94TH CONGRESS
2d Session

SENATE

REPORT
No. 94-998

PART 1

DEVELOPMENTS IN AGING: 1975 AND JANUARY–MAY 1976

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 62, JULY 23, 1975

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

TOGETHER WITH

MINORITY VIEWS

JUNE 26 (legislative day, JUNE 18), 1976.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
68-701 O WASHINGTON : 1976

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[1] In the 1st session, 94th Congress, two vacancies in the Committee membership occurred with the departure from the Senate of (1) Senator Alan Bible (D-Nevada), who resigned from the Senate on December 17, 1974; and (2) Senator Edward J. Gurney (R-Florida), who resigned from the Senate on December 31, 1974. Senator Dick Clark (D-Iowa) was appointed to the Committee on January 17, 1975, and Senator Dewey F. Bartlett (R-Oklahoma) was appointed to the Committee on January 27, 1975. With the election to the Senate of Senator John A. Durkin (D-New Hampshire), the Senate party ratio changed. S. Res. 258 increased the Committee on Aging membership from 22 to 23, changing the party ratio for 13 to 9 to 14 to 9. Senator Durkin was appointed to membership on the Special Committee on Aging September 19, 1976.

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LETTER OF TRANSMITTAL

JUNE 23, 1976.

Hon. NELSON A. ROCKEFELLER,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 62, agreed to on July 26, 1975, I am submitting to you the annual report of the Senate Special Committee on Aging, "Developments in Aging: 1975 and January–May 1976."

Publication has been delayed this year to allow some discussion of major new developments in the field of aging and to allow adequate time for review by members of the committee.

Senate Resolution 373, approved by the Senate Committee on Rules and Administration, authorizes this committee to continue inquiries and evaluations of issues on aging. This pertains not only to those of age 65 and beyond but others who find that advancing years affect their lives in one way or another.

On behalf of the members of the committee and its staff, I want to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 62, 94th CONGRESS, 1st SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 29, 1976.[1]

SEC. 2. (a) The committee shall make a full and complete study and investigation 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 or assistance. No proposed legislation shall be referred to such committee, and such committee shall not have power to report by bill, or otherwise have legislative jurisdiction.

(b) A majority of the members of the committee or any subcommittee thereof shall constitute a quorum for the transaction of business, except that a lesser number, to be fixed by the committee, shall constitute a quorum for the purpose of taking sworn testimony.

SEC. 3. (a) For purposes of this resolution, the committee is authorized from March 1, 1975, through February 29, 1976, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to hold hearings, (3) to sit and act at any time or place during the sessions, recesses, and adjournment periods of the Senate, (4) to require by subpena or otherwise the attendance of witnesses and the production of correspondence, books, papers, and documents, (5) to administer oaths, (6) to take testimony orally or by deposition, (7) to employ personnel, (8) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel information, and facilities of any such department or agency, and (9) to procure the temporary services (not in excess of one year) or intermittent services of individual consultants, or organizations thereof, in the same manner and under the same condition as a standing committee of the Senate may procure such services under section 202 (i) of the Legislative Reorganization Act of 1946.

(b) The minority shall receive fair consideration in the appointment of staff personnel pursuant to this resolution. Such personnel assigned to the minority shall be accorded equitable treatment with respect to the fixing of salary rates, the assignment of facilities, and the accessibility of committee records.

SEC. 4. The expenses of the committee under this resolution shall not exceed $485,000, of which amount not to exceed $15,000 shall be available for the procurement of the services of individual consultants or organizations thereof.

[1] Agreed to July 23, 1975.

SEC. 5. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable to the Senate at the earliest practicable date, but not later than February 29, 1976. The committee shall cease to exist at the close of business on February 29, 1976.[2]

SEC. 6. 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 an annual rate.

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[2] S. Res. 373, agreed to March 1, 1976, extended the committee through February 28, 1977.

PREFACE

Older Americans told the Senate Committee on Aging during 1975 and 1976 about their desperate struggle with today's cost of living. They told of daily decisions:

—How to make retirement dollars stretch to cover at least some of the prescription drugs they need while at the same time setting aside enough for the electric or heating bill.

—Trying to anticipate the next rent or property tax increase and somehow finding the money for it.

—Searching the supermarket counters for food and often giving up on meat or other items which have become out of reach.

—And arriving at the conclusion that more and more items which were "musts" in their monthly budgets have become "maybe's" or "not-at-all's."

Many of the witnesses were well above official poverty levels, but they wondered how long they—or anyone else on retirement income—could withstand rising costs on all sides.

This firsthand testimony should provide impetus for corrective legislation with fairly immediate impact, such as the proposal to make the social security cost-of-living adjustment mechanism more responsive to actual need. (See chapter II. this report, for a summary of testimony taken at field hearings on "Future Directions in Social Security: Impact of High Cost of Living.")

But it also helps make a powerful case against administration proposals which would have had adverse effects on the economic well-being of the elderly, including:

—Proposals which would have the effect of stripping food stamp eligibility from vast numbers of the elderly.

—Inadequate budget requests for Older Americans Act programs such as the title VII meals program and in-home services which can keep the elderly out of institutions.

—Housing regulations which would have stripped the 202 direct loan program of much of its usefulness for nonprofit sponsors of housing for older persons.

—And, most startling of all, a full-fledged administration "catastrophic" medicare revision which would have increased sharply the cost that most participants would have paid for hospital or other protection under medicare. (See the introduction for additional information about the medicare proposal and other examples given above.)

Fortunately, the Congress has expressed firm resistance to the medicare proposal and most of the other administration moves toward regression instead of progress. Not the least of the congressional achievements has been a firm insistence upon more adequate funding

levels for Older Americans Act programs in the face of administration reluctance.

The following report must, of necessity, describe the struggle between the executive branch and the Congress on a multitude of issues related to Federal policy on aging. It is regrettable that so much attention must be devoted to such matters. But it is also reassuring that—despite the troubled economic times through which we are passing and despite the insistent administration pressure to the contrary—the Congress has maintained and broadened its concern about the harsh problems confronting so many older Americans.

These problems are by no means overcome; the struggle to deal with them must continue.

But at the same time the Congress and the executive branch have a responsibility to recognize the very positive—and exciting—changes which are occurring as, more and more, older Americans organize at the community level to build a new pattern of life in the later years.

Although our focus at the cost-of-living hearings was necessarily on the difficulties encountered in those years, I was impressed by the evidence, everywhere, of individualized response to challenge, such as:

—An innovative congregate housing project in Massachusetts, where a former convent now houses elderly tenants.

—A large-scale meals program which has become a growing part of the life of the Portland metropolitan area in Oregon.

—An adult day care center in Rhode Island which helps participants stay in their own homes while receiving the attention they need to maintain independence.

—A senior center in Tennessee which has become the headquarters, not only for recreation, but for important services provided in an efficient manner.

Heartening as such examples are, they are still in early stages of development; they need sustained support, encouragement, and understanding from the Congress and from the executive branch if they are to reach full fruition. It is my hope that this report will help make the case for sustained concern and effective action.

FRANK CHURCH,
Chairman, Special Committee on Aging.

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EVERY TENTH AMERICAN [1]

Two hundred years ago, when we declared our independence, the colonies had a total population estimated at about 2.5 million. Virginia was the most populous with about 0.5 million. Pennsylvania was next with about 0.3 million. Then came North Carolina, Massachusetts, Maryland, New York, and Connecticut, ranging down in that order to about 0.2 million, with the remaining colonies following. Life expectancy at birth was probably about 38 or 39 years so that the older population numbered about 50,000 or 2 percent of the total.

By 1900, there were 3 million older Americans—those aged 65 and over (65+)—comprising 4 percent of the total population, or every twenty-fifth American. As of mid-1975, 22.4 million older persons made up better than 10 percent of the over 213 million total civilian resident population—or every tenth American.

In 1975, the largest concentrations of older persons—12 percent or more of a State's total population—occur in nine States: Florida (16.1), Arkansas (12.8), Iowa (12.7), Kansas, Missouri, and Nebraska (all three at 12.6 percent), South Dakota (12.5), Oklahoma (12.3), and Rhode Island (12.2).

California and New York each have more than 2 million older people and Pennsylvania, Florida, Texas, Illinois, and Ohio each have more than a million.

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

What is this population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew to almost three times its size in 1900 while the older part grew to almost seven times its 1900 size—and is still growing faster than the under-65 portion. Between 1960 and 1970, older Americans increased in number by 21 percent

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

as compared with 13 percent for the under-65 population (a further 12 percent versus 4 percent in 1970–1975).

The most rapid growth (the largest percentage increases) in 1960–1970 occurred in Arizona, Florida, Nevada, Hawaii, and New Mexico, in each of which the 65+ population increased a third or more. These five States and Alaska were the fastest growing in 1970–1975 as well. Florida, with considerable in-migration of older persons, had the highest proportion of older people, 14.5 percent in 1970 and 16.1 percent in 1975. California is now the State with the largest number of older people, 2,056,000, outnumbering New York, 2,030,000, which was first in 1970.

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 3,600 persons aged 65+ die. The net increase is about 1,400 a day or 500,000 a year but the 5,000 "newcomers" each day are quite different from those already 65+ and worlds apart from those already centenarians who were born during or shortly after the Civil War.

AGE

As of mid-1975, most older Americans were under 75 (62 percent); half were under 73; and more than a third (36 percent) were under 70. Between 1960 and 1975, the population aged 65 through 74 increased 26 percent but the population aged 75+ increased 52 percent. Close to 1.9 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available but well over 7,000 persons who produced some proof of age are 100+ and receiving social security benefit payments.

HEALTH

Eighty-two percent of the elderly get along quite well on their own, suffering no limitation on their mobility. While only 14 percent have no chronic conditions, diseases, or impairments of any kind, the vast majority that do have such conditions still manage by themselves. Older individuals are subject to more disability, see physicians 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 83 percent of the 65+ population report no hospitalization in the previous year.

Of the 960,300 older people in nursing homes in 1973–1974, 17 percent were 65–74, 40 percent were 75–84, and 43 percent were 85+ (in the total older population, the percentages are 62, 30, and 8); 70 percent were women (in the total, 60 percent); 64 percent were widowed, 19 percent single, and 12 percent married; and 94 percent were white.

In fiscal year 1974, per capita health care costs for older Americans came to $1,218 or 3.7 times the $330 spent for each under-65 person. $573 went for hospital care, $182 for physician services, $39 for other professional services, $103 for drugs, $289 for nursing home care, and $32 for other items. Older people represent some 10 percent of the population but account for 30 percent of personal health care expendi-

tures. Of the health care costs for older persons, about $734 of $1,218 total (slightly over 60 percent) came from public program resources of all kinds. Medicare covered 38.1 percent (about $465) of the total costs per older person, a continuation of the decreasing role of medicare.

PERSONAL INCOME

Older persons have half the income of their younger counterparts. In 1974, half of the families headed by an older person had incomes of less than $7,298 ($13,760 for families with under-65 heads); the median income of older persons living alone or with nonrelatives was $2,956 ($5,862 for younger unrelated individuals). Some 3.3 million or a sixth of the elderly lived in households with incomes below the official poverty threshold for that kind of household. This is a considerable improvement over the 4.7 million or quarter of the elderly in 1970 and results primarily from the increases in social security benefits. Women and minority aged are heavily over-represented among the aged poor. Many of the aged poor became poor after reaching old age because of the half to two-thirds cut in income from earnings that results from retirement from the labor force. About 43 percent of the aged couples could not afford the costs of the theoretic retired couple budget prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living ($6,041 in autumn of 1974).

EXPENDITURES FOR CONSUMPTION

Older Americans spend proportionately more of their income on food, shelter, and medical 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 command little potential for personal adjustment of income. Even formulae that adjust retirement payments for changes in price indices are of only partial assistance, since they do not provide the increases until well after the fact and older people have little in savings to carry them over until income levels are increased to catch up.

LIFE EXPECTANCY

Based on death rates in 1974, average life expectancy at birth was 71.9 years, 68.2 for males but close to 8 years longer or 75.9 for females. At age 65, average remaining years of life were 15.6, 13.4 for men but 4 years longer or 17.5 for women. The 27-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—little improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. More people now reach old age but, once there, they do not live much longer than did their ancestors who reached such age in the past.

SEX RATIOS

As a result of the yet unexplained longer life expectancy for females, most older persons are women—13.2 million as compared with 9.1 million men in mid-1975. Between ages 65 and 74, there are 130

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women per 100 men; after 74, there are 171. In the 85+ group, there are more than two women for every man. The average for the total 65+ population is 144 women per 100 men. (See "Projections," p. XIX.)

MARITAL STATUS

In 1975, most older men were married (6.9 million or 79 percent) but most older women were widows (6.5 million or 53 percent). There are 5.5 times as many widows as widowers. Among 75+ women, almost 70 percent were widows. Of the married 65+ men, almost 40 percent have under-65 wives. In 1972, among the 2.3 million marriages of persons of all ages, there were about 20,200 brides and twice as many, 40,400, grooms aged 65+. For almost 6 percent of these older brides and grooms, it was a first marriage; for the rest, it was a remarriage, mostly after previous widowhood. The marriage rate for 65+ widows was 2.2 per 1,000 but 18.4 per 1,000 for widowers.

EDUCATIONAL ATTAINMENT

In 1974, half of the older Americans had not completed one year of high school, while the median for the 25–64 age group was high school graduation. About 2.5 million older people were "functionally illiterate," having had no schooling or less than 5 years. About 7 percent were college graduates.

LIVING ARRANGEMENTS

In 1974, more than 8 of every 10 older men but only 6 of every 10 older women lived in family settings; the others lived alone or with nonrelatives except for the less than one in 20 who lived in an institution (which jumps to one in five in the 85+ 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. More than a third of all 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 1970, a somewhat smaller proportion of older than of younger persons lived in metropolitan areas (64 versus 69 percent). Within the metropolitan areas, however, most (53 percent) of the older people lived in the central city while most (55 percent) of the under-65 lived in the suburbs. The aging of the suburbs will soon bring a reversal with proportions and problems for older persons similar to those in central cities.

VOTER PARTICIPATION

In the 1974 elections, older people were 14.8 percent of the 18+ voting age population but cast 17 percent of the votes. Some 51 percent of the older population voted, the highest proportion of all age groups except for the middle aged from 45 through 64.

MOBILITY

In the March 1975 household survey, 20 percent or 4.2 million of the persons then aged 65+ reported that they had moved from one residence to another in the 5-year period since March 1970. Some 12 percent moved within the same county, 4.1 percent moved to a different county in the same State, and only 3.9 percent moved across a State line. The extent of interstate movement seems larger because such migration tends to flow toward a very small number of States—Florida, Arizona, and Nevada.

EMPLOYMENT

In 1975, about 22 percent of 65+ men (1.9 million) and 8 percent of 65+ women (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 discouraged older workers stop seeking jobs and are not counted as being in the labor force. For those remaining actively in the labor force and counted as unemployed, the average length of unemployment was greater 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 a good part of the explanation rests with income level rather than age, health, or choice. A 1972 survey shows the lowest proportion of households owning one or more cars was for those with 65+ heads (58 percent) and the highest was for those with 35–44 year old heads (88 percent). However, only among the households with under-$5,000 annual income was there a decrease in automobile ownership with advancing age. In the over-$5,000 per year income households, there was practically no difference by age. Some 92 percent of elderly households with $15,000+ incomes owned at least one automobile.

PROJECTIONS TO 2000

Projections of the size of the population based on an ultimate completed cohort fertility rate of 2.1 (an ultimate level of 2.1 children per woman), no change in net migration, and no new major medical "cures," show the following:

[Numbers in thousands]

Year	Both sexes		Female		
	Number	Percent of all ages	Male	Number	Per 100 men
1975	22,400	10.5	9,173	13,228	144
1980	24,523	11.0	9,914	14,609	147
1985	26,659	11.4	10,684	15,975	150
1990	28,933	11.8	11,518	17,415	151
1995	30,307	11.9	11,995	18,311	153
2000	30,600	11.7	12,041	18,558	154

These "averages," however, mask significant differences between age and color groupings as follows:

PERCENT INCREASE, 1975 TO 2000

Group	Both sexes	Men	Women
Total:			
65 plus	37.0	31.6	40.8
65 to 74	23.0	22.6	23.4
75 plus	60.0	49.2	66.4
White:			
65 plus	33.5	28.5	36.9
65 to 74	18.8	19.0	18.6
75 plus	57.3	46.8	63.3
Black:			
65 plus	63.0	56.1	67.9
65 to 74	54.7	52.1	56.8
75 plus	79.4	64.7	88.6

The change in "burden" on the so-called productive-age population (18–64) as measured by a gross dependency ratio is 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
1975	53.0	17.9	70.9
2000	44.2	19.0	63.2

Recent State Trends in the Older Population, 1970–75

Between 1970 and 1975, the Nation's older population (aged 65-plus) increased from 20 to 22.4 million at a rate much faster than was true for the under-65 population (12 percent versus 4 percent). This was an acceleration of the faster rate of growth of the 65-plus population between 1960 and 1970 (21 percent versus 13 percent).

These national trends, however, represent the averaging out of a variety of separate State trends. Details are presented in the accompanying analytical tables.

PROPORTION OF POPULATION AGED 65-PLUS

For the Nation as a whole (the 50 States and the District of Columbia), the proportion of the total population aged 65-plus rose from 9.8 to 10.5 percent. In two States, the proportion fell as the under-65 population grew faster than the older population (Colorado, 8.5 to 8.3 percent, and Wyoming, 9.1 to 8.8 percent). In one State, the proportion remained unchanged (New Hampshire at 10.6 percent) and in two States the gain was only 0.1 percentage point over the 5-year period (Idaho, 9.5 to 9.6, and Montana, 9.9 to 10.0). In the remaining 46 States, the gains ranged from at least 0.2 percentage point to 1.3 in Connecticut and 1.6 in Florida.

In 1975, three States were at the U.S. average of 10.5 percent (Alabama, New Jersey, and Tennessee), 21 were within 1 percentage point of the U.S. average (11 between 9.5 and 10.4, and 10 between 10.6 and

11.5); 13 were between 1 and 2 percentage points away from the average (7 between 8.5 and 9.4, and 6 between 11.6 and 12.5), and 14 were 3 or more percentage points away (8 at less than 8.5, and 6 at more than 12.5).

SUMMARY: PERCENT OF STATES' POPULATION AGED 65-PLUS, 1975

Under 8.5 (8)—Alabama, Colorado, Hawaii, Maryland, Nevada, New Mexico, South Carolina, Utah.

8.5–9.4 (7)—Delaware, Georgia, Louisiana, Michigan, North Carolina, Virginia, Wyoming.

9.5–10.4 (11)—Arizona, California, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Montana, Ohio, Texas, Washington.

10.5 (3)—Alabama, New Jersey, Tennessee.

10.6–11.5 (10)—Kentucky, Massachusetts, Minnesota, Mississippi, New Hampshire, New York, North Dakota, Oregon, Vermont, Wisconsin.

11.6–12.5 (6)—Maine, Oklahoma, Pennsylvania, Rhode Island, South Dakota, West Virginia.

Over 12.5 (6)—Arkansas, Florida, Iowa, Kansas, Missouri, Nebraska.

Variations in the relative rates of increase changed the rankings of the States between 1970 and 1975. While 11 States maintained the same rank number in 1975 as in 1970, 18 States dropped from 1 through 8 and 22 rose from 1 through 7.

DISTRIBUTION AMONG THE STATES

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

	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	9.9	9.9	9.2	9.2
New York	8.5	18.4	9.1	18.3
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.8	48.2	31.0	49.3
New Jersey	3.4	51.6	3.4	52.7
Massachusetts	2.7	54.3	3.0	55.7
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, Louisiana, Alabama, Washington, Kentucky, Connecticut, Iowa, South Carolina, Oklahoma, Colorado, Mississippi, Oregon, Kansas, Arizona, Arkansas, West Virginia	39.4	93.7	38.4	94.1
Nebraska	.7	94.4	.9	95.0
Utah, New Mexico, Maine, Rhode Island	2.0	96.4	1.9	96.9
Hawaii, Idaho, New Hampshire, Montana, District of Columbia, South Dakota, North Dakota	2.4	98.8	2.2	99.1
Nevada, Delaware, Vermont	.8	99.6	.6	99.7
Wyoming	.2	99.8	.2	99.9
Alaska	.2	100.0	.1	100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1975

State	Number (thousands)		Percent increase		Percent of all ages		State rank [2] Number		Percent increase		Percent of all ages	
	[1] 1970	1975	1960–70	1970–75	1970	1975	1970	1975	1960–70	1970–75	1970	1975
Total, 51 States	19,972	22,400	21.1	12.2	9.8	10.5						
Alabama	324	378	24.7	16.6	9.4	10.5	21	19	16	13	[3] 30	[3] 23
Alaska	7	9	27.9	32.4	2.3	2.6	51	51	11	4	51	51
Arizona	161	223	79.0	38.6	9.1	10.0	35	32	1	2	[3] 34	[3] 29
Arkansas	237	271	22.0	14.5	12.3	12.8	28	28	21	19	[3] 3	2
California	1,792	2,056	30.9	14.8	9.0	9.7	2	1	9	16	36	34
Colorado	187	210	18.8	12.3	8.5	8.3	33	34	24	24	38	[3] 44
Connecticut	288	321	19.1	11.7	9.5	10.4	26	26	23	26	[3] 27	[3] 26
Delaware	44	50	22.6	14.7	8.0	8.6	48	48	20	[3] 17	[3] 42	42
District of Columbia	70	71	2.4	1.0	9.3	9.9	41	45	51	51	[3] 32	[3] 32
Florida	985	1,347	78.2	36.7	14.5	16.1	7	4	2	3	1	1
Georgia	365	430	26.4	17.7	8.0	8.7	17	17	15	10	[3] 42	41
Hawaii	44	57	51.3	29.6	5.7	6.6	47	46	4	5	50	50
Idaho	67	79	16.3	17.2	9.5	9.6	44	42	29	12	[3] 27	35
Illinois	1,089	1,153	12.2	5.9	9.8	10.4	4	6	40	[3] 47	24	[3] 26
Indiana	492	531	10.8	8.0	9.5	10.0	12	12	[3] 45	[3] 40	[3] 27	[3] 29
Iowa	349	364	6.9	4.2	12.4	12.7	19	22	49	49	2	3
Kansas	265	285	10.8	7.4	11.8	12.6	27	27	[3] 45	43	7	[3] 4
Kentucky	336	368	15.1	9.6	10.4	10.8	20	20	35	[3] 31	21	[3] 20
Louisiana	305	346	27.0	13.4	8.4	9.1	23	23	12	23	[3] 39	37
Maine	114	125	7.6	9.6	11.5	11.8	36	36	48	[3] 31	9	10
Maryland	298	340	32.3	14.0	7.6	8.3	25	24	8	21	45	[3] 44
Massachusetts	633	672	11.3	6.1	11.1	11.5	10	10	43	46	[3] 10	[3] 13
Michigan	749	815	18.0	8.8	8.4	8.9	8	8	25	[3] 37	[3] 39	39
Minnesota	408	440	15.4	8.0	10.7	11.2	15	16	[3] 33	[3] 40	[3] 14	[3] 16
Mississippi	221	253	17.0	14.4	10.0	10.8	30	30	27	20	22	[3] 20
Missouri	558	601	11.4	7.6	11.9	12.6	11	11	42	42	6	[3] 4
Montana	69	75	5.1	9.5	9.9	10.0	43	43	50	34	23	[3] 29
Nebraska	183	194	11.8	6.2	12.3	12.6	34	35	41	45	[3] 3	[3] 4
Nevada	31	44	70.4	42.9	6.3	7.4	49	49	3	1	49	49
New Hampshire	78	87	15.8	11.4	10.6	10.6	39	40	[3] 31	27	[3] 19	22
New Jersey	694	767	24.4	10.6	9.7	10.5	9	9	17	28	[3] 25	[3] 23
New Mexico	70	90	37.7	28.2	6.9	7.9	42	39	5	6	48	47
New York	1,951	2,030	15.8	4.0	10.7	11.2	1	2	[3] 31	50	[3] 14	[3] 16
North Carolina	412	492	32.7	19.5	8.1	9.0	14	14	7	8	41	38
North Dakota	66	73	13.3	10.3	10.7	11.5	45	44	36	29	[3] 14	[3] 13
Ohio	993	1,066	11.2	7.3	9.3	9.9	5	7	44	44	[3] 32	[3] 32
Oklahoma	299	334	20.1	11.8	11.7	12.3	24	25	22	25	8	8
Oregon	226	259	23.5	14.7	10.8	11.3	29	29	19	[3] 17	13	15
Pennsylvania	1,267	1,377	12.7	8.7	10.7	11.6	3	3	37	39	[3] 14	12
Rhode Island	104	113	16.1	8.9	10.9	12.2	37	37	30	[3] 35	12	9
South Carolina	190	229	26.8	20.7	7.3	8.1	32	31	13	7	[3] 46	46
South Dakota	80	85	12.5	5.9	12.1	12.5	38	41	[3] 38	[3] 47	5	7
Tennessee	382	441	24.0	15.5	9.7	10.5	16	15	18	15	[3] 25	[3] 23
Texas	988	1,158	32.9	17.3	8.8	9.5	6	5	6	11	37	36
Utah	77	91	29.4	18.2	7.3	7.6	40	38	10	9	[3] 46	48
Vermont	47	52	8.6	9.9	10.6	11.0	46	47	47	30	[3] 19	19
Virginia	364	424	26.6	16.4	7.8	8.5	18	18	14	14	44	43
Washington	320	365	15.4	13.9	9.4	10.3	22	21	[3] 33	22	[3] 30	28
West Virginia	194	211	12.5	8.9	11.1	11.7	31	33	[3] 38	[3] 35	[3] 10	11
Wisconsin	471	512	17.4	8.8	10.7	11.1	13	13	26	[3] 37	[3] 14	18
Wyoming	30	33	16.6	9.6	9.1	8.8	50	50	28	[3] 31	[3] 34	40

[1] Corrected for errors in numbers of centenarians.

[2] States ranked in decreasing order: State with largest quantity is ranked "1".

[3] Tied in ranking. States with identical quantities receive identical rank numbers with following rank number or numbers skipped to allow for the number in the tie; e.g., 3 States tied for 5th place will each receive rank of "5" but next State will be ranked "8" to compensate for skipping of 6th and 7th rank. The 3 States would be shown as rank "[3] 5."

Source of data: Bureau of the Census. Estimates and computations supplied.

RESIDENT POPULATION, TOTAL AND AGED 65-PLUS, STATES IN RANK-NUMBER ORDER, 1975

	Total, all ages				65-plus			
		Number (thousands)	Percent			Number (thousands)	Percent	
Rank	State		Distribution	Cumulative	State		Distribution	Cumulative
1	California	21,185	9.9	9.9	California	2,056	9.2	9.2
2	New York	18,120	8.5	18.4	New York	2,030	9.1	18.3
3	Texas	12,237	5.7	24.1	Pennsylvania	1,377	6.2	24.5
4	Pennsylvania	11,827	5.6	29.7	Florida	1,347	6.0	30.5
5	Illinois	11,145	5.2	34.9	Texas	1,158	5.2	35.7
6	Ohio	10,759	5.1	40.0	Illinois	1,153	5.2	40.9
7	Michigan	9,157	4.3	44.3	Ohio	1,066	4.8	45.7
8	Florida	8,357	3.9	48.2	Michigan	815	3.6	49.3
9	New Jersey	7,316	3.4	51.6	New Jersey	767	3.4	52.7
10	Massachusetts	5,828	2.7	54.3	Massachusetts	672	3.0	55.7
11	North Carolina	5,451	2.6	56.9	Missouri	601	2.7	58.4
12	Indiana	5,311	2.5	59.4	Indiana	531	2.4	60.8
13	Virginia	4,967	2.3	61.7	Wisconsin	512	2.3	63.1
14	Georgia	4,926	2.3	64.0	North Carolina	492	2.2	65.3
15	Missouri	4,763	2.2	66.2	Tennessee	441	2.0	67.3
16	Wisconsin	4,607	2.2	68.4	Minnesota	440	2.0	69.3
17	Tennessee	4,188	2.0	70.4	Georgia	430	1.9	71.2
18	Maryland	4,098	1.9	72.3	Virginia	424	1.9	73.1
19	Minnesota	3,926	1.8	74.1	Alabama	378	1.7	74.8
20	Louisiana	3,791	1.8	75.9	Kentucky	368	1.6	76.4
21	Alabama	3,614	1.7	77.6	Washington	365	1.6	78.0
22	Washington	3,544	1.7	79.3	Iowa	364	1.6	79.6
23	Kentucky	3,396	1.6	80.9	Louisiana	346	1.5	81.1
24	Connecticut	3,095	1.5	82.4	Maryland	340	1.5	82.6
25	Iowa	2,870	1.4	83.8	Oklahoma	334	1.5	84.1
26	South Carolina	2,818	1.3	85.1	Connecticut	321	1.4	85.5
27	Oklahoma	2,712	1.3	86.4	Kansas	285	1.3	86.8
28	Colorado	2,534	1.2	87.6	Arkansas	271	1.2	88.0
29	Mississippi	2,346	1.1	88.7	Oregon	259	1.2	89.2
30	Oregon	2,288	1.1	89.8	Mississippi	253	1.1	90.3
31	Kansas	2,267	1.1	90.9	South Carolina	229	1.0	91.3
32	Arizona	2,224	1.0	91.9	Arizona	223	1.0	92.3
33	Arkansas	2,116	1.0	92.9	West Virginia	211	.9	93.2
34	West Virginia	1,803	.8	93.7	Colorado	210	.9	94.1
35	Nebraska	1,546	.7	94.4	Nebraska	194	.9	95.0
36	Utah	1,206	.6	95.0	Maine	125	.6	95.6
37	New Mexico	1,147	.5	95.5	Rhode Island	113	.5	96.1
38	Maine	1,059	.5	96.0	Utah	91	.4	96.5
39	Rhode Island	927	.4	96.4	New Mexico	90	.4	96.9
40	Hawaii	865	.4	96.8	New Hampshire	87	.4	97.3
41	Idaho	820	.4	97.2	South Dakota	85	.4	97.7
42	New Hampshire	818	.4	97.6	Idaho	79	.3	98.0
43	Montana	748	.3	97.9	Montana	75	.3	98.3
44	District of Columbia	716	.3	98.2	North Dakota	73	.3	98.6
45	South Dakota	683	.3	98.5	District of Columbia	71	.3	98.9
46	North Dakota	635	.3	98.8	Hawaii	57	.2	99.1
47	Nevada	592	.3	99.1	Vermont	52	.2	99.3
48	Delaware	579	.3	99.4	Delaware	50	.2	99.5
49	Vermont	471	.2	99.6	Nevada	44	.2	99.7
50	Wyoming	374	.2	99.8	Wyoming	33	.2	99.9
51	Alaska	352	.2	100.0	Alaska	9	.1	100.0

Source of data: Bureau of the Census. Computations supplied.

94TH CONGRESS } SENATE { REPORT
2d Session } { No. 94–998

PART 1

DEVELOPMENTS IN AGING: 1975 AND JANUARY–MAY 1976

JUNE 26 (legislative day, JUNE 18), 1976.—Ordered to be printed

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

REPORT

together with

MINORITY VIEWS

[Pursuant to S. Res. 62, 94th Cong.]

INTRODUCTION

LAGS AND PROGRESS [1]

Congress and the executive branch differed often during 1975 and early 1976 on policies and programs affecting aging.

In general, the legislators rejected proposed cutbacks or hold-the-line proposals which, at a time when costs are swollen by inflation, would actually reduce operating budgets of key programs. An unusual number of Presidential vetoes also were challenged by Congress, with mixed results.

Nevertheless, several important advances were made on behalf of aged and aging Americans, including:

—An 8-percent social security cost-of-living adjustment for nearly 32 million persons, instead of the 5-percent ceiling recommended by the administration.[2]

[1] Additional details on many of the matters described in this introduction may be found later in this report.

[2] For more detailed information about the 8-percent Social Security cost-of-living adjustment, see chapter III.

—A one-shot $50 payment ($100 for couples) for 34 million Social Security, Railroad Retiree, and Supplemental Security Income beneficiaries.[3]

—Enactment of the Older Americans Amendments of 1975, which extended and expanded the Older Americans Act, the Older American Community Service Employment Act, and other legislation for the elderly.[4]

—Approval of tax relief measures to help stimulate our sagging economy.[5]

I. THE VETOES

By the end of 1975, President Ford had vetoed 45 bills since becoming President in August 1974. The Congress had overridden eight of his vetoes, including several measures of direct importance to older Americans.

Emergency Employment Appropriations.—In May 1975, the House and Senate reached final agreement on an emergency employment appropriations bill (H.R. 4481). Of special significance, the bill included an additional $30 million appropriation for the title IX Older American Community Service Employment Act—above the $12 million already provided in the Fiscal 1975 Labor-HEW Appropriations Act.

President Ford, however, considered the bill to be inflationary and vetoed it on May 28. In his veto message, he said:

> Further stimulus would hurt more than it would help our economy in the long run. H.R. 4481 provides too much stimulus, too late, and I must therefore veto the bill.[6]

The President's veto was later sustained by the House.[7] However, the Congress provided an additional $30 million for the senior community service employment program in the first continuing resolution.[8] This amount was extended through March 31, 1976, under the second continuing resolution.[9]

The effect of this action was to enable 12,400 low-income older persons to obtain community service employment under title II, compared with 3,000 previously. But, this did not result in an overall increase in the total number of older workers because nearly 9,000 Mainstream participants from the title III Comprehensive Employment and Training Act were transferred to title IX when Mainstream was phased out on July 1.

Congress later provided $55.9 million for the title IX program as a part of an Emergency Swine Flu Appropriation Act (Public Law 94–266), which became law on April 15, 1976. (For more detailed information, see chapter IX, Older Workers in Hard Times.) This funding level will be available from July 1, 1976 to June 30, 1977. In addition, it will increase the number of enrollees in the program from 12,400 to 15,000.

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[3] Public Law 94–12, approved March 29, 1975.
[4] Public Law 94–135, approved November 28, 1975.
[5] Tax Reduction Act of 1975, Public Law cited in footnote 3.
[6] *Congressional Record*, June 2, 1975, page H4706.
[7] By a vote of 277 yeas to 145 nays (two-thirds not voting in the affirmative), the House sustained the President's veto of H.R. 4481, *Congressional Record*, June 4, 1975, pages H4873–74.
[8] Public Law 94–41, approved June 27, 1975.
[9] Public Law 94–159, approved December 20, 1975.

Special Health Revenue Sharing Act.—In December 1974, the Congress sent to the President a special health revenue sharing package, Kennedy reintroduced this bill (S. 66) in 1975. Again, the Congress approved this package, despite the administration's opposition. In which the President pocket vetoed on December 23, 1974. Senator its final form, S. 66 included several provisions of direct importance to older Americans. Among the key provisions:

1. An $8 million authorization to establish new home health agencies and to expand services of existing units. S. 66 further authorized $2 million to train professional and paraprofessional personnel.

2. Creation of a nine-member Committee on Mental Health and Illness of the Elderly to conduct a study and make recommendations concerning the future needs of mental health facilities, manpower, research, and training.

3. A funding authorization to nursing schools to provide in-service training programs for nursing home aides and orderlies.

4. A funding authorization to nursing schools to provide training for nurse practitioners in geriatrics to enable them to provide primary care in nursing homes.

President Ford vetoed the bill on July 26 because he considered the authorization levels excessive. He also opposed the bill because "it would authorize several new, narrow, categorical, and potentially costly programs which duplicate existing authorities including . . . $10 million for home health service demonstration agencies." [10]

The Congress decisively overrode the veto (by a vote of 67 to 15 in the Senate on July 26 and by a vote of 384 to 43 in the House on July 29, and S. 66 became law on July 29 [11]).

Educational Appropriations.—The Congress and the administration had another confrontation on the fiscal 1976 education appropriations bill. For older Americans, $3.53 million was at stake for launching the community schools program authored by Senator Church.[12]

President Ford again opposed the bill because the Congress approved funding levels in excess of his budget requests. In his veto message, President Ford said, "Taken as a whole, this appropriation bill is too much to ask the taxpayers—and our economy—to bear." [13] The Congress insisted on its appropriation level, and passed the bill over the President's veto.[14]

Labor-HEW Appropriations.—Congress and the administration clashed once more in 1975 on the Fiscal 1976 Labor-HEW Appropriations Act, which included several measures of direct importance to older Americans:

1. A $125 million appropriation for the title VII nutrition program for the elderly, $25.4 million above the administration's budget request. More importantly, committee report language directed that the title VII level of operations should be $187.5 million. This new spend-

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[10] *Congressional Record,* July 26, 1975, page S13889.

[11] Public Law 94-63.

[12] The Church amendment to the 1974 Elementary and Secondary Education Act would provide the framework for the establishment of a nationwide community education program. The Community Schools Act (section 405) authorizes the Commissioner of Education to make grants to local and State educational agencies to plan, establish, expand, and operate community education programs.

[13] *Congressional Record,* July 25, 1975, page H7543.

[14] The House overrode the Presidents veto of H.R. 5901 by a vote of 379 to 41. *Congressional Record,* September 9, 1975, page H8498. The Senate overrode the President s veto by a vote of 88 to 12. *Congressional Record,* page S15785.

ing level would enable nearly 350,000 older Americans to obtain low-cost nutritious meals at prices within their reach.

2. A $17.5 million funding level for the National Institute on Aging—nearly $3.1 million above the administration's request—to support biomedical, social, and behavioral research and training relating to the aging process.

3. A $31.9 million appropriation for Foster Grandparents and Senior Companions—almost $4.4 million above the budget recommendation—to provide increased service opportunities for older Americans.

4. Funding to continue the Senior Opportunities and Services (SOS), Emergency Energy Services Conservation, and Community Food and Nutrition programs. The administration had proposed to phase out these programs.

President Ford vetoed H.R. 8069 on December 19. H.R. 8069 became law when the House and Senate mustered the required two-thirds majority to override the President's veto. The House passed over the Presidential veto on January 27, 1976, and the Senate overrode the veto 1 day later.[15]

II. CUTBACKS IN MANY FORMS

Throughout 1975 and in early 1976, the administration proposed cutbacks in aging programs in many forms: rescissions,[16] reductions in budget requests, increasing the elderly's out-of-pocket payments under Medicare, and others.

In early 1975, the administration called for a 5-percent ceiling for the July 1975 Social Security cost-of-living increase, although this measure would have undermined the basic purpose of the automatic adjustment mechanism. Senator Frank Church, chairman of the committee, led a bipartisan drive to reject this measure and to insist that Social Security beneficiaries receive the full 8-percent increase authorized by law. Nearly 32 million Social Security beneficiaries will receive, on the average, an additional $70 this year to pay for food, fuel, medicines, utilities, and other necessities because of this action.[17]

President Ford called for the enactment of an earlier Nixon administration proposal to impose new and onerous costs on Medicare beneficiaries. All in all, the administration's new "cost-sharing" proposals would have reduced Medicare outlays by $1.3 billion.[18]

The Ford administration attempted to increase food stamp charges—to the point that most elderly recipients would find it uneconomical to participate in the program. Under proposed regulations announced on December 6, 1974, practically all food stamp households would pay 30 percent of their income to purchase food stamps, despite near record-breaking increases in food costs. Once again, the Congress

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[15] The House overrode the President's veto of H.R. 8069 by a vote of 310 to 113. *Congressional Record*, January 27, 1976, page H331. The Senate overrode the President's veto by a vote of 70 to 24. *Congressional Record*, January 28, 1976, page S733.

[16] A rescission occurs when the President proposes that funds already appropriated either not be spent or not be totally obligated. Under the Congressional Budget and Impoundment Control Act, both the House and Senate must pass a rescission bill within 45 days of the President's proposal. Otherwise, the funds must be spent by the administration. Usually, rescission proposals are made near the start of the calendar year. They should not be confused with budget requests for the following fiscal year.

[17] See chapter III for more detailed discussion.

[18] This legislative package was later incorporated in the fiscal 1977 budget. See page 90 for more detailed description.

balked and blocked the administration's proposal by passing legislation [19] to prohibit an increase in food stamp charges for 1975. President Ford allowed the bill to become law.[20]

But still another effort was then made to make drastic reductions in the food stamp program.

In September 1975, the Department of Agriculture proposed regulations in response to a court order directing the Department to upgrade food stamp benefits so that recipients could obtain the "nutritionally adequate diet" guaranteed by the Food Stamp Act. The proposed regulations applied three formulas for determining food stamp allotments. Two of the proposals would have seriously cut back benefits for more than 60 percent of the recipients, particularly the elderly. The proposed regulations would have reduced assistance for approximately 11 million of the country's 18.8 million food stamp recipients. After negative comments from recipients, consumer organizations, State administrative agencies—as well as a hearing by the Senate Committee on Aging—the administration agreed to block implementation of the regulations.

On other fronts, the administration recommended rescissions as a means to reduce or terminate programs. A $25 million cutback in funding was proposed for the title VII nutrition program for the elderly. If the Congress had adopted this recommendation, participation in the food stamp program would have been slashed by nearly 35,000. However, the Congress rejected this proposal.

A $9 million cutback was recommended for the title III State and community programs on aging. Yet, title III services—homemaker, home health, telephone reassurance calls, friendly visitor, and others—help older Americans to live independently in their own homes, instead of being unnecessarily or perhaps prematurely institutionalized at a much higher public cost. An estimated 85,000 elderly persons would be denied services if the Congress had acquiesced.

The Congress also rejected the administration's proposed $12 million rescission for the title IX Older American Community Service Employment Act. The effect of this proposal was to phase out the senior community service employment program, although unemployment for persons in the 55-plus age category increased by 53 percent from January 1974 to January 1975.

III. THE FISCAL 1977 BUDGET [21]

President Ford submitted his fiscal 1977 budget to the Congress on January 21, 1976.

A $52 million reduction in funding is recommended for Older Americans Act programs, from a $245 million appropriation in fiscal 1975 to $192 million proposed for fiscal 1977. AoA programs—with the exception of the title VII nutrition program—were operating under a continuing resolution because the authorization legislation had not been enacted when the House and Senate considered the fiscal 1976 Labor-HEW Appropriations bill.

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[19] H.R. 1589, 94th Cong., 1st Sess.
[20] Public Law 94–4 became law without Presidential approval on February 20, 1975.
[21] For a detailed analysis, see "The Proposed Fiscal 1977 Budget: What It Means for Older Americans," U.S. Senate Special Committee on Aging, February 1976.

Major proposed cutbacks in the Older Americans Act include:

—An $8 million reduction in the title III State and community programs on aging, from $105 million in fiscal 1975 to $97 million for fiscal 1977.

—No funding for the section 308 model projects program and title IV training.

—A $37 million reduction for the title VII nutrition program.

No funding was requested again for multidisciplinary centers of gerontology and multipurpose senior centers.

Moreover, the fiscal 1977 budget called for the termination of the title IX Older American Community Service Employment Act. Senator Church expressed opposition to this recommendation, saying:

> This is penny-wise and dollar-foolish because title IX enables low-income elderly persons to work their way out of poverty by helping others in their communities, instead of being forced onto the welfare rolls.
>
> Unemployment has nearly doubled during the past 2 years for persons 55 and above. I strongly believe that we should make every effort to maximize job opportunities for older Americans, as well as younger Americans.[22]

Major cutbacks in Medicare coverage were again proposed in the fiscal 1977 budget. In his state of the Union message, President Ford referred to these recommendations as a catastrophic health insurance package. But in reality these proposals would reduce Medicare outlays substantially for aged and disabled beneficiaries.

The administration's catastrophic health care package would:

1. Require Medicare beneficiaries to pay a coinsurance charge equal to 10 percent of all hospital charges above the $104 inpatient deductible payment. Now Medicare patients pay the first $104 of their qualifying hospital bills, and nothing thereafter until the 61st day.

2. Raise the part B Supplementary Medical Insurance deductible from $60 to $77. Afterwards, the deductible would rise proportionately with percentage increases in Social Security benefits.

3. Impose a new 10-percent coinsurance charge on hospital-based physician and home health services under part B.

4. Limit a patient's liability to $500 per benefit period for qualifying hospital services. This ceiling, though, would rise proportionately with Social Security benefit increases. President Ford later provided a $500 annual ceiling (instead of per benefit period) in his message on older Americans. (See p. 9 for more details.)

5. Place a $250 limitation per calendar year on part B covered services. Here again, this amount would rise proportionately with Social Security increases.

Senator Church introduced legislation (S. Con. Res. 86) on January 22, 1976, to express congressional opposition to proposals to increase out-of-pocket payments for Medicare beneficiaries.[23] In his introductory statement, Senator Church said:

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[22] *Congressional Record*, January 21, 1976, page S. 236.

