi-gap, a popular term describing private health insurance sold to supplement medicare's essential but uneven coverage, became a major consumer issue in 1978.

Hearings[1] before this committee exposed unscrupulous sales practices which feed upon confusion and fears related to medicare.

Testimony and related studies, coupled with growing concern by the Federal Trade Commission and other agencies, led to the beginnings of a joint action by the end of the year.

Additional action on consumer issues of importance to older Americans occurred as:

—A bill to encourage establishment of consumer cooperatives became law.

—Automated electronic banking transactions, including direct deposit of social security checks, became the subject of a law offering new safeguards.

—The Federal Trade Commission continued to advance trade regulation rules intended to eliminate abuses in hearing aid sales and funeral industry practices.

I. HIGH PRESSURE MEDI-GAP SALES DRAW FIRE

The specter of rising health care costs and constant fear of an illness which will deplete all assets is a way of life for many older Americans.[2] Medicare has been a great help, but most find ways to fill in the gaps in medicare payments (which now pay for about 40 percent of the total health care bill for older Americans). A number of private health insurance companies have responded by marketing medicare supplemental, or medi-gap, insurance policies. There are vast differences among the policies offered—in benefits, in price, and in the ways they are sold.

As Wisconsin State Insurance Commissioner Harold R. Wilde told the committee: "Millions make a good choice. Millions of others do not."[3]

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[1] "Medi-Gap: Private Health Insurance Supplements to Medicare," part 1, Washington, D.C., May 16, 1978; part 2, Washington, D.C., June 29, 1978. Hearings before the Special Committee on Aging, U.S. Senate.

[2] See chapter III, p. 42 for discussion of most recent statistics on health expenditures for the elderly.

[3] The following discussion of the sale of medicare supplemental insurance to the elderly, based on committee hearings in May and June 1978, focuses attention on specific sales abuses which have been detected in a number of States, primarily involving high-pressure sales techniques employed by some insurance agents to sell policies to the elderly. Not all insurance agents operate unethically. The widespread incidences of oversale and abuse, however, clearly offer reasons for concern.

Additional testimony before both the Senate and House Committees on Aging challenged the value of health insurance policies marketed by some insurance companies. That private health insurance to supplement medicare is a valuable purchase for many older Americans

(Continued)

Two-thirds of the Nation's population age 65 and over have purchased some form of private health insurance to supplement medicare's payments for hospital charges. Over one-half purchased some form of private health insurance to supplement medicare's payments for physicians and other medical services.[4]

At least $1 billion is spent each year by older Americans for premiums for private health insurance policies to supplement medicare coverage.[5] Policies are purchased by older Americans at all income levels, including the lowest. There is increasing evidence that many older Americans who participate in State medicaid programs—and therefore may receive services not covered under medicare—nevertheless purchase supplemental health insurance policies from a number of companies.[6]

The largest single seller of medicare supplemental health insurance are the Nation's Blue Cross and Blue Shield plans. Blue Cross and Blue Shield supplemental hospital policies are held by half (51.7 percent) of those over the age of 65 with any form of supplemental coverage. Private insurance companies sell insurance to 43.4 percent of the medicare-eligible population.[7]

All the plans offered to older consumers by Blue Cross and Blue Shield are different, and there is even more variation among the many forms of medi-gap insurance marketed by private insurance companies.[8] Plans vary widely; some mesh better with medicare benefits than others; the costs range markedly, and it is difficult to make comparisons from one policy to another.

Medi-gap insurance is usually sold through company agents, door-to-door in the home, or through direct mail advertising.

Nationwide, private health insurance pays for about 5 percent of all health expenditures of the elderly.[9]

(Continued)
is not in dispute. Many companies offer good protection at reasonable cost. The testimony, however, and scrutiny by some States of the ratio between premiums paid and benefits paid on certain policies, make it clear that this is not always the case. For example, medicare supplemental plans offered by Blue Cross and Blue Shield throughout the country traditionally pay between 80 cents and 90 cents in benefits for every $1 in premiums collected. In contrast, the State of California recently revoked the license of the Cosmopolitan Life Insurance Co. to sell health insurance policies to California's elderly after the department of insurance found that the company was paying less than 50 cents in benefits on every premium dollar it collected for the policies. (Source: News release, California Department of Insurance, Nov. 10, 1978.) Wisconsin Insurance Commissioner Harold R. Wilde, in testimony before the committee in May, said that an audit of policies filed with his office revealed some with a 10-percent loss ratio—or policies which were paying 10 cents in benefits for every $1 collected in premiums.

[4] Estimates of the Social Security Administration, contained in "Private Health Insurance Plans 1976: An Evaluation," Social Security Bulletin, September 1978. See chart on p. 90.

[5] An earlier committee report estimated that, at a minimum, over half a billion dollars on premiums for private health insurance policies were spent by older Americans each year. See "Private Health Insurance Supplementary to Medicare," working paper, U.S. Senate Special Committee on Aging, December 1974.

There were not then, nor are there now, official industry estimates of this amount. The 1974 estimate was based on the average monthly charge by Blue Cross-Blue Shield low-cost option plans as of April 1974. Increases in premiums, number of elderly purchasing private health insurance, and variety of higher cost private plans available since that time make the earlier estimate no longer applicable.

[6] Testimony taken from Wisconsin State Insurance Commissioner Harold R. Wilde estimated that 20 percent of Wisconsin's medicaid population hold some form of private health insurance. Hearings cited in footnote 1, part 1. A survey conducted by the GAO suggests that somewhat over 10 percent of elderly medicaid recipients hold some form of private health insurance. See p. 101, following, for description of the survey and results.

[7] Report cited in footnote 4.

[8] No reliable statistics or estimates exist on the number of companies which sell this type of health insurance.

[9] Report cited in footnote 4.

A. Common Benefits and Types of Medi-Gap Insurance

Most medi-gap policies sold to older Americans are designed to supplement benefits for medicare-covered services, paying for some, or all, of medicare's deductibles and coinsurance charges for covered medical and hospital services. Few supplemental policies are designed to provide benefits for medical services which are not covered by medicare, such as out-of-hospital prescription drugs, most nursing home care, and dental or eye care. Many older Americans, however, do not realize that insurance sold with a claim to "cover all of medicare's gaps" rarely includes the largest gaps—those medical services for which medicare pays nothing.

As the following chart shows, there is less private coverage available for essential services not included under medicare than for deductibles and coinsurance charges. For example, only 3.3 percent of the over-65 population have private insurance coverage for dental services, which is also excluded from medicare benefits. About 21 percent have some form of coverage for nursing home services, primarily to extend medicare's daily reimbursement rates for skilled nursing services in medicare-certified nursing homes only. There is little, or no, coverage for custodial nursing home services available either through medicare or any private supplemental insurance.

TYPES OF PRIVATE HEALTH INSURANCE COVERAGE AGE 65 AND OVER[1]

Type of service covered	Number (thousands)	Percent
Hospital care	14,592	62.8
Physician's services:		
Surgical services	12,917	55.6
In-hospital visits	10,078	43.4
X-ray and laboratory examinations	7,955	34.2
Office and home visits	5,602	24.1
Dental care	770	3.3
Prescribed drugs (out of hospital)	4,782	20.6
Private-duty nursing	4,643	20.0
Visiting nurse service	5,022	21.6
Nursing home care	4,862	20.9

[1] Social Security Administration estimate as of Dec. 31, 1976. Adapted from report cited in footnote 4. The Health Insurance Association of America estimates that 55.6 percent of the population age 65 and over hold private insurance policies for hospital services, and 45.7 percent hold private insurance policies for surgical services.

There are three major types of medi-gap policies most frequently sold to older Americans. Not all are specifically designed to fill in medicare's gaps.

Medicare supplemental policies.—Sometimes referred to as "wrap-around" policies, medicare supplemental policies are commonly offered by health, accident, and life insurance companies to medicare beneficiaries as protection against health care costs not covered by medicare. The most common policies are designed to pay the deductibles and coinsurance charges required by medicare.[10]

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[10] Medicare (part A) hospital insurance carries a deductible of $160, beginning in January 1979, for each hospital benefit period which the beneficiary is responsible for paying. This amount, by law, increases each year with increases in the Consumer Price Index for hospital services. Since 1966, when medicare took effect, there has been a four-fold increase in this amount, from $40 to $160. After the deductible, part A pays for all hospital costs for the first 60 days of hospitalization. From the 61st through the 90th day, the beneficiary is responsible for $40 per day. During a one-time "lifetime reserve" period of an additional 60 days of hospitalization coverage, the patient is responsible for $80 per day.

Medicare (part B) medical insurance requires the beneficiary to pay a medical insurance deductible of $60 in "reasonable charges" for medical services received each calendar year. In addition, the beneficiary is responsible for payment of 20 percent of the "reasonable charges" for all medical services received, after the initial deductible has been met.

See chapter III, p. 42 of this report for further discussion of medicare payments and the total out-of-pocket medical expenses which beneficiaries must pay themselves.

Some offer supplements to medicare part A—hospitalization benefits—only, paying for the initial deductible of $160 per benefit period. Some add benefits for prolonged hospital stays, paying a specified daily rate for hospitalization after medicare benefits run out. Some also cover some of the gaps left by medicare's part B benefits—medical services.[11]

More specialized types of medicare supplemental policies offered by many insurers are nursing home policies. Nursing home policies most often pay a limited daily rate for services received in a skilled nursing facility, beginning after the bulk of medicare's skilled nursing payments have been used up. Virtually no private policies offer benefits for custodial nursing home services or for care received in other than medicare-certified skilled nursing facilities.[12]

Hospital indemnity policies.—Indemnity policies typically pay a specified dollar per day amount for periods of hospitalization. The daily benefits vary widely—anywhere from $10 a day to $60 a day. Some will pay in addition to medicare benefits, while others will pay only after medicare hospitalization benefits have run out.[13] Indemnity policies are often sold by advertising geared to an "extra cash on hand" promotion, as many will make benefit payments regardless of other insurance policies held by the purchaser. Hospital indemnity policies are available to consumers of all ages, but they are marketed heavily to the over-65 population.

Limited benefit and "dread disease" policies.—A number of insurance companies offer policies which will pay benefits only for one particular problem. The most common example is a "cancer policy," which is designed to pay benefits only if the purchaser contracts cancer, sometimes particular kinds of cancer. Many policies are also designed to pay benefits only for certain kinds of treatment for cancer and contain other limitations and exclusions. Even though such limited-benefit policies are often aggressively marketed to the over-65 population, they are usually designed for all age groups and therefore overlap medicare benefits, as well as other health insurance policies.

An analysis of the availability of medi-gap policies by staff of the Urban Institute has produced the following characterization of available policy benefits:[14]

[11] See footnote 10.

[12] After certain conditions have been met, medicare's part A hospital insurance will pay all the costs of care received in a medicare-certified skilled nursing facility for up to 20 days of care. From the 21st to 100th day, the beneficiary is responsible for $13 a day. Medicare pays for about 1 percent of the total costs of nursing home care in the country. Most private nursing home policies require that the same conditions be met.

[13] See footnote 10.

[14] "Medical Expenditures Among the Elderly: The Impact of Medicare Gaps," working paper, Urban Institute, Washington, D.C., revised March 1978. This analysis is reinforced by a summary of the 103 medicare supplement plans offered throughout the country by Blue Cross and Blue Shield Associations. All of these plans, with the exception of a few with special riders, pay the initial deductible for medicare part A hospital insurance. A few offer a somewhat lower dollar amount. All pay the deductible from the 61st to 90th day of hospital confinement. Most pay the daily deductible during the 60-day lifetime reserve period. About half (54) provide some coverage for hospital days beyond the medicare limit. There are usually ceilings on the number of days for the extension or the maximum benefit which can be paid, with the most common limitation on number of days, usually 30 days. A few plans, classified as major medical plans, provide coverage for more extensive hospital stays.

About 60 percent will pay medicare's daily deductible for skilled nursing care from the 21st to 100th day. About 80 percent will pay the yearly $60 deductible and 20 percent coinsurance charge for medicare's part B medical insurance. About 15 percent, however, will meet the 20 percent coinsurance charge only, not providing coverage for the initial $60 per year deductible.

Source: "Medicare Complementary Coverage Revisions—Summary of Plan Programs for the Other-Than-Group Market," Blue Cross/Blue Shield, Subscriber Relations Bulletin No. 51, April 24, 1978.

—Private hospital insurance sold to medicare beneficiaries covers medicare part A deductibles more frequently than stays beyond medicare limits.
—Medical insurance covers coinsurance, or open-ended expenditures, more frequently than deductibles, but may cover charges in excess of medicare's reasonable charge.
—Nursing home coverage more frequently covers medicare cost-sharing than additional levels of care.
—Major medical coverage is of limited availability.
—Most benefits have ceilings.

B. The Committee's Hearings: Problems in the Marketplace

Testimony presented to the Committee on Aging in May and June 1978 revealed widespread misinformation regarding medi-gap insurance and marketing abuses of elderly consumers.[15]

Members of the committee summarized reports received by the committee which led to the hearings:

> A number of questions have been raised about such insurance, including suggestions that many older Americans purchase policies of questionable value, multiple policies well in excess of probable need, and policies offering benefits inappropriate to need. The committee wants to know how pervasive these problems are and what factors may contribute to unnecessary expenditures of precious retirement income.[16]
>
> Adequate health insurance is a protection everyone needs, particularly in these days of ever-increasing hospital costs. The elderly, however, are most concerned about insurance coverage as they fear the prospect of a catastrophic illness or prolonged ill health, either of which may deplete their life savings. As a result, the elderly have become a new and expanding market, as well as an easy mark, so to speak, for insurance salesmen who sell expensive policies to the elderly, assuring them that the insurance will pay for what medicare does not cover. Unfortunately, this is not always the case.[17]

CASE EXAMPLES

The following case examples emerged during the committee hearings:

Wisconsin.—An 87-year-old woman was sold 19 health insurance policies from 9 different companies by 6 different agents in just over 1 year. She was committed to payments of almost $4,000 a year in insurance premiums. Most of the policies were overlapping and duplicative of each other.[18]

A social service worker found that 103 of 191 elderly she counseled had insurance problems. All 103 needed information and counseling on how to use their medicare and private health insurance policies. Twenty-four had purchased too much health insurance, holding overlapping and duplicate policies.[19]

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[15] Hearings cited in footnote 1.
[16] Opening statement of Senator Lawton Chiles, hearings cited in footnote 1, pt. 1, p. 1.
[17] Opening statement of Senator Pete Domenici, hearing cited in footnote 1, pt. 1, p. 27.
[18] Letter to Senator Lawton Chiles, hearings cited in footnote 1, pt. 1, p. 3.
[19] Statement of Mary M. Bach, staff attorney, Center for Public Representation, Madison, Wis. Hearings cited in footnote 1, pt. 1, p. 162.

Ohio.—An elderly couple were told by an insurance agent at their door that the medicare program would "run out" in 1979 and that they needed more health insurance. The couple gave him a check for $787.80 before they found out that the agent's statement was not accurate.[20]

A 76-year-old woman was sold 13 health and life insurance policies by 5 different agents from the same insurance company during one 5-month period. Two of the life policies had forged signatures. An additional three policies, originally sold to her by the same agents, were refunded when the company's computer detected duplicate sales. The woman was committed to annual premium payments of $9,158.61 to Bankers Life & Casualty Co. of Illinois—68 percent of her total annual income.[21]

California.—A 77-year-old man was sold a life insurance policy by an insurance agent who claimed that the product he was selling was an investment in a savings and loan association, planning to build an establishment in San Diego soon. After 2 years, and two payments of $1,176 each, when the business had not materialized, the man sought advice and was informed that he had purchased a life insurance policy.[22]

New Mexico.—An elderly New Mexico resident purchased over 30 insurance policies during a 2-year period. Total premiums of $3,843.18 were paid to nine companies. Another elderly New Mexican purchased 16 insurance policies during a period of 2 years.[23]

A New Mexico insurance agent who said he was collecting medicare premiums sold health insurance policies to 157 elderly. He told them he was soliciting funds to maintain the medicare program until Congress could appropriate more funds.[24]

Florida.—An elderly couple paid $2,882 to one insurance company for 19 separate health insurance policies in a period of slightly more than 1 year. Their situation was discovered by visiting children when the couple complained that they did not have enough money to keep their stove, refrigerator, and television set working.[25]

An 88-year-old woman, with an income of less than $5,000 a year, was sold more than $10,400 in health insurance in a 1-year period.[26]

Texas.—A Texas district attorney investigated and prosecuted a group of insurance agents who had obtained $200,000 from elderly Texans claiming sales of "paid-up" hospitalization insurance. No such insurance existed, and no policies were delivered. When pressed, salesmen delivered deeds for worthless lots of land, some of which were deeded to more than one victim.[27]

A number of elderly women were also solicited for accident and health insurance policies, but received instead worthless vehicle repair warranties. One victim, age 92, was solicited for insurance 13 times between April 1972 and July 1974, and paid $4,440 for insurance policies she never received. An 83-year-old woman paid insurance agents

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[20] Letter to Senator John Glenn, hearings cited in footnote 1, pt. 1, p. 29.
[21] Testimony of Robert E. Lowry, hearings cited in footnote 1, pt. 1, pp. 30–46.
[22] Testimony of Jules Klowden, hearings cited in footnote 1, pt. 1, p. 47.
[23] Testimony of Manuel A. Garcia, Jr., Department of Insurance, Santa Fe, N. Mex. Hearings cited in footnote 1, pt. 2, p. 263.
[24] Testimony cited in footnote 23.
[25] Testimony of W. W. Cooper, Office of Florida Insurance Commissioner. Hearings cited in footnote 1, pt. 1, p. 87.
[26] Letter to Senator Lawton Chiles, hearings cited in footnote 1, pt. 2, p. 212.
[27] Testimony of C. L. Woodard, U.S. Postal Inspector, Houston, Tex., and Wiley Cheatham, district attorney, Cuero, Tex. Hearings cited in footnote 1, pt. 2, pp. 214–234.

$11,035 for health and accident and life insurance policies. She received no insurance. She did not own a car, but she was eventually provided with a vehicle-repair warranty contract.[28]

WIDE ROOM FOR AGENT ABUSES

Most medi-gap insurance is sold either through the mail on a direct-response advertising basis, or door-to-door by individual insurance agents.

Witnesses appearing before the committee made it clear that many insurance agents were eager to make high commissions by taking advantage of fears of rising health costs. Common tactics used by agents were misrepresentations of policy benefits, piling policy on top of policy, and switching policies from one company to another.

Mr. C. L. Woodard, U.S. Postal Inspector, Houston, Tex., presented the committee with a list of 14 separate tactics examined in Texas investigations: [29]

> One: The seeking out of elderly people who are known to be susceptible to repeated insurance sales.
>
> Two: The use of "goose lists" in identifying and locating aged victims, and in disseminating information from one agent or ex-agent to another on the pitch or technique to be used.
>
> Three: Salesmen claiming to be there to collect on accident and health premiums due on existing policies while actually soliciting new business.
>
> Four: Salesmen claiming to represent the victim's accident and health companies.
>
> Five: Salesmen claiming to be combining their insurance and sometimes getting money back.
>
> Six: Unlicensed agents soliciting insurance sales to be "fronted" by licensed agents.
>
> Seven: Licensed and unlicensed agents claiming to represent companies that were familiar to the aged victims, such as American Insurance Co.—anything with "American" in it is good to use on an old person—and tricking them into signing new applications for insurance with other companies.
>
> Eight: Salesmen representing that "Our company has bought out your company" and that "The company has sent us out here to collect for your insurance and get these new papers signed," while actually soliciting new hospitalization business.
>
> Nine: Salesmen's representations such as "No waiting periods." "This policy will pay everything" or "Everything that medicare does not pay," "This is a paid-up hospitalization policy," and "You will start getting so many dollars per month back on this paid-up policy."
>
> Ten: Salesmen represented that they would reinstate expired accident and health policies which in some cases had been expired for 2 or 3 years and had been issued by companies they did not represent.

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[28] Testimony cited in footnote 27, p. 220.
[29] Testimony cited in footnote 27, pp. 218–219.

Eleven: Some solicitations were as simple as "Get your checkbook; your insurance is due."

Twelve: Salesmen claiming that they were there to help the aged victims with their social security while actually soliciting accident and health business.

Thirteen: The use of familiar sounding and appealing agency trade styles such as the American Agency, Senior Citizens Agency, and First Continental Agency—these names were actually used in Texas—to induce aged people to listen to the sales pitches.

Fourteen: Falsification of applications for new accident and health policies by clean sheeting—omitting unfavorable information such as age, health conditions, and additional policies in force; forging signatures of applicants; and fence-post policies—completing applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.

A State insurance commissioner noted that such tactics were prevalent in his State. He said:

> Agents tell us about lists of "mooches," or "cripples," or "marks" that have been circulated among the medi-scare peddlers. . . . We are aware of teams of agents switching from one company to another company and, in the process, thousands of people getting caught in a war as policies are switched from one company to another company. . . . We go into a company's files and we find dozens of medical applications from particular agents which have been "clean sheeted" . . . then when they find that the person had a medical history, they retract the claim and refund the premium. . . . It is a process quite frequently engaged in unannounced to the purchaser. . . . We come across evidence of systematic forgery and routine postdating of applications.[30]

Additional tactics reported to the committee include tearing out insurance policy riders which limit benefits before policy delivery; writing policies under a variety of names to avoid detection of multiple sales to the same person; forging names on applications; and writing health and life policies on relatives, without the relative's knowledge. Agents also frequently postdate applications for insurance policies, which in effect lengthens waiting periods for effective coverage, lessening the chances of payments. Purchasers are often under the impression, however, that the policy is effective as of the date the first premium check is cashed. Many agents also find it easy to "roll over" policies—coming back again and again to replace old policies with new ones, receiving a new, higher commission each time, but leaving the consumer with no more protection, higher premiums, and a brandnew waiting period for effective date of coverage.[31]

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[30] Testimony of Harold Wilde, commissioner of insurance, State of Wisconsin. Hearings cited in footnote 1, part 1, pp. 77–78.

[31] See testimony of Lowry, Klowden, Grubbs, Wilde, and Cooper, hearings cited in footnote 1, part 1. See testimony of Woodard, Cheatham, Dole, Mike, and Garcia, hearings cited in footnote 1, part 2.

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DIFFICULTIES IN ABUSE DETECTION

After hearing witness testimony, Senator John Glenn commented:

> Too often, there is no control exercised by the companies involved. How can we correct this? How can we get these people recompensed for their expenses and the excess policies they have already bought? More importantly, how can we control this better in the future, through whatever Government action, if that is required, or through action by the insurance companies and State insurance commissions controlling what has gotten to be a real flimflam, a real fraud situation? [32]

Many witnesses pointed to the difficulties faced by State insurance commissioners and State and local prosecutors in monitoring the actions of individual insurance agents.

First, many older Americans are simply not aware of the fact that they are being victimized.[33]

When insurance commissioners receive information which leads them to believe that an agent, or ring of agents, is systematically bilking the elderly in their State, they first have to explain to victims what is wrong with the insurance they have and how they are being victimized.[34]

Even then, most commissioners cannot act without a formal complaint. Victims are often too embarrassed to either admit that they have been victimized, or participate in court proceedings against the agent.[35]

State insurance commissioners and others asked whether insurance companies do enough to monitor and control the actions of their own agents.

Witnesses testified that:

—Multiple sales are encouraged by policies which are designed to provide limited, incomplete coverage.[36]

—High "front-end" commission structures provide incentives for agents to continually exchange old policies for new. Some companies allow a very high commission on new, first-year policies with decreasing commission percentages on policy renewals, or pay higher percentages for shorter term policies.[37]

—Lax screening of agents employed to sell policies and insufficient review of agent performance may encourage agent abuse of consumers. Some companies do not accept responsibility for the actions of their selling agents, contracting for their services rather

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[32] Senator John Glenn, hearings cited in footnote 1, part 1, p. 29.

[33] Testimony of Joseph C. Mike, insurance commissioner, State of Connecticut, and chairman, National Association of Insurance Commissioners Accident and Health Subcommittee. Hearings cited in footnote 1, part 2, p. 251.

[34] Testimony of Joseph C. Mike, cited in footnote 33, p. 251. Testimony of Harold R. Wilde, cited in footnote 30, p. 76.

[35] Testimony of Joseph C. Mike, cited in footnote 33. Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Manuel A. Garcia, cited in footnote 23. See also testimony of Dole, Woodard, and Cheatham, hearings cited in footnote 1, part 2.

[36] Testimony of Elizabeth Hanford Dole, Federal Trade Commission, at hearings cited in footnote 1, part 2, pp. 234–245. Also see testimony of Jules Klowden, cited in footnote 22 and testimony of Harold R. Wilde, cited in footnote 30.

[37] Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Elizabeth Hanford Dole, cited in footnote 36. See also testimony of Russell Van Kampen, marketing vice president, Bankers Life & Casualty Co., Chicago, Ill. Hearings cited in footnote 1, part 1, p. 69.

than treating them as company employees. Charges were also made that unofficial company policies encourage agents not to worry about the company's written policies, or State regulations, as long as their sales volume stays high.[38]

LACK OF INFORMATION

Widespread confusion on the part of medicare beneficiaries regarding what is covered under medicare, and therefore does not require additional insurance is compounded by a paucity of useful information.

According to Federal Trade Commissioner Elizabeth Dole:[39]

> . . . there is such a dearth of consumer information in the medicare supplemental market that it is almost impossible for consumers to make rational purchase decisions. Agent misconduct is thus facilitated. A great variety of differing policies effectively precludes buyers from comparing benefits or premiums, resulting in lack of price competition and the sale of duplicate coverage to hundreds of thousands of people who are under the impression that they are filling all gaps in medicare. Other areas of widespread misunderstanding are the limited nature of medicare supplement coverage, the relatively high cost of coverage for the initial deductibles compared to insurance against catastrophic medical expenses, and exclusions of preexisting medical conditions.

Joseph C. Mike, commissioner of insurance, State of Connecticut, and chairman of the National Association of Insurance Commissioner's Subcommittee on Health and Accident Insurance, told the committee that State insurance commissioners had "serious doubts" that the public fully understood the functions of medicare, and the value or the benefits of the private health insurance they bought.[40]

The same point was made by Wisconsin State Insurance Commissioner Harold R. Wilde:

> When you're dealing with a subject which causes you and your peers continuous and daily worry, when the terms of medicare and health insurance coverage in general are extremely confusing and nonstandardized, and when you've been identified as a target group by a class of hard-selling predator-agents and companies, it is difficult to be either smart or lucky.[41]

An FTC staff report submitted to this committee in July speculated on the consequences of limited information or misinformation about medi-gap insurance policies:[42]

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[38] Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Manuel A. Garcia, cited in footnote 23. Testimony of C. L. Woodard and Wiley Cheatham, cited in footnote 27. See also testimony of representatives of Bankers Life & Casualty Co., Chicago, Ill., hearings cited in footnote 1, part 1, pp. 53–75.

[39] Testimony of Elizabeth Hanford Dole, cited in footnote 36, p. 235.

[40] Testimony of Joseph C. Mike, cited in footnote 33, p. 247. See also testimony of Jules Klowden, cited in footnote 22, p. 48.

[41] Testimony of Harold R. Wilde, cited in footnote 30, p. 82.

[42] "Policy Planning Issues Paper: Private Health Insurance to Supplement Medicare," staff report. Federal Trade Commission, submitted to the Committee on Aging in July 1978. See hearings cited in footnote 1, part 2, pp. 275–318. See specifically pp. 286–289.

No price competition.—The lack of standardization and complexity of available coverage make comparison shopping and price competition almost impossible. An example was offered of two supplemental policies offered to Wisconsin's elderly. One policy providing what was described as fairly comprehensive coverage was available for $95 a year. Another, offering much more restrictive benefits, was available for between $200 and $236 a year, depending on age.

Duplicate coverage.—Consumers often buy two or more policies to obtain "complete" coverage. But policies generally contain coordination of benefits clauses, precluding more than one payment in areas of overlap.

Coverage not equal to expectations.—Many older Americans think they have much more extensive coverage than they actually do. Advertisements and agents suggest that a policy will cover everything medicare doesn't. Since advertising and agent solicitations are usually the only source of information on the insurance in question (other than the difficult-to-read policy form), it is difficult to determine the validity of the claim.

Inability to challenge claims handling.—Medi-gap insurers have little incentive to be responsible to their policyholders, as elderly are often reluctant to cancel health insurance policies even if they are dissatisfied. They are often afraid they will not be able to obtain other health insurance protection because of advanced age and existing health problems. The report cites examples of high rates of claim denials by one medi-gap insurer and points out that insurance commissioners and others receive many complaints from elderly insurance policy holders.

C. Additional Evidence of Abuses

The House Select Committee on Aging conducted similar hearings in December 1978, which further reinforced the evidence of widespread abuses in the sale of medi-gap insurance to older Americans.[43]

NEWSPAPER INVESTIGATIONS

Independent investigations conducted in Illinois, New Jersey, and Tennessee also uncovered medi-gap abuses.

A team of investigative reporters for the Chicago Tribune made an undercover investigation of insurance sales to the elderly and documented similar cases in rural Tennessee, Illinois, and Georgia.[44]

An investigative reporter examined the sale of medi-gap insurance to the elderly in New Jersey. In a series of articles published in the Newark Star-Ledger during February and March, reporter Herb Jaffe charged that more than $500 million a year was being spent in the State by consumers of all ages for health insurance policies which were not regulated or approved by the New Jersey State Insurance Commission, including "useless" health insurance policies. He also found widespread use of medicare "scare" tactics to sell policies to the elderly.[45]

[43] "Abuses In the Sale of Health Insurance to the Elderly," hearing, House Select Committee on Aging, Nov. 28, 1978. Hearing not in print at time of publication of this report.
[44] Chicago Tribune, "Insurance Firms That Feast on Fears of the Aged," Sept. 29, 1978, p. 1.
[45] Newark Star-Ledger, series of articles by Herb Jaffee, January through March 1978. Also see hearings cited in footnote 1, part 1, pp. 5–20.

Legal Services of Nashville and Middle Tennessee, Inc., conducted an investigation of the sale of low-premium "industrial" life insurance and medi-gap insurance to Nashville residents early in 1978. Their report charged that the elderly were the most vulnerable to oversale of inferior insurance policies and that the State department of insurance was not doing enough to protect low-income elderly and others from abusive insurance practices.[46] Similar charges were made by a separate investigation conducted by a team of reporters for the Nashville Tennessean.[47]

D. Actions Taken Since Committee Hearings

Groups representing State insurance commissioners and the health insurance industry have taken action to investigate reported abuses and propose changes in the way health insurance policies are sold to the elderly. In addition, the Federal Trade Commission has begun an evaluation of the relative effectiveness of State insurance regulation of medi-gap policy sales. The Department of Health, Education, and Welfare is making a number of changes in the way information is provided to medicare beneficiaries.

NEW STANDARDS TO BE PROPOSED BY NAIC

In June, the National Association of Insurance Commissioners created a special task force "to examine the need for, and draft in accordance with perceived needs, rules governing the sale of medicare supplement health insurance."[48]

The task force met in October and drafted a position statement on medi-gap insurance, acknowledging that "serious marketing abuses occur in the sale of health insurance to the elderly, both in the area of agent's sales tactics and company advertising and solicitation practices."[49]

The task force agenda includes development of model State legislation and regulations governing minimum standards and information disclosure requirements for medi-gap insurance as well as standards for conversion of employee group health insurance to medicare supplemental coverage upon retirement. The task force will also make recommendations to State insurance commissioners and insurance companies on ways to improve control of agent practices and insurer marketing abuses.[50]

The NAIC adopted the task force's position paper and proposed model legislation to set minimum standards and information disclosure for medicare supplemental policies in December. Work is continuing on model regulations and a consumer buyer's guide, and final action is expected by the NAIC during 1979.

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[46] Report, "Poor People and the Insurance Industry in Tennessee," prepared by staff attorneys, Legal Services of Nashville and Middle Tennessee, Inc., Nashville, Tenn., 1978.

[47] The Nashville Tennessean, series of articles by Carolyn Shoulders and Linda Solomon, August and September 1978.

[48] Testimony of Joseph C. Mike, cited in footnote 33, p. 246.

[49] "Position Paper for the Task Force on Medicare Supplement and Limited Health Insurance," Task Force on Medicare Supplement and Limited Health Insurance, National Association of Insurance Commissioners. The position paper was later adopted by the NAIC. "Proceedings of the National Association of Insurance Commissioners," semiannual meeting, Las Vegas, Nev., Dec. 3–8, 1978.

[50] Documents cited in footnote 49.

NAIC-proposed legislation and regulations governing the sale of medi-gap insurance will be advisory only. Final action must be taken by each individual State legislature and State insurance commission.

THE FTC STUDY

Federal Trade Commissioner Dole discussed the different directions being taken by State insurance commissions to regulate medi-gap sales.[51] Noting that State actions to date had taken three major policy approaches,[52] she proposed an evaluation of existing State regulation of medi-gap insurance with central focus on the effectiveness of different regulatory approaches. The evaluation, she said, should be a joint effort by the Department of Health, Education, and Welfare, the National Association of Insurance Commissioners, and the Federal Trade Commission.

Members of the Committee on Aging urged all three groups to participate in such an effort,[53] and the committee was notified by the FTC in November that the study would be undertaken.[54]

INDUSTRY RESPONSE

Representatives of the health insurance industry have acknowledged the problem. Addressing members of the Health Insurance Association of America (HIAA), Mr. Robert Beck, chairman of the association and president of the Prudential Insurance Co. of America, said that "the few companies" selling medi-gap policies to the elderly gave a bad name to the whole industry. Mr. Beck also suggested that many medi-gap policies have a ratio of benefits to premiums far too low to ever be expected to provide a reasonable return, and he charged the association to recognize certain industry shortcomings and face up to its responsibilities in correcting them.[55]

Shortly after the committee hearings, HIAA created its own medicare supplement task force to make recommendations to insurance companies for changes in marketing medi-gap insurance.

The HIAA task force is surveying about 320 member companies to determine the total sales volume in medi-gap insurance for the elderly, develop a profile of the kinds of policies being sold, and determine company policies and procedures for agent training and detection of duplicative and overlapping policies sold to consumers.[56]

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[51] Hearings cited in footnote 1, part 2, pp. 234–245.