[23] Cosponsors of S. Con. Res. 86 include Senators Church, Kennedy, Williams, Clark, Humphrey, Ribicoff, Pell, Schweiker, Cannon, Bayh, Abourezk, McGee, McGovern, Randolph, Pastore, Hart (Mich), Brooke, Stevenson, Hartke, Tunney, Chiles, Mondale, Mansfield, Stone, Stafford, Metcalf, Culver, Inouye, Durkin, Jackson, Haskell, Magnuson, Glenn, Hatfield, Leahy, Case, Javits, McIntyre, Eagleton, Weicker, Bumpers, Moss, Mathias, Gravel, Burdick, Montoya, Biden, Cranston, and Allen.

The Ford plan would only intensify the costs for the overwhelming proportion of Medicare beneficiaries. In fact, only a tiny fraction of Medicare patients with costly and catastrophic illnesses would benefit under the administration proposal, but at the expense of the vast majority of Medicare beneficiaries.

The higher charges may also cause large numbers of aged persons to delay seeking necessary medical services—or perhaps wait until treatment is no longer effective.

It is time to put a lid on rising medical expenditures which hit those hardest who can least afford these costs.[24]

Despite the many negative features in the fiscal 1977 budget, there are a few encouraging developments for the field of aging. In certain cases these policy changes were the direct result of earlier administration defeats to terminate or reduce programs for older Americans. Among the encouraging developments:

—A $375 request in new loan authority for section 202 housing for the elderly and handicapped. This funding level would finance nearly 16,000 units.

—A $55.3 million request for ACTION's older American volunteer programs (Foster Grandparents, $34 million; Retired Senior Volunteer program, $17.5 million; and Senior Companions, $3.8 million), nearly $6 million above the fiscal 1976 appropriation.

—A $26.22 million recommendation for the National Institute on Aging, almost $8.7 million above the fiscal 1976 appropriation.

—A recommendation to continue the Senior Opportunities and Services program.

—A decision not to place an arbitrary ceiling on the July 1976 Social Security cost-of-living increase (6.4 percent), as had been the case in 1975.

IV. THE OLDER AMERICANS ACT: A CASE STUDY

The Older Americans Amendments of 1975—perhaps more so than any other proposal—symbolized administration and congressional differences of opinion on aging issues.

On January 30, 1975, the administration sent to the Congress a draft bill for extending the Older Americans Act.[25] This proposal would have extended the Older Americans Act for 2 years. In addition, the bill would have authorized—for each of the fiscal years 1976 and 1977:

—$91 million for title III area planning and social services and State agency operations, $39 million below the fiscal 1975 authorization of $130 million and $6 million below the fiscal 1975 appropriation of $97 million.

—$5 million for section 308 model projects, $3 million under the fiscal 1975 appropriation of $8 million.

—$7 million for title IV research.

—$200,000 for the National Information and Resource Clearing House for the Aging.

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[24] *Congressional Record*, January 22, 1976, page S312.
[25] *Congressional Record*, February 7, 1975, page S1610.

The administration further called for the termination of the training, multidisciplinary centers of gerontology, and multipurpose senior centers programs.

When it became evident that the Congress would reject these recommendations, the administration launched a frontal attack to block congressional efforts to provide more substantive and far-reaching changes to the Older Americans Act and other legislation affecting the elderly. Secretary of HEW Weinberger and Under Secretary of Labor Schubert sent letters on March 20 [26] to House Minority Leader Rhodes, expressing opposition to the House Education and Labor Committee proposal.[27]

Secretary Weinberger strongly opposed the provisions to designate four priority services (transportation, legal counseling, residential repairs, and in-home services) for funding by local agencies on aging. He urged that the measure to authorize direct funding of Indian tribes be deleted. Instead, he called upon Congress to rely upon existing enforcement authority to insure that Indians receive their proper share of services under the act.

As for the proposed new Age Discrimination Act, Secretary Weinberger recommended that the Congress ask the Federal Council on the Aging to study the matter.

In addition, the administration opposed the new authority to train lawyers and paraprofessionals to provide legal counseling services, giving this rationale:

> This proposal, if enacted, would run directly counter to our goal to end the proliferation of programs designed to grant institutions specific funds to train specific types of personnel.[28]

Under Secretary of Labor Schubert objected to the extension of the title IX Older American Community Service Employment Act. He contended: "Authority and adequate funding for this type of activity are available under the Comprehensive Employment and Training Act (CETA)." [29]

The House rejected these arguments and approved the Education and Labor Committee bill by a vote of 377 to 19 on April 8. The Senate approved a similar measure by voice vote on June 26. House and Senate conferees then resolved the differences in the two bills. Final approval of the conference bill came on November 17 in the House and November 19 in the Senate.

The overwhelming bipartisan support for the conference bill—404 to 6 in the House and 89 to 0 in the Senate—clearly demonstrated that a veto would be overridden. On November 28, President Ford signed the Older Americans Amendments of 1975 into law,[30] although he expressed disagreement with key features in the act. He objected to the new Age Discrimination Act, in particular:

> The delineation of what constitutes unreasonable age discrimination is so imprecise that it gives little guidance in the development of regulations to prohibit such discrimination.

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[26] *Congressional Record*, March 20, 1975, pages E1303–4.
[27] "Older Americans Amendments of 1975," H.R. 3922, 94th Cong., 1st Sess.
[28] *Congressional Record*, March 20, 1975, page E1304.
[29] Page E1304 of *Congressional Record* cited in footnote 28.
[30] Public Law cited in footnote 4.

> Also, the provisions raise a question on the extent to which the Federal Government should seek to regulate private activity, particularly without holding hearings to permit affected persons and institutions to be heard.[31]

President Ford also was "not pleased" with the authorization levels included in the act: "The authorization for social service programs for fiscal year 1976, for example, is almost twice that of my budget request." [32]

V. THE PRESIDENT'S MESSAGE ON OLDER AMERICANS

President Ford submitted his message on older Americans on February 9, 1976. To a very large degree, his recommendations were based upon earlier proposals advanced in his state of the Union and budget messages.

The President again called for the enactment of his catastrophic health care proposal. He made one modification, however, in his aging message. He urged that Medicare be expanded to provide unlimited hospital and skilled nursing home care coverage. Senator Church expressed support for this provision, as well as the recommendations to place a limit on hospital and physician charges for Medicare beneficiaries (see page 90 for further discussion). However, he pointed out:

> But the benefits from these proposals are greatly outdistanced by the "cost sharing" arrangements which would substantially increase the elderly's out-of-pocket payments. The new 10-percent coinsurance charge for part A services would reduce medicare benefits by more than $1.7 billion.[33]

Nearly 5.9 million Medicare beneficiaries are expected to receive reimbursable hospital services in fiscal 1977. Of this total, only 150,000—or less than 3 percent—would pay less under the administration's catastrophic health care package. Independent analyses reveal that an elderly patient must ordinarily be hospitalized about 75 days to benefit from the administration's $500 ceiling for qualifying hospital charges.

Approximately 14.2 million persons are projected to receive reimbursable service under the Supplementary Medical Insurance program in fiscal 1977. But only 1.8 million—or about one out of seven of those receiving reimbursable services—would pay less under the administration's proposal.

President Ford also proposed to limit increases in Medicare daily payment rates in 1977 and 1978 to 7 percent for hospitals and 4 percent for physicians. The purpose of these provisions is to reduce Medicare expenditures. However, Senator Church warned that these measures may shift the cost to aged and disabled and Medicare beneficiaries. He noted that the 4-percent ceiling on physician charges may cause doctors not to accept Medicare reimbursement in full. Elderly patients may then be forced to pay more for physician services, since Medicare pays 80 percent of "reasonable charges" after the deductible payment is met.

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[31] "Weekly Compilation of Presidential Documents," December 1, 1975, pages 1326–7.
[32] Page 1327 of document cited in footnote 31.
[33] *Congressional Record*, February 25, 1976, pages S2293–4.

President Ford recommended major changes in Social Security benefits, including:

—Phasing out over a 4-year period Social Security benefits for full-time students.

—Eliminating the retroactive payment of actuarially reduced payments when a beneficiary would have a permanent reduction in monthly benefits. A retired worker may now receive up to 12 months retroactive payments, provided all factors of entitlement are fulfilled during the retroactive period.

—Removing the monthly test of the Social Security earnings limitation, except for the first year a beneficiary receives a cash benefit. Now a beneficiary under age 72 may earn $2,760 a year before $1 in benefits is withheld for each $2 of earnings above the earnings ceiling. However, a person may receive benefits during any month that earnings do not exceed $230.

President Ford urged two major proposals to insure the financial integrity of the Social Security trust funds. He called for a 0.3 percent increase in the Social Security contribution rate, from 5.85 to 6.15 percent effective in 1977 (for further discussion on financing proposals, see p. 69). In addition, he urged that the Social Security system be "decoupled" (for further discussion of "decoupling," see p. 69).

FINDINGS AND RECOMMENDATIONS

The administration's fiscal 1977 budget falls far short of responding to many key problems of older Americans. If allowed to stand, it will intensify the difficulties of large numbers of elderly persons.

Major changes are needed in several areas. The committee recommends that:

—Funding levels for the Older Americans Act should be raised to more realistic levels.

—The Title IV training program should be continued and expanded.

—The Title V Multipurpose Senior Center program should be funded.

—The Title IX Older American Community Service Employment Act should be continued and expanded.

—Legislation [34] should be approved to express congressional opposition to proposals to increase out-of-pocket payments for Medicare beneficiaries.

The committee on Aging renews its pledge to cooperate with the administration to improve the budget for older Americans. The committee strongly believes there is genuine bypartisan interest in such an objective.

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[34] On January 22, 1976, Senator Church introduced S. Con. Res. 86 to express congressional opposition to proposals to increase out-of-pocket payments by Medicare beneficiaries. As of May 1976, he had 48 cosponsors.

CHAPTER I

MAJOR SUPPORT FOR THE OLDER AMERICANS ACT

Difficulties of the kind described in the introduction were counterbalanced somewhat in 1975 and in early 1976 by several strong expressions of congressional support for continuation, expansion, and more adequate funding of the Older Americans Act.

That act has been on the books since 1965.[1] A major responsibility, as administered through the U.S. Administration on Aging, has been the title III area planning and service grants[2] made in conjunction with State agencies on aging and—since 1974—sub-State or area agencies on aging. In addition, the AoA is authorized to support model and demonstration projects, research, training, and gerontology centers. Funding is also available for a national nutrition program for the elderly.

Gradually, the Older Americans Act has assumed increasing importance in terms of increased responsibility and increased funding.

That process was accelerated over the past year by actions clearly expressing strong support in both Houses of the Congress:

—Extension of the act was overwhelmingly approved. The final vote in the House of Representatives was 404 to 6. The Senate vote was unanimous, 89 to 0.[3]

—Together with extension, both Houses endorsed significant increases in authorizations for major titles.

—Congress then resisted administration attempts, at the start of this year, to lower funding levels through the rescission process (see introduction, page 1).

—And then, supporters in both Houses took up the cause of making actual appropriations come closer to the amounts authorized,[4] making significant progress in the face of administration reluctance to raise these levels.

Together with several new programmatic innovations called for in the 1975 amendments, the struggle for increased funding provided heartening evidence of sustained congressional interest in the Older Americans Act as it completed its first decade of existence.

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[1] Public Law 89–73, July 14, 1965.

[2] For a description of accomplishments under the Older Americans Act during its first 10 years and a description of its area agency on aging strategy, see pages 81–100, *Developments in Aging 1974 and January–April 1975*, Annual Report, U.S. Senate Committee on Aging, June 24, 1975. For the U.S. Administration on Aging's own report on activities in 1975, see appendix 2.

[3] *Congressional Record*, November 19, 1975, page H 11449, and November 20, 1975, pages S 20705–5.

[4] Congress arrives at funding levels in two stages. Authorizing legislation, in this case are the 1975 amendments to the Older Americans Act, sets dollar goals for each title in the legislation or merely calls for "such sums as may be deemed necessary." The amount actually committed to program operations, however, are determined later when appropriations committees in each House clear spending bills for approval by vote of the membership in each House. Authorization levels may not be exceeded by appropriations, but appropriations may, and often are, lower than authorizations.

I. VICTORIES ON FUNDING

Often, during the hearings on the 1975 Older Americans Amendments, witnesses said that mere continuation of programs at existing funding levels would really be cutbacks in those programs.

For one thing, inflation was causing rising costs of running those programs. The title VII meals for the elderly program, for example, was particularly hard hit by increases in the cost of food.

Moreover, the number of area agencies was on the increase[5] and they were being called upon to reach more people in more ways. Normal growth of the Older Americans Act, even without inflation, would have caused a need for higher authorizations.

A. The New Authorizations

The Older Americans Act Amendments of 1975[6] continue all titles[7] of the Older Americans Act through fiscal year 1978 (which ends September 30, 1978), thus providing a substantial time frame for the further evolution of programs under that act.

In addition, the amendments authorized significant increases for the Older Americans Act, the Older American Community Service Employment Act, and the older American volunteer programs under the Domestic Volunteer Service Act.

The following table provides some basis for judging the magnitude of the increases by listing the actual appropriations for fiscal year 1975 with the authorizations enacted in the 1975 amendments:

FUNDING FOR OLDER AMERICANS AMENDMENTS

[Dollar amounts in millions; fiscal years]

		Authorized funding levels			
	1975 appropriation	1976	Transitional quarter	1977	1978
Title III:					
Area planning and social services	$82	$180	$57.75	$231	$287.2
Model projects	8	(1)	(1)	(1)	(1)
State agency operations	15	(2)	(2)	(2)	(2)
Title IV:					
Training	8	(1)	(1)	(1)	(1)
Research	7	(1)	(1)	(1)	(1)
Multidisciplinary centers of gerontology	0	(1)	(1)	(1)	(1)
Title V—Multipurpose senior centers	0	(1)	(1)	(1)	(1)
Title VII—Nutrition	125	(3)	62.5	(4)	275.0
Title IX—Older American Community Service Employment Act	12	100	37.5	150	200.0
Domestic Volunteer Service Act:					
Retired Senior Volunteer program	15.98	[5] 20	6	22	22.0
Foster Grandparents	28.28	[6] 32	8.75	35	35.0
Senior Companions	2.56	[7] 8	2	8	8.0

[1] Such sums as may be necessary.
[2] Included in the authorized funding for area planning and social services.
[3] Public Law 93-351 authorized $200,000,000 for fiscal year 1976.
[4] Public Law 93-351 authorized $250,000,000 for fiscal 1977.
[5] Public Law 93-113 authorized $20,000,000 for RSVP for fiscal 1976.
[6] Public Law 93-113 authorized $37,000,000 for the Foster Grandparent program for fiscal 1976.
[7] Public Law 93-113 authorized $8,000,000 for Senior Companions for fiscal 1976.

[5] The latest number of area agencies approved by the States and reported to AoA as of December 31, 1975, is 483.

[6] Public Law 94-135, signed November 28, 1975.

[7] The title VII, Nutrition Program for the Elderly, had been extended individually through fiscal year 1977 by Public Law 93-351, signed July 12, 1974. Public Law 94-135 extended title VII through fiscal year 1978.

President Ford, in a statement issued when he signed the legislation, said he was "pleased to give . . . approval of this bill," but he also said:

> At a time when we are struggling to restrain growth in the Federal budget, I am not pleased to see the high authorization levels included in this bill. The authorization for social service programs for fiscal year 1976, for example, is almost twice that of my budget request.[8]

For reasons already discussed, however, Members of Congress expressed their conviction that a "no-growth" policy on authorizations and appropriations was actually regression instead.

B. Progress on Appropriations in 1976

Authorizations notwithstanding, the final decisions on funding levels are made in the appropriations process (see footnote 4, page 11).

Actions taken in both Houses early in 1976 indicated a widespread congressional awareness of the need to buttress last year's authorization actions with concrete victories on appropriations.

The Eagleton-Brooke Amendment: Senators Thomas F. Eagleton and Edward W. Brooke paved the way for increased appropriations in March 1976 when they urged major funding increases in the Older Americans Act as a part of the fiscal 1976 second supplemental appropriations bill (H.R. 13172). Cosponsors of the Eagleton-Brooke amendment included Senators Church, Williams, Kennedy, Tunney, Pell, Case, Abourezk, Hart (Mich.), and Weicker. In its final form, the Eagleton-Brooke amendment proposed the following funding levels for Older Americans Act programs and the title IX Older American Community Service Employment Act:

FISCAL YEAR 1976 FUNDING

[Dollar amounts in millions]

Program	Administration budget request	Eagleton-Brooke amendment
Title III:		
Area planning and social services	$76	$93
Model projects	5	10
State agency operations	16.235	17
Title IV:		
Training	0	15
Research	5.765	8
Multidisciplinary centers of gerontology	0	1
Title V—Multipurpose senior centers	0	15
Title VII—Nutrition	99.6	[1] 125
Older Americans Act total	202.6	284
Older American Community Service Employment Act	0	56
Total	202.6	340

[1] See discussion under "The Title VII Situation," page 14.

In terms of individual impact, the Eagleton-Brooke amendment would enable nearly 4.1 million elderly persons to receive information and referral, transportation escort, and outreach services, compared with an estimated 3.6 million in fiscal 1975. Almost 1.7 million older

[8] Weekly Compilation of Presidential Documents, December 1, 1975, volume II, No. 48, "Older American Amendments of 1975," statement by the President on signing of H.R. 3922, November 28, 1975.

Americans used title III gap-filling services (counseling, homemaker-home health aides, chore services, and others) in fiscal 1975. The Eagleton-Brooke amendment would increase this total to more than 1.9 million.

In addition, the Eagleton-Brooke amendment would boost the number of participants in the title IX Older American Community Service Employment Act from 12,400 to 15,000.

The House Committee on Aging Initiative: A companion amendment to the fiscal 1976 second supplemental appropriation bill was advanced by the House Select Committee on Aging members—under the leadership of Representative William Randall, the chairman of the committee. Representatives Randall and Spark Matsunaga (chairman of the House Subcommittee on Federal, State, and Community Services) led a bipartisan drive to provide $139 million in new funding for fiscal 1976 for the title III State and community programs on aging and title IV training and research. In addition, the House Committee on Aging amendment included the following appropriations for the transitional quarter (July 1 to September 30): $38 million for title III, $7 million for title IV, and $5 million for title V.

On May 18 and 19, the House and Senate approved the conference report on the second supplemental appropriations bill (H.R. 13172). H.R. 13172 was signed into law on June 1, 1976. Public Law 94–303 includes:

FISCAL YEAR 1976 APPROPRIATIONS FOR THE OLDER AMERICANS ACT AS PROVIDED IN THE 2D SUPPLEMENTAL APPROPRIATIONS BILL (P.L. 94–303)

[In millions of dollars]

Program	Fiscal year 1976	Transitional quarter
Title III:		
Area planning and social services	$93.0	$31.25
Model projects	13.8	2.5
State agency operations	17.0	4.25
Title IV:		
Training	10.0	4
Research	8.0	2
Multidisciplinary centers of gerontology	1.0	1
Title V: Multipurpose senior centers	0	5
Title VII: Nutrition program	[1] 125.0	[1] 46.875

[1] See discussion under "The Title VII Situation," below.

Separate Action on Title IX: Senators Eagleton and Brooke also won approval of a $55.9 million funding level for the title IX senior community service employment program. The amendment was attached as a rider to an emergency swine flu appropriations resolution, H.J. Res. 890. The funding level—scaled down from the original proposal of $56 million to $55.9 million—will be available from July 1, 1976, to June 30, 1977. H.J. Res. 890 became law (Public Law 94–266) on April 15, 1976. (For additional details on title IX operations, see discussion in chapter IX, page 149, and report by the Department of Labor, appendix 2.)

The Title VII Situation: The administration called for a $25.4 million cutback in funding for the title VII nutrition program in fiscal 1976, from the $125 million appropriated in fiscal 1975 to $99.6 million. Congress, however, rejected this measure and provided $125 million in

the fiscal 1976 Labor–HEW Appropriations Act.[9] President Ford vetoed this measure, but the Congress overrode the veto.[10] In addition, the appropriations bill and the conference report directed that the level of operations for title VII should be $187.5 million because of the existence of carryover funds.

Despite this clear expression of congressional intent, some doubt remained whether the administration would actually release the full amount of title VII funds. The nutrition program had been operating at $150 million under the Fiscal 1975 Supplemental Appropriations Act because carryover funds were used to supplement the $125 million appropriation.

The Administration on Aging released, on March 27, 1976, an additional $37.5 million for the nutrition program. These funds will be used during fiscal 1976, but a portion will probably be carried over into the fiscal 1977 operations (this is expected because of the late release of funds during fiscal 1976). State offices on aging can obligate the new funds until September 30, 1977.

For the transitional quarter (July 1, 1976 to September 30, 1976), title VII has a $9.775 million appropriation (as a part of the Fiscal 1976 Labor–HEW Appropriations Act). In addition, title VII will be supported by $37.1 million from the fiscal 1976 appropriations which was forward-funded into the transitional quarter.[11]

As of December 31, 1975, nearly 245,000 meals were served daily under the title VII program at 764 projects (5,493 meal sites). Nearly 86 percent of the meals were served in congregate settings (at senior citizen centers, schools, and other nonprofit settings) and 14 percent of the meals were home delivered. Approximately 61 percent of the participants had incomes below the poverty line. (For additional information about title VII operations, see chapter X, page 153, and report by the U.S. Administration on Aging, appendix 2.)

II. PROGRAM CHANGES IN THE 1975 AMENDMENTS

Important new refinements in program objectives under the Older Americans Act were built into the 1975 amendments, many of them as the result of congressional insistence.

A. Priority Services

Area agencies on aging came into being as a result of the 1973 Older Americans Act Amendments. As envisioned by administration spokesmen, the AAA's are intended to make full use of existing or potential resources, rather than providing direct services as their major activity. This concept has led to a heavy emphasis on coordination and planning functions of AAA's, so much so that some Members of Congress have complained that AAA's seem to be overwhelmed

[9] Public Law 94–206 became law on January 28, 1976.

[10] President Ford vetoed the fiscal 1976 Labor-HEW Appropriations Act (H.R. 8069) on December 19, 1975. The House passed over the Presidential veto on January 27, 1976. The Senate passed over the Presidential veto on January 28, 1976.

[11] On May 17, 1976, in *Kennedy et al. v. Mathews et al.*, the U.S. District Court of the District of Columbia held that the Department of Health, Education, and Welfare had to release the total $187.5 million during fiscal year 1976. The court further ordered that all such funds in addition to the amount Congress mandates for fiscal year 1977 must be obligated by the States by September 30, 1977.

by demands that have little to do with everyday needs of the elderly. As the Senate Committee on Labor and Public Welfare expressed it in its report on the 1975 amendments, the heavy planning and needs-assessment activities of AAA's have "given rise to concern that direct provision of services to the aging has been deemphasized."

Public Law 94–135 identified four priority services—transportation, legal counseling, residential repair, and in-home services—for funding under title III. Beginning in fiscal 1977 (October 1, 1976, to September 30, 1977), States must commit at least 50 percent of the increase in their allotment for planning and social services (the difference between their allotment in fiscal 1977 compared with fiscal 1975) for the four enumerated services. However, this amount may not be less than 20 percent of the title III State planning and social services funding. States, though, are exempt from the 20- or 50-percent requirements if they use at least one-third of their title III allotment to provide some or all of the four priority services. A major goal of the four services is to enable older Americans to live independently in their own communities and homes.

B. Model Projects

First established in 1973, section 308 model projects provide Federal funding for demonstrations to improve social services or otherwise promote the well-being of older persons. The Older Americans Comprehensive Services Amendments identified several priority areas for funding, including housing assistance, continuing education, preretirement counseling, and services for handicapped persons. The 1975 amendments expanded the section 308 program to include: (a) Ombudsman services for nursing home residents; (b) improving the delivery of services for low-income, minority, Indian, and limited English-speaking individuals and the rural elderly; and (c) assisting in the establishment and operation of senior ambulatory day care centers.

C. Definition of Social Services

The 1975 amendments broadened the definition of social services (section 302) to include legal services (including tax and financial counseling) and programs to promote physical fitness for the elderly. This action was prompted by the growth and demand for legal and related services throughout the country. The definition change—together with the listing of legal counseling as a priority service for funding under title III—gives added emphasis to the importance of legal counseling for older Americans.

D. Direct Funding of Indian Tribes

Direct funding of Indian tribes is now authorized under title III, provided the Commissioner determines:

(1) Indian tribe members are not receiving benefits equivalent to other older persons in the State; and

(2) They would be better served through direct funding.

E. Administration of State Plans

Public Law 94–135 increased the floor for State administration costs from $160,000 to $200,000. The act further provides that a State's allotment shall not be less than the amount received in fiscal 1975. The Commissioner may also provide additional funds to a State, provided three conditions are fulfilled:

(1) The State is unable to carry out programs effectively unless additional amounts are available.

(2) The State is using effectively and fully its allotment and personnel.

(3) The State agency and area agencies on aging are carrying out, on a full-time basis, programs and activities in furtherance of the act. The additional funds, however, may not exceed three-quarters of 1 percent of the sums allotted title VII and title III area planning and social services.

These changes required a $1.235 million increase in State agency operation funds for fiscal 1976. The administration recommended that $1.235 million be transferred from title IV research to title III. This recommendation was rejected by the Senate Labor-HEW Appropriations Subcommittee. In a letter (dated March 2, 1976) to the Department of Health, Education, and Welfare, Senator Warren Magnuson (chairman of the Labor-HEW Appropriations Subcommittee) said: "The committee has no objection to your increasing by $1,235,000 funding for aging community services, but it does object to reducing aging research by this amount." On April 13 the House voted to increase funding for State agency operations by $2 million, from $15 million to $17 million. On May 12, the Senate voted for a $17 million level for State agency operations and this amount was later agreed to by the conferees and signed into law (Public Law 94–303).

F. Training Needs in Aging

The 1975 amendments were responsive to the demand for more trained personnel in the field of aging. The new law makes it clear that authority for title IV training includes both short-term and long-term arrangements—as well as workshops, conferences, institutes, post-secondary education courses, and financial support for students. Title IV was also expanded to include the training of lawyers and paraprofessionals to (a) provide legal counseling or (b) monitor the administration of programs for older Americans. In addition, training is authorized to identify legal problems affecting the elderly and to develop solutions for their needs.

G. Changes in Nutrition Program

Public Law 94–135 now directs the Secretary of Agriculture to donate surplus commodities to title VII nutrition projects. In addition, the 1975 amendments direct the Secretary to maintain an annually programed level of assistance in commodities to equal at least 15 cents per meal in fiscal 1976 (compared with 10 cents per meal in 1975) and at least 25 cents per meal in fiscal 1977. Moreover, the new

law requires the Secretary of Agriculture to purchase meats and other high protein foods for title VII projects.

H. Community Service Employment

The 1975 amendments also provided a 3-year extension of the title IX Older American Community Service Employment Act at a $487.5 million authorization. In addition, the act requires the Secretary of Labor to reserve a sufficient sum under each year's appropriation for the title IX program to continue older worker employment programs conducted by national contractors at their fiscal 1975 jobs level. Any remaining funding may be distributed to the States by a formula, taking into account the 55-plus population and a State's relative per capita income.

III. THE AGE DISCRIMINATION ACT

A major innovation in the 1975 amendments was the establishment of an Age Discrimination Act to prohibit discrimination on the basis of any age in any program or activity receiving Federal assistance. Exceptions, however, exist for:

(1) Programs providing benefits or assistance on the basis of age (e.g., Headstart or the Older Americans Act).

(2) Programs or activities reasonably taking into account age as a factor necessary to the normal operation or the achievement of a statutory objective.

(3) Employment practices of any employer, employment agency, or labor organization, except programs or activitives receiving financial assistance under the Comprehensive Employment and Training Act.

The new law would, in no way, change the Age Discrimination in Employment Act, enacted in 1967.

The amendments also direct the U.S. Commission on Civil Rights to conduct a study to identify those areas where age discrimination is being practiced in federally assisted programs. The Commission is required to report its findings to the Congress 18 months after enactment of the act (enactment was on November 28, 1975).[12]

Following the Commission's report, the Secretary of the Department of Health, Education, and Welfare is directed to publish regulations carrying out the provisions of the Age Discrimination Act. These regulations will be published no later than 12 months after the issuance of the Commission's report or 30 months after the enactment of the law, whichever occurs first.

In providing this timetable, the Congress attempted to guard against unforeseen effects of the law, such as occurred after the implementation of title IX (to prohibit sex discrimination) of the higher education amendments. House and Senate conferees emphasized the importance of a thorough study concerning the effect of the new law on existing programs and statutes. The purpose is to provide "a final resolution by the Congress of the difficult policy issues that are left undecided by this legislation." [13]

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[12] The second supplemental appropriations bill (P.L. 94–303) includes $154,000 for this study by the U.S. Commission on Civil Rights.

[13] Conference report to accompany H.R. 3922, Older Americans Amendments of 1975, November 17, 1975.

FINDINGS AND RECOMMENDATIONS

The year 1975 marked the 10th anniversary of the Older Americans Act. A decade of experience under this legislation has amply demonstrated its value and worth for the Nation's elderly.

Title III social services enable many older Americans to continue to live independently, instead of being institutionalized at a much higher public cost.

The title VII program provides low-cost, nutritious meals at prices within the reach of most elderly persons. In addition, it provides another dividend for many older Americans—an opportunity to meet and socialize with other elderly persons.

Money spent on title IV training has proved to be a prudent investment, responding to the critical shortage of adequately trained personnel in the field of aging and the elderly's everyday problems.

With the near-unanimous passage of the Older Americans Amendments of 1975, the Congress reaffirmed its intent that the Older Americans Act should not only be continued but also expanded.

The committee fully supports the title IV-C multidisciplinary centers of gerontology and the title V multipurpose senior centers programs that are funded for the first time in fiscal 1976. The need for these programs has been well documented in compelling testimony presented at hearings to extend the Older Americans Act.

For fiscal 1977, the committee urges that increased funding be adopted to provide the financial wherewithal to permit essential growth in Older Americans Act programs.

The committee strongly believes that the section 308 model projects program should be continued and expanded. In addition, the committee reaffirms its support for projects to improve legal representation for older Americans.

Moreover, the committee urges the administration to take prompt action to implement the new provisions in the Older Americans Amendments of 1975.

CHAPTER II

COPING WITH THE COST OF LIVING

"We have heard from many expert witnesses in our Senate hearing rooms, and they have dealt with vital subjects: financing, future and present; failures in the supplementary security income, or SSI, program; inequitable treatment of women; the social security earnings limitation; and so on. Important as this sometimes technical testimony is, it has real meaning only if we can relate it to what is actually happening to the people who depend on social security and SSI either as the sole or major source of retirement income."

—Senator Frank Church,
Nashville, Tenn., Dec. 6, 1975

Testimony taken by the Senate Committee on Aging as part of its study of "Future Directions in Social Security" reached out into seven States [1] in 1975 and early 1976 for direct reports on the daily battles older Americans are fighting with the cost of living.

What emerged were vivid and often deeply disturbing accounts, many of them based on personal experiences or firsthand knowledge of problems encountered by friends and neighbors.

What also emerged was a call for action on a number of issues and Federal programs.

I. THE CONTEXT: AN ALL-ENCOMPASSING SQUEEZE

"One does not have to be poor to feel the effects of inflation . . . who is there so far removed from reality that they cannot understand what it means for anyone, especially the elderly and the disabled with their special aggravated needs, to be condemned to live in this country on $140 a month or $235. Surely, such amounts have no relationship to what it costs to sustain life, and let's not forget that supportive services and health services under Medicare and Medi-Cal [2] are shrinking also."

—Testimony [3] by Isabel Van Frank,
San Francisco, Calif., May 15, 1975

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[1] "Future Directions in Social Security: Impact of High Cost of Living": Part 13, San Francisco, Calif., May 15, 1975, Senator John V. Tunney, presiding. Part 14, Los Angeles, Calif., May 16, 1975, Senator John V. Tunney presiding. Part 15, Des Moines, Iowa, May 19, 1975, Senator Dick Clark presiding. Part 16, Newark, N.J., June 30, 1975, Senator Harrison A. Williams, Jr., presiding. Part 17, Toms River, N.J., September 8, 1975, Senator Harrison A. Williams, Jr., presiding. Part 20, Portland, Oreg., November 24, 1975, Senator Frank Church, chairman, presiding. Part 21, Portland, Oreg., November 25 1975, Senator Frank Church, chairman, presiding. Part 22, Nashville, Tenn., December 6, 1975, Senator Frank Church, chairman, presiding; Senator Bill Brock, Congressman Clifford Allen, and Congresswoman Marilyn Lloyd present. Part 23, Boston, Mass., December 19, 1975, Senator Frank Church, chairman, presiding. Part 24, Providence, R.I., January 26, 1976, Senator Frank Church, chairman, presiding; Senators John O. Pastore, Claiborne Pell, and Congressman Edward P. Beard present. Part 25, Memphis, Tenn., February 13, 1976, Senator Bill Brock presiding; Congressman Harold E. Ford present.

[2] California's medicaid program.

[3] Page 1160, part 13.

Statistical poverty, as chapter IV reports, remains a major problem among older Americans, faced as they are by particularly sharp increases in the items for which they pay proportionately more of their incomes than do other age groups: food, health, shelter and energy, and transportation.

In addition, the "special aggravated needs" mentioned in the excerpt above cause additional drains on retirement income. Perhaps the most obvious "special aggravated needs" are out-of-hospital prescription drugs not covered by medicare. A less apparent need is the frequent doctor's order for a special diet, often causing a need for additional shopping on transportation which may be highly expensive, if available.

Testimony from retired witnesses and others confirmed the severity of the poverty problem, but also documented an all-encompassing economic squeeze on other persons who might ordinarily be regarded as middle-income or even well-to-do in terms of retirement income.

The major message was: Any one of the cost-of-living increases described at the hearings would have been bad enough even if one at a time. But the cumulative impact is devastating to retirement income.

As one witness expressed it:

> We recognize that rents, food, utilities, and clothing have all gone up beyond reason, but we must also keep in mind that there isn't a single item on sale that has not increased in cost two-, three-, and more-fold even to the postage stamp and sheet of paper we need to write to you. Servicemen in this area charge from $15 to $25 just to come and tell you why your refrigerator or what have you isn't working and what it will cost to repair. So the roof continues to leak, the house goes unpainted, the telephone is cut off, and the radio and TV go unrepaired. Newspapers become a dispensable luxury.[4]

A similar theme was sounded in Rhode Island by a man who said he is associated with a group of retirees who devote their time to leisure learning and whose incomes are admittedly over the poverty level but are still fixed and inelastic.

He said:

> Some say needs diminish when you retire. After 40 or 50 years of married life, however, material things begin to fall apart. A range you bought 20 years ago for $100 has to be replaced and now you discover something similar costs $500 or $600. The same for refrigerators, sweepers, all household needs. Many of us are property owners. Taxes take a bigger and bigger slice from the family dollar. If the roof goes or the cellar wall springs a leak, repair costs are astronomical for us. We are no longer do-it-yourselfers. And where, 20 or 30 years ago, we could float a loan to meet such costs, now we worry that the loan will last longer than we will.[5]

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[4] Testimony by Isabel Van Frank, page 1161, part 13.
[5] Testimony of Clifford Shaw, in part 24.

And a reminder about the especially severe impact upon elderly members of minority groups was provided by Mrs. Melnea Cass of the Roxbury Council of Elders in Boston:

> Now, as far as the poor and elderly are concerned, you have heard a lot about them this morning, but there are some poor and elderly, particularly black elderly, who, way back, never made money under social security, and who now find themselves at the very bottom of the totem pole, with very little income and very little to live on. They are a real responsibility to the rest of us who probably might make it just a little bit better. We have many of these seniors, and we find that they have a lack of everything and need help.[6]

A. Glimpses Into Two Personal Budgets

Many of the elderly witnesses expressed some difficulty about describing their own personal expenditures. But, as one woman in Toms River, N.J., said:

> I often thought if I only could do something for somebody—but I thought by telling all my private business it would help a little.[7]

The most detailed account of overall impact of rising costs on an individual budget was provided at the Boston hearing by a woman[8] who described herself as "way up in the 70 bracket, in age," trying to speak about others over and under her age.

Among the items she enumerated:

—An oil bill which was $550 the previous winter and would reach $600 "for oil alone to heat my house" by the end of this winter.

—A real estate tax bill which will reach $1,150, even with a $350 tax rebate for seniors.

—A gas bill which "was a small amount back in 1970" but has "gone way up" even though she cooks only for two people.

These kinds of increases have a major impact on food shopping practices:

> So, I have to go into a lower price of food. When I buy the cheaper hamburger, there is 25 percent fat. So, that means that for one pound of hamburger steak, I don't even get three-fourths of 1 pound of meat, because there is 28 percent fat. That means that there is seven-tenths percent of meat in the pound of hamburger.
>
> Then, you go and you look, and you buy other things in the store. You buy bacon, and it's gone from $1 and some odd cents a pound to $1.89—at one time, a couple of years ago, it was 79 cents for bacon in cut-rate stores, and today it has reached in some stores, $2 and some odd cents a pound.
>
> Then you buy potatoes. You see a sign on the store, 3 for 49 cents. 3 potatoes, Idaho, for 49 cents. You get the ones on sale

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[6] Page 2017, part 23.

[7] Testimony by Jessie Nairn, page 1573, part 17. Senator Harrison A. Williams, presiding, said it is "the vibrant personal testimony that will help."

[8] Testimony by Florence Leyland, Waltham, Mass., in part 23.

for 15 cents a pound, and after you cook them, you find many times that they turn black, because they are so old.

Then you go and you buy all your vegetables, and they have gone up two or three times their prices.

Your milk has gone from 39 cents to 80 some odd cents a half gallon, and your margarine that used to be 20 cents has gone as high as 59 cents a pound, three times the price of what it was.

Then, I have the Edison electric bill; which in 1970, was $20; and, now, in 1975, it is $34. We get a reading every 2 months, and so this is the 2-month bill.

So, with everything going up, and you get just your social security to carry on; it presents quite a problem.

* * * * * * *

So, how do you figure it? How are you going to carry on? How are you going to live if things stay as they are, or even go up higher than they are? This is not counting any of the hospital bills that are scandalously high; your medicine that you have for prescriptions, you will find that it costs $5 or $6 for a small prescription of cough medicine; you will see that nothing is under $1. Everything is top, top, "top value."

So, how are you going to keep on existing with conditions as they are? If they venture any higher, we just won't be able to do anything.

Another glimpse into a personal budget was provided, not from the person who was trying to live on it, but by an agency which was trying to provide help. The agency director said that it and other hypothetical budgets presented for the hearing transcript [9] were based on a March 1975 Bureau of Labor indices in the Los Angeles area and "our professional placement experience with our clients." He also said that the following and other budgets "speak directly to the question of the adequacy or inadequacy of existence on social security benefits alone."

One of the budgets was for a single person living in an apartment or room:

	Per month
A. Medical costs (same as at home)	$45
B. Apartment costs (1 bedroom, water and trash paid):	
1. Rent	130
2. Utilities—gas, electric, phone	35
3. Housekeeper	40
C. Food	100
Total expenses for food, shelter, and health	350

Comments: At this point expenses exceed social security income by $185 per month and the average income needed to maintain an intermediate level of existence by $70; but is even with the average pension.

Faced with these facts the average senior will sacrifice companion care insurance, other noncovered physical needs, pharmaceuticals, and housekeeper, leaving no money for food,

[9] See pages 1307–1314, part 14, for budgets and other information submitted for Planned Protective Services, Inc., by John M. Mills, executive director.

clothing, recreation, eye, ear, dental, or foot care, not to mention personal care and sundries.

The above apartment would be located in an older, but not necessarily depressed, area within walking distance to a grocery store and public transportation line (hopefully). There is cheaper rent available in downtown hotels; however, these hotels are neither safe nor sanitary. Most of them are in violation of city and county fire regulations, not to mention department of health requirements due to needed maintenance and repairs. Since our seniors are not as agile as we are, they need to be located on the first floor if a fire should break out. This, however, makes them prey for robbery, burglary, et cetera.

B. The Statistical Backup

Statistical evidence of the specially sharp impact of rising living costs upon older Americans was provided by Herbert Bienstock, Assistant Regional Director, U.S. Regional Bureau of Labor Statistics. At the Newark hearing, he described the New Jersey-New York Metropolitan area as being second only to the Boston area in terms of high living costs.

He said:

> Increases in family consumption for a specifically defined four-person family headed by a 38-year-old worker, as compared with increases for the retired couple budgets, indicate that the total cost of goods and services rose at a faster pace for the retired. At the three levels of living studied, consumption cost increases for retired couples ranged from 47 to 51 percent between 1967 and 1973, as compared with increases of 40 to 41 percent for the four-person family.
>
> When personal income taxes are considered, there is some narrowing of the differential. Total budget costs, including personal income taxes, for 1967 to 1972 (the latest date for which such data are available) indicate that at the higher level differences in change were marginal, up 35.6 percent for the four-person family, as compared with 36.5 percent for the retired couple's budget. At the lower and intermediate levels, increases for retired couples continued to outpace those for the four-person family budget. At the lower level, the 1967–72 increase for the retired was 38.4 percent, as compared to 30.2 percent for the four-person family; at the intermediate level, 37.9 percent and 32.1 percent, respectively.[10]

Additional insights into the actual spending patterns of the elderly was provided by John Dobra[11] of the Institute on Aging at Portland (Oregon) State University. Mr. Dobra is field director of a research project commissioned by the Social Security Administration to evaluate the impact of SSI at the local level. Interviews were conducted with a sample of 400 elderly persons in the Portland area who ranged in age from 65 to 98. Since all were on SSI, their incomes were definitely below the national average for retirees; the average

[10] Page 1475, part 16.
[11] See pages 1848–1849 of part 20 for Mr. Dobra's testimony.

reported income of respondents to the survey was $248 per month, or $2,976 annually. As Senator Church pointed out, the average monthly income of $248 "is just $6 a month above what the Government conceives to be a poverty level."

Mr. Dobra said that the sample spends a greater proportion of average monthly income on expenditures for housing, food, utilities and medical care than the general public. He also provided this table:

CHART 1.—ABSOLUTE AND RELATIVE BUDGET SHARES

	Amount	Percent
Housing	$84	34
Utilities	32	13
Food	65	26
Medical	36	14
Transportation	2	1
Other	29	12
Total	248	100

After receiving this and other data, Senator Church commented:

> I think what your chart shows, based on your own studies here in the Portland area, is what we are finding everywhere in the country: that elderly people on limited income spend nearly all of what they get—as much as 85 and 90 percent of what they get each month—for housing and for food and for medical care. Which leaves practically nothing for everything else. It is no wonder that your chart shows that they only spend 1 percent for transportation; they have so little left, they have to stay right where they are—stay put.

The situation in another part of the Nation was described at the Nashville, Tenn., hearing by Senator Bill Brock:

> It goes without saying that the negative aspects of inflation have been felt by every person living in Tennessee. However, that impact on our elderly citizens is particularly severe. According to a March 1974 census estimate, 45 percent of all households headed by people over the age of 65 earn less than $6,000 and almost 35 percent had an income below $5,000. These are very distressing statistics, and clearly deserve our attention.[12]

II. THE HEALTH COST DRAIN

> "There should be something done about the medicare expenses on a senior's social security which leaves them strapped and nothing or not enough to live on, after the medicare deductions. They raise our social security income and turn around and raise the medicare deductions—plus everything else."
>
> —Statement by Mrs. Van H. Steel, Eugene, Oreg.[13]

[12] Page 1905, part 22.
[13] Page 1900, part 21.

Shortcomings of medicare are described in chapter IV, along with proposals to improve the situation.

Testimony at the field hearings was generally supportive of medicare's general purposes, but also marked by general concern about the erosion of its coverage in the face of rapidly rising health care costs.

A retired surgeon who maintains an active interest in community concerns gave this picture of what he called the devastating effect of inflation in every aspect of medical care, from doctor's office visits to laboratory procedures:

> For example, internists generally accepted a fee of $10 for a routine office visit 4 or 5 years ago. That fee is now $15 to $20. The fee for a complete physical examination used to be about $25. It is now $50. Although medicare may approve a fee of $10 and $25, respectively, the patient still has to pay 20 percent of that amount.
>
> The previous charge for an electrocardiogram was generally about $25 and is now $30, but medicare will approve only $17 to $19 which means the patient may have to pay $11 to $13 or more if the doctor insists on his full fee—if he chooses not to accept the medicare approved fee.
>
> Routine office blood counts and urines were charged at the rate of about $5 to $6 only a few years ago and are now $15. X-rays of the chest were $15 to $20 2 years ago and are now $22 to $25; medicare approves a fee of $20. Upper GI series were $35 to $50, and medicare approves a fee of $60. Colon X-rays were $50, and medicare now approves $70. Mammograms, X-rays of the breast which are becoming more and more commonly used, were $30 to $35, and medicare now approves a fee of $60. I think I should tell you there is an additional cost factor which is not generally known. All medicare and Medi-Cal bills are approved routinely by, we hope, trained clerical help. Approval of the individual statement is made dependent upon the so-called profile of the individual physician. That profile is based on what that particular doctor has charged for each type of service during the prior year. That, in effect, freezes the schedule of the physician who has been in practice for some years, but it means a considerably higher schedule for the young physician just starting out. His schedule will be based on his brandnew profile which could be, and almost always is, at a higher level.
>
> Surgical fees have been affected by inflation, generally, to a greater degree than have even office visits and procedures. When I retired from surgical practice 3½ years ago, I usually charged $500 to $600 for a radical mastectomy for the individual in moderate financial circumstances. I am informed that medicare now approves fees of $1,100 for some of the younger surgeons.

Hospital, Pharmaceutical Charges

> I have not dealt with the subject of hospital charges but the degree of inflation can be judged by the fact that where the charge for a bed in a two-bed ward just a half dozen years ago

might have been anywhere from $6 to $12, medicare now approves a charge of $102.

And the cost of brand-name pharmaceuticals, which has already been alluded to, is terribly high in relation to the same medication purchased by its generic name. I take a good deal of medication because of hypertension. The average monthly cost of my medication is $25. I purchase a good deal of it by generic name from a mail order house in New York which caters to physicians. I shudder to think what the cost would be to the average person.[14]

Compounding problems of the kind described above is that a growing number of physicians are refusing to "take assignment" [15] under part B of medicare.

Without assignment, a medicare beneficiary is oftentimes required to pay more than prevailing medicare fees. Hence, if those fees have sharply increased, so will the medical bills presented to medicare recipients.

Difficulties in obtaining supplementary health insurance to pay for items not covered by medicare were described by Ron Wyden, coconvenor of the Oregon Gray Panthers:

Some have argued that medicare was not intended to provide complete medical coverage for the elderly and that seniors should take out private medical coverage to fill in the gaps of medicare.

However, when the food, utility, and housing bills are paid, approximately 40 percent of Oregon's elderly have nothing left over to buy insurance.[16]

Another physician's testimony focused on the actual medical needs of older people in a low-income area (the Tenderloin area of San Francisco) as compared with what is actually available under medicare and even medicaid:

What do they already have? They have all of the chronic diseases that have been sneaking up on them over the years. What do they need? They need cough syrups; they need laxatives; they need antacids; they need stool softeners, hormone supplements. These are all things that are not supplied by any of the governmental programs. They need them day in and day out. They have to pay $6 or $7 for stool softeners. How do you find $6 or $7 on their income? There is no extra income. How do they pay $13 for the Aldomet they need for their high blood pressure? The $13 is just not available; there is no getting around it.

How do you tell an elderly woman suffering from progressive and deforming arthritis that she is only allowed $100 for the whole year for physical therapy? I don't care who is in

[14] Testimony by Max Bay, M.D., pages 1240–43, part 14.

[15] For additional discussion of "assignment' issues, see chapter IV. One Los Angeles witness, Robert A. Forst, executive director of the National League of Senior Citizens, was so concerned about the problem that he proposed that county medical associations make available a list of physicians who accept medicare or Medi-Cal assignments.

[16] Page 1813, part 20.

Washington making the laws, there is no way they can tell me that you can help a lady with arthritis for $100 a year.[17]

Somebody should be thinking about changing that kind of law. How do you tell a gentleman who is eating dog food that his medications don't cover it? I have had to do this. It might be easy to make a law in Washington, but it is certainly not easy to tell a gentleman: "I can't get this drug free for you so you are going to have to do without."

Another one of the big things that medicare and Medi-Cal has left behind is the actual care of the person in the home. You have to put a person into a hospital—subject him to 3 days in a hospital to get them the service they should have even without having to go in. I know doctors who will put down a false diagnosis to get the person into a hospital, make him go through his 3 days in the hospital and then go home so he can have his physical therapy; so he can have his home health agency; so he can be taken care of.

* * * * * * *

Another thing the Government has decided: "OK, we will let you have mild analgesics for your arthritis and cough syrups for your chronic respiratory problems, but you can only have them if they have codeine in them." What does codeine do to an old person? It constipates them like you can't believe.

So what kind of a position are they putting the doctor and the patient in? They are saying: "OK, you can overtreat the patient," which I consider malpractice, or "you can say he can't have anything because he can't afford to pay for it," and no Government program will give it to him. I don't think the Government has a right to put either the patient or the doctor in that situation.

To sum up, I think we have a big problem. The Government in the America that these people built is now telling these people: Yes; we have medicare for you; yes, there are supplemental programs to get you all the rest of the health care you need." As a doctor, I can say the services are not there. Either we tell them the truth or we get out of the business.[18]

Additional analysis of the costs to participants and narrowing areas of coverage were provided by a Los Angeles agency [19] which deals with people in need of protective services. First, said its statement, the part B medicare premiums must be paid, but it now is increasing. In 1975, the premium amounted to $80.40 on an annualized basis. Beginning in July, the annual part B premium will reach $86.40.

Describing other "hidden" medicare costs, the statement said:

> Medicare payments begin after the $60 per year deductible is reached ($5 per month). Part B covers only 80 percent of out-of-hospital costs ("cost" being defined as the rate accept-

[17] See page 1229, part 14.
[18] Testimony by Dr. Dennis L. Stone, medical director, North of Market Senior Health Service, pages 1148–49, part 13.
[19] Agency cited in footnote 8.

able by medicare for the service rendered). The acceptable cost of care under medicare has not increased at the inflation rate of approximately 11 percent per annum since 1972 in the Los Angeles area (see table I). Medicare does not cover extended, long-term care in a convalescent hospital or nursing home which is so often required by seniors who are no longer ambulatory and/or incontinent. Medicare covers the first 20 days of convalescent care after a stay in an acute facility (hospital) within certain limitations. Nor does medicare cover many of the areas of physical care needed by our seniors, such as dental, optical (eye care and glasses), podiatry services, or optical needs (hearing aids). The costs of this care must be secured from a senior's personal assets which usually are quite limited.

* * * * * * *

Companion care (medicare supplemental) health insurance coverage for seniors with only social security income and medicare coverage is not a luxury, but a necessity. However, a truly comprehensive companion care policy taken out by an individual costs, on the average, $13 per month (Blue Cross of Southern California, Blue Shield, White Cross, AARP). This premium is prohibitive for the senior with only social security income. Also, these individual policies do not ordinarily cover dental, eye, ear, or foot care of correctional devices needed in these areas.

Let us examine the areas of noncoverage in more detail. Statistically the age group most often in need of false teeth, hearing aids, eyeglasses, and podiatry care is the senior citizen. The cost of a hearing aid (with insurance against loss or damage) approximates $350. The cost of eyeglasses (including the attendant examinations) approximates $150 (not including replacement provisions); with adjustments as needed costing $10 per adjustment. One wonders if ATB (aid to the totally blind) would have as many participants if seniors could afford proper, albeit preventative optical care. Podiatry care costs $10 per visit to the podiatrist, or $25 per visit if the podiatrist must make a house call (which not very many podiatrists do). This type of correctional or preventive care and maintenance would allow many seniors to stay at the residential (board and care) care facility level far longer before they became nonambulatory and, thus forced into a nursing home facility which would put most of our seniors on the Medi-Cal (welfare) roles in a very short space of time, if not immediately. (See the following budgets.)

False teeth costs range from $500 to $1,500 depending on the extent and quality of work done. One wonders how many of our seniors would be eating baby food, or other "palpable" diets, if they had teeth to chew with. Preventing this type of diet would lead to a decrease of seniors admitted to acute facilities for malnutrition and its attending illnesses, which more likely than not, means placement in a long-term care nursing facility on Medi-Cal.

Additional Medicare Shortcomings: Medicare, generally credited with doing a good job in covering major hospital expenses, came up for its sharpest criticism for its shortcomings in the outside-of-hospital area, or part B. In addition to the criticisms voiced by the physicians, there were also specific complaints from elderly witnesses.

Said one:

> I want to just say this, that I was shocked myself—about a week and a half ago I had my annual physical. I am not complaining about what I had to pay my doctor for the annual physical because I can afford to do it, but it cost me $110, and I haven't yet gotten the bill from the hospital for the X–rays.
>
> I don't know of any senior citizen who can put out $110 to $115 for an annual checkup, and yet that could go toward helping the country in keeping down the costs for senior citizens because, in a sense, if they had an annual checkup, they probably wouldn't be using the hospitalization and everything that they are doing today. They could find that they might not need it.[20]

Major criticisms were voiced about medicare's failures to pay, as well, for eyeglasses, dentures,[21] and the transportation costs to medical services. In Iowa, where the commission on aging reported [22] an "alarming lack of . . . medical resource persons" in rural counties where high percentages of the elderly reside, instances of patients having to travel 30 miles to see a doctor or dentist were not unusual.

In addition, other witnesses complained about the lack of adequate in-home care under medicare.

The Big Complaint: Prescription Drugs: But the most frequent complaint heard about medicare was its failure to cover out-of-hospital prescription drugs.[23]

In Memphis, a widow [24] testified that her husband—ill for at least 15 years before his death—had paid during his last 9 years at least $100 a month for medications needed to deal with several ailments:

> Well . . . we were fortunate that we could pay for it. We have other retirement (income) besides our social security, and had we not had it, why we would have been in a very bad situation there . . . it has not been too many days ago, I happened to be in the drugstore, and two ladies were there,

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[20] Testimony by Howard Hauze, page 1151 of part 13.

[21] Describing the "extremely critical" health care situation among the disadvantaged, James S. Bennett, D.M.D., and professor at the University of Oregon Health Sciences Center, said (page 1822, part 20): "The dental perspective is particularly disheartening. The majority of elderly—about 60 percent—have combinations of natural teeth and various forms of prostheses. We estimate about 70 percent have some type of prosthetic device, with complete dentures being more common with increasing age. This situation begets increasing varieties of dental problems which are complicated and costly to solve. With decreasing ability to maintain oral health, the older person often experiences disfiguring losses of tooth and bone structure with subsequent oral dysfunction and increasing risk of infection.

"It is ironic that while most oral diseases and their sequelae are widespread and costly, they can be prevented and controlled through proper nutrition and careful home care.

"About 70 to 80 percent of elderly need basic dental care, but the diseases are often silent until extensive damage has occurred."

[22] See testimony by Leona I. Peterson, executive director, Iowa Commission on the Aging, pages 1368–70, part 15.

[23] See chapter X, part V for additional information about prescription drug expenses of older Americans.

[24] See testimony by Mrs. Larn E. Bloodworth, part 25.

> and one had to be helped, and she had come for her prescription, and as she turned . . . and she said, "Well, I will tell you, I do not know what I am going to do. I have spent most of my Social Security on this medicine," and then I heard them say, "Well, I just want a half a prescription filled, because with other things that I need, my food, I cannot get the full prescription, so the need is great."

In Los Angeles, a senior citizen leader who has made a point of investigating prescription drug costs said the "tremendous drain" of such costs is caused by chronic ailments which require constant, regular administration of costly, life-preserving drugs which must be taken by older persons every day for the rest of their lives.

He added:

> Many of these patients may be required to take as many as four or five drugs daily at an annual cost of several hundred dollars without assistance from medicare which pays for no prescription drugs and which, because of the indifference of the physician, the ignorance of the patient, or exploitation by the dispensing pharmacist, involves the purchase of brand-name drugs at unnecessarily high prices. [25]

An Ocean County, N.J., director of consumer affairs,[26] described the area of prescription drugs as "particularly critical for senior citizens." She said that drug prices may vary by 200 percent in the same community and called for advertising of drug prices (further discussed in chapter X).

She added:

> How can the senior citizen, who already has little money, afford to travel around Ocean County, which has virtually no public transportation, to find the best buy? The Federal Trade Commission has estimated that competitive prescription drug advertising could save consumers $130 million a year and logically the lion's share of this savings would go to our older Americans.

A retired nurse from a rural county of Oregon said:

> You may be told you have high blood pressure. The medication is going to cost you possibly $7 or $8 a month at the least. You do not have that much left after you pay your rent, your light bill, your fuel oil; and after that you buy some food. So you do not buy the medicine. Some people I talked to told me that their health is so bad that their medication bill for the month will average as high as $50. That is a lot of money out of a small income.[27]

Wherever the subject of prescription drugs came up at the hearings, strong support was expressed for legislation which would provide medicare coverage for essential medications.[28]

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[25] See testimony by Kaiser Gordon, page 1237 of part 14.
[26] See testimony by Hazel Gluck, pages 1597–98, part 17.
[27] Testimony by Mrs. Lee Miller, page 1817, part 20.
[28] Thirty-three bills were introduced in 1975 to extend medicare coverage to include out-of-hospital prescription drugs. Four bills (S. 440, S. 862, S. 1456, and S. 1504) were introduced in the Senate in 1975.

An Overall View of Medicare: Former U.S. Senator Maurine Neuberger, who served on this committee from 1961 to 1967, testified at the Portland, Oreg., hearing and said that medicare, enacted in 1965, was a landmark in social legislation of this Nation.

She added:

> All of us who served at that time will never forget the well-financed lobby that fought to defeat the legislation that we are discussing now.
>
> The dire things that were predicted have not come to pass.
>
> I am happy for these 10 years of "comfort to the aged."
>
> But as "new occasions teach new duties," so we must re-evaluate the program and note that the aged population is increasing, that costs are increasing, and that the administration proposes to increase the deductible from $92 to $104.
>
> We have been reared to seek regular dental care before it is too late, to have eye examinations, and to have a regular physical examination.
>
> Preventive measures insure better health and less likelihood of prolonged illness, and witnesses that have preceded have testified to that effect. . . . All of who served in those years will recall poignant letters we received concerning individual cases of hardships that old people were enduring and pleading for a program like medicare. And these letters came from young people faced with the care of their aged parents and not really seeing how to make ends meet with their own family responsibilities. They also came from people who were middle-aged and middle-income, who could foresee their inability to meet the costs of illness. So it is not just the aged population in this country that is concerned with these programs.[29]

Senator Church, who in his opening remarks at Portland had called medicare "an extraordinarily valuable program," said later that medicare nevertheless is deficient in meeting pressing needs of older Americans. Providing an example from his own household, Senator Church said that an 88-year-old woman and her 86-year-old sister are able to take care of one another and get about.

> But everything they need is not covered.
>
> They need eyeglasses; that is not covered.
>
> They have denture work that needs to be done, and, of course, that is not covered.
>
> They are both hard of hearing now, and of course, that is not covered.
>
> They have, as many elderly people, problems with their feet, and they need to have foot treatment every once in a while, which really does give them lots of relief, and that is not covered.
>
> They have been fortunate enough to stay out of the hospitals because we can get them the medicines they need, but that is not covered.

[29] Page 1811, part 20.

Now you see if we had an adequate program to cover these things, that so many elderly people need, we could keep an awful lot of them out of the hospitals where the price is over $100 a day. . . . We just have a program that is so full of gaps that it is not doing the job. Even when you mention home nursing help, or some kind of help in the home that could prevent institutionalization, that is practically not covered, because the regulations are now so restrictive that almost any kind of help that is available is not covered, and I think this whole program has to be completely overhauled, and greatly expanded. . .[30]

III. HOUSING AND UTILITIES—ONE-THIRD AND UP OF THE BUDGET

"There are some medium-priced apartments available. . . but the type of housing which is in abundant supply is in the $200 to $300 a month price range, which is out of the financial reach of all but a very few of the elderly."

—Testimony by Leon Stevenson,
Memphis, Tenn., Feb. 13, 1976

"One 84-year-old widow, with social security benefits of $148.40, must spend another $3 to file a protest because her taxes went up from $551 to $900 on a home purchased back in 1926."

—Testimony by Evelyn Frank,
Newark, N.J., June 30, 1975

One of the "must" items in anyone's budget is money for a roof over one's head. Other necessities may somehow be deleted, but not living quarters.

And yet, in widely varying locales, witnesses told the committee of intensifying difficulties in meeting this prime need.

Three statewide assessments were provided.

New Jersey: Gov. Brendan Byrne's statement said that housing costs are mounting at a frightening rate:

We find that one-fourth of all homeowners over the age of 62 have incomes of less than $4,000, hardly sufficient to cover 90 percent increases in fuel and electricity, rising property taxes and spiraling food costs. Aged renters are not immune from the effect of inflation. Landlords traditionally pass on to their tenants the rising costs of fuel and electricity by either or both of two means—reduced service or increased rents. This situation should not be tolerated for any of our citizens, least of all our elderly.[31]

Governor Byrne said that a total of 29,448 units for low to moderate incomes are available, planned, or under construction.

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[30] Pages 1817–18, part 20.
[31] Page 1549, part 16.

He added:

> The State agency on aging estimates that the present need for low to moderate income housing units for seniors in 1975 to 1980 is 101,103. This leaves us over 70,000 units short. We need a vastly expanded building program and we need an adequately funded program of home maintenance and home services to enable our seniors to remain as long as possible in their present environment.

Massachusetts: Walter H. Cross, supervisor of the Massachusetts Association of Older Americans, Inc., gave this analysis:

> Housing for the large majority of elderly and disabled is catastrophic. Thousands of senior homeowners who worked all their lives to pay for housing are literally starving to death, because of inflationary taxes and energy bills. They are in constant fear of ill health and resultant exorbitant medical bills that would wipe out the equity they have in their homes. In the State of Massachussetts, elderly from age 65 to 70 can have the property taxes deferred each year but a lien is placed on the property and interest of 8 percent is levied. Another penalty imposed by our great society for growing old.
>
> When they arrive at 70 years of age, if they make it, they are entitled to a tax rebate of $350 or the assessed value up to $4,000 whichever is higher.
>
> This means that tax rebates on a home valued at $25,000 which is the limit that a senior can have on his home value, to qualify for supplemental security income (SSI) can vary from $350 in a city using 100 percent evaluation to $800 where a 25-percent evaluation is used. This, also, is only another inequity in our hodge-podge of tax programs.
>
> It is also a fact that many of the senior homes have grown old with the owners and are not adequately maintained and insulated. The average cost for heating alone averages $50 to $60 per month with another average cost of $20 per month for electricity.
>
> Many of the homes of the elderly are in urgent need for repairs but because low-income seniors on a fixed income cannot borrow for home repairs and would be unable to pay off if they are eligible for loans; their homes are slowly deteriorating and decreasing in value. Comparable reduction in property tax assessment is not provided.
>
> With top SSI budgets in Massachusetts of $269 monthly for a single senior living alone and $410 monthly for a couple it is obvious the low-income fixed elderly cannot continue to pay over 50 percent of income for shelter without sacrificing health and other desperately needed services.
>
> For low-income elderly renters ... assistance programs are available in Massachusetts. Altogether, they are still only a drop in the bucket in relation to the thousands of seniors that are eligible and in desperate need of rental assistance.[32]

[32] Page 2038, part 23.

California: Arnold Sternberg, director of the State Department of Housing and Community Development, said that 1970 census figures showed that fully 70 percent of families and persons with incomes under $5,000 were paying 35 percent or more of their income for shelter in the Los Angeles, Long Beach, San Francisco, and Oakland standard metropolitan areas.

He also said:

> Now when you consider that we in this country have always felt that the proper standard was 25 percent of income, you can readily see what that means—35 percent of income or more for those families $5,000. That was 5 years ago. I shudder to think what the figures look like now.[33]

Admitting the possibility of statistical error, Mr. Sternberg said that in 1975 it was likely that the same elderly families and individuals were probably approaching payments of 45 percent of income for shelter.

"That," he said, "is a situation that cries out for relief."

He also said that the "second dimension to the problem" is caused by 1 million units of housing (out of a total of 7.5 million for California) which are substandard:

> Three hundred thousand should have been bulldozed or are ready for the bulldozer today but are occupied. Also 1.2 million of these 7.5 million are overpriced by our 25 percent standard. *If we look at the percentages, a minimum of 20 percent of all the units in each of these categories—substandard, overpriced, ready for the bulldozers—are occupied by California senior citizens today.* (Emphasis added.)

Mr. Sternberg's statement included a discussion of vacancy rates for rental housing:

> People look around the State, around the Nation, and they say: "We do have vacant units, therefore there is very little need to increase the supply." *I would submit to you that for the elderly, for the senior citizens on fixed incomes, the vacancy rate is zero.* If it is 3 to 7 percent for the general population, as indeed it is in our larger urban areas, for the elderly, those on fixed incomes, for the disabled, for the handicapped, for those who, for whatever reason, can't leave their homes, that vacancy rate for those people is zero. There is simply no place for them to go. (Emphasis added.)

Mobile homes, added Mr. Sternberg, are also becoming too expensive for many elderly persons, including those who already live in them. Of 619 mobile home parks in California surveyed, 439 raised their rents in 1974. Another witness,[34] whose husband is confined to a wheelchair, said that mobile home ownership imposes a "dual role" for which they were not prepared:

> When you realize that you own the home but you don't own the land upon which that home sets, you are not only an owner

[33] All excerpts from Mr. Sternberg's testimony, pages 1137–40 of part 13.
[34] Ada Ruth Rose, pages 1134–36, part 13.

but a renter. . . . Fortunately for us we had chosen a mobile home park of unusually good reputation and high standards . . . but we have talked to others, and we have found untold discrepancies on the part of park managers and owners who slip in additional charges to people who rent the spaces upon which they place their mobile homes.

Iowa: Leona I. Peterson, executive director of the State commission on aging, said that low-cost housing in rural areas—where 45 percent of Iowans live—"is virtually nonexistent."

She added:

> There is also the urban housing crisis where many elderly are simply warehoused in dilapidated hotels that might as well have signs out saying "Fire Trap."
>
> There is no centralized bureau of housing in Iowa, although there are 125 minihousing authorities throughout Iowa. A recent survey of these 125 authorities showed there is an immediate need for 9,600 units. There is a necessity for a wise distribution of housing units in that some towns might need as few as a half dozen or a dozen units. Since 40 percent of elderly Iowans—some 195,000 persons—live in or near poverty, it seems only logical that some rental relief and some mortgage adjustments are needed on a subsidy basis. The Bureau of Labor Statistics shows that elderly Iowans put 35 percent of their incomes into housing.[35]

Davenport Mayor Kathryn Kirschbaum, in a letter [36] to Senator Dick Clark, said that many low-income renters in that city are "trapped by spiraling rental costs generated by the housing shortage." Elderly homeowners may have little or no debt on the homes, but "taxes, utilities, and insurance can amount to a large percentage of income." She provided this summary of the situation in Davenport:

ELDERLY HOUSING PROBLEMS 1970–74

	1970	1974
Elderly population	10,435	10,588
Elderly households	6,586	6,646
Owners	4,419	4,484
1-person households	1,587	1,610
Renters	2,167	2,162
1-person households	1,356	1,350
Median income, all elderly households	$3,900	$5,450
Owners	4,300	6,200
Renters	3,100	3,750
Incomes below poverty level:		
Elderly persons	2,300	2,300
Percent of all persons below poverty	24.6	
Elderly households	1,650	1,650
Percent of all households below poverty	44.5	
Number of elderly households lacking complete plumbing facilities	584	450
Number of elderly renters paying more than 25 percent of income toward rent	1,435	1,412
Number of elderly renters paying more than 35 percent of income toward rent	1,074	962

Sources: 1970 Census Report HC(2)–55, "Metropolitan Housing Characteristics: 1974 THIS Survey"; Department of HUD income estimates.

[35] Page 1370, part 15.
[36] May 16, 1975. Reproduced on pages 1412–14, part 15.

Mayor Kirschbaum added that approximately 600 assisted housing units for the elderly will have to be added to the existing 113 such units within the next 3 years:

> Depending upon the state of the housing market in the city, approximately 400 of these units will have to be new construction in order to satisfy the special housing needs of the elderly.

Rhode Island: Edmund Beck, a witness at the Providence hearing, quoted a 1973 report from the Rhode Island Department of Community affairs which said:

> There exists a need for 10,600 elderly public housing units in the State, and 2,750 moderate-income units.[37]

A. The Individual Impact

One witness [38] in Boston said he would have to wait 3 more years, when he will reach age 70, before he could become eligible for property tax relief on his home. Meanwhile he does not know how he is going to keep up with taxes.

Ben Wolfe, president of the Los Angeles City Federation of Senior Citizens Clubs, said [39] that many elderly renters are finding that apartment owners are reluctant to grant leases, and "thus rentals can be, and frequently are, increased two, three, or more times yearly. He said that some elderly tenants are "being forced to pay as much as $50 or $60 increases per month in renewing leases, if indeed leases are granted."

He also submitted letters received by his Federation. Among them:

> Dear Mr. Wolfe: I paid $110 per month for my apartment—no utilities, no carpeting. January 4 my landlord gave me a verbal increase of $15 per month, making my rent $125 per month.
>
> He then gave me a written notice which was dated January 1, for $125 per month. On the 28th of January, I got another notice raising my rent to $160 or $170. I was told if I paid it by the 6th of March it would be $160, and if not it would be $170 per month. He said the building was sold and the new rate was the rate by the new owner.
>
> I only receive $255 per month including my subsidy and have no other income, not even food stamps.

> Dear Mr. Wolfe: This is to inform you that on January 15, 1974, I paid $155 as rent for my apartment. On February 15, 1974, I had to pay $190 a month, an increase of $35, and then on April 15, 1975, I will have to pay $250 as rent if I want to remain there. I have my canceled checks to prove this.
>
> It is almost unbelievable that a $155 apartment could be increased $95 in 15 months.

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[37] In part 24.
[38] Thomas Warren, page 1994, part 23.
[39] Pages 1243–44, part 14.

DEAR MR. WOLFE: When I was widowed 10 years ago, I rented a tiny 3-room unit in a 12-unit court for $77.50 a month. The old owner gradually raised my rent to $95. Early this month, the new owner notified me as of May 1 my rent will be $140.

I cannot afford the $45 increase, nor can the other elderly tenants, to whom the excessive increase means unbearable hardship.

To protect senior citizens, I think rents should be frozen as of last January 1.

DEAR MR. WOLFE: My husband and myself occupy a small one-bedroom apartment for the sum of $100. Recently these 12-unit rentals were all increased to $140 per month by the new owner.

Only 2 weeks ago my husband returned from the hospital after a very big operation. I too was operated on. With this large increase my husband and I won't even be able to afford to buy our medicines we need.

Our only income is social security. Hope you can do something about this matter and oblige.

Mr. Wolfe said that the writer of the first letter had tried to "get into Federal housing and was told there was a waiting list from 5 to 6 years." Other applicants have found waiting lists "of anywhere from 3,000 to 6,000 applications ahead of them." In Sacramento, where the housing authority has 800 units for the low-income elderly, "There is a waiting list of over 5,000 applicants."

In Portland, Oreg., a witness [40] described intensifying cost pressures upon elderly persons who make their homes in old downtown hotels or apartment houses.

One of his examples:

> Another lady in a residential hotel—70 years old and diabetic—3 years ago her rate was $154; it is now $169. She feels she is paying too much for having to share bath facilities with several other roomers. When not able to get to the dining room, she has to pay extra for her meals. Her rent has been raised twice since Christmas. She has $5.70 left for discretionary spending a month.

The seashore community of Long Beach Island in New Jersey was described by a witness [41]—an outreach worker—as a "beautiful place to live," but one which has a major senior citizen housing problem.

She gave these examples:

> Example No. 1: Client is a 73-year-old female whose annual income is $4,000 per year. She owns a one-story house on a 50-by-100-foot lot. The land is assessed at $17,000 and the house is assessed at $19,400; the total assessment is $36,400.

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[40] William Saenger, housing director, Northwest Pilot Project, Portland, Oreg., pages 1800–01, part 20.

[41] Testimony by Jane Maloney, pages 1584–87, part 17.

The taxes for 1975–76 are $731.64, less the senior citizen tax reduction of $160. Her electric bills average $50 per month—the house is total electric; the water bill is $54 per year. Client spends $1,225.64 annually on taxes and utilities. This figure does not include moneys spent for fire and flood insurance and normal repairs and maintenance on the house. The client spends so much of her income on maintaining her house that she has difficulty fulfilling her other needs. She no longer takes vitamins because she cannot afford them.

Example No. 2: Client is a 90-year-old male who receives $117.80 social security per month. He lives in a dilapidated bayfront property. The property is assessed at over $26,000, even though the house has no heating system.

The client uses a kerosene stove during the winter months. Several applications for supplementary security income have been initiated for the client, but the applications have been rejected because the client's property is assessed at over $26,000. Because all of the client's income is used for housing, St. Francis Center has been providing home-delivered meals—client is too debilitated to come to a congregate site—to help alleviate one of his many problems.

Unless the supplementary security income property assessment requirements are adjusted, there does not appear to be any solution to this client's desperate situation.

Example No. 3: Client is an 84-year-old female who rents an apartment. Her total income is social security of $184.20 per month. Her housing expenses, which include rent and utilities, are $175 per month. Client's total assets are savings in the amount of $1,100. Her savings, which were $3,000 in May 1975, have decreased to $1,100 in August 1975 because she uses her savings to buy medicine and food.

At this rate, her savings will probably be gone by December. An application for supplementary security income has been intiated for this woman and, hopefully, she will be eligible for financial assistance.

The Property Tax Crunch: Joseph A. Aragona, President of the Ocean County (N.J.) Senior Coordinating Council, said:

> Today, many of our senior citizens throughout our land are living under conditions that hurt the body, soul, and pocketbook.
>
> We say, thank God for social security and the medicare program; but we have many shortcomings in this important aspect of life. You have heard or will hear testimony on the high cost of living, impact on food, utility rates, medical, and transportation, but I would like to briefly bring forth the plight we have on tax problems of the elderly.
>
> Each year we get a notice our property tax rates are going up. Many, in the ages of 60 years and over, you would think would have reached the plateau of security, not to have the worry of losing our homes because we will never be able to pay these rates or, if we do meet this mandatory expense, we

must deprive ourselves of food, clothes, or not going to a doctor when we should be going.

Where can we turn? Where do we go?

If you appeal your tax rate to the township, you will go through the motions, but your appeal will be denied. This may be a local problem, Senator, but it affects us in other aspects of life.

Our tax rates have increased by close to 100 percent in the last 10 years and it will continue to rise.[42]

Additional information about the property tax problem is provided in this exchange between Senator Church and Frank Manning at the Boston hearing:

Senator CHURCH. We have been considering some Federal legislation to encourage States all over the country to adopt a tax relief on property taxes, based on some kind of circuit breaker formula, so that people of lower income, would get some tax advantage. Massachusetts has a proposal for such a law, and some States have "circuit breaker" laws, but many States do not, and we think that a Federal law might help accelerate this sort of thing nationwide.

Mr. MANNING. I believe that there are about 14 States, including California, that have some form of it.

Now, the reason I would like to get that going is because it not only helps the taxpayer, but it also helps the rent payer. Twenty-five percent of his payment is considered as tax money, and a percentage of that 25 percent, according to our figures, is refundable to the taxpayer, and so you not only have the property owners as beneficiaries but you also have the rent payers as well.

Senator CHURCH. I agree with you, and I have sponsored legislation in the past for this purpose.[43]

Mr. MANNING. I know you do, and I hope it passes.[44]

B. UTILITY COSTS: UP, UP, UP

As indicated in the above excerpt, rising utility bills increase the overall costs of shelter. (See chapter VIII for a detailed discussion of energy costs.) Again and again at the field hearings, witnesses referred to the latest electricity or utility bill as the final blow to an already stretched-tight budget.

In San Francisco, representatives of E.G.P. (Electricity and Gas for People),[45] asked for a "lifeline" gas and electricity rate (see chapter VIII for additional information on energy issues including the "lifeline rate."). One witness said that recent social security increases have been "practically wiped out" by constantly rising utility bills. The director of a housing project[46] said that 18 to 19 percent of his

[42] Page 1579, part 23.

[43] Senator Church introduced the Emergency Property Tax Relief Act (S. 471) on January 18, 1973. S. 471 was designed to protect elderly homeowners and tenants from being overwhelmed by excessive property taxes or high rental payments.

[44] Page 2005, part 23.

[45] Edna Peralta, page 1130, part 13.

[46] Donald W. Holler, administrator, Bethany Center Senior Housing, Inc., pages 1129–30, part 13.

operating budget goes for utilities, and that he fears additional increases will push rents beyond acceptable limits.

An official [47] whose agency had conducted an outreach effort in Iowa during the previous winter to locate elderly individuals who were having difficulties in meeting fuel costs gave this report:

> In the rural parts of Linn County, we found instances of older adults *paying up to as much as 50 percent of their monthly income for fuel.* We found instances of poorly insulated homes and homes being heated solely by a gas burning stove or a small electric heater. In most instances, this was occurring because the occupant of the home could not afford proper insulation or heating measures. (Emphasis added.)

In Nashville, Tenn., a representative [48] of a neighborhood health center said:

> Adequate heat often becomes an impossibility when coal is the fuel and is selling at $48.65 per ton as it is here. Inadequate facilities for warmth coupled with certain handicaps have resulted in frozen and near frozen elderly every year, the latter having to be hospitalized. In many cases we have seen the elderly dismissed from the hospital to return to the same fate.

Clifford Allen, elected in a special election as Representative in Congress from the Fifth District of Tennessee on the Tuesday before the Nashville hearing, said he had devoted special attention to utility costs during the campaign. He testified that "the elderly and the poor are paying for the first electricity they use merely to subsist at 3.5 times more per kilowatt of electricity that they use than major industries." He, too, called for the "lifeline" method of setting utility rates.

At a later hearing in Memphis, another witness [49] said he had talked to large numbers of older persons who complained about "the skyrocketing costs of utilities."

He added:

> I got real curious; I went home and dug up my canceled checks to see what had really happened to me. Now, 5 years ago, my utility bill was running $25 to $27 a month, and that was a year-round average. That bill in the last few months has been $56 to $58. I live in the same house. I do not have any new appliances. Now, my bill runs completely steady the year round because I heat with gas, and cool with electricity in the summer, and so there is not a whole lot of variation, but we have jumped from $25 to $58 a month just on utilities. I do not include the telephone bill, and they have gone up, too.

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[47] Marcia W. Swift, adult services supervisor, Linn County Department of Social Services in letter to Senator Dick Clark, May 27, 1975, reproduced on pages 1418–20, part 15.
[48] Mrs. Lettie Galloway, director, patient welfare services, Matthew Walker Health Center, part 22.
[49] Null Adams, part 25.

Frank J. Manning, president of the Massachusetts Legislative Council for Older Americans, said:

> What will this winter be for many of our senior citizens? For many of them it will be trading one necessity of life with another. Will it be a winter coat or the fuel bill? How can I get my home winterized and still pay my taxes? [50]

Howard Willits, chairman of the Committee to Lower Utility Rates in Portland, Oreg., gave several examples of "need on the part of some elderly poor," including:

> Mrs. R., 69 and asthmatic, with ulcers, heats with oil, has only small electric appliances, electric bill ranges from $7 or $8 up to $43. Now she must choose between "breathing, freezing, medicine, and food," as she says.[51]

Mrs. Rose Tritendi said that in Rhode Island many utility bills have increased by more than 100 percent in 2 or 3 years.
She added:

> Shutoff of utilities is another serious problem of fixed income elderly. . . . For instance, a woman in Pawtucket in her seventies owed $150 to Blackstone Valley Gas. She was shut off in the summer. When winter came again she could not afford what the company demanded to have it turned on again. She had to move.[52]

IV. FOOD ON A RETIREMENT BUDGET

> "She told me that she and her husband, when he was alive, were great meat-eaters. They just loved meat—steaks and roasts. But, she said, 'Meat is out for the rest of my life.' I said, 'What are you going to eat?' She said, 'I don't know, but I'm going to have to go to beans and spaghetti and starches. Any meat is out.'"
>
> —Testimony by Anthony Lamb,[53]
> Los Angeles, Calif., May 16, 1975

Rising food costs were raised frequently at the hearings, often posing the same problem described in the above excerpt: retirees who are forced to choose between proper food and other essentials.
[See Chapter X, part I, for additional discussion of issues and programs related to nutrition.]
That complaint was voiced in widely varying hearing sites:
In Iowa:

> Over the last 2 years the cost of food has risen a whopping 27 percent. Older Iowans are spending a little less than 30 percent of their income on food. Indications are, human nature being constant, that many are eating insufficient diets.

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[50] Page 1991, part 23.
[51] Page 1804, part 21.
[52] Part 24.
[53] Mr. Lamb, Ventura County senior citizen coordinator, said that 13,000 of the 40,000 seniors in that county are just below the poverty level. "Many seniors," he said, "are slowly starving. I don't think anyone argues that point. Most of those who are poor at least lack proper nutrition, which is a form of starvation—and things are getting worse."

> So-called cheap food is generally viewed as nonnutritional. Most elderly simply skip a meal or two daily to save money. An added cost to food is transportation. Many small towns have no mom-or-pop store and the elderly must travel to a town with a shopping center. Food stamps have reduced the cost of food to those who receive them. However many rural Iowans, because of their antiwelfare philosophy and conservative views, would rather starve than be humiliated by taking food stamps.
>
> Letters to the commission indicate that some people would use food stamps if they could get them in the next town or county where they would not be identified.[54]

In Memphis, Tenn. (in regard to a nearby rural area):

> Food is often as difficult to obtain as is health services. Most of the elderly who live alone do not have an adequate balanced diet. They often pay high prices because, of necessity, they must shop at convenience stores. They complain that they are unable to purchase food stamps which may be due to lack of understanding as to how to use them. Some of the elderly must travel 25 to 30 miles, or even more to the food stamp office. This can be an all-day project and cost an additional $10 to hire a ride.[55]

In downtown Los Angeles:

> My income is about $239 a month social security—or maybe it's "insecurity"—and from it I spend about 25 percent for food. Because meat has gone up and dairy products have gone up, I have been forced to give up meat, chicken, fish, yogurt, and cottage cheese to make ends meet. I also find that I am eating more grain, more fresh fruit, and more fresh vegetables.[56]

Does Food Cost Less for Elderly? In response to that question, one witness [57] presented findings prepared by a nutritionist for the Consumers Cooperative of Berkeley, Calif. He chal'enged the common assumption that older persons "can make do on less" and said that just the reverse may be true: proper nutrition can be more costly, rather than less, for them. Among the factors he described: many people do not cook for themselves, either due to limitations in their housing arrangements or due to physical handicaps; "special diets like low salt, diabetic diets, and so forth add to the cost of the food that we have to buy;" buying in small quantities can be expensive as in the case of potatoes which are 19 cents a pound when bought by the pound and 5 cents when bought in 10-pound bags, "but the heavier bags are more difficult for the seniors to carry, and it is harder for us to tote the load." Widespread dental problems among the elderly also limit

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[54] Testimony by witness cited in footnote 35.

[55] Testimony by Erika K. Voss, M.D., director, Poor People's Health Center, Rossville, Tenn. Part 25.

(Limited access to food stores is not limited to rural areas. Testimony by Mary Johnson at the Newark hearing (page 1503, part 16) described supermarket closings in densely populated parts of Jersey City. The City Food Action Committee, concerned about the shutdowns, is exploring means of providing relief, including food co-ops and a possible food supplement program.)

[56] Testimony by David Siedman, page 1260, part 14.

[57] Charles Dorr, page 1145, part 13.

the types of food available to many older persons, and the high cost or unavailability of transportation make it difficult for many seniors to "shop" for "specials."

Additional information on difficulties encountered by many older people living alone in cooking meals was provided by Mrs. Jean Mellor, president of the North of Market Senior Organization, in San Francisco:

> Very many of them have utterly no cooking facilities. Even in the wintertime I see them out on the street at 5 and 6 in the morning dying for a cup of coffee, knowing some places will be open where they can go for a cup of coffee. They buy their food in very small quantities—they have to. Very many of them hope there is enough hot water that they can run in a pail or a sink to heat their little cans of food, and they put bread on the radiator to toast it. Their box of crackers lives on the radiator so it will be kept crisp.[58]

Impact on Nutrition Programs: Throughout the hearings, elderly individuals and government officials were emphatic in their praise for the meals for the elderly program made possible through title VII of the Older Americans Act. (See chapter X, part I, for additional information about title VII.) But the rising costs of foods were having an impact upon food programs, as well as upon individuals.

Mr. Willie Saunders, president of the South Berkeley Senior Citizens Council, testified in San Francisco about one such food program:

> We formerly asked for 1,400 meals a day in the county of Alameda. We were then reduced to 800 meals a day. Because of inflation, 150 of those meals were cut off. When we begin to think of the thousands of people already who were not receiving a meal, then cut back 150, it means that there were many more than were not able to get food.
>
> We are thinking in trends here; even those who come to the center—the center is open 5 days a week and on Saturdays, Sundays, and holidays most of these people do not have sufcient food to carry over until they are able to get some. Certainly this will bring about ill health and this increases the dangers along those lines.[59]

Shirley Curtin, administrator of senior programs for the Pasadena (California) Community Services Commission, said in a statement submitted to the committee:

> As a title VII nutrition director, I would like to tell you how inflation has hit these programs designed to aid our elderly. Increases in social security have caused personnel fringe costs to climb. Food costs have climbed; as a result, many programs can no longer serve the number of meals they contracted to serve; i.e., contracted for 350, with inflation, now only able to serve 300. In one month during 1974 the cost of paper and plastic ware jumped 13 percent. Utility bills have gone up at the sites—almost double over 1974. Gasoline costs have gone sky high, and the President is preparing to

[58] Page 1141, part 13.
[59] Page 1144, part 13.

pass a bill which will raise it even higher. Volunteers who drive their own cars for the projects are extremely scarce. Gas was 35¢ a gallon when the title VII programs were initially funded, now it is 60¢ a gallon. As the costs climb, the projects get no additional moneys to cover inflation; they are forced to cut back on services to seniors. They received not a penny more in the second funding cycle than they did the first, but are expected to serve the same number of meals and provide the same amount of supportive services. In addition, many title VII grantees are community action agencies, which have SOS programs. These SOS programs provide the supportive services to the nutrition programs. Currently the SOS programs are operating under a continuing resolution. President Ford says there is no need for them—they duplicate other services. Should they be discontinued, the title VII programs and our elderly will suffer severely. Also, the EFMS programs, currently known as community food and nutrition programs, sits waiting for a decision from Washington as to whether they will continue. These programs supplement the title VII projects and provide daily nutritionally balanced meals to our elderly.[60]

Mary Johnson, director of the Jersey City (N.J.) meals-on-wheels project described problems in that program:

> The high cost of food has its effects on the housewife in planning her weekly shopping. How well the elderly eat at the beginning of the month—not so well at the end of the month. Also, the amount of persons one may put on a program such as meals-on-wheels—going over the prices and doing a little comparison with 1974 prices and 1975 costs, I have found vegetables cost $3 to $4 a case more; $5 to $6 more a case for fruits—puddings as much as $11 more a case.
>
> Meats have risen as much as 50 cents to $1.50 per pound. Packaging, plates, bags, wrappings have doubled in price. The cost of putting a meal together last September was $1.20. Today for the same meal, it is $1.50 to $1.75. Our food budget calls for $1 per person for food, and we are serving 256 persons a day. This goal of feeding 400 a day cannot be reached because of the high cost of food and packaging.[61]

The importance of meals programs was described by witnesses as extending far beyond the food served. "Loaves and Fishes" program in Oregon received extensive praise [62] for its steady broadening of services. Another—in Salem, Oreg.—was described by Beth Sprinkle, president of the Oregon State Council for Senior Citizens:

> They serve approximately 70 meals onsite and meals-on-wheels 5 days a week through the cooperation with other agencies such as outreach—transportation, recreation. They also present a nutrition education program in cooperation with their county health department and others. They are

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[60] Page 1317, part 14.
[61] Page 1502, part 16.
[62] See testimony in part 21 by Jean Wade (pages 1847–49), Yvonne Walborn, (pages 1850–51), and Etho Husel (pages 1851–52).

also able to provide at the centers a health screening, blood pressure, urinalysis, glaucoma, blood sugar clinic, flu shots, a comprehensive physical checkup, and the services of a podiatrist, which is very much needed.

These food services are being expanded to outlying areas where, at present, 100 meals a day seems quite limited service for the area. I was talking to the nutrition specialist in Salem and she stated that they would appreciate more cooperation from the State program, such as the public schools and hospitals, for use of center space, and to expand their services at less cost by using some of these facilities.