[52] Dole testimony, cited in footnote 51, pp. 238–240. (1) Minimum standards: Commissioner Dole pointed out that California had established a minimum loss ratio of 55 percent for medicare supplemental policies. An Illinois statute requires that all policies delivered in the State must fill certain gaps, including the initial part A deductible, part A copayments, and part B coinsurance. (2) Establishing categories of medicare supplemental insurance and requiring that each policy sold in a State carry an appropriate label as a way to bring about standardization: Wisconsin has pursued this alternative, establishing four benefit levels for medi-gap policies. California has established three categories for medicare supplements. (3) Efforts to provide information to consumers to permit the market to perform more effectively: Policy disclosure is the most common, and different disclosure policies are now in effect in Wisconsin, California, Oregon, and New Mexico.

[53] Letters to Joseph Califano, Secretary, Department of Health, Education, and Welfare; Michael Pertschuck, Director, Federal Trade Commission; and Harold B. McGuffey, chairman, National Association of Insurance Commissioners; from Senators Frank Church, Lawton Chiles, John Glenn, and Pete Domenici, July 18, 1978.

[54] Letter to Frank Church, chairman, Committee on Aging, from Michael Pertschuk, Director, Federal Trade Commission, Nov. 22, 1978.

[55] Speech, Robert A. Beck, Chicago, Ill., May 1, 1978. See also hearings cited in footnote 1, part 1, pp. 3–5. HIAA represents insurance companies which write 85 percent of the private health insurance in the country.

[56] Communication with HIAA staff. Survey not completed at time of publication of this report.

HEW ACTIONS

The Department of Health, Education, and Welfare announced that it would provide medicare beneficiaries with information to help evaluate supplementary insurance coverage in January 1979.

Secretary Califano said the Department would prepare special mailings to all beneficiaries, revise the medicare handbook and forms to provide explanations of supplemental policies, and work with senior citizen groups to distribute information.[57]

GAO SURVEYS

At committee request, the General Accounting Office undertook a preliminary survey of the capabilities of selected State insurance commissions to detect and deter medi-gap abuses.[58]

A second survey of a sample of elderly SSI beneficiaries in five States was undertaken by the GAO to determine the incidence of purchase of medi-gap policies by those elderly who already had both medicare and medicaid protection.[59]

Over 11 percent of the sample had purchased at least one medi-gap policy. Most of those who had purchased policies (79 percent) said they bought the policy to pay for medical expenses which they believed would not otherwise be covered.

Most of the sample (about 90 percent), however, were already participants in medicare and State medicaid programs. Since most State medicaid plans pay for medicare's major gaps, there would be little need for additional private insurance.[60] Information on specific benefit provisions of the medi-gap policies held by SSI recipients was not collected by the GAO, but it is unlikely that many purchasers would receive benefits from policies which would only pay what is not paid for after medicare and medicaid are both used up.

II. INCENTIVES FOR CONSUMER CO-OPS

The National Consumer Cooperative Bank Act, signed into law on August 20, 1978,[61] establishes a bank to provide loans to nonprofit consumer cooperatives. An Office of Self-Help Development and Technical Assistance, within the bank, is to provide technical assistance and support to nonprofit groups and organizations to develop self-help consumer cooperatives.

The bank is required to make at least 35 percent of its funds available to cooperatives which have a membership consisting largely of persons with low incomes. It must also give additional priority to other cooperatives providing services which will be used predominately by low-income individuals.

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[57] Press release, Health Care Financing Administration, Department of Health, Education, and Welfare, Jan. 18, 1979.

[58] Survey not completed at time of this report.

[59] Survey conducted by GAO staff during October and November 1978. Questionnaires and data maintained in committee files.

[60] Most State medicaid plans, for instance, offer a "buy in" arrangement to elderly medicaid beneficiaries which pays for medicare's deductibles and coinsurance charges. In addition, most State medicaid plans provide payment for nursing home stays not covered by medicare, and for hospital stays beyond medicare's limits. Some also provide benefits for drugs, home health, and dental and eye care.

[61] Public Law 95-351. H.R. 2777, originally passed by the House of Representatives on July 14, 1977, by a vote of 199-198; passed by the Senate on July 13, 1978, by a vote of 60-33. A similar Senate version of the bill, S. 1010, was cosponsored by Committee on Aging members Church, Melcher, and Brooke.

The bill was strongly supported by major national aging organizations, which cited cooperatives as a viable competitive alternative to retail purchasing of food, clothing, furniture, and gasoline as well as services such as health care, housing, legal aid, and repair work.[62] During Senate hearings, testimony about existing cooperatives demonstrated their ability to lower prices to consumers.[63]

The bank is to be governed by a presidentially appointed 13-member board of directors. Seven of the directors are to be officers of Federal agencies and departments. Six directors must be members of the general public with extensive experience in cooperative development in the areas of housing, consumer goods, low-income cooperatives, and consumer services.

It is expected that the bank will begin operations during 1979. Public hearings will be conducted throughout the country during the year to solicit suggestions for priority areas of concern.

III. PROTECTION FOR ELECTRONIC FUND TRANSFERS

A bill to provide consumers with safeguards in automatic banking transactions, including direct deposits of social security checks and other retirement income, was signed into law on November 10, 1978 [64]

Direct deposit of social security and other retirement checks has proven to be an advantage to older Americans. Many have cited the increased protection against crime and robbery as direct deposit reduces chances for checks to be stolen, lost, or having endorsements forged. When checks are deposited directly, it also means that older Americans no longer have to cash their checks, risking carrying large amounts of cash. For others, it has meant elimination of troublesome monthly trips to a bank.

The Social Security Administration offered a direct deposit option to all beneficiaries in 1975. Almost 5 million beneficiaries, about 15 percent of the total population receiving social security benefits, were using the direct deposit option by the first quarter of 1977.[65]

Once the system was widely implemented, however, fears were expressed that direct depositors would no longer be able to keep track of the amounts in their bank account, and that they would no longer know exactly when their check arrived. As the implications of further advances in electronic fund transfer became more widely known, new fears rose about the security of electronic systems and consumer liability for fraudulent or unauthorized bank transactions.

Most of the provisions of Public Law 95-630 provide guidelines for regulation of bank officials and a number of banking transactions. The following provisions for consumer rights and safeguards in automated banking tellers, direct deposit transactions, and other electronic fund transfers, however, were included:

—Limits to $50 the liability of a customer for unauthorized fund transfers.

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[62] Senate hearings on S. 1010 and H.R. 2777, Senate Subcommittee on Financial Institutions, Jan. 25 and 26, 1978. The National Council on Senior Citizens presented testimony in favor of the bill, and the National Association of Retired Teachers/American Association of Retired Persons submitted a statement urging the bill's enactment.

[63] Hearings cited in footnote 62.

[64] Public Law 95-630. The provisions were contained in H.R. 14279, which cleared Congress on Oct. 15, 1978.

[65] "Social Security Beneficiaries Using the Direct Deposit Procedure, June 1976," Research and Statistics Note, Office of Research and Statistics, Social Security Administration, Washington, D.C., 1978.

—Requires disclosure to consumers of terms and conditions of EFT transfers.
—Provides for rights to documentation of transfers and periodic statements of account.
—Establishes error resolution procedures.
—Provides for institutional liability for failure to make transfers or to stop payment of preauthorized transfers.

IV. RULES FOR HEARING AIDS AND FUNERALS?

Staff of the Federal Trade Commission's Bureau of Consumer Protection issued a final report on the FTC's proposed trade regulation rule for the sale of hearing aids in September 1978.[66]

The report was based on extensive hearings and rulemaking proceedings begun by the FTC in 1975. The FTC investigation and proceedings began after allegations were made that many older Americans with low incomes were spending large sums of money for hearing aid devices which did not perform as represented by dealers.[67]

The staff-recommended rule, geared toward a comprehensive approach to advertising and marketing of hearing aids, would cover the sale or rental of all hearing aids by sellers, distributors, physicians, and audiologists.

The recommended rule would:

—Require sellers to provide each buyer with the opportunity to cancel purchase within 30 days after delivery of the hearing aid, and inform the buyer of his right to cancel both orally and in writing. Sellers would be required to refund all payments made for the returned hearing aid, including finance charges and taxes. The seller could deduct, however, certain charges (up to about $50), depending upon circumstances of the original sale. Two earlier exemptions to this provision, for physician- or audiologist-prescribed aids and for replacement of identical aids, are no longer recommended by the FTC staff.[68]
—Require sellers to disclose their status as sellers of hearing aids and prohibit any statements which would lead consumers to believe they were hearing experts or specialists.
—Prohibit false or misleading claims regarding the performance of a hearing aid; including claims that a hearing aid would restore normal hearing, would retard the progression of hearing loss, or would shut out all unwanted background noise.

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[66] "Hearing Aid Industry Staff Report. Final Report to the Federal Trade Commission and Proposed Trade Regulation Rule, 16 CFR Part 440," Bureau of Consumer Protection, Federal Trade Commission, September 1978. The new "plain English" version of the proposed rule is contained in the staff report. Notification of its availability was published in the Federal Register on Nov. 20, 1978 (43 CFR 54103).

[67] For further information on the FTC rulemaking process for hearing aid sales, see "Developments in Aging: 1976," part 1, pp. 156–157, Senate Report No. 95–88, U.S. Senate Special Committee on Aging. Also see report cited above for discussion of regulations promulgated by the Food and Drug Administration to establish uniform professional patient labeling requirements and conditions for sale of hearing aid devices. Proceedings were initially undertaken after Committee on Aging hearings had documented widespread instances of abuse in the sale of hearing aids to older Americans: "Hearing Aids and the Older American," hearing of the Senate Special Committee on Aging, Subcommittee on Consumer Interests of the Elderly, Sept. 10, 1973.

[68] The rules, as originally proposed in 1975, specified that if an audiologist or a physician had recommended, or prescribed, a specific hearing aid model, the seller would be exempt from the 30-day right to cancel provision. The 1975 proposed rule also exempted sellers who had replaced an identical aid. Both these exemptions have been removed from the recommended rule.

—Require oral consumer consent to a home sales visit before coming to the home to make a sales presentation.[69]
—Require sellers who advertise aids with a phone option to disclose, in the advertising, that the phone option may not be compatible with all phones in the area.

The FTC staff found that about 650,000 hearing aids are purchased every year, at an average price of $350 each. Most are purchased without the involvement of a medical specialist. About half the sales take place in the home.[70]

Staff also found a "multitude of abusive sales transactions and sales tactics" within the hearing aid industry, including selling used hearing aids as new, and claiming that hearing aids will help restore normal hearing power.[71]

The recommended rule is intended to supersede only those State laws and regulations which do not provide consumers with equal or greater protection than the FTC rule.

The rule has not yet been accepted by the Commission. An additional 60-day comment period on the recommended rule will be open until January 19, 1979. The FTC may either extend the comment period then, or act on the final rule.

FUNERAL INDUSTRY PRACTICES

In June 1978, the FTC issued its final staff report on a proposed trade regulation rule on funeral industry practices. The report, based on extensive public proceedings and hearings covering a period of 3 years, concludes that new rules are required to eliminate abuses within the funeral industry.[72]

The recommended rule would:
—Prohibit practices which take unfair advantage of the grief-stricken state of funeral purchasers, including unauthorized removal of remains, embalming without permission, requiring a casket for cremation, and overcharging on items such as flowers and obituary notices;
—Prohibit misrepresentations by funeral directors of legal, religious, and cemetery requirements for funerals, including the preservative or protective value of embalming, caskets, and burial vaults;
—Prohibit selling techniques which unfairly or deceptively interfere with the consumer's ability to freely select a funeral, including attractive display of expensive items only and misrepresentation of the availability of merchandise;
—Require disclosure of prices, including furnishing consumers with price lists for funeral items before purchase and quotation of prices over the phone and through the mail; and
—Prohibit funeral directors from interfering with memorial society arrangements.

[69] The 1975 proposed rule would have required written consent to a home sales visit.
[70] Report cited in footnote 65.
[71] Reported cited in footnote 66.
[72] 16 CFR part 453. "Funeral Industry Practices," final staff report to the Federal Trade Commission, and Proposed Trade Regulation Rule, Bureau of Consumer Protection, Federal Trade Commission, June 1978. See "Developments in Aging: 1976," part 1, U.S. Senate Special Committee on Aging, Senate Report No. 95–88, pp. 157–161 for further discussion of rule as originally proposed in 1975 and for comment and reaction to the rule during 1976.

Staff found that consumers spend about $6.4 billion annually on funeral, burial, and related expenses. An average funeral costs over $2,000.[73]

Final rules are not expected until sometime during 1979.

[73] Report cited in footnote 72.

CHAPTER VII

A REVISED OLDER AMERICANS ACT

Congress altered the Older Americans Act significantly in 1978, assigning new responsibilities to units in the aging network and regrouping major service titles.

As agreed to by House-Senate conferees on September 23, the Comprehensive Older Americans Act[1] Amendments of 1978 (signed into law as Public Law 95–478 on October 18), includes these features:

—A new comprehensive title III which now encompasses nutrition (formerly title VII) and multipurpose senior center funding (formerly title V), as well as social services. This means that area agencies will become the channels for funds formerly provided separately through State agencies for nutrition services and senior centers. In signing the bill, President Carter said: "We are improving these services by strengthening their coordination and planning at all levels of Government. . . . They also improve planning for these services to add efficiency at all levels of Government and eliminate countless hours of paperwork and administrative burdens."

—The act is extended through 1981; a 3-year planning cycle replaces the present 1-year State and area planning requirement.

—The advocacy function of the Administration on Aging and the State and area agencies is sharpened.

—The AoA is also instructed to maintain active review and comment on all Federal policies affecting the aging. This broad change also assigns AoA a strengthened involvement "in development of policy alternatives in long-term care and to insure that the development of community alternatives is given priority attention." Another section authorizes grants for community long-term care model projects.

—Area agencies on aging are to "target" 50 percent of their social service allocations on in-home, access (transportation outreach, information and referral, etc.), and legal services.

—New authority is provided for home-delivered meals.

—Senior centers as focal points for actual delivery of services are emphasized throughout; funding for center personnel, operating costs and limited construction is added to the earlier authority for center renovation.

—A national manpower policy on aging is mandated.

—A nursing home ombudsman program is required of each State

[1] Enacted in 1965, the Older Americans Act had earlier been amended and extended in 1967, 1969, 1972, 1973, and 1975. Eligibility for services extends to all persons 60 years or older except for the title V employment program which has an eligibility age of 55 and over.

agency on aging to monitor and investigate complaints from residents of nursing homes or their families.

—A new title is authorized to allow Indian tribes and tribal organizations the option of receiving direct funding from the Commissioner of the Administration on Aging.

—The community services employment programs eligibility is liberalized by allowing persons with 125 percent of the poverty guidelines to participate.

I. 1978 EXTENT OF OLDER AMERICANS ACT OPERATIONS

What is often called "aging network" under the Older Americans Act has grown markedly since area agencies on aging were first established under 1973 amendments to the act.[2]

Early in 1978, the agencies and programs already in place had these dimensions:

—All 50 States and 5 territories had State units on aging, which employed more than 1,300 persons. These offices are responsible for coordinating their efforts with other State programs, including health services, transportation programs, educational programs, employment programs, income maintenance programs, etc., which could provide assistance to the elderly.

—The 558 area agencies on aging within 612 planning and service areas employ approximately 6,000 persons and enlist 14,000 volunteers. These agencies were responsible for tapping approximately $200 million per quarter for elderly services from other resources, including 21 percent from local funding, 9 percent from State funding, and 70 percent from Federal funding. The area agencies served about 4,686,000 older persons each quarter during 1978, including 44 percent who were low-income and 18 percent who were minority (3 percent American Indian, 58 percent black, 6 percent oriental, 22 percent of Spanish origin and 11 percent "other minority").

—There were 9,732 nutrition sites operating during 1978 under the administration of 1,074 nutrition projects. These sites employed about 22,000 persons and had 127,000 volunteers (82 percent of whom were elderly). More than 1,534,000 persons enjoyed meals at the nutrition sites, 66 percent were low-income and 22.5 percent were minority (6.4 percent American Indian, 61.8 percent black, 3.4 percent oriental, 18.1 percent of Spanish origin and 10.3 percent of "other minority"). The sites served approximately 470,000 meals per day—83 percent in congregate, community sites and 17 percent to the homebound.

—There were 1,100 senior centers supported by the Older Americans Act during the last year. Centers were in every State as separate facilities or within housing complexes, churches, schools, community centers, and recreational facilities.

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[2] For a detailed description of the aging network, see chapter V of "Developments in Aging: 1976," part 1, a report of the Special Committee on Aging, U.S. Senate.

II. THE NEW FRAMEWORK

Administration on Aging Commissioner Robert Benedict, testifying early last year on extension of the Older Americans Act, posed these questions:

> How can we insure that our support systems in the community respond effectively to the widely varying circumstances of the elderly and their families?
> How can we make certain that the efforts of government actually enhance and add to the compassionate care and support of families for their elders?
> How can we halt the fragmentation, waste, and duplication which have come with the proliferation of programs for the elderly at every level of government? [3]

Responding to these and other challenges, the House and Senate architects of the new amendments developed new strategies and mechanisms, including as a centerpiece the new alignment of service titles.

A. Consolidating Titles III, V, and VII

Every major bill offered early in 1978 to extend the Older Americans Act offered varying forms of consolidation.

Senator Thomas Eagleton described the consolidation provision contained in his bill (S. 2850) as insuring "that coordination and cooperation among the various programs contained under the umbrella of the Older Americans is achieved. . . . It is my belief that all Older Americans Act programs should be implemented through this central network so that a focal point for services to the elderly can be established in each community in order to insure a proper coordination of services." [4]

Senator Pete Domenici authored the consolidation in S. 2609—applying only to titles III and V—as a "reform which will streamline the planning procedures, lessen the paperwork burden at all levels of government, and improve the coordination of services to our senior citizens." [5]

"Our bill, S. 2969," said Senator Frank Church, would simply attempt to enhance the effectiveness and efficiency of the act by requiring the States and area agencies to have one comprehensive plan which would include all of the services provided under new title III. It would also reduce the paperwork burdens for State and local personnel." [6]

In cosponsoring S. 2609, Senator Charles Percy stated that "from numerous hearings conducted by the Aging Committee, both in Washington and throughout the country, we found that coordination of various programs needed to be improved; that paperwork needed to be reduced . . . this bill represents the practical approach." [7]

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[3] Testimony by Commissioner Robert C. Benedict, Administration on Aging, before the U.S. Senate Subcommittee on Aging, Apr. 21, 1978.

[4] Statement of Senator Thomas Eagleton upon introduction of S. 2850 to extend the Older Americans Act, Apr. 6, 1978.

[5] Statement of Senator Pete Domenici upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

[6] Statement of Senator Frank Church upon introduction of S. 2969 to extend the Older Americans Act, Apr. 20, 1978.

[7] Statement of Senator Charles Percy upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

Most of the national aging organizations supported the consolidation of service titles. However, the National Association of Title VII Directors expressed opposition to such a merger on grounds "that a decision of such magnitude should not be made at the Federal or State level but at the local level among those parties involved." [8]

The National Council of Senior Citizens assessed the pros and cons of such a consolidation.

> In principle, there would appear to be scant reason to oppose streamlining the planning process by this measure. . . . If the merger currently discussed is but an incremental step towards eventual amalgamation of the authorizations into a bloc grant, we would strenuously oppose the move.[9]

The final legislation—Public Law 95–478—reflected these varying views by consolidating the service titles, but including separate authorizations or special emphasis language to show the intent of Congress as to which programs should be continued or emphasized.

THE FINAL AGREEMENT

Under the new consolidated title, part A of title III contains the administrative framework for all of the service programs. Therefore, all social services, nutrition services, and senior center programs will be governed by the general provisions related to authorizations, allotment formulas, organizations, area plans, State plans and administration outlined in part A.

Part B lists the social services and senior center activities supported under title III. All services with the exception of the congregate and home-delivered nutrition services are authorized under this part.

Part C provides for the authorization of a congregate nutrition program under subpart 1 and a new home-delivered meals program under subpart 2.

AUTHORIZATIONS

The new title III authorizations were increased substantially to allow for an expansion of existing programs, support of new programs and the inclusion of senior centers under the social services authorization. However, the 95th Congress ended without providing appropriations for fiscal year 1979.[10] Therefore, all programs under the act were funded in fiscal year 1979 under a continuing resolution which continues existing programs at the "current rate." Several programs authorized by the new amendments did not exist in fiscal year 1978. These programs cannot be implemented until appropriations legislation is enacted.

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[8] Statement of National Association of Title VII Directors, before the U.S. House of Representatives Subcommittee on Select Education, Mar. 13, 1978.

[9] Statement of the National Council of Senior Citizens, before the U.S. Senate Subcommittee on Aging, Feb. 8, 1978.

[10] Appropriations legislation for the Older Americans Act was not enacted by the 95th Congress because the legislation extending the act for fiscal years 1979–81 was not signed into law before the beginnnig of fiscal year 1979, Oct. 1, 1978. Additional funding for these programs can be included in a supplemental appropriations bill.

The 1978 amendments authorized the following ceiling levels for the social services and nutrition programs:

[In millions of dollars]

	Fiscal years		
	1979	1980	1981
Social services	$300	$360	$480
Congregate nutrition	350	375	400
Home-delivered meals	80	100	120

ALLOTMENT FORMULA

Title III's allotment formula continues to be a formula grant program which allocates each State an amount equal to the States' proportion of persons aged 60 and over. Under the new title III, each State will receive four allotments: one for administration, one for social services, one for congregate nutrition programs, and one for home-delivered meals programs.

The new amendments also specify that each State may use up to 8.5 percent of its title III allotment for administration of area agencies on aging. This new formula, proposed by Senator Frank Church and Representative John Brademas (S. 2969 and H.R. 12255), allows Older Americans Act funding to be used to support 75 percent of the cost of administration—for area agencies as well as State agencies. State and local agencies will be responsible for meeting the other 25 percent. For social services, the non-Federal match will be 10 percent until 1981 when the percentage is to be increased to 15. The new amendments require that the increase in 1981 must be the responsibility of the State. The non-Federal share may be in cash or in-kind but at least 25 percent of the non-Federal match must be cash.

B. ORGANIZATION

Public Law 95-478 is consistent with the former organization of State and area agencies but provides for additional responsibilities by them.

State agencies on aging are now required to:

—Serve as effective and visible advocates for the elderly by reviewing and commenting upon all State plans, budgets, and policies which affect the elderly and providing technical assistance to any agency, organization, association or individual representing the needs of the elderly. This language was proposed by Senator Frank Church in recognition of the aging network's responsibility and impact as an active advocate.

—Develop a formula for the distribution of title III funds within the State taking into consideration the geographical distribution of persons 60 years of age and over and then making this formula available to the public for review and comment.

—Provide assurances that preference will be given to providing services to those elderly with the greatest economic or social need.

—Allow a unit of general purpose local government of 100,000 popu-

lation or more to apply for designation as a single planning and service area and be afforded the opportunity for a hearing if they are dissatisfied with the State's decision; and

—Allow the chief executive officers of each State involved to apply to the Commissioner for designation of an interstate planning and service area, including interstate Indian reservations.

AREA PLANS AND "TARGETING"

The area plan requirements of an agency designated as an area agency on aging will continue under the new law with the following changes:

—A requirement that the area agency develop a 3-year plan with annual amendments as necessary.

—A requirement that the plan will provide assurances that at least 50 percent of the area agency's part B social services allotment is spent on access services (transportation, outreach and information and referral) in-home services (homemaker, home health, chores services, and so forth) and legal services; however, the State agency may waive this requirement if the area agency can show how it is meeting these services with other resources.

This formula for targeting services was proposed by Senator Eagleton, Chairman of the Human Resources Committee's Subcommittee on Aging, who was concerned that the scattering of Federal dollars among many services results in a large number of ineffective services.[11] Therefore, he proposed a concentration of the dollars in these targeted areas. Area agencies are also required to:

—Provide assurances that the area's plan will show how preference is being given to providing services to those elderly with the greatest economic or social need; and

—Serve as the "advocate and focal point for the elderly within the community" by monitoring and commenting upon all policies which affect the elderly.

Again, this language was proposed by Senator Church in an effort to define more clearly the role of advocacy for each agency in the aging network. Until the 1978 amendments, the advocacy role had been implied but now it has been legislatively defined as a major responsibility of each agency.

STATE PLANS AND NEW RURAL EMPHASIS

The State plan would also be changed from an annual document to a 3-year presentation with annual adjustments as necessary. Other new requirements include:

—Authorizing the State to base its State plan on the contents of the plans developed by the area agencies and to develop a uniform format for the areas to follow in developing their plans.

—Mandating the State to increase its spending on social services, nutritional services, and senior centers in rural areas by 5 percent above what the State was spending in these areas in 1978. (However see exceptions on page 113.)

[11] For additional discussion of Senator Eagleton's emphasis on "targeting" see pp. 149–153 "Development in Aging 1977."

This provision was based upon Senator Domenici's floor amendment to change the national allotment formula so that those States having the largest number of rural elderly would receive an allotment which gave additional weight to that per centum of the population of the State's elderly who reside in rural areas. Senator Domenici described this amendment as modifying the current formula to "allow a greater recognition of the special needs of the older Americans who live in rural areas." [12]

Additional provisions affect State-area relationships by:

—Allowing the State agency to give an opportunity for a hearing to any area agency submitting a plan under title III, any service provider under the plan, or any applicant to provide a service under the plan;

—Mandating each State agency to support with 1 percent of their title III, part B social services allotment or $20,000, whichever is greater, a statewide nursing home ombudsman program which will be responsible for investigating and resolving complaints of residents in nursing homes—including such duties as data collection, developing procedures for access to facilities as well as patients records, and providing technical assistance and training for volunteer and citizen organization groups to participate in the ombudsman program.

C. HOME-DELIVERED MEALS

State agencies are authorized to provide a congregate nutrition program and a home-delivered meals program to persons aged 60 and over and spouses. Contributions received for meals are to be used to increase the number of meals served. Each project must provide outreach efforts. The use of nutrition funds for supportive services (up to 20 percent of the nutrition budget except in those areas with high supportive services costs where the Commissioner can approve requests up to 50 percent) is continued for only 2 years.

The home-delivered meals program will be funded as a separate program for the first time under the Older Americans Act. The efforts to support a separate authorization, were led by Senators Kennedy, Church, McGovern, Dole, and Percy, who stressed the need to keep the elderly in their homes where they want to be and at the same time provide them with nutritional meals and contacts with the outside world. The home-delivered meals programs, as well as the congregate nutrition programs, will all be administered through the area agencies, as required under the consolidation. This consolidation also is the basis for the discontinuation after 2 years of the supportive services funding under the nutrition program. In order to encourage coordination with the nutrition program and other services under title III, the new law requires that by fiscal year 1981 the cost of supportive services under the nutrition program must be met by funds under part B, social services funds. Senator Church, who offered the amendment to allow a 2-year continuation of funding for supportive services, stressed:

> A 2-year grace period is needed to permit the State to work with the nutrition programs to develop a comprehensive

[12] Statement by Senator Pete Domenici upon introduction of an amendment to the formula of the Older Americans Act, July 24, 1978.

service system that will satisfactorily coordinate the nutrition services with other programs.[13]

D. Senior Centers

State agencies may approve the use of title III, part B funds for the acquisition, renovation, and alteration of facilities to be used as senior centers and allow such funds to be used for limited construction and to support operational and staffing costs.

Although the act no longer provides for a separate authorization for senior centers, language in title III emphasizes centers as community focal points for the delivery of services. In addition, in describing requirements for nutrition sites, the law states that particular attention be given to multipurpose senior centers.

House and Senate conferees stated their intent that senior centers continue to receive support by the act in conference report:

> The conferees emphasize the importance of multipurpose senior centers in developing a comprehensive social services network and expect that area agencies will continue to place appropriate emphasis on their development and expansion.

E. Legal Services

Legal services funded under title III are to be provided by a legal services corporation program or a program which provides legal services to older persons with the greatest economic or social need, who agree to coordinate their efforts with existing legal services corporation projects. Such legal services will be in addition to any legal services being furnished by the provider with funds from sources other than the Older Americans Act.

The targeting of legal services was advanced in legislation by Senator Kennedy and Representative Brademas, who called for a separate authorization for legal services under title III.[14] However, the final legislation incorporated legal services as one of the targeted services under title III, recognizing its impact as a tool for providing other nécessary benefits to the elderly—income, health care, tax counseling, et cetera. Therefore, each area agency will be required under the new amendments, to make legal services available for their elderly population through the use of title III funds or other sources included in their area plan.

Although the new amendments require major changes in administrative mechanics, waivers are allowed for a 2-year period to allow State and area agencies time to make the necessary transition. Each State is allowed to waive any provisions of the consolidation for fiscal years 1979 and 1980 provided the area agency shows it is making good faith efforts toward the requirements of consolidation. In addition, each State agency is allowed to waive the rural formula if the service needs of the elderly in a particular rural area are being met or if the number of individuals living in a particular area is not sufficient to warrant the increase provided under the formula.

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[13] Statement by Senator Frank Church upon introduction of amendment to nutrition program under Older Americans Act, July 24, 1978.

[14] S. 2394 by Senator Kennedy and H.R. 9079 by Congressman Brademas.

F. Administration

As described earlier, each State receives an administration allotment based on its 60-and-over population. The new amendments increase the minimum a State may receive under the formula to $300,000 for small States and $75,000 for the territories.

In addition, the administration section allows a State, with the approval of the Commissioner, to transfer funds between its congregate nutrition allocation and its home-delivered meals allocation, if conditions warrant.

G. Disaster Relief

The new law allows the Administration on Aging to reimburse a State for services provided during a Presidentially declared disaster; up to 5 percent of the funding for model projects may be used. The law states that the Commissioner shall reserve the 5 percent up to the third quarter of the fiscal year for disaster reimbursement and then proceed to use any remaining fraction of the 5 percent to support model projects.

H. Surplus Commodities

The new amendments continue the availability of USDA surplus commodities for nutrition projects and continues the option for each project to elect cash in lieu of commodities. The commodities or cash are provided in accordance with the number of meals served by the projects and the 1978 amendments increase the price per meal to at least 30 cents, as adjusted by the Consumer Price Index.

III. SOCIAL AND NUTRITION SERVICES AUTHORIZATION

Under the new structure created by the 1978 amendments, part B authorizes the continuation of social services as provided under title III in the past. In addition, the authorization for senior centers is included in this part.

Part B specifically identifies health services, continuing education, welfare services, information and referral, recreational, homemaker, counseling services, transportation services, housing, alternative services to institutionalization, legal services, tax and financial counseling, physical activity, health screening services, preretirement and career counseling, ombudsman services and "any other services if such services meet standards prescribed by the Commissioner and are necessary for the general welfare of older individuals."

Nutrition Services

Title III's part C, subpart 1, authorizes the continuation of congregate nutrition programs which 5 days or more each week, provide at least "one hot or other appropriate meal" which provides at least one-third of the daily recommended dietary allowances. The law also allows each nutrition project to provide nutrition education and other appropriate nutritional services for its participants.

Subpart 2 sets forth the newly created home-delivered meals program for the elderly and requires each project to provide at least five meals per week which are "hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life)" and provide at least one-third of the daily recommended dietary allowances.

In addition, this subpart requires the Commissioner to develop minimum criteria, with advice by nutrition organizations, to guide the efficiency and quality of the home-delivered meals.

IV. THE EXPANDED TITLE IV

In addition to research, training and multidisciplinary centers of gerontology, the new title IV authorizes all demonstration projects including special demonstrations for long-term care, legal services, national impact demonstrations, and utility and home heating cost demonstrations.

A. Training

Public Law 95-478 requires the Commissioner to develop a national manpower policy on aging which represents the present and future need for personnel in all programs serving the elderly. This national policy, which was based on Senator Church's bill (S. 2969), was developed to assist the Administration on Aging in overcoming its past training efforts which "have been fragmented and small." [15]

The new law requires that the manpower policy shall give priority to the training of persons involved with the operation of senior centers and nutrition projects. In addition, the law requires that the policy be implemented in cooperation with other departments and agencies including the Public Health Service, the Social Security Administration, the National Institutes of Health—particularly the National Institute on Aging—the Administration for Public Services (title XX), the Rehabilitation Services Administration, the Department of Labor, the Department of Transportation, the Department of Housing and Urban Development, and other appropriate agencies.

B. Research

Research efforts of the AoA in the past were largely contracted out to individuals and institutions of higher education. The new law, however, requires the Commissioner to make grants or contracts to any public agency or nonprofit private organization or institution for the purpose of conducting specific mandated research efforts: a study analyzing the problems experienced in operating transportation services with emphasis on the difficulties in obtaining insurance for high occupancy vehicles; a study related to the revision of existing Federal transportation systems to provide more coordinated and comprehensive services doing away with unnecessary duplication among such programs; a study analyzing methods to eliminate differences in eligibility requirements in transportation programs; and a study related to the differences in access to and the unit costs of services delivered in rural areas and urban areas.

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[15] Statement by Senator Frank Church upon introduction of S. 2969 to amend the Older Americans Act, Apr. 20, 1978.

The new law requires that the results of the mandated studies be reported to the Congress no later than 2 years after enactment of the amendments (October 18, 1978) and be made available to the public through the National Information and Resource Clearing House of the Administration on Aging.

C. Demonstration Projects

Formerly a part of title III, the demonstration or model projects are now authorized under title IV. Part C of title IV continues to allow the Commissioner on Aging to make grants and contracts to public agencies or nonprofit private organizations, for the purpose of supporting "statewide, regional, metropolitan, county, city, or community model projects" which will demonstrate effective methods of providing social or nutrition services to older persons. The Congress describes certain areas in which the Commissioner is required to fund demonstration projects including, alternative health care delivery systems, advocacy and outreach programs and transportation services. In addition, the Commissioner is required to give special consideration to funding projects which demonstrate innovative methods of providing housing for the elderly, property tax relief, continuing education, preretirement education and training, special services for the physically and mentally impaired elderly and ambulatory day care centers. Further demonstration projects are encouraged which show methods of meeting the special needs of the rural elderly and methods of coordinating all available social services for the homebound elderly, the blind, and the disabled.

D. Special Projects In Long-Term Care

The need for a comprehensive long-term care program for the elderly was recognized in most of the legislative proposals to amend the Older Americans Act.

Senator Lawton Chiles discussed the need for a comprehensive program when he introduced S. 2967, a bill to provide special projects in long-term care under the Administration on Aging:

> Too often, noninstitutional long-term care services are available only on a piecemeal basis: skilled home nursing may be available, but not equally needed maintenance support, such as a homemaker or chore services . . . The needed services are not often all present in the same community. If they are in place, they are rarely fully coordinated with each other so that support needed by a single person at different times can be efficiently determined and met.[16]

Congressmen William Cohen, Claude Pepper, and John Brademas, and Senators Domenici and Church also included long-term care initiatives in their legislation, recognizing the need for the Administration on Aging, in cooperation and coordination with other health and services agencies, to develop a comprehensive system to meet the total needs of the elderly for long-term care.