V. TRANSPORTATION—WHEN AVAILABLE

> ". . . what good is it if we have services where they give them a meal if they can't get there? They have to go to the doctor, and they have to go to the dentist. They live six or eight blocks away from the main artery of transportation of the city. They are old; they can't walk that six blocks. They must have transportation to take them to these main lines or to the doctor or to the bank when they want to cash their checks—that they don't get mugged, robbed, or injured."
>
> —Testimony by Nathan Matlin,
> Los Angeles, Calif., May 16, 1975

Mobility needs of older Americans are being recognized more and more at the Federal level, but in such a way that some concern has arisen about the possible danger of fragmenting services or developing them on such a limited basis that they will never meet overall need. (See chapter VII for additional discussion of transportation issues.)

To a participant in such a program, however, even imperfect service can mean a great deal, as indicated in this excerpt from testimony provided by a widow in a predominantly suburban area of New Jersey:

> I used to use the taxis, but they became so unreliable and expensive that I gave them up last year. . . . Because of the van transportation that is supplied, I now regularly attend a number of classes at the center 4 days each week, including crocheting and senior exercises. Whenever I am at the center, I enjoy an inexpensive nutritious lunch which is my main meal for the day. Every Thursday, two vans from the center each take 10 seniors to Manahawkin Shopping Center approximately 12 miles from my home. There we buy our weekly supply of groceries and needed drugs. We are able to avail ourselves of this service only if we are among the first 10 to call. In this shopping area is a pharmacy which gives senior citizens a 10-percent discount on prescriptions. To take advantage of the discount, we must have transportation to get to the pharmacy, the only one in the area offering the discount.[63]

[63] Testimony by Jeannette Reid, page 1621, part 17.

The dollar savings made possible by even a modest transportation service thus becomes readily evident. The other side of the coin was provided in Los Angeles, where an estimated 54 percent of the older population are without automobiles and thus public transit dependent.[64] Cab fares on a per mile basis are among the highest in the Nation, but "it appears that low-income areas make higher use of taxi services in spite of their higher costs" because of gaps in availability or quality of alternatives.

A witness from Antelope Valley—a part of Los Angeles County separated from the city of Los Angeles by the San Gabriel Mountains—said that one elderly lady living in a mobile home park pays $10 every week for one trip a week to a local downtown shopping area.

She gave other examples:

> A low-income, elderly man in the Pearblossom area, a little more than 20 miles from Lancaster, saved his money for 2 months for the necessary taxi trip to the medical center in Lancaster. He was going there for diagnostic service. This trip would cost him about $30. When he reached the medical center, he was told: "The machine is out of order. Come back tomorrow." A few minutes later a volunteer found him out in the lobby crying. He didn't have the money to come back tomorrow.
>
> Recently a man called our information and referral service and reported that his tenant, an old man, was ill and needed to be taken to the county hospital immediately. The taxi fare would be $7 and the man didn't have it. Fortunately, we had a volunteer in our office right at the moment who was available and took him to the hospital.
>
> Now, at this hospital it is required that the patient, on his initial visit, must provide his own transportation, and if no friend is available to transport him, then he usually goes by taxi and $7 is about the usual charge. That means $7 each way. Unlike taxis in metropolitan areas, the taxi operator in Lancaster is seldom, if ever, able to pick up a return fare.
>
> Only yesterday an elderly gentleman flew into our local Fox Airfield for a call at one of our county offices. The distance is about 7 miles. The taxi fare was $6 each way.
>
> It may seem that we are criticizing the taxi company for these high fares. We are not. They go long distances to pick up and deliver passengers. There is practically no possibility that they can pick up a return fare when they have made a transport. And, because of inflation, their costs are going up, too.
>
> The high cost of transportation is not the only critical factor here in our area. Unavailability of transportation creates situations just as grave. Sometime ago our local volunteer transportation organization, which is called Someone Cares, received a call from the sheriff's department asking them to go out and pick up an old lady in a wheelchair

[64] Information about transportation resources in Los Angeles provided by Robert Newcomer, University of Southern California, a paper, "Transportation, Land-Use Planning, and the Aged," provided by the staff, Ethel Percy Andrus Center, in appendix 3, part 14.

on the road between Palmdale and Littlerock. She had gone in her wheelchair to a grocery store about 2 miles away, but on her return trip with her groceries she had become exhausted and wheeled herself off the road, where the deputy sheriff found her and called Someone Cares.[65]

Pasadena—the "City of Roses," located fairly close to the heart of the Los Angeles metropolitan area—provided a statement on the interrelationships of mobility deficiencies with other problems plaguing the elderly within its borders:

Many of our elderly, due to their fixed incomes, are forced to live in low-rent housing in deteriorated, high-crime neighborhoods. Where transportation is non-existent, where they must walk blocks, and blocks in order to do their shopping, or get to a bus stop—making them easy prey to muggings and robberies. In Pasadena, take the case of Minnie Levine, age 72—mugged three times. The latest attack was the worst; she was pushed to the ground, kicked and beaten about the face and chest. In addition to the money stolen, she almost lost an eye, suffered traumatic shock, and heavy medical expenses. Then there is Mrs. Francisca Avalos, 75 years of age, nearly blind. In March of this year she was attacked as she was on her way to the market to cash her SSI check and do her shopping. Her check was stolen. Along with contusions and bruises about the head and face, her left leg was broken. As a result of this beating she is now deaf in her left ear. Again, costly medical expenses, and a 6-month wait for replacement of the SSI check which was immediately reported stolen to the SSA.

* * * * * * *

The issues I bring before this committee are indeed timely this month of May—which President Ford has proclaimed Older Americans' Month"—what better time to focus attention on the plight of the elderly.

The problems facing senior citizens in Pasadena today are many fold, but no different than those facing any other segment of our Nation's population: transportation, nutrition, housing, health, income maintenance—except that they may be more severe due to mandatory retirement. As one writer phrased it, the retiree goes from being a "person to a nonperson." In addition, this abrupt severance from roles of friendship caused by mandatory retirement brings with it a sharp reduction in income, often one-third or one-half of the level of the work income. So sharp is this drop that it carries many older people to the poverty level. They are the instantly poor . . .[66]

VI. SHORTCOMINGS OF SOCIAL SECURITY, SSI

". . . even with a cost-of-living adjustment, the purchasing power of the elderly is gradually being eroded."
—Testimony of Isaac Fine,
Boston, Mass., Dec. 19, 1975

[65] Testimony by Lilly Briggs, page 1271, part 17.
[66] Statement by Shirley Curtin, administrator of senior programs, Pasadena Community Services Commission, page 1315, part 14.

Much of the testimony during the California hearings was critical of the administration proposal to limit a social security cost-of-living increase due in July 1975 to 5 percent instead of the 8 percent due under terms of the 1972 law and subsequent legislation which established the adjustment mechanism. James Carbray, vice president of the National Council of Senior Citizens, said:

> It's almost unbelievable that anyone could hold fast and give serious consideration to the request to reduce the 8 percent cost-of-living increase in social security benefits to 5 percent, as proposed by the administration, when, at the present time it's a matter of record that we have over 1½ million recipients of social security benefits presently receiving less than $100 a month; that 25 percent of all of the older people in this Nation who are recipients of social security are living below the poverty level.[67]

Mary Voeller, chairman of the social security committee for the California State Joint Legislative Council of the National Retired Teachers Association/American Association of Retired Persons, said:

> Our news last week warned of increases of 6 to 8 percent by the end of 1975 for food alone. The 8-percent social security increase due now in July would just keep the recipient in the same place he is right now. Have you had to eat oatmeal sandwiches for lunch? Did you know that much of the pet food sold is being consumed by the elderly? Have you ever watched the shopping cart of an older person at a supermarket and noticed the few articles the older American can afford at a checkout counter? Have you ever watched a meal being served to the elderly and see how many carefully wrap one-half of it to take home for another meal, even though what was served was just enough for one meal?
>
> I have had three cases in my area brought to my attention where suicide was attempted by desperate older persons. No food, no money, and SSI had been applied for in October but still not received by February. I had sleepless nights and I shed tears over this.[68]

Rebuffed by the Congress in 1975 on the 5 percent proposal, the administration did not propose a similar reduction at the start of 1976.

Testimony or statements at several of the hearings questioned general adequacy of social security benefits, even with automatic cost-of-living adjustments.

Walter Cross, supervisor of the Massachusetts Association of Older Americans, Inc., gave the following assessment and touched upon a matter of special concern to many who presented information to the committee—the social security "retirement test":

> The majority of the elderly are covered by social security. However, because the largest percentage of seniors over 65 are women, many of them widows, the average social security monthly income of $170 per month is entirely inadequate to

[67] Page 1227, part 14.
[68] Pages 1231–32, part 14.

maintain a decent standard of living. Much needs to be done to insure yearly cost-of-living increases sufficient to provide a fixed income above the poverty level.

The limitation on taxable earned income for social security, now $15,300 annually should be abolished. Surely, persons with income of $25,000 or more can afford to pay social security taxes on their entire income in comparison to individuals struggling to raise a family on $7,500 or $10,000 yearly. The additional revenue could surely help to raise the social security income payments.

The so-called means test limiting earnings of social security recipients to $2,760 without a reduction in social security payments should be abolished, or at least increased to allow $5,000 in earnings without financial penalties. The employment discrimination practiced against seniors is almost total and the means test only adds another penalty regarding employment discrimination. Is it any wonder that limiting earned income of seniors living on small fixed incomes is contributing to a class of low-income seniors living below the poverty level? [69]

Another issue raised at practically every hearing was the need to improve the social security and SSI cost-of-living adjustment mechanism.

The National Senior Citizens Law Center provided the committee with this analysis:

To the extent that social security benefits do not keep pace with the Consumer Price Index, hardship is created. One measure of how substantial this hardship is, is the number of recipients who rely on their social security benefits for subsistence. Although social security benefits were not originally expected to be sole sources of retirement income, there is no doubt that they are for many, many people. The Social Security Administration's own Claims Manual states, in section 5000, that "[m]ost people who get an RSDI (retirement, survivor, or disability) check depend upon it for the necessities of life."

The automatic escalator provisions now in the law peg increases in benefits to changes in the Consumer Price Index, but, wholly aside from the timelag inherent in the mechanism, social security benefits have not kept pace with the Consumer Price Index since 1972. Even though the law now requires benefits to be raised with the pace of inflation, the ground lost between 1972 and 1975 will not be recovered.

A more serious problem with the mechanism is the timelag. The much heralded 8 percent increase in benefits effective for June of 1975 (which will not show up in benefit checks until the beginning of July 1975) only reflects changes in the Consumer Price Index between the first calendar quarter of 1974 and the first calendar quarter of 1975. Thus, not until the second 6 months of 1975 will beneficiaries get any increase, and that increase will reflect only a portion of the changes in the Consumer Price Index since the first quarter of 1974. The in-

[69] Pages 2041–42, part 23.

crease does not reflect continuing upward changes in the Consumer Price Index in 1975 at all. Such changes will not be accounted for until July of 1976. The combination of continuing substantial increases in the cost of living and the fact that many recipients have, as their sole source of income, their social security benefits adds up to the conclusion that the escalator mechanism does not give the retired population adequate protection against the effects of inflation.

Another problem with the cost-of-living mechanism is that it does not reflect differential increases in the cost of various essential goods and services. Although in 1974 increases in the cost of basic necessities such as food were pretty much the same as the general overall increase in the Consumer Price Index, this was not true in previous years and may not be true again. If the cost of food increases substantially more than the cost of other items, then an individual with a very low income is hurt much more than an individual with a higher income, since he must pay an ever higher percentage of his income for food.[70]

On June 23, 1975, Senator Church introduced the Social Security Cost-Of-Living Improvement Act, S. 1992. The bill would direct the Secretary of Health, Education, and Welfare to develop a special consumer price index for the elderly.

Senator Church said:

> A special index is needed, it seems to me, because the inflationary rate for specific items in the overall consumer price index can vary markedly. In recent years some of the sharpest increases have occurred in those areas where the aged's greatest expenditures are concentrated. A special index could give appropriate weight to these increases in terms of the impact upon older Americans.[71]

In addition, S. 1992 would authorize cost-of-living adjustments twice a year, provided the Consumer Price Index increased by at least 3 percent from one base period to another. Social security beneficiaries now receive only one adjustment—in July—whether the inflationary rate is 3 percent or 13 percent. The Church proposal would authorize cost-of-living adjustments in April and October.

Senator Church gave this rationale for the provision:

> This change would allow social security benefits to be kept current with rising prices during periods of accelerated inflation. It would also provide an extra hedge against inflation, particularly when prices rise precipitously.[72]

Vera Weinlandt of the National Legislative Council, NRTA/AARP, said the associations support S. 1992 and added:

> This bill would better preserve the purchasing power of social security benefits during periods of high inflation and would ultimately provide a standard more accurate than the existing Consumer Price Index . . .[73]

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[70] Pages 1347–48, part 14, in statement written by Anne Silverstein.
[71] *Congressional Record*, June 23, page S11298.
[72] Page S11298 of *Congressional Record* cited in footnote 71.
[73] Page 1507, part 16.

SSI Shortcomings: As mentioned in chapter III, the supplemental security income program has received widespread criticism because of inadequacy of payments in the face of rising needs and also because of administrative problems. A comprehensive analysis of practical, day-to-day operating problems was provided in statements by Mario Guitierrez of the North of Market Health Council, Senior Health Services, San Francisco, and Marie White of the same agency.[74]

The Planned Protective Services, Inc., of Los Angeles, said that in May 1975, SSI payments are "substantially below the $280 per month needed for an intermediate level of existence in the Los Angeles area." [75]

One comparison of SSI payments with the cost of one essential—housing—was provided by Virgilio Lopez at the Newark hearing:

> Mr. LOPEZ. Some of them are renting from $100 up to $182. The majority of these clients are paying between $125 up to $160 and $165, depending on where they live.
> Senator WILLIAMS. And these are recipients of SSI?
> Mr. LOPEZ. Yes, SSI recipients.
> Senator WILLIAMS. Which is $182 a month?
> Mr. LOPEZ. That is the maximum . . .[76]

Problems of Spanish-speaking applicants for social security or SSI benefits are complicated by the fact, said Mr. Lopez, that:

> The social security office does not provide any additional services and it has no Hispanic employees.

A major SSI shortcoming—failure to enroll all those eligible for its help—was described by Dr. Woodrow Morris, chairman, Iowa Commission on Aging. Nationally, he said, it was estimated in May 1975 "that less than 2 million of the 5.2 million identified by the Social Security Administration who might be eligible for SSI are now benefitting from the program."

He estimated that 28.3 percent of Iowans over age 64 are living below poverty levels and that they would therefore qualify for SSI.

He said:

> Now, if these data are correct then SSI has not yet reached eligible Iowans to a fairly large extent. We have 350,000 people 65 or over in Iowa. A recent yearend summary of the first year of SSI in Iowa reported in *Iowa Prime Time*, April 1975, shows 27,000 beneficiaries, of whom about 18,000 are aged. Using the 28.3 percent figure reported to be living below the poverty level in Iowa suggest that 99,050 people are in need of supplementary income benefits.[77]

Asked by Senator Clark how outreach could be improved, Dr. Morris said:

> A lot of people, particularly elderly people themselves—I would like to see this combined with the Comprehensive Employment and Training Act (CETA), or with title IX—

[74] Pages 1187–96, part 13.
[75] Page 1308, part 14.
[76] Page 1464, part 16.
[77] Page 1373, part 15.

could be employed to go out and, on a house-to-house, person-to-person basis, contact every potentially eligible older person and sit down with them and help them fill out the two- or three-page form of very perplexing questions.

I will give you a rough example of a question: "List your cumulative income for the past 5 years." I couldn't do that myself; but I have some benefits; I could go to the university business office and have somebody in the business office do it for me. This is an unusual benefit I have that not everybody has, and I realize that. So I think that, if we could train people to go out and make personal contact with eligible elderlies to sit down with them and fill out the forms with them and for them, we would have a good chance of contacting close to 100 percent of the eligible elderly.[78]

An additional assessment of barriers to SSI participation was provided by Sister Mary Phyllis Soreghan, community aide at the Northwest Pilot Project in Portland, Oreg.:

Have you considered, Senator, what type of initiative and energy is expended by the elderly on even one visit to program offices? First would be negotiations for transportation; buses are often not feasible for a crippled person; taxis are prohibitive to a $5 a month personal spending budget; long waits for a turn to be interviewed at the office; failure to comprehend explanations of details on forms because of poor sight, poor hearing, unfamiliarity with technical terms and their implications.

This is not to underrate the workers of Social Security Administration, but we who assist the aging know that added years have a way of slowing up to a greater or lesser degree.

When an individual knows that time is important for everyone to get a fair share, and that the waiting room is full, he is not about to overextend his turn.

With memory not as sharp and reliable as it once was on his return home from this new experience, many questions arise which need further clarification. Thus, back again and again until all is understood and in operation. But this could mean at least 2 months of waiting after the application is made.

In the life of the elderly, days are precious because they are becoming, without doubt, fewer and fewer. Even 1 day of waiting in these times of severe inflation is difficult for them.[79]

Mrs. Clint Pickens, director of the Marshall County Senior Citizens Center in Lewisburg, Tenn., described a problem of special importance in rural areas:

Many rural area people often cannot qualify for SSI due to the fact that they own five or more acres of land. I have known of some of our senior citizens to be denied SSI (supplemental security income) because of the fact that they owned 5 or more acres when the fact was that the small

[78] Page 1378, part 15.
[79] Page 1838, part 21.

acreage was so poor and rocky, and untenable that even if the owner was physically able to cultivate the land it would be economically not feasible to do so.

I can cite you one old man who is very ill who owns about 35 or 40 acres that he can't sell because there is no road to reach the land, no timber to cut, only rocky inaccessible land really worthless to him, yet he is being denied SSI, which he desperately needs so he can qualify for medicaid to take care of his medical problems that he is unable to finance with his limited social security checks.[80]

A summing up of the challenge to SSI in terms of payment adequacy was given at the Nashville hearing by Senator Brock:

I think we have to work in the Congress until the SSI does do the things that we wanted to do as we started it, that is, to eliminate poverty once and for all among the elderly people of this country, and that it is a matter of entitlement and not a matter of charity. Then we will achieve the objective that social security has not achieved, which was meant way back in the 1930's.

Senator Church introduced S. Con. Res. 58, calling upon the President to submit recommendations to the Congress for the purpose of eliminating poverty for older Americans. This measure was referred to the Senate Finance Committee.

VII. STRETCHING RETIREMENT DOLLARS: SERVICES AND JOBS

"Yes, there is work to be done in improving the flow of retirement dollars to Americans, and there is work to be done in providing the services that will help them to save dollars, as well."

—Senator Frank Church,
Nashville, Tenn., Dec. 6, 1975

"I do not think we can expect our social security system to pay for all the inadequacies of our transportation systems, our health care resources, and the social services needed by so many older persons. We need positive programs under the Older Americans Act and under other auspices, to deal with those problems."

—Senator Harrison A. Williams, Jr.,
Newark, N.J., June 30, 1975

Under heavy pressure from inflated costs of basic necessities, retirement income should not be called upon to pay for unavoidable expenses.

For many older persons, such "unavoidable expenses" become inevitable for a variety of reasons: the aforementioned taxi rides when other forms of transportation are not available; having to pay neighbors,

[80] Pages 1933–34, part 22.

if they are willing, for services a trained homemaker could provide; paying for expensive "convenience" foods when in fact a title VII group meal would be preferable but is not available; and so on.

At every hearing conducted in the cost-of-living series, efforts were made to demonstrate the dollar value of social and related services to older Americans.

In addition, testimony was invited on the value of employment opportunities for people of retirement age, particularly in the community services area.

A. The Dollar Value of Services

Testimony dealing with economic and social benefits of transportation projects and the title VII meals for the elderly program under the Older Americans Act has already been described in this chapter.

In addition, the hearing transcripts provide examples of: "a special automobile that carries complete hot meals like a TV dinner, but better geared to a senior citizens diet;" [81] the value of cooperative food buying—and gardening—efforts; [82] the importance of health maintenance and day care services, when available; [83] value of innovative housing arrangements, including congregate; [84] additional examples of operating transportation projects; [85] and the value of outreach services.[86]

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[81] Testimony by Anthony Lamb, page 1258, part 14.

[82] Testimony by Herbert Frederick, director, Hub City Buyers Club, pages 1264–66, part 14; Ray Taintor, Food Co-op of Brick Town, N.J., and Donna Serber of Brick Town, pages 1609–16, part 17; Oscar Robbins, volunteer, Project Able, Portland, page 1853, part 21; Dorothy Craighead, part 24; and Mr. Stanley Dillard, part 25. (Mr. Dillard described a forthcoming "cannery" project in Tipton County, Tenn., which will help "many families, especially elderly persons, (who) are unable to preserve food products.")

[83] See, for example, testimony or statements by Nancy A. Williams, page 1354, part 14; Freeholder Donald M. Payne, page 1489, part 16; Otto Neurath, M.D., pages 1490–91, part 16; Alice Ganster, R.N., North Jersey Community Union, pages 1493–96, part 16; Hattie Edwards and Nancy Baer, Strawberry Hill Senior Citizen Center, pages 1529–32, part 16; Lena Edwards, M.D., pages 1571–72, part 17; Ocean County, N.J. report on Health Counseling Service, pages 1638–40, part 17; Summary of Need of Homemaker Services in Ocean County, page 1642, part 16; Donald G. Clark, chairman, Multnomah (Oreg.) County Board of Commissioners, describing "Project Health," pages 1793–99, part 20; Mrs. Lee Miller and Staff Captain Joyce Osika, pages 1816–21, part 20; V. J. Huffman, pages 1874–75, part 21; Virginia Patterson, pages 1922–23, part 22; Lewis Levenson, executive director, Somerville-Cambridge (Mass.) Home Care Corp., pages 2013–16, part 23; Louis Lowy, pages 2034–35, part 23; Walter Cross, pages 2040–41, part 23; comments by Senator Claiborne Pell on Warwick, R.I. Geriatric Day Care Center and Appendix Three, part 24; testimony by Dr. Mary Mulvey on Rhode Island Group Health Association, and discussion by Senator Pell and Janet Lewis, part 24; comments by Senator Bill Brock to Dr. Erika Voss, part 25; and statement by Senior Citizens Services, Inc., part 25.

[84] See, for example: testimony or statements by Dr. Rose Marshall, page 1247, part 14; Ethel Cherry, page 1252, part 14; Richard Fox, assistant to the director, Housing Authority of Plainfield, N.J., pages 1532–36, part 16; Robert Notte, executive director, Newark (N.J.) Redevelopment and Housing Authority, pages 1550–52, part 16; Thomas E. Hamilton, Middlesex (N.J.) County Office on Aging, page 1555, part 16; discussion, Senator Church and William Saenger, page 1802, part 20; Mercie Fogg, pages 2007–09, and appendix 3, brochure on Elderly Center and Congregate Housing Facility, Cambridge, pages 2053–54, part 23; and Edmund Beck, part 24.

[85] See, for example, testimony or statements by Adolph Hartmann, pages 1162–63, part 13; Larry Chrisco, president, Senior Citizens Association, pages 1274–75, part 14; Anthony Anzalone, chairman, Committee on Transportation for Senior Citizens, Central Bergen Chapter, Red Cross, pages 1527–28, part 16; The Rev. Donnon McNally, page 1617, part 17; Harriet A. Grove, page 1647, part 17; Bert Higert, Special Mobility Services, Portland, Oreg., page 1857, part 21; Mabel Bailey, Senior Lobby, Eugene, Oreg., pages 1862–63, part 21; V. J. Huffman, chief planner for aging, District 3, Oreg., pages 1874–75, part 21; Nancy C. Peace and John C. Buck, Upper Cumberland (Tennessee) Area Agency on Aging, page 1963, part 22.

[86] See, for example, testimony or statements by James Vasselli, pages 1470–71, part 16; Essex County (N.J.) Freeholder Donald M. Payne, page 1486, part 16; Neal C. Clark, executive director RSVP Program of Essex County (N.J.) (in letter to Senator Williams), pages 1553–54, part 16; Ivon Jones, Outreach Worker, Chattanooga (Tenn.) Human Services Department, page 1952, part 22.

Senior Centers: If services to the elderly have dollar value—in terms of retirement income saved or enhanced—then more efficient means of delivering services should increase that value.

Several witnesses were invited to discuss the role of senior centers in serving as service hubs, in addition to performing other essential roles.

Among those who dealt with this question was Sebastian Tine, executive director of Senior Citizens, Inc., at the Joseph B. Knowles Senior Center in Nashville. This center, established before the Older Americans Act became law, developed its own meals program and other activities. It now draws some Federal support for its day care program and a few other activities, but maintains several programs on a pay-as-you-go basis from membership fees and other member contributions, including volunteer activity.

Mr. Tine said:

> In our own program here, in the Knowles Center, we have to charge 85 cents for a full-course lunch, and I know there are other centers that charge something in that neighborhood, or perhaps even less. I think it is 60 cents in Memphis.
>
> So what I am trying to emphasize is that in my opinion, many older people are meeting the price squeeze by taking advantage of the nominal cost of food and participation in the senior center.
>
> In our own program, in addition to the meals to be served here, we have two for our home delivered meals.
>
> One is called mobile meals, and it is for older persons referred to us by public health nurses.
>
> These individuals receive food free of charge, but the cost of food is provided by private gifts and donations made to us by church groups, private individuals, civic organizations, and the like.
>
> The other home delivery program is for people who are disabled, who do need the food and who can pay, or whose families can pay, and the average cost to the recipient in this case is $1.25.
>
> Now, the third area in which the participants in a multipurpose center, such as ours, are receiving great economic benefits is health. In our center we have a nurse, and we conduct a full program of nursing services and health services, which include injections, blood pressure monitoring, influenza vaccine, immunization, first aid, blood sugar screening, hematocrit screening, individualized health classes, physical fitness classes, breast examinations, hearing screening, loan of wheelchairs, walkers, and so forth, classes for the blind, classes for hard of hearing, health workshops, multiphasic health screening, health lectures, and water exercises.
>
> In talking with a nurse about the value of these services, it was not possible for us to put a price on services of this kind, but I would strongly urge each one of you to think of each specific service and what you may be paying for it, and you may get some idea of the savings to our members. I would like to add some of these services do require doctor's orders.
>
> I would like to tell you just a little bit about multiphasic screening. Through the work of the metro health department

and the senior citizens center, and in cooperation with about seven health agencies, we have conducted, for the past 3 years, a multiphasic screening program here at the building in which examinations in a number of disease categories are given free to older individuals.

We had our last one in October. My own rule of thumb estimate on the economic value of this matter of screening examinations would be somewhere in the neighborhood of between $100 and $200. So in this area, the economic advantages are very great.[87]

William R. Pothier, executive director, San Francisco Senior Center said that 80 percent of the 2,000 persons served by the downtown center are on SSI.[88] He also gave this excerpt from a center staff member's statement:

As social worker at the San Francisco Senior Center, one of my main tasks is to counsel the seniors and/or family and friends regarding concerns or problems with which an elderly person is faced. By phone or in person, I counsel approximately 8 to 10 people per day and of the many problems that they need help with, the underlying instigator of the problems appears to be money or lack of it. With the rising costs and their incomes remaining unchanged, the seniors have difficulty obtaining the necessities of life (decent housing, proper nutrition, health care) not to mention the necessities for mental health of being able to buy attractive clothing, have their hair done, or go to the movies just to help them feel good. More than 50 percent of the people I see express the real fear of becoming ill. They or their friends have had difficulty paying for their share of the medical bills even with medicare. Some would rather go without the necessities of life just to insure proper health coverage.

Mr. Pothier also described plans to bring the "social supportive services and some health services of the San Francisco Senior Center together with the medical services of the St. Francis Memorial Hospital and its medical staff, to provide a comprehensive health program for San Francisco's senior population." [89]

Jose Garcia, director for Migrant Education in Washington County, Oreg., told of a cooperative effort with the county council on aging to establish a center which will pay special attention to the needs of a large elderly Chicano population.

We are now looking forward to opening our center to our seniors and in providing one nutritious meal per day to each needy senior, as well as one home delivered meal to shut-ins. We also hope to attack the health problem through our companion and adjacent clinic.

We have a clinic we started. We also plan to provide services, the opportunity to socialize, and to bring our elderly out of their present state of isolation, poor health, and lack of access to governmental services. Loaves and Fishes, through its title VII nutrition program under the Older Americans

[87] Pages 1944–45, part 22.
[88] Page 1218, part 13.
[89] Page 1219, part 13.

> Act, is working closely with us. We expect to serve the first meals the end of this month. We also have an application pending with the State program on aging, which has been strongly supported by Dr. Richard's county council on aging, for $6,000. This will permit us to expand our transportation service for our Ancianos—as we call our elderly—and to permit us to hire a full time coordinator of the elderly in our center.[90]

Richard Block, chairman of the board for the Josephine K. Lewis Center for Senior Citizens in Memphis, Tenn., said:

> Depending on the size of a center and the depth of program offered, the cost per member for the operation of a multipurpose center varies between 20 cents and 40 cents per person per day. Contrast this with $17 a day institutional care. Many of my friends, members of this center, would be institutionalized or in need of institutionalization were it not for Lewis Center.[91]

B. Supplementing Retirement Income With Jobs

A growing number of service-oriented jobs are being provided under public auspices (see part II, chapter IX, for additional details), offering opportunities to buttress income at least up to the point where the "retirement test" under social security results in reduced benefits. In addition to public jobs, nonprofit job placement programs—many based in senior centers—are also providing help.

Supplementation of retirement income is a major objective of such work programs, but a number of other important objectives are often met, as indicated in the following excerpts:

> I am 68 years old and proud to be a senior citizen. I live in Newark and am presently working at the North Jersey Community Union under the CETA (Comprehensive Employment and Training Program). . . . After my husband died I tried to do domestic work. I was suffering from arthritis very badly, and that was much against me. But still I did my best, as to be a self-supporter and to live within my social security check, which is very, very hard with my check. . . . After going to North Jersey Community Union, I thanked God; my physical condition has become very good, and my arthritis has improved. . . . I feel now that I have something to live for . . . it is a privilege for me to go out and lend a hand; when I can help somebody else, then I know that my life is worthwhile.[92]

From a member of the Senior Aides program in Memphis, Tenn., who has been trained as a "paralegal":

> In the last 6 months, I have seen many senior citizens with problems which could only be solved by help from persons

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[90] Page 1870, part 21.

[91] Part 25. For additional discussion of senior centers, see letter to Senator Tunney from Don Rogers, Supervisor, Senior Citizen Center, Culver City, Calif., pages 1349–51, part 14; and statement by Joyce Osika, staff captain, Volunteers of America, Portland, Oreg., pages 1819–20, part 20.

[92] Testimony of Jessie Porter, pages 1496–97, part 16.

with legal training. . . . Mrs. X was 68 years old and living on a low, fixed income. . . . Mrs. X's mother had died. Mrs. X was the rightful heir to this money, but could not prove it because she had no legal proof of her adoption. . . . She came in and one of our attorneys worked with her and was successful in obtaining her money for her. Eventually she got $11,755 from the estate. Without "Legal Services for Senior Citizens," Mrs. X would never have gotten her money.[93]

From a participant in the Portland, Oreg., Older Worker Manpower System who had formerly been an accompanist to the "Inkspots" singing group:

I have been a musician all of my life until just recently, when I was struck down with emphysema. Now the only sort of work I can do is just part-time work, and so it has been a godsend to me to have this opportunity to work with the senior citizens. I think everyone has been benefited by my services; I certainly am; and I am able to make ends meet, but before that I just got my SSI check which I could not do very well with, Senator.[94]

A witness in Iowa said:

Today we are discussing the impact of inflation upon the elderly. The Foster Grandparents program has done a great deal to alleviate the pain of poverty-level living, but I must emphasize we will not and we cannot divorce the financial benefits from the emotional and psychological benefits. Much of the success of the program is in the reduction of the loneliness, isolation, and rejection so often synonymous with growing old.[95]

From the director of an employment program in Chattanooga, Tenn.:

Since January 1, 1975, a recession year, the service has made 126 job placements covering a wide range including companions, maids, sitters, office managers, secretaries, salesmen, and delivery men. Among those benefiting from the service are: a retired 77-year-old general contractor who had spent all his life's savings during his wife's long illness prior to her death. He was unable to re-enter the construction business because of lack of capital. He received social security but needed more income. He was placed with a company who had requested a man skilled in payroll and tax preparation and the handling of semiskilled employees. His last report to us is that after being on the job 3 months he is now being groomed as manager of the establishment.

A 65-year-old black male with a third-grade education worked as a laborer or janitor and his wife did day work to maintain the family. The wife became ill and could no longer

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[93] Testimony of Mrs. Elizabeth Leach, part 25

[94] Testimony by Donald L. Anderson, page 1824, part 20.

[95] Testimony by Paula Maxheim, Foster Grandparents, project director, Iowa Commission on the Aging, pages 1384–85, part 15. In the same part, see also testimony by Foster Grandparents Homer Dunlap, Mildred Waltz and Gordon Dana, pages 1386–90.

work. He was desperate for regular employment. . . . He now works 5 days per week while his wife receives a small disability check.[96]

From California:

The bureaucrats in Washington, the regional Federal offices, and the States agencies through which these (manpower) funds are channeled, systematically subvert the intent of Congress to help older workers. An example from one manpower council in California: their plan for 1976 appeared in a public notice this week. It included job assistance for 770 so-called seniors in an area where over 100,000 people over 60 years of age live. This works out to 0.77 percent. It is so small I don't even know how to say it.[97]

FINDINGS AND RECOMMENDATIONS

Testimony taken during 1975 and 1976 in the field on the subject of "Future Directions in Social Security: Impact of High Cost of Living" clearly documents the special impact of rising living costs on older Americans.

Items for which the elderly pay proportionately more of their incomes are among those in which the greatest cost increases are occurring. Together, these increases have brought the low- and modest-income elderly to the point of desperation and they have shaken the economic security of those on retirement incomes which might have been regarded as "comfortable" under other conditions.

Whatever national actions are taken to reduce inflation and unemployment it becomes clear that these additional steps should be taken to help the elderly through these trying times:

- **—The cost-of-living adjustment mechanism under social security and SSI should be made payable twice a year when warranted and should be based upon an index more accurately reflecting actual spending patterns of older persons (see similar recommendation in chapter I).**
- **—An improved and better-administered SSI program should become the vehicle for ending poverty, once and for all, among the aged population of this Nation.**
- **—Employment programs, for those older persons who can and want to work, should play a far more effective role in meeting that objective and meeting other needs, as well.**
- **—Congress should continue its active resistance to any proposal for reducing service programs for older persons at a time when those programs—and the dollar savings in retirement income which they can provide—are badly needed.**

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[96] Testimony of J. P. W. Brown (75 years old), coordinator, Senior Employment Service, Senior Neighbors of Chattanooga, Inc., pages 1949–50, part 22.

[97] Testimony by Eleanor Fait, page 1156, part 13. For additional employment-related discussion of employment-related issues, see testimony or statements of: Pacia Rogers, page 1393, part 15; Joseph L. Weinberg, executive director, Jewish Vocational Service of Metropolitan New Jersey, pages 1519–24, part 16; Memorandum from Thomas E. Kennedy to Philip Rubenstein, "Manpower Services to Seniors of Ocean County, N.J.," pages 1640–41, part 17: Helen W. Aldredge, Older Worker Manpower System, Portland, Oreg., pages 1823–24; and Nell M. Bayley, page 1825, part 20; and Mrs. Lucille Waller, Employment Counselor, Josephine P. Lewis Center, Memphis, part 25.

CHAPTER III

CHALLENGES TO SOCIAL SECURITY AND SSI

Two bulwarks protecting the economic security of older persons—each designed by the Congress to keep pace with rising living costs—ran into serious challenge in 1975: Social Security and the Supplemental Security Income program.

One challenge was posed by the near double-digit inflation described in the previous chapter. Higher than projected cost-of-living adjustments added to the total cost of the Social Security program at a time when the highest unemployment in 34 years reduced the amount of income (through employer and employee payroll contributions) for the Social Security trust funds.

Another challenge was directed at the financial soundness of the Social Security system. Critics questioned whether the system could withstand severe new demands, and the more extreme skeptics said Social Security was "going broke." Despite authoritative arguments to the contrary, such criticisms persisted in 1975.

Finally, serious complaints were directed at the efficiency and responsiveness of the Social Security Administration in administering the SSI program. Allegations of SSI blunders or unsound practices were so intense that concern grew about the overall ability of the Social Security Administration to maintain high standards of quality performance in the face of the heavy workload imposed upon it in recent years.

I. WHAT SOCIAL SECURITY NOW DOES

Social Security is the primary source of income for older Americans. It accounts for 45 percent of all income for aged persons living alone and 32 percent of the income for families with an aged head. Nearly 32 million persons receive Social Security benefits, including 20.4 million in the 65-plus age category.

Social Security cash benefits (August 1975) [1]

Total monthly beneficiaries (in thousands)	31,525
Total aged 65 and over	20,354
Retired workers	14,617
Survivors and dependents	5,501
Special age-72 beneficiaries	237
Total under age 65	11,171
Retired workers	1,728
Disabled workers	2,398
Survivors and dependents	7,045
Total monthly benefits (in millions)	$5,593

[1] Incorporates 8 percent cost-of-living increase authorized in 1975.

Source: *Social Security Bulletin*, December 1975, p. 1.

More than 90 percent of individuals 65 or older are eligible for Social Security benefits. Nearly four out of five persons aged 21 to 64 have disability protection, and 95 percent of all mothers and dependent children are eligible for benefits if the father dies.

Social Security also keeps 10 million persons out of poverty, including 7 million aged persons. Without these benefits, millions of older Americans would be forced onto the welfare rolls. Others would be required to depend upon relatives—many of whom would be financially hard-pressed to provide economic assistance. And without Social Security, the overwhelming proportion of older Americans could not hope to achieve even a moderate standard of living.

A. Benefit Levels Today

In July 1975 the Social Security cost-of-living adjustment mechanism came into operation for the first time. Nearly 32 million persons received an 8-percent benefit increase. On an individual basis, the cost-of-living adjustment had the following impact:

SOCIAL SECURITY BENEFITS (JULY 1975)

	Average monthy benefits	
	Prior law	8-percent increase
Retired worker (without dependents)	$184	$200
Retired couple, both receiving benefits	314	341
Aged widow	178	193

	Monthly benefits for others	
	Prior law	8-percent increase
Maximum, male worker retiring in 1975 at age 65	$316.30	$341.70
Maximum, retired couple, man retiring in 1975 at age 65 and wife is 65	474.50	512.60
Minimum, worker retiring at age 65	93.80	101.40
Minimum, retired couple, both 65	140.70	152.10

In addition, nearly all persons 65 or older received a one-shot $50 special payment ($100 for couples) under the Tax Reduction Act of 1975.[1] Nearly 34 million Social Security, Railroad Retiree, and Supplemental Security Income beneficiaries received an additional $1.7 billion. The special payment, which was financed out of general revenues, was nontaxable. It was also disregarded in determining eligibility under State or Federal public assistance programs.

B. Poverty Among the Elderly

Social Security beneficiaries have received five across-the-board increases since 1970, totaling 82 percent.[2] These increases have helped

[1] Public Law 94–12, approved Mar. 29, 1975.

[2] Social Security benefits increases since 1970:

Effective date:	Percent increase
January 1970	15
January 1971	10
September 1972	20
June 1974 (payable in two steps—7 percent beginning for March 1974, with the full 11 percent payable effective for June)	11
June 1975	8

The increases total 64 percent. However, the aggregate benefit boost is 82 percent because of the compound effect of adding one increase on top of another.

considerably in improving the retirement income position of older Americans.

SOCIAL SECURITY CASH BENEFITS—HISTORY OF PERCENTAGE INCREASES IN BENEFITS AND PRICES

Act	Date of enactment	Effective date	Across-the-board increases in benefits (percent)		Increases in CPI (percent)	
			Each amendment	Cumulative	Between effective dates	Cumulative
1939	Aug. 10, 1939	January 1940				
1950	Aug. 28, 1950	September 1950	77.0	77.0	75.5	75.5
1952	July 18, 1952	September 1952	[1] 12.5	99.1	9.3	91.8
1954	Sept. 1, 1954	September 1954	13.0	125.0	.5	92.8
1958	Aug. 28, 1958	January 1959	[2] 7.0	140.8	7.9	108.1
1965	July 30, 1965	January 1965	[3] 7.0	157.6	7.9	124.4
1967	Jan. 2, 1968	February 1968	13.0	191.1	9.3	145.3
1969	Dec. 30, 1969	January 1970	15.0	234.8	10.8	171.8
1971	Mar. 17, 1971	January 1971	10.0	268.2	5.2	185.9
1972	July 1, 1972	September 1972	20.0	341.9	5.9	202.8
1974	Dec. 31, 1973	June 1974	[4] 11.0	390.5	16.6	253.0
1974		June 1975	8.0	429.7	9.3	285.9

[1] Greater of 12.5 percent or $5.
[2] Guarantee of 7 percent or $3.
[3] Guarantee of 7 percent or $4.
[4] This 11-percent increase was payable in 2 steps—7 percent for March, April, and May 1974, with the full 11 percent payable for months after May.

For example, the number of older Americans living in poverty declined from 4.7 million in 1970 to 3.3 million in 1974,[3] in large part because of Social Security increases. But this figure represents only one dimension of the economic deprivation endured by many older Americans.

Other factors must also be taken into account in assessing the economic position of the elderly. First, the poverty line is at a bare minimum existence. Some authorities have contended that the threshold is unrealistically low and should be raised. The weighted threshold for an individual 65 or older is $2,352, or $45 per week (approximately $6.50 per day) for food, shelter, clothing, utilities, medical care and other everyday necessities. For a couple with an aged head of household, the poverty line is $2,958, or $56 per week (approximately $9.25 per day).

POVERTY THRESHOLDS (1974) FOR PERSONS 65 OR OLDER (MARCH 1975 SURVEY)

	Weighted	Nonfarm	Farm
Individual	$2,352		
Total		$2,364	$2,013
Male		2,387	2,030
Female		2,357	2,002
2-person family with head aged 65 or older	2,958		
Total		2,982	2,535
Male		2,987	2,535
Female		2,966	2,533

Source: Bureau of the Census.

Second, the Bureau of the Census poverty figures do not include:
—Elderly poor persons living in institutions, and
—Older Americans with incomes below the poverty lines who live with others (such as family members) with sufficient incomes to raise them above the poverty thresholds.

[3] The 1974 poverty figures are based upon a March 1975 survey conducted by the Bureau of the Census. The 1975 poverty figures will be based upon a March 1976 census survey. The information, though, will not be available until the summer of 1976.

If these individuals were counted, the number of elderly persons would probably exceed 5 million.

Third, nearly 2.2 million older Americans are classified as marginally poor—having incomes below 125 percent of the poverty thresholds.

Poverty is also much more prevalent among certain groups of older Americans, especially members of minorities, women, and those living alone or with nonrelatives. In fact, elderly blacks are nearly three times (2.6) as likely to be poor as aged whites. Although the relative income position of Negroes 65 or older has improved substantially, it has not kept pace with the advances for older whites. In 1970 the likelihood of being poor among aged blacks was 2.1 times as great (compared with 2.6 in 1974) for elderly whites.

POVERTY AMONG ELDERLY BLACKS AND WHITES (PERSONS AGED 65 OR OLDER)

[In thousands]

	Calendar year 1970 (March 1971 survey)			Calendar year 1974 (March 1975 survey)		
	Total	Black	White	Total	Black	White
65-plus population	19,254	1,422	17,684	21,127	1,722	19,206
Poverty	4,709	683	3,984	3,308	626	2,642
Percent poor	24.5	48.0	22.5	15.7	36.4	13.8

Source: Bureau of the Census.

Many elderly blacks are just barely above the poverty line. In fact, over half of the aged Negro population (911,000 or 52.9 percent) would be classified as poor or marginally poor.

Elderly Negro women living alone would be among the most disadvantaged groups in our society today. More than seven out of 10 (70.8 percent) now live in poverty.

Aged single persons run a much greater risk of living in poverty than elderly persons living in families. Nearly one-third (31.8 perment) of all unrelated aged individuals living alone or with nonrelatives would be considered poor under the Bureau of the Census poverty definition. More than three out of five (60.5 percent) elderly blacks in this category now live in poverty. Among older whites comparably situated, the rate is 28.9 percent.