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[16] Statement of Senator Lawton Chiles upon introduction of S. 2967, a bill to amend the Older Americans Act, Apr. 20, 1978.

Public Law 95-478, therefore, includes a special demonstration section authorizing the Commissioner on Aging to make grants to selected State and/or area agencies, institutions of higher education, and other public agencies and nonprofit private organizations, associations or groups to support the development of a comprehensive long-term care system for the elderly.

This system should include alternative services to institutionalization, an assessment of need of the individual, the development of a plan of care, and the referral of the individual to the appropriate level of care. The programs to be coordinated into a comprehensive system could include adult day health, monitoring and evaluation of services effectiveness, supported-living in public and private nonprofit housing, family respite services, preventive health services, home health, homemaker services as well as other rehabilitative and maintenance inhome services, geriatric health maintenance organizations, and other appropriate services.

Applicants for the special long-term care demonstrations must assure that adequate State standards are developed to insure the quality of services; that the State has a commitment to carry out the long-term care program with the agency responsible for administering medicaid—title XIX—and the title XX social services; that the State will develop plans for financing the comprehensive system designed to meet the long-term care needs; and that the State has a plan for a statewide or regional basis to provide access to the services provided under the comprehensive system.

The long-term care special demonstration project funds may not be used to support the cost of services which are eligible for reimbursement under medicare—title XVIII—medicaid—title XIX—or title XX social services.[17]

E. Special Demonstrations in Legal Services

In the past, the Commissioner has made grants under model projects to support legal service programs for the elderly, technical assistance in the legal problems of the elderly and training of paralegals to work with the elderly. The new amendments authorize a special section under part C, model projects, to support legal research, technical assistance, training, information dissemination, and other support activities to agencies, organizations, institutions and the private bar that can show the capabilities of providing, developing, or supporting pro bono or reduced-fee legal services to elderly persons. The section also supports demonstration projects which show methods of expanding or improving the delivery of legal services to the elderly.

The new amendments required that at least $5 million of the funds appropriated for model projects under title IV be used to support legal services demonstration projects.

F. Other Special Demonstrations

In addition to special projects in long-term care and legal services, the 1978 amendments authorize two additional special demonstrations. First, the Commissioner is authorized to make grants or contracts to support demonstrations of national significance to show methods of

[17] For additional discussion of comunity-based long-term care, see page 84.

improving or expanding the overall delivery of services to the elderly on a nationwide basis.

Special demonstrations in providing elderly relief from utility and home heating costs are also supported under title IV. Such projects are to demonstrate methods of relieving the burden of such costs to the elderly, such as reduced rates by private business and public utilities.

V. TITLE V—COMMUNITY SERVICE EMPLOYMENT

The new amendments redesignate the former title IX, community service employment for older Americans, as a new title V. However, the program remains substantially the same—to provide part-time job opportunities in community service for low-income persons aged 55 years and older. The program is administered by the Department of Labor.

Under Public Law 95-478, several major changes were made in the community service employment program and increased authorizations were provided. The House and Senate conferees agreed to authorizations for 3 years—$350 million for fiscal year 1979, $400 million for fiscal year 1980, and $450 million for fiscal year 1981. However, appropriations for title V, like the entire Older Americans Act, have also been maintained at the fiscal 1978 level—$250 million—under the continuing resolution. Unless actual appropriations are enacted, the increased authorizations cannot be realized.[18]

Major changes made in the new title V include raising the definition of low income to 125 percent of the poverty index. This will enable near-poor as well as the poor to participate in the program. Senator Church, who sponsored the eligibility expansion, explained:

> The overall emphasis would still be on low-income elderly because their needs are the greatest. But there are many instances where individuals with incomes slightly above the poverty levels are in as great need, if not greater.[19]

In the past, title IX job slots were largely administered by national organizations under the auspices of the Department of Labor.[20] The 1978 amendments direct more slots to the States by changing the allocation formula by stipulating that any additional funding in succeeding fiscal years will be allotted at 55 percent for the States and 45 percent for the national organizations. The national contractors will, however, retain at least the number of job slots they had during fiscal year 1978.

In addition, each national organization conducting a community service employment program must submit to the State in which the program is located, a description of the program 30 days prior to the implementation date.

[18] Appropriations legislation for the Older Americans Act was not enacted by the 95th Congress because the legislation extending the act for fiscal years 1979-81 was not signed into law before the beginning of fiscal year 1979, Oct. 1, 1978.

[19] Statement of Senator Frank Church upon introduction of S. 2969 to extend the Older Americans Act, Apr. 20, 1978.

[20] National Council on the Aging, National Council of Senior Citizens, American Association of Retired Persons, National Farmers Union, and the Forest Service have been the contractors in the past. In 1978, the Department of Labor made a decision to expand the list to include the Associacion Nacional Pro Personas Mayores and the National Center on Black Aged and Urban League.

The new law also directs the Secretary of Labor to reserve up to 1 percent of the appropriations over the fiscal year 1978 level for efforts to improve the transition from a community service employment job to the private sector. When this amendment was offered by Senator Domenici on the Senate floor he noted that similar efforts are being made in other programs, such as the CETA program, but no such effort is being made in the community service employment program for senior citizens.[21]

Domenici went on to explain that his amendment:

> . . . would seek to increase the turnover in the title V program. As older workers come into the program and develop job skills, improve working habits, and renew self-assurance, the opportunity begins to arise for placement in the private sector. . . . where it can be done. I think it will benefit the older worker, the program, and those yet unserved.

The Secretary is also directed to create a new part-time program, in consultation with the Environmental Protection Agency and the Department of Energy, which will relate to environmental improvement and energy conservation. This program is an outgrowth of a small joint project involving EPA and AoA.

VI. TITLE VI—DIRECT FUNDING OF INDIAN TRIBES

A new title VI was enacted to give Indian tribes and tribal organizations the option to be directly funded by the Commissioner on Aging. Thus, tribes receiving funds under the Older Americans Act may choose between direct funding or funding through the State or area agencies on aging.

To be eligible for direct funding, a tribe or tribal organization must have at least 75 elderly members age 60 and over and demonstrate the ability to deliver social and nutrition services. The tribe's application must show how it intends to develop a comprehensive service system for its elderly tribal members.

This new method of funding was authorized by Senator Domenici (S. 2609) in an effort to give the tribes more autonomy in managing their own programs for the elderly. Direct funding is already authorized in other Federal programs, including the comprehensive employment and training program (CETA) and the State and Local Fiscal Assistance Act of 1972 (revenue sharing).

The new title VI also allows surplus educational facilities to be used as multipurpose senior centers, nutrition centers, long-term care facilities, and so forth. This measure was sponsored by Senator Domenici to "allow us to significantly expand Indian services while taking full advantage of existing surplus facilities." [22]

In order to provide sufficient funding for the tribes, the act requires that at least $5 million be appropriated for title VI before it can be implemented. Because these programs are under a continuing resolution, with no provision for new programs, title VI will not be funded until appropriations legislation is enacted.

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[21] Statement by Senator Pete Domenici upon introduction of a floor amendment to the Older Americans Act, July 24, 1978.

[22] Statement by Senator Pete Domenici upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

CHAPTER VIII

CHANGES IN ACTION, CSA

Significant changes were made in programs serving or enlisting older persons when the Congress extended the Community Services Administration and ACTION agency during 1978.

In addition, President Carter's reorganization project focused, in a staff working paper, on proposals which could move the ACTION and CSA aging programs to the Administration on Aging in the Department of Health, Education, and Welfare.

This option was justified as "strengthening the Administration on Aging's role as the principal Federal agency for older people and providing opportunities to coordinate more effectively programs designed specifically for older persons. . . ."[1]

At year's end, the Office of Management and Budget was analyzing final draft recommendations of the President's reorganization project, but details were not yet public.

I. ACTION PROGRAMS

Congress gave close scrutiny to ACTION's Older American Volunteer programs (OAVP) during 1978. The performance and goals of programs for Retired Senior Volunteers, Foster Grandparents, and Senior Companions were examined in the wake of an administration-proposed budget cut and change in focus for the Retired Senior Volunteer program,[2] and charges were also received from program participants and major aging organizations that the ACTION agency was not demonstrating a commitment to the goals of the OAVP.

The outcome of the reauthorization process reaffirmed congressional commitment to the unique nature of the Older American Volunteer programs, which now give opportunities for community involvement and activity to 269,350 Americans age 60 and over.[3]

A. Older American Volunteer Programs Reauthorized for 3 Years

The Retired Senior Volunteer program, Senior Companion program, and Foster Grandparent program were reauthorized for 3

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[1] Staff working paper, Human Services Study, President's reorganization project, July 1978. (This paper is for background information only and does not represent any final conclusions and recommendations of the President's reorganization project.)

[2] See "Developments in Aging: 1977" part 1, Senate Report 95–771, Special Committee on Aging, U.S. Senate, pp. 215–216, for discussion of administration proposals for fiscal year 1979.

[3] Fiscal year 1978 enrollment was 269.350. Fiscal year 1979 enrollment was projected to be 269,900. See "Developments in Aging: 1978" part 2, for complete description of volunteer activities as reported to the committee by the ACTION agency.

years—through fiscal year 1981—by the Comprehensive Older Americans Act Amendments of 1978.[4]

During 1978, the Retired Senior Volunteer program enrolled 250,000 volunteers age 60 and over. The Foster Grandparent program, which provides low-income Americans age 60 and over with opportunities to work with children with special needs, had 16,250 participants during the year. Senior Companions, who must also be age 60 and over and have low incomes, provide volunteer services to other older Americans with special needs. Approximately 3,100 Senior Companions worked with other elderly as friendly visitors, providing transportation, chore services, and other similar services during 1978.

B. Funding Authorizations Increased

Action taken by Congress significantly increased the authorization levels for the Older American Volunteer programs as follows:

[In millions of dollars]

	Fiscal year 1978 appropriation	Fiscal year 1979 administration budget request	New authorization, fiscal year		
			1979	1980	1981
RSVP	20.1	15.4	25	30.0	35
FGP/SC	41.9	42.54	55	62.5	70

Increased appropriations for fiscal year 1979, however, were not approved by Congress by the end of the 95th Congress. Public Law 95–482, signed by the President on October 18, 1978, continued funding for fiscal year 1979 at the fiscal year 1978 appropriations level. A supplemental appropriations bill will have to be passed by Congress early in the 96th Congress if any program growth is to occur.

C. Program Changes

A number of significant program changes were made by Congress in addition to increases in the authorized funding levels.

Closer coordination with State agencies on aging and community action programs: Public Law 95–478 contains provisions to insure that State agencies on aging and community action agencies will be given preference for grant awards for the administration of new Foster Grandparent and Senior Companion programs. State agencies on aging and community action agencies are given 45 days in which to

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[4] Public Law 94–478: Older American Volunteer programs are authorized under title II of the Domestic Volunteer Service Act of 1973, as amended. During 1978, provisions extending the authorizations of appropriations for these programs were passed by the House of Representatives as part of the Comprehensive Older Americans Act Amendments of 1978 (H.R. 12255). Similar provisions were passed by the Senate as part of the proposed Domestic Volunteer Service Act Amendments of 1978 (S. 2617). Final action was taken on the Older American Volunteer programs as part of the House-passed bill.

No final action was taken on the Domestic Volunteer Service Act Amendments of 1978 during the 95th Congress. The bills included provisions for other programs which may serve the elderly, such as VISTA (Volunteers in Service to America) and the proposed new Urban Neighborhood Volunteer programs. Two of the proposed new programs—Helping Hand and Fixed Income Counseling—would primarily assist older Americans. Controversy over other aspects of the proposed Urban Neighborhood Volunteer program, the absence of any congressional hearings on these proposals, and the crush of legislative activity in the last days of the 95th Congress contributed to no final action on S. 2617. Further action is expected in the 96th Congress.

comment on grant proposals made by other applicants. Proposals from applicants other than State agenices on aging and community action agencies must contain assurances of coordination with these agencies. The comment and review period for State agencies on aging on applications for new RSVP programs, mandated by previous law, was reduced from 60 to 45 days.

Stipend increase for Foster Grandparents and Senior Companions.—Foster Grandparents and Senior Companions are usually provided with a small hourly stipend to help defray the expenses of their volunteer work. Volunteers work an average of 20 hours a week and are paid a stipend of about $1.60 an hour. This amount has not been increased since the inception of the programs. Public Law 95–478 authorized a stipend increase to $2 an hour. The law conditions any increase, however, on an appropriation of funds sufficient to maintain the number of volunteers serving in these programs during the prior fiscal year. Without a supplemental appropriations bill for fiscal year 1979, there will not be sufficient funds to implement the authorized stipend increase.

Broadened program eligibility for Foster Grandparents and Senior Companions.—Previous law restricted participation in the Foster Grandparent and Senior Companion programs to individuals age 60 and over who had incomes at or below the official poverty level.[5] In an effort to broaden these volunteer opportunities to more older Americans, Public Law 95–478 authorized participation by older Americans with incomes up to 125 percent of the official poverty level. Preference is retained, however, for those with the lowest income.

Reaffirmation of volunteer goals of RSVP.—Concern was expressed by spokesmen for the ACTION agency during reauthorization hearings that many retired senior volunteers were participating in programs which did not reflect areas of basic human needs. Testimony revealed an equal concern on the part of program participants that a change in program direction would tend to limit participation to low-income and minority elderly.[6] Public Law 95–478 includes language stipulating that RSVP volunteers are not "employees" for any purpose which the Director of the ACTION agency finds not to be fully consistent with the provisions and purposes of the Domestic Volunteer Services Act. The conference report accompanying the reauthorization bill reaffirms the intent of Congress that it is "not appropriate" to apply a means test for volunteers participating in the RSVP program.[7]

D. A Transfer to the Administration on Aging?

On February 28, 1978, Senators Domenici, Percy, and Brooke, of this committee, and Senators Dole, Schmidt, Bellmon, and Hatfield introduced S. 2609, a bill to extend and expand the Older Americans Act of 1965. S. 2609 contained a provision which would have trans-

[5] Title II of the Domestic Volunteer Service Act of 1973, as amended.

[6] Hearings before the Senate Subcommittee on Child and Human Development, "Domestic Volunteer Services Act Extension of 1978." Feb. 9, and 20. 1978. See also hearings on "The Older Americans Act of 1978," before the Senate Subcommittee on Aging, Feb. 1, 3, 7, and 8, and Apr. 21, 1978; and hearings before the House Subcommittee on Select Education. "Oversight on the Age Discrimination Act of 1975 and Extension of the Older Americans Act of 1965." Mar. 6, 13, and 20, 1978.

[7] House of Representatives, Report No. 95–1618, 95th Congress, 2d session. "Comprehensive Older Americans Act Amendments of 1978," conference report, Sept. 22, 1978.

ferred the OAVP from the ACTION agency to the Administration on Aging, effective September 30, 1978.

During reauthorization hearings, major national aging organizations recommended that the Older American Volunteer programs be transferred to the Administration on Aging, stressing the importance of improved coordination of all programs serving the elderly. Testimony was also presented, however, from program directors and participants which stressed the advantages of retaining administrative authority within the ACTION agency.[8]

Public Law 95–478 retains administration of RSVP, Foster Grandparents, and Senior Companions within the ACTION agency through fiscal year 1981. Conferees conditioned this provision, however, on the results of oversight hearings to be conducted early in the 96th Congress by the Senate Subcommittee on Child and Human Development and the House Select Education Subcommittee. Hearings are to assess ACTION's commitment to the Older American Volunteer programs and determine whether or not to transfer these activities to the Administration on Aging.[9]

The President's reorganization project, within the Office of Management and Budget, is also considering a transfer of these ACTION programs to the Administration on Aging as part of a broader study of possible options for reorganizing a number of human service programs now scattered between 10 Federal departments and agencies. A recommendation is not expected until 1979.[10]

E. Administration Fiscal Year 1980 Budget Request

The administrations budget request for fiscal year 1980 requested an increase of $3.1 million for the Retired Senior Volunteer Program, an increase of $1.1 million for the Senior Companion Program, and an increase of $5.8 million for the Foster Grandparent Program. The requested increases were to be used primarily for increases in volunteer stipends and administrative support, rather than program expansion.

II. COMMUNITY SERVICES ADMINISTRATION

Reauthorization of the Economic Opportunity Act of 1964, including a number of programs providing specialized services to the elderly, took place during 1978.

Programs of senior opportunities and services, community food and nutrition, emergency energy conservation and crisis intervention, and local initiative programs through community action agencies were reauthorized. Additional emphasis was placed on coordination with other Federal programs serving low-income elderly and on the expansion of community action agencies in rural areas.

A. Reauthorization of Economic Opportunity Act

Title II of the Economic Opportunity Amendments of 1978 [11] extended the senior opportunities and services, community food and

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[8] Hearings cited in footnote 6. Additionally, correspondence to Senator Frank Church, chairman, Special Committee on Aging, from Betty Herrman, president, National Association of Retired Senior Volunteer Program Directors.

[9] Report cited in footnote 7.

[10] Staff working paper, Human Services Study, President's reorganization project, Executive Office of the President, Office of Management and Budget, July 1978.

[11] Public Law 95–568, signed by the President on Nov. 2, 1978.

nutrition, emergency energy conservation, and community action agencies through fiscal year 1981. Funding levels for all title II programs were left to the discretion of the House and Senate Appropriations Committees. Appropriations for fiscal year 1979 were covered by a continuing resolution, based on fiscal year 1978 funding levels,[12] unless altered by a supplemental appropriations bill.

[In millions of dollars]

	Fiscal year 1978 appropriations	Fiscal year 1979 administration budget request	Fiscal year 1979 appropriation [1]
SOS	10.5	10.5	10
CFNP	29.5	22.0	30
Energy:			
EEC [2]	65.0	10.0	65
ECI	200.0		200

[1] Continuing resolution based on fiscal year 1978 funding levels, Public Law 95-482.
[2] Appropriations for fiscal year 1978 for emergency energy conservation activities ($65 million) were primarily for CSA's home weatherization activities. The low fiscal year 1979 budget request ($10 million) reflects a shift in all programs of home insulation and weatherization from CSA to the new Department of Energy. Authorization of DOE weatherization activities retained the emphasis on low-income elderly and handicapped, however, and increased funding was provided for an expanded national effort to insulate homes. (See "Developments in Aging: 1977", part 1, Senate Report 95-771, p. 47, and p. 165 of this report for further discussion of DOE weatherization authorization.) Even though the operational authority for weatherization activities was shifted to the Department of Energy, Congress retained a similar authorization for the Community Services Administration in order to preserve the emergency nature of the program. The full $65 million appropriation for fiscal year 1979, based on the continuing resolution, however, may not be fully utilized for weatherization activities in recognition of DOE activities in this area.

SENIOR OPPORTUNITIES AND SERVICES [13]

The Senior Opportunities and Services program, administered by the Community Services Administration, was designed to provide services to low-income elderly, primarily to individuals not being served by other Federal programs for the elderly. SOS also gives preference to the employment of low-income elderly as service providers.

During 1978, approximately 1 million elderly were served by SOS through transportation, outreach, and advocacy activities. In addition, the programs provided support to a number of statewide elderly advocacy organizations.

Reflecting increasing concern for more efficient coordination between the SOS program and other Federal social service programs for the elderly, the 1978 amendments added new language to require that SOS program, when feasible, utilize the direct services of other agencies serving the elderly poor.[14]

COMMUNITY FOOD AND NUTRITION

The community food and nutrition program serves as the base for programs of congregate meals, home-delivered meals, nutrition counseling, and food stamp outreach and assistance activities. Although CFNP services are available to all low-income individuals, a primary emphasis has traditionally been given to low-income elderly.

[12] Public Law 95-482, signed by the President on Oct. 18, 1978.
[13] See "Developments in Aging: 1978," part 2, for a more detailed report on SOS program activities during the year.
[14] Public law cited in footnote 11. See also House of Representatives. Report No. 95-1766 conference report, Economic Opportunity Amendments of 1978, Oct. 11, 1978.

Previous law had limited administration of the CFN program to local community action agencies. The 1978 amendments, however, also made public and private, nonprofit agencies eligible for program grants.[15]

COMMUNITY ACTION AGENCIES

Approximately 875 community action agencies provide a wide range of services to low-income individuals, including low-income elderly.

The 1978 amendments took a number of steps to strengthen and expand community action agency services in rural areas: [16]

—Removed a prior prohibition against establishment of a community action agency to serve a geographic area with a total population of less than 50,000;
—Authorized $15 million over 3 years for special poverty programs in rural areas; and
—Increased the Federal matching share for community action agencies from 60 percent to 80 percent.

B. Energy Crisis Intervention—A Confusing History

During the past 3 years, the Community Service Administration's programs of emergency energy assistance and weatherization of homes for low-income individuals have undergone considerable change. The program, authorized under section 222 of the Economic Opportunity Act of 1964, as amended, provides funds for weatherization of homes of low-income individuals, with priority given to low-income elderly and disabled. Authority is also provided for a portion of these funds to be used to help pay utility bills or purchase fuel for home heating in emergency situations, although most of the energy program appropriation had been used for the weatherization program. In 1978, however, weatherization activities were shifted into the new Department of Energy and CSA placed increased emphasis on crisis intervention and emergency payment of home heating bills.[17]

An exceptionally cold winter during 1976 and 1977, coupled with drastic increases in the cost of home heating fuels, prompted Congress to make a special appropriation of $200 million to be used for energy crisis intervention.[18] The funds were allocated to States according to a formula which took into account the number of low-income households in the State, the relative severity of the winter, and the relative costs of heating fuels. An additional factor was included to give special emphasis on distribution of funds to the low-income elderly. Funds were distributed to individuals with incomes at or below 125 percent of the official poverty level who could not meet payments on outstanding bills for home heating or who needed cash assistance to continue delivery of home heating fuels. The program set a maximum amount of cash assistance at $250 per household and payments went directly to utility companies and fuel suppliers. Approximately 2.6 million people received this aid during the winter of 1976–77.

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[15] Public law cited in footnote 11.
[16] Public law cited in footnote 11.
[17] Public Law 95–617 through Public Law 95–621 authorized transfer of home insulation programs to the Department of Energy. See footnote 2 of preceding table for detail.
[18] Public Law 95–26. Supplemental appropriations, fiscal year 1977.

A second severe winter, during 1977–78, led to a congressional appropriation of $200 million during fiscal year 1978.[19] For the second year, distribution of funds was limited to States in which the Director of the Community Services Administration designated an emergency situation and further emphasis was placed on providing assistance to low-income elderly. Individuals aged 60 and over with incomes at or below 150 percent of the official poverty level were eligible for assistance, as well as all elderly who participated in the supplemental security income program. Inability to pay outstanding home fuel bills was an additional eligibility criterion.

The supplemental appropriations bill making the second $200 million available for energy crisis intervention was not finally approved until March 1978, and the measure specified that all funds were to be distributed by May 1, 1978.[20] Even though the distribution period was only about 1 month, approximately $150 million was distributed to 2.7 million low-income individuals to pay delinquent fuel bills from the winter.

A court order subsequently extended the cutoff date for distribution of the fiscal year 1978 funds through March 1979. The funds remaining from the 1978 appropriation will be distributed to applicants eligible under the same 1978 guidelines.

For fiscal year 1979, the continuing resolution passed by Congress means that $200 million for energy crisis intervention will be made available during the winter of 1978–79. This is the third time that this funding amount has been provided.[21] Distribution guidelines have again been changed.

The future of the energy crisis intervention program is, at best, uncertain. The temporary, and emergency, nature of the program has caused delay, administrative problems, and congressional criticism.[22] Continuing threats to health and life in this and subsequent winters, however, have encouraged program extension.

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[19] Public Law 95–240, March 1978; supplemental appropriations, fiscal year 1978.
[20] Public law cited in footnote 19.
[21] Public law cited in footnote 12.
[22] See "Developments in Aging: 1977," part 1, for discussion of criticism.

CHAPTER IX

NEW INITIATIVES ON HOUSING AND COMMUNITY ISSUES

Adequate and affordable housing in safe and supportive neighborhoods is a primary need of America's elderly. A Department of Housing and Urban Development study [1] released in mid-1978 provided new data about the housing characteristics and problems of older households. That study, based upon the 1975 housing survey, reported:

—The elderly, who now represent 11 percent of the population, comprised 20 percent of all households—homeowners and renters. More than 14 million households were headed by elderly individuals, 65 years or older, while only 5 percent of all older Americans lived in institutions.

—Homeownership is widespread, with 70 percent of all older heads of households, and 82 percent of all elderly married couples, residing in their own homes. Nationally, the elderly comprise 21 percent of all homeowners and 17 percent of renters.

—Most of the 3.3 million elderly poor in 1975 owned their homes—1.9 million—while 1.4 million were renters. The elderly comprise a disproportionate share of all poor households.

—The housing occupied by the elderly is older, cheaper, and of slightly lesser quality than that occupied by younger households. Close to 1 million elderly resided in units falling below HUD's minimum standards.

—HUD considers a housing unit to fall within this category if it has at least two of the following four deficiencies: (1) Lack of adequate indoor plumbing and a complete kitchen, (2) overcrowding, this is almost nonexistent for elderly households, (3) structural problems and unreliable heating, plumbing, and electrical systems, and (4) location in an environment having excessive crime, trash and litter, noise, and blight problems, or lacking access to transit, shopping, and health services.

—In general, the elderly have lower out-of-pocket expenses for housing than younger persons. The absence of mortgage indebtedness makes this particularly true for older homeowners, as 51 percent of them own, free and clear, a house valued at more than $25,000.

—For many elderly, however, housing costs are a burden. About 1.1 million older homeowners with incomes under $5,000 devote more than 35 percent of income to shelter. Elderly women renters are particularly hard hit, with 56 percent paying more than 35 percent of income for rental units. *In total, about 2.8 million elderly households*—1.1 million owners and 1.7 million renters—*pay ex-*

[1] "Housing Options for the Elderly," by Irving Welfeld and Raymond J. Struyk, HUD Office of Policy Development and Research, July 1978. Statistics on housing characteristics taken from pp. 18–38.

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cessive (more than 35 percent) portions of their income for housing. Additional elderly households, while paying less, reside in the poorest quality housing.

During 1978, the Committee on Aging initiated a new series of hearings on neighborhood issues to examine the forces which place new pressures on older households and to study new methods, aside from traditional Federal housing programs, successfully to address the shelter needs of the elderly. The summary of a recent national symposium on "Community Housing Choices" provided compelling reasons to launch this study.

> Our country has devoted a large proportion of its effort in the area of housing to planned, clustered housing. The results have on the whole been deemed successful by experts, research workers, and users; perhaps 700,000 older people are currently being served by these efforts. The 20 million who are neither in institutions nor in planned housing have been far less well served. New construction of planned units can never accommodate the demand for improved housing among those willing to move. Even if enough new planned units were built, evidence is very strong that the majority of older people will sacrifice much to remain in a familiar neighborhood, to spin out their lives in a home to which they are symbolically and affectively attached, or to avoid the perceived stress of change. Currently, planned housing in its usual age-segregated form meets the needs of a substantial number of elderly, but the majority prefer continued residence in "normal" communities. Because of this majority's preferences, it is clearly time for our previous disproportionate emphasis on planned housing for the elderly to become balanced with proportionate concern for those who wish to maintain their lifestyle in ordinary communities.[2]

The 1978 Housing Act included two new neighborhood-oriented initiatives, reauthorized other programs of benefit to older households, and established a new congregate services program for the frail elderly residents of federally assisted housing. The Committee on Aging, in other actions, issued a new report on the problems of elderly residents of single-room occupancy (SRO) facilities, and held field hearings focusing on the problems encountered by retirees choosing condominium residences. The Federal Home Loan Bank Board also authorized the availability of a new mortgage instrument which can provide older homeowners with a new source of income based on their accumulated home equity.

I. THE 1978 HOUSING ACT

The Housing and Community Development Amendments of 1978[3] contain many provisions which should be of assistance to elderly households and their neighborhoods. They include:

Section 312 rehabilitation loans.—An authorization of $245 million is provided for the continuation of this low-interest loan program.

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[2] "Community Housing Choices for the Elderly: An Early Summary of Program and Policy Suggestions," Philadelphia Geriatric Center, May 1978, pp. 3–4.

[3] Public Law 95–557, enacted Oct. 31, 1978.

Low- and moderate-income owner-occupants, and low- and moderate-income tenants in multifamily housing are to be the primary beneficiaries of the section 312 program. Interest for loans may rise above 3 percent when extended to households earning more than 80 percent of area median income.

Urban development action grants.—In selecting applicants for this innovative urban upgrading portion of the community development block grant program, the Secretary must now evaluate the impact of the proposed UDAG project on the low- and moderate-income tenants of the target neighborhood.

Financial assistance to troubled housing projects.—In order to promote the fiscal soundness and improve the management of federally assisted public housing projects, $74 million is authorized for operating subsidies in fiscal 1979.

Section 202 housing.—New language requires that the governing board of any nonprofit corporation assisted under this low-interest loan program for elderly and handicapped housing must be selected to assure significant representation of community views. This provision, while intended to increase the involvement of local residents in the development and operation of section 202 projects, will not preclude the participation of national nonprofit organizations in the program.

Public housing security demonstrations.—In response to the threats to life and property afflicting low-income and elderly tenants of public housing, $12 million is authorized for demonstration projects, during fiscal 1979, for the development and evaluation of anticrime methods for such projects and their surrounding neighborhoods. In order to derive maximum benefit from this new program, preference will be given to proposals stressing coordination with other Federal agencies. The HUD Secretary is required to report to the Congress on the results of the program within 18 months after enactment, and to make appropriate legislative recommendations.

Homeownership expansion demonstration.—The Secretary is authorized to undertake demonstrations to determine the feasibility of expanding homeownership opportunities in urban areas through the conversion of multifamily buildings to condominiums and cooperatives.

Rural rehabilitation assistance.—The section 504 program of low-interest rehabilitation loans to rural households received an authorization of $48 million for fiscal 1979.

Congregate housing services.—Title IV of the bill, the Congregate Housing Services Act of 1978, establishes a new program of services for frail elderly and younger handicapped residents of public and section 202 housing, in order to promote independence and prevent unnecessary institutionalization. The full history and provisions of this title are set forth later in this chapter.

Neighborhood Reinvestment Corporation.—Title VI of the act establishes the Neighborhood Reinvestment Corporation to carry on the innovative neighborhood conservation programs of the urban reinvestment task force through the neighborhood housing services (NHS) program. An authorization of $12.5 million is set for fiscal 1979.

Neighborhood self-help development.—A new program of grants and assistance for qualified nonprofit neighborhood organizations is

established by title VII of the act, to assist with housing and revitalization projects in low- and moderate-income neighborhoods. Authorizations of $15 million each were set for fiscal years 1979 and 1980.

Livable cities.—Title VIII of the bill contains another new program for neighborhood organizations. Authorizations of $5 million for fiscal 1979, and $10 million for 1980, are provided for projects having substantial artistic, cultural, and design merits which can help to revitalize communities and enhance civic identity and pride.

Displacement study.—The Housing Act declares that the Federal Government, in its housing and community development programs, should minimize the involuntary displacement of people from their homes and neighborhoods. In addition, the HUD secretary is required to undertake a study on the nature and extent of the displacement problem, and to report her findings to Congress by January 31, 1979, along with recommendations for the formulation of a national policy to minimize displacement due to both public and private development.

In sum, the Housing and Community Development Amendments of 1978 evidence an increasing Federal concern about the stabilization and revitalization of neighborhoods, and a commitment—through the reauthorization and expansion of existing programs, and the creation of new tools—to facilitate these goals while minimizing the adverse effects for low and moderate income residents.

II. CONGREGATE HOUSING SERVICES

As noted, title IV of the 1978 housing act—the "Congregate Housing Services Act of 1978"—provides assistance for meals, housekeeping assistance, and personal care for disabled or frail elderly and younger handicapped residents of public housing and section 202 projects. The title is largely based on legislation introduced on March 8, 1978, by Senator Harrison A. Williams, Jr., Senator Frank Church,[4] and Senator Pete V. Domenici. Senator Church stated:

> This bill is but one part of the emerging strategy . . . for the extension of services to the frail elderly to help keep such persons in their homes and out of nursing homes and other institutions.
>
> The need for such innovative and effective means is great now and will continue to grow . . . between now and the year 2000, the number of Americans between 65 and 75 will increase by 23 percent, but the number who are between 75 and 85 will increase by 57 percent . . . it is precisely this segment of the elderly which is likely to need some assistance to maintain independent lives within their own residences. Without this assistance, they are likely to be institutionalized unnecessarily and prematurely, at great psychological harm to them and great expense to the government. . . .
>
> The Federal share alone for the annual maintenance of a low-income elderly person in a nursing home currently stands

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[4] Additional Committee on Aging members cosponsoring at introduction were Senators Lawton Chiles, Edward Brooke, Dennis DeConcini, and John Glenn. On July 20, 1978, during Senate debate on the 1978 housing act, Ranking Minority Member Domenici introduced an amendment, which was adopted, adding section 202 housing as eligible for congregate services. Additional Committee on Aging cosponsors of the amendment were Senators Church, Chiles, Brooke, Percy, and DeConcini.

at $5,500 under the medicaid program. In contrast, by subsidizing the difference between the cost of supportive services and the ability of elderly . . . residents to pay for them, this bill can sustain independence at a cost of approximately $1,000 annually.

The Congregate Housing Services Act will finally implement housing law enacted in 1970 by providing a missing element—the availability of long-term financing for comprehensive service packages. . . . Hearings held by the Special Committee on Aging in 1975 revealed that only a handful of congregate public housing facilities had been established across America. That situtation remains unchanged today.[5]

Senator Domenici, ranking minority member of the committee, introduced an amendment which authorized congregate services for section 202 housing participants. Senator Domenici stated:

HUD programs could be instrumental in meeting the spectrum of needs of the elderly if they were broadened to incorporate basic congregate services in housing serving the elderly. Presently, the section 202 program, while intended to specifically serve the elderly and handicapped, falls far short of its potential.

We must consider the needs of elderly and handicapped persons residing in section 202 funded projects. In order for these individuals to remain in their homes and continue to live as independently as possible, it is necessary that they be provided with supportive services consistent with their needs. For the program to be a truly effective governmental effort, it is important that congregate services be available within the context of the program.

Hearings, chaired by Senator Williams, were conducted in the Senate Subcommittee on Housing and Urban Affairs on April 13, 1978. Strong support for the legislation was voiced by gerontology specialists, national aging organizations, and housing officials.[6] John Martin, testifying on behalf of the American Association of Retired Persons/National Retired Teachers Association, stated:

Every test we've made shows that older people do not want to go to nursing homes unless there is absolutely no alternative. . . . The National Housing Act of 1970, which led in the direction of congregate housing, produced no results. . . . The result has been that there has been a steady drift into nursing homes, largely because there were no alternative services. . . . S. 2691 appears to us to be a very good and innovative approach to this whole problem.

A spokesman for the National Association of Housing and Redevelopment Officials characterized the bill as "equal in importance to the pioneering legislative provisions of 1956 which first authorized the admission of single elderly persons into public housing." And Perfecto Villarreal, executive director of the San Antonio, Tex., Hous-

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[5] Congressional Record, Mar. 8, 1978, p. S3256.

[6] "Strong Support for the Congregate Housing Services Act," a statement by Committee Chairman Frank Church summarizing the testimony presented at the hearing, appears in the May 1 Congressional Record at p. S6616.

ing Authority, provided a special perspective on the need for the legislation:

> The two primary reasons for our people moving out of housing for the elderly is either because they die, or they are forced to move to a nursing home. . . . The cost in both human and monetary terms of not taking action to stem this tide of elderly evictions is too great . . . in San Antonio, the nursing home expense varies from $25 to $50 per day . . . many elderly persons are forced to live in San Antonio State Hospital because there is no housing available which provides a basic package of support services. The average daily cost for caring for a person in the State hospital is $59. . . . I estimate that providing a good basic package of supporting services in San Antonio would cost from $2 to $5 a day. . . . The monetary savings of a congregate housing program to the taxpayer would be very, very substantial.

As enacted, the Congregate Housing Services Act contains the following major provisions:

—The HUD Secretary is authorized to enter into 3- to 5-year contracts with public housing authorities and nonprofit section 202 sponsors for the provision of congregate services.

—Applicants are required to afford local area agencies on aging an opportunity to participate in the determination of the means of providing services, and to review and comment upon applications for funding prior to their submission to HUD. This provision is meant to encourage the coordination of housing and human service programs at the local level.

—Eligibility of residents for appropriate services will be determined by a professional assessment committee including qualified medical experts.

—The HUD Secretary is required to submit an annual report to the Congress evaluating the impact and effectiveness of assisted congregate services programs.

—New employment opportunities are provided for elderly project residents to participate in the provision of assisted congregate services.

—A 4-year authorization is provided: $20 million for fiscal 1979, $25 million for 1980, $35 million for 1981, and $40 million for 1982.

The Congress made an initial appropriation of $10 million to implement the congregate services program in 1979. HUD anticipates that guidelines for the program will be finalized by the spring of 1979, and applications will be processed and selected for funding by the end of the summer. This initial appropriation will provide approximately $1.8 million annually for 5-year service contracts; the act requires that 10 percent—$1 million—be held in reserve for supplementary adjustments. HUD estimates that from 50 to 75 demonstration projects can be initiated at this funding level.

III. INQUIRIES INTO CHANGING NEIGHBORHOOD DYNAMICS

The 1978 housing act's increasing emphasis on programs which assist in revitalizing neighborhoods and rehabilitating existing housing stock acknowledges that the housing and community needs of Americans cannot be met by new construction alone. This is particularly true for older Americans, because 70 percent of all elderly households own their own homes and need assistance primarily in the areas of maintenance, and financial relief from rising property taxes and utility bills. A November 1978 report on "Neighborhood Conservation and the Elderly," [7] funded by the Administration on Aging, found that most elderly prefer a home in a familiar neighborhood—even a deteriorating neighborhood—to a new unit in unfamiliar surroundings. The trauma which accompanies the involuntary displacement of older individuals is of such a high degree as to merit consideration of special treatment for older residents confronting increasing housing pressures.

In December 1978, the Committee on Aging began a new series of hearings on "Older Americans in the Nation's Neighborhoods." Senator Dennis DeConcini, who presided at the opening inquiries in Washington, D.C., and Oakland, Calif., outlined the committee's interest in this area:

> Federal and private urban renewal efforts are having positive effects in many neighborhoods of this Nation. These new signs of city renaissance are welcome, but redevelopment activities can create new problems for existing neighborhood residents—and particularly for elderly homeowners and renters, who are least able to adjust to forced relocation or to cope with rising rents, property taxes, and maintenance costs.
>
> Mr. Rolf Goetze, director of housing revitalization at the Boston Redevelopment Authority, sums up the peril and promise of the new neighborhood efforts in a recent report prepared for the Department of Housing and Urban Development (HUD), "Stabilizing Neighborhoods: A Fresh Approach to Housing Dynamics and Perceptions." He states:
>
> "Most know of the baby bulge, the large number of children born between 1940 and 1965 . . . At each turn, accommodating this bulge has strained the system.
>
> "But even more drama is in store for the period from 1975 to the year 2000, because during this period 16 percent more than normal will seek to come to roost. The stresses this will cause are hard to visualize in advance. Those who have spent the last twenty years fighting blight will be unprepared.
>
> "When the tidal move of new households engulfs urban areas, most of the existing housing supply will be brought into place because the Nation simply cannot produce enough housing in the next fifteen or twenty years to meet the new demand.
>
> "For policymakers, the implications should be clear. The last twenty years can be characterized as the period when problems of urban blight caused special stress; and the com-

[7] This report, authored by Senior Associate Phyllis Myers, is available from the Conservation Foundation, 1717 Massachusetts Avenue N.W., Washington, D.C. 20036.

ing twenty years as the period of rediscovery, speculation, and dislocation. Lest we confuse this with the Biblical image of lean years followed by years of plenty, we must realize that coming events can bring with them a full measure of trauma, particularly for existing residents.

"Revitalizing neighborhoods offer an unprecedented opportunity to maintain diversity if appropriate public policies are pursued . . . public policies must actively foster a better partnership with the residents and the private sector."

Shortcomings in available data leave us unable to accurately gage the nationwide extent of neighborhood revitalization activities and their long-term prospects, but growing anecdotal evidence suggests that such activity is on the rise nationwide. The National Urban Coalition's August 1978 report, "Displacement: City Neighborhoods in Transition," said its 44-city survey showed:

"A combination of circumstances . . . has created an uneven but definite inmigration of middle-class homeowners and renters who are taking up residence in city neighborhoods that they and financial institutions once shunned. . . . The benefits of a strengthened tax base and of some gains in residential and commercial revitalization are clashing with the deprivation, frustration and anger of those who are becoming the new urban nomads. . . .

"The elderly are the most often displaced." [8]

Senator DeConcini also observed that the same features which make neighborhoods attractive to newcomers—public transit, close proximity to stores and services, and special local character—make them excellent locales for residence by the elderly. He noted that "rethinking is also needed in the public and private sector if market dynamics are to benefit whole cities rather than select areas."

In his opening statement at the Washington hearing, the Senator noted: "healthy neighborhoods are a prerequisite for healthy cities . . . at a time when renewed interest, and new capital, is conserving the physical resources of neighborhoods, equal attention must be paid to their human resources." Declaring that the implications of new reports of shifting urban investment patterns and ensuing displacement "are more than academic matters for older Americans," he continued:

> More than half of America's elderly reside in urbanized areas; a full one-third reside in central cities.
>
> For the 7 out of 10 older Americans who own their own home, will these changes bring enhanced equity, better municipal services, and lowered crime on the streets?
>
> Or will it bring agonizing choices as speculation results in skyrocketing property taxes, or even in displacement as code enforcement is stiffened? For the 30 percent of the elderly who rent, will escalating prices or condominium conversions force them out of long-occupied dwellings and into more affordable, but less desirable, parts of the city?

[8] Saving the Cities: For Whom?"; statement of Senator Dennis DeConcini Congressional Record, Oct. 11, 1978, p. S18261.

. . . How can we continue to maintain the diversity of age, economic status, and ethnic background that are drawing so many of the urban pioneers back into the hearts of our metropolitan area?

Witnesses at the opening hearing generally concurred on the following key points:

—Altered urban dynamics and long-term demographic and economic trends were resulting in increased displacement of low-income persons, particularly the elderly. However, much more data is required to fully gage the extent of this problem and its specific impact on older individuals.

—Reinvestment in urban neighborhoods can have positive effects for cities and elderly residents. But both public policy and market perceptions must change if benefits are to be spread and speculation is to be discouraged.

—The aging network established under the Older Americans Act could play a vital role in assisting elderly residents through the coordination of rehabilitation assistance and other services promoting neighborhood revitalization.

—Successful efforts to stabilize and revitalize neighborhoods are most often developed by local government and community organizations. The Federal Government can best assist these efforts by refraining from massive programmatic responses, providing instead technical assistance and modest grants of funds.

—While HUD is shifting the emphasis of portions of its housing and community development programs to small-scale targeted activities, the most successful neighborhood assistance effort to date has been the Neighborhood Housing Services (NHS) program operated by the Urban Reinvestment Task Force (now transformed to the Neighborhood Reinvestment Corporation by title VI of the 1978 housing act). NHS has operated best in neighborhoods whose housing stock requires maintenance but is essentially sound. The program is based on the strong participation of residents, community groups, and representatives of municipal government and local financial institutions. The elderly have been most active in NHS, both as community proponents and assisted households. A high-risk revolving loan fund to meet the needs of residents, such as the elderly, who generally cannot meet commercial credit requirements; and the offering of rehabilitation counseling, construction monitoring, and related services, are the key ingredients of the NHS strategy.

California Testimony

A followup hearing in Oakland, Calif., focused on the particularly severe housing pressures in the San Francisco Bay area. In San Francisco, more than 17,000 elderly now reside in the crime-infested "Tenderloin," a downtown area whose low-priced hotels are also frequent arson targets. And, in Chinatown, real estate speculation fueled by foreign capital is replacing already insufficient housing stock and neighborhood businesses with stores and services for the tourist trade. A representative of the Chinatown Neighborhood Improvement Resource Center—recipient of a HUD grant for the study of means to improve housing conditions without creating massive

displacement—testified that, although the neighborhood contains some of the most substandard housing in the United States, continued occupancy in this ethnic enclave is essential to the survival of Chinese elders.

I. Donald Terner, director of housing and community development for the State of California, testified that the combination of fixed incomes and rising shelter costs have produced a situation where more than two-thirds of the State's elderly now pay more than one-quarter of income for housing. He also noted that many landlords, fearing rent control initiatives in the wake of the successful passage of the "proposition 13" property tax reduction measure, were rushing to convert rental properties to condominiums. He cited a number of instances in which the trauma of forced moves due to conversions had resulted in physical deterioration or even death for older tenants.

The committee is considering a continuation of its "neighborhoods" hearings, including closer scrutiny of the condominium conversion issue, during 1979.

IV. REPORT ON SRO QUARTERS

In cities large and small across the Nation, single-room occupancy hotels (SRO's) provide low-cost shelter to tens of thousands of elderly. These facilities are often located in areas—such as San Francisco's "Tenderloin"—which offer good access to transit and social services, but also present many dangers.

In August 1978, this committee released an information paper [9] on these "invisible elderly" who occupy SRO's.

Committee on Aging Chairman Frank Church, and ranking minority member Pete Domenici, commented on differing characterizations which have been made of these older individuals:

> Some have painted SRO's as the final home on skid row for society's misfits, the transient loners and drifters who have not so much retired as have simply become cut off from even marginal employment. Others picture SRO's as a hospitable environment providing friendship, access to services, freedom, and a superior alternative to the nursing home for those who, for reasons often beyond their own control, have fallen to the bottom rungs of a society which cares little for the aged.

The paper presents a summary of what is known about SRO's and the Federal policies which affect them. Specific legislative recommendations for providing tools for upgrading SRO's, in order to provide a decent housing option in revitalized neighborhoods for those elderly who prefer this lifestyle, are being considered in the context of the committee's "Neighborhoods" hearing.

V. HEARINGS ON CONDOMINIUMS

While condominium conversions are creating problems for some elderly tenants, this form of residence has many attractions for older

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[9] "Single Room Occupancy: A Need For National Concern," an information paper prepared for use by the Special Committee on Aging, June 1978.

Americans. In a time of rising housing prices, condominium ownership offers retirees a means of accumulating equity while maintaining relatively stable maintenance costs. Further, many condominiums offer amenities which would otherwise be beyond the means of older consumers.

While virtually unknown in the early sixties, there are now more than 2 million condominium units housing 5 million Americans—and many experts predict that condominiums will constitute at least half of all new housing construction by the mid-1980's. Older Americans and young marrieds have been the two demographic groups most attracted to this housing form.

The lack of uniform national standards for consumer protection and disclosure in condominium sales is a problem, however—particularly for those elderly who, upon retirement, move across State lines to senior communities. Committee on Aging member Lawton Chiles cosponsored "The Condominium Act of 1978," [10] legislation drafted by a special HUD task force designed to establish such minimum national safeguards, and to encourage States to enact stricter protections, while holding paperwork burdens for developers to a minimum. That bill did not receive hearings in either the House or Senate during the 95th Congress, but it will be reintroduced in the 96th, and prospects for Banking Committee consideration appear improved.

Florida Hearings

In November 1978, the Committee on Aging held field hearings on "Condominiums and the Older Purchaser" in Hallandale and West Palm Beach, Fla. Senator Chiles, in his opening statement, outlined the advantages which condominiums could offer the elderly, the need for Federal standards, and the objectives of the hearings:

> Today's hearing on "Condominiums and the Older Purchaser" is undertaken in the belief that condominiums and other new forms of residence ownership will be chosen increasingly by the growing ranks of older Americans. Despite the problems which characterized the early years of Florida's condominium industry, the 1975 HUD condominium/cooperative study found that 96 percent of south Florida unit owners were either satisfied or very satisfied with the condominium lifestyle, and that more than 70 percent would again purchase a condominium if they could choose again. Clearly, condominium living can offer good housing, recreational opportunities, and a potential for community self-management and social interaction which is attractive to retirees, and well within the means of many....
>
> Florida is in the forefront of condominium construction, and is unique in the percentage of retirees occupying those units. Florida now has one of the Nation's exemplary condominium laws. However, this body of law was not developed to forestall difficulties but came as a result of abusive practices, carried out by a destructive minority within the devel-

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[10] S. 2919, introduced Apr. 13, 1978. Senator Chiles' remarks at introduction appear in the Congressional Record at pp. S5538–40.

opment industry; at one point threatening not only the savings and well-being of purchasers, but the entire condominium industry. . . .

In one specific area, the "Condominium Act of 1978" would offer substantial relief to tens of thousands of older Floridians who have been unduly victimized. This is in regard to the abusive practice of escalating, 99-year leases for recreation facilities. . . .

These contractual arrangements are intolerables.

Purchasers were unaware of them and had no power to negotiate and modify them.

They extend far beyond the useful life of these recreational facilities and reimburse developers many times over for their costs.

And, due to escalation clauses tied to the consumer price index, they threaten to rob elderly residents of their dignity and their life savings, and even to destroy the fiscal stability of the condominiums they occupy. . . .

Today's hearing has a wider purpose beyond an examination of the need and specific form of Federal condominium legislation. We want to consider such questions as:

How are retirees coping with the self-management responsibilities, often of enormous proportions, in multi-million-dollar projects?

What effect is inflation having upon older residents who have retired on fixed incomes and anticipated relatively stable residential expenses as one of the chief benefits of condominium living?

And, with the conversion of rental units to condominiums on the rise both in Florida and nationwide, is enough being done to protect the interest of both long-term renters and new purchasers?

Finally, we will inquire into whether sufficient thought and planning is being directed to meeting the present and future needs of aging condominium populations.

Testimony received at the hearings indicated that the burden of long-term escalating recreation leases on residents of projects built prior to prohibitive State laws was the greatest burden and threat for affected elderly residents. Instances were cited of exorbitant returns to developers—in one instance, a facility which cost $200,000 to construct had returned more than $300,000 in fees in its first year of operation and, given an average inflation rate of 5 percent annually, could be expected to return $700 million to the developer over its 99-year term. Some unit owners associations are attempting to "buy out" their leases, but again face abuses—one developer is asking $31 million for a 10-year-old facility constructed at a cost of $750,000. Assistant Florida Attorney General Thomas Pflaum, assessing the future impact of these contractual arrangements on the accumulated equity of tens of thousands of retirees and the fiscal soundness of their residences, concluded:

The economics of the situation are impossible. In the cases that I have handled, the rent under the leases has doubled,

> gone up 100 percent in 5 years, and it probably will do so again. That bubble is inconceivable, it simply can't continue to grow.

Other witnesses described additional problems which have afflicted older consumers, including shoddy construction, misuse of deposits, deliberate underestimating of monthly operating assessments, and incomprehensible legal documents. Rod Tennyson, a West Palm Beach attorney, cited the need for further investigation of the "company store concept," whereby developers reserve for themselves the exclusive right to provide insurance, cable television, management, vending and laundry machines, and garbage collection and exterminating services, through self-dealing contracts secured by liens on each condominium unit.

Withdrawal of services, or their absence, is an additional problem. Lucille Stang, a resident of Lauderdale Lakes, Fla., recalled how the availability of a courtesy transportation service played a major role in her decision to purchase her condominium. But, she recounted, "After the developer sold the last unit, they moved out the buses."

Nan Hutchinson, director of the Broward County Area Agency on Aging, testified that a lack of local planning and sufficient funds had resulted in thousands of elderly in outlying condominium developments being without adequate transit, social services, and commercial facilities.

These hearings, and continuing committee attention to the condominium issue, will be utilized to demonstrate, in Senator Chiles' words, that "uniform national standards and access to the Federal courts are essential if retirees moving to other States are not to suffer the same agonies that took place in Florida before adequate minimum State laws were enacted.[11]

VI. REVERSE MORTGAGES APPROVED

Although a majority of America's elderly own their own homes, traditional mortgage instruments and discriminatory lending practices have made it difficult or impossible for them to utilize this accumulated and appreciating equity as a source of additional income. In the past few years, a small number of State-chartered lending institutions have begun offering so-called "reverse annuity mortgages" (RAM's) which permit older homeowners to convert part of their home equity into a steady, reliable flow of income.

On June 12, 1978, Committee on Aging Chairman Frank Church wrote to Robert McKinney, Chairman of the Federal Home Loan Bank Board, to advise him "of the strong support which the reverse annuity mortgage concept has received from this committee's membership" and to urge that they be made available on a nationwide basis with adequate consumer safeguards. This action followed a statement made on the Senate floor by Chairman Church, in which he outlined the usefulness of this new mortgage instrument and the types of protections required:

> Most older Americans do not live in Government-aided housing but in the community at large. About 70 percent own

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[11] Congressional Record, Jan. 29, 1979, p. S809.

their own homes, which are generally free and clear of debt. The total equity they have built up in their dwellings is estimated to be at least $90 billion. Despite this illusion of wealth, older Americans are faced by shelter problems which may be building toward crisis proportions. Rising property tax assessments, higher fuel costs, expensive maintenance requirements, and general inflation, all combine to produce a need for additional income.

Yet the elderly's "home equity" is usually unavailable to them unless they are willing to sell the homes they worked so hard to buy. Persons over 65 cannot obtain a 20- or 30-year traditional second mortgage. The only options open to many older homeowners are forced sale, doing without necessities, or forgoing home maintenance.

This need not be the case. The Federal Home Loan Bank Board (FHLBB) has extensively studied a proposed new mortgage instrument, known as the reverse annuity mortgage (RAM). RAM's permit the older homeowner to convert part or all of his home equity into a series of monthly payments. Certain types of RAM's also provide insurance against the outliving of one's resources. In effect, the operation of a RAM is like a normal annuity, with a savings and loan institution making a loan, secured by the home, to purchase the annuity. The annuitant's estate would be responsible for settling that debt in probate.

RAM's have been available in England for over a decade, and are permitted in other European nations. It is high time that this means of helping the elderly to help themselves—and of redressing the discrimination they currently face in the mortgage market—be authorized in the United States. FHLBB's studies reached the conclusions that RAM's "can provide a fundamental financial service of major social significance," "are entirely feasible," and face complications "of form rather than substance."

. . . The FHLBB should be required to approve and regulate RAM's under statutory language specifically assuring adequate safeguards for older homeowners. In particular, sufficient and understandable information must be furnished to the prospective purchaser, and interest must be calculated in a reasonable manner.[12]

In August 1978, the Senate Committee on Banking, Housing, and Urban Affairs held hearings on several new mortgage instruments proposed for availability by the FHLBB, including RAM's. Chairman McKinney testified:

For older homeowners with substantial equity who are looking to supplement their monthly incomes, the reverse annuity mortgage would be attractive. . . . In principle, a RAM may be tailored to fit almost any individual's objectives or needs . . . the homeowner retains the same rights of ownership, use, and possession as any other mortgagor. The equity retained . . . allows the homeowner to enjoy any

[12] Congressional Record, May 18, 1978, p. S7767.

increases in the property's value, encourages maintenance of the property, and may be used for bequests at death.

However, he concluded:

> As a general rule, RAM's could be expected to entail more careful counseling and planning and occasionally much more involved calculations than any other form of mortgage if the best buy is to be obtained for the homeowner.

On December 14, 1978, the FHLBB authorized the more than 2,000 Federal savings and loan associations to begin offering a number of new mortgage instruments, including RAM's. Because of the wide variety of forms which RAM's can take, the FHLBB will approve associations' applications to offer this financial service on a case-by-case basis. However, in all instances, consumers must receive full disclosure of the terms and costs of the mortgage; the interest rate for the entire term of the RAM must be fixed; and the homeowner retains the right to refinance the RAM at its expiration.

CHAPTER X

TRANSPORTATION: SLOW PROGRESS TOWARD BETTER MOBILITY

Adequate, appropriate, and affordable transportation remains a continuing need for many older Americans. Diminished physical abilities, combined with the ever-increasing costs of maintaining a private automobile, cause many elderly persons to forsake driving as their principal mode of transit. At the same time, improved transportation services are needed if the elderly are to continue to live independently and have access to suitable social services programs.

During 1978, a major step was taken to continue and improve Federal support for public transportation with the enactment of a comprehensive reauthorization of highway and mass transit programs. Questions concerning the implementation of the "Transbus mandate" were resolved, assuring that full-sized buses purchased in the future with Federal assistance would be fully accessible to the elderly and handicapped. However, debate on the accessibility issue shifted to the means by which the Department of Transportation will comply with section 504 of the Rehabilitation Act.

Insurance costs and accessibility problems for special transportation services—which were brought to public attention by 1977 Senate Committee on Aging hearings—seemed closer to resolution as a White House task force joined the search for solutions. Legislation setting Federal no-fault auto insurance requirements, however, was deferred.

I. THE NEW FEDERAL TRANSPORTATION BILL

Faced with ever-increasing usage of mass transit[1] and a growing need for new funds to maintain and improve these services, the Congress passed, in 1978, a combined transit and highway bill[2] which authorized $16.4 billion in public transportation aid for fiscal years 1979–83.

A. Senate Action

The Senate, in developing new transit legislation, adopted a modified version of the bill advanced by the administration: the Federal Public Transportation Act of 1978 (S. 2441). This bill strengthened transportation planning and encouraged improved coordination of highway and transit programs, simplified funding categories while permitting recipients to exercise greater flexibility in the use of as-

[1] The Senate Committee on Banking, Housing and Urban Affairs, in its report on the Federal Public Transportation Act of 1978, noted: "Since 1973, total ridership has increased by almost half a billion riders annually, accounting for a 10-percent increase over that period." S. Rept. 95–857, p. 4. More recent figures indicate a continuation of that trend, with ridership for the first 10 months of the 1978 up 5.5 percent over the total for the same period in 1977; New York Times, Dec. 19, 1978, p. D22.

[2] H.R. 11733, Public Law 95–599, enacted Nov. 6, 1978.

sistance, and established a predictable funding mechanism for routine captial and operating needs.

In addition, a new formula grant program for small urban and rural areas was attached to the bill to foster more effective transit services in these areas. The report of the Committee on Banking, Housing, and Urban Affairs explained:

> . . . a program of capital assistance alone for these areas was insufficient to encourage the development or improvement of public transportation services. Without the availability of operating assistance, few communities were interested in applying for vehicles that the communities could not afford to operate. . . . The committee believes that a separate program can be particularly effective in focusing both Federal and local attention on the need to promote public transportation in small urban and rural areas. . . . The committee wishes to stress the need for the development of coordinated transportation programs in these areas. Many programs sponsored by different Federal agencies . . . provide transportation services to meet various social service and other needs. Coordination of these services, especially in rural areas, will provide a much more effective network of transportation services. Also, a reasonable portion of funds apportioned under this program should be used to promote the development of appropriate public transportation services on or serving Indian reservations.[3]

The Senate bill also ended the separate permissive set-aside for special transportation services for the elderly and handicapped—the so-called 16(b)(2) program. However, the committee report emphasized that such activities would continue to be eligible for funding from the urban formula grant program; that it was intended that the Secretary of Transportation issue guidelines to insure that the 16(b)(2) program continue as a distinct and adequately funded program;[4] and that such special services would be eligible for funding, including operating expenses, under the new rural and small urban funding program.[5]

B. Revisions in Conference

Title III of the Surface Transportation Assistance Act of 1978, the highway-transit bill agreed to by House and Senate conferees, substantially restructures and simplifies the funding mechanisms for

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[3] S. Rept. 95–857, p. 25. Administration on Aging Information Memorandum No. 78–30, transmitted to State agencies administering Older Americans Act programs on Apr. 7, 1978, advised them of General Accounting Office suggestions for improving the coordination of special transportation services.

[4] Early in 1978, in order to assess the effect of the administration transit proposal upon services for the elderly and to assure that 16(b)(2) activities would not be diminished under the revisions. Committee on Aging Chairman Frank Church and Ranking Minority Member Pete Domenici dispatched a number of questions to Transportation Secretary Brock Adams. That text and the Secretary's reply, are contained at pp. 267–71 of "Developments in Aging: 1977"

[5] During Senate debate on S. 2441, Committee on Aging Chairman Frank Church and Senator Harrison A. Williams, Jr., engaged in a colloquy concerning the effect of the reauthorization bill on the transit needs of the elderly. Congressional Record, Sept. 28, 1978, pp. S16410–412. The Senators agreed that adequate levels of support for special and rural transit programs were a continuing necessity.

mass transportation services, although not in as sweeping a manner as set out in the Senate version.

The Senate action terminating the separate set-aside for 16(b)(2) special transit activities was deleted by the conferees. Instead, these services will continue to be funded at a level of up to 2 percent of the discretionary grant program; providing potential levels of assistance of $27.5 million in fiscal 1979, rising to $32 million in fiscal 1982, for the capital purchase costs of special transit vehicles.

For rural and small urban areas, the conferees agreed to a new formula grant program for the development and support of coordinated transit services. Report language specifies that Indian reservations should receive a fair and equitable portion of funding; that eligible recipients include public bodies and nonprofit organizations; and that the Transportation Secretary should develop simplified regulations which facilitate rapid rural transit development with a minimum of redtape. Authorization levels for the new program start at $90 million in fiscal 1979, and rise to $105 million in fiscal 1982.

The Federal commitment to expanded and coordinated public transportation services in both urban and rural areas, exhibited in this reauthorization legislation, should help to better meet the needs of America's elderly. However, while the 16(b)(2) capital purchase program was continued at increased funding levels, questions persist as to the availability and adequacy of operating funds for such special transportation.

Further revision of Federal transportation aid is possible during the 96th Congress: Secretary Adams has indicated that he would like to consolidate the separate highway and mass transit programs within a reorganized Department of Transportation. It is not yet clear whether this goal will be achieved through legislation or an executive reorganization.[6]

II. THE ISSUE OF BARRIER-FREE ACCESS

Because many older persons suffer from physical limitations,[7] it is important to them that public transportation vehicles and facilities be designed in a manner which facilitates their use. During 1978, a compromise was reached concerning Secretary Adams' ruling of the prior

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[6] Washington Post, Nov. 10, 1978

[7] A new report issued by the Urban Mass Transportation Administration (UMTA) provides a better picture of the "Transportation disadvantaged"—those individuals who, while not homebound, have physical problems which result in their having difficulty in using public transportation. UMTA's national study found that there were 7.44 million transportation handicapped individuals in the urban United States, representing 12.1 percent of all urban households.

The elderly comprise a large portion of this group. "The typical transportation handicapped person: Is older (47 percent are 65 and over; 67 percent are 55 and over); has multiple physical problems which create more difficulty in using public transportation than a person without those problems; and has demographic characteristics that are associated with older age, i.e., predominantly female, less educated, lower income, not likely to be employed" (pp. 8–9).

The study also found that transportation-handicapped persons took fewer total trips than the general population but more trips for medical and therapy purposes. Buses are the dominant mode of transportation for this group, but nearly half of the transportation disadvantaged either cannot use public transportation, or can use it only with great difficulty, due to multiple barriers which restrict ease of access.—Summary report of the National Survey of Transportation Handicapped People, June 1978; prepared for U.S. Department of Transportation. Urban Mass Transit Administration, Office of Transportation Planning, Management and Demonstrations, Service and Methods Demonstration program.

year that, in the future, all full-sized buses purchased with Federal aid must be of the barrier-free low-floor transbus design. However, a new debate—with greater implications for the design and cost of public transportation—arose following publication of the Department of Transportation's proposed regulations to comply with the requirements of section 504 of the Rehabilitation Act of 1973.[8]

A. Transbus: Revision of the 1977 Mandate

In May 1977, Transportation Secretary Brock Adams issued an order stating that all new full-sized transit buses purchased with Federal assistance after September 30, 1979, must be of the low-floored, ramped-entrance transbus design. The Secretary based his decision on language in transportation and rehabilitation legislation requiring that elderly and handicapped persons be able to fully utilize mass transit facilities and services.[9]

However, after the protests by the American Public Transit Association and the General Motors Corp. about the potential cost of transbus and an alleged lack of adequate testing, the House Public Works Committee adopted an amendment sponsored by Representative Bud Shuster in May 1978. The Shuster amendment called for the Transportation Secretary to conduct a 3-month field test of the transbus, and report to the Congress a reevaluation of the transbus mandate by January 1, 1979.[10]

The immediate result of the adoption of this amendment was to delay indefinitely bidding by a consortium of cities for transbus vehicles, and the withdrawal of American Motors—which provides about half of the Nation's buses—from the field of manufacture due to "uncertainty" over the final shape of Federal standards.[11] On May 30, 1978, Secretary Adams informed the House Public Works and Transportation Committee:

> I believe that the transbus rule meets the congressional directive that buses be made accessible to the elderly and handicapped in a fair and practical way. I urge you and your colleagues to reconsider the Shuster amendment and the consequences it would have, in view of this overriding concern for the mobility of these disadvantaged citizens.

The Secretary also questioned whether it was practical to meet the January 1 deadline for in service testing, given that problems in

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[8] The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (Public Law 95–602, enacted Nov. 6, 1978) made several important changes in the 1973 act. Chief among these was a 4-year extension and increased authorizations for the Architectural and Transportation Barriers Compliance Board (A&TBCB), which is charged with enforcing Federal accessibility statutes by the 1973 act. Under the amendments, the Board is empowered to "establish minimum guidelines and requirements" for standards issued pursuant to the Architectural Barriers Act of 1968, and to "insure that public conveyances, including rolling stock, are readily accessible to, and usable by, physically handicapped persons." As to the cost of compliance with barrier-removal statutes, the Board is directed to report to the Congress, within 1 year, "an assessment of the amounts required to be expended by States and political subdivisions thereof to provide handicapped individuals with full access to all programs and activities receiving Federal assistance."

[9] The 1977 transbus mandate is described in "Developments in Aging: 1977," part 1, pp. 217–18.

[10] National Journal, June 10, 1978, pp. 1476–77.

[11] Wall Street Journal, June 1, 1978, p. 6.

tooling for mass production would require test vehicles to be made by hand.[12]

These concerns were apparently resolved on September 14, 1978. DOT revised the transbus mandate to permit manufacturers to meet the accessibility standards with either a ramp or a hydraulic lift, while still requiring that bus floor height be no more than 22 inches. Further, while the September 30, 1979, implementation was retained, DOT issued a statement that it would be "reviewed and reassessed in the near future when the manufacturers' initial delivery commitments for transbus are known."

As a result, the Shuster amendment was deleted on the House floor. The DOT actions may result in the transbus being of a somewhat different design, and may cause first deliveries of the vehicles to be put off until 1983,[13] but they leave intact the Federal decision to require full accessibility in all new transit buses as soon as manufacturers can deliver them.

B. DOT's Proposed Accessibility Regulations

Section 504 of the Rehabilitation Act of 1973 declares:

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The Department of Health, Education, and Welfare was assigned principal responsibility for coordinating governmentwide enforcement of the Rehabilitation Act. On January 13, 1978, HEW issued final rules setting forth guidelines and standards for Federal agencies to follow in implementing section 504.[14] In regard to DOT programs, the HEW standards required that handicapped individuals be afforded program accessibility—utilization of public transportation in the most integrated way possible—within 3 years.

DOT was ordered to draft proposed rules for making its programs accessible within a reasonable and definite period; following the issuance of final rules, transit authorities are given 1 year to prepare detailed transition plans for achieving the required accessibility.

On June 8, 1978, DOT issued its proposed regulations for implementing section 504. The major provisions are as follows:

—All new transit facilities must be barrier free.

—Existing fixed facilities must be made accessible within 3 years, except for mass transit facilities. The limited number of cities

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[12] Source cited in footnote 10, p. 1477. On July 12, 1978, a coalition of groups representing the elderly and handicapped held a rally at the Capitol to support the 1977 transbus mandate. In remarks delivered on his behalf, Committee on Aging Chairman Frank Church stated: " . . . I want you to know of my strong support for Brock Adams' transbus mandate, and my opposition to calls for a reevaluation of that decision. America's taxpayers have already spent $27 million studying the need for and feasibility of transbus. How much more study do we need? It has been 8 years since the Congress first declared that the elderly and handicapped have equal transportation rights. Senior citizens need usable transportation now to get to shopping, doctors, friends, and service programs. . . .To ask them to await yet another study is to strain their capacity for patience. To suggest that the elderly and handicapped should be barred from regular transit services and relegated to "separate but equal" transit is to suggest a denial of equal protection that is out of step with the present, and with the law."

[13] Wall Street Journal, Sept. 15, 1978, p. 10; Washington Post, Sept. 15, 1978, p. A10.

[14] 43 Federal Register 2131.

with older subway systems[15] would have an extended time period, as yet undetermined but in the range of 12 to 30 years, to make all stations fully accessible.

—All new mass transit and intercity rail vehicles must be accessible.