II. CHALLENGE TO THE FIRST COST-OF-LIVING ADJUSTMENT

Social Security beneficiaries became eligible for the first cost-of-living adjustment in July 1975.[4] But the administration launched a campaign before the increase became effective to place a 5-percent cap on the adjustment.

Senators Church, Kennedy, and Mondale introduced legislation (S. Con. Res. 2) on January 21, 1975, to express congressional opposi-

[4] Public Law 93-233, approved December 31, 1974. Public Law 93-233 changed the effective date for the cost-of-living adjustment from January 1975 to June 1975 (checks are received on the third of the following month). Public Law 92-336 (approved July 1, 1972) established the cost-of-living adjustment mechanism.

tion to any legislation to impose a ceiling on Social Security cost-of-living increases. S. Con. Res. 2 generated strong bipartisan support. Fifty-four Senators sponsored the proposal.

Senator Church, the author of the cost-of-living adjustment provision, said:

> The automatic escalator provision was designed to make Social Security inflation-proof. Democrats and Republicans alike joined me in fighting for this goal. We believe that it assures older Americans of prompt action when needed.
>
> President Ford's proposal, however, strikes at the very heart of the cost-of-living adjustment principle. At a time when the elderly need all the help they can to deal with inflation, the President would put an arbitrary limit on Social Security increases due to them by law.[5]

Senator Kennedy added:

> Of all the proposals of the President in his economic program and his energy program, this proposal strikes at the group that is least able to defend itself in the current economic crisis.
>
> Elderly Americans have been paying higher prices for food, higher prices for fuel, higher prices for electricity, and now they are being asked to bear perhaps the greatest burden of any group in the land.[6]

If the administration's proposal had been adopted, the purchasing power of Social Security beneficiaries would have been reduced by $2.1 billion during fiscal year 1976. Individually, Social Security beneficiaries would have received, on the average, nearly $70 less for 1976.

On May 6, Senator Church won approval of an amendment (by a vote of 76 to 13) to S. 409 (to extend the Council on Wage and Price Stability) to express congressional opposition to any ceiling imposed upon the July 1975 Social Security cost-of-living increase.[7] The effect of the amendment was to assure enactment of the 8-percent adjustment authorized by law, instead of the 5-percent ceiling proposed by President Ford.

The Church amendment also had spillover effects, since other cost-of-living adjustments were based upon the Social Security automatic escalator provision. The Federal SSI income standards, for example, were increased by 8 percent instead of 5 percent. The 8-percent increase will provide an additional $52.80 for individual recipients during fiscal year 1976 and $79.20 for qualifying couples.

MINIMUM MONTHLY INCOME PROVIDED UNDER THE FEDERAL SSI PROGRAM

	June 1975	5 percent	8 percent
Individual	$146	$153.30	$157.7
Couple	219	230.00	236.6

[5] *Congressional Record*, January 21, 1975, page S575.
[6] Page 575 of *Congressional Record* cited in footnote 5.
[7] *Congressional Record*, May 6, 1975, page S7555.

The fiscal 1977 budget projects a 6.7 percent cost-of-living for Social Security and Supplemental Security Income beneficiaries in July 1976. No ceiling, however, is proposed by the administration for this adjustment. Social security beneficiaries, though, will receive a 6.4 percent increase because of the decline in the inflationary rate.

III. IS SOCIAL SECURITY GOING BROKE?

On May 6, 1975, the board of trustees for the Social Security cash benefits trust funds submitted their annual report,[8] projecting that the assets in both the old age and survivors insurance trust fund and the disability insurance trust fund will decline from 1975 to 1979.

"Without legislation to provide additional financing," the board of trustees concluded, "the assets of both trust funds will be exhausted soon after 1979." [9]

The board computed the long-range actuarial deficit at 5.32 percent of taxable payroll.

A. Why Is Social Security Confronted With Financing Problems?

The Committee on Aging devoted 3 days of hearings in 1975 solely to the short-term and long-range financing problems confronting the Social Security system.[10]

Witnesses generally agreed that the short-term deficit is caused by our extraordinary economic situation: substantial unemployment coupled with high inflation. The net impact is that Social Security is being strained at both ends. Benefit payments are rising because the cost-of-living adjustments are higher than initially projected. Yet, income for the system is reduced because unemployment in 1975 reached its highest level in 34 years.

However, Social Security has a $44 billion trust fund to meet such temporary problems until appropriate corrective action can be taken. This is equivalent to 56 percent of the 1976 outgo from the cash benefits program. Social Security Commissioner James B. Cardwell says, "This is why the reserves were created in the first place—to act as a cushion during a depressed economic period." [11]

Mr. Robert Ball, Commissioner of Social Security from 1962 to 1973 and now a scholar in residence at the National Academy of Sciences, said the short-term problem is "easily manageable" [12] in a way that can retain the self-financing principles of Social Security.

National Council of Senior Citizens president Nelson Cruikshank emphasized that "Social Security is the answer to the problem—not the problem itself." [13]

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[8] "1975 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Funds," H. Doc. 94–135, 94th Cong., 1st Sess., May 6, 1975.

[9] Page 44 of report cited in footnote 8.

[10] "Future Directions in Social Security," parts 9, 10, 11, hearings before the U.S. Senate Special Committee on Aging, 94th Cong., 1st Sess., March 18, 19, and 20, 1975.

[11] Remarks by James B. Cardwell, Commissioner of Social Security, Washington editorial conference, American Business Press, Washington, D.C., November 5, 1975.

[12] Page 953 of hearing cited in footnote 10, part 11, March 20, 1975.

[13] Page 942 of hearing cited in footnote 10, part 11, March 20, 1975.

To make his point, he added:

> Inflation too greatly increases Social Security outlays now that benefits are adjusted to increases in the cost of living. But the Social Security system is not the cause of inflation. Again, it is one means of ameliorating an intolerable situation.[14]

The long-range actuarial deficit is more complicated, and is caused primarily by three factors:

1. The birth rate has declined sharply in recent years and is projected to remain at a low level for a longer period of time than previously projected. Since 1957 the expected number of births per woman has declined from 3.77 to 1.9 in 1974. Today there are about 30 beneficiaries per 100 workers. If current population and labor force projections prove accurate, there will be 50 beneficiaries per 100 workers in 2030.

2. The rate of inflation over the long haul is expected to be higher than the historical average. Present projections suggest that the current inflationary rate will not continue indefinitely. But there will be steady inflation during the long-term forecast—resulting in higher than expected future costs to the program.

3. The existing automatic escalator provision is vulnerable to high rates of inflation. With a relatively low average price increase, the system works well. But under higher projected price increases, it produces excessive wage replacement. Now Social Security benefits rise automatically with increases in the Consumer Price Index. This not only increases benefits for all retirees, but also for persons still in the work force. They will eventually obtain the advantages of the higher benefit schedule when they retire. At the same time, though, persons in the work force can expect higher earnings because of general wage increases. In effect, they stand to receive a double increase. Thus, benefit boosts for today's workers are coupled with benefit increases for retired persons, producing instability in the existing wage replacement ratios.

Witnesses pointed to a number of offsetting factors that may cause the actuaries to revise their present predictions. Nelson Cruikshank had this to say:

> Full employment permits workers to continue in their jobs to more advanced ages; women, with fewer children, will increasingly enter the labor force; and we have every expectation that productivity will continue to rise over the long run. These factors, coupled with the reduced burden of support for children, all serve to make it more possible for the workers of the future to provide adequately for their older people—so that they in turn can retire with dignity and independence.[15]

Robert Ball pointed out that fertility rates are difficult to predict. He noted that if the fertility rate would rise to the 2.5 level (near the level between 1967 to 1970), the financing problem would be reduced considerably. Increased productivity levels may also offset cost effects of the population shift. However, Robert Ball concluded that the

[14] Page 942 of hearing cited in footnote 10, part 11, March 20, 1975.
[15] Page 943 of hearing cited in footnote 10, part 11, March 20, 1975.

prudent course is to assume that the demographic shifts will occur and productivity increases will average about 2 percent. In addition, he emphasized that the increasing aged population will be offset by a decline in the number of younger dependents.

> If we look not just at the elderly but at the combined number of people below 20 and over 65 and consider this combined group to be the number to be supported by active workers, we get a very different picture than when looking at the aged alone. Even allowing a higher per person living cost for older people than for children, it still can be said with considerable confidence that the kind of population shift that would occur under the 1974 trustees' assumptions does not represent an increase in the overall economic burden on active workers, but rather an increased obligation to support older people, balanced by a lessening of the obligation to support children.[16]

ACTUAL PAST AND PROJECTED FUTURE POPULATION OF THE UNITED STATES BY BROAD AGE GROUPS AND DEPENDENCY RATIO

[Population in thousands]

Year	Under 20	20 to 64	65 and over	Total
Actual:[1]				
1930	47,609	68,438	6,634	122,681
1940	45,306	77,344	9,019	131,669
1950	51,295	86,664	12,257	150,216
1960	73,116	98,687	17,146	188,949
1970	80,637	112,500	20,655	213,792
1973	79,665	117,956	21,916	219,538
Projected:[2]				
1980	75,806	131,913	24,969	232,689
1990	78,433	146,745	29,265	254,443
2000	81,368	158,678	31,034	271,080
2010	80,593	172,642	33,629	286,864
2020	83,493	174,020	42,766	300,279
2030	84,271	173,499	51,383	309,153
2040	85,543	179,322	50,347	315,212
2050	87,324	181,046	51,239	213,609

Year	Under 20	65 and over	Total
Dependency ratio:[3]			
1930	69.6	9.7	79.3
1940	58.5	11.7	70.2
1950	59.2	14.1	73.3
1960	74.1	17.4	91.5
1970	71.7	18.4	90.0
1973	67.5	18.6	86.1
1980	57.5	18.9	76.4
1990	53.4	19.9	73.4
2000	51.3	19.6	70.8
2010	46.7	19.5	66.2
2020	48.0	24.6	72.6
2030	48.6	29.6	78.2
2040	47.7	28.1	75.8
2050	48.2	28.3	76.5

[1] Figures for 1930, 1940, and 1950 are for the United States according to census counts. Figures for 1960 and 1970 are according to census counts and include adjustment for other areas covered by social security as well as for net undercount. Figures for 1973 are census estimates for the United States including net undercount, plus an adjustment for other areas covered by social security.

[2] Based on the population projections prepared by the Office of the Actuary for the 1974 long-range cost estimates.

[3] Dependency ratio is here defined as the total number of persons aged under 20 and/or over 65 per 100 persons aged 20 to 64.

Source: Office of the Actuary, Social Security Administration.

B. Financing Proposals

Several proposals have been offered to place the Social Security System in actuarial balance.

In March 1975, Robert Ball proposed increasing the maximum taxable wage from, in 1977, the projected level of $16,500 to $24,000. With this higher base, it would be possible to shift the scheduled hospital insurance (HI) rate increase for 1978 (0.2 percent) to the cash benefits program. The effect is that the 1978 contribution rate would be 5.15 percent (instead of 4.95 percent as under present law) for OASDI and 0.9 percent (instead of 1.1 percent under present law) for HI.

[16] Page 954 of hearing cited in footnote 10, part 11, March 20, 1975.

The 1975 Advisory Council on Social Security recommended that the hospital insurance part of Medicare be supported from general revenues, allowing the contribution rate for HI to be transferred to OASDI.[17]

President Ford, in his fiscal 1977 budget message, called for 0.3 percent increase in the overall contribution rate for Social Security in 1977, from 5.85 percent to 6.15 percent. The entire 0.3 percent rise would be applied to the cash benefits program, increasing the existing rate of 4.95 percent to 5.25 percent.

For the long-range financing problem, the administration proposed to stabilize the relationship between a Social Security beneficiary's preretirement earnings and benefit level at retirement through a wage index system. This proposal would eliminate approximately one-half of the long-range deficit. The administration, however, did not spell out the details of this recommendation in the budget message.

Secretary of HEW David Mathews provided more details when he testified before the House Ways and Means Committee on February 2, 1976. In describing the administration's recommendation to "decouple" the Social Security system, he said:

> The purpose of our decoupling proposal is, then, to remove the extreme sensitivity of future benefit levels to fluctuations in both wage and price increases and to assure that future replacement rates will be relatively constant in relation to future wage levels. Our objective is to stabilize replacement rates—not social security benefit amounts. Under the proposal, future replacement rates will remain at current levels and benefit amounts will generally rise over time.
>
> I would emphasize that this change would have no effect on existing automatic cost-of-living increases available to people after they retire and start to receive benefits. Under our proposal, as under present law, benefits will be adjusted automatically for changes in the cost of living as measured by the Consumer Price Index. The beneficiary's purchasing power will be maintained as long as he or she is on the beneficiary rolls.[18]

On May 24, 1976, the board of trustees estimated the long-range actuarial deficit at 7.96 percent of taxable payroll. Two factors accounted primarily for the increase:

(1) The trustees now project an ultimate fertility rate of 1.9 children per woman, compared with a rate of 2.1 children projected in the 1975 report.

(2) The increase in productivity is now estimated at 1.75 percent, in contrast to 2 percent under last year's assumptions.

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[17] In testimony before this committee, Mr. Rudolph T. Danstedt, assistant to the president of the National Council of Senior Citizens and a member of the Advisory Council on Social Security, opposed the Advisory Council's recommendation to finance part A of Medicare entirely from general revenues. He feared that this change may possibly lead to the introduction of an income or means test for the program. He said: "I fear that the recommendations of the majority could over time transform the Medicare social insurance program into a relief program. There is enough experience with the income-tested Medicaid program to predict what the implications of such a transformation would be for the perpetuation of a two-class system of medicine and in terms of undermining the dignity of the recipient." (At a hearing on "Future Directions in Social Security," March 18, 1975, Washington, D.C.)

[18] Statement by David Mathews, Secretary of Health, Education, and Welfare, before the Subcommittee on Social Security of the Committee on Ways and Means, House of Representatives, February 2, 1976, pages 9–10.

The trustees noted, however, that correcting the overindexed benefit structure under the cost-of-living adjustment mechanism could reduce the long-term deficit to 4.28 percent of taxable payroll.

IV. AREAS OF SPECIAL CONCERN

The Committee on Aging has examined several questions related to Social Security as a part of its overall study concerning "Future Directions in Social Security." Major issues include the retirement test, the financing of Social Security, proposals to make the Social Security payroll tax less regressive, adequacy of benefit levels, the extent of coverage, and the administration of the Social Security program. In 1975 the committee focused primarily on three issues: (1) The short-term and long-range financing problems confronting Social Security (see page 66 for more detailed discussion). (2) the impact of the cost of living upon the elderly (see chapter II for more detailed discussion), and (3) the treatment of women under Social Security.

A. Women and Social Security

A six-member Task Force [19] prepared a working paper which served as a springboard for discussion during hearings conducted by the committee on women and Social Security.

The Task Force made several important findings:

—A retirement income crisis affects millions of elderly women and threatens to engulf many more.

—Older women are nearly twice as likely to be poor than older men.

—Nearly 2.3 million women live in poverty, or 18.3 percent of all elderly women.

—Poverty among older men is significantly lower. About 1 million men are now considered poor under the Bureau of the Census definitions, or 11.8 percent of all males in the 65-plus age category.

The Task Force listed two major factors accounting for the higher degree of deprivation among aged and aging women. First, more women are concentrated in low-paying and part-time jobs. Second, many women have an in-and-out labor force pattern because of interruptions for bearing and rearing children.

The Task Force asserted that Social Security has not shortchanged aged and aging women beneficiaries. Quite to the contrary, it has helped provide protection for women workers against long-standing discriminatory patterns in our society. One clear-cut example is that women receive a greater advantage from the weighted benefit [20]

[19] The members of the Task Force on Women and Social Security include: Verda Barnes, former administrative assistant to Senator Church before her retirement in 1975; Herman Brotman, consultant, Senate Committee on Aging, and former Assistant to the U.S. Commissioner on Aging; Alvin M. David, former Assistant Social Security Commissioner in charge of program evaluation, legislative planning, and related functions; Juanita M. Kreps, professor of economics and vice president of Duke University, member of the board, New York Stock Exchange; Dorothy McCamman, consultant to the Senate Committee on Aging and the National Council of Senior Citizens, former Assistant Director of Research, Social Security Administration; Lawrence Smedley, associate director, AFL–CIO Social Security Department.

[20] Social Security benefits are weighted to provide larger wage replacement for low-income workers. This is an equity consideration because low-income wage earners are less likely to have other types of outside income (such as savings, dividends, and rental income) to supplement Social Security benefits.

formula because a substantially larger proportion have worked in lower paying jobs. In addition, the Task Force said:

> Taking the total of all benefits (including retirement benefits) paid on the earnings of women, the amounts are slightly greater than those paid on the earnings of men. This is true—even though male-worker accounts generate more secondary benefits—essentially for three reasons:
>
> 1. Women have a longer life expectancy than men;
> 2. Fewer women work beyond age 65; and
> 3. Women receive a greater advantage from the weighted benefit formula, since a much larger proportion work in low-paying employment.[21]

However, the Task Force stressed that there are areas where Social Security can be improved for women and their dependents.

The Task Force urged that benefit rights for women workers should be equalized by (1) removing the dependency test for father's benefits (including a surviving divorced father) with a child in his care, (2) eliminating the dependency requirement for husband's or widow's benefits, and (3) providing divorced husband's benefits.

Other recommendations include:

—The substantial recent current work test (generally 20 out of 40 quarters) should be eliminated.

—An occupational definition of disability should be established for workers aged 55 or older.

—Disabled widows or widowers and disabled surviving spouses should be eligible for Social Security without regard to age, and their benefits should not be subject to an actuarial reduction.

—Disabled spouses of Social Security beneficiaries should also be entitled to monthly payments.

—The duration of marriage requirement should be reduced from 20 to 15 years for a divorced spouse to qualify for benefits, and the consecutive years requirement should be eliminated.

—An age-62 computation point should be made applicable for men born before 1913 to provide larger benefits for retired male workers, older married women, aged widows, and others.

—The computation of primary benefits and wife's or husband's benefits should be adjusted to increase primary benefits for workers by approximately one-eighth and to reduce the proportion for spouses from one-half to one-third. This would maintain the present benefit total of 150 percent for a couple. At the same time, it would improve protection for single workers, working couples, and widows.

B. Need for an Independent Social Security Administration

About one out of every seven Americans receives Social Security benefits. As things now stand, most older Americans do not have a private pension to supplement their Social Security benefits. Only

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[21] "Women and Social Security: Adapting to a New Era," a working paper prepared by the Task Force on Women and Social Security for use by the U.S. Senate Special Committee on Aging, October 1975, page 38.

about one out of four Social Security beneficiaries aged 62 or older receive private pensions based upon their own or their spouse's work record. Approximately one-half of male Social Security beneficiaries have a private pension, but only about one out of seven female Social Security beneficiaries have a private pension. However, the proportion is slightly greater—about one out of four—for women who earned their own benefits in employment covered under Social Security.

These facts underscore the importance that Social Security be administered impartially and effectively. They also provide compelling reasons to safeguard the system from exploitation for narrow, partisan advantage.

Senator Frank Church introduced legislation—the Social Security Administration Act, S. 388—in January 1975 to maintain and strengthen the administrative objectivity of the Social Security system. S. 388 would re-establish the Social Security Administration as an independent agency under the direction of a three-member governing board, appointed by the President with the advice and consent of the Senate. Second, the bill would prohibit the mailing of notices with Social Security and Supplemental Security Income checks which make any reference whatsoever to Federal elected officials. Third, S. 388 would separate the transactions of the Social Security trust funds from the unified budget.

S. 388 has won solid bipartisan backing in the Senate. Fifty-one Senators have sponsored the Social Security Administration Act, including Senator Mike Mansfield (the majority leader) and Senator Hugh Scott (the minority leader).[22] Efforts are underway to obtain House and Senate action on the proposal.

V. SSI—GROWTH AND PROBLEMS

During 1975, approximately 4.6 million persons received benefits from the Supplemental Security Income (SSI) program:

—2.5 million of the recipients were 65 years of age and older, while the remaining 2.1 million were blind and disabled.

—34.2 percent of the recipients were male and 61.8 percent were female (5 percent were unreported).[23]

—63.2 percent of persons receiving SSI were white and 25.9 percent were black (11 percent were unreported).

—85.4 percent of the beneficiaries lived in their own homes, 10 percent lived in other persons' households, and 4.6 percent lived in a Medicaid institution.

—53.2 percent of the recipients also received Social Security. The rate ranged from 69.8 percent for the elderly to 35.7 percent for the blind and 32.3 percent for the disabled.

—10 percent of the recipients had unearned income other than Social Security at an average of $56.86 per month.[24]

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[22] Sponsors of S. 388 include Senators Church, Clark, Humphrey, Kennedy, Biden, Ribicoff, Williams, Burdick, Tunney, Huddleston, Hart (Mich.), Hatfield, Schweiker, Jackson, McGovern, Abourezk, McGee, Scott (Pa.), Cannon, Bayh, McIntyre, Stevenson, Case, Brock, Hartke, Symington, Brooke, Randolph, Javits, Stone, Mondale, Magnuson, Montoya, Metcalf, Eagleton, Nelson, Hollings, Eastland, Stafford, Domenici, Mathias, Haskell, Pastore, Moss, Durkin, Mansfield, Allen, Leahy, Inouye, Morgan, and Pell.

[23] "Unreported" refers to those statistics that do not relate to the applicant's eligibility which the claims representative failed to mark on the application.

[24] Figures based on Social Security estimates of June, 1975.

NUMBER OF PERSONS RECEIVING SSI FEDERALLY ADMINISTERED PAYMENTS BY STATE*

State	Total	Aged	Blind	Disabled
Total [1]	4,240,912	2,316,155	74,207	1,850,550
Alabama [2]	145,675	102,060	2,048	41,567
Alaska [2]	3,050	1,485	74	1,491
Arizona [2]	27,748	14,205	441	13,102
Arkansas	88,650	59,868	1,683	27,099
California	649,876	331,602	13,004	305,270
Colorado [2]	35,341	20,390	336	14,615
Connecticut [2]	22,698	9,320	289	13,089
Delaware	6,717	3,346	273	3,098
District of Columbia	15,999	5,506	211	10,282
Florida	153,365	93,329	2,394	57,642
Georgia	163,283	95,092	3,107	65,084
Hawaii	9,352	5,474	119	3,759
Idaho [2]	8,904	4,181	107	4,616
Illinois [2]	136,381	48,453	1,631	86,297
Indiana	43,880	23,299	1,158	19,423
Iowa	28,561	17,548	899	10,114
Kansas	23,804	12,891	379	10,534
Kentucky [2]	99,400	60,012	2,069	37,319
Louisiana	149,650	95,750	2,169	51,731
Maine	23,887	13,277	293	10,317
Maryland	47,917	18,985	517	28,415
Massachusetts	130,256	81,611	3,079	45,566
Michigan	114,580	50,346	1,668	62,566
Minnesota	39,833	20,032	743	19,058
Mississippi	125,455	83,313	1,973	40,169
Missouri [2]	101,478	66,056	2,188	33,234
Montana	8,325	3,855	148	4,322
Nebraska [2]	16,401	8,891	229	7,281
Nevada	5,814	3,849	180	1,785
New Hampshire [2]	5,381	3,098	168	2,115
New Jersey	78,796	38,790	1,001	39,005
New Mexico [2]	25,914	12,592	415	12,907
New York	389,104	170,823	4,294	213,987
North Carolina [2]	148,322	81,532	3,857	62,933
North Dakota [2]	8,191	5,097	63	3,031
Ohio	130,029	54,799	2,490	72,740
Oklahoma [2]	84,445	52,563	1,111	30,771
Oregon [2]	25,603	11,048	599	13,956
Pennsylvania	145,213	66,151	4,996	74,066
Rhode Island	15,932	7,111	199	8,622
South Carolina [2]	79,960	47,239	1,955	30,766
South Dakota	9,089	5,787	119	3,183
Tennessee	137,374	80,645	1,785	54,944
Texas [3]	275,049	192,320	4,008	78,721
Utah [2]	9,306	3,694	180	5,432
Vermont	9,107	4,789	102	4,216
Virginia [2]	74,814	43,366	1,377	30,071
Washington	52,899	21,453	503	30,943
West Virginia [2]	42,826	20,802	642	21,382
Wisconsin	64,504	36,927	894	26,683
Wyoming	2,569	1,396	34	1,139
Unknown	205	107	6	92

* Estimates of the Social Security Administration, December 1975.

[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.

[2] Data for Federal SSI payments only. State has State-administered supplementation but data for such payments are not available.

[3] Data for Federal SSI payments only; State supplementary payments not made.

SSI is a Federal program which supplements the incomes of persons who are 65 and older, blind or disabled, and who are in financial need. Currently, the program guarantees all recipients a minimum income of at least $157.70 for an individual and $236.60 for a couple, with the States having an option to increase the level by supplementation.[25] Thirty-nine States are now making State optional supplements to the aged totaling approximately $1.2 billion (Arkansas, Georgia, Indiana, Kansas, Louisiana, Mississippi, New Mexico, Tennessee, Texas, West Virginia, and Wyoming do not supplement aged recipients).

[25] An automatic cost-of-living adjustor will increase the SSI benefits by approximately 6.4 percent in July of 1976, making the minimum level $167.80 for an individual and $251.80 for a couple.

A. Administration of SSI — Difficulties

However, most Americans did not associate SSI with such benefits and statistics during 1975. Rather, the SSI program has become associated with such terms as "overpayments," "bureaucratic bungling," and "error percentage." Such criticisms were intensified by press accounts during 1975 of millions of dollars of overpayments. Specifically, the criticisms were directed at the Social Security's admission that 1 out of every 12 of SSI recipients was found to be ineligible or eligible for a smaller benefit than he or she received. Thus, the Social Security Administration was charged by the press with making approximately $547 million in overpayments during SSI's 2-year history. The agency decreased the rate of overpayments from 13.3 percent in December 1974 to 11 percent in June 1975. However, coincident with this decrease was an increase in the rate of payments to ineligibles which rose from 6.1 percent in December 1974 to 7.7 percent in June 1975.[26] Social Security Commissioner James B. Cardwell stated in a letter to Senator Frank Church, chairman of the Senate Committee on Aging:

> We believe that a number of actions that have been taken will eventually result in improved efficiency, as measured by the QA (quality assurance) system. As the above data indicate, those measures had not produced any significant improvement during the first 6 months of the 1975 calendar year. However with about one-half of the sample complete, sampling for the subsequent 6-month period (July–December 1975) suggests that significant improvement will be shown when the final QA results are tabulated for the period.

The Commissioner also pointed out that a system for "automated interface" with the Social Security program and SSI had been put in place in June 1975 and has significantly aided in decreasing the errors in overpayments and payments to ineligibles.

A factor contributing to criticisms of SSI administration was inadequate staff to administer the SSI program. As Commissioner Cardwell related in testimony before this committee, "It is quite clear that 15,000 is not enough, was not enough originally, and that was probably the fundamental mistake. I do not think it is the lack of support on anybody's part. I think it was a miscalculation concerning the relative capacity of the Federal system versus the State systems."[27]

In response, Congress awarded $78.7 million for additional employees in fiscal 1975, the Supplemental Appropriations Act.[28] Approximately 8,000 of these new employees reportedly were assigned to full- and part-time positions in the SSI program, with the majority of the positions placed in district Social Security offices throughout the country.

However, there is still a recognized need for more personnel, especially the number of hearing examiners and administrative law judges to handle appeals and reconsideration cases.

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[26] Data presented to the Senate Special Committee on Aging in a letter dated January 19, 1976, from Commissioner James B. Cardwell.

[27] Testimony before the Senate Committee on Aging's hearings on "Future Directions in Social Security," part 12, May 1, 1975.

[28] Public Law 94–32, signed into law on June 12, 1975.

In spite of the problems, SSI did provide relief to many needy individuals. The program's efforts were defended by the Deputy Commissioner of the Social Security Administration, Arthur E. Hess, who said:

> Despite the problems of overpayment and other serious transitional systems and staffing problems we faced in putting SSI into place, the fact remains that the program is putting $490 million a month (almost all of it through correct payments) into the hands of 4.2 million of our very neediest aged, blind, and disabled people. This is about 1 million more people and about $200 million more a month than was paid out under the State-Federal categorical assistance programs that SSI replaced January 1, 1974.[29]

Mr. Hess went on to say that possibly the most effective method of improving the program might lie in simplifying it—a philosophy that has been echoed by many in the Congress.

B. Congressional Reaction

SSI recipients suffered directly from delays, inconvenience, and confusion related to that program. In addition, the fine reputation of the Social Security Administration suffered some damage. Considerable strain on SSA staff has also occurred.

Such issues were discussed by Senator Edward Kennedy as he opened hearings before the Senate Committee on Aging on the subject of SSI and administration. Senator Kennedy stated:

> . . . we are asking whether the Social Security Administration can retain its credibility when computers fail, workers operate on pressure creating mandatory overtime schedules, and when many beneficiaries of the system find their checks too low, too high, or nonexistent. . . . And we are talking about individuals who rely on that check, not for extra dollars, but for the money they need to pay for the food they eat, for the oil they burn, for the clothes they wear—for the basic necessities of life.[30]

Such concerns about the credibility of the system and the accounts of fraud and mismanagement have prompted an array of congressional action.

In a statement on the floor, Senator Frank Church announced his request for a study by the General Accounting Office of the reports of incongruous situations, overpayments, and staff inadequacies. At the same time, the Senator stressed the need for a sound Social Security system. He stated:

> Overpayments, underpayments and deterioration of standards of performance in SSA offices cannot be tolerated. Over the decades, SSA has won the confidence of the Congress and the people it serves. We cannot allow present difficulties—transitional difficulties, we hope—to affect the overall service

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[29] Letter to the editor, *Washington Star*, Sept. 7, 1975, by Arthur E. Hess.
[30] Remarks in an opening statement by Senator Edward M. Kennedy, at a hearing of the Senate Committee on Aging. "Future Directions in Social Security," part 12, May 1, 1975.

SSA gives to the Nation. To overcome these problems, we will have to take a balanced view.[31]

In addition:

—The Senate Finance Committee commissioned its staff and consultants to conduct an extensive study of the SSI program;
—The House of Representatives Ways and Means Committee's Public Assistance Subcommittee initiated a comprehensive series of hearings on the program's effectiveness; and
—The House of Representatives Government Operations Committee commissioned an outside firm to conduct a study of the program and its administrative difficulties.

C. Legislative Action

Corrective action has also been suggested in numerous bills. Among them: Bills which would make more efficient the system for replacing lost and stolen checks; bills which would disregard various kinds of income, including cash and in-kind, in determining the income of SSI recipients; bills which would increase the amount of benefits payable to individuals under the SSI program; bills which would prevent reductions in SSI benefits because of cost-of-living increases in Social Security benefits; bills which would authorize States to pass along the annual cost-of-living increases in SSI benefits; bills which would provide more effective procedures for the conduct of judicial reviews and hearings; bills which would allow SSI recipients in cashout States to elect to receive food stamps; and numerous bills to provide that recipients whose income is increased by reason of general increases in Social Security benefits will not suffer a loss or reduction in the benefits that the recipient has been receiving under other Federal or federally assisted programs.

Measures enacted into law during the 94th Congress which would affect the SSI system and/or the recipient include:

Public Law 94–12.—Provided a one-shot payment of $50 ($100 for a couple) to SSI beneficiaries (a provision of the Tax Reduction Act).

Public Law 94–44.—Extended for 1 year, through June 30, 1976, the food stamp eligibility for SSI recipients, except for those recipients who live in the so-called "cashout" States—New York, Massachusetts, California, and Nevada.

Public Law 94–48.—Would protect approximately 50,000 persons, including many SSI recipients, from the loss of Medicaid benefits because of the 20-percent Social Security increase in 1972 (this law made permanent a provision which had only been temporary).

Public Law 94–202.—Would provide that hearings and judicial reviews under the SSI program would be virtually identical to those of the Social Security and Medicare programs—60 days as the time limitation for a person to request a hearing after the disallowance of the claim had been issued.

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[31] Remarks made by Senator Frank Church on the floor of the U.S. Senate, September 4, 1975.

In addition, the Senate expressed its disapproval (through a Senate resolution of Senator Frank Church) of the administration's attempt to impose a ceiling upon the July 1975 cost-of-living increase. Such opposition was instrumental in allowing the full 8-percent increase to become effective for both Social Security and SSI recipients.

FINDINGS AND RECOMMENDATIONS

Social Security is the economic bulwark for the overwhelming proportion of older Americans. It accounts for more than half the income for seven out of 10 individual beneficiaries and one out of two elderly couple beneficiaries. Social Security also represents almost the entire source of support—90 percent or more of total income—for one out of four single elderly beneficiaries and one out of twelve older couples. In one form or another, Social Security affects almost every American family. It is imperative that the financial integrity of the Social Security system be safeguarded as well as its administrative objectivity.

Recent "scare" stories about Social Security do a disservice to elderly retirees, today's workers, and our Nation as a whole. Similar accounts have surfaced in the past. They were discredited then, and they will be now. No beneficiary need fear that the Social Security check will stop coming.

A need does exist, though, for additional financing to meet the short-term and long-range financing problems confronting Social Security. These problems can be, and will be, corrected. This point has been made emphatically during hearings conducted by the Committee on Aging on "Future Directions in Social Security," but continuing scrutiny and concern are essential.

The committee strongly believes that prompt action is needed to bring the Social Security trust funds into actuarial balance, with special emphasis on decoupling the Social Security system.

Further actions are needed to strengthen and improve the Social Security program. Until the financial integrity of the trust funds is restored, the committee urges that any immediate improvements be high yield, low-cost changes. The committee recommends the following short-term and long-range changes in the Social Security system:

- **—The Social Security Administration Act [32] should be promptly enacted into law.**
- **—The social security cost-of-living adjustment mechanism should be strengthened by authorizing two adjustments during periods of rampant inflation and by establishing a special index to measure more accurately the impact of inflation upon older Americans.[33]**
- **—The automatic cost-of-living adjustment mechanism should be made applicable to special minimum beneficiaries.**

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[32] See p. 72 for details.

[33] Senator Church introduced the Social Security Cost-of-Living Improvement Act (S. 1992) on June 23, 1975, to implement these recommendations.

—Legislation should be adopted to assure that the contributions of women generate as much in benefits for their family members as the contributions of men. Examples would include proposals (1) to remove the dependency test for father's benefits when the father has a child in his care, and (2) to eliminate the dependency requirement for husband's and widower's benefits.

The committee will focus on the special problems of elderly minority members during further hearings on "Future Directions in Social Security."

In addition, the committee recommends that the minimum Federal income standards under SSI be raised to a level to abolish poverty for older Americans. SSI should provide prompt payment for lost checks and more expeditious consideration of applications and appeals.

The one-third reduction applied when an SSI recipient lives in another person's household should be eliminated. The SSI asset limitations should be updated. The same exemptions should be provided for earned or unearned income for the noneligible spouse as allowed the eligible SSI recipient.

Adjustments should be made in veterans' pensions and other Federal benefit programs to assure that these beneficiaries will not suffer a loss in benefits when social security payments are raised.

CHAPTER IV

MEDICARE AND MEDICAID UNDER PRESSURE

Spiraling health costs continue to be a major worry to older Americans, who spend more of their budgets on health care, proportionately, than any other age segment of our society.

That dollar bite was documented in a June 1975 social security analysis [1] which said that Medicare in fiscal year 1974 paid only 38 percent of the health bill of the elderly.

The average direct payment made by people 65 and over reached $415, or $26 higher than the previous year and more than double the $206 paid out in 1969, the year in which Medicare reached a high point in percentage of coverage of expenditures for the elderly.

The social security analysis said that a number of factors have contributed to the steady drop in Medicare's share of expenditures for hospital care:

—The average length of a hospital stay has been declining by more than 3 percent a year during most of the period from 1969 through 1974, and "because Medicare requires the patient to pay an initial deductible roughly equivalent to the average day of care, his proportion of the total bill becomes larger and Medicare's proportion becomes smaller, as the average length of stay goes down."

—Expenses for outpatient hospital and diagnostic services are going up but are reimbursed at a lower rate than inpatient hospital care.

—Medicare paid 60 percent of physicians' services to Medicare participants in 1969, but only 52 percent in 1974. One reason: the increase in the deductible from $50 to $60 in 1973. Another is the decrease in the proportion of claims for which physicians "take assignment." [2]

—*The magnitude of the assignment issue is indicated by the decline in the number of physicians who participate: 61 percent in 1969; 53 percent in fiscal year 1974; approximately 52 percent in fiscal year 1975.*

—"Thus," said the social security article, "Medicare's proportion of the expenditures for physicians' services has decreased, and Medicaid and private insurance or out-of-pocket payments have taken up the slack." [3]

Medicaid, however, is not a foolproof substitute for Medicare, by any means. Budgetary problems are causing demands in many States

[1] "Age Differences in Health Care Spending, Fiscal Year 1974," by Marjorie Smith Mueller and Robert M. Gibson, pages 3–16. *Social Security Bulletin,* June 1975.

[2] As explained on pages 11 and 12 of the article cited in footnote 1, "Physicians who take assignments accept Medicare's determination of a 'reasonable charge' and bill the patient only for the unmet part of the annual $60 deductible plus 20 percent of the remaining part. Physicians who do not accept assignment may bill the patient for fees in excess of the 'reasonable charge.' "

[3] Page 12, article cited in footnote 1.

for cutbacks in the State share of that program. Hearings by the Subcommittee on Long-Term Care and the Subcommittee on Health of the Elderly (see chapter V, page 103) disclosed waste or fraudulent procedures clearly calling for tighter program controls.

Additional documentation on loose or questionable practices under medicare were provided in a February 1976 report [4] by the General Accounting Office which criticized the Department of Health, Education, and Welfare (HEW) for delay in implementing laws passed by the Congress to help control medicare and medicaid costs.

Congressional concern about problems of older persons in obtaining appropriate health care at costs within their reach was reflected in several ways, including:

—A strong challenge to the "catastrophic health insurance" proposal advanced by President Ford at the start of 1976. Senator Frank Church's resolution opposing increases in medicare charges—which he said are built into the President's plan—had the cosponsorship of 48 other Senators as this report neared publication.

—A strong congressional current was running in favor of home health services and other so-called alternatives to institutionalization.

—Senator Herman Talmadge, in March 1976, introduced the Medicare Reform Act of 1976, which calls for significant new means of combating wasteful or illegal practices. Senator Talmadge is Chairman of the Health Subcommittee of the Senate Finance Committee.

I. MEDICARE: COSTS TO CONSUMERS GO UP

Nearly $17 billion will be spent for the aged and disabled under the Medicare [5] program in fiscal year 1976, an increase of $2.7 billion over fiscal year 1975.[6]

Further, the President's proposed budget for fiscal year 1977 estimates expenditures under the Medicare program at $21 billion.

But even though the cost of the Medicare program goes up each year, these additional amounts are eaten up by inflation and an increasing number of eligible participants in the program, not through additional benefits to current participants.

A. Increasing Medical Costs

Rising health costs have stretched the medicare dollar thinner and thinner. For instance, hospital expenditures (which constitute the largest single item of health care expense—approximately 40 percent of the total) increased 15.8 percent in 1975 compared to an increase of 9.6 percent in 1974.[7]

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[4] "History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966–1975." GAO, February 1976.

[5] For additional information on parts A and B Medicare, and the differences between that program and medicaid, see appendix 3, *Medicare-Medicaid,* by Glen Markus, Education and Public Welfare Division, Congressional Reference Service, updated December 12. 1975.

[6] *The Proposed Fiscal 1977 Budget: What It Means for Older Americans,* a staff report prepared for the Special Committee on Aging, U.S. Senate. February 1976. page 4.

[7] "National Health Expenditures, Fiscal Year 1975," Marjorie Smith Mueller and Robert M. Gibson, *Social Security Bulletin,* February 1976, pages 3–4.

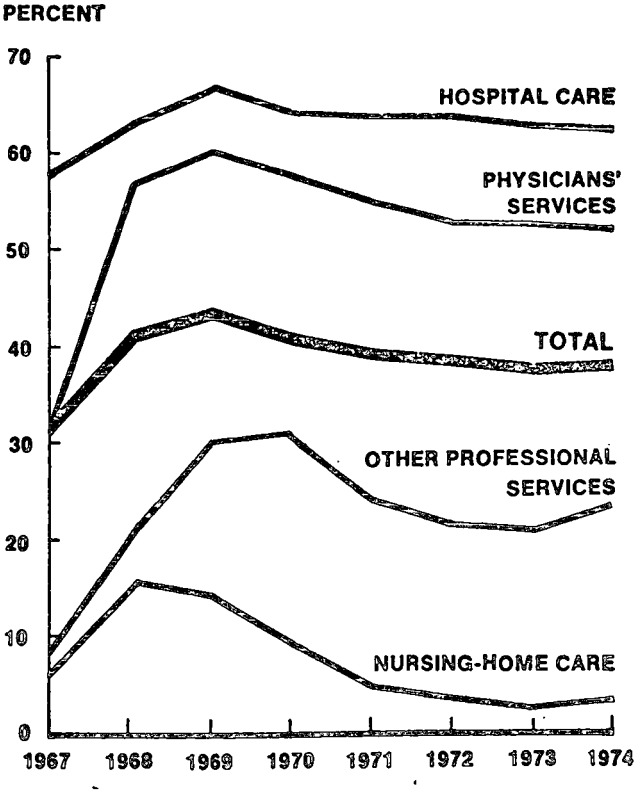
And physician's services—the second largest category—increased 12.9 percent in 1975, as compared to 8.8 percent the preceding year.[8]

Further, a study by the Council on Wage and Price Stability released in April 1976, indicated that in the first 3 months of 1976, "overall medical care services rose at a 14-percent annual rate, physicians' fees at a 14.2-percent rate, and hospital service charges at a startling 20.1-percent rate." In comparison, other service prices rose at an 8.9-percent annual rate and the overall Consumer Price Index, less medical care, at a 2.4-percent rate.[9]

B. Diminishing Medicare Benefits

Several factors causing a decline in the percentage of older Americans' health care costs covered by medicare have already been mentioned: reduction in length of hospital stay; increases in the cost of certain outpatient services, and refusal of more and more physicians to "take assignment."

Chart 2.—Percentage of expenditures for personal health care for persons aged 65 and over paid by Medicare, by type of expenditure, fiscal years 1967–74



Source: Social Security Bulletin, June 1975.

[8] Report cited in footnote 7, pages 3–4.
[9] "The Problem of Rising Health Care Costs," Council on Wage and Price Stability, staff report, April 1976, page iii.

In one important area, "other professional services," the portion of expenditures covered by medicare actually increased from 21 percent in 1973 to 24 percent in 1974, for reasons explained in the social security study: [10]

> The 1974 increase reflects in part the extension of Medicare coverage to services by independent physical therapists, speech pathologists, and chiropractors, and the elimination of home health copayments.

Despite this one gain, the overall trend was one of diminishing medicare benefits and increased cost of participating in the program.

The participants in the program themselves recognize the gaps in medicare coverage. More than 50 percent of the elderly medicare beneficiaries, for instance, purchase private health insurance policies primarily to fill the gaps in medicare protection. The elderly spend more than half a billion dollars each year on premiums for private health insurance policies, in addition to the $1.6 billion they pay for the optional part B medicare premiums.[11]

Despite payments for the optional part B medicare coverage, and supplementary coverage under a private policy with payments of $21.26 a month, a woman in Providence, R.I., told the committee of only partial reimbursement for some expensive medical treatments:

> After calling medicare offices, I called Blue Cross on this $104.50 which is every month. They said they felt they could review it, and very possibly they would pay a percentage.[12]

In more and more instances, persons with both private insurance and medicare are finding that coverage is limited.

The Medicare program does not provide reimbursement for out-of-hospital prescription drugs, and in Portland, Oreg., a physician addressed the committee regarding his experiences with elderly patients who failed to take the necessary prescribed drugs because they could not afford them:

> As one elderly patient stated to me not too long ago, "I can live without medicine, and I can cut down on groceries, but the rent has to be paid, or I'll be evicted." [13]

Moreover, 1976 brought even further increases in out-of-pocket costs through the imposition of increases in part B premiums ($6 a year, from $80.40 to $86.40), an increase in the medicare deductible from $92 to $104, and a 13-percent increase in copayments toward the cost of hospital stays of more than 60 days and posthospital stays of more than 20 days in skilled nursing homes.

C. Medicare Deadline Amendments

Although there was growing concern about the shortcomings in the medicare system, only minor changes were made in the program during 1975.

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[10] Study cited in footnote 1, pages 12–13.
[11] "Private Health Insurance Supplementary to Medicare," prepared for the Senate Special Committee on Aging by Dr. Gladys Ellenbogen, December 1974, p. 1.
[12] Hearings, "Future Directions in Social Security," Providence, R.I., Jan. 26, 1976.
[13] Hearings, "Future Directions in Social Security," Portland, Oreg., Nov. 24–25, 1975.