—At least one-half of peak hour bus service must be accessible within 6 years. Because sufficient numbers of transbus vehicles may not be operational by that date, this could require some retrofitting of existing buses with wheelchair lifts.[16]

During September 1978, DOT held hearings in five cities to receive public comments on the proposed rules. Additional comments were accepted until October 20. Final proposed regulations will be forwarded to HEW for review in February 1978, with publication expected in the first part of March.[17]

These proposed regulations have generated considerable controversy due to their projected costs and potential inflationary impact. DOT estimates that the full cost of compliance would total $1.7 billion in 1977 dollars, of which $1.1 billion would be needed to make existing subway systems fully accessible. However, others—such as the American Public Transit Association—estimate these costs at the much higher level of $3 to $5 billion. Such projections have caused concern among officials of the cities and transit authorities that would have to undertake subway renovations and retrofit existing vehicles, despite the fact that Federal transit moneys would cover 80 percent of these costs.

Debate has also extended as to whether these actions are actually required by section 504. Some advocates for the elderly and handicapped argue, however, that section 504 is civil rights legislation, and that costs of compliance cannot be permitted to dilute its clear intent.

Finally, there is no clear consensus as to whether removing physical barriers in existing mass transportation systems is the best means of meeting the transportation needs of the elderly and handicapped. Critics of this approach contend that the provision of more door-to-door paratransit services would provide mobility in a more sensitive and comprehensive manner. Even if physical barriers are removed, they say, the transportation-disadvantaged will still be unable to utilize regular mass transit services due to distances from their home to facilities, bad weather, fear of crime, and routes and schedules which do not correspond to their needs.

Proponents of the barrier-free approach counter that separate transit facilities for the elderly and handicapped are inherently unequal and, due to the high labor costs of paratransit services, can never meet the full mobility needs of this group. Removing barriers to existing services are seen as the best means of providing better service rapidly, while more fully integrating elderly and handicapped individuals with the larger society.

During 1978, the staff of the Regulatory Analysis Review Group, the White House task force charged with calculating the inflationary

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[15] The cities involved are New York, Philadelphia, Chicago, Boston, and Cleveland.

[16] A letter from Secretary Adams to Committee on Aging Chairman Frank Church, transmitting the proposed rules, and a more elaborate summary, including economic costs, are reprinted in part 2 of this report.

[17] Timetable provided by Kenneth Birnbaum, Congressional Liaison Officer, Department of Transportation, Jan. 3, 1979.

impact of Federal regulations, recommended that the proposed DOT regulations be modified to require that existing subway stations be made barrier-free only when undergoing major renovations.[18] However, the divergent view taken by HEW; and the lack of common agreement as to the costs and efficiency of removing barriers versus providing special transit services, make this issue particularly difficult. What is certain is that DOT's final regulations for compliance with section 504 will have a substantial long-term impact on the quality, type, and availability of transit services to older Americans who currently experience difficulty in utilizing them.

III. CONTINUING EFFORTS TO RESOLVE INSURANCE PROBLEMS

The debate concerning accessibility standards has not yet been resolved. However, special transportation services are already being provided to tens of thousands of older Americans with funds secured through DOT and HEW.

A Committee on Aging hearing, held in 1977, revealed that many of these efforts were threatened by skyrocketing insurance premiums, and by restrictions placed on program activities by underwriters.[19]

Several actions have been taken by the executive branch, in response to the facts uncovered by that committee inquiry, which promise to facilitate relief for rural and special transit service operators who are experiencing insurance difficulties.

The Department of Transportation has sponsored an investigation of the extent and causes of the insurance barrier to efficient and reasonably priced special transit. The University of Tennessee Transportation Center, which carried out the project, released its findings in September 1978.[20] Its report made six major recommendations to help resolve current problems:

(1) State laws must better identify and classify social service transit activity.

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[18] National Journal, Oct. 21, 1978, pp. 1672–5.

Further analysis showed that cost was the biggest threat to continuation of programs. The average per vehicle premium reported by AAA's considering termination was $1,000, compared to an average annual cost of $600. Also, the most significant short-term means of reducing premium costs appeared to be joining with units of local government to qualify for fleet rates. AAA's taking this step paid an average of $500 per annum, compared to $750 for those who insured independently.

[19] Details of the hearing are contained in "Developments in Aging: 1977," pp. 222–3. As a followup to the Senate Special Committee on Aging hearing on transit insurance, the Senate computer center was instructed to analyze a questionnaire on this subject distributed by the National Association of Area Agencies on Aging. The center completed its analysis in May 1978, and its most important findings were as follows:

A slim majority of responding AAA's reported no substantial increase in insurance costs, but 45 percent reported annual increases ranging above 25 percent; 17 percent experienced price hikes of 100 to 250 percent. One-quarter reported that they could not purchase sufficient coverage. Three-eighths reported experiencing difficulty in retaining or renewing policies. Nearly half of all AAA's reported that insurance costs affected their overall transportation program; 27 percent had to cut back on services, and 10 percent were considering termination of all transportation. One-third reported a cutback in other services in order to pay higher insurance charges. Nearly all had good accident records, with 48 percent reporting no incidents in the preceding year, and an additional 48 percent reporting 1 to 2 accidents. Nearly half felt that their premiums were unjustifiably high. One-sixth are prohibited from employing older drivers under the terms of their insurance policies.

[20] "The Social Service Insurance Dilemma: Problems, Analysis, and Proposed Solutions" by Frank W. Davis, Jr., Ph. D., associate professor, Department of Marketing and Transportation; David A. Burkhalter, legal adviser; William W. Dotterweich, Ph. D., professor of insurance; and Tim Cleary, research associate; Transportation Center, the University of Tennessee, Knoxville, Tenn. 37916; September 1978. Available to the public through the National Technical Information Service, Springfield, Va. 22161.

(2) State laws must be changed to permit social service agencies to purchase insurance that provides certain, unconditional coverage for all users of social service transit.

(3) Congress and executive agencies must take steps to coordinate better benefits which injured users can obtain from a combination of Federal benefit programs, such as medicare, and payments from insurers under tort liability.

(4) The Insurance Services Office, which establishes rating categories for the insurance industry, must develop and collect data for new classifications encompassing social service transit.

(5) Claims procedures should be developed in which social service agencies could help injured parties coordinate the benefits due them under a combination of public programs and private insurance.

(6) The insurance industry and the Government should develop jointly a risk-management program, including driver selection and training procedures, for social service transit.

These suggestions, and others,[21] are now under consideration by a White House task force. That group—chaired by Jack Watson, Assistant to the President for Intergovernmental Affairs—is bringing together representatives of interested congressional units, State and local officials, DOT, HEW, insurance and public utility commissioners, academicians, and the insurance industry to better define the problem and propose coordinated actions to expeditiously resolve it. It is hoped that those recommendations can be the subject of a White House-sponsored meeting early in 1979,[22] and that the actions taken as a result of that forum can provide adequate relief to threatened social service transportation programs. In the meantime, actions are already being taken in some States to provide relief.[23]

Action on No-Fault Insurance Deferred

On May 8, 1978, the Senate Commerce Committee, by a 9–7 vote, favorably reported legislation to the Senate (S. 1381) requiring all

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[21] Unsuitable vehicles are another factor in operating and insurance cost problems. A recent National Academy of Sciences report found that more than half of the small bus fleets of transit providers were used in fixed route service, and an additional 36 percent provide special transportation for the elderly and handicapped. Yet these vehicles have discouraging operating and maintenance problems and "No fully transitworthy small bus is available on the market . . . the technological gap between what is available and what is needed will become even wider if the accessibility requirements—such as low floors—that have been mandated for large transit buses are applied to their smaller counterparts . . . private industry is hesitant to undertake a costly development program given present market conditions." The academy suggested that the Urban Mass Transit Administration should, with the assistance of consumers, operators, and manufacturers, develop and issue guideline specifications for small buses; and should indirectly support the development of more transitworthy vehicles. Final Report of the Workshop on Small Buses; Transportation Research Board, National Academy of Sciences; September 1978. (Available from Urban Mass Transportation Administration, Office of Policy and Program Development, Washington, D.C. 20590.)

[22] An August 11 Congressional Record statement by Committee on Aging Chairman Frank Church on this White House initiative, and subsequent correspondence between Senator Church and Jack Watson, Secretary of Transportation Brock Adams, and Commissioner on Aging Robert Benedict. Retained in committee files.

[23] In California, the State Department of Aging is surveying all service agencies to determine how insurance hikes are affecting their programs, is improving driver training, and will begin self-insuring all vehicles under State fleet coverage. In addition, the California Coalition for Insurance Reforms for Non-Profit Agencies, a coalition of that State's 37,000 nonprofit organizations, has prepared a risk management and loss prevention manual in an attempt to stem further premium hikes. Further information about this "Risk Management and Auto Liability Insurance Manual," prepared with the advice of the State Department of Aging, is available from the coalition at P.O. Box 418, Pasadena, Calif. 91101.

States to provide drivers with no-fault automobile insurance, and setting minimum Federal standards for that coverage. This action followed 1977 hearings in which Secretary of Transportation Brock Adams, and groups representing the elderly, argued that mandatory no-fault would provide less expensive and more prompt protection for drivers and pedestrians.[24] Proponents of Federal no-fault standards have maintained that the present tort liability system is unfair, provides inadequate benefits, and is slow and inefficient. Opponents have argued that the Federal bill would unduly restrict the right of individuals to seek damages through litigation, and that it would constitute an unwarranted Federal intrusion into State regulation of insurance.

At present, 16 States have full mandatory no-fault insurance; an additional eight States permit compensation from the victim's own insurance company, but do not place limitations on the right to sue. Only Michigan's no-fault plan, however, met the minimum standards of the proposed Federal bill, and that statute was declared unconstitutional by the Michigan Supreme Court in June 1978 because it continued the industry practice of basing premiums on broad classifications such as age, sex, marital status, and residence.[25]

On August 1, 1978, the House Commerce Committee voted, 22–19, not to report this no-fault bill to the full House, effectively ending its chance of passage in the 95th Congress. This issue has been under consideration by the Congress since 1971, and it is expected that another amended no-fault bill will be introduced in 1979.

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[24] For further background on the Commerce Committee hearings, see "Developments in Aging: 1977," pp. 220–21.

[25] Washington Post, July 17, 1978, p. A15. Wall Street Journal, Sept. 19, 1978, p. 8. In the fall of 1978, the rates and ratings procedures task force of the National Association of Insurance Commissioners recommended that age, sex, and marital status be eliminated as factors in setting auto insurance rates.

CHAPTER XI

AREAS OF CONTINUING OR EMERGING CONCERN

I. MINORITIES

Poverty has declined markedly during the past 10 years for older Americans, from 5.4 million in 1967 to 3.2 million in 1977. (See also chapter II for more information.) Nearly 30 percent of all persons 65 or older were poor in 1967, compared with 14 percent in 1977.

But in terms of aggregate numbers, practically all of the reduction in poverty has been concentrated among aged whites. Nearly 2.2 million elderly whites moved off the poverty rolls from 1967 (4.6 million) to 1977 (2.4 million).

However, the number of aged poor minority members has remained essentially unchanged during the past 10 years (742,000 in 1967 compared with 751,000 in 1977), although their poverty rate has declined sharply—from 51 percent in 1967 to 35 percent in 1977.

The year 1978 brought some moderately good economic news for aged whites, but not for the minority elderly.[1] In some respects, they suffered setbacks. More than 200,000 aged whites escaped from poverty from 1976 to 1977,[2] while the number (from 680,000 in 1976 to 751,000 in 1977) and percentage (from 32.7 percent in 1976 to 34.9 percent in 1977) of low-income aged blacks and other races actually increased. The economic situation for the Spanish-speaking elderly remained essentially unchanged, although the number living in poverty declined from 128,000 in 1976 to 113,000 in 1977. However, this figure (113,000) is still above the number of Spanish-speaking persons 55 years or older living in poverty in 1973 (95,000).

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[1] Each March, the Bureau of the Census conducts a survey to determine the money income for older and younger Americans for the preceding year. Thus, the 1978 Bureau of the Census survey provides information about the money income of all Americans in 1977.

[2] See following table:

WEIGHTED AVERAGE THRESHOLDS—POVERTY CUTOFFS IN 1977, BY SIZE OF FAMILY AND SEX OF HEAD BY FARM-NONFARM RESIDENCE

		Nonfarm			Farm		
Size of family unit	Total	Total	Male head	Female head	Total	Male head	Female head
1 person (unrelated individual)	$3,067	$3,075	$3,214	$2,969	$2,588	$2,672	$2,498
14 to 64 years	3,147	3,152	3,267	3,023	2,709	2,776	2,569
65 years and over	2,895	2,906	2,936	2,898	2,475	2,495	2,563
2 persons	3,928	3,951	3,961	3,907	3,318	3,325	3,174
Head 14 to 64 years	4,054	4,072	4,095	3,981	3,466	3,474	3,278
Head 65 years and over	3,637	3,666	3,670	3,646	3,128	3,131	3,076

Source: Bureau of the Census.

PERSONS BELOW THE POVERTY LEVEL BY FAMILY STATUS, SEX OF HEAD, AND RACE; 1959 TO 1977

[Numbers in thousands. Persons as of March of the following year]

Year, race, and sex of head	Total number below poverty level		Total poverty rate	
	All persons	65 years and over	All persons	65 years and over
All persons, all races;				
1977	24,720	3,177	11.6	14.1
1976	24,975	3,313	11.8	15.0
1975	25,877	3,317	12.3	15.3
1974 [1]	23,370	3,085	11.2	14.6
1974	24,260	3,308	11.6	15.7
1973	22,973	3,354	11.1	16.3
1972	24,460	3,738	11.9	18.6
1971	25,559	4,273	12.5	21.6
1970	25,420	4,709	12.6	24.5
1969	24,147	4,787	12.1	25.3
1968	25,389	4,632	12.8	25.0
1967	27,769	5,388	14.2	29.5
1968 [1]	28,510	5,114	14.7	28.5
1966	30,424	NA	15.7	NA
1965	33,185	NA	17.3	NA
1964	36,055	NA	19.0	NA
1963	36,436	NA	19.5	NA
1962	38,625	NA	21.0	NA
1961	39,628	NA	21.9	NA
1960	39,851	NA	22.2	NA
1959	39,490	5,481	22.4	35.2
White;				
1977	16,416	2,426	8.9	11.9
1976	16,713	2,633	9.1	13.2
1975	17,770	2,634	9.7	13.4
1974 [1]	15,736	2,460	8.6	12.8
1974	16,290	2,642	8.9	13.8
1973	15,142	2,698	8.4	14.4
1972	16,203	3,072	9.0	16.8
1971	17,780	3,605	9.9	19.9
1970	17,484	3,984	9.9	22.5
1969	16,659	4,052	9.5	23.3
1968	17,395	3,939	10.0	23.1
1967	18,983	4,646	11.0	27.7
1966 [1]	19,290	4,357	11.3	26.4
1966	20,751	NA	12.2	NA
1965	22,496	NA	13.3	NA
1964	24,957	NA	14.9	NA
1963	25,238	NA	15.3	NA
1962	26,672	NA	16.4	NA
1961	27,890	NA	17.4	NA
1960	28,309	NA	17.8	NA
1959	28,484	4,744	18.1	33.1
Black and other races:				
1977	8,304	751	29.0	34.9
1976	8,262	680	29.4	32.7
1975	8,107	683	29.3	34.0
1974 [1]	7,634	625	28.3	32.5
1974	7,970	666	29.5	34.7
1973	7,831	656	29.6	35.5
1972	8,257	666	31.9	37.5
1971	7,780	668	30.9	38.4
1970	7,936	725	32.0	46.2
1969	7,488	735	31.0	48.1
1968	7,994	693	33.5	46.6
1967	8,786	742	37.2	51.0
1966 [1]	9,220	757	39.8	53.4
1966	9,673	NA	41.7	NA
1965	10,689	NA	47.1	NA
1964	11,098	NA	49.6	NA
1963	11,198	NA	51.0	NA
1962	11,953	NA	55.8	NA
1961	11,738	NA	56.1	NA
1960	11,542	NA	55.9	NA
1959	11,006	737	56.2	60.8

See footnote at end of table.

PERSONS BELOW THE POVERTY LEVEL BY FAMILY STATUS, SEX OF HEAD, AND RACE; 1959 TO 1977—Continued

[Nunbers is thousands. Persons as of March of the follcwing year]

Year, race, and sex of head	Total number below poverty level		Total poverty rate	
	All persons	65 years and over	All persons	65 years and over
Black:				
1977	7,726	701	31.3	36.3
1976	7,595	644	31.1	34.8
1975	7,545	652	31.3	36.3
1974 [1]	7,182	591	30.3	34.3
1974	7,467	626	31.4	36.4
1973	7,388	620	31.4	37.1
1972	7,710	640	33.3	39.9
1971	7,396	623	32.5	39.3
1970	7,548	683	33.5	48.0
1969	7,095	689	32.2	50.2
1968	7,616	655	34.7	47.7
1967	8,486	715	39.3	53.3
1966 [1]	8,867	722	41.8	55.1
1959	9,927	711	55.1	62.5

[1] Based on revised methodology.

Note. For the year 1959, data for persons 65 years and over and for blacks are based on 1-in-1,000 sample of the 1960 census. For the years 1969 to 1977, data are based on 1970 census population controls.

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States; 1977," (advance report), series P-60, No. 116, issued July 1978, p. 21.

PERSONS OF SPANISH ORIGIN BELOW THE POVERTY LEVEL BY FAMILY STATUS AND SEX OF HEAD: 1972 TO 1977

[Numbers in thousands. Persons as of March of the following year]

Year and sex of head	Total number below poverty level		Total poverty rate	
	All persons	65 years and over	All persons	65 years and over
All persons:				
1977	2,700	113	22.4	21.9
1976	2,783	128	24.7	27.7
1975	2,991	137	26.9	32.6
1974 [1]	2,575	117	23.0	28.9
1974	2,601	116	23.2	28.5
1973	2,366	95	21.9	24.9
1972	2,414	NA	22.8	NA
Persons in families with male head: [2]				
1977	1,497	67	15.3	17.6
1976	1,639	76	17.9	22.6
1975	1,802	78	20.1	26.6
1974 [1]	1,563	69	16.9	23.3
1974	1,580	70	17.1	23.6
1973	1,395	54	15.4	19.2
1972	1,592	NA	18.4	NA
Persons in families with female head: [2]				
1977	1,204	46	53.3	34.0
1976	1,144	53	54.3	40.9
1975	1,189	59	55.6	46.8
1974 [1]	1,012	48	51.4	43.7
1974	1,021	47	51.6	42.3
1973	971	42	55.5	41.1
1972	822	NA	51.5	NA

[1] Based on revised methodology.
[2] For unrelated individuals, sex of the individual.

Note. Persons of Spanish origin may be of any race.

Source. Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977," (advance report), Series P-60, No. 116, Issued July 1978, p. 24.

On other fronts, some positive developments occurred for elderly minority members in 1978. The Department of Labor selected three minority organizations—National Urban League, National Center on Black Aged, and Asociacion Nacional Pro Personas Mayores—to expand senior community service job opportunities for low-income persons 55 or older in 21 States during program year 1978–1979. Senior aides work in a wide variety of community service facilities and activities, including day-care centers, senior citizen centers, schools, hospitals, nutrition programs, transportation programs, and beautification, conservation, and restoration projects.

Organization	Authorized positions	Funds	States
National Urban League	660	$2,871,000	Connecticut, Illinois, Indiana, Massachusetts, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Virginia, and Wisconsin.
National Center on Black Aged	300	1,305,000	Alabama, Kentucky, Mississippi, North Carolina, and Tennessee.
Asociacion Nacional Pro Personas Mayores	300	1,305,000	California, Kansas, Louisiana, Oklahoma, and Texas.

In addition, the Comprehensive Older Americans Act Amendments of 1978 [3] direct the Administration on Aging to assess future national personnel needs, with special attention devoted to the minority elderly. The 1978 amendments also call upon AoA to train members of minority groups to meet the special needs of aged minority members.

A. National Center on Black Aged

The National Center on Black Aged engaged in a wide range of activities in 1978, especially in the areas of employment, housing, crime prevention, and training. Major NCBA activities in 1978 include:

—Land was obtained for the construction of a section 202/section 8 housing project for the elderly in the Nation's Capital. NCBA broke ground on the construction of the 175-unit project at the end of the year. In Houston, NCBA and the Eliza Johnson Nursing Home jointly sponsored a 150-unit housing for the elderly project. Present plans call for construction to begin in 1979.

—NCBA maintained a job bank to alert black professionals about possible employment in the field of aging.

—NCBA conducted an antivictimization program on behalf of the elderly in Washington, D.C. The program included three major components: (a) counseling for crime victims, (b) preventive services and education, and (c) escort services to banks, grocery stores, and other services.

—In Springfield, Mass., NCBA operated a transportation program serving about 2,000 people each month. The escort services program operated 6 days a week and provided bus service for older persons to nutrition sites, medical facilities, and shopping centers.

—AoA's quality improvement grant to NCBA to provide technical assistance to minority faculty, educational institutions, and students resulted in five schools receiving funds for gerontological

[3] Public Law 95–478, approved Oct. 18, 1978.

programs. In addition, NCBA helped these schools—University of Arkansas at Pine Bluff, Virginia Union University, Huston-Tillotson College, Mississippi Valley State University, and Prairie View A. & M.—design their gerontological curricula.

—NCBA developed an annotated bibliography of unpublished material concerning the black aged. NCBA annotated about 300 bibliographical references which coincided with the AoA National Information and Resource Clearing House system.

—NCBA issued a publication concerning major research and training affecting the minority aged.

Dr. Dolores Davis testified on behalf of NCBA at the Senate Committee on Aging's September 8 hearing on "Retirement, Work, and Lifelong Learning." She opposed proposals to raise the eligibility age for full social security benefits. She added, "That is the greatest fear, and because of the differentials of life in the black aged population and other minority populations as well, this is a very, very serious concern." [4]

Dr. Davis provided the following table of life expectancy at selected ages by race and sex:

LIFE EXPECTANCY AT SELECTED AGES, BY SEX AND RACE: 1959–61, 1970 AND 1973

Year and age	Male			Female		
	Black and other races	White	Difference in years	Black and other races	White	Difference in years
1970:						
19590	61.5	67.6	6.1	66.5	74.2	7.7
40	28.7	31.7	3.0	32.2	37.1	4.9
65	12.8	13.0	.2	15.1	15.9	.8
:						
0	61.3	68.0	6.7	69.4	75.6	6.2
40	28.6	31.9	3.3	34.2	38.3	4.1
65	13.3	13.1	.2	16.4	17.1	.7
1973:						
0	61.9	68.4	6.5	70.1	76.1	6.0
40	28.7	32.2	3.5	34.4	38.5	4.1
65	13.1	13.2	.1	16.2	17.3	1.1

Source: Bureau of the Census, 1974. Current Population Reports, series P–23, No. 54, "The Social and Economic Status of the Black Population in the United States," table 81.

Dr. Davis also emphasized that institutional care is oftentimes inaccessible to aged blacks, saying:

> For every 21 white females living in an institution, there is only 1 black female, and, of course, females live longer than the males. We would like to do some research into this because it would have a great impact and meaning for all older persons.[5]

In addition, she pointed out that some Federal programs discourage family members from caring for their spouses. Dr. Davis cited the supplemental security income program as an example. She noted that SSI benefits are reduced for low-income aged, blind, or disabled persons who live in the household of a relative.

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[4] "Retirement, Work, and Lifelong Learning," hearings before the Senate Special Committee on Aging, Washington, D.C., Sept. 8, 1978.
[5] Testimony at hearing cited in footnote 4.

B. New Developments Affecting Indian Elders

Older Indians are confronted by severe socioeconomic problems. A June 1978 HEW compilation of statistical information on the Indian elderly, based primarily upon 1970 census data, concluded:

> The economic, social, and health situations of persons in the older Indian population were worse than for elderly persons of all races. The proportion of elderly Indians living below the poverty level . . . was nearly double that of the total older population (51 percent versus 27 percent. . . . Although life expectancy among Indians has increased, it is still below that of the general population." [6]

In 1976, with the assistance of a model project grant from the Administration on Aging, the National Indian Council on Aging [7] was established to provide a research and advocacy focus for older Indians, and to speak on their behalf before Congress and the executive agencies.

In August 1978, the Second National Indian Conference on Aging was convened by the council in Billings, Mont. Health care was the primary focus of this gathering. However, the 3,000 participants also discussed the full range of problems and programs affecting Indian elders.

Committee on Aging Chairman Frank Church, in remarks prepared for the conference, stated:

> In those 2 years you have made commendable progress. The National Indian Council on Aging has become an effective voice and agent for action. Its testimony . . . and diligent work have brought about one of the most important goals which you set in Phoenix—under the newly revised Older Americans Act . . . tribes may now choose to receive their funding for aging services directly from the Commissioner on Aging in Washington.[8]

The conference also received messages from Committee on Aging member John Melcher and ranking Republican Pete V. Domenici, who described his efforts to strengthen tribal authority for health planning, and to focus greater resources on the continuing problem of alcoholism. Montana Gov. Thomas Judge noted that, due to the high incidence of early death, disease, and poverty among Indians, his State had successfully sought to have Indians considered "old" at age 45 for Older Americans Act purposes.[9]

Ranking Minority Member Senator Pete V. Domenici introduced an amendment to the Older Americans Act to permit direct funding to Indian tribes. The amendment establishes a separate title to authorize the Commissioner to make funding directly available to tribal organizations to pay all the cost for delivering social and nutritional services to older Indians.

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[6] "Social. Economic. and Health Characteristics of Older American Indians." June 1978. Administration on Aging. DHEW publication No. (OHDS) 78-20289; p. 16.

[7] For further information about the National Indian Council on Aging. inquiries should be directed to P.O. Box 2088. Albuquerque. N. Mex. 87103.

[8] Title VI of the revised Older Americans Act is described in greater detail in chapter VI.

[9] Billings Gazette. Aug. 18. 1978. p. B1.

Participants at the Billings conference singled out two areas for special concern. First, complaints were voiced that present Federal policies put the approximately 25,000 older Indians residing in urban areas in competition with those living on reservations for funding assistance, and fail to establish clear responsibility for addressing the needs of urban Indians. Second, it was reported that few advances had been made in improving the housing conditions of older Indians.

Earlier in 1978, a GAO report [10] confirmed this lack of progress on shelter, finding that:

> The number of Indian families living in substandard housing has increased from 63,000 in June 1970 to 86,500 in June 1976, while the number of new units started annually has dropped from 5,000 to 3,500.

The GAO found that existing Federal programs could meet the increasing housing needs of all Indians, if properly carried out and funded.

The GAO also noted that HUD's "slow and cumbersome" administrative system, combined with a lack of adequate staff and resources on the part of Indian housing authorities, contributed to the problem. It concluded:

> Existing Federal programs have not been successful in meeting the Indian housing needs because they are underfunded, have not received enough emphasis, require too many complex and time-consuming procedures, lack flexibility, require more trained people, and are uncoordinated.
>
> The present goal of eliminating substandard housing on Indian reservations in the 1970's cannot be achieved under present programs and is no longer feasible.

GAO recommended that the Congress consolidate all Indian housing programs, and develop a new range of flexible housing assistance mechanisms, in a single Federal agency. Congress has not yet acted on these recommendations. HUD, however, has proposed sweeping revisions of its Indian program regulations in response to criticism from the GAO and other sources.[11]

The National Indian Council on Aging is now directing priority attention to the two major objectives established at billings—the development of home health services and reservation-based nursing homes—and to assure that the Congress provides adequate appropriations for title VI (grants for Indian tribes) of the revised Older American Act.

C. Activities of the Asociacion Nacional Pro Personas Mayores

The Asociacion Nacional Pro Personas Mayores was established in 1975, with the assistance of an AoA model project grant, to promote greater involvement of the Hispanic elderly in State and Federal aging programs, and to assist researchers and lawmakers to better understand the needs of the elderly members of the Hispanic ethnic groups.

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[10] "Substandard Indian Housing Increases Despite Federal Efforts—A Change Is Needed." GAO report CED–78–63, Mar. 31, 1978.

[11] "Housing Affairs Letter." Jan. 19, 1979, p. 6.

The asociacion furthers these goals through its participation in Congressional hearings, gerontological conferences, and ongoing research. It has also established a national office and a number of regional centers, which were involved in these activities during the year:

—Southeastern center. The Miami office participated in the Dade County Transportation Board's policy deliberations on matters affecting the elderly and handicapped. The center established a working relationship with the Miami Jewish Home for the Aged, and presented testimony at a wide range of public hearings.

—Eastern center. The development of innovative outreach and technical assistance programs for Hispanic elderly in the Northeastern part of the Nation has been the primary goal of the New York City office. Training programs for senior centers and for Hispanics wishing to enter the field of aging have been established, as well as working relationships with the gerontology departments of Fordham University, Manhattan University, and Hunter College. To promote better outreach, a weekly broadcast prepared by the New York office is broadcast over a local Spanish language radio station.

—Southwestern center. The Albuquerque office has developed a special focus on the rural elderly, and during 1978 the Council on Rural Elderly of New Mexico was established to focus the attention of Federal aging programs to the special needs of the Hispanic elderly. However, due to a decrease in funding, the asociacion was forced to temporarily close this center until an alternate, private funding mechanism can be created.

—Western center. The Los Angeles office serves Southern California, which has one of the Nation's largest Hispanic community. The center has particularly stressed the development of nutrition and transportation services, and has promoted the increased participation of Hispanics in aging programs.

—National office. The Washington office entered its fourth year of operation, and has been named as a national sponsor by the Department of Labor for the senior community service employment program under the Older Americans Act. The national center's immediate goal is to locate sources of private funding to supplant reduced grants from the Administration on Aging.

NEW DATA ON HISPANIC HOUSING

Federal activities outside the AoA also affect elderly Hispanics. In 1978, HUD's Department of Policy Development and Research released a new compilation of data on the housing conditions of Hispanics. Generally, HUD found that only 71 percent of Hispanics could afford adequate housing without spending more than one quarter of their income, Cubans are better housed than most Hispanic minorities. Mexican-Americans suffer worse housing conditions than the average American family, and only 48 percent of Puerto Ricans, compared to 80 percent of all U.S. households, can find adequate housing for one-quarter of their income.

Among the low-income elderly Hispanics, men living alone reside in poor quality housing, while Hispanic women were the least likely to

live in such units. The table below shows the probability of a very poor aged Hispanic residing in inadequate housing, in comparison to other racial and ethnic groups:

THE CHANCE OF BEING INADEQUATELY HOUSED ALSO DEPENDS ON AGE, SEX, AND FAMILY SIZE

Other demographic characteristics of the household			Race/ethnicity				
Age of head	Household size	Sex of head	Hispanic	White (excluding Hispanic)	Black (excluding Hispanic)	Ratio of Hispanic to white probability [1]	Ratio of Hispanic to black probability [1]
65 and up	1 person	Female	0.18	0.13	0.27	1.4	0.7
		Male	.56	.27	.43	2.1	1.3
	2-5 persons	Female	.24	.16	.33	1.5	.7
		Male	.21	.13	.27	1.6	.8

[1] Probabilities refer to a household with an adjusted income of less than $2,500 living in an SMSA under 250,000 in population located in the North Central census region.

Source: "How Well Are We Housed?" Hispanics; HUD PDR-333, September 1978, p. 18.

In August 1978, HUD awarded a 2-year, $785,000 grant to the National Hispanic Coalition for Better Housing (NHCBH) in order to better assure the full participation of Hispanics in the development of housing and community development programs. NHCBH will assess the housing needs of the Hispanic community, and identify local Hispanic groups involved in housing activities. Staff members from those groups will then receive training and technical assistance. These activities should help to insure that Federal housing programs better serve Hispanics, including the elderly.[12]

D. Final Report on the Pacific/Asian Elderly

The Pacific/Asian elderly research project (PAERP) was established in 1976 with the assistance of an AoA grant. PAERP is dedicated to the development of health and social services which can be effectively delivered to and utilized by the elderly of oriental and Pacific ethnic background.

PAERP's final report [13] was issued in May 1978. Its major conclusions were:

—There is a major continuing need for research on the current status of service delivery strategies directed to this group of elderly.

—Community based research, emphasizing cooperative efforts, is the most desirable, practical, and beneficial means of fulfilling further data needs.

—Greater efforts must be undertaken to disseminate information on the Pacific/Asian elderly to researchers, service providers, and

[12] The University of Southern California's Andrus Gerontology Center has developed a unique research program dubbed project MASP (minority aging and social policy) to develop and disseminate data about the minority aged. A 1978 publication, "Housing: The Diverse Aged," focused on the shelter issues, policies, and concerns of Los Angeles' elderly. Persons wishing further information about project MASP should contact the Sociology of Age Laboratory, Ethel Percy Andrus Gerontology Center, USC, Los Angeles, Calif. 90007.

[13] "Final Report of the Pacific/Asian Elderly Research Project," May 1978, prepared under AoA Grant No. 90-A-980/02. PAERP, 2400 South Western Avenue, Suite 206, Los Angeles, Calif. 90018. The special needs and problems of Japanese and Chinese elders were considered in a December 4 committee hearing on "Older Americans in the Nation's Neighborhoods" in Oakland, Calif. See chapter VIII for details.

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community organizations. This can best be accomplished through the establishment of a national clearinghouse.

—Pacific/Asian communities need better technical assistance in order to develop and implement service delivery systems.

—Further assessment of the desirability and feasibility of establishing a national Pacific/Asian elderly organization—including a cost-benefit analysis and a clarification of functions—is required prior to making a final decision on this matter.

—A clarification is needed of the present interrelationships between service delivery methods, organizational developments, and research.

The report also found that the Pacific/Asian elderly have unique service needs growing out of their cultural heritages which require a sensitivity on the part of service providers. Bicultural and bilingual staffs and services were deemed essential to successful efforts, particularly if they are to accommodate the general inclination of this ethnic grouping to seek assistance from friends and family, rather than a public agency.

Those involved in PAERP will continue their gerontological research and service delivery efforts, and their report will be considered by congressional and AoA officials as steps are taken to make Older Americans Act services better serve this group.

II. DEVELOPMENTS IN AGE DISCRIMINATION ACT

The Age Discrimination Act (ADA) of 1975 (Public Law 94–135) provides that "no person in the United States shall, on the basis of any age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance." The law exempts employment programs which fall under the jurisdiction of the Age Discrimination in Employment Act of 1967 (Public Law 90–202).[14] The ADA statute defines three other categories which could be exceptions:

(1) If such action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity.

(2) If the differentiation made by such action is based upon reasonable factors other than age.