The Medicare Deadline Amendments of 1975 (Public Law 94–182) were enacted in December 1975 and provided that the prevailing charges for physician fees in fiscal year 1976 would not be less than in fiscal year 1975, allowed the Secretary of HEW to grant temporary waivers of nurse staff requirements in small rural hospitals, and corrected a technical error in the 1973 social security amendments, which had prevented an adjustment in the premiums.

II. MEDICAID: PUSH ON FOR CUTBACKS

More and more State governments, reacting to inflation, have reduced medicaid help provided to the medically needy.[14]

According to a report of the National Health Law Program,[15] 20 States cut back services under medicaid during 1975 alone.

These cutbacks took six major forms:

(1) Fifteen States eliminated or reduced the amount or duration of optional services under the medicaid program. Dental services were cut by seven States, for instance, as was the coverage of prescription drugs.

(2) Eleven States reduced the amount or scope of mandatory services: For instance, five States cut back on inpatient hospital care, four cut back on skilled nursing facilities (usually this took the form of reduction in the personal needs allowances), and four States reduced physicians' services.

(3) Ten States limited or reduced reimbursement for institutional or individual providers.

(4) Five States imposed some form of cost-sharing.

(5) Four States increased "prior authorization" requirements.

(6) Four States tightened eligibility standards.

As one witness told the committee in Boston:

> In the State of Massachusetts, we are faced with the discontinuance of the so-called optional medical services. What are those medical services? They are prescription drugs, without which many of our senior citizens could not live; dentures, eyeglasses, clinical visits, not fringe medicine, but life-sustaining medicine. These are the things that are at stake here, and if the State doesn't provide them, the medically indigent person is saying: "How can I get these drugs? Where am I going to get the money to pay for them?" [16]

Another measure of the shortcomings of medicaid—even before the 1975 curtailments—was provided in a social security study which first pointed out that medicare does not cover dental care, out-of-hospital prescribed drugs, and eyeglasses; and then added:

> Medicaid and other public programs picked up the bills for only about 7 percent of dental costs, 14 percent of prescribed

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[14] See appendix 3 for description of medicaid.

[15] "Medicaid Cutbacks: A Handbook for Beneficiary Advocates," National Health Law Program. Los Angeles, Calif., April 1976.

[16] Frank J. Manning, president, Massachusetts Legislative Council for Older Americans, hearings, "Future Directions in Social Security," Boston, Mass., December 1975. (Hearings before the State legislature regarding these cuts are underway.)

drug expenditures, and less than 2 percent of the costs to be met by the elderly by direct out-of-pocket payments or private insurance.[17]

Diminishing benefits under the State medicaid programs resulted in a greater plea for improvements in the medicare program, especially that the program provide reimbursement for out-of-hospital prescription drugs, dental services, eyeglasses, hearing aids, and such. Although provisions of this type are included in the Medicare Reform Act of 1975, S. 1456, introduced by Senator Abraham Ribicoff,[18] and S. 862, introduced by Senator Church,[19] no action has yet been taken by the Senate Finance Committee on this extension of coverage.

III. THE GAO ANALYSIS: REFORMS NEEDED

In February 1976, the General Accounting Office released a report prepared for the Human Resources Task Force of the House Committee on the Budget entitled "History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966–1975."

GAO said it has issued 31 reports to the Congress, its committees, and the Secretary of HEW with 83 recommendations for controlling the costs of the medicare and/or medicaid programs. Of that number, 29 recommendations have been fully or substantially carried out by HEW; 47 have been partially fulfilled; and 7 have not been implemented. Two recommendations were not implemented because of congressional actions.

Further, the report asserts:

> Congress passed two important acts to help control medicare and medicaid costs—the 1967 and 1972 Amendments to the Social Security Act. HEW has been slow in issuing regulations and carrying out many of the provisions of these acts.[20]

A. Medicare Costs

The report cites three factors responsible for the increased costs of providing medicare hospital services—$2.7 billion in 1967 as opposed to $10.1 billion in 1975:

(1) $6.2 billion due to inflation and, perhaps, more extensive types of hospital services;

(2) $870 million because of a 4.7-million-person increase in eligibles; and

(3) $315 million due to a 9-percent increase in the use of hospital benefits by eligibles.

According to GAO, the total cost of providing inpatient hospital care increased about 270 percent from fiscal year 1967 to fiscal year 1975, and the cost per day of care increased about 173 percent.

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[17] Article cited in footnote 1, page 13.
[18] For a description of S. 1456, see part IV, this chapter, page 89.
[19] S. 862, introduced on Feb. 26, 1975, provides for coverage of prescription drugs under part A medicare.
[20] GAO report, page ii.

TABLE 3.—COST OF INPATIENT GENERAL HOSPITAL CARE UNDER MEDICARE PT. A

Fiscal year	Total cost (millions)	Total days of care (thousands)	Cost per day of care	Percent change in cost per day of care	Economic inflation rate [1]
1967	$2,729	71,245	$38.30	----------	18.6
1968	3,465	77,712	44.59	16.4	15.1
1969	4,200	81,716	51.40	15.3	14.7
1970	4,662	80,554	57.87	12.6	10.6
1971	5,354	80,553	66.47	14.9	13.2
1972	5,945	80,038	74.28	11.7	9.4
1973	6,505	81,081	80.23	8.0	5.0
1974 [2]	7,911	89,361	88.53	10.3	6.0
1975 [2]	10,090	96,441	104.62	18.2	16.4

[1] Consumer Price Index for semiprivate hospital room charge.
[2] Includes data for the disabled and those with chronic kidney disease.

Although there has been a 30-percent increase in the number of hospital admissions per 1,000 eligibles, a 16-percent decrease in the average length of stay has resulted in an increase of only 9 percent in the days of care per 1,000 eligibles provided by medicare.

TABLE 4.—GENERAL HOSPITAL UTILIZATION UNDER MEDICARE

Fiscal year	Admissions (millions)	Admissions per 1,000 eligibles per year	Average length of stay (days)	Days of care per 1,000 eligibles per year
1967	5.13	269	13.9	3,475
1968	5.47	283	14.2	4,013
1969	5.75	293	14.2	4,159
1970	5.92	297	13.6	4,039
1971	6.24	308	12.9	3,975
1972	6.45	314	12.4	3,888
1973	6.81	326	11.9	3,875
1974 [1]	7.68	332	11.6	3,868
1975 [1]	8.29	350	11.6	4,074

[1] Includes data for the disabled and those with chronic kidney disease.

Whereas in fiscal year 1968, 21 million days of nursing home care were provided to medicare beneficiaries at a cost of more than $341 million, by fiscal year 1975, both the cost and the total days of nursing home care had decreased to about $243 million and 8.6 million days.

TABLE 5.—COST OF NURSING HOME CARE UNDER MEDICARE

Fiscal year	Total cost (millions)	Total days of care	Cost per day of care	Percent change in cost per day of care	Economic inflation rate [1]
1967 [2]	$139	9,797,000	$14.19	----------	8.0
1968	341	21,050,000	16.20	14.2	7.9
1969	392	20,454,000	19.16	18.3	7.6
1970	277	13,223,000	20.95	9.3	7.3
1971	204	8,592,000	23.74	13.3	7.8
1972	167	6,588,000	25.35	6.8	5.3
1973	180	6,989,000	25.75	1.6	3.6
1974 [3]	213	8,162,000	26.10	1.4	6.4
1975 [3]	243	8,617,000	28.20	8.0	13.3

[1] Consumer Price Index for all medical services.
[2] Benefit only available for 6 mo.
[3] Includes data for the disabled and those with chronic kidney disease.

Between fiscal year 1968 and fiscal year 1975, the number of nursing home admissions per 1,000 eligibles decreased 43 percent, the average length of stay decreased 40 percent, and the days of care provided per 1,000 eligibles per year decreased 66 percent.

TABLE 6.—NURSING HOME UTILIZATION UNDER MEDICARE

Fiscal year	Admissions (millions)	Admissions per 1,000 eligibles per year	Average length of stay (days)	Days of care per 1,000 eligibles per year
1968	0.45	23	47	1,087
1969	.45	23	45	1,041
1970	.33	16	40	663
1971	.27	13	32	424
1972	.25	12	26	320
1973	.28	13	25	334
1974[1]	.30	13	27	353
1975[1]	.31	13	28	364

[1] Includes data for the disabled and those with chronic kidney disease.

According to GAO:

> The reason for the decrease in utilization of nursing home services under medicare was a stricter enforcement of the requirement included in the Social Security Act that nursing home services be medically necessary. However, even though total utilization and costs are now lower than they were in fiscal year 1968, the cost per day of care in nursing homes has increased about 99 percent between fiscal years 1967 and 1975. Inflation was primarily responsible for this increase.[21]

B. Medicaid Costs

Comparable figures on the increases that have occurred in the medicaid program are not as readily obtainable, according to GAO. The chart below, however, indicates to some degree the expenditures which have taken place under the medicaid program.

TABLE 7.—MEDICAID EXPERIENCE: FISCAL YEARS 1967–75

Fiscal year	Total cost (millions)	Total number of recipients (millions)[1]	Cost per recipient	Percent change in cost per recipient
1967	$2,269	5.2	$436	
1968	3,538	8.6	411	−5.7
1969	3,988	9.5	420	2.2
1970	4,634	15.0	309	−26.4
1971	5,895	18.2	324	4.8
1972	8,138	20.6	395	21.9
1973	8,714	23.5	371	−6.1
1974	9,756	24.3	401	8.1
1975	12,086	22.5	537	33.9

[1] The number of recipients is the number of people who received medicaid services at some time during the year. Since some people eligible for medicaid never receive services, the figures given do not represent the number of eligibles.

These figures indicate a 433-percent growth in total medicaid costs, a 333-percent increase in the number of persons receiving services, and

[21] GAO report, page 10.

a 23-percent increase in the cost per recipient. GAO points out that these figures may be misleading, however, since they only represent the number of eligibles who had at least one medical service paid during the year by medicaid, not the entire population of eligibles.

To more accurately compare what is taking place under the medicaid program, the GAO report compares three States: California, Michigan, and New Mexico.

Increases in general hospital costs are reflected in the table below. During the period between 1968 and 1974, California's costs per day of general hospital care increased by 40 percent, Michigan experienced a 77-percent increase, and New Mexico's costs went up 102 percent.

TABLE 9.—GENERAL HOSPITAL COSTS FOR THE MEDICAID PROGRAM IN 3 SELECTED STATES (RECIPIENTS UNDER 65 YRS. OF AGE)

Year	California			Michigan			New Mexico			Economic inflation rate [1]
	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	
Calendar year:										
1968	$185.8	$100	.....	$41.1	$53	.....	$3.7	$52	.....	13.6
1969	230.6	111	11.0	44.8	69	30.2	3.6	58	11.5	13.4
Fiscal year:										
1972	314.3	102	[2]	101.7	91	[2]	5.2	80	[2]	9.4
1973	316.7	114	11.8	135.4	84	−7.7	6.8	99	23.8	5.0
1974	369.5	140	22.8	147.0	94	11.9	7.8	105	6.1	6.0

[1] Consumer price index for semiprivate hospital room charges.
[2] Percent changes were not calculated because of the change from calendar year to fiscal year data.

In addition, California's cost per day of nursing home care increased 32 percent during the same period; Michigan's increased by 48 percent; and New Mexico's by 36 percent.

TABLE 10.—NURSING HOME COSTS FOR THE MEDICAID PROGRAM IN 3 SELECTED STATES

Year	California			Michigan			New Mexico			Economic inflation rate [1]
	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	
1968	$165.4	$10.83	.....	$89.7	$11.67	.....	$3.5	$10.63	.....	7.3
1969	194.3	11.14	2.9	80.9	15.29	31.0	2.2	12.22	15.0	8.1
1972	227.7	11.14	[2]	116.6	14.99	[2]	1.7	13.97	[2]	5.3
1973	258.5	11.99	7.6	159.8	14.76	−1.5	.8	13.93	−.3	3.6
1974	305.1	14.26	18.9	130.1	17.22	16.7	.1	14.48	3.9	6.4

[1] The inflation rate is for all medical care services not just services provided in nursing homes. The inflation rate is taken from the Consumer Price Index.
[2] Percent changes were not calculated because of the change from calendar year to fiscal year data.

The report determines that most of these increases are attributable to inflation.[22]

C. GAO Recommendations

GAO strongly suggested that the recommendations made in earlier reports be fully implemented by HEW.

[22] GAO report, page 14.

The report also makes two legislative recommendations:

(1) That the Congress enact H.R. 8717, to amend medicare to make it clear that payments may be made under the supplementary medical insurance program for wheelchairs and other durable medical equipment furnished on a lease purchase basis.

(2) Congress consider repealing section 263(d)(5) of Public Law 92–603 which authorized the Railroad Retirement Board to contract with carriers to pay for medicare claims for its beneficiaries. The use of a separate carrier to process and pay claims for a special, small group of beneficiaries seem inherently duplicative in administrative costs according to GAO.[23]

IV. THE LEGISLATIVE PROPOSALS

Medicare and medicaid programs clearly stand in need of major revision. In 1975 and early 1976, several proposals had emerged calling for such action.

A. Medicare Reform as a Catalyst

Testifying before the committee in March 1975, Nelson Cruikshank, president of the National Council of Senior Citizens, suggested an intermediate step between the existing medicare program and a comprehensive plan of national health insurance, which he supports.[24]

Mr. Cruikshank commented:

> With out-of-pocket payments the aged pay for medical treatment higher now than before medicare became law, it is urgent that the financial burden of the elderly be reduced.... Pending enactment of a comprehensive health security program we urge the following changes in medicare:
>
> (1) Eliminate the monthly premium beneficiaries now pay for physicians' services (part B).
>
> (2) Include coverage of prescription drugs.
>
> (3) Reduce the present 2-year and 5-month waiting period that the disabled must meet to be eligible for health benefits and start medicare coverage after 5 months when cash disability benefits begin.[25]

This concept was endorsed by Dr. Mary Mulvey, vice president, National Council of Senior Citizens, who later told the committee:

> Our recommendations are to merge medicare and medicaid in a federally administered program covering all persons, 65 and over, and all other medicare and SSI beneficiaries. Part A and part B would be combined so that premiums now charged under medicare part B would be terminated and beneficiaries

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[23] GAO report, page iii.

[24] S. 3 and H.R. 21 of the 94th Congress introduced by Senator Edward Kennedy and Representative James Corman respectively.

[25] Hearings, "Future Directions in Social Security," part 11, Washington, D.C., Mar. 20, 1975, pages 934–944.

would no longer have to meet these payments out of limited and fixed incomes.

Benefits now under medicare would be expanded and payable without coinsurance or deductibles. Nursing home services, regardless of prior hospitalization, would be covered up to 120 days, and without limit if furnished in a nursing home affiliated with a hospital. Other benefits would include outpatient drugs, care of eyes, ears, and feet.

Some portion of the cost of coverage would be borne by general revenues, and the remainder by payroll taxes—the same for employee and employer.[26]

B. Other Approaches

1. The Ribicoff bill—S. 1456: In April 1975, Senator Abraham Ribicoff introduced the Medicare Reform Act of 1975 which he indicated would "restructure the medicare program to provide health care benefits to all older Americans as a matter of entitlement."

Essentially, his proposal would:

(*a*) Combine part A and part B of the medicare program into a single, expanded benefit structure with a single trust fund.

(*b*) Establish coinsurance payments on a sliding fee basis, and eliminate the existing requirements for premium payments and deductibles.

(*c*) Provide coverage for all care and services for the aged presently covered by the medicaid program.

(*d*) Expand the medicare program to all persons 65 years of age or older regardless of insured status under the social security or railroad retirement cash benefit program.

(*e*) Provide more comprehensive benefits to include unlimited inpatient hospital coverage, outpatient hospital coverage, skilled nursing coverage, intermediate care service, home health services, and physicians' services; 150 days coverage for psychiatric inpatient treatments; dental services; outpatient prescription drugs; medical devices such as hearings aids, eyeglasses, and so forth; services of optometrists, podiatrists, and chiropractors; and other support services.

(*f*) Provide for an income-related catastrophic ceiling on health expenditures incurred under the medicare program.

(*g*) Require participating physicians to accept medicare assignment, but establish fee schedules through a negotiation process.

2. The Beall bill—S. 2702: In November 1975, Senator J. Glenn Beall introduced legislation to establish within the medicare system a special program of long-term care services for individuals covered under part B of medicare, receiving SSI benefits, or eligible to enroll under part B medicare; and to provide for special Federal, State, and local administrative organizations. This proposal would do the following:

(*a*) Establish a part D long-term care services program within title XVIII of the Social Security Act.

(*b*) Establish a Federal advisory council on long-term care.

(*c*) Establish a monthly premium for part D participation at $3.

[26] Hearings cited in footnote 12.

(*d*) Establish a State long-term care agency which will designate service areas within the State and assist the organization of the community long-term care centers.

(*e*) Establish a Federal long-term trust fund to finance the program.

(*f*) Establish community long-term care centers to provide for local control and accountability in the program.

(*g*) Provide a $36 per year increase in supplemental security income benefits which will cover the $3 per month premium payment for part D coverage.

(*h*) Amend the Public Health Service Act to provide for the training of personnel to implement this system.

3. The Talmadge bill—S. 3205:[27] In March 1976, Senator Herman Talmadge introduced S. 3205, to reform the overall administrative and reimbursement procedures of the medicare and medicaid programs. He said the bill is designed to make the medicare-medicaid dollar go further by making the system more efficient.

The bill would:

(*a*) Establish a new combined administration for health care financing, headed by an Assistant Secretary of Health Care Financing. Within the new agency there would be established a central fraud and abuse control unit.

(*b*) Require the Secretary of HEW to conduct annual onsite evaluations of each State's medicaid administrative structure and operation to determine whether a State was making proper payments in timely fashion for eligible persons and maintaining reasonably current data necessary for timely evaluations. A formal uniform Federal performance standards index would be established.

(*c*) Require appropriate means of classifying and categorizing health care facilities, with performance-based reimbursement procedures.

(*d*) Include a section designed to encourage acceptance of "assignment" of medicare reasonable charges by doctors.

(*e*) Preclude automatic increases in medicare prevailing charge levels.

(*f*) Provide that the Secretary of HEW will be the final certifying officer with respect to the eligibility of skilled nursing and intermediate care facilities to participate in either medicare or medicaid.

(*g*) Bar any limitation on a patient's ability to leave the facility for reasonable periods of time.

(*h*) Terminate the Health Insurance Benefits Advisory Council.

C. The Administration's "Catastrophic" Proposal

In the 1976 state of the Union message, President Ford proposed to the Congress a program of catastrophic health insurance for the elderly. In light of the many inequities in the President's plan, however, Committee Chairman Frank Church introduced legislation, Senate Concurrent Resolution 86, to oppose cost increases to medicare participants. Senator Church's bill has gained wide bipartisan support in the Senate.

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[27] See chapter V, page 112, for additional discussion of this bill.

1. The Ford proposal.—This administration plan would:

(*a*) Require the aged and disabled to pay 10 percent of all hospital charges above their $104 deductible payment. Now medicare beneficiaries pay a $104 deductible and nothing thereafter until the 61st day for qualifying hospital charges.

(*b*) Increase the part B deductible for doctors' services from $60 to $77. In addition, the deductible would rise thereafter in proportion to increases in social security benefits. This provision would undermine the effectiveness of the automatic cost-of-living adjustment mechanism, which is designed to protect social security beneficiaries from inflation.

(*c*) Impose a new 10-percent charge for hospital-based physician and home health services under part B.

(*d*) Provide unlimited hospital and skilled nursing care coverage under part A of medicare.

(*e*) Limit a patient's liability to $500 for qualifying hospital and skilled nursing facility services. But this ceiling would also rise proportionately with social security increases.

(*f*) Place a $250 limitation on the amount a patient must pay for covered physician services. Once again, this ceiling would increase proportionately with social security adjustments.

2. The Church response.—The legislation introduced by Senator Frank Church—opposing the President's plan—expressed the sense of Congress that proposals to increase out-of-pocket payments for medicare beneficiaries should not be enacted. In introducing this legislation, Church noted that the President's plan would add nearly $1.3 billion to the out-of-pocket payments of aged and disabled medicare beneficiaries. He also said that the overall impact of such a proposal would serve to benefit less than 3 percent of the users of the medicare program. Of the nearly 5.9 million persons who will be hospitalized under the program in fiscal year 1977, only 150,000 would benefit from the administration proposal. Moreover, those who would benefit would do so at the expense of all other medicare participants since they would be picking up the tab through larger out-of-pocket payments.[28]

Citing social security figures that indicate that the average medicare patient stays in the hospital 11 days, Church pointed out that the President's proposal would not offer a savings until after a patient had been hospitalized for 75 days.

Further, under part B of the medicare program—which provides reimbursement for physician charges at an additional cost—it is projected that approximately 14.2 million persons will receive services in fiscal year 1977. However, only 1.8 million—or 1 out of 7 of those receiving reimbursable services—would pay less under the administration's plan.

According to Dr. Mary Mulvey, vice president, National Council of Senior Citizens, the President's catastrophic proposal:

> . . . imposes upon the elderly $2 billion more than they are paying now, and provides a paltry $500 rebate in the form of catastrophic coverage, the result being a Federal budget savings of $1.5 billion at the expense of the elderly sick and

[28] Senator Church, *Congressional Record*, January 22, 1976, page S312.

disabled. Implications are that the Federal budget will be balanced on the backs of the elderly, sick, and poor.[29]

At this writing, Senator Church had 48 other Senators as cosponsors of this resolution.

V. IMPETUS FOR "ALTERNATIVES"

As the costs of care in hospitals and nursing homes continue to rise, alternative methods of health care treatment take on even greater significance.

The most widely acknowledged of these alternatives are home health services and day-care services for the elderly.

A. Home Health —A Breakthrough

Home health services—a complex of services which may be brought, when needed, into the home—can be a viable approach to providing alternatives to institutionalization. Nonetheless, less than 1 percent of the total medicare budget goes toward such alternatives as home health care.

On the other hand, a provision advanced by Senator Church to provide demonstration grants for home health services was enacted in July 1975 as part of Public Law 94–63. This new provision of law provides for an $8 million demonstration program to establish new home health agencies and to expand services of existing units. An additional $2 million is authorized to train professional and paraprofessional personnel.

Although the Congress appropriated $3 million in December 1975 to fund this demonstration program, the administration has yet to issue the necessary regulations to get the program underway.

Before any major expansion of home health services can take place, however, restrictions regarding reimbursement of these services under medicare must be removed.

During the past two sessions of Congress, Senator Church has introduced legislation which would liberalize the reimbursement of home health services under part A medicare by doing the following:

(1) Remove the requirement that only "skilled" nursing care or physical or speech therapy would qualify as reimbursable home health services under medicare,

(2) Broaden medicare coverage to include homemaker services, and

(3) Increase the number of reimbursable visits from 100 to 200.

Many bills to broaden medicare reimbursement for in-home services—including several which propose incentives for the development of agencies to provide such services—have also been introduced. (For a summary of each, see appendix 4.)

Regulations governing the participation of home health providers—nonprofit versus proprietary—were the topic of hearings before the Subcommittee on Long-Term Care, and for further information, see chapter V of this report.

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[29] Hearings cited in footnote 12.

B. Day Care—Still at Early Stages

Day care services for the elderly continue to be widely supported as an alternative to institutionalization, but much like home health, still fight an uphill battle for recognition in our Federal policy.

Legislation has been introduced [30] to authorize the reimbursement of day care services for the elderly under part B medicare. However, no action has yet been taken by the Senate Finance Committee on this measure. Like home health, such coverage is necessary for the program to become widespread.

National experiments—on a limited basis—are currently being conducted under section 222 of Public Law 92–603 which authorizes experimental and demonstration programs relating to health care. Research findings from several of these projects are now emerging and will receive intensive attention from this committee.

The committee will release, shortly, a working paper prepared by Brahna Trager, a recognized expert in the field of health care alternatives and author of two earlier reports released by the committee regarding home health services in the United States.[31]

VI. MENTAL HEALTH NEEDS OF THE ELDERLY

Legislation advanced by Senator Edmund Muskie, chairman of this committee's Health Subcommittee, to establish a Committee on Mental Health and Illness of the Elderly was incorporated into Public Law 94–63 (July 29, 1975). The committee would be studying and making recommendations about:

(1) The future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons,

(2) The appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and

(3) Proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.

Although the nine-member committee was to have reported its findings and recommendations within the year, Senator Muskie found it necessary to submit legislation extending the committee's authority due to what he termed the "administration's foot dragging." Upon introducing S. 3481, to grant a 1-year extension for the Committee on Mental Health and Illness of the Elderly to perform its functions, Senator Muskie charged:

> [The committee] was not intended to be a new bureaucratic entity. It was not supposed to keep studying the problem for the indefinite future. It was to report within a year.
>
> But nothing has yet been done. Now, we are faced with letting the committee die without hearing its recommendations, or extending its life to make up for the inattention of those most responsible in government for caring for the needs of our elderly.

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[30] S. 1162, introduced by Senator Moss, March 12, 1975.

[31] *Home Health Services in the United States*, April 1972, Senate Committee on Aging. *Home Health Services in the United States: A Working Paper on Current Status*. July 1973, Senate Committee on Aging.

It is no wonder that people feel government does not care any more.[32]

FINDINGS AND RECOMMENDATIONS

Per capita health care costs for older Americans are almost seven times the level for individuals under 19 and nearly three times as great for Americans aged 19 to 64. Older Americans constitute 10 percent of the total U.S. population, but account for 30 percent of health care expenditures.

Medicare and medicaid have helped to provide valuable and essential protection for the elderly's health care needs. However, the high cost of health care continues to be a major drain upon the elderly's limited budgets.

This problem has been intensified by rapidly rising medical and hospital charges.

Medicare now covers only about 38 percent of the aged's health care costs, and this coverage appears to be dwindling.

Several crucial gaps in medicare still exist: Out-of-hospital prescription drugs, eyeglasses, hearing aids, dentures, physical checkups, and others.

The committee urges that these gaps be closed in a timely fashion in order that medicare can provide truly comprehensive coverage for the aged and disabled.

Medicare coverage now tends to place an overreliance upon hospital care for treatment of patients. Approximately 96 percent of medicare reimbursement under the part A—hospital insurance—program is for hospitalization. In many cases medicare beneficiaries are hospitalized because effective alternatives to institutionalization are not available. Yet, in-home services can be substantially less expensive and more appropriate for the patient's needs. Most older Americans would prefer to remain in their homes if at all possible, rather than being prematurely or unnecessarily institutionalized. The committee recommends that:

- **—The requirement that only "skilled" nursing care or physical or speech therapy can qualify for reimbursable home health services under medicare be removed.**
- **—Medicare coverage be expanded to include homemaker services.**
- **—The number of reimbursable home health visits be increased from 100 to 200 under parts A—hospital insurance—and B—supplementary medical insurance.**

The committee urges that the part A deductible charge for medicare patients be frozen in 1977 at the 1976 level of $104.

In addition, the committee strongly opposes the administration's proposals to increase the aged's out-of-pocket payments.

Furthermore, the committee calls upon the Social Security Administration to develop comprehensive administrative reforms to eliminate wasteful spending and fraud, as well as insure quality care for older Americans.

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[32] *Congressional Record*, May 24, 1976, p. S7801.

CHAPTER V

NURSING HOMES: ON THE CUTTING EDGE OF REFORM

During 1975 and early 1976, the Subcommittee on Long-Term Care continued its documentation of profiteering and poor care in nursing homes and broadened the scope of its investigation to take in other providers associated in one way or another with long-term care. Findings of the subcommittee's New York hearings—in which the records of more than 60 nursing home operators, vendors, and other providers were subpenaed—provided the impetus for this expanded effort. During this period 11 hearings were held, 7 reports were issued, and a 48-bill medicare-medicaid reform package was introduced by Senator Frank E. Moss. Several of these measures have now been incorporated in the Medicare and Medicaid administrative reform bill introduced on March 25 by Senator Herman Talmadge, chairman of the Health Subcommittee of the Senate Finance Committee. Prospects for enactment in this session are regarded as excellent.

I. THE SUBCOMMITTEE'S REPORTS: ACTION IN 1975

In November of 1974, the subcommittee released an introductory report, the first of a 12-volume series entitled: *Nursing Home Care in the United States: Failure in Public Policy.* In that report, the subcommittee pointed out that the number of nursing homes and beds has grown dramatically (140 percent and 232 percent, respectively) during the interval 1960 to 1970. Total Federal expenditures to the nursing home industry increased by 1,400 percent from 1960 through 1974 (from $500 million to $7.5 billion). The report then documented the inadequacy of medicare and medicaid in meeting the needs of older Americans, charging that thousands of seniors are going without the nursing home care they need because they cannot afford it. Moreover, there is a distinct lack of sufficient in-home services or alternatives to institutionalization.

The report criticizes the Department of Health, Education, and Welfare (DHEW) for its failure to establish a national policy with respect to long-term care; for limiting funding for home health care to less than 1 percent of either medicare or medicaid expenditures, and for its lackluster implementation and enforcement of nursing home standards. The report concludes a long list of recommendations designed to promote a comprehensive national policy directed toward the needs of the infirm elderly.

Following the subcommittee's plan, 11 other reports were prepared and scheduled for release at intervals in 1975 and 1976. Following is a brief summary of each of the reports which have been released to date.

Supporting Paper No. 1 (December 1974), "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy":

> Abuses of patients in nursing homes have been well publicized and well documented. And yet they persist, perhaps because of the belief that they are exceptions to the rule. However, subcommittee transcripts are replete with examples of cruelty, negligence, danger from fires, food poisoning, virulent infections, lack of human dignity, callousness and unnecessary regimentation, and kickbacks to nursing home operators from suppliers.
>
> Estimates on the number of substandard nursing homes in the United States vary widely, but the overwhelming evidence indicates that a majority of the nursing homes fail to meet standards of acceptability.
>
> Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuse; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

Supporting Paper No. 2 (January 1975), "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks":

> According to most studies, the average nursing home patient takes 4.2 different medications each day. However, more recent studies reveal that the average may be seven medications, or perhaps even higher. Prescriptions for nursing home patients typically total $300 per year, more than three times the cost for the noninstitutionalized elderly. In 1972, drugs accounted for 10 percent of all nursing home expenditures—$300 million in all.
>
> And yet, the flow of drugs through many of America's 23,000 nursing homes is largely without controls. It is haphazard; it is inefficient; and it does not help the patient desperately dependent upon others for protection when put in a state of semisleep or outright unconsciousness.

Supporting Paper No. 3 (March 1975), "Doctors in Nursing Homes: The Shunned Responsibility":

> Physicians have, to a large degree, shunned the responsibility for personal attention to nursing home patients. One of the reasons for their lack of concern is inadequate training at schools of medicine. Another is the negative attitude toward care of the chronically ill in this Nation. Medical directors are needed in U.S. nursing homes and will be required in HEW regulations effective January 1976. The subcommittee's May 1974 questionnaire to the 101 U.S. schools of medicine indicates a serious lack of emphasis on geriatrics and long-term care:
>
> Eighty-seven percent of the schools indicated that geriatrics was not now a specialty and that they were not con-

templating making it one; 74 percent of the schools had no program by which students, interns, or residents could fulfill requirements by working in nursing homes; and 53 percent stated they had no contact at all with the elderly in nursing homes.

Supporting Paper No. 4 (April 1975), "Nurses in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel)":

Of the 815,000 registered nurses in this Nation, only 65,235 are found in nursing homes, and much of their time is devoted to administrative duties. From 80 to 90 percent of the care is provided by more than 280,000 aides and orderlies, a few of them well trained, but most literally hired off the streets. Most are grossly overworked and paid at, or near, the minimum wage. With such working conditions, it is understandable that their turnover rate is 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic. The present Federal standard calls for one registered nurse coverage only on the day shift, 7 days a week, regardless of the size of the nursing home. By comparison, Connecticut requires one registered nurse for each 30 patients on the day shift, one for every 45 in the afternoon; and one each 60 in the evening.

Supporting Paper No. 5 (August 1975), "The Continuing Chronicle of Nursing Home Fires":

In 1973, there were 6,400 nursing home fires; 51 persons were killed in multiple death fires and an estimated 500 more in single death fires. An estimated $3.6 million loss was directly attributable to nursing home fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

Supporting Paper No. 6 (September 1975), "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care":

It is unjust to condemn the entire nursing home industry. There are many fine homes in America. A growing number of administrators are insisting upon positive approaches to

therapy and rehabilitation, innovations in physical structure of the physical plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

"Ombudsmen" programs have been established by Presidential direction and are making some headway. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a "peer review" mechanism. These efforts offer the prospect of improving nursing home conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a "cool line" telephone number for relatives, visitors, or patients who have complaints.

Supporting Paper No. 7 (March 1976), "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)":

> Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 56 percent between 1969 and 1974, according to subcommittee data, dropping from 133,264 to 59,685. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of $1,000 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Four other reports in this series are scheduled to be released this year. Supporting Paper No. 8 concerns the "Access to Nursing Homes by U.S. Minorities." Supporting Paper No. 9 details "Profits and the Nursing Home: Financial Incentives in Favor of Poor Care." One of these two final supporting papers will be a report containing the response of national organizations. DHEW, consumer groups, and other interested parties to the subcommittees series of reports. These reactions will be printed without subcommittee comment. The 12th and final report will include the subcommittee's recommendations to the Congress.

II. THE SUBCOMMITTEE'S HEARINGS

During 1975 and early 1976, the subcommittee held 11 hearings: Five in the continuing series, "Trends in Long-Term Care"; four in a new series "Medicare and Medicaid Fraud"; and two special hearings: a joint hearing with the Subcommittee on Health of the Elderly on "Mental Health and the Elderly" and a joint hearing with Congressman Claude Pepper's House Subcommittee on Health and Long-Term Care on the impact of the proposed August 21, 1975, regula-

tions mandating the participation of for-profit home health agencies in the medicaid program. These hearings have resulted in the introduction and enactment of legislation as well as to the indictment and conviction of a number of providers.

A. The New York Hearings

On January 21, 1975, Senator Frank E. Moss convened hearings in New York City to "assess the adequacy of New York's cost-related reimbursement formula and its effect on the quality of care; to test the adequacy of regulations protecting patients' personal funds from abuse and mishandling; to assess the frequency of kickback arrangements between nursing homes and various vendors including pharmacists and clinical laboratories, and to test the adequacy of ownership disclosure provisions incorporated in the medicaid law."

The central figure in the New York hearings soon became Dr. Bernard Bergman, a substantial shareholder in the publicly traded nursing home chain called Medic-Home Enterprises. The value of Dr. Bergman's nursing home holdings was reported as $24 million.

On January 21, 1975, Dr. Bergman made a brief appearance before the subcommittee in response to subpena. He stated that the charges of fraud and misuses leveled at him by reporter John Hess of the *New York Times*, Representative Andrew Stein, and others, were "totally unfounded, baseless, and false." He stated that he had been the target of abuse that had "no parallel in modern American history since the days of Senator Joseph McCarthy." He closed his testimony, agreeing to reappear before the subcommittee on February 4, 1975, after the committee staff and General Accounting Office auditors had an opportunity to review the records he had submitted in compliance with subcommittee subpenas.

Dr. Bergman failed to appear at the followup hearing. His lawyer claimed that he was not obligated to do so under the terms of the original subpena. Chairman Moss ruled to the contrary and suggested he would seek to hold Dr. Bergman in contempt. The full Committee on Aging discussed the matter in an unprecedented executive session. With 17 Senators present, the committee voted to hold the contempt citation in abeyance, issuing the full committee's subpena commanding Dr. Bergman to appear in Washington at a hearing on February 19, 1975.

At the February 19 hearing, Dr. Bergman and the business manager of his Towers Nursing Home, Mark Loren, appeared but asserted their constitutional right against self-incrimination. At the earlier February 4 hearing, Dr. Bergman's accountant, Samuel Dachowitz, had also asserted his rights and refused to testify.

Following these hearings the subcommittee turned over literally truckloads of files which it had received under subpena (as well as GAO and committee staff analyses) to Charles J. Hynes, appointed by New York Gov. Hugh Carey as the special prosecutor for nursing homes.

To date the special prosecutor has:

(1) Obtained 12 felony indictments involving over $3.4 million in medicaid fraud and larceny.

(2) Obtained guilty pleas and agreements to return over $2 million in medicaid moneys obtained by fraud from two major nursing home operators in New York City, Dr. Bernard Bergman and Eugene Hollander.

(3) Found overcharges totaling nearly $12 million in in-depth audits of 40 of the State's nearly 400 for-profit nursing homes.

(4) Projected total overcharges to the State at $70 million for the period 1969 through 1973.

(5) Found $2,500 in medicaid overcharges for every man-day of auditing.

While the special prosecutor continues his probe of criminal activities, the Moreland Commission headed by Attorney Morris B. Abram completed its work of investigating abuses in the system which foster fraud and abuse as well as poor care. Seven reports have been released to date relating to ineffective enforcement, real estate manipulations, and political influence on the administration of medicaid laws and regulations relating to nursing homes.

B. Home Health Care: The For-Profit Issue

On October 28, the Subcommittee on Long-Term Care conducted a joint hearing with its counterpart from the House Aging Committee, chaired by Congressman Claude Pepper of Florida. The reason for the unusual hearing was the August 21 proposed DHEW regulations which would have the effect of mandating the participation of for-profit home health agencies in the medicaid program. (Under present law, for-profit agencies are excluded, absent specific State action, including legislation, licensure, and regulation.) On December 12, 1975, Chairmen Moss and Pepper sent a joint letter to Secretary David Mathews summarizing testimony from the hearing. The letter and enclosures asked the Secretary to personally examine the proposed regulations and their probable effect, asking that the Secretary "eliminate language facilitating the entry of for-profit agencies in the home health field." Their reasoning may be summarized as follows:

(1) The August 21 proposed regulations preempt State licensure laws, removing the present choice as to whether a State wants to allow the participation of for-profit home health agencies in medicaid. The new regulations would mandate the participation of for-profit agencies unless a State expressly acts to prohibit them.

(2) The proposed regulations in so doing are not in concert with congressional intent. Senator Moss was the sponsor of the 1967 amendment requiring States to establish home health care programs as a precondition of their continuing to participate in the medicaid program.

(3) HEW conducted no studies relating to the need for the participation of for-profit home health agencies in medicaid or of the possible effects such participation would bring.

(4) HEW conducted no studies of the comparative cost or quality of for-profit home health care.

(5) If HEW's stated goal was to make home health services more generally available to the needy aged, the proposed regulations would not accomplish this goal. Rather, what is needed is a greater commitment of funds to in-home services under both medicare and medicaid.

(6) If HEW's goal is to create home health agencies in areas where they are in short supply, then HEW should request funding in implementation of the amendment introduced by Senator Frank Church to Public Law 94–63 which was expressly designed for this purpose. Moreover, it is unlikely that for-profit agencies will locate in rural areas since bringing in-home services to the rural area is more costly and for-profit agencies have historically located in areas of high concentration of elderly.

(7) Some spokesmen at the subcommittee's hearings flatly claimed that profit was incompatible with proper care because care inevitably becomes a byproduct subordinated to the need to show a profit. Others claim profit in the area of human services was unconscionable, particularly when the source of the profits is tax dollars.

(8) The August 21 standards would establish a two-tiered delivery system, one set for medicare and another for medicaid and a resulting weakening of patient care standards under medicare.

(9) Allowing the participation of for-profit interests in nome health care could bring to this field all of the fraud, abuse, and inequity for which the for-profit nursing home field has been criticized for so long.*

(10) HEW's rulemaking procedures were less than fair. Early drafts of regulations were shared with for-profit nursing home interests who were allowed to suggest changes in the drafts before they were announced in the *Federal Register* in proposed form. Spokesmen for nonprofit home health and other consumer groups were denied this same privilege.

In addition to the chairmen of the Subcommittees on Long-Term Care, other members of Congress, including Senator Herman Talmadge, wrote to Secretary Mathews asking him to reassess the proposed August 21 regulations. That process continues at HEW, and no final regulations have been announced.

C. Kane Hospital

On December 9, the Subcommittee on Long-Term Care held hearings in Washington, D.C., concerning alleged fraud and abuse in Allegheny County's (near Pittsburgh, Pa.) 2,200-bed nursing home, called Kane Hospital. This huge facility has been under scrutiny by the staff of the subcommittee for more than 9 months. Members of the staff made numerous undercover visits to the facility at various hours to observe the facility's operation. The visits were an effort to verify or disprove the charges in a report, *Kane Hospital: A Place to Die*, prepared by present and former employees of the facility. Only after this were these employees and Allegheny County officials given the opportunity to testify before the subcommittee.

The charges included:

(1) Using the facility's payroll for political purposes. Former county commissioners were charged with placing relatives or others on the payroll. It was alleged that some individuals did no work at the facility. (This charge was deemed so serious that the General Accounting Office was asked to conduct a complete audit of the home's financial affairs.)

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* The proposed regulations contained no initiatives to control possible fraud and abuse perpetrated by home health agencies.

(2) Poor food.
(3) Unsanitary conditions.
(4) Lack of rehabilitation.
(5) Lack of recreation or social services.
(6) Misuse of patients' funds.
(7) Physical and verbal abuse.
(8) Poor medical and nursing care.
(9) Poor management of medications.
(10) Failure to isolate infectious diseases.

The charges brought by former employees Mary Lewin, Emily Eckel, and Joseph Nagy (who wrote the report) were among the most shocking received by the subcommittee in its more than 13 years of operation. These same charges were echoed by current employees R.N. Eileen Frenchick, Father Hugh McCormley, chaplain at Kane Hospital, and by R.N. Joan Kiefer, inservice training instructor at Kane Hospital.

Senator Charles Percy asked Father McCormley:

"Would you put your mother into Kane Hospital?"

He received the following response:

> My mother is an invalid. She had a stroke 4 years ago and we have been able to maintain her at home, and we are just running on a shoestring.
>
> We are inches away from making a decision to put her in an institution, and the only thing I can say to that is that I would rather bury her, I would bury my mother rather than put her in an institution, especially Kane.

Mr. Harold Silverstein, corresponding secretary of the Action coalition of Elders, told the committee:

> Hitler's concentration camps had a sign that gave hope, "Arbeit macht frei." Work brings freedom. Even that false promise is denied the Kane population. It is written in invisible letters and spoken in soundless words, "Abandon all hope ye who enter here. This is the last stop. We are waiting for you to die." Hitler was less cruel. He gave hope, albeit false, with death—Kane gives despair and creates a desire to die. Five times as many bodies leave the morgue as the discharge office.

Other supportive testimony was offered by committee consultants Margaret Cushman, R.N., and Robert Butler, M.D.,[1] who accompanied the committee staff on one of their nine separate visits to the facility. Nurse Cushman emphasized that large numbers of patients which were classified as needing "skilled nursing care" were really in need of only custodial care. Dr. Butler agreed:

> Having seen numerous nursing homes and homes for the aging in the United States of all types, and under the various types of sponsorship, municipal, nonprofit, church related, commercial, despite the obvious possibilities inherent in the physical plant and despite the obvious interests of a great many of the personnel there, it was frightening and disturb-

[1] Pulitzer Prize winning author of the book "Why Survive? Being Old in America," and recently named Director of the National Institute on Aging.

ing to see the extent to which basic human care and skilled nursing care was provided in any kind of dignified manner. One would simply have to conclude professionally that at the very most what was offered was minimal custodial care.

Mr. James M. McLean, testifying for the Allegheny County commissioners, appeared briefly and promised to provide a full response to the above charges for the record. Under questioning from Pennsylvania Senator Richard Schweiker, he agreed to set up a meeting between Allegheny County's newly elected commissioners and witnesses who testified in order to try to work out the many problems detailed at the hearing.

D. Mental Health and the Elderly

On September 29, the Subcommittee on Long-Term Care conducted a joint hearing with Senator Edmund S. Muskie's Subcommittee on Health of the Elderly. Witnesses included Mr. Kenneth Donaldson, former mental patient who spent 15 years in a Florida institution prior to his release, and representatives of the Mental Health Law Project who helped bring about the successful conclusion to the Supreme Court opinion in the case *Donaldson* v. *O'Connor*. In this suit the Supreme Court clarified conditions under which individuals may be involuntarily committed, and some contend, established a constitutional right to treatment.

The highlights from this hearing were incorporated in Supporting Paper No. 7, described above.