(3) The provision of the act shall not apply to any program or activity established under the authority of any law which (a) provides any benefits or assistance to persons based upon the age of such persons; or (b) establishes criteria for participation in age-related terms or describes intended beneficiaries or target groups in such terms.

It was recognized when developing the ADA it would be essential to define the distinctions between practices which were discriminatory on the basis of age and those which were not before full implementation of the act could take place. For this reason, the statute required a study of age discrimination in federally assisted programs and activities, to be conducted by the U.S. Commission on Civil Rights and

[14] Although the Age Discrimination Act does not apply to employment practices, its authority does cover the Comprehensive Employment and Training Act (CETA).

presented to the Congress before the promulgation of regulations. This study was presented to the Congress in December 1977. It concluded:

> Barriers have been erected by both public and private administrators between persons falling within particular age groups—especially children and older persons—and services which are financed in whole or in part by the Federal Government, and erection of these barriers has had and is having a serious adverse impact on the lives of children and older persons who need these services—it is a depersonalized approach which is in direct conflict with the concept of the dignity and worth of the individual.[15]

A. The 1978 Amendments

> I feel that one of the most effective things that can be done is for the Congress to exercise the kind of leadership that is reflected in the Age Discrimination Act, and to do it in such a way that the line is drawn sharply by the Congress because of the belief of Congress that service and benefit programs financed by the Federal Government should be handled in a manner that is consistent with the concept of the dignity and worth of each individual.[16]

Arthur S. Flemming, Chairman of the U.S. Commission on Civil Rights, appeared before the Congress in January 1978 to present the Commission's recommendations for amending the Age Discrimination Act before its implementation. The Commission's legislative recommendations were based on its 2-year study and report on documented age discrimination in service and benefit programs. Congressman John Brademas, chairman of the House Subcommittee on Select Education, heard testimony from the Commission during oversight hearings on the Age Discrimination Act of 1975. Brademas described the law as being "founded on the belief that it is a fundamental injustice to deny to any individual access to the fruits of our society based on arbitrary age criteria." He used many of the recommendations of the Commission as the basis for his amendments to the ADA as incorporated in H.R. 12255, to amend the Older Americans Act, Domestic Volunteer Service Act, and Age Discrimination Act. Several of these amendments to the ADA and others were included in the final legislation Public Law 95-478. The 1978 amendments to the Age Discrimination Act include:

(1) Striking of the word "unreasonable" from section 302 of the original 1975 statute in order to remove any suggestion that all other forms of adverse discrimination are by definition reasonable and lawful.

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[15] "The Age Discrimination Study," a Report of the U.S. Commission on Civil Rights, December 1977. In addition, for a detailed description of the age discrimination identifications and recommendations in the Commission on Civil Rights study, see chapter IX of "Developments in Aging: 1977," U.S. Senate Special Committee on Aging.

[16] Testimony by Hon. Arthur S. Flemming, Commissioner, U.S. Commission on Civil Rights, before the Subcommittee on Select Education, U.S. House of Representatives, Jan. 20, 1978.

(2) Granting a private right of action to those individuals who, after a 180-day negotiation period, have not reached an agreement with the agency being charged.

(3) Allowing Federal agencies who enforce the ADA to "bypass" any State or local recipients of Federal assistance who are found guilty of age discrimination and disburse such funds to other agencies capable of providing the appropriate services and/or benefits.

(4) Requiring the Secretary of HEW to approve all regulations governing the ADA which are required of all agencies and departments who provide Federal financial assistance.

(5) Delaying the ADA's original implementation date of January 1, 1979, to July 1, 1979, in order to allow the necessary time for issuance of proposed and final regulations by each department and agency.

Senator Frank Church, chairman of the Senate Committee on Aging, applauded the amendments as strengthening the ADA by providing "far-reaching effects on the elderly as well as other age groups." [17]

B. The Proposed Regulations

On December 1, 1978, the Department of Health, Education, and Welfare proposed the statutory requirement for general regulations to carry out the Age Discrimination Act of 1975.[18] These proposed regulations will guide the Federal agencies and departments in developing their required specific regulations, and will attempt to interpret the enforcement of ADA and the amendments of 1978.

Secretary of Health, Education, and Welfare Joseph Califano sent copies of the regulations to all Members of Congress, saying: "Since the impact of this act and these regulations will be considerable, I am making every effort to expose the regulations to broad and searching public scrutiny." [19]

These efforts for "public scrutiny" are extensive. The public's comments were invited on "which age distinctions seem rational and necessary, and which are based on nothing more than stereotypes and misconceptions about the abilities and needs of persons of different ages." In addition, the public was asked to "identify uses of age which might not be prohibited by these regulations, but should be prohibited . . . and those which may be prohibited by these regulations, but should not be prohibited."

Public comment is further encouraged by the format of the proposed regulations. Instead of having a specific departmental position on several of the more important provisions of the ADA, the Department chose to adopt "alternatives" for comment. Each alternative is discussed and an indication is given to which alternative "the Department is leaning toward." Therefore, if insufficient comment or rationale is received justifying one of the alternatives, then the final regulations will most probably reflect the position to which the Department indicates it is leaning.

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[17] Statement of Senator Frank Church upon Senate adoption of the conference report on the Comprehensive Older Americans Act Amendments of 1978, Congressional Record, Oct. 7, 1978, p. S17683.

[18] Federal Register, vol. 43, No. 232, Dec. 1, 1978.

[19] Letter from Secretary Joseph Califano, Department of Health, Education, and Welfare, to Members of the U.S. Senate, December 1978.

THE PROPOSED CONTENTS

The Age Discrimination Act of 1975, as amended, is substantially different from other civil right statutes. This differenec is centered around the fact that the ADA prohibits age discrimination but allows certain exceptions to be made on certain age distinctions and reasonable factors other than age.

These exceptions are the basis for the Department's concern about interpretation of the statute and therefore, the issuance of alternative positions in the proposed regulations. The major areas of importance for which the Department lists options are those which will govern the law's scope of authority.

First, the Department seeks comment on language stating that the act does not have authority over programs or activities "established under the authority of any law." The proposed regulations give four options for what is meant by "any law":

(1) A Federal statute, State statute, or local statute or ordinance, or Federal, State, or local regulation; (2) a Federal statute, State statute, or local statute or ordinance; (3) a Federal statute or State statute; or (4) a Federal statute, which;

(a) provides any benefits or assistance to persons based on age;
(b) establishes criteria for participation in age-related terms; or
(c) describes intended beneficiaries or target groups in age-related terms.

The difference in impact between options 1 and 4 is considerable. Option 1 would make the scope of enforcement of the ADA very narrow; option 4 would allow only the Congress to legislate where age distinctions are legal. The Department indicates it is "leaning toward" option 3 (section 90.3).

An area closely related to the definition of "any law" is the definition of the act's term "statutory objective." The Department proposed two alternatives for this definition: One, "statutory objective" includes any purpose expressly stated in a statute. Or, the other option would be to define "statutory objective" as including any purpose either expressly stated in a statute or inferred from its provisions or legislative history (sec. 90.13).

A third area needing clarification is an exception based on "reasonable factors other than age." The Department states that it could be interpreted as meaning a rational, direct, substantial, or necessary relationship to the normal operation of a program or activity, or to the achievement of a statutory objective. The Department states that it believes that the Congress intended this exception to be a "less rigorous" one and, therefore, would prefer regulatory language stating the exception as one which "bears a rational relationship" to normal program operations or statutory objectives.

Adoption of the other terms (direct, substantial or necessary) is thought to result in more restrictive interpretation of this exception, whereas use of the term "rational" could mean utilizing a test similar to the "rational relationship" test applied by the courts to challenges under the equal protection clause of the 14th amendment (sec. 90.15).

Other regulations being proposed include:

—A listing of the actions which could be reasonably taken into account when determining "a factor necessary to the normal operation or the achievement of any statutory objective, including: (a) Age is used as a measure or approximation of one or more other characteristics (that is, maturity); (b) the other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; (c) the other characteristic(s) can be reasonably measured or approximated by the use of age; and (d) the other characteristic(s) are difficult, costly, or otherwise impractical to measure directly" (sec. 90.14).

—A requirement placing the burden of proof on the recipient of Federal assistance to determine which of its age distinctions or factors other than age is entitled to any of the exceptions listed above (sec. 90.16).

—A requirement that each agency receiving Federal assistance must conduct a review of any age distinctions being practiced in policy or regulation and publish the results of this review and a listing of such age distinctions in the Federal Register (sec. 90.32).

—A requirement that each agency receiving Federal financial assistance must submit annually to the Secretary of DHEW all information and data pertaining to the agency's enforcement of the ADA.

—A requirement that each agency extending Federal financial assistance must provide written notice, technical assistance and educational materials to all of their recipients (sec. 90.43(b)).

—A requirement that each agency extending Federal financial assistance must require each of its recipients to conduct a written self-evaluation of its compliance under the ADA within 18 months of the effective date of the agency regulations (sec. 90.43(c)).

—A requirement that each agency extending Federal financial assistance shall refer all complaints to a mediator and require the participation of the recipient and the complainant in the mediation process (the Department and Office of Management and Budget are considering requiring that all such mediation processes be conducted by the Federal Mediation and Conciliation Service who would train mediators from its staff or the community to handle the ADA complaints (sec. 94.43(d)).

—A requirement that each agency extending Federal financial assistance must develop a procedure for disbursing funds to another recipient if it is forced to bypass a recipient who is found to be out of compliance with the ADA (sec. 90.47).

—A requirement that each recipient found to have discriminated on the basis of age must take any action necessary to remedy the situation and overcome the effects of the discrimination (sec. 90.49).

C. Implementation

Under the 1978 amendments to the Age Discrimination Act, the effective date of the regulations was delayed from January 1, 1979 to

July 1, 1979. This time lapse is necessary for the final promulgation of the general regulations issued on December 1, 1978, by the Department of Health, Education, and Welfare and the issuance of proposed and final regulations by each agency and department who provide Federal financial assistance. Therefore, the first half of 1979 will be a very important period toward the enactment of the ADA.

This time period for the completion of the regulatory process required by the ADA will be structured in accordance with the promulgation of the general regulations which were proposed on December 1. These regulations will be open for comment until February 28, 1979. Then, the issuance of the final general regulations will occur within a month of this time. These final regulations will govern the agencies and departments drafting of their specific regulations to enforce the ADA. These specific regulations will be issued in proposed form for public comment. After the comment period has ended, the agencies "and departments" final specific regulations will be issued, but not before July 1, 1979.

III. ACTIONS ON ENERGY COSTS, WEATHERIZATION

Older Americans, particularly those living on fixed incomes, have been severely affected by increasing energy costs which are currently rising at a rate faster than the Consumer Price Index.[20] The National Energy Act, an altered version of the administration proposal, provides new incentives and assistance for residential insulation, encourages the States to move toward more equitable utility rate systems, and improves Federal weatherization programs for low-income elderly. However, it is likely that the gradual decontrol of natural gas prices will result in increased costs to consumers of this fuel.

Concern continues about irregularities in our present Federal weatherization programs designed to assist the poor. And better ways of insuring that elderly consumers do not experience service terminations due to nonpayment of utility bills during harsh winters are still being sought.

A. The National Energy Act

On October 15, 1978, the Senate and House adopted the conference report on the National Energy Act.[21] This comprehensive legislation contains a number of provisions of importance to the elderly:

Low-income weatherization assistance.—The act retains language introduced by Committee on Aging Chairman Frank Church which brings the new Department of Energy (DOE) weatherization effort into uniformity with similar programs now being administered by the Community Services Administration (CSA).[22] DOE assistance will now be available to all persons with incomes up to 125 percent of poverty level, with special emphasis placed on helping elderly

[20] Hearings held by the Committee on Aging on "The Impact of Rising Energy Costs on Older Americans," as well as a description of the original National Energy Act, are contained in chapter III of "Developments in Aging: 1977."

[21] Public Laws 95–617–21, enacted Nov. 9, 1978.

[22] The CSA also operates a program of emergency energy assistance for low-income individuals who cannot fully pay their fuel bills. Its history and status are discussed in chapter VII.

individuals. The limit on costs for insulation materials was doubled to $800 per dwelling. Consultation is required between CSA and DOE, and older workers employed under title V of the revised Older Americans Act are permitted to participate in DOE weatherization efforts.

Residential tax credits.—Homeowners are provided a nonrefundable tax credit of 15 percent of the first $2,000 (maximum: $300) spent on insulation and other energy conservation improvements—such as flue and furnace modifications, and storm doors and windows—between April 20, 1977, and January 1, 1986. These credits can be carried over for 2 years, through January 1, 1988, if they exceed the amount of tax owed by the homeowner.[23]

Stronger incentives are provided for the installation of solar, wind, or geothermal energy equipment in principal residences. A nonrefundable credit of 30 percent of the first $2,000, and 20 percent of the next $8,000 (maximum: $2,200) of such expenditures, made between April 20, 1977, and January 1, 1986, is authorized.

Utility rate reforms.—State utility commissions and other regulatory bodies are required to consider new rate structures to encourage conservation at hearings during the next 2 years. Changes to be considered, on a utility-by-utility basis, include lifeline rates for elderly or low-income individuals, and discounts for using electricity in off-peak periods. The Department of Energy is authorized to participate fully in the ratemaking process, including appeals, on behalf of energy conservation steps.

Conservation assistance.—Electric and gas utilities are required to offer their customers a home energy evaluation service in order to assist with informed decisionmaking about weatherization expenditures. Utilities are prohibited from actually selling or installing conservation measures, but they are required to help arrange for weatherization and to arrange financing if customers request it. Customers, at their option, can pay for improvements as a portion of their monthly fuel bill; utility service cannot be terminated if a customer falls into arrears in repaying conservation financing. Utilities are also permitted to make direct weatherization loans up to $300.

Such assistance will not be fully implemented until final regulations are published by DOE, sometime late in 1979. The act, once fully implemented, should provide considerable assistance to older homeowners in their conservation and weatherization efforts.[24]

Natural gas deregulation.—Prices of newly discovered natural gas will be permitted to rise about 10 percent annually until January 1, 1985, when all price controls will be ended. Industrial and other commercial users, rather than residential customers, will be required to bear the brunt of these price increases until decontrol occurs. Some

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[23] Improperly treated cellulose—the most popular insulation material—can present fire and corrosion hazards. The Consumer Product Safety Commission now sets safety standards for insulation materials, and consumers are advised not to purchase weatherization products lacking Government specifications.

[24] Some States have enacted more extensive conservation programs. Oregon, for example, provides low-interest loans for conservation measures: requires utilities to provide a range of weatherization services: gives low-income elderly individuals property tax or rent refunds to offset utility costs, as well as weatherization grants: and has established a consumer protection network to oversee the conservation industry. Homeowners are also permitted a State income tax credit for conservation. As of May 1978, more than 1,000 elderly taxpayers had received more than a quarter-million dollars in tax credits: and almost 60,000 elderly with incomes under $5,000 had received about $3 million from the utility rate relief program. New York Times, May 7, 1978, p. 61.

Federal price controls will be extended for the first time to the intrastate gas market.

Starting 6 months after price controls end, either the President or the Congress can, within a 2-year period, reimpose controls for up to 8 months if prices are deemed to be rising too rapidly. By the end of 1988, all controls must be terminated in the absence of new legislation.

B. The GAO Weatherization Report

While the Church amendment to the National Energy Act brought the DOE and CSA weatherization programs under uniform standards, difficulties in administering Federal efforts to help the poor insulate their dwellings remain unresolved.

An August 1978 report by the General Accounting Office [25] found a number of problems, including:

—A failure on the part of the Community Services Administration to provide sufficient guidance, require program controls, or adequately monitor program operations. These have contributed to problems in the administration of weatherization efforts by local grantees.

—A lack of availability of sufficient trained manpower due to ineffective implementation of the working agreement between CSA and the Department of Labor. This results in improper use of materials due to poor workmanship and an inability to complete substantial portions of weatherization work prior to winter's onset.

—A systematic exclusion by CSA of rental housing, which constitutes the shelter of a majority of the Nation's poor. This has resulted from a lack of guidance on operating the program in a way which is equitable to the Government, tenants, and landlords. However, weatherization of multifamily housing could be accomplished at a lower cost per household than single-family dwellings.

The GAO did note that, in August 1977, DOE, CSA, and the Department of Labor signed an agreement of understanding to encourage better information exchange; joint research, demonstration, and evaluation efforts; and coordinated planning, funding, and employment strategies. But additional issues—in particular, uniform technical standards for weatherization materials, and criteria for rental units—remained to be resolved.

The GAO advanced several recommendations to improve Federal weatherization efforts for the poor, including:

—The establishment of procedure, including periodic reporting, to resolve interagency disagreements, with additional oversight carried out by the Office of Management and Budget (OMB).

—The provision of affirmative guidance from CSA to grantees for the weatherization of rental property, including the requirement that grantees submit goals for implementation.

—A congressional clarification of the roles of CSA and DOE in future Federal weatherization efforts. GAO suggested that the Congress consider placing all responsibility for this program in DOE, with CSA retaining responsibility for the emergency en-

[25] "Complications in Implementing Home Weatherization Programs for the Poor," GAO report HRD-78-149, Aug. 2, 1978.

ergy assistance program, and providing the Secretary of Labor with the authority to set aside Comprehensive Employment and Training Act (CETA) funds for weatherization manpower.

In response to the GAO report, both CSA and OMB agreed that the primary responsibility for low-income residential weatherization should be placed in the Department of Energy. CSA also agreed that better coordination of CETA plans with weatherization efforts was needed, but expressed a preference for direct labor funding for its efforts. Labor, on the other hand, proposed to develop procedures to encourage CETA prime sponsors to cooperate in resolving weatherization difficulties. DOE generally concurred with all the GAO recommendations. All three agencies questioned the appropriateness of OMB oversight of the interagency agreement.

As 1979 began, the Department of Energy issued new amendments to its weatherization regulations[26] which permit greater flexibility in program operation at the State and local levels. For fiscal 1979, the Congress provided no direct funding for community action agencies from CSA for weatherization, but did appropriate $200 million for DOE's grant program, which is administered by the States. This action ended the split funding of Federal weatherization efforts. However, while the source of funding has been centralized, the weatherization program continues to be implemented by the network of 900 local community action agencies. Further, DOE has already implemented the changes in their weatherization program mandated by the Church amendment. DOE has also started demonstration projects in an effort to resolve the difficulties which have prevented the extension of weatherization assistance to low-income households residing in rental property.[27]

The changes initiated by GAO's scrutiny and congressional reforms may have far-reaching results. GAO noted that, according to CSA estimates, this effort could result in the conservation of nearly 3 million barrels of oil annually, as well as a reduction of the fuel costs of poor households by $60 million. However, a resolution of the difficulties of reaching rental housing, and better assurances of trained labor, are required for the program to reach its full potential.

C. Concern About Utility Terminations

The Public Utilities Regulatory Policies Act, one of the five parts of the National Energy Act,[28] sets Federal standards for procedures to be followed in the termination of electric service and natural gas to consumers. It requires that they be given reasonable prior notice, including their rights and remedies, and a reasonable opportunity to dispute termination. Further, during any period when termination would be especially dangerous to health, no termination may take place if the consumer establishes that he is unable to pay, or can do so only in installments. Elderly and handicapped consumers are singled out for priority attention.

Under this act, State regulatory authorities must, within 2 years after enactment, adopt these standards, or state in writing their rea-

[26] Federal Register, Jan. 2, 1979, p. 51.
[27] Information supplied by Mary M. Bell, director, Office of Weatherization Assistance, DOE, on Jan. 17, 1979.
[28] Public Law 95–617. Standards for electric utilities are contained in title I, subtitle B, and for natural gas utilities in title III. The Department of Energy's powers for intervention and enforcement are set out in title I, subtitle C, and in title III, section 305.

sons for not doing so. In addition, within 1 year after enactment, regulatory authorities must begin to submit an annual report to the Secretary of Energy regarding compliance with these and other standards. Based on those reports, the Secretary must submit to the President and Congress an annual summary of State actions, and recommendations for further necessary Federal steps. The Secretary also has the power to intervene in ratemaking and judicial procedures to advocate adoption of these standards.

In the fall of 1978, a coalition of labor and civic organizations was formed to seek immediate compliance with these termination standards, citing at least 200 deaths resulting from fuel cutoffs during recent winters. William Hutton, director of the National Council of Senior Citizens, stated that the elderly were being confronted with "life-and-death economic choices. . . . In fact, they've had to make the cruel choice between heating or eating in many cases."[29] The coalition announced that it would focus its immediate efforts on State regulators in 23 selected States, seeking bans on winter terminations such as those already in effect in Wisconsin, Maryland, and Rhode Island.

IV. NATIONAL INSTITUTE ON AGING

The National Institute on Aging made some gains in 1978, but was limited to a $7 million increase in its budget. Operating on a budget of approximately $37.7 million, the NIA supported 325 grants and contracts in 1978, only 49 above the previous year. Mandated by law to conduct biomedical, social, and behavioral research,[30] the Institute distributed its awards as follows:

—209 awards (64.3 percent) for biomedical/biological efforts.
—79 awards (24.3 percent) for behavioral/societal efforts.
—23 awards (7.1 percent) for clinical efforts.
—14 awards (4.3) for multicategorical efforts.

Of the NIA's $37.7 million budget, $26.3 million was used to support these awards for research (83.4 percent), training (9.1 percent), and contracts (7.5 percent).

The Institute attempts, according to Director Robert Butler:

> . . . to find ways to reverse, delay, or in some other way ameliorate the deleterious effects of human aging, and in this way enhance the overall quality of life. These efforts would also contribute to increased life expectancy, as would the research being conducted by the other National Institutes of Health.[31]

In addition to its grants and contracts, the NIA influences research, training, and social services through conferences and workshops with other institutes and agencies. For example, during 1978 the NIA conducted joint efforts with:

—The National Institute of Mental Health and the National Institute of Neurological and Communicative Disorders and Stroke on senile dementia/Alzheimer's disease and related disorders.

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[29] Washington Post, Nov. 15, 1978, p. A15.
[30] Public Law 92-296, Research on Aging Act.
[31] Remarks by Robert N. Butler, M.D., Director, National Institute on Aging, National Institutes of Health, at conference on "Frontiers in Aging: Life Extension," University of Minnesota, Apr. 27, 1978.

—The Fogarty International Center on treatable brain diseases.
—The National Institute of Mental Health on "The Older Woman: Continuity and Discontinuity."
—The National Institute of General Medical Sciences on pharmacology/aging.
—The Fogarty International Center on persons thought to be centenarians in Vilcabama, Ecuador.

The Institute also sponsored a workshop with experts and practitioners on nutrition and the aging; contracted with the Boston collaborative drug surveillance program to study the age-related effects of drugs; initiated a special "think tank" within the National Institutes of Health to examine the social, behavioral, and medical ramifications of the revised retirement policies; and brought together a group of physicians, researchers, scientists, ethicists, and lawyers to discuss methods of protecting elderly research subjects.

The Institute's own structure grew during the year with the establishment of the position for an associate director of epidemiology, demography, and biometry. The NIA's study of the effects of race, gender, and ethnic factors on disease in the elderly will be enhanced with the addition of this position. More studies on the relationship of hypertension and nutrition in the elderly are also expected.

The Institute's intramural program at the Baltimore Gerontology Research Center continued to expand research efforts, with the addition of women to the longitudinal study. Many of the women subjects are related to the men who have been studied since 1958; the GRC also will be looking at the possibility of a family longitudinal study.

A. The Research Plan

Public Law 92–296, which created the National Institute on Aging, also mandated that the Institute and its advisory council develop "a plan for a research program on aging designed to coordinate and promote research into the biological, medical, psychological, social, educational, and economic aspects of aging." This plan, "Our Future Selves: A Research Plan Toward Understanding Aging," was presented to the Congress in December 1977.[32]

In 1978, the Institute presented a supplement to "Our Future Selves" providing the reports of the three panels of specific research areas of the National Advisory Council on Aging—biomedical research, behavorial and social sciences research, and research on human services and delivery systems.

B. Biomedical Research

The National Advisory Council on Aging defines the goal of biomedical research on aging "to prolong the useful and active lives of the elderly and to raise the quality of their lives." [33]

The Council divides biomedical research into three categories: Basic biological aspects of aging, interaction of aging and disease, and interaction of aging and external influences.

[32] For a summary of the research plan, see "Developments in Aging: 1976," part 1, U.S. Senate Special Committee on Aging.

[33] "Our Future Selves," a research plan toward understanding aging, summary reports, panels on biomedical research, behavioral and social sciences research, and research on human services and delivery systems, National Advisory Council on Aging, U.S. Department of Health, Education and Welfare, DHEW Publication No. (NIH) 78–1446.

Basic aspects of aging addressed by the Institute include genetics of aging, mutation and repair of genetic material, ability of cells to synthesize and maintain key molecular components, maintenance and integrity of cellular organelles, cell function and loss, and physiological function and decline.

As to studies on the interaction of aging and disease, the Council points out that the Institute is in a "unique position to support research emphasizing the role of intrinsic aging in the interaction of aging and disease." [34] The Council lists several particularly significant areas, including senile dementia, cerebrovascular disease, cardiovascular disease, prostatic disease, menopause, renal diseases, endocrinopathies, osteoarthritis, osteoporosis, chronic lymphatic leukemia, breast cancer, hematologic disease, and response to infection.

External or environmental influences in the panel's summary include: Nutrition, drug metabolism, physical and chemical factors, experimental model systems for study of aging, study of human populations, and resources and training needs.

C. Behavioral and Social Science Research

"The gain in life expectancy during the 20th century represents an achievement for modern industrialized societies, but it brings with it substantial changes in the society as a whole and enormous challenges for policymakers," according to the Council's report.[35] This trend toward longer life is leaving the country with two categories of older persons: the new-old, in their late 50's and 60's, and the old-old, in their 70's, 80's, and 90's. Each group represents different needs and problems and the Institute's efforts will have to address these differences. In addition, the Council warns that the programs developed for the new-old and old-old of today will most probably not apply to "future cohorts."

To meet the needs of the growing numbers of new-old and old-old persons, the Council describes the areas of research which the Institute is addressing:

(1) Research on how social, economic, and physical dependency can be reduced and prevented.

(2) Research on which specific personality, social, cultural, and environmental factors produce social competence and personal satisfaction in late life.

(3) Research on intergenerational relationships, on the changing roles of women, on how family networks may be changing as social resources for the older person, and on the role of the family in maintaining the old-old person as a member of the community.

(4) Research on the relationships among psychological, social, and physical aspects of health in middle and late life and on how health is related to socioeconomic status, ethnicity, rural-urban residence, and other social factors.

(5) Basic research to understand the observed differences between life expectancy between men and women, and methods of improving life expectancy of men.

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[34] Reference cited in footnote 33.
[35] Reference cited in footnote 33.

(6) Studies on what we have learned from "natural" social experiments, such as medicare and medicaid programs, and their effects upon older persons, their families, and upon the health care system.

(7) Research on understanding how impairment is translated into functional disability, what social and biomedical factors are involved, and how the intellectual competence of middle age can be maintained.

(8) Research on how policies directed toward the aging and aged effect the aging and aged—for example, what is the effect of manpower and training programs on the employment of the aging and the aged?

Training of researchers should also be recognized as an integral part of the Institute's overall program plan. Professionals and students should be trained in the field of aging at all levels. The Council suggests that perhaps a modest goal should be sought—to increase the number of persons competent in aging research over the next 10 years in the same proportion as the increase in the number of persons aged 85 and over in the population, which could be nearly 50 percent.

D. Research on Human Services and Delivery Systems

The Council's summary proclaims that "research on human services and delivery systems overlaps the biomedical and behavioral/social fields, which produce the knowledge directly or indirectly applicable to the provision of services to the aging and aged." They compare services and the delivery system as "the bridge between biomedical-behavioral-social findings and the actual provision of services." [36]

According to the Council, research has not yet given us the adequate knowledge to design appropriate services and delivery systems. They indicate that the Institute will attempt to develop a more sufficient data base. Service programs and delivery systems across the board will be studied, including health services, mental health services, dental health services, nutrition and food services, physical environments impact, transportation, communication, legal services, commerce, education, social-emotional services, and economic support.

In addition to these specific services, data is needed about number and kinds of services, the adequacy of such services, the gaps in services, who is utilizing them, and the extent of utilization or underutilization.

V. ONE-YEAR INCREASE IN TITLE XX CEILING

The Revenue Act of 1978, signed on November 6, 1978, by President Carter (Public Law 95–600) included an amendment—added in the final weeks of the session—raising for 1 year the title XX social services program ceiling from $2.5 billion to $2.9 billion. Of that increase, $200 million is earmarked for child day care. Each State is to receive, at a 75–25 matching ratio, a share of the remaining, $200 million based upon its population. Decisions concerning how to allocate this increase will be determined by the States.

The new ceiling may prove to be temporary, since it is to apply to fiscal year 1979 only. If the Congress does not legislate future increases, the ceiling will revert back to the $2.5 level which had been effective since 1972 when the Congress mandated the ceiling because of escala-

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[36] Reference cited in footnote 33.

tion in the costs of social services programs.[37] In 1975, when the Congress enacted title XX, to replace the former social services program under title VI,[38] the legislators expanded the eligibility standards but retained the ceiling. Therefore, the States were forced to open up programs for more people with the same amount of funding, unless the State contributed more than its 25 percent share.

This concern grew as inflation took hold. Senator Daniel Patrick Moynihan, chairman of the Senate Finance Committee's Subcommittee on Public Assistance, described the situation in 1978:

> Title XX of the Social Security Act embodies the principal source of Federal support for social services. The expenditure ceiling for that important program has remained at $2.5 billion since 1972. Had it risen apace with inflation, it would now exceed $3.6 billion. It is little wonder that State and local governments, and other providers of these useful services, are now demanding an increase.[39]

The House of Representatives had responded earlier by approving a 3-year increase for title XX—$2.9 billion in fiscal year 1979, $3.15 billion in fiscal year 1980, and $3.45 billion for 1981.[40] In addition, the House provided for emergency shelter for adults under title XX (only shelter for children is now allowed), increased authorizations for the territories, required consultation between State and local officials prior to drafting of the State plan, and a multiyear planning option. All of these provisions and others died at the end of the 95th Congress. Instead, the Congress agreed to the tax bill amendment which provides for a simple 1-year increase.

The short history of title XX has also provoked much concern about who actually receives services, what kind of services are provided, and how title XX can be better coordinated with other service programs. The Senate Finance Committee included an amendment in the title XX reform bill to require the General Accounting Office to analyze the effectiveness of title XX, its cost benefits, and the capability of the State and Federal agencies to evaluate the program. This amendment was not acted upon.

When the Older Americans Act was under Senate consideration in 1978, a floor amendment was added to require the Secretary of Health, Education, and Welfare to conduct a study of the relationship of Older Americans Act programs and title XX. The study would center around methods of integrating and coordinating title XX and Older Americans Act programs in the planning process and the delivery of services. This amendment was deleted in the conference between the House and Senate.

GAO Survey

In 1978, Senator Frank Church requested the General Accounting Office to conduct a study of the use of title XX services by aged recipients of Supplemental Security Income (SSI). The GAO responded by examining title XX programs in seven States: Ohio, Pennsylvania, Florida, Maryland, Colorado, Mississippi, and New Mexico.

[37] Public Law 92–512 placed the $2.5 billion ceiling on the annualized Federal support for social services under the Social Security Act.
[38] Public Law 93–647 authorized a new social services program under the Social Security Act under title XX.
[39] Statement of Senator Patrick Moynihan, chairman of Subcommittee on Public Assistance, Senate Finance Committee, Aug. 8, 1978.
[40] H.R. 12973 was passed by the House of Representatives on July 25, 1978.

In December 1978, the GAO staff informed Committee on Aging staff of certain preliminary findings. GAO data shows that the needs of elderly SSI recipients are not being adequately met by title XX services. Reasons for the failure of title XX services to reach these persons vary from State to State but include poor outreach efforts, lack of planning and coordination among services and income maintenance agencies, and inadequate funding to satisfy all of the needs of the various interest groups who are served by title XX.

In the States surveyed, the GAO found that small proportions of the low-income elderly were receiving social services under the title XX program. The variation was great from State to State, ranging between 3 and 33 percent of each State's elderly SSI population receiving title XX social services

The GAO also found, however, that the need for services was great. More than 80 percent of those elderly SSI recipients who did not receive any title XX assistance had a need for one or more services.

The GAO found that 80 percent of the services received by elderly SSI recipients fall within 5 categories: homemaker/chore services, health services, transportation, counseling, and protective services. The GAO will recommend that the Department of Health, Education, and Welfare develop standards for the provision of in-home services for the States to use as guidelines.

Of the seven States examined, the GAO found that only Pennsylvania had a special earmarking of title XX funds for the elderly and only Pennsylvania had a formal coordinated effort between the Older Americans Act and title XX. The GAO will recommend that HEW encourage formal planning coordination and needs assessments for the Older Americans Act programs and title XX services. The final GAO study will be issued in April 1979.

VI. CRIME AND THE ELDERLY

Fear of criminal victimization remains a continuing problem for older Americans. While available statistics indicate that the elderly are less often the targets of crimes than younger persons, there is also a general consensus among authorities that:

—In some urban areas, low-income and minority elderly are disproportionately victimized.

—Criminal attacks have a more devastating impact upon the elderly. Physical injuries are slower to heal; great psychological distress results; and economic losses are difficult to recoup.

—A majority of older individuals limit their activities, resulting in a self-imposed isolation, due to apprehension about possible criminal assaults.

In 1978, the administration presented a sweeping proposal for the revision of anticrime funds disseminated to States and localities by the Law Enforcement Assistance Administration. Currently, LEAA provides money for a variety of anticrime programs benefiting older Americans.[41]

Two proposals which would have provided compensation to crime victims were approved by the Senate during the 95th Congress, but neither was passed in the House.

[41] A Dec. 22, 1978, letter from LEAA Deputy Administrator for Policy Development Henry S. Dogin, to Committee on Aging Chairman Frank Church, fully sets out these activities.

The National Committee on Crime and the Elderly continued its work during the year. However, the future course of the committee is uncertain due to questions about the availability and adequacy of Federal assistance in the coming year.

A. The Proposed LEAA Reorganization

The Law Enforcement Assistance Administration (LEAA) was established in 1968 to provide Federal assistance to States and localities for anticrime activities. In fiscal 1979, LEAA will distribute $641 million. Existing language in the Crime Control Act requires that each State's comprehensive plan for use of its LEAA funding provide for the development of programs and projects for the prevention of crime against the elderly.

On July 10, 1978, President Carter proposed a major overhaul of LEAA activities, and a reorganization of Justice Department responsibilities in "The Justice Department Improvement Act of 1978." [42] This legislation, developed with the assistance of Senator Edward Kennedy and Representative Peter Rodino, would:

—Reauthorize LEAA for 4 years, at an annual funding level of approximately $825 million.