E. Medicare-Medicaid Fraud Hearings

On September 26, the subcommittee began to examine alleged fraud and abuse with respect to other providers associated in one way or another with long-term care. Three subsequent hearings were held. Senator Frank E. Moss recently summarized these hearings in a March 17 speech before the National League of Nursing. The following excerpts are taken from the Senator's speech and provide an excellent overview of the subcommittee's concerns and findings:

Hospitals

Over the years we have paid little attention to hospitals. We believe that most hospitals are reputable and provide good care. However, there seems to be a new kind of hospital springing up in our major cities. This is a cause for serious concern. These are what I call "welfare hospitals" that specialize in the care of public assistance patients.

At our recent hearings, one investigator testified of the unnecessary charges and unnecessary surgery being performed at one Chicago hospital. Employed as a janitor he learned that one doctor performed more tonsillectomies in a day than six doctors performed in a week at Chicago's busiest ear, nose, and throat clinic. The victims included a family of six youngsters who had this surgery on the same day with little evidence of medical necessity. The investi-

gator, clad in his janitorial overalls, was requested to help move patients in the operating room and was assigned the task of monitoring patients after surgery.

A second investigator took a room in a skid row hotel to test the theory that it served as a recruiting point for an unscrupulous ambulance company and a second Chicago welfare hospital. He found the story to be true. Upon finding that the investigator (an apparent drunk) had a medicaid card, the flophouse operator gave him a jug of wine and arranged an ambulance ride to the hospital on the opposite side of town. The ride cost the taxpayers $45 for the pickup and $1.35 a mile thereafter. While at the hospital the falsely alcoholic investigator received little attention; however, the hospital records suggested medical complications for which the hospital was reimbursed.

Physicians

As is the case with hospitals, the number of physicians who cheat the system appears to be small. Most are honorable and true to their Hippocratic oath. In Michigan, 13,500 physicians are enrolled in medicaid services but less than 2 percent of these receive 25 percent of the medicaid dollars available for physicians services. This means that last year 200 doctors in that State received $25 million from the medicaid program. Similarly, in Illinois, 70 physicians were paid $10 million for treating welfare patients; one got $500,000.

The most common abuses included: Seeing patients on a repetitive basis without substantiation of medical necessity; charges for services not performed; and ordering an unusual number of laboratory tests absent of medical necessity.

Clinics

Another abuse relating to physicians relates to the formation of clinics or "medicaid mills." In New York, the U.S. attorney's office is currently investigating nine clinics that function in Manhattan's ghettos. Some 150 practitioners from physicians to chiropractors are involved. Authorities suspect that $2 million in fraudulent payments was collected by the group.

One common practice in such mills is called "ping-ponging," describing a practice whereby welfare recipients will be seen by all practitioners in a particular clinic irrespective of need. Typically a patient would be seen by a general practitioner, a podiatrist, a chiropractor and a dentist—all in one visit, on one day.

Pharmacies

The most common abuses relating to pharmacists are:

—Billing for nonexistent prescriptions.

—Supplying generic drugs and charging for brand name drugs.

—Dispensing less than the prescribed amount and charging for the full amount.
—Fee splitting for supplying two 15-day supplies of medication instead of one 30-day supply. The purpose is to collect a prescription fee twice.

In Michigan, a pharmacist was recently found supplying 28 nursing homes with generic drugs and charging the State for higher priced brand names. He kept the generics in panel trucks that he would move whenever investigators from the State were in evidence. Michigan is one of the few States that has a postpayment surveillance unit in its medicaid program, and has recovered $120,000 from this pharmacist. The Michigan group has been labeled the "Fraud Squad." They have recovered over $5 million in questionable payments in the last 2 years. For every dollar they have spent in investigation or salary, the Fraud Squad has recovered $6 in fraudulent or inappropriate payments.

Illinois investigators reported a new kind of prescription racket. It works like this. A pharmacy in collusion with eligible medicaid recipients falsifies a prescription for an expensive medicine. The medicaid recipient then takes the prescription to another pharmacy where it is filled and the cost is billed to medicaid. The medicaid recipient then returns to the first pharmacy which produced the bogus prescription and sells the medicine to that pharmacy for a fraction of its actual cost. The crooked pharmacy is able to retain an inventory of certain medicine at little expense and the medicaid recipient has pocket money.

Factoring Companies

A factoring company is a brokerage. Physicians who have large outstanding accounts receivable from medicare or medicaid can transfer their accounts for cash, while the factoring firm takes a cut of 12 to 24 percent for collecting them. Pharmacies, ambulance companies, clinical laboratories, nursing homes, and even hospitals avail themselves of the services of factoring companies. This is true because payment from medicaid is slow in most States. Providers usually wait months and years for payment. Michigan is the exception with 97 percent of all claims paid within 30 days.

The real tragedy of this situation is that money Congress has appropriated for health care is diverted into the hands of middlemen. Many of these "middlemen" have been loansharks in the past. The Better Government Association of Chicago testified that organized crime is muscling into the factoring business. The present take is thought to be about $10 million. Factors also have a way of receiving early payment, suggesting collusion with State welfare employees. Moreover, the physicians' bills are often increased by factors. In 3,569 cases studied by the BGA, some 1,711 bills had been raised to larger amounts by the factors.

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CLINICAL LABORATORIES

Physicians and laymen rely upon clinical laboratories to perform essential medical tests. But there is increasing evidence that large numbers of such tests are in error, varying an estimated 7 to 25 percent. Obviously, consequences can be severe. There is also increasing evidence of fraud and abuse among clinical laboratories. These matters were brought to subcommittee attention in our September 26 hearing by Edmond L. Morgan, executive secretary of the Illinois Clinical Laboratory Association. He testified that millions are being siphoned out of Illinois' medicaid program by the padding of laboratory bills. He cited the most frequent abuses in his profession as:

—Performing additional tests not ordered by a physician.
—Claiming that laboratory tests were performed manually when the tests were performed using automated machines.
—Billing twice for the same services by falsifying dates.
—Reporting that the completion of procedures when the clinic does not have the equipment to perform the procedure.

Mr. Morgan also presented the committee staff with a detailed memorandum citing suspected abuses by laboratories in Illinois. He had presented this same memo to a number of State authorities a year before with what he described as little or no action. In the course of its investigation the staff found a physician who admitted he had been approached by a laboratory and offered a kickback of 30 percent. Investigator William Recktenwald [2] was allowed to sit in a closet in this physician's office when the laboratory representative returned to renew the kickback offers. Recktenwald overheard the solicitation.

These events led to the establishment of a storefront medical center (clinic) on Morse Avenue in Chicago in conjunction with the Better Government Association, a nonpartisan civic watchdog group in Chicago. BGA investigators posed as representatives of physicians who were reportedly about to open a medical center in the area. A total of 12 laboratory firms entered the storefront clinic. Eleven made kickback offers to the investigators. The offers were filmed through a one-way glass by CBS's "60 Minutes" and formed part of the basis for their broadcast on February 15, 1976.

Having positive knowledge that 11 laboratory firms in Chicago were offering kickbacks, the committee staff went to medicaid records in Springfield and constructed a profile on each laboratory, isolating a list of more than 100 physicians who used these 11 laboratories. The staff soon learned that these 11 laboratories controlled more than 60 percent of the medicaid laboratory business in Illinois, and that the targeted physicians who were interviewed readily admitted their participation in kickback schemes. This information (in the form of sworn affidavits from BGA and committee staff) was turned over to Mr. Richard J. Thornburgh, Assistant Attorney General, Criminal Division, U.S. Department of Justice, in advance of the subsequent February 16 subcommittee hearing on the topic.

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[2] Chief investigator with Chicago's Better Government Association on a leave of absence while serving as an investigator with the Committee on Aging from September 1, 1975, through February 29, 1976.

But the committee staff did not end its investigation with Illinois. Evidence was collected in several other States, including New Jersey, California, Pennsylvania, New York, and Michigan. Facts gathered in these States were released on February 16 in the form of a staff report entitled, "Fraud and Abuse Among Clinical Laboratories." The report concluded:

> The full dimensions of medicare and medicaid fraud with respect to clinical labs is unknown. However, it is our judgment that at least $45 million of the $213 million in medicare and medicaid payments for clinical laboratories is either fraudulent or unnecessary. In short, almost $1 out of $5 for lab services is wasted. This figure is deliberately conservative. A reasonable case can be made that 50 percent of current payments are inappropriate. This can be demonstrated by New York's experience and conclusion that payments to labs could be reduced 50 percent without any loss of service. This conclusion is further supported by New Jersey's action in cutting lab fee schedules by 40 percent and finally by the findings of our investigation, that the Illinois medicaid program, in the extensive sample already described, overpays for lab services by 116 percent. In a larger context some experts estimate that 10 percent of $12 billion in payments for laboratory services last year consisted of fraudulent or questionable payment. By this standard the total volume of the fraud and abuse may be more than $1.2 billion a year.
>
> The average kickback in Illinois was 30 percent of total public aid business. Kickbacks took several forms including cash, long-term credit arrangements, gifts, supplies and equipment, and furnishing business machines. Most commonly, it involved the supposed rental of a small space in a medical clinic, and paying for the doctors staff and assistants. It is apparent that the larger the kickback the greater the opportunity for obtaining public aid business.
>
> Just as apparent as the kickbacks, is the fact that section 242 of Public Law 92–603, otherwise known as 42 U.S. Code 1395nn., and other pertinent fraud provisions are not being enforced.
>
> *In practical terms this all means that any medical testing laboratory which is so inclined can bill medicaid for a patient a doctor has never seen, for blood never drawn, for tests never performed, at a rate exceeding four times cost and twice the prevailing charge for private paying patients, with a nearly absolute assurance that they will not be caught and prosecuted.*
>
> There is an immediate need for the Congress, the Department of Health, Education, and Welfare and the Department of Justice and appropriate State officials to act. Through modification of the fee schedule, proper monitoring and surveillance, and the enforcement of current laws and regulations, much of the current medicaid expense for medical tests could be saved.

In addition to criminal prosecutions in Illinois, the report has already led to corrective legislation. In the February 17 markup of Health Subcommittee on the Clinical Laboratory Improvement bill, S. 1737, Senator Thomas Eagleton—acting on behalf of himself and the bill's sponsors, Senators Jacob Javits and Edward Kennedy—added three amendments barring kickbacks, the filing of false, fictitious or fraudulent billings and barring the use of double price lists for purpose of charging medicaid patients more than private paying patients. The bill passed the Senate on April 29, 1976. Senator Henry Bellmon of Oklahoma added new provisions requiring detailed financial disclosure by laboratories. Senator J. Glenn Beall added an amendment increasing the bill's criminal penalties for offering or accepting a kickback, making the offense a felony punishable by up to 3 years in jail, the imposition of a $10,000 fine, or both. Similarly, Senator Herman Talmadge added an amendment to his bill, S. 3205, at the request of Senator Moss which would make the offering or receipt of a kickback under medicaid and medicare a felony instead of a misdemeanor, as under present law.

III. LEGISLATION

In response to the problems raised in the subcommittee's hearings and the recommendations of its reports, Senator Moss introduced a 48-bill medicare-medicaid reform package. As might be expected, most of the package focuses on nursing home problems. The first 12 bills were introduced on March 12, 1975, and the remaining 36 on April 29, 1975. The bills fall essentially into seven categories, as summarized below. Identical bills were introduced in the House of Representatives by Congressman Claude Pepper.

A. Bills Designed To Make Long-Term Care More Readily Available to All Older Americans

S. 1552, to provide nursing home coverage under medicare without requiring prior hospitalization, by establishing a second level of care—intermediate care, by requiring standards for intermediate care facilities and by providing such services under medicare. Intermediate care services are presently authorized under medicaid but not under medicare.

S. 1553, to amend the Internal Revenue Code to allow a family to deduct as a "medical expense" payments made by such family for nursing home care received by a relative.

S. 1554, to provide for a modification of the medicare reimbursement formula to allow small hospitals in rural areas with chronic low occupancy to provide long-term care but only in those areas where there are no appropriate nursing home beds available.

S. 1555, to allow the use of supplementary security income payments plus State supplementary payments to house residents in shelter care facilities which meet certain Federal minimum standards.

S. 1161, to authorize an experimental program to subsidize families to care for their elderly in their own homes.

S. 1162, to authorize payment for day care under medicare.

S. 1163, to expand home health services authorized under medicare and medicaid. This bill originated with Congressman Edward I. Koch of New York.

S. 1165, to authorize funding for "campuses for the elderly"—a nursing home, home for the aged, congregate living facility, hospital and senior citizens center located on one site.

B. Bills To Create New Minimum Federal Standards for Nursing Homes Participating in Medicare and/or Medicaid

S. 1556, to require physician visits to patients in skilled nursing facilities at least once every 30 days.

S. 1557, to require skilled nursing facilities under titles 18 and 19 to have registered nurse coverage 24 hours per day, 7 days per week effective January 1, 1978.

S. 1558, to require that only licensed personnel—registered nurses or licensed practical nurses—are authorized to set up and distribute medications in skilled nursing homes.

S. 1559, requiring skilled nursing facilities to place responsibility for medical care in a medical director and/or a nurse practitioner trained in geriatrics.

S. 1560, to require HEW to promulgate minimum ratios for nursing personnel to patients and for supervisory nurses to total nurses and further requiring that there should be no less than 2.25 hours of nursing care per patient per day for skilled nursing care.

S. 1561, to require skilled nursing homes to provide medically related social services.

S. 1562, to require admission contracts between the nursing home and patients paid for by medicaid and to prohibit life care contracts.

S. 1563, to require the upgrading of fire safety standards for nursing homes by requiring compliance with the 23d edition, 1973, of the Life Safety Code instead of the 21st edition, 1967, presently mandated by law.

S. 1564, to require the posting of a nursing home's license, medicare/medicaid certification, a description of the services provided by the facility, a list of the owners and staff of the facility, a patient's bill of rights and other pertinent information.

S. 1565, to require nursing home administrators of facilities participating in medicare and medicaid to treat epidemic diseases, accidents and significant changes in patient condition.

S. 1164, to require nursing homes participating in Federal programs to file CPA-audited cost and financial statements and to provide penalties for fraud or misrepresentation.

S. 1166, to require full and complete ownership disclosure of every nursing home interest with penalties for misrepresentation of a material fact.

C. Bills To Improve Nursing Home Inspection, Enforcement, and Auditing Procedures

S. 1566, to require State inspection of public and private skilled nursing and intermediate care facilities at least once every 90 days and to require State enforcement of the rights of patients in such facilities. This bill originates with Congressman Ed Beard.

S. 1567, to first, require that State plans to provide care for the aged, blind and disabled be approved by both the State's legislative and executive branch; second, require such plan to be posted and available to the public; third, require the Secretary of HEW annually to evaluate each State's compliance and administration of its plan, to publish State performance ratings and when necessary and after appropriate hearing, cut off funds to States not complying with their own plan; and fourth, authorize any title 19 recipient or a class of such recipients to bring a suit of specific performance against a State which substantially fails to comply with the provisions of its State plan.

S. 1568, to require HEW to establish a rating system for nursing homes participating in Federal programs as a guide to consumers.

S. 1569, to require States to establish ombudsman programs to investigate nursing home complaints and represent consumer interests.

S. 1570, to establish the Office of Inspector General in the Department of Health, Education, and Welfare to investigate medicare and medicaid fraud and to report to the Congress.

S. 1571, to make unlawful the offer or receipt of money or other consideration for the referral of clients, patients or customers under medicare and medicaid.

S. 1572, to require strict controls for the handling of patient's accounts and personal expense funds.

S. 1573, to make unlawful the solicitation or receipt of charges to a medicaid recipient over and above the rates established by the States and soliciting or receiving any gift, money, donation or other consideration as a precondition of admitting a patient to a long-term care facility.

S. 1574, to require minimum qualifications for surveyors inspecting nursing homes under medicare and medicaid.

S. 1575, to require that forms submitted for payment by providers participating in the medicare and medicaid programs carry warnings of the criminal penalties under the law for fraud, kickbacks or misrepresentation of a material fact.

S. 1576, to continue 100-percent Federal financing of the cost of State inspections provided that the States enact new enforcement tools as an alternative to license revocation including but not limited to citation systems and protective custodianship.

S. 1577, to provide 100-percent Federal funding of the audits of medicare and medicaid facilities conducted by State personnel.

S. 1578, to create a cadre of Federal inspectors to conduct spot checks of medicare and medicaid facilities to test the quality of State inspection procedures.

S. 1579, to authorize medicare/medicaid recipients individually, or as a class, to bring suit for specific performance against a long-term care facility for violation of its provider agreement.

D. Bills Intended To Provide Accountability and Financial Incentives in Favor of Good Care in Nursing Home Reimbursement

S. 1580, to authorize the States to allow financial incentives for good care as a component of their cost-related reimbursement of nursing homes participating in the medicaid program.

S. 1581, first, to increase Federal responsibility for inspection and certification of nursing homes under medicare and medicaid; second, clarify conditions under which States can withhold Federal funds; third, require audited prospective cost-related reimbursement for nursing homes with cost pegged to what a prudent buyer would spend for such services; fourth, require ownership disclosure of any nursing home interest including real estate as well as any operating interests; fifth, require the disclosure of interest in nursing home supply companies and prohibit reimbursement to suppliers in whom the nursing home operator has a substantial interest; and, sixth, broadening the scope of medicare and medicaid nursing home benefits to provide assessment of patient's medical, psychological, and social needs. This bill originates with Congressman Ed Koch.

E. Bills To Help Nursing Homes Upgrade

S. 1582, to provide for the making of direct loans for the construction, and rehabilitation of nursing homes owned and operated by churches and other nonprofit agencies.

S. 1583, to authorize grants for the planning, development, construction and rehabilitation of nursing homes in black and minority communities.

S. 1584, to authorize interest subsidy payments to assist nursing homes in repair and renovation in order to comply with Federal standards.

F. Bills To Provide Training in Geriatrics and the Needs of Nursing Home Patients for Physicians, Nurses, Aides, and Orderlies

S. 1585, to authorize the Secretary of HEW to enter into contracts with, or make grants to, colleges and universities

to provide graduate programs for nurses in geriatrics and gerontology.

S. 1156, to provide funds to schools of medicine to help establish departments of geriatrics.

S. 1157, to provide continuing education programs in geriatrics for physicians.

S. 1158, to train medical corpsmen, discharged from the armed services, in the field of geriatrics and in the needs of nursing home patients.

S. 1159, to provide for the training of physician's assistants trained in geriatrics to serve in nursing homes.

S. 1160, to provide for the training of nurse practitioners in geriatrics in order that they may provide primary care in nursing homes.

S. 1155, to provide funds to schools of nursing to provide in-service training programs for nursing home aides and orderlies.

G. MISCELLANEOUS

Senate Joint Resolution 75, to establish the sense of the Congress that the President call a White House Conference on Long-Term Care in 1976 and authorizing $500,000 for this purpose.

S. 1586, to make it an unfair labor practice to discharge an employee because he testifies before any committee of the Congress.

The bulk of these bills are currently pending before the Senate Finance Committee. The exceptions are bills listed under "E" which are pending before the Senate Committee on Banking, Housing and Urban Affairs, and the bills under the headings "F" and "G" which are pending before the Senate Committee on Labor and Public Welfare.

Three bills have been enacted as amendments to other legislation. S. 1155 and S. 1160 were added as amendments to the Nurse Training Act which passed the Senate on April 10, 1975 (Public Law 94–63). S. 1563, in principle was added to H.R. 10284 (Public Law 94–182). Other bills, such as S. 1570 and S. 1554 have been included as part of S. 3205, Senator Talmadge's Medicare and Medicaid Administrative and Reimbursement Reform Act, introduced on March 25. The heart of the Talmadge bill is the provision calling for consolidation of medicare, medicaid, the Office of Long-Term Care, and the Bureau of Quality Assurance agencies of HEW into a single Administration for Health Care Financing, headed by an HEW Assistant Secretary. This effort is designed to promote efficiency and accountability. Within the new agency there would be a central Fraud and Abuse Unit which would be responsible for monitoring health care programs. This unit would be under the direction of an Inspector General who would be accountable directly to the Secretary of HEW.

This bill is in part a response to the work of the Subcommittee on Long-Term Care and that of other House and Senate committees which pointed out that until recently, HEW had only 10 investigators to track down fraud and abuse for the entire medicaid program, and

that 21 States had not audited a single medicaid provider since the inception of the program in 1967 and 21 States had not reported a single case of fraud (as required by regulations) to HEW during this same time period. Experts estimated that perhaps $3 billion out of the $30 billion combined total for medicare and medicaid is ripped off.

Senator Moss commented in his March 17 speech:

> You can perhaps appreciate my dismay and later my anger upon learning these facts. I know that the number of cheaters is small but the dollar volume is large. I remembered all those days of hearings before the Senate Aging Committee. I remembered listening to the needs of the elderly and wondering why we couldn't find the dollars to take care of them. I remembered the agony of sessions in the Senate Budget Committee as we made the hard money choices. Sometimes we curtailed or cut back good government programs to help bring government spending in line in order to move toward that balanced budget that all of us want.
>
> I was struck by the paradox of our squeezing so hard to save dollars while millions are being diverted by the unscrupulous minority in so many professions. I think we can all agree that the best way we can pare the budget is to eliminate the fraud, the waste, the graft and the inefficiency in this field and elsewhere.

The outlook for the passage of the Talmadge bill and for the incorporation of additional Moss bills in 1976 is considered very good.

CHAPTER VI

ADVANCES IN HOUSING

Uncertainty and concern about administration intentions in implementing the 202 direct loan housing for the elderly program deepened during the first few months of 1975.

But by autumn, a reversal of administration policy and other victories had transformed 202 from stepchild status to one of the most promising programs at the Department of Housing and Urban Development (HUD).

So popular was the 202 program that the number of applications in 1975 far outdistanced available funding.

This widespread acceptance, together with deepening concern about increasingly high costs or unavailability of housing for older Americans, led Senator Harrison Williams, chairman of this committee's Subcommittee on Housing for the Elderly, to introduce new legislation [1] which would increase borrowing capability for 202 by $2.5 billion, from $800 million to $3.3 billion.

In his introductory remarks,[2] Senator Williams said:

> The bill that we now introduce can help to build an additional 100,000 apartments for aged and handicapped persons—above what can be constructed under the existing authorization.
>
> This is vitally important because housing is the No. 1 expenditure for the elderly. It typically accounts for about one-third of their income . . . I can testify as to the need for additional units of elderly housing. The Nixon housing moratorium brought the wheels of progress to an abrupt halt with respect to the production of elderly housing. Today it is estimated that more than one-third of our older Americans are living in substandard housing and/or are paying beyond their means for housing.
>
> We have a long way to go before the goal of the 1971 White House Conference on Aging to provide an additional 120,000 units of elderly housing annually will be more than just a dream.

The Subcommittee on Housing also took action during 1975 on three other significant issues:

—Recognizing that no single program can deal with the widely varying housing needs of the elderly, Senator Williams began a study of congregate housing—a living arrangement offering shelter and services for a semi-independent lifestyle, the need for

[1] S. 3174, the Housing for the Elderly Act of 1976, introduced on March 18.
[2] Page S 3720, *Congressional Record*, March 18, 1976.

which will increase markedly as growing numbers of Americans live to ages well beyond even today's levels. (Between 1960 and 1975, the population aged 65 through 74 increased 26 percent, but the population aged 75 and over increased 52 percent.) This is not to equate advanced years with decrepitude; 82 percent of the elderly get along quite well on their own, suffering no limitation on their mobility .(See "Every Tenth American," page XV for additional statistics). But even 18 percent of 22.4 million, the number of 65-plus older Americans as of mid-1975, constitutes a major challenge. And the need for congregate housing is not limited to those with physical disability. It may become increasing by popular as a means of combating isolation and lowering of morale.

—The slow development of section 8—a program meant to help low-income renters who pay more than a reasonable proportion of their incomes for shelter—has caused concern and some doubts as to its potential helpfulness to the elderly.[3] In addition, HUD has a firm intention to link section 8 to section 202 as a means of reducing section 202 interest payments. The future of one program is therefore somewhat dependent on the other,[4] and is receiving subcommittee attention.

—Management problems continue to plague many housing projects serving the elderly. Senator Williams has expressed support of initiatives to step up efforts for training and certification of housing managers. (See section IV of this chapter for details.)

I. MOMENTUM FOR 202

Congress, during deliberations on the Housing and Community Development Act of 1974, made clear that it wanted restoration of the 202 direct loan program along the lines which had made that program so attractive to nonprofit sponsors during the 1960's.

That prospect seemed assured when both the Congress and the administration made concessions[5] which modified 202 but which, in the eyes of its chief sponsors, preserved essential features.

A. Hearings on Regulations

However, on May 15, 1975, HUD issued proposed regulations for the revised section 202 program and immediately encountered opposition so strong that Senator Williams called hearings within 3 weeks after the regulations were issued. In his opening statement, the Senator said:

> My friends, 24 days are left in fiscal year 1975, and not 1 penny of approved section 202 funding has left HUD, and not one elderly person is the better for our efforts.

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[3] Senator Williams, at a hearing, "Examination of Proposed Section 202 Housing Regulations," June 26, 1975, expressed concern (page 97) about the "long gestation period" for section 8. HUD Secretary Carla Hills said she agreed and that she was "disappointed at the time it has taken."

[4] For a description of the 202-section 8 strategy and for additional discussion of other programs authorized by the landmark Housing and Community Development Act of 1974 (Public Law 93-383), see chapter 6, Developments in Aging 1974 and January–April 1975. U.S. Senate Special Committee on Aging, June 24, 1975. For HUD's own report on section 8 and other programs, see appendix 2, item 6 of this report.

[5] For a description of the 1974 congressional-administration discussions of 202, see pages 71–73 and 75–78 of Committee on Aging report cited in footnote 4.

> After a long delay, HUD finally issued proposed regulations for the revised section 202 program on May 15, 1975. It is these regulations that we are here today to examine.
>
> Some may ask why it is necessary to call such a hearing before regulations become final. The answer is very simple. The objections to these proposed regulations have been so strong that I felt it was imperative to air these differences publicly, not only for the benefit of Congress but for the benefit of HUD.[6]

At issue in the hearings was the administration's determination to provide construction loans with the 202 funding even though the intent of Congress was clearly to provide permanent financing.[7]

Without the permanent financing provision, according to witnesses, the program would favor big profitmaking developers over the nonprofit sponsors.

Explaining the pitfalls to the nonprofit sponsor of using construction loans, Ronald D. Pittman, senior vice president, Bethany Villa Housing Association, commented to the subcommittee:

> First, it [the proposed regulations] will provide funds for construction only, provided a mortgage commitment has been secured. If we secure a mortgage with FHA at nine points on a project totaling $6.5 million in construction, it means that we, as a nonprofit corporation, have to come up with equity funds totaling $585,000 for the nine points on the FHA financing of construction—plus closing costs, plus $300,000 for the purchase of the 20 acres of land—or a total equity of $885,000 to $950,000.
>
> Second, if we seek mortgage funds through a broker from commercial sources, we are confronted with the commercial lenders' reluctance to provide mortgage funds for a period in excess of 20 years because of the 20-year section 8 limit on rent supplement support . . . commercial lenders look upon this feature as a strong potential interruption in the mortgage payment schedule in the 21st year.
>
> Third, a 20-year mortgage would require a higher rent schedule to assure the necessary cash flow for the earlier liquidations of the mortgage loan.
>
> And fourth, if we secured a 20-year mortgage from private commercial sources, what are our chances of securing a section 8 contract if the proposed 202 law is the main vehicle?[8]

Another sponsor, Jno. W. Williams, executive director, Methodist Home for the Aging, Birmingham, Ala., told the subcommittee:

> It does not shame me to tell you that a program must be fairly simple or we cannot participate . . . I fear these regula-

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[6] Hearing, "Examination of Proposed 202 Housing Regulations," June 6, 1975, page 2.

[7] A construction loan is a short-term loan (usually 18–24 months) advanced by a commercial bank or other lending institution for the purpose of paying for the physical construction of the building (i.e., labor, supplies, fees, etc.). Because this loan must be repaid shortly after construction is completed, it is usually necessary to then take out a subsequent long-term mortgage loan to pay off the construction loan. (Construction loans generally bear a higher interest rate than mortgage loans.) Permanent financing takes the form of a long-term mortgage (usually 20–50 years), secured by improvements (construction of a building, etc.) placed on the property. This is a one-step operation, as opposed to the two-step operation of construction loans combined with permanent financing.

[8] Page 34, hearing cited in footnote 6.

> tions will do what section 236 [9] did in so many places—have borrowers "pretend" a ministry in order to have access to the Federal funds. For a little while under section 236, the real profit was in the nonprofit work . . . What HUD is really saying is: "Nonprofit sponsors stay out. We deal only with mortgage brokers and promoters." [10]

HUD Secretary Carla Hills had been unable to appear at the June 6, 1975 hearing, and a second hearing was held on June 26. The Secretary, however, offered no change at all in the Department's proposed guidelines during her testimony.

B. Congress Reaffirms Intent

Consequently, Senator Williams took action resulting in a new reaffirmation of congressional intent on the need for permanent loans.

He recommended to Senator William Proxmire, chairman of the Housing Subcommittee of the Senate Appropriations Committee, that the fiscal year 1976 appropriations bill include language directing HUD to make funds available for long-term direct loans to nonprofit sponsors of housing for the elderly. This action was taken by the committee and the full Senate and then by the House of Representatives.

The Williams request to Senator Proxmire had also included a proposal that the amount of money which could be borrowed during fiscal year 1976 should be increased from the $215 million available in fiscal year 1975—but never expended—to $500 million. A compromise with the House of Representatives brought this amount down to $375 million.

The $375 million and the language on permanent construction loans were included in Public Law 94–116 (October 17, 1975); and the tide turned for the section 202 program.

The administration, already accepting applications under their earlier rules, revised these rules to concur with the intent of Congress.

C. Avalanche of Proposals

When the deadline for the applications arrived in mid-December, HUD was swamped with more than 1,500 proposals totaling 230,000 units of housing for the elderly and handicapped.[11] *Projected estimates by HUD however indicated that fewer than 100 projects—or approximately 12,600 units—could be funded from the $375 million available.*

By HUD's own evaluation, over 50 percent of the applications received were "top-notch" proposals.[12]

D. Meeting the Demand

Given the demand for participation in the 202 program by qualified nonprofit sponsors, and given the great need for affordable housing for the elderly, Senator Williams introduced legislation in March

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[9] Section 236 of the 1968 Housing Act provided interest-subsidies to the sponsors of housing for the elderly. It was intended to replace the old section 202 direct loan program.

[10] Page 39, hearing cited in footnote 6.

[11] For HUD's own report on section 202, see appendix 2, item 6 of this report.

[12] HUD spokesperson at meeting of the Ad Hoc Coalition of Housing for the Elderly, January 5, 1976, at American Association of Homes for Aging, Washington, D.C.

1976 (S. 3174), to provide an additional $2.5 billion in borrowing capability for the section 202 program.

Senator Williams commented:

> $2.5 billion is roughly the additional amount that would be needed if HUD were to fund all the applications it now says have merit. . . . The bill that we now introduce can help to build an additional 100,000 apartments for aged and handicapped persons—above what can be constructed under the existing authorization.[13]

Following hearings in late March, the Senate Committee on Banking, Housing and Urban Affairs reported out S. 3295, the Housing Amendments of 1976 on April 12, 1976, which incorporated the Williams provision to increase the borrowing authority for the 202 program by $2.5 billion. In addition, the committee revised the interest rate computation method for 202 sponsors to reflect more clearly the actual cost to the Government of making these loans. As a result, upon enactment of this legislation, the interest rates for the 202 program should drop by approximately 2 percentage points, consequently lowering rental costs to potential elderly and handicapped residents.[14] This legislation, S. 3295, passed the Senate on April 27, 1976, by a vote of 55 to 24. Similar legislation passed the House on May 26, 1976.

On April 13, 1976, the House of Representatives approved H.R. 13172, the second supplemental appropriation bill, which provided an additional $375 million for the 202 housing program, thus doubling the potential of the fiscal year 1976 funding of this program. The Senate approved this measure on May 12, 1976, and it was subsequently signed into law on June 1, 1976 (Public Law 94–303).

E. The Long-Awaited Selections

On April 20, 1976, HUD announced its selections for allocation of the $375 million then available for lending: 136 projects were chosen around the country, assuring the development of 12,663 units of housing for the elderly and handicapped.[15]

Thus, the picture for the future of the newly renovated section 202 program is far brighter now than 1 year ago, so much so that 202 can be labeled as a "success story of 1975" with respect to Federal programs on aging.

II. CONGREGATE HOUSING—A BEGINNING

> *"Congregate housing—assisted independent living—is a residential environment which incorporates shelter and services needed by functionally impaired and socially deprived but not ill elderly to enable them to maintain or return to a semi-independent lifestyle and avoid institutionalizations as they grow older."* [16]
>
> —Wilma Donahue, Ph. D., Director,
> International Center for Social Gerontology.

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[13] Page S 3721, *Congressional Record*, March 18, 1976.
[14] S. Rept. 94–749, April 12, 1976.
[15] HUD memorandum, April 20, 1976.
[16] Hearing, "Adequacy of Federal Response to Housing Needs of Older Americans, Service Needs in Public Housing," part 13, October 7, 1975, page 893.

Recognizing that a "bricks and mortar" approach to housing for the elderly is not sufficient to meet the growing needs of our elderly population, the Subcommittee on Housing embarked on a study of congregate housing. Initial efforts in 1975 included hearings by the subcommittee on service needs in public housing, and the release of a working paper, *Congregate Housing for Older Adults*, prepared for the committee by Marie McGuire Thompson, former U.S. Commissioner of Public Housing.

As suggested by Dr. Donahue's definition, and as spelled out in the Thompson report, congregate housing usually requires the joint use of certain rooms or facilities even while it usually meets the need for privacy in quarters a tenant can regard as "personal property."

A tenant in such housing recently provided the Committee on Aging with an account of personal reaction to such quarters:

> [At Norfolk House [17]] you have your own toilet and basin attached to your room, but you share bathing and the kitchen . . . It all sounded rather weird to me, but I thought about it, went down to see the place . . . and decided that I could make the adjustment . . . .
>
> There is all the privacy that one wants. No one wanders into my room . . . . If they want to talk to me, they see me in the kitchen or in one of the little nooks that have been prepared for relaxing . . . .
>
> Congregate houses need security as tight as any apartment house. Security involves a sense of responsibility among the residents as well as the planning of the building and the hardware put on it. Norfolk House gives me, at least, a feeling of security. I know that, as I get more infirm, all will be done that can be done to keep me independent, yet cared for. The place is run by caring people.[18]

A. Service Needs in Public Housing

To begin its inquiry into the national need for congregate housing, the Subcommittee on Housing for the Elderly examined the service needs of the elderly residents in conventional public housing.

Opening these hearings on October 7, 1975, Senator Williams stated:

> Today and tomorrow our subcommittee turns its attention to a little-noticed emergency which seems to be developing in many public housing projects throughout our country, and that emergency has been slow in developing, but it has certainly become more intense as older persons in public housing continue to grow in numbers and in age.[19]

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[17] Norfolk House is owned by the Cambridge Housing Authority and managed by New Communities Management Corp., 100 Boylston Street, Boston, Mass.

[18] Hearings, "Future Directions in Social Security," part 23, Boston, Mass., December 19, 1975.

[19] Page 889, hearings referred to in footnote 16.

As Marie McGuire Thompson described the problem:

> . . . an increasing number of public housing agencies are faced with the fact that either they must evict the more frail or impaired who cannot sustain the shopping, cooking, or heavy housekeeping chores designed for the hale and hearty, or they must develop—on a crash and, perhaps, ill-founded basis—some semblance of the services these aging occupants need to maintain at least semi-independence in a residential setting.[20]

These same concerns were echoed before the subcommittee by Dr. Powell Lawton, Philadelphia Geriatric Center, and author of *Planning and Managing Housing for the Elderly:*

> . . . the public housing program for the elderly is now 19 years old, and many waves of tenants have grown older in this type of housing. Most of them began as healthy, independent people who were provided for the first time with a physically decent place to live. However, people unfortunately change as they grow older, and the kind of environment that was originally appropriate may become less so, as it becomes more difficult for them to shop, to travel for medical care, to cook for themselves, and to do the housekeeping required in traditional housing.

Further, Dr. Lawton quoted from a study of 2,000 public housing residents which indicated:

> That fully two-thirds of these tenants expressed the need for some security giving, onsite medical service . . . a very high level of support for the availability of assistance with housekeeping and personal care . . . [and] half of the tenants also expressed a desire that onsite meal services be available.[21]

Dr. Donahue told the committee of the results of a study she had just completed which indicated that "better than 3 million persons can be considered to need assisted living; of these, 2.4 million are candidates for residential congregate housing with services. If the services are not provided, the entire 3 million may be forced to resort to nursing homes, 80 percent of them unnecessarily." [22]

Dr. Thompson described three barriers to action in the development of congregate housing:

> The first and primary reason, I believe, is the possible gap between the cost of food and other services, as well as rent, and the paying ability of very low-income older persons.
>
> A second barrier . . . is unfamiliarity with a tenant selection policy that requires a judgment of the capability of the applicant to perform the usual activities of daily living.
>
> The third significant barrier, and perhaps the most important, is that operational feasibility of congregate housing is

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[20] *Congregate Housing for Older Adults*, a working paper, S. Rept. 94–478, November 1975.
[21] Hearing, "Adequacy of Federal Response to Housing Needs of Older Americans, Service Needs in Public Housing," part 14, October 8, 1975. For more detailed information on Dr. Lawton's findings, see *Planning and Managing Housing for the Elderly*, M. Powell Lawton, John Wiley & Sons, 1975.
[22] Page 898, hearing cited in footnote 16.

dependent upon the service element. Housing authorities do not have service resources within their program capability.[23]

Concerning this problem of providing services to public housing tenants, a director of a public housing authority [24] commented:

> . . . we have been providing services under title IV–A.[25] But because of the changes taking place in that particular funding, we are right now in the process of making very substantial cutbacks in this particular program. . . . The difficulty seems to be that you have to look to annual funding from outside programs in putting together the package of services, and from my own point of view, it seems that once we are making substantial progress, the rules of the game change, and we have to start under another program to try to put it together again.[26]

Concerning the need to involve residents in the delivery of services, a public housing resident asked for greater participation by the elderly:

> I am the Indian among the chiefs today. My interests are of the tenant . . . and I see one area in which the tenant can help. You people with the authority in housing all over the country might enlist the aid of people like myself who want to do something more than just live in the tenement, who would like to help educate the local community so they would support you, and there are many that would like to. In my last years I would like to contribute something more than just living in a housing facility. . . . Please engage us in your activities.[27]

B. The Thompson Report

Soon after the hearings on service needs in public housing, the committee released a working paper in November 1975, entitled *Congregate Housing for Older Adults*, prepared for the committee by former U.S. Commissioner of Public Housing Marie McGuire Thompson. In this report, Dr. Thompson presents broader aspects of congregate housing, including the need for such options for a growing number of older persons:

> There can be little doubt that the demand and need for residential living with basic services will increase dramatically within the next decade, and probably more markedly after that. The number of "middle-old" and "old-old" aged Americans is growing faster than that of almost any other age group. Given such a trend, there will be greater and greater need for assisted residential living arrangements with services similar to those rendered in a family setting for an older relative.

As U.S. Commissioner of Public Housing from 1961 to 1967 and an early advocate of congregate housing, Dr. Thompson includes in the

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[23] Page 902, hearing cited in footnote 16.
[24] Robert H. McCann, Manchester Housing Authority, New Hampshire.
[25] Title IV–A of the Social Security Act which funded social service programs was replaced by title XX of the Social Security Act. (See chapter X, page 157, for additional discussion of title XX.)
[26] Page 932, hearing referred to in footnote 16.
[27] Page 936, hearing cited in footnote 16.

paper President John F. Kennedy's directive of February 21, 1963, encouraging the development of facilities for the elderly "integrated with the various community resources which can sustain and encourage independent living as long as possible."

As a result, four pilot congregate projects under the public housing program (in conjunction with cooperating State and local governments) were begun in the sixties. These projects—located in Toledo and Columbus, Ohio; Alma, Ga.; and Burwell, Nebr.—are described in detail in Dr. Thompson's report. In addition, the report contains an analysis of the potential resident population, architectural considerations, and management techniques that must be considered in the development of congregate facilities.

The report also describes provisions contained in both the Housing Act of 1970 and the Housing Act of 1974 for the development of congregate housing. However, in Dr. Thompson's words:

> Despite statutory authority for it, we can today expect little effort to develop this type of housing without local or State support for food and services being reasonably guaranteed.
>
> At present the provision of and funding for congregate housing must be the mutual responsibility and goal of Federal, State, and local service and housing agencies, working together to insure the support needed for food and other services essential in congregate housing. Such coordinated action by housing and service agencies at all levels will decide the future lifestyle of many of the Nation's older persons now deprived of opportunities to retain and enhance their independence as they grow older.

Following the release of Dr. Thompson's working paper, Senator Williams continued the assessment of the need for additional services in public housing. As a result, the subcommittee has efforts underway to develop an initial congregate package to meet the needs of elderly persons in public housing, and this will be followed by the development of a more comprehensive congregate housing proposal to address the needs of the 2.4 million population described by Dr. Wilma Donahue.

C. The Maryland Program

The Maryland Office on Aging has taken a major step in providing "sheltered housing" for elderly persons in that State.

On February 23, 1976, the State's first such units were dedicated at the Takoma Tower Retirement Center in Takoma Park, Md.[28]

Forty units there, built under the old section 202 program,[29] were converted to "sheltered housing" units, one-half of which will be subsidized (the program provides a mix of rent and service subsidies) by the Office on Aging. Dr. Matthew Tayback, State director on aging, described sheltered housing as a "level of residence between elderly housing intended for independent living and nursing homes." The services for the specially designated units at Takoma Tower include

[28] "The Outlook," Maryland Office on Aging, March 1976, page 1.
[29] See part I, this chapter, for description of section 202 program.

three meals a day, light housekeeping, and personal services such as grooming and dressing.

In addition, the Maryland Office on Aging has efforts underway to provide more "sheltered housing" units in conjunction with the section 8 rental assistance program, and the State housing agency has agreed to set aside 300 units of the State allotment for individuals qualified to participate in the sheltered housing program.[30]

III. SECTION 8—WILL IT WORK?

Section 8 of the Housing Act of 1974 enables HUD to provide housing assistance payments to families with incomes not exceeding 80 percent of median income of their localities in newly built, extensively rehabilitated, or existing housing.

Very low income tenants generally pay no more than 15 percent of their incomes for rent; higher income tenants pay no more than 25 percent.[31] HUD makes up the difference between tenant payments and the local "fair market rent."

The goal of the administration in utilizing this rental assistance program is to make use of existing housing wherever possible, although in areas where there is a shortage of existing housing, sponsors who find their own means of financing can apply to HUD for FHA insurance on these mortgages to build housing meeting section 8 standards.

Originally, the administration indicated that the section 8 rental assistance program would benefit 400,000 households in fiscal year 1976. After an extremely slow start, the administration revised its estimate to include only 200,000 households. Now the prediction is that 140,000 households will receive assistance this year,[32] even though less than 8,000 units of section 8 were occupied as of January 1, 1976.

Although the administration had predicted also that the guarantee of rental assistance would draw developers and builders into section 8, at the start of 1976, only 366 units nationwide had been constructed.

Additional problems are encountered by rural communities which attempt to use section 8. Oriented toward the use of existing housing, section 8 fails to recognize the special problem found in rural areas where there is a shortage of vacant, habitable units. Also, rural communities are more familiar with the working of the Farmers Home Administration (FmHA) than they are with the procedures of HUD, as HUD efforts within a State are geared generally toward the urban areas.

Rental assistance should be an integral part of the Federal housing effort. For the elderly on fixed incomes, it can allow them to remain in present units as rents continue to increase. It also can allow some choice in the selection of a rental unit, and can be particularly beneficial to elderly persons who do not choose to live in developments exclusively for the elderly. However, the less mobile elderly will need assistance in locating available units in a community if they are to benefit fully from this "freedom of choice" option.

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[30] Pages 925–929, 959–965, hearing cited in footnote 16.

[31] Under Public Law 93–383, the Secretary is required to take into consideration the income of the family, the number of minor children in the household, and the extent of medical or other unusual expenses incurred by the family in determining tenant payments.

[32] See appendix 2, item 6, for HUD's report on section 8.

IV. GOOD MANAGEMENT—A KEY INGREDIENT

To assure that housing provides "more than a roof," managers of housing for the elderly should be able to deal with the special needs of their elderly residents. Special training programs for managers of elderly housing, therefore, have special importance.