—Simplify the process by which LEAA funds are distributed to States and localities, and substantially reduce related paperwork.

—Require that State plans be filed in the agency only once every 3 years, in contrast to the present requirement of annual submissions. Seventy percent of LEAA funds would be distributed without "strings," in the same manner as general revenue sharing moneys, although prohibitions would be enacted against the use of the Federal assistance for equipment and hardware construction general salary increases, excessive administrative costs, and programs which have not demonstrated their effectiveness.

—A new funding formula would take crime rates into account, and would guarantee fixed allocations of funds to municipalities with populations of more than 100,000 persons, and counties exceeding 250,000. However, the new legislation specifies that no city or State would lose money under this new formula.

—Increase participation of community and neighborhood organizations in determining the use of Federal anticrime assistance through required public hearings and representation on State and local advisory boards.

—Establish a new National Institute of Justice within the Justice Department, to conduct anticrime and justice system improvement research, together with a new Buretau of Justice statistics, for the collection of data on criminal and civil justice matters, and their analysis and dissemination.[43]

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[42] The President's message to Congress, July 10, 1978.

[43] The suspension of LEAA's national crime survey prevented the publication of new nationwide statistics on criminal victimization by age; the most current available data, for 1974–75, is reprinted in "Developments in Aging: 1977," part 1, pp. 193–5. New data made available by the SCAN (Senior Citizens Anti-Crime Network) in New York City is encouraging. During 1977, in comparison to 1976, the total number of crimes against the elderly reported to the New York police declined by nearly one-quarter. The elderly victimization rate was 5 to 10 times less than that for the city population as a whole. Street robberies continue to be the most common crime perpetrated against older persons, with the average victim being an older woman 69 years old and the average offender a male 20 years old. Thirty percent of those persons charged with the most common offenses committed against the elderly in 1977 were juveniles of less than 16 years old. SCAN Bulletin No. 5, March/April 1978. 150 Nassau Street, New York, N.Y. 10038.

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—Found a new Office of Justice Assistance, Research, and Statistics to designate "national priority grants" to proven anticrime programs, and to coordinate the activities of LEAA and the other two new entities.

Hearings on this proposed reauthorization and reorganization were conducted by the Senate Subcommittee on Criminal Laws and Procedures in August 1978, and additional hearings may be conducted in the first part of 1979. Attorney General Griffin Bell, testifying at the initial hearing, said:

> The current statute imposes about 25 broad requirements regarding plan content upon States. Implementation of these requirements has resulted in annual State plans of extraordinary length. In 1977, they totaled over 50,000 pages. . . . Despite this massive and costly effort, planning in many States has been more ritual than reality—focusing to a large degree on statutory compliance. . . . Enactment of the administrations' bill will reverse this trend. Statutorily mandated requirements will be reduced from 25 to 8.

Under the administration proposal, the existing requirement that State plans provide for projects to reduce elderly victimization would be one of those eliminated. However, the proposed increased participation of community groups and neighborhood organizations in specifying the use of Federal anticrime dollars, and expansion of the community anticrime program was expected to provide older persons and their advocates with a means of assuring that this priority is not overlooked.

Both Houses of Congress must report legislation to reauthorize LEAA by May 15, 1979, in compliance with the congressional budget process, and such legislation must be enacted and become law by October 1 of the LEAA, in whatever form, is to continue.[44]

B. Victim Assistance Defeated in House

Two Senate-passed measures which would have made new resources available for the compensation of the victims of violent crime were defeated in the House of Representatives during 1978.

S. 1437, a comprehensive revision of the Federal Criminal Code, was approved by a 72 to 15 Senate vote in January. Included in this recodification was the establishment of a new fund for the compensation of victims of Federal crimes of bodily violence, or their survivors. Awards of up to $50,000, and emergency compensation of up to $1,500, was permitted under the Senate bill. However, the membership of the House Subcommittee on Criminal Justice, after a month-long review of the legislation, issued a unanimous statement that the omnibus approach to Criminal Code revision favored by the Senate and the Department of Justice was "undesirable." [45] Instead, the subcommittee

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[44] At the same time at which he announced the proposed reorganization of LEAA, the President also noted that he was reprograming $209 million in appropriated funds for the rehabilitation and improvement of physical security in 50 to 60 large public housing projects. Washington Post, July 11, 1978, p. A4; New York Times, July 11, 1978. The 1978 Housing Act also contains $12 million for 1-year demonstration projects to improve crime prevention within public housing. Further details can be found in chap. VIII of this report.

[45] National Journal, Aug. 26, 1978, p. 1374.

filed a much less extensive bill for consideration by the House (H.R. 13959), which was rejected by that body on October 4, 1978.

Most criminal offenses committed against the elderly, however, are State and local rather than Federal offenses. In 1977, the House passed legislation which would have extended Federal assistance to State victim compensation programs meeting certain minimum requirements (H.R. 7010). Corresponding legislation (S. 551) was approved by the Senate on September 11, 1978, containing additional language permitting States to waive a $100 "deductible" provision for victims age 62 and over, and encouraging the States to establish emergency compensation procedures for elderly victims. Committee on Aging Chairman Frank Church, in floor remarks, said:

> . . . criminal victimization—even though the resultant personal injury loss may be small—may have a devastating financial impact for older Americans struggling on limited income. A $50 loss, for example, may result in unpaid utility bills, unfilled prescriptions, or missed meals. . . . Many older Americans live under a form of house arrest becaue of fear of criminal victimization. To the extent that a Federal contribution can encourage the establishment and expansion of victims compensation programs, it can help to reduce this fear by letting the elderly know that a criminal attack need not result in crippling financial losses. . . . Immediate aid is often essential for the traumatized older person. Fourteen States already provide immediate assistance . . . the program has two beneficial effects: First, to give direct and immediate help, and second, to see that the State compensation program is functioning properly for older victims.[46]

Senate and House conferees subsequently agreed to a compromise bill which included both Senate provisions concerning elderly victims, and which would have reimbursed States for one-quarter of the first $35,000 awarded to victims provided that the State program met minimum Federal criteria. The conference report was adopted by a voice vote in the Senate on October 15. However, that same day, the House rejected the conference report by a vote of 199 to 184. The apparent reason for this reversal was the raising of the 3-year authorization for assistance to $120 million, compared to the $90 million originally approved by the House.

Similar legislation is expected in the 96th Congress. Meanwhile, as of July 1978, 25 State programs were distributing a total of more than $17 million per year for victims' compensation. However, a recent survey of these programs strongly questions their effectiveness as presently structured.[47] That study found:

> Despite the expenditure of these funds, the ambitious goals of victims' compensation have not been realized. . . . The failure to compensate more victims is primarily attributable to the inherent limitations in the laws and program characteristics, and not to any lack of concern among administra-

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[46] Congressional Record, Sept. 11, 1978, p. S14930.

[47] "Victim Compensation and the Elderly: Policy and Administrative Issues," by Richard Hoffrichter, research associate, criminal justice and the elderly program, legal research and services for the elderly, National Council of Senior Citizens, September 1978.

> tors. . . . Under existing legislation in all States, only a narrow class of victims . . . are eligible for reimbursement. Even if one accepts that definition of the eligible class, only a very small percentage of the intended beneficiaries ever learn about the existence of the programs.[48]

This comprehensive survey found that four central problems reduced the effectiveness for the elderly of compensation programs:

—Insufficient staff and monetary resources result in a low public awareness of program existence and benefits.
—Legislative exclusions—including "means tests," denial of awards for injuries inflicted by family or household members, minimum loss requirements, universal exclusion of compensation for property and monetary losses, and lack of provision for emergency awards—all work to deny benefits to elderly victims or discourage their participation in the program.
—Administrative "redtape" and delay also discourage participation and deny benefits when they are most needed.
—Lack of personalized and sensitive outreach results in older persons being unable to deal effectively with compensation program and the criminal justice system.

The conference version of the Victims of Crime Act of 1978 would have addressed several of these shortcomings, and these findings may well be considered by the Congress if further attempts are made to provide Federal assistance to State programs on the proviso that they meet minimum national standards.

C. Activities of the National Committee on Crime and the Elderly

The national committee began its second full year of operations in 1978.[49] Its national coordination project is continuing its oversight of seven model projects, and has more fully developed its research, policy, and information dissemination functions. The model projects are in the process of institutionalizing and expanding activities on a citywide basis, while also providing greater information and technical assistance resources. In particular, they hope to devote more attention to crisis intervention and "neighborhood strengthening" through community anticrime efforts. However, funding for all projects expires during the spring-summer of 1979, and it is not yet clear whether the Federal agencies involved will make funds available for the third and final year of project activity.[50]

The national committee, which was instrumental in helping Senate supporters insert special language in S. 551 for the benefit of older crime victims, will seek action on its Federal victims compensation assistance in the 96th Congress, including provisions for "elderly emergency assistance units," at the local level, to help elderly victims

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[48] Ibid., p. 1.
[49] For further background on the organizational makeup, history, and goals of the committee, see "Developments in Aging: 1977," pp. 197–8.
[50] Conversation with John Stein, deputy director, National Committee on Crime and the Elderly, Dec. 29, 1978. Of the four Federal funding agencies (HUD, LEAA, Community Services Administration, and AoA), only HUD has indicated that it expects to be able to provide third-year funding at present levels.

deal with the physical, psychological, and financial traumas associated with being the target of violent crime.[51]

VII. EDUCATION PROGRAMS FOR THE OLDER ADULT

The National Institute on Aging's Advisory Council on Aging states that there are two kinds of education in the field of aging: (1) Education for improving the delivery of human services to the aged, and (2) education throughout life as a human service to our society.[52] This section will describe the efforts in the later type—those educational programs for the older adult.

Scattered throughout the Federal departments and agencies are educational and training programs for older persons. Some develop new and improved skills for the aging person while others provide entertainment and stimulation of the mind. Both are important and both have been shown to keep the person more active and more alert.

According to the lifelong learning study mandated by the Congress,[53] approximately 50 programs perform functions which serve older adults in educational opportunities.[54] Many are administered under the Office of Education, the Administration on Aging, the ACTION agency, and the Department of Labor.

The Office of Education supports an array of basic education programs for older persons. For example, elderly participate in many of the programs offered under occupational adult education. Title I of the Higher Education Act has funded several programs ranging from teaching aging adults about skills needed for seeking employment to courses in arts and crafts which utilize seniors with special talents to keep alive some of the dying forms of art.

The Fund for the Improvement of Postsecondary Education in the Department of Health, Education, and Welfare has funded projects at institutions of higher education. For example, the fund supported a United Auto Workers' retired and older workers program in Michigan to assist in providing pre- and post-retirement training to its nonmanagement employees. In New Hampshire, the fund has supported a pioneer program at New England College to allow older persons to attend standard academic courses which are structured for 2 weeks or in modular form. Some of the participants became campus residents. A training team was supported in Minnesota to travel from campus to campus training staff and faculty in programs for older persons and intergenerational courses.

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[51] Comprehensive research on the sociological, economic, and psychological impact of crime on the elderly is being conducted by the University of Miami Institute for the Study of Aging and the Department of Applied Social Sciences. With funding provided by the Administration on Aging, the research will seek out answers regarding the impact, over a period of time, on the elderly individual whose life may become more restricted and frightening as a result of victimization. Local police officials are cooperating both with the research project and in educational activities to make law enforcement personnel more cognizant of the aging process. (From "Aging Update," Institute for the Study of Aging, University of Miami, Coral Gables, Fla., November 1978.)

[52] "Our Future Selves," a research plan toward understanding aging, summary reports on biomedical research, behavioral and social sciences research, research on human services and delivery systems, National Advisory Council on Aging, National Institute on Aging, National Institutes of Health, Department of Health, Education, and Welfare, DHEW Publication No. (NIH) 78–1446.

[53] "Lifelong Learning and Public Policy," a report prepared by the lifelong learning project, Education Division, Health, Education, and Welfare, February 1978.

[54] For a description of lifelong learning, see part C of this section.

The Administration on Aging has funded several education programs for the elderly in the past. However, in 1978 the model projects award listed only one educational demonstration project: a "community-based learning center for older adults" at the University of Wisconsin. It brings education to the older student in a senior center, housing project, nutrition center, or day care center.

A. Community Education

Community education grants are made to State and local educational agencies to support programs for all age groups in local neighborhood schools. In sponsoring legislation to extend community education programs, Senator Frank Church said:

> As chairman of the Senate Committee on Aging, I have witnessed the successful teamwork among community schools, senior centers, and our older Americans. Such cooperation with aging programs builds bridges of communication and interests throughout the community.[55]

A small program in the past, community education (under the Office of Education) received increased authorizations and status under the Elementary and Secondary Education Amendments of 1978 as a new title VIII.[56]

B. Other Programs

Another expanding program is Elderhostel. With the support of The Fund for Post-Secondary Education (HEW) and other Federal grants in the past, and growing private support and tuitions, Elderhostel programs have spread to 40 States and approximately 230 colleges and universities. Elderhostel, which began at the University of New Hampshire in 1975, is a higher education program for persons 60 and over who are housed on campus and participate in weeklong academic programs during the summer. The students have a choice of classes and universities and an opportunity to experience campus life and interaction with younger students at close hand.

Private foundations and organizations have demonstrated an increasing interest in learning programs for the older person in the last few years. The American Association of Community and Junior Colleges in Washington, D.C., has established an older Americans program which assists its member colleges with information and materials about programs for the aging person. AACJC also maintains a lifelong learning program which oftentimes overlaps with the activities of the older Americans program.

The Academy for Educational Development in New York has maintained a program for aging for several years. This program has been responsible for leading the academy's efforts for programs for the older student including the publication of "Never Too Old to Learn" and "Never Too Old to Teach" These publications, which were widely distributed to educational institutions and organizations, described older persons and their needs and the types of programs which can benefit them.

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[55] Statement of Senator Frank Church upon sponsoring the Community Schools and Comprehensive Education Act of 1978 (S. 2711). Mar. 20. 1978.

[56] Public Law 95-561, enacted Nov. 1, 1978.

A new program was begun in 1978 to monitor and disseminate information on how organizations can use the skills and talents of older persons. Elderworks, Inc., in New York issues a newsletter and other publications describing successful approaches to utilizing the talents of older persons and encourages further development of these approaches and others. Elderworks does not operate a program but concentrates its efforts on informing other employers about the potentials of the older person.

C. Lifelong Learning

Two years ago, the Congress included a study project within the Higher Education Act Amendments of 1976 which directed the Office of Education to establish a Office of Lifelong Learning.[57] This Office would be responsible for identifying all educational, training, volunteerism, and employment efforts of Federal agencies which could be classified as lifelong learning. The Office of Lifelong Learning was required to report its findings to the Congress with its recommendations for improving or coordinating lifelong learning efforts.

The Lifelong Learning and Public Policy report was presented to the Congress in February 1978. The report defines lifelong learning as "the process by which individuals continue to develop their knowledge, skills, and attitudes over their lifetimes." This process is offered through a variety of "learning opportunities" which, as indicated earlier, are not limited to the traditional educational programs, but also include training, employment, volunteerism, and other learning opportunities.

The report points out the growing population of persons 65 and over, who are in better health and living longer. However, the older population's participation in educational or lifelong learning programs is considerably lower than other interest groups.

What obstacles do they encounter? At hearings on "Work, Retirement, and Lifelong Learning," Senator Frank Church asked:

> Now that the end of mandatory retirement is in sight, isn't educational opportunity in later years even more important, not only as a means of adapting to new work demands and making oneself a continuing valuable employee, but also as a way of adjusting to new interests when work hours decrease or, at an agreed-upon date, end entirely? [58]

Traditional barriers to learning by older persons include the biases toward the young in education programs, financial aid policies, and the overall philosophy of education. Other problems include: Inadequate transportation, limited incomes, scheduling of programs, unfamiliarity with classroom structures and campus routines, and overall unawareness of the opportunities. According to the lifelong learning study:

> "Perhaps the most formidable barrier is the one cited by the 45 percent of those 65 and over who were surveyed by the National Council on the Aging. Quite simply, they were not interested.[59]

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[57] Public Law 94-482.

[58] Opening statement of Senator Frank Church at hearings on "Work, Retirement, and Lifelong Learning," Senate Special Committee on Aging, July 17, 1978.

[59] Harris and Associates Poll for the National Council on the Aging, 1975.

A change in society's concept of education as an important component of lifelong learning is urged in the study, which adds:

> Since human learning takes place within the context of social life, it is always possible to ask whether the social arrangements of everyday life inhibit or enhance learning opportunities that may lead to the enrichment of individual, human experience.

VIII. EMPLOYMENT

In many respects, 1978 was one of the most productive years for middle-aged and older workers—not only in terms of concrete action, but also innovative developments.

The 1978 Age Discrimination in Employment Act Amendments [60] abolish mandatory retirement for practically all Federal workers.[61] The new law also prohibits mandatory retirement before age 70 for covered workers in private employment and State and local government employees.[62]

An Age Discrimination Act, enacted into law as a part of the 1978 Older Americans Act,[63] offers the prospect of increased jobs and training for unemployed or underemployed older Americans.[64]

Congress reaffirmed its support for the senior community service employment program [65] by substantially enlarging it over a 3-year period. Congress also voted to expand flexitime [66] and part-time employment [67] opportunities in the Federal Government.

A. Comprehensive Employment and Training Act Amendments

CETA, the Nation's primary jobs and training program, underwent major changes in 1978, with potentially far-reaching implications for middle-aged and older workers. Shortly before adjournment, Congress approved a 4-year extension of CETA.[68]

A restructured title II directs comprehensive employment and training services to the economically disadvantaged.[69] Funds authorized for title II are available for two distinct programs. Parts A, B, and C include a wide range of employment and training services for the economically disadvantaged: Job counseling, skill training, work experience programs, on-the-job training, and many others.

Part A establishes a transitional public service employment program for economically disadvantaged persons. These jobs will be

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[60] Public Law 95–256, approved Apr. 6, 1978.

[61] Public Law 95–256 abolishes mandatory retirement, effective Sept. 30, 1978, for about 95 percent of all Federal employees. Persons engaged in hazardous jobs—such as firefighters or law enforcement officials—are not affected by the provision to eliminate mandatory retirement.

[62] This provision becomes effective Jan. 1, 1979.

[63] Public Law 95–478, approved Oct. 18, 1978.

[64] The Age Discrimination Act prohibits discrimination on the basis of age concerning any program or activity receiving Federal financial assistance.

[65] The senior community service employment program was extended as a part of the Comprehensive Older Americans Act Amendments of 1978, Public Law 95–478, approved Oct. 18, 1978.

[66] Public Law 95–390, approved Sept. 29, 1978.

[67] Public Law 95–437, approved Oct. 10, 1978.

[68] Public Law 95–527, approved Oct. 24, 1978.

[69] For purposes of title II, an "economically disadvantaged" person in an individual who receives public assistance or has or is a member of a family with total income (exclusive of welfare and unemployment compensation) not exceeding the poverty level or 70 percent of the lower living standard income level, whichever is higher.

coupled with appropriate training and supportive services to enhance the future employment prospects of participants. The new law directs the Secretary of Labor to insure that prime sponsor's plans for serving older workers include provisions for coordinating services with those provided by senior centers, area agencies on aging, and State agencies on aging.

Title III authorizes special national programs and activities for several groups, and includes several provisions for middle-aged and older workers (persons 55 or older), based upon legislation sponsored by Senators Chiles and Domenici and Representative Waxman. Public Law 95-527 directs the Secretary of Labor to:

—Establish programs and policies to enable middle-aged and older workers to obtain a more equitable share of employment and training resources.

—Facilitate the transition of workers over 55 years of age from nonparticipation to participation in the labor force, including work experience, vocational education, public service employment, on-the-job training, occupation upgrading, job placement, and technical assistance to employers to establish flexitime, job sharing and other innovative arrangements.

—Conduct research on the relationships between age and employment.

—Establish programs to increase labor force participation by older workers who are able and willing to work but are unable to secure work or are discouraged from seeking employment.

A special program to provide employment opportunities and supportive services is also established for displaced homemakers. Older women are expected to be among the major beneficiaries of the training and supportive services—including job training, job readiness services, job counseling, job search, job placement services, and information on education opportunities—since they represent a sizable number of all displaced homemakers in the United States. A major emphasis of the program is to create new jobs in the private sector.

Title VI establishes a countercyclical employment program to provide public service jobs for the long-term unemployed [70] and public assistance recipients (including persons receiving supplemental security income payments) who are out of work because of an economic downturn.

B. Senior Community Service Employment

Congress approved a major expansion of the senior community service employment program as a part of the 1978 Older Americans Act Amendments.[71] This program provides jobs in a wide range of community service endeavors—such as hospital aides, beautifying the countryside, handyman jobs, and many others—for low-income persons 55 or older. The new law authorizes $1.2 billion for the older

[70] Participants must be unemployed for at least 10 of the 12 weeks immediately prior to determination of eligibility. In addition, their income for the preceding 3 months (when annualized) must not exceed the lower living standard income or their family must receive AFDC or SSI benefits.

[71] The senior community service employment program was redesignated as title V of the Older Americans Act; Public Law 95-478, approved Oct. 18, 1978.

American community service employment program over a 3-year period: $350 million for fiscal 1979, $400 million for fiscal 1980, and $450 million for fiscal 1981.

Approximately 47,500 persons now participate in the national senior service corps. If fully funded, the program would provide about 75,000 jobs in 1979, 81,000 in 1980, and 88,000 in 1981.

Other important changes in the new legislation include:

—Persons with incomes not exceeding 125 percent of the poverty guidelines can work as senior aides. The effect is to allow the marginally poor to participate in the program.[72]

—National contractors must submit a description of a senior community service employment project to the appropriate State agency at least 30 days prior to the project's starting date.

—National contractors will be authorized to retain at least the number of jobs supported during fiscal year 1978. Additional funding after 1978 will be allocated at 55 percent for the States and 45 percent for the national contractors.

—The Secretary of Labor is directed to develop innovative work modes and provide technical assistance in creating job opportunities through work sharing and other experimental methods to prime sponsors, unions, and employers.

—The Department of Labor is directed to reserve up to 1 percent of appropriations above the fiscal 1978 level in order to enter into agreements to improve the transition from the senior community service employment program to private employment.

—The Secretary of Labor is authorized to fund and expand a Senior Environmental Employment Corps.

C. Title X Older Workers Projects

A stopgap funding resolution for fiscal 1979 [73] continued 71 older worker projects originally funded by the Administration on Aging under the title X job opportunities program of the Public Works and Economic Development Act. The resolution directs the Department of Labor to use CETA funding to continue about 4,700 jobs for workers 50 or older in a wide range of capacities benefiting their communities, including environmental aides, parks and recreation aides, home health

[72] See following table:

POVERTY LEVELS (125 PERCENTUM) FOR ALL STATES; ANNUAL FAMILY INCOME

Family size	Continental United States		Alaska		Hawaii	
	Nonfarm	Farm	Nonfarm	Farm	Nonfarm	Farm
1	3,925	3,362	4,925	4,225	4,525	3,912
2	5,200	4,437	6,512	5,563	5,987	5,137
3	6,475	5,512	8,099	6,901	7,449	6,362
4	7,750	6,587	9,686	8,239	8,911	7,587
5	9,025	7,662	11,273	9,577	10,373	8,812
6	10,300	8,737	12,860	10,915	11,835	10,037

Note: Income limits for families of more than 6 persons are determined by adding for nonfarm and farm levels these amounts for each additional family member: Continental United States: $1,275 nonfarm and $1,075 farm; Alaska: $1,587 nonfarm and $1,338 farm: Hawaii: $1,462 nonfarm and $1,225 farm.

[73] Public Law 95-482, Oct. 18, 1978.

aides, nutritional aides, legal services aides, ombudsmen, and preretirement counselors. The Senate Appropriations Committee report emphasized that older workers meeting the qualifications for the title V senior community service employment program should be transferred at the earliest possible date.[74] Title V provides part-time jobs for low-income persons 55 years or older. The title X job opportunities program applies primarily to persons 50 or older. In addition, it provides full-time employment as well as part-time jobs for older workers.

D. Flexible and Compressed Work Schedules Act

President Carter signed into law (Public Law 95–390) on September 29 the Federal Employees Flexible and Compressed Work Schedules Act, which is designed to promote innovative work arrangements for Federal employees. Public Law 95–390 establishes a 3-year experimental program to test the expanded use of flexible and compressed work schedules in the Federal Government. A compressed work schedule permits full-time employees to work less than 10 working days during an 80-hour biweekly basic work period. Individuals, for example, can work 10 hours a day for 4 days a week.

Flexitime permits workers to alter the standard 9 to 5 workday to accommodate personal needs or preferences. It is expected to be most helpful for older workers, handicapped individuals, and persons with child care responsibilities.

Persons participating in flexitime or compressed work schedules programs are still subject to the same number of hours and other regulations that Government agencies establish for other employees. The General Accounting Offices estimates that 10,000 private sector organizations with 1.2 million workers are using compressed work schedules, and 300,000 to 1 million private employees are employed on a flexitime basis.

E. Federal Employees Part-Time Career Employment Act

Another potentially important legislative development for older workers is the Federal Employees Part-Time Career Employment Act (Public Law 95–437). In recent years the number of part-time employment opportunities in the private sector has increased markedly. About one out of every six workers in private employment—or 17 percent—is now working part-time.[75] Public Law 95–437 is designed to promote part-time employment in the Federal Government by authorizing the Civil Service Commission to: (1) establish a part-time employment program, (2) provide technical assistance to agencies, and (3) report annually to the Congress on part-time hiring by Government agencies. Older persons are expected to be among the principal beneficiaries of the legislation, since many prefer part-time employment to provide (*a*) an alternative to retirement or (*b*) additional income to supplement retirement benefits.

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[74] Continuing appropriations, 1979, S. Rept. 95–1317 to accompany H.J. Res. 1139, 95th Cong., 2d sess., Oct. 11, 1978, p. 4.

[75] Federal Employees Part-Time Career Employment Act of 1978, H. Rept. 95–932 to accompany H.R. 10126, 95th Cong., 2d sess., Mar. 8, 1978, p. 2.

F. Age Discrimination in Employment Amendments of 1978 (Public Law 95-256)

The Age Discrimination in Employment Amendments of 1978 make potentially far-reaching changes affecting mandatory retirement policies and practices.

The new amendments will eliminate mandatory retirement for most Federal workers and prohibit mandatory retirement for most public and private workers before age 70 as of January 1, 1979.

Coverage under the new law does not extend to non-Federal employees over the age of 70.

Among the other significant exemptions are:

—The employer demonstrates that age is a bona fide occupational qualification. For example, Federal air regulations provide that an airline may not allow a flight crew member to fly as pilot in command after age 60.

—Employees who for 2 years prior to retirement occupy an executive or high policymaking position and are entitled to annual retirement income, excluding social security, of at least $27,000.

—Tenured college and university faculty members may be mandatorily retired at age 65 until July 1, 1982, when the mandatory retirement age is increased to 70 for them.

—Persons who are covered by a bona fide collective bargaining agreement in effect on September 1, 1977, may be mandatorily retired at age 65 until January 1, 1980, or until the agreement expires, whichever is later.

The new legislation also requires the Secretary of Labor to conduct a study on the effect of raising the upper age limitation to age 70 and the feasibility of raising the limitation above that age. This study—due to be presented to the President and Congress by January 1, 1982, with an interim report submitted by January 1, 1981—will also make recommendations on the effect of the bona fide executive and tenured faculty exemptions.

One of the new amendments is the revision of section 4(f) (2) which deals with the structure and management of the employee benefit plans.

Landmark age discrimination litigation involving interpretations of congressional intent regarding involuntary retirement resulted from the original construction of this section which, when enacted in 1967, stated:

> It shall not be unlawful for an employer, employment agency, or labor organization . . . to observe the terms of a bona fide seniority system or any bona fide employee benefit plans such as retirement, pension, or insurance plan which is not a subterfuge to evade the purposes of this act, except that no such employee benefit plans shall excuse the failure to hire any individual.

According to Members of Congress, the original intent of this wording was to make clear that employers should not be discouraged from hiring older workers because of any requirement that would bear increased benefit costs afforded younger workers.[76]

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[76] For a complete discussion of the legislative history of the Age Discrimination in Employment Act, see The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, a working paper prepared for use by the Special Committee on Aging by Dr. Marc Rosenblum, 1977.

In *McMann* v. *United Airlines* (1977), the first age discrimination case to reach the Supreme Court, it was held that a company could terminate an employee in accordance with pension plan terms instituted in good faith before the passage of the Age Discrimination in Employment Act of 1967.

The 1978 amendments modify section 4(f)(2) by adding:

> . . . and no such employee benefit plan shall require or permit the involuntary retirement of any individual specified by section 12(a) of this act because of the age of such individual.

Representative Augustus F. Hawkins, a member of the House-Senate Conference Committee on the amendments, explained:

> . . . the purpose of this amendment is to make absolutely clear that this exception does not authorize an employer to require or permit involuntary retirement of an employee within the protected age group on account of age. . . . The purpose of section 4(f)(2) is to encourage the employment of older workers by permitting age-based variations in benefits where the cost of providing the benefits to older workers is substantially higher. Any age-based differences in benefits would have to be evaluated under the standard section 4(f)(2).[77]

The establishment of fair benefit cost differentials for older worker employee benefits plans is expected to be crucial to employee benefit plan sponsors as they undertake to conform benefit plans and personnel policies to the requirements of the new law.

The Department of Labor issued an interpretive bulletin on the establishment of these differentials on September 22, 1978. The Department conducted a hearing to receive comments on the proposed interpretations on October 23.

Additional interpretive bulletins are scheduled on the subject of involuntary retirement, and the exemptions of the act with respect to executive and policymaking employees and tenured faculty members.

TRANSFER TO EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

An Executive order implementing the President's Reorganization Plan No. 1 of 1978, transferred day-to-day enforcement of the overall act from the Wage and Hour Division of the Department of Labor to the Equal Employment Opportunity Commission. This transfer is scheduled for completion by July 1, 1979.

G. Humphrey-Hawkins: The Full Employment and Balanced Growth Act of 1978 (Public Law 95–523)

Originally designed as a detailed action plan to coordinate economic policy in order to make a comprehensive attack on unemployment, the Humphrey-Hawkins bill emerged in the latter days of the 95th Congress as a goal-setting proposal.

As a statement of national policy regarding unemployment and balanced growth, this measure directs special attention to middle-aged

[77] Congressional Record, Mar. 21, 1978, p. H2270.

and older workers in actions taken to reduce unemployment in accordance with the act's broad goals. The act requires the President to:

> . . . transmit to the Congress during the first 20 days of each regular session . . . an economic report together with the annual report of the Council of Economic Advisers submitted in accordance with section 11(c) of this act, setting forth employment objectives for certain significant subgroups of the labor force, including youth, women, minorities, handicapped persons, veterans, and middle-aged and older persons.[78]

Unemployment for persons 45 and older typically ranges from 19 to 21 percent of the total unemployment; middle-aged and older workers ordinarily account for approximately 25 to 33 percent of the total long-term unemployment.

This act sets an unemployment goal of 4 percent by 1983, along with the anti-inflation goals of a 3-percent rate by 1983 and zero by 1988. It also calls for a balanced budget, a trade surplus, and higher price supports for farmers.

Additionally, it requires the President, the Congress, and the Federal Reserve Board to set forth their economic goals and policies each year to achieve the broad purposes of the act. There are no requirements for either executive or congressional action should these policies fall short of their goals.

IX. NEW ACTIONS ON PENSIONS

Mounting concern about shortcomings in national retirement policy [79] has focused new attention on private pension issues. A Presidential reorganization plan offered in 1978 was intended to provide an interim framework for regulatory improvement. New analyses of pension issues, however, called for additional corrective action. The Supreme Court, by deciding to take a controversial pension case in one instance and handing down a decision related to women's rights in another, also contributed to the national pension discussion.

A. ERISA Reorganization and Other Changes

The Employee Retirement Income Security Act of 1974 established minimum standards, protection, and disclosure requirements for private pension systems. Implementation has been hampered, however, by a number of difficulties, including delays in issuing regulations and administrative decisions, due to the dual jurisdiction shared by the Departments of Labor and Treasury under the act.

On August 10, 1978, President Carter issued Reorganization Plan No. 4, which took effect 60 days later. In his message the President said:

> ERISA was an essential step in the protection of worker pension rights. Its administrative provisions, however, have resulted in bureaucratic confusion and have been justifiably criticized by employers and unions alike.

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[78] Public Law 95-523, approved Oct. 27, 1978.
[79] The committee's hearings on retirement policy are described fully in chapter I.

The Reorganization Plan provides:

—The Treasury Department is given statutory authority for setting minimum standards for pension plan funding, and employee participation and vesting of benefit rights. The Department of Labor, however, retains a veto right over Treasury decisions which significantly affect plans established through collective bargaining.

—The Department of Labor is given statutory authority for setting the fiduciary obligations of pension trustees, to assure that instances of conflict of interest and management abuse do not occur.

—Both Departments retain enforcement powers, with Treasury empowered to audit plans and levy tax penalties and Labor authorized to bring civil court actions against plans and trustees.

While the plan is expected to improve ERISA's administration, and to cut processing times and paperwork,[80] it is only a temporary arrangement. The Office of Management and Budget will evaluate the experience of both Departments under this division of jurisdiction and, by April 30, 1980, the administration will present the Congress with legislative proposals for permanent changes.[81]

The Congress continued to examine other aspects of ERISA. The Senate Committees on Finance and Human Resources held 3 days of joint hearings in August 1978 on seven legislative proposals for improving the act. In testimony presented at that inquiry, Committee on Aging Chairman Frank Church emphasized the need for improving the private pension system:

> The increased longevity of the American population, the national trend toward earlier retirement, fiscal strains on the social security system, and the recent enactment of the Age Discrimination Employment Amendments of 1978 point up the need for a strong and equitable private pension system. . . . The Committee on Aging stands ready to make its contribution to the congressional consideration of pension issues by supplying data on the broad societal transformations which must necessarily impact on the form and adequacy of the private pension system. The soundness of the private pension system is second only to the fiscal integrity of social security in our joint objectives of guaranteeing security in retirement and expanding work and retirement options for all Americans.

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[80] An Apr. 27, 1978, GAO report on the "Effect of the Employee Income Retirement Security Act on the Termination of Single Employer Defined Benefit Pension Plans" (HRD–78–90) found that "the act did contribute greatly to pension plan terminations" but "the adverse effect on American workers indicated by the number of terminations is misleading" because: (a) terminating plans generally did not meet the act's minimum participation and vesting requirements; (b) participants in terminated plans received almost all their vested benefits; and (c) 40 percent of the sponsors of terminated plans continued pension coverage for their workers through new means, and additional workers set up individual retirement accounts. The GAO also found that all of the agencies with administrative duties under the act had made progress in issuing guidelines and reducing paperwork; and that the act's provisions should "strengthen responsible management of new and continuing plans and give tens of millions of workers a better chance to earn and receive vested benefits without having to work an unreasonable number of years."

[81] In testimony before the Senate Governmental Affairs Committee on Sept. 7, 1978, Harrison Wellford, Executive Associate Director of OMB, stated: "We will consult closely with Senators and Members of Congress who have an interest in ERISA administration in this process of designing and implementing the evaluation, and analysing other options—including the single-agency approach contained in S. 3017 sponsored by Senators Williams and Javits, and the division or jurisdiction approach contained in S. 2352 sponsored by Senator Bentsen."

CONCERN ABOUT MULTIEMPLOYER PLANS

Of the 35 million American workers who are covered by ERISA's protections, about 8 million are participants in multiemployer pension plans.[82] In 1977, the Pension Benefit Guaranty Corporation (PBGC)—the agency established by ERISA to provide insurance to employees against the loss of benefits resulting from pension plan termination—alerted the Congress that these plans faced major problems. In response, the Congress deferred mandatory coverage of multiemployer plans by PBGC until July 1, 1979, and ordered the Corporation to submit a further report on the situation.[83]

That report,[84] issued on July 1, 1978, found that about 10 percent of multiemployer plans, covering 15 percent of participants in such plans (1.3 million workers), were experiencing financial difficulties that could result in plan termination within 10 years. If all of these plans were to terminate, the cost which would have to be covered under the present termination insurance program would total $8.3 billion, and would place a severe strain on both the protective scheme and the healthy pension plans which contribute to it. However, if only those plans actually expected to terminate in the next decade went bankrupt, the net liability which PBGC would be obliged to cover would total only $560 million, and would not pose as severe a threat.

The Corporation found:

> Two characteristics of multiemployer plans—pension portability and protection of an employee's benefits, even though the employee's employer leaves the plan—provide participants with much greater benefit security than single-employer plans. These features, however, have resulted in some benefit plans having very high unfunded liabilities for benefits of participants whose employers have ceased contributing.[85]

While the PBGC made no specific recommendations for resolving these difficulties, it did advance a number of alternative statutory proposals which could provide relief. These include changes in how the plans are organized, financed, and regulated, as well as revisions in the operation of the protective insurance program. The Congress is expected to act on these suggestions prior to July 1979.

IRA'S: CHANGES AND WARNINGS

ERISA, besides establishing protections and standards for pension plans, also provides a simple method of accruing retirement income for the approximately 35 million Americans who are not covered by a plan—the Individual Retirement Account (IRA). These employees are permitted to contribute 15 percent of earnings, up to $1,500 annually, tax free to a savings account, annuity, or mutual fund. The money can be utilized without tax penalties after the worker reaches the age of 59½. In 1976, the most recent year for which figures are available, nearly 2 million Americans deposited almost $2 billion into IRA's.

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[82] Multiemployer plans exist primarily in the trucking, construction, retail, printing, shipping, and mining industries, where groups of employers pay into a single pension plan.

[83] For further background, see "Developments in Aging: 1977," pt. 1, p. 212.

[84] "Multiemployer Plan Required by Public Law 95–214," Pension Benefit Guaranty Corporation, July 1, 1978.

[85] Ibid., p. 3.

The 1978 Revenue Act[86] provides taxpayers with more time to place contributions in their IRA's. That decision can now be deferred until the date a tax return is filed—up to April 15—compared to the former deadline of February 14. This revision should reduce the number of instances in which taxpayers are charged a penalty for excess contributions. Further, this law permits a one-time, retroactive balancing out, on 1978 returns, for overpayments made in 1976 and 1977.

While the availability of IRA's has provided millions of uncovered employees with a new means of providing for their retirement, the Federal Trade Commission has issued warnings about certain plans issued by insurance companies which require fixed monthly payments. In a report to the House Ways and Means Committee, the FTC found that "the potential for consumer injury is substantial," and that thousands of persons have already lost the money which they invested in such plans.[87] The FTC report made a number of recommendations for improving the protection of persons seeking to establish IRA's, which are currently under consideration by the Internal Revenue Service and the Congress.

B. Court Actions Affecting Pensions

A major Supreme Court ruling on pension treatment of the sexes, and that forum's agreement to hear a controversial pension fraud case which has pitted Federal agencies against each other, promise to have major effects on the Nation's retirement income system.

EQUAL PENSIONS FOR WOMEN

Discriminatory treatment of employees is prohibited by title VII of the Civil Rights Act of 1964. In April 1978, the Supreme Court ruled, in a 6–2 decision,[88] that a pension plan operated by the city of Los Angeles which charged women 15 percent more than men for equal monthly retirement benefits violated that statute. Los Angeles had argued that this treatment should not be held illegal because women, as a class, do tend to live longer than men. However, the Court stressed that the civil rights statute protects individuals, and that most men and women (about 85 percent) die at similar ages:

> Even a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply. . . . When insurance risks are grouped, the better risks always subsidize the poorer risks. . . . Nothing more than custom makes one "subsidy" seem less fair than the other.

Differential pension treatment occurs mainly in plans covering public rather than private employees. It is these plans which are expected to be primarily affected by the Court's decision.[89] The differences generally occur in the monthly contribution, the monthly retirement benefit, or the cost of options.

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[86] Public Law 95–600, Nov. 6, 1978.
[87] The Wall Street Journal, May 5, 1978, p. 36.
[88] *City of Los Angeles, Department of Water and Power* v. *Manhart,* 98 S. Ct. 51, Apr. 25,
[89] New York Times, Apr. 27, 1978, p. 44.

However, the Court emphasized that insurance companies would remain free to weigh the relative longevity of men and women—and their presence in an employer's work force—in calculating retirement plan costs. Further, recognizing that the ruling was "a marked departure from past practice," the Court refused to award retroactive financial relief to the women who brought the suit. That denial of monetary damages stemmed largely from the Court's fear that such relief could threaten the solvency of many pension plans.

The Labor Department, responding to the Court's action, is preparing new policies to insure that employers do not discriminate against women in their pension plans and other employee benefit programs.[90]

PENSION FRAUD SLATED FOR REVIEW

John Daniels of Chicago worked for employers who, for 23 years, contributed to the Teamsters Pension Trust Fund on his behalf. But, in 1973 when he was forced to retire, Daniels was told that he would not receive a single penny from his pension because, 12 years before, he had been laid off for a 3-month period. Because ERISA's protections do not extend retroactively before its enactment, Daniels sued in Federal court on the grounds that his pension was a security, and that the lack of disclosure of his poor chance of ever collecting on it constituted a securities fraud under Federal law. In 1977, the U.S. Court of Appeals for the Seventh District agreed with Daniels. In February 1978, the Supreme Court accepted that case on appeal.

The Departments of Justice and Labor filed briefs with the Court urging that the lower decision be overturned because, they contended:

—There is no legislative or judicial record indicating that the securities laws were ever intended to apply to retirement plans.

—Affirming the decision would add a new layer of Federal law to pensions, beyond what exists now in collective bargaining legislation and ERISA.

—Retroactive application of securities law could result in suits being filed seeking billions in back payments, threatening the viability of the private pension system.[91]

The Securities and Exchange Commission, however, backed Daniels' claim and filed a brief, with the Court arguing that failure to affirm would open up new avenues to unscrupulous promoters seeking to profit from a limitation of antifraud provisions, and that projections of potential retroactive liabilities have been inaccurate and exaggerated.[92]

S. 3017, which would have negated the *Daniels* case by exempting pension interests from securities law, was not passed in the 95th Congress. It is likely that any pension revisions in the next Congress will strengthen ERISA's antifraud provisions, but such action will probably occur after the Supreme Court decision. The Supreme Court held in the *Daniels* case that an interest in a private pension was not subject to the antifraud provisions of the security laws.

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[90] Pension World, Oct. 1978, p. 31.
[91] New York Times, Aug. 7, 1978, p. D1 ; Washington Post, Aug. 17, 1978, p. D15.
[92] Wall Street Journal, Aug. 21, 1978, p. 10 ; Pension World, October 1978, p. 34.

C. New Looks at the Pension System

ERISA exempted governmental retirement systems from its provisions but mandated that the Congress undertake studies to analyze the adequacy of funding, protections, and fiduciary standards for public plans; and make recommendations for Federal legislation to correct deficiencies.

In March 1978, the House Pension Task Force released the results of its 3-year examination of public pension systems. That report [93] found:

—A lack of understanding of the public employee retirement system (PERS) by officials and the public has resulted in an inadequate regulatory framework which fails to protect vital national interests.

—The absence of a single Federal agency to coordinate the administration and enforcement of the various laws relating to retirement income has precluded the development of a unified national policy with regard to public or private pensions. Inconsistency and confusion sharply limit the protections currently afforded public employees.

—The States have generally failed to establish clear standards or effective remedies for State and local government retirement systems. Court rulings have frequently reduced statutory protections.

—The absence of uniform accounting, auditing, and actuarial standards has resulted in serious deficiencies, inadequate information, and great potential for abuse.

—Benefit levels and provisions of public plans compare favorably with the private sector. However, a majority of the plans fail to meet ERISA's minimum vesting requirements.

—There is a compelling need for uniform actuarial measures, terminology, and standards to enable participants, officials, and taxpayers to assess the present and future funding needs of public retirement systems.

—Control over plan administration and management of assets is frequently inadequate. A lack of safeguards has resulted in many instances of fiduciary abuse. Further, the investment of public pension funds in securities issued by State and local government was found to be generally inappropriate. Uniform standards of fiduciary conduct are required.

These findings will be considered by the Congress as steps are taken to bring public employee plans under ERISA-like standards. That task will also be aided by the findings of the President's Commission on Pension Policy, established [94] to conduct a 1-year study of public and private plans. The Commission is required to report to the President its recommendations for policies "designed to insure that the Nation has effective and equitable retirement, survivor, and disability programs which take into account available resources and demographic changes that are expected into the middle of the next century."

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[93] "Pension Task Force Report on Public Employee Retirement Systems," House Committee on Education and Labor, Mar. 15, 1978.

[94] Executive Order 12071, July 12, 1978.

X. TAXES AND THE ELDERLY

Tax policy occupied center stage for much of the 95th Congress, especially during 1978. Growing pressure to reduce Federal income taxes was fueled to a large degree by:

—Inflation, which often acts as a surtax for taxpayers who are pushed into higher tax brackets when they receive wage increases to compensate for price hikes.

—Social security tax increases to take effect in 1979, particularly for workers earning more than $20,000.

In the closing hours of the 95th Congress, the House and Senate concluded action on a $19 billion tax cut for individuals and businesses for fiscal year 1979. President Carter signed the 1978 Revenue Act into law on November 6, 1978.[95]

Additionally, the Congress voted to provide tax incentives for persons who install insulation and other energy conserving devices in their homes.[96] Congress also took steps to improve tax preparations assistance for older and younger Americans.[97]

A. Revenue Act of 1978

Individual income tax reductions totaling $13.6 billion for calendar year 1979 were included in the 1978 Revenue Act. Several of these provisions will have either a direct impact or a potentially important effect for older Americans. Some became effective in 1978, but most will become effective in 1979. Among the key provisions affecting older Americans:

INDIVIDUAL INCOME TAX REDUCTIONS

Public Law 95-600 reduces individual income taxes primarily through two devices for taxable year 1979. First, the tax brackets are widened. Thus, an individual will not move as quickly into higher tax brackets as under prior law. Second, the new law provides rate reductions in certain brackets.

INCREASE IN ZERO BRACKET AMOUNT

The zero bracket amount—commonly called the standard deduction—will increase from $2,200 to $2,300 for single persons and from $3,200 to $3,400 for married couples, beginning in 1979. This measure will benefit taxpayers who do not itemize their allowable deductions (e.g., medical, interest, taxes, and charitable contributions).

PERSONAL EXEMPTIONS

Public Law 95-600 increases the personal exemption deduction from $750 to $1,000 for each taxpayer, effective in 1979. Persons 65 or older will receive a double benefit from this provision, since they are entitled to an additional personal exemption because of age. However,

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[95] Public Law 95-600, approved Nov. 6, 1978.
[96] Public Law 95-618, approved Nov. 9, 1978.
[97] See page 197 for more details.

the general tax credit—equal to $35 for each personal exemption or 2 percent of the first $9,000 of taxable income (above the zero bracket amount), with a minimum credit up to $180—terminates at the end of 1978. The increase in the personal exemption deduction, though, will equal or exceed the loss in tax benefits because of the repeal of the general tax credit.

CAPITAL GAINS EXCLUSION FOR INDIVIDUALS

Beginning with sales after October 31, 1978, the capital gains exclusion for individuals is increased from 50 to 60 percent. The effect is that persons will be taxed on only 40 percent of their net capital gains, compared with 50 percent under prior law. Capital gains typically occur on the sale of stocks, bonds, or other capital assets.

EXCLUSION OF GAIN ON RESIDENTIAL SALES

One of the most significant measures for older Americans is a modified version of the Church-Packwood-Nelson amendment[98] to permit taxpayers 55 years or older to exclude up to $100,000 of gain from the sale of a principal residence from Federal income tax. A taxpayer can claim this exclusion only once. Qualifying persons who sell their homes on or after July 27, 1978, will be eligible for the exclusion.

Under prior law, homeowners 65 years or older could exclude the entire gain on the sale of a personal residence, provided (1) the adjusted sales price did not exceed $35,000, and (2) they owned and used the home as a principal residence for 5 years within the 8-year period preceding the sale. If the adjusted sales price exceeded $35,000, the amount excludable from Federal income tax was the total gain multiplied by $35,000 divided by the adjusted sales price of the personal residence.

The new law changes the ownership and use tests for older homeowners to qualify for the exclusion. They must own and use the home as a principal residence for 3 years within the 5-year period preceding the sale. A special transition rule applies to persons 65 or older who sell their homes before July 26, 1981. They may qualify under the former ownership and use test (5 out of 8 years preceding the sale) or the new rule (3 out of 5 years preceding the sale). In addition, taxpayers 65 or older who claimed an exclusion on the sale of a home before July 27, 1978, may also exclude the gain on the sale of another home on or after July 27, 1978.

The Church-Packwood-Nelson amendment makes no change in the so-called rollover provision, which permits individuals of all ages to postpone the tax on the gain from the sale of a home if they purchase a replacement residence costing as much or more than the one sold.

Four examples are provided to illustrate the time savings of the amendment when a husband and wife (one or both of whom are 55 or older) sell their personal residences and do not purchase a replacement residence costing as much or more than their present residence. The

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[98] Other sponsors of the Church-Packwood-Nelson amendment include Senators McIntyre, Stafford, Stone, Randolph, Anderson, Goldwater, McGovern, Inouye, Wallop, Domenici, DeConcini, Riegle, Clark, Thurmond, Durkin, Melcher and Bayh.

following tax computations assume that the taxpayers claim the standard deduction and do not income average.

Situation A.—Family income is $25,000, and the home was purchased in 1968 for $27,000. It has just been sold for $54,000, showing a capital gain of $27,000. With a capital gains tax in effect on this profit, the family's total bill would equal $9,751 (including a $525 minimum tax and $4,288 in incomes taxes). Total savings because of the amendment: $5,463.

Situation B.—Family income is $20,000, and the home was purchased in 1968 for $27,000. It has just been sold for $54,000, showing a capital gain of $27,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $7,747 (including a $525 minimum tax and $2,899 in income taxes). Total savings because of the amendment: $4,848.

Situation C.—Family income is $15,000, and the home was purchased in 1968 for $20,000. It has just been sold for $40,000, showing a capital gain of $20,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $4,288 (including no minimum tax, but $1,701 in income taxes). Total savings because of the amendment: $2,587.

Situation D.—Family income is $10,000, and the home was purchased in 1958 for $10,000. It has just been sold for $30,000, showing a capital gain of $20,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $2,899 (including no minimum tax, but $757 in income taxes). Total savings because of the amendment: $2,142.[99]

CHILD CARE SERVICES PROVIDED BY GRANDPARENTS

Qualifying taxpayers may claim a 20-percent credit on up to $2,000 of child care expenses for one child ($4,000 for two or more children), for a maximum credit of $400 ($800 for two or more children). Under prior law, the credit applied if the child care was performed by nonrelatives or by aunts, uncles, nieces, or nephews, but not by grandparents. Beginning in 1979, the new tax law provides that payments to grandparents will qualify for the child care tax credit.

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[99] See following table:

EFFECT OF AMENDMENT

	Situation A	Situation B	Situation C	Situation D
Income	$25,000	$20,000	$15,000	$10,000
Tax before capital gain [1]	4,288	2,899	1,701	757
Selling price of home (July 27, 1978 or later)	54,000	54,000	40,000	30,000
Cost	27,000	27,000	20,000	10,000
Gain	27,000	27,000	20,000	20,000
Tax with capital gain [2]	9,226	7,222	4,288	2,899
Minimum tax [3]	525	525	0	0
Total tax [4]	9,751	7,747	4,288	2,899
Tax before capital gain and minimum tax	4,288	2,899	1,701	757
Savings under the amendment	5,463	4,848	2,587	2,142

[1] The tax computation assumes that the taxpayers claim the standard deduction.

[2] Before Nov. 1, 1978, taxpayers reported 50 percent of their long-term capital gains. Effective Nov. 1, 1978, taxpayers report only 40 percent of their long-term capital gains.

[3] Before Nov. 1, 1978, the minimum tax was computed by taking the total of tax preferences (e.g., untaxed long-term capital gains) in excess of $10,000, and then multiplying the net amount by 15 percent. Gains from the sale of personal residences on or after Nov. 1, 1978, are not subject to the minimum tax.

[4] The computation does not include income averaging, which would reduce the tax.

B. Tax Counseling Assistance

Congress enacted two measures to make tax counseling assistance more readily available for younger and older Americans. First, the fiscal 1979 Treasury-Postal Services Appropriations Act[100] includes an amendment sponsored by Senators Chiles and Church to increase funding from $800,000 to $1,300,000 for the volunteer income tax assistance (VITA) program. VITA is administered by the Internal Revenue Service, which trains tax consultants to assist taxpayers in preparing their returns.

IRS plans to use the additional funding to make tax counseling assistance more readily available for taxpayers encountering difficulty with Federal income tax forms. In addition, the amendment will enable IRS to improve and strengthen the quality review and program management of VITA. IRS also plans to update its training program to assure that tax counselors are completely current in their understanding of the tax law.

Second, the 1978 Revenue Act builds upon the VITA program by establishing an older Americans tax counseling assistance program for taxpayers 60 or older. This measure authorizes IRS to enter into training and technical assistance agreements with private or public nonprofit agencies or organizations to prepare volunteers to provide tax counseling assistance for elderly individuals. The legislation would permit IRS to reimburse volunteers for out-of-pocket expenses incurred by them in counseling taxpayers or undergoing training. IRS is also authorized to conduct special alerts to make older Americans aware of helpful tax relief provisions, such as the tax credit for the elderly or the exclusion on the sale of a personal residence.

C. Tax Credit for the Elderly

The tax credit for the elderly is designed primarily for persons with little or no social security benefits, including policemen, firemen, teachers, and other Government pensioners. Taxpayers 65 or older may claim a 15-percent credit on up to $2,500 for individuals and $3,750 for elderly couples. This produces a maximum savings of $375 for a single person ($2,500×.15=$375) and $562.50 ($3,750×.15=$562.50) for a couple.

The maximum amounts for computing the credit, however, are reduced (1) dollar-for-dollar by social security and other tax-exempt Federal benefits, and (2) by $1 for each $2 of adjusted gross income above $7,500 for aged individuals and $10,000 for elderly couples. Thus, the credit is phased out completely for single persons with income of $12,500 or more and aged couples with $17,500 or more.

As approved by the Senate on October 10, the 1978 Revenue Act (H.R. 13511) would have increased the maximum tax credit from $375 to $450 for an elderly individual and from $562.50 to $675 for an aged couple. The Senate-passed bill would also have raised the adjusted gross income phase-out provision from $7,500 to $15,000 for qualifying single persons and from $10,000 to $17,500 for eligible couples. This change would have permitted individuals with up to $21,000 in adjusted gross income and couples with up to $26,500 in

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[100] Public Law 95–429, approved Oct. 10, 1978.

income to be potentially eligible for the 15-percent credit. The House approved an identical proposal (H.R. 9893) on October 10.

However, the conferees deleted the elderly tax credit provision from the final version of the 1978 Revenue Act.

D. The Energy Tax Act of 1978

The 1978 Energy Tax Act [101] includes several provisions to encourage energy conservation. Of special importance for homeowners, the act provides a 15-percent credit on up to $2,000 in expenditures for the installation of insulation and other energy-conserving items. Persons with $2,000 or more in qualifying expenditures can claim the maximum $300 credit. Items eligible for the credit include: (1) insulation, (2) furnace replacement burner, (3) automatic flue opening modifier, (4) automatic furnace ignition system, (5) exterior storm or thermal door or window, (6) automatic setback thermostat, (7) electric energy usage display meter, and (8) exterior caulking or weatherstripping. The credit is available for expenditures dating back to April 20, 1977. However, taxpayers are to claim all 1977 and 1978 credits on their 1978 tax returns.

XI. WHITE HOUSE CONFERENCE IN 1981

Congress acted in 1978 to assure that White House Conferences on Aging will continue their one-a-decade pattern.[102]

Health, Education, and Welfare Secretary Joseph Califano and Administration on Aging Commissioner Robert Benedict endorsed congressional [103] proposals for the conference at hearings in the Senate and the House of Representatives.

As requested by key members of this committee,[104] the final legislation [105] put heavy emphasis on developing a factual base at an early date. It stated:

> . . . the Secretary shall assure that current and adequate statistical data and other information on the well-being of

[101] Public Law 95-618, approved Nov. 9, 1978.

[102] Authority for the conference was included in Public Law 95-478, signed Oct. 10, 1978.

[103] Congressionally mandated White House Conferences on Aging took place in 1971 and 1961. A National Conference on Aging in 1950 was convened at the suggestion of Oscar Ewing, head of the Federal Security Agency. Henry Pratt, in his book "The Gray Lobby," described the 1950 predecessor to the later White House conferences: ". . . the 816 delegates in attendance did give explicit attention to the problems of aging persons and helped to legitimize this topic as a focus of public concern—something that had not been done before." The official report of the 1961 White House Conference, "The Nation and Its Older People," said: "From Jan. 9 to 12, 1961, more than 2,500 delegates met in Washington and participated in this forum. Behind them lay nearly 2 years of preconference study and analysis by thousands of professional and lay persons in the States and communities. The delegates represented 53 States and territories, and more than 300 national voluntary organizations interested or active in the field of aging." The 1971 conference report, "Toward a National Policy on Aging," said that 4,000 delegates met "to explore the circumstances of the Nation's older population and to recommend policies needed to improve those circumstances."

[104] Secretary Califano, in testimony before the House Subcommittee on Select Education, said on Mar. 20: "We feel that this conference will provide a similar forum to that in 1971: a forum for developing comprehensive approaches to the problems that will confront the Nation's elderly citizens over the next generation." Commissioner on Aging Benedict, before the Senate Subcommittee on Aging on Apr. 21, said he was pleased that the bill under consideration contained authority for a White House Conference on Aging: "The demographic trends which I set forth earlier give special emphasis to the need for such a conference in order to stimulate public attention to the 'graying of America,' and to generate an effective response to the issues raised by the 'graying' process."

[105] Senator Frank Church, then chairman of the committee, and Ranking Minority Member Pete Domenici, in the preface to "Developments in Aging: 1977," report of the Senate Committee on Aging, stated: "As valuable as the 1971 conference was, the 1981 conference can accomplish far more if: . . . determined efforts are made to obtain essential data well in advance of the actual conference . . . preparations for the conference are begun at the grassroots level at the earliest possible date . . . wherever possible, pilot programs to demonstrate experimental approaches are in place for close examination before and during the conference." For additional information about the legislative origins of the 1981 conference, see pp. 247-249, "Developments in Aging: 1977."

older individuals in the United States are readily available, in advance of the conference, together with such information as may be necessary to evaluate Federal programs and policies related to aging.

In its declaration of need for the 1981 White House Conference, the law said:

> The Congress finds that:
>
> (1) the number of individuals fifty-five years of age or older was approximately 43,000,000 in 1976, and will, by the end of this century, be over 57,000,000;
>
> (2) nearly 5,200,000 individuals fifty-five years of age or older had incomes below the poverty level in 1976, as determined by the Federal Government;
>
> (3) there is a great need to improve the economic well-being of older individuals;
>
> (4) there is a great need to make comprehensive and quality health care more readily available to older individuals;
>
> (5) there is a great need for expanding the availability of suitable and reasonably priced housing for older individuals, together with services needed for independent or semi-independent living;
>
> (6) there is a great need for a more comprehensive and effective social service delivery system for older individuals;
>
> (7) there is a great need for a more comprehensive long-term care policy responsive to the needs of older patients and their families;
>
> (8) there is a great need to promote greater employment opportunities for middle-aged and older individuals who want or need to work;
>
> (9) there is a great need to develop a national retirement policy that contributes to the fulfillment, dignity, and satisfaction of retirement years for older individuals;
>
> (10) there is a great need for a national policy with respect to increasing, coordinating, and expediting biomedical and other appropriate research directed at determining the causes of the aging process; and
>
> (11) false stereotypes about aging and the process of aging are prevalent throughout the Nation and policies should be developed to overcome such stereotypes.
>
> (b) (1) It is the policy of the Congress and the Federal Government should work jointly with the States and their citizens to develop recommendations and plans for action to meet the challenges and needs of older individuals, consistent with the objectives of this title.
>
> (2) In developing programs for the aging pursuant to this title, emphasis should be placed upon the right and obligation of older individuals to free choice and self-help in planning their own futures.

Other features of the final legislation include:

—The conference will be planned and conducted under the direction of the HEW Secretary, together with the Commissioner of Aging, the Director of the National Institute on Aging, "and the heads

of such other Federal departments and agencies as are appropriate. . . ."

—Participants will include "representatives of the Federal, State, and local governments, professional and lay people who are working in the field of aging (including researchers on problems of the elderly and the process of aging) and representatives of the general public, including older individuals."

—The final conference report—including "a statement of a comprehensive coherent national policy on aging together with recommendations for the implementation of the policy" will be submitted to the President no later than 180 days after conference adjournment. Within 90 days after this, the Secretary of HEW is to transmit to the President and to the Congress departmental recommendations for administration action and legislation to implement the recommendations.

—A conference advisory committee will include representation from the Federal Council on Aging, other appropriate public agencies, and private nonprofit organizations. The Secretary also has the authority to establish "such other committees, including technical committees as may be necessary to assist in planning, conducting, and reviewing the conference." Each such committee must include "individuals from low-income families and from minority groups. A majority of the public members of each such committee shall be 55 years of age or older."

Conference planning is in preliminary stages. The President's supplemental budget request for fiscal year 1979 allocates $3 million for the conference.

XII. UNITED STATES, U.N. ACTION ON A WORLD ASSEMBLY IN 1982

Acting on a resolution [106] advanced by the U.S. delegation, the General Assembly of the United Nations, late in 1978, authorized a World Assembly on Aging in 1982.

The resolution, as approved by the third Committee on the U.N. on November 16 and by the fifth committee on December 18:

—Authorizes the Assembly "as a forum to launch an international action programme aimed at guaranteeing economic and social security to older persons, as well as opportunities to contribute to national development." [107]

—Postpones until a later date a decision on the feasibility of an International Year of the Elderly.

—Requests the Secretary-General to submit a draft program for the World Assembly, with recommendations on its organization and objectives.

Dr. Ruth Schachter Morgenthau, U.S. Representative to the U.N. Commission for Social Development, said in a statement of support

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[106] For additional information about the resolution and prior actions by the U.S. Congress, see pp. 245–7 of "Developments in Aging: 1977," report of the U.S. Senate Special Committee on Aging.

[107] From text of A/C. 3/33/L. 21/Rev. 1, agenda item 87, 33d session, third committee "Problems of the Elderly and the Aged," United Nations, Nov. 14, 1978.

on October 30 that older persons of all nations "are long overdue for priority consideration in the United Nations."

She added:

> Modern science and improved medical technology have assured greater longevity. As a result, all nations are experiencing an increase in numbers of older citizens. For example, in 1970, there was a worldwide population of approximately 291 million persons 60 years and over. It is projected that this will increase to nearly 585 million over the next 22 years. Significantly, these increases will be more pronounced in the developing nations, where the over-60 population is expected to increase by 158 percent, while the total population is expected to increase by 98 percent. By the year 2000, 354 million older persons will inhabit the developing nations.

The U.N. Secretary General, in a report [108] listing 44 member states which supported the World Assembly and 14 which opposed it, also emphasized the need for more international attention:

> In countries where the situation of the aging was not yet severe, it was emphasized that preventive action should be initiated immediately.

U.S. Funding Action

The 1978 International Development and Food Assistance Act (signed into law on October 6 as Public Law 95-424) includes an amendment, advanced in the Senate by Frank Church and in the House by Claude Pepper, authorizing the United States to contribute up to 25 percent of the cost of a World Assembly on Aging or $1 million, whichever is lower. Action on the actual appropriation is to be sought in 1979.

[108] "Problems of the Elderly and the Aged," report of the Secretary-General, United Nations General Assembly, Sept. 26, 1978.

ADDITIONAL VIEWS OF SENATOR HEINZ

In chapter V, "New Directions in Nursing Home Care," the report states that the two long-term care issues focused on in 1978 were the high cost of care and quality of care. Although I did not serve on the Aging Committee in the 95th Congress, my concern with the quality of care provided in nursing homes prompted a Senate Governmental Affairs Federal Spending Practices and Open Government Subcommittee investigation of those Federal programs established to insure this care.

The hearings held by the subcommittee revealed surprising consensus that the elaborate and costly system of standards, survey, and enforcement DHEW established to insure the quality of care in nursing homes was a failure. The standards concentrated on the facility and its assumed capabilities, but ignored the actual medical, psychological, and social care delivered to the patient. The survey/certification process was uneven, repetitive, and often failed to identify deficiencies in the homes. Even when substandard homes were identified, the available enforcement mechanisms for bringing nursing homes into compliance were woefully inadequate.

A copy of the hearings and a planned subcommittee report provide added background for any review and comment of the proposed regulations for SNF's and ICF's, due to be announced by HCFA in late spring. I am sure the Aging Committee will want to follow up on their oversight responsibilities when the proposed regulations are issued.

JOHN HEINZ.

Supplement 1

HEARINGS HELD BY THE SPECIAL COMMITTEE ON AGING DURING 1978 AND JANUARY-MARCH 1979

Tax Forms and Tax Equity for Older Americans:
  Washington, D.C., February 24, 1978.
Health Care for Older Americans: The "Alternatives" Issue:
  Part 8, Washington, D.C., April 17, 1978.
Medi-Gap: Private Health Insurance Supplements to Medicare:
  Part 1, Washington, D.C., May 16, 1978.
  Part 2, Washington, D.C., June 29, 1978.
Retirement, Work, and Lifelong Learning:
  Part 1, Washington, D.C., July 17, 1978.
  Part 2, Washington, D.C., July 18, 1978.
  Part 3, Washington, D.C., July 19, 1978.
  Part 4, Washington, D.C., September 8, 1978.
Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units:
  Washington, D.C., July 25, 1978.
Vision Impairment Among Older Americans:
  Washington, D.C., August 3, 1978.
The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives":
  Chicago, Ill., August 30, 1978.
Condominiums and the Older Purchaser:
  Part 1, Hallandale, Fla., November 28, 1978.
  Part 2, West Palm Beach, Fla., November 29, 1978.
Older Americans in the Nation's Neighborhoods:
  Part 1, Washington, D.C., December 1, 1978.
  Part 2, Oakland, Calif., December 4, 1978.
The Impact of Rising Energy Costs on Older Americans:
  Part 7, Missoula, Mont., February 14, 1979.
Commodities and Nutrition Program for the Elderly:
  Missoula, Mont., February 14, 1979.

Supplement 2

PUBLICATIONS LIST

COMMITTEE HEARINGS AND REPORTS

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Introductory Report, Report No. 93–1420, November 1974 (Cat. No. 93/2, S. Rept. 1420)—$1.75.*
Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print report, December 1974 (Cat. No. Y4.Ag4:N93/5/No. 1)—$1.20.*
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HEARINGS

Retirement Income of the Aging:**
- Part 1. Washington, D.C., July 12–13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
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- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
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Problems of the Aging (Federal-State activities):**
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- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
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- Part 5. Eugene, Oreg., November 8, 1961.
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- Part 7. Boise, Idaho, November 15, 1961.
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- Part 9. Honolulu, Hawaii, November 27, 1961.
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- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

Housing Problems of the Elderly:**
- Part 1. Washington, D.C., August 22–23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Nursing Homes:**
- Part 1. Portland, Oreg., November 6, 1961.
- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
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- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.
- Part 5. Los Angeles, Calif., December 5, 1962.
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The War on Poverty As It Affects Older Americans:**
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Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.**

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- Part 2. Tampa, Fla., February 2–3, 1967.

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- Part 2. New York, N.Y., October 19, 1967.
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- Part 2. Ann Arbor, Mich., July 26, 1967.

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Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.**

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Trends in Long-Term Care (Cat. No. Y4.Ag4:C18/Pts.):
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Part 27. New York, N.Y., March 19, 1976—$1.20.
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Hearing Aids and the Older American:
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Transportation and the Elderly: Problems and Progress (Cat. No. Y4.Ag4:T68/Pts.):
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Improving Legal Representation for Older Americans (Cat. No. Y4.Ag4:L52/4/Pts.):
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Establishing a National Institute on Aging, Washington, D.C., August 1, 1974 (Cat. No. Y4.Ag4:N21)—75¢.
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The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975 (Cat. No. Y4.Ag4:R88/2)—$1.35.
Examination of Proposed Section 202 Housing Regulations (Cat. No. Y4.Ag4:H81/Pts.):
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The Recession and the Older Worker, Chicago, Ill., August 14, 1975 (Cat. No. Y4.Ag4:R24)—$1.35.
Medicare and Medicaid Frauds (Cat. No. Y4.Ag4:M46/5/Pts.):
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Mental Health and the Elderly, Washington, D.C., September 29, 1975 (Cat. No. Y4.Ag4:M52/3)—$2.10.
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[2] Not available at time of this printing.

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