In response to a recognized need to upgrade the field of housing management, the National Center for Housing Management was established by Executive order in 1972. In 1975, NCHM received partial funding from the Administration on Aging to develop and test a 2-week training program for managers of elderly housing which effectively combines the teaching of management skills with insights into the aging process. More than 1,000 managers of housing for the elderly were trained under this program. In addition, NCHM is currently developing a training program which leads to certification for the manager.

A. Other Training Programs

In April 1975, HUD announced grants to five universities to develop academic training programs and complementing internship programs for housing managers. Each program selected had a different orientation; Temple University, for instance, was awarded $105,000 to train managers in specialized subjects such as elderly, handicapped, and Indian housing and residential security.

A few other university programs offer specialized training in the management of elderly housing as part of their curriculum. North Texas State offers two sequences of courses relating to the elderly. One (for administrators of elderly housing, i.e., congregate, dependent care, and nursing homes) is a 21-month program with a 7-month internship resulting in a masters degree in gerontology. The second course (for program planners) leads to a masters degree. Approximately 36 people per year are in the two courses.

The University of Arizona offers a 2-year program leading to a masters degree in gerontology designed to train administrators of retirement facilities. Approximately 10 persons graduate from the program each year. The university also offers ad hoc internship courses in elderly housing management.

The Ethel Percy Andrus Gerontology Center at the University of Southern California offers a 6- to 8-week program for administrators of nursing homes designed to provide background in gerontology. An individual receives a certificate of completion and can get up to 30 hours of continuing education credit. At present, the Leonard Davis School of Gerontology which is a division of the Andrus Center, is developing a graduate degree program related to housing.

The University of Michigan Institute of Gerontology has in the past offered a 14-week course, funded by AoA, which consists of basic information about the aging process as well as practical field experience in one of three areas—retirement housing management, senior center management, and milieu therapy. However, beginning in 1976, the Institute will offer a shorter version which includes (1) a 4-week, in-residence intensive course segment, (2) a 4-week, on-the-job or field placement period for skill application, and (3) an optional 2-day followup consultation session.

Several industry-supported programs which provide training and certification of housing managers are offered by the National Association of Home Builders, the Institute of Real Estate Management, Real Estate Management Brokers Institute, and the National Society of Professional Resident Managers. However, none of these programs provides special training for the managers of elderly housing.

B. Certification

In June 1975, HUD proposed regulations establishing a certification program for the managers of public housing. Under this proposal HUD will qualify certain organizations for the purpose of training and certifying managers of public housing.

In September 1975, HUD proposed a separate program for the certification of the managers of FHA-insured housing. This proposed program is based on a point system, with a total of 30 points being needed for an individual to be certified—some or all of which can come from courses offered by professional organizations.

The two departmental proposals differ substantially in their general approach to the issue of certification of housing managers, and neither of the proposals suggests any requirements for the specialized training of managers of housing for the elderly.

FINDINGS AND RECOMMENDATIONS

Housing is the No. 1 expenditure for the elderly—typically accounting for one-third of their budgets.

Housing is also the No. 1 problem for many older Americans. Large numbers now live in unsatisfactory, dilapidated, or deteriorating housing.

Rising property taxes and maintenance costs are intensifying housing problems for the elderly. Large numbers must "make do" in old houses badly in need of repair, or even beyond repair. But, they cannot find suitable alternative housing at prices within their reach.

Recent congressional actions to reactivate the section 202 housing for the elderly program offer much promise for responding to the elderly's housing needs. Further actions, however, are needed on several fronts. Specifically, the committee recommends that:

- **—The 202 program be expanded to provide at least 35,000 units annually.**
- **—The borrowing capability for section 202 be increased to $3.3 billion, as proposed in the Senate-passed housing bill (S. 3295).**
- **—A minimum of 120,000 total housing units for the elderly be developed annually, as recommended by the 1971 White House Conference on Aging.**
- **—Legislation be enacted to provide supportive services to enable elderly persons to live independently in public housing.**
- **—The concept of "congregate housing" be expanded to include food and service operating subsidies if such services are not**

available in the community or cannot be provided by service agencies.

—Training and certification requirements be developed for all managers of federally assisted and federally subsidized housing.

—A special certification program be established for housing for the elderly.

—The Administration on Aging take steps to promote home repair services through the implementation of the Older Americans Amendments of 1975.

—A comprehensive national housing policy be established which includes essential supporting services, in addition to bricks and mortar.

CHAPTER VII

TRANSPORTATION: PROBLEMS AND PROGRESS

Transportation needs of older Americans have been documented in growing detail by reports [1] and surveys which have proliferated since the 1971 White House Conference on Aging.

In 1975, after long delays, two transportation programs meant to help older Americans overcome some mobility problems finally became operational.

But at hearings of the Senate Committee on Aging, it became evident that one program—intended to provide specialized and localized service for the elderly and disabled—and the other—a demonstration project for rural areas—were accompanied by fears about fragmentation and misplaced priorities.

Testimony at the hearings also expressed complaints about redtape and confusing directives in both programs.

In spite of the problems, a second round of funding for each program was about to be granted in the spring or early summer of 1976, and impressive examples of innovative programs under the first round were beginning to emerge.

In addition, major transportation legislation was moving forward in Congress; and it included a provision which would significantly amplify earlier congressional expressions of support for the principle that all transportation systems which receive Federal assistance should be accessible and useful to the elderly and the handicapped.

I. DELAYED BEGINNINGS AND EARLY PROBLEMS

Senator Lawton Chiles, who in 1974, on behalf of the Senate Committee on Aging, had conducted 3 days of hearings on transportation and the elderly, opened a July 29, 1975, session by expressing some gratification about actions taken since the first hearings.

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[1] For example: Cutler, Stephen J., "The Availability of Personal Transportation, Residential Location, And Life Satisfaction Among The Aged," *Journal of Gerontology*, volume 27, No. 3, July 1972, pages 383–9; Hoel, Lester A., and Ervin S. Rozner, "Impact Of Reduced Transit Fares For The Elderly," Traffic Quarterly, volume 26, No. 3, July 1972, pages 341–58; Notess, Charles B., and Robert E. Paaswell, "Demand Activated Transportation For The Elderly," *Transportation Engineering Journal* (American Society of Civil Engineers), volume 98, TE–4, No. 9320, November 1972, pages 807–21; *Planning Handbook: Transportation Services For The Elderly*, The Administration on Aging, DHEW Publication No. (OHD) 76–20280, November 1975; Swain, Ryland, "Trends In Transportation, Moving With the Aging," *Rehabilitation Record*, volume 13, July–August 1972, pages 22–25; Transportation Conference, 3d, St. Petersburg, Fla., 1973, "New Directions In Planning And Action In Transit Programs For The Transportation Disadvantaged," *Proceedings of the Third Annual Transportation Conference*, Tallahassee, Fla., 1973, 3 volumes (Main HE 4487.F6A23 1973); *Transportation For The Elderly: The State Of The Art*, The Administration on Aging, DHEW Publication No. (OHD) 75–20081, January 1975; *Transportation Of The Elderly (TOTE)*; a pilot project to develop mobility for the elderly and the handicapped, interim report, Tallahassee, Fla., Department of Transportation, 1974, 51 pages (main HE 4491.S22T83 1974).

The U.S. Department of Transportation (DOT) had proposed rules for elderly and handicapped transportation services that, in Chiles' view, "should go a long way in sensitizing the providers of transportation services to the special needs of our older citizens."

In addition, a number of initiatives had been taken by Congress, by DOT, and the courts to assure the rights of the elderly to some degree of mobility, and the DOT and the Administration on Aging (AoA) had signed a working agreement as part of an ongoing cooperative relationship.

"However," said the Senator, "we still face a number of important problems. Many elderly are still isolated, whether they live in rural areas without any kind of transportation, or whether they live in suburban or urban areas with transportation systems oriented to the commuter peak-hour traffic." [2]

Senator Chiles has said the hearing was centered on two programs which, he said, "have a great deal of potential, but only if their mission is clear cut and sensitively met."

One of the programs to which the Senator referred is authorized under 16(b)(2) of the Urban Mass Transportation Act.

Enacted in 1973, 16(b)(2) is intended to help nonprofit organizations and associations provide specialized transportation subsystems so often needed by individuals not likely to be served by transportation systems.

The other was section 147 of the Federal Aid Highway Act, and it was designed to fund demonstration programs for the "transportation disadvantaged" in rural areas. Such projects are not limited to the elderly, but DOT has acknowledged that a disproportionately high percentage of the elderly live in rural areas and that "consequently one of the selection criteria will evaluate specifically the adaptability of the systems to the needs of the elderly and the handicapped." [3]

A. Problems With 16(b)(2)

At the time of the July 29, 1975, hearing, 16(b)(2) had been on the books for almost 2 years. It was not until June 1974 that DOT issued "procedures" intended to guide States in developing a single comprehensive proposal concerning the proposed use of a State's allotment of funds. And it was not until more than a year later that DOT made its first announcement of grants. These awards, totaling $20.8 million, went to 1,032 nonprofit organizations,[4] including community action programs, senior service societies, Easter seal units, county councils on aging, and the like.

In addition to voicing complaints about the long delay in implementing 16(b)(2), witnesses also expressed concern about the impact of such a large number of small, highly specialized transportation subsystems at a time when coordination and regional perspective is needed both in programs on aging and in transportation planning.

For example, Margaret MacAdam, program director for Cape Island Home Care in Hyannis, Mass., complained that, while the

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[2] Hearing, "Transportation and the Elderly: Problems and Progress," July 29, 1975, Washington, D.C., page 1.
[3] Administrative Guidelines, *Federal Register*, volume 39, No. 215, pages 39264–39265, November 6, 1974.
[4] Summary made by General Davis, hearing cited in footnote 2, page 376.

ostensible goal was to support transportation services for the elderly as part of a coordinated and comprehensive system:

> The funding timetables of these 16(b)(2) programs have not been coordinated in a manner to facilitate the implementation of the stated objective. . . . I have mentioned that important regulations have been transmitted verbally, that the bidding procedures are unclear, that the reporting requirements have not yet been transmitted, physically handicapped groups have not been able to meet the requirements while larger agencies such as ours have not been able to coordinate possible funding sources because of delays and uncertainties.[5]

Jacob L. Miklojcik, supervisor of policy and program analysis for the Michigan Office of Services to the Aging, testified:

> From the State perspective, it appears that UMTA really has no idea what it is trying to accomplish with the 16(b)(2) program, or it is deliberately intending to undermine its chances of success.[6]

Mr. Miklojcik said that delays had caused a reduction in vehicle fleets because of ever-rising purchase prices. His overall concern about 16(b)(2) rested on his belief that it encouraged further fragmentation of services, tended to let public transit "off the hook"[7] while developing an age-and-disability segregated system limited to certain types of destinations, did not provide operating funds, and excluded rural areas where the isolation of older Americans was greatest.

Fred W. Duncan, a community development specialist for city and county government in Pensacola, Fla., reiterated that 16(b)(2) promoted fragmentation of services. He questioned the logic of UMTA's funding two kinds of transportation systems; the elderly/handicapped and existing mass transit. Summing up, he said:

> Regrettably, the journey to actual implementation has reduced the 16(b)(2) program to a program to foster the development of costly, unstable jitney transit systems based upon the identified needs of single nonprofit organizations, inadequate planning . . . goals and objectives unlikely to be achieved, and based upon a nearly nonexistent, at the best, financial base.[8]

THE ADMINISTRATION RESPONSE

Gen. Benjamin O. Davis, Jr., Assistant Secretary for Environment, Safety, and Consumer Affairs at DOT, said that DOT was "vitally concerned" that these programs succeed. He explained that the first year of the grants under 16(b)(2) was understandably plagued by some inefficiency and delay but that an evaluation program, when completed, should do much to rectify matters. He added that the $20.8 million set aside and distributed in 1975 represented nearly the full 2 percent of national mass transit funds authorized to be spent and, when

[5] Hearing cited in footnote 2, pages 355–356.
[6] Hearing cited in footnote 2, page 360.
[7] Hearing cited in footnote 2, page 359.
[8] Hearing cited in footnote 2, page 367.

UMTA grants to public agencies for special transportation are included, the 2-percent figure is exceeded.[9]

General Davis stated that "we believe assistance to private groups continues to be desirable where no public transportation today exists"; this philosophy is partly based in the difficulties raised by section 13(c) of the UMT Act, which requires public operators to enter into wage protective agreements. The wage rates that prevail in such situations are generally far in excess of those paid by private social agencies (who, of course, also utilize a great deal of volunteer labor).

In response to complaints that the DOT procedures should have been published in the *Federal Register*, Mr. Jerome C. Premo, who accompanied General Davis and is associate administrator of UMTA's Office of Capital Assistance, said:

> I certainly hope and do believe that it is the flexibility that we were seeking as opposed to wandering aimlessly. A program of this sort has never been administered, to my knowledge, in the government and we tried to put together guidelines that were sufficiently general to allow for the interplay in States of health and welfare and transportation agencies.[10]

The last witness heard was Donald F. Reilly, Deputy Commissioner of HEW's Administration on Aging (AoA). Mr. Reilly was confident that the joint working agreement between AoA and DOT heralded a new era in coordinated, multifunded transportation for the elderly. He also described a technical assistance document transmitted to State and area agencies on aging which offered a step-by-step procedure for developing transportation services whose capital costs could be provided by 16(b)(2) funds while other financial obligations would be met by titles III and VII of the Older Americans Act.

B. The Rural Demonstration Program: Section 147

About 27 percent of the Nation's elderly, nearly 6 million persons, live in rural areas, primarily on farms. In fact, the percentage of the population age 65 and over is highest in rural towns with populations ranging from 1,000 to 2,500.[11] The rural resident who cannot drive or can no longer afford an automobile is in an even worse predicament than his urban counterpart. While income is generally less, and isolation is reinforced by distance, the social services that could alleviate these hardships become inaccessible.

The rural highway public transportation demonstration program was developed to encourage the development and improvement of public highway transportation systems in rural America. A 2-year demonstration effort, it was established by section 147 of the Federal Aid Highway Act of 1973 and authorized to begin in fiscal year 1975. More than 300 applications were received from around the country for a share of the $9.65 million appropriated for the first year of operation;[12] while all could not be accommodated, since funding all requests would have taken $100 million, 45 projects in 31 States were selected and an additional 17 programs were identified for possible

[9] Hearing cited in footnote 2, page 376.
[10] Hearing cited in footnote 2, page 381.
[11] *Transportation for The Elderly: The State Of The Art*, page 6, full citation in footnote 1.
[12] Hearing cited in footnote 2, pages 377 and 378.

funding and assigned priority for fiscal year 1976 moneys.[13] For fiscal year 1976, $15 million [14] has been appropriated although DOT had requested $20.35 million.[15]

Testimony was heard at the committee hearing which pointed to several weaknesses standing in the way of successfully realizing the full potential of section 147. Dr. John Dickey, of the Center for Urban and Regional Studies at Virginia Polytechnic Institute and State University in Blackburg, found a lack of commitment inherent in the short-term nature of the program and voiced concern that "if the Federal funds cease, these efforts may fold just like the OEO-sponsored programs did."

He added: "What is lacking is coordination between agencies . . . because of the competitive nature of the section 147 grants, it was difficult, and sometimes not possible, to coordinate the proposal with section 16(b)(2) projects." In summation, Dr. Dickey offered his recommendations for future action on 147:

> . . . I think the section 147 program should definitely be supported for several years. . . . DOT should provide assurances that a set of consistent, uniform statistics on travel and transportation costs result from the demonstration projects.
>
> DOT should propose means by which the worthwhile demonstration projects can be continued beyond the end of the demontration period without section 147 or equivalent subsidies. . . . DOT needs to make an aggressive effort to centralize and give priority to cross administrative programs for transportation for selective groups such as the elderly. . . . DOT needs to take an aggressive role in analyzing, coordinating, and deregulating transportation programs, particularly those traditionally handled by various social services agencies.[16]

THE ADMINISTRATION RESPONSE

General Davis and other DOT spokesmen present at the hearing emphasized that, while the selection process for 147 projects had not yet been completed, DOT criteria were designed to promote an effective demonstration program. Among these measures were: An emphasis on accessible vehicles and terminals, a requirement that all projects with rolling stock include at least one vehicle capable of accommodating wheelchairs, and representation of the AoA on the selection panels. In addition, DOT was committed to a policy encouraging the pooling of all existing financial assistance sources.[17]

C. Second Round of Funding for 16(b)(2) and Section 147

It was apparent even at the time of the committee hearing that the 16(b)(2) program was, at last, having some impact. General Davis testified that, in fiscal year 1975, $20.8 million was distributed as

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[13] Conversation with Barbara Reichart, community planner, Office of Highway Planning, Washington, D.C., April 29, 1976.
[14] Administration on Aging Information Memorandum AoA–IM–76–51, March 3, 1976.
[15] Hearing cited in footnote 2, page 377.
[16] Hearing cited in footnote 2, pages 369–74.
[17] Hearing cited in footnote 2, pages 377–8, 383.

grants to 1,032 private nonprofit agencies located in 47 States, the District of Columbia, and Puerto Rico. Three-quarters of the vehicles purchased under the program had a 10- to 16-passenger capacity; some of these 2,282 conveyances were equipped with communications equipment, and some had wheelchair ramps or lifts.[18]

More recent data on the 16(b)(2) program is not yet available because of delays and deficiencies in the monitoring process. As of spring 1976 there were still no definitive answers as to how many States were contributing their funds for 16(b)(2) operating expenses because questionnaires had just been sent out to regional offices. While regulations have not been published in the *Federal Register*, in mid-March of 1976 a package of procedural guidelines was sent to the Governors of all States and territories.[19] All 16(b)(2) applications are processed by the designated State agency, which screens these requests and then forwards those it has approved to Washington.

Funding for 16(b)(2) for fiscal year 1976 was up slightly, to $22 million. Implementation procedures were revised somewhat to reflect the experience gained in the first operational year. The aims of these alterations were the coordination of the activities of all participating planning and service agencies and the conservation of Older Americans Act funds through the utilization of existing transit operators wherever feasible.[20]

Recently, the committee communicated with Jacob Miklojcik to discern the present situation in Michigan. He reported that the State still had no 16(b)(2) vehicles but attributed this delay to implementation difficulties at the State level. He felt that UMTA is still "sluggish" in its operations but that its overall effort was improving as administrative responsibility was shifted from Washington to the regional office.[21]

As noted earlier in this chapter, section 147 funding for fiscal year 1976 was up over $5 million above the 1975 level, and 45 projects had been selected for initial implementation. Information received by the special committee asserts that the selection process was operating smoothly, utilizing an interagency review team composed of representatives from AoA, DOT, the Department of Agriculture, and the Office of Human Development (in addition, regional panels may also contain persons representing other HEW divisions or the Departments of Commerce or Labor, depending on the particular project's funding source).[22] Stress is being laid on the coordination of 16(b)(2) and 147 activities.[23]

OUTCOME OF BALTIMORE SUIT

Finally, citizens concerned with inequities in transportation should be reminded that action may emanate from the judicial as well as the legislative branch. A suit brought in Baltimore (see pages 112–13 of *Developments in Aging: 1974 and January–April 1975*) was settled by negotiations which resulted in 205 new buses being modified to facili-

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[18] Hearing cited in footnote 2, page 376.
[19] Conversation with Deborah Noxon, public information specialist, UMTA, April 29, 1976.
[20] Administration on Aging Technical Assistance Memorandum TA–AOA–76–28, March 15, 1976.
[21] Conversation with Jacob Miklojcik, April 16, 1976.
[22] Conversation cited in footnote 13.
[23] Conversation cited in footnote 13.

tate their use by the ambulatory handicapped and disabled, and by the establishment of a demand/responsive minibus network to serve the nonambulatory.

And, in the Nation's capital, an Urban League action resulted in a U.S. district court decision declaring that the handicapped must have access to all stations on Washington's new subway system. Hence, all underground stations opening for Metro's debut in 1976 were elevator-equipped;[24] meanwhile, further litigation is on the docket over the precise meaning of what constitutes the "ready access" required by the original decision. (For further information see appendix 5, item 1, Judicial Action-Equal Transportation Rights.)

D. Extension Legislation Needed

General Davis noted in his testimony before the special committee that section 147 had been enacted as a 2-year demonstration effort.[25]

If this program for rural transit is to continue beyond fiscal year 1976, it will be necessary for Congress to pass enabling legislation extending its mandate.

Extension legislation is not necessary for 16(b)(2); the Secretary of Transportation is authorized to set aside 2 percent of the funds in the basic mass transportation capital grant and planning programs for the use of public agencies and private nonprofit organizations under this section. Hence, it remains active for as long as UMTA remains operational and receives appropriations.

II. POTENTIAL IMPORTANCE OF S. 662[26]

On September 15, 1975, the Senate passed S. 662, a group of amendments to the Urban Mass Transportation Act of 1964 which were introduced by Senator Harrison Williams. As of mid-April 1976, these far-reaching amendments were slated for consideration in the near future by the House Transportation Subcommittee in the form of H.R. 3155. One goal of S. 662 is to meet the transportation needs of older Americans through extended operational assistance, increased technical know-how, and a solid reaffirmation of the Federal commitment to fully accessible public transportation.

Two portions of S. 662 are designed for those purposes:

—Section 1 recognizes that the 1974 National Mass Transportation Act's limitation of authorized funds to capital grants has become a roadblock to the establishment of viable transit systems in rural and small urban locales. By freeing this half-billion dollars for operating assistance in "areas other than urbanized areas," section 1 will aid in the meeting of day-to-day costs and will demonstrate a long-term Federal commitment to this type of transit. Section 1 operational funding will be subject to such terms and conditions as the Secretary of Transportation may require.

—Section 4 reaffirms the right of older Americans and the handicapped to equal transportation. It places the primary responsi-

[24] Conversation with Cleve R. Amos, information specialist, Metro Office of Community Services. April 28, 1976.
[25] Hearing cited in footnote 2, page 377.
[26] Report of the Senate Committee on Banking, Housing and Urban Affairs, September 9, 1975. Calendar No. 356, Report No. 94–365.

bility for the creation of barrier free public transit with the Secretary of Transportation. Where circumstances dictate that the existing system cannot be made accessible, the alternative transit established must have the same fee schedule and operating times, and must be available on a few hours' notice. Section 4 is also designed to bring the elderly and handicapped within the decisionmaking process: local and national advisory committees with at least 50-percent membership from these two groups must be established, and public hearings in regard to new services must be held in accessible locations.

III. PROGRESS ON OTHER FRONTS

A. DOT's Activities in 1975

The Department of Transportation's Summary of Activities, reprinted in appendix 2, item 9, and transmitted by Secretary Coleman, indicates that DOT may have recognized some of the difficulties which barred the special transportation program from attaining its full potential, and has made a greater commitment to transportation for older Americans. Evidence for this may be found in the fact that five UMTA notices pertaining to the mobility of older Americans were published in the *Federal Register* in 1975. These issuances dealt with (1) interim guidelines for the implementation of non-peak-hour reduced fares, (2) proposed new requirements fashioned to bring transportation services into greater harmony with the special needs of the elderly and disabled, (3) administrative regulations for the rural highway public transportation demonstration program, (4) suggested criteria for fostering local decisionmaking with respect to major Federal mass transit investments, and (5) joint planning regulations requiring that urban transportation design insures public involvement and takes special efforts to plan facilities and services compatible with the needs of older Americans.

Also during 1975, UMTA and the Federal Highway Administration issued joint regulations for program administration; and section 147 regulations, reissued in January 1976, were expected to result in twice as many projects being funded as in the previous year. In addition, Transbus prototypes were being extensively tested, although commercial production of this handicapped-accessible vehicle is not expected until 1979, and the Paratransit and small bus projects were advancing.

B. The AoA–DOT Working Agreement

The working agreement between AoA (Administration on Aging) and DOT, signed on September 16, 1975, and transmitted to State agencies administering titles III and VII of the Older Americans Act on October 20, 1975, sets three objectives for future action in the special transportation area.

Objective No. 1 is continued implementation of UMTA grant programs.

Objective No. 2 is continued implementation of the rural highway public transportation demonstration program.

Objective No. 3 calls for joint research, demonstration, and technical assistance activities.

As noted in part I–C of this chapter, feedback from AoA indicates that efforts are being made to implement both the spirit and letter of this agreement, and in particular to coordinate 16(b)(2) and section 147 activities. The continuation and expansion of such cooperative efforts are essential to the full and rational utilization of available resources in the cause of improved transportation for older Americans.

C. Two Noteworthy AoA Publications

Two AoA publications, one published prior to the committee hearing and the other afterwards, have done much to assess the current situation in transportation for the elderly and to assist people in establishing viable systems within their communities.

In January of 1975 the Administration on Aging issued *Transportation for the Elderly: The State of the Art*,[27] a study required by title IV, section 412(a) of the Older Americans Act. This volume surveys up-to-date developments in public transportation, special systems, and personal transit and explores the problems and constraints in each area. It is a comprehensive look at mobility problems of older Americans and efforts to deal with them. Another volume of significant value to the individual or group seeking to start a viable transit program is *Planning Handbook—Transportation Services for the Elderly*,[28] prepared for AoA by the Institute of Public Administration and issued in November 1975. It aims to provide the nonprofessional with guidance and assistance, proceeding from the data-gathering process through system design and equipment selection, administration and budgeting, monitoring and evaluation, and successful funding through Federal sources. Followed carefully, the handbook should greatly facilitate the founding and survival of any special transportation project.

D. Examples: Programs at Work

Despite the problems discussed earlier in this chapter and despite the impression they may give that special transportation projects are still at a very early stage, examples of well-advanced efforts can readily be found. Some success stories have been based upon a pooling of funding sources. Some have benefited from years of preparatory work at the community or State level. Some may seem to contribute to the fragmentation problem so deplored by the witnesses at the hearing mentioned earlier in this chapter.

Whatever the final outcome of each effort, they can provide useful precedents for action elsewhere, as the following summary indicates:[29]

DEMAND RESPONSIVE SYSTEMS

1. Valley Transit District (VTD), Naugatuck Valley, Conn.—VTD was started in 1971 as an UMTA demonstration project, and has received funding from that agency, the Administration on Aging, the State of Connecticut, and the four involved municipalities. The UMTA moneys financed 90 percent of the original program and were

[27] Full citation in footnote 1.
[28] Full citation in footnote 1.
[29] This material extracted from *Transportation For The Elderly: The State Of The Art*, pages 14–43, 47–65, full citation in footnote 1, and from an AoA handout titled "Examples of Coordinated Transportation Services."

increased in 1974 to permit program expansion. AoA subsidies were directed to participating social service agencies to subsidize client transportation. VTD began with six vehicles, five accommodating 21 seated passengers and 14 standees and the sixth seating 14 passengers and providing three tie-down areas for wheelchairs entering by electrohydraulic lift; three small vans supplemented these vehicles. VTD provides both door-to-door service for the elderly, handicapped, and social service clients and contract and charter service for local health and social service agencies.

VTD fares covered only 42 percent of costs and the remainder of operating expenses are covered by the various grants. Besides providing much-needed transit capacity, VTD has been a proving ground for a computerized billing system dubbed Fairtran. With Fairtran, the traditional coinbox is replaced by a terminal into which a coded card is inserted. The card's information allows for monthly billing to the proper agency or individual and thereby facilitates the development of coordinated transit services. In addition, a "fare share" feature provides for an agency to be billed for a specific percentage of a client's usage, this proportion having been predetermined on the basis of income and need.

2. Human Services Transportation Project, Chattanooga, Tenn.—This program is the end result of a 6-year demonstration effort initiated by the Department of Housing and Urban Development's Neighborhood Services Program (NSP), and supported by HEW, the Department of Labor, OEO, and the Bureau of the Budget. Transportation services are administered by Chattanooga's human services department; prospective passengers need to have a HSD client number or an income falling below OEO poverty guidelines. By eliminating a system which consisted of 40 separate social agencies utilizing passenger cars and replacing it with a single radio-dispatched operation, transportation costs were cut from $2.93 to $0.60 per client-mile.

STATEWIDE/REGIONAL

1. Older Adults Transportation Services (OATS), Missouri.—OATS serves persons 55 years and older, and the handicapped of all ages, in 84 primarily rural counties. The program was initiated in 1971 with sponsorship from the State office of aging and over 80 percent funding through title III of the Older Americans Act (however, that support had dropped to 75 percent by late 1974). OATS operates through a reservation system that requires riders to call in at least a week in advance; priority for bus space is given to medical needs. A basic fare of 4.5 cents per mile is charged, with a special 8.75 cents per mile charge for roundtrips and a 50-cent fare for trips within a town's limits. OATS' emphasis has been on conveyance from small rural communities to more urbanized county centers; consideration has recently been given to switching from the exclusively demand-responsive character to a mixed service with some fixed, scheduled routes. Continuing high costs have plagued OATS; the rural nature of the system makes for long hauls and underutilization of equipment. In addition, like many other special transport systems, OATS had to pay high insurance premiums until it could establish a record of low-accident frequency and responsible driver selection.

2. Delaware Authority for Special Transportation (DAST).—A special State statute allowed for the creation of this authority with the power to coordinate all elderly and handicapped transportation within Delaware. Coordinated activities include centralized vehicle purchase and maintenance and the pooling of all special vehicles into a centrally dispatched system offering fixed route and door-to-door service. DAST was started with funds derived from title III of the Older Americans Act and is slated to receive operational moneys through section 5 of the National Mass Transportation Act of 1974, commencing in fiscal year 1977.

3. Free Transportation Program for Senior Citizens, Pa.—On July 1, 1973, Pennsylvania began providing State lottery financed free transit to all persons aged 65 and over. The only identification required is the Medicare card, locally issued identification, or other proof of age; the broad coverage includes 95 percent of all public and private carriers (only taxis, dial-a-ride, and social agency systems are excluded), allows for a 30-mile ride (or 35 miles if the additional distance will bring the rider within a city limit), and is in effect during all but peak hours on weekdays. At last count this program was being utilized by 52 million riders annually and had resulted in improved local transit systems, increased patronization of various merchants, and greater participation by older Pennsylvanians in social service and community activities.

4. UPTRAN/Transit Authority Mix, Mich.—Michigan's Agency on Aging and Department of Transportation have developed a systems mix in which all funds derived from UMTA section 16(b)(2) have been directed to developing dial-a-ride UPTRAN systems in cities and counties not served by public transit, while in areas already so served the transit authorities offer special demand-responsive systems.

The UPTRAN program is funded one-third by the State and the remainder by local subsidy; while not restricted by age, over 50 percent of users have been 60 or older. Most of the transit systems operate their special services on a subcontract basis.

VOLUNTEERS

1. Whistlestop Wheels, Marin County, Calif.—The Marin County Transit District provides 65 percent of this program's monetary requirements; the remainder is raised from the local volunteer bureau, senior coordinating council, and fundraising events. Vehicles utilized include a program stable of 12 varied conveyances, 2 of them able to accommodate wheelchairs, and an additional 10 to 20 private passenger cars. All drivers are volunteers, while funds from title III of the Older Americans Act pay the salary of a fulltime dispatcher/manager. Services available to seniors on both a demand-responsive and fixed-schedule basis include trips to medical facilities, shopping centers, educational and recreational activities, and evening meals at senior centers.

TRANSPORTATION STAMPS

1. Transportation Remuneration and Incentive Program (TRIP), W. Va.—Begun in 1974, TRIP is receiving 47 percent Federal fund-

ing over its first 3 years of operation through OEO, DOT, AoA, and the Appalachian Regional Commission; the remaining 53 percent is provided by 23 percent State and local subsidy and 30 percent user payments. All West Virginia residents aged 60 and over, and all handicapped, regardless of age, are eligible to participate. One $8 ticket book is issued per month; the user pays between $1 to $5, depending on income. TRIP tickets can be used in months other than that of purchase and can be used on all transit forms including taxis and social agency vehicles. TRIP services approximately 125,000 West Virginia handicapped and elderly. Aside from subsidizing travel on existing transit, TRIP aims to develop a wide range of new transport services. This will begin with regional systems having fixed routes based on attractors such as hospitals, shopping areas, and community centers, will have some vehicles specially equipped for the handicapped, and will eventually be expanded to such services as a non-emergency health transporter program, mobile libraries, and meals-on-wheels.

REDUCED FARES

Over 60 reduced fare programs for public transit operate nationwide. While it is difficult to generalize, most programs set 65 as the participation age, use the medicare card as identification, offer 25 to 50 percent reductions in off-peak hours, and do not have income eligibility requirements. More detailed information on these programs is contained in AoA's *Transportation for the Elderly: The State of the Art.*

TAXI FARE SUBSIDIZATION

Taxis are the most traditional form of demand/responsive transportation. At present about 300 programs incude taxis in their service offerings. Funding is derived largely under titles III and VII of the Older Americans Act and titles VI and XIX of the Social Security Act. Again, a detailed discussion of experience with these programs is contained in the "State of the Art" handbook. Taxis appear to hold promise as a component of the overall transportation network if methods can be developed to effectively administer and monitor the billing process.

CHAPTER VIII

ENERGY AND THE ELDERLY: HIGH COSTS AND GETTING HIGHER

Energy prices have shot upwards at a record-breaking pace since 1973—in large part because of the oil embargo, energy shortages, and inaccurate projections by utility companies concerning future capital requirements.

The cost-of-living chapter has already made some reference to the direct testimony about the desperate situation facing older Americans throughout the Nation.

A more detailed examination of the dimension of the problem occurred at a committee hearing on November 7 on "The Impact of Rising Energy Costs on Older Americans." That hearing demonstrated that, despite regional variations, the energy cost squeeze problem for older Americans has reached a common level of intensity in every region of the Nation.

I. COST OF ENERGY

Fuel and energy costs have soared during the past 3 years. The price of home heating fuel oil has nearly doubled from March 1973 to March 1976, increasing by 94 percent. Natural gas costs have risen sharply. During the past 3 years, the price of residential heating gas has jumped by 52.8 percent. And electricity has increased by 41.5 percent since March 1973.

Inadequately insulated homes can also waste substantial quantities of fuel and energy.

The Federal Energy Administration estimates that 5 million homes occupied by low-income persons are insufficiently insulated. For older Americans, this can intensify health problems, particularly for the infirm or frail.

Nearly 85 percent of the noninstitutionalized aged have at least one chronic condition. This not only increases their medical charges, but also their ability to absorb rising energy prices. It may, moreover, affect their tolerance for adjusting room temperatures to reduce their energy consumption.

The energy cost squeeze affects the elderly in many other ways. Failing health or limited income, for example, may create serious barriers for making necessary repairs or purchasing needed insulation to conserve fuel and energy. It may also pose impossible choices about whether to heat or eat.

II. IMPACT OF INDIVIDUALS AND PROGRAMS

All Americans have been affected by rising energy costs in one form or another. But the elderly are among those experiencing the greatest hardship and deprivation.

At the committee's hearing on "The Impact of Rising Energy Costs on Older Americans," Senator Chiles said:

> As a group, the elderly and other low-income persons typically spend about 14 percent of their income for energy, or nearly 3½ times the percentage amount of other Americans.[1]

These points were confirmed in a recent study for the Federal Energy Administration.[2] That study included these major findings:

—The elderly poor consume less energy than other age groups but spend a much higher proportion of their income for energy-related expenditures.

—The aged poor's energy costs are primarily for everyday necessities—such as cooking and heating—rather than discretionary luxury items.

—The elderly poor pay a higher per unit cost for electricity and natural gas than other income groups.

At the committee's hearing, Senator Chiles emphasized:

> Their limited incomes may make it difficult—and sometimes hopeless—to absorb rising energy prices. Many simply do not have the sufficient margin between income and outgo to withstand higher fuel, transportation, and electrical costs.[3]

Mr. Glen Soukup, executive director for the Nebraska Commission on Aging, pointed out that monthly fuel bills exceeding $100 were not unusual in Nebraska. He also stressed that the elderly consumer pays the highest unit costs:

> His rates subsidize the consumptive habits of the large industrial and commercial users. Often the base rate includes construction work in progress, so an older person winds up shouldering the burden of future demand costs—for generating facilities he may never use.[4]

Mr. Soukup called for the development of lifeline service rates, which would provide a minimum amount of electricity at a low price for the elderly and poor to meet basic needs. He added:

> Under the lifeline structure, the consumer would have a price incentive to keep his energy usage as close to the lifeline amount as possible, thereby rewarding, rather than penalizing, his conservation efforts.[5]

Peak pricing, in his judgment, would also help to encourage energy conservation for the elderly. Under this system, consumers would pay more during hours of the day and seasons when larger amounts of

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[1] "The Impact of Rising Energy Costs on Older Americans," hearing before the U.S. Senate Special Committee on Aging, part 3, Nov. 7, 1975, page 138.

[2] See pages 147–8 of hearing cited in footnote 1 for more detailed discussion of this study.

[3] Page 138 of hearing cited in footnote 1.

[4] Page 184 of hearing cited in footnote 1.

[5] Page 184 of hearing cited in footnote 1.

energy are consumed. Rates, however, would decline when energy demand is lower, such as during the evenings or perhaps on the weekends. Mr. Soukup gave this rationale for peak pricing:

> Under the present predominant rate structures, offpeak users pay an undue portion of service expansion costs. There is no economic justification to penalize those customers who use electricity primarily or exclusively in offpeak periods. Peakload pricing would also help to flatten a utility's demand curve, and thereby lower its requirements for new generating capacity.[6]

III. EFFORTS TO DEAL WITH THE PROBLEM AND TO HELP PEOPLE

Witnesses at the hearing described several innovative approaches to ease the energy cost squeeze for older Americans, as well as provide relief in crisis situations. One such example was "Energy Cold Line," launched by an area agency on aging in southeastern Wisconsin. Title III Older Americans Act funds were used by the area agency on aging to provide seed money to generate local funding to meet emergency fuel needs. The area agency on aging worked with a local church, the Salvation Army, and others in the community to provide emergency assistance.

Ms. Joyce Poulsen, executive director for the Southeastern Wisconsin Area Agency on Aging (District 2–B) described for the committee how individuals were helped:

> A 67-year-old widow living alone received $194 monthly from social security and paid $95 per month rent. She was provided with funds to pay 2 back months' gas and electricity bills.
>
> A 60-year-old man requested assistance in paying a sizable fuel bill from a local company. He lived with his wife (who was employed) and his 87-year-old mother-in-law and two sons of high school age. The family had been trying to get by, but with a total monthly income of $450 and a sizable mortgage, this was impossible. After meeting the emergency fuel needs, this family was referred to a private agency for budget counseling, and the mother-in-law was signed up for SSI.
>
> An 81-year-old woman who had heard of the service from a neighbor called the information and referral service to request assistance in paying a past utility bill. A son living with her, who was receiving disability benefits, and herself "never left the house." Staff from the screening agency visited her to arrange to have her bill paid, as well as to provide some emergency clothing items for the family. One of these items was shoes for both persons, which were reluctantly accepted on the basis that "we don't go out much, so we don't really need shoes." The referral agency has continued to keep in contact with this family and are, 1 year later, encouraging the

[6] Page 184 of hearing cited in footnote 1.

> 81-year-old woman to become part of a socialization group of older persons that meet at the agency.[7]

On other fronts, Maine's elderly citizens have been assisted by a handyman project under the Comprehensive Employment and Training Act. The handyman performs a wide variety of services, including insulating roofs and attic floors, repairing broken windows, installing storm doors, and fixing combination storm windows. Mrs. Blanche Applebee, of North Jay, Maine, pointed out that the handyman enabled many people to live independently in their own homes, instead of becoming a burden on society:

> If we lost our handyman services, we would have to give up our homes, and when we do that, we become a burden on society in one way or another, and I assure you there are plenty of ways.[8]

In Nebraska, community action agencies have helped to weatherize about 500 homes for elderly persons by installing insulation, caulking windows, and performing minor repairs. The weatherization effort was aided by a local utility's unique aerial infrared photography scanning project which identified poorly insulated buildings. The utility shared its thermograms with local community action agencies. Outreach workers then used these infrared aerial photos to pinpoint the homes requiring weatherization. Mr. Soukup estimated that a statewide scan of all low-income elderly households needing insulation would cost $15 million. But he emphasized that the program could pay for itself in 2 years because it could reduce energy costs by $7 million to $9 million a year.

IV. LEGISLATIVE ACTIONS AND PROPOSALS

The Congress has devoted considerable attention to energy problems throughout 1975 and 1976. However, it will undoubtedly be some time before a comprehensive and coordinated national energy policy emerges. Important actions have been initiated, though, in the form of concrete legislative achievements and promising proposals.

A. Energy Conservation and Insulation in Buildings Act

One example is the Energy Conservation and Insulation in Buildings Act, H.R. 8650, which passed the Senate on March 9, 1976. H.R. 8650 was approved by the House on September 8, 1975. Title I (Residential Insulation Assistance Act) of the bill would authorize the Federal Energy Administration to make grants to States for financing residential insulation for low-income persons. Priority attention would be given to the needs of low-income elderly and handicapped persons. H.R. 8650 would authorize $55 million annually for fiscal years 1976, 1977, and 1978. The Senate committee report estimates that this bill can conceivably reduce fuel bills for low-income persons by nearly $200 million by 1980. In addition, it can help to save over 12 million barrels of oil each year.[9] Title II (the Building Energy Conservation Standards Act) would direct the Secretary of Housing

[7] Page 180 of hearing cited in footnote 1.
[8] Page 174 of hearing cited in footnote 1.
[9] Senate Report 94-623, to accompany H.R. 8650, "Energy Conservation in Buildings Act of 1976," 94th Cong., 2d Sess., Feb. 3, 1976, page 3.

and Urban Development to establish conservation standards for new residential and commercial buildings. The Secretary of HUD would also facilitate State and local adoption and implementation of these standards within a reasonable time.

B. Older Americans Amendments of 1975

The Older Americans Amendments of 1975 (Public Law 94–135) also identified residential repairs as one of four priority services[10] for funding under the title III State and community programs on aging. Beginning in fiscal 1977, States must commit at least 50 percent of the increase in their allotment (compared with fiscal 1975) for planning and social services for the four enumerated services, but in no event can this be less than 20 percent of the title III funds. States using at least one-third of their title III allotment to provide some or all of the four priority services would be exempt from either the 50-percent or 20-percent requirements. About 1 percent of fiscal year 1974 Older Americans Act area planning and social service funds were employed for home repair purposes. Kentucky ranked first with 10 percent of its allotment. Several States, however, provided no funds at all for home repairs.

C. Lifeline Rate Act of 1976

On January 22, 1976, Representative Clifford Allen introduced the Lifeline Rate Act, H.R. 11449. The bill would require all electricity distributors to charge residential users the same rate charged to business and industrial customers. H.R. 11449 would permit a residential consumer to purchase a subsistence quantity of electricity at the lowest rate offered by the utility.

In his introductory remarks, Representative Allen said:

> This bill would reverse the common practice of today, where the more electricity a consumer uses, the lower the rate becomes per kilowatt-hour. It seems to me that the consumer who is not wasteful in the use of electricity, but who patriotically seeks to conserve in the use of all forms of energy, should be rewarded by having to pay the least amount per kilowatt-hour. This is what this bill would accomplish.[11]

D. Energy Savings Demonstration Act

Senator Church introduced the Energy Savings Demonstration Act (S. 3371) on May 4, 1976. It would authorize demonstration projects to test out more fully lifeline rates, peak pricing, effective load management techniques, and other innovative methods to make energy costs more equitable and less burdensome for consumers. The bill has two important goals:

(1) The reduction of nonessential or unnecessary consumption of energy.

(2) The stabilization of energy prices.

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[10] The other three priority services are legal counseling, transportation, and in-home services.

[11] *Congressional Record*, Jan. 26, 1976, page H283.

S. 3371 would also fund demonstration projects to consider several alternatives—such as emergency loans or grants—when a person's power is shut off or about to be terminated.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The energy problems confronting our Nation are very real and immediate. In all likelihood they will intensify in the months ahead unless effective and comprehensive actions are launched soon.

The committee urges that any national policy on energy take into account the special problems confronting older Americans, particularly the low-income aged.

For immediate actions the committee recommends prompt approval of:

—The Energy Conservation in Buildings Act; and
—The Energy Savings Demonstration Act.

The committee also calls upon the Administration on Aging to encourage States to expand the availability of home repair projects under title III of the Older Americans Act.

CHAPTER IX

OLDER WORKERS IN HARD TIMES

In 1975, the United States bottomed out of the worst recession since 1937. But the economic upturn produced few concrete improvements for middle-aged and older workers.

Throughout the year, unemployment for persons 45 or older hovered between 1.4 million and 1.7 million. *Overall, joblessness averaged nearly 1.6 million (1.565 million)—the highest*[1] *unemployment in history for middle-aged and older workers.*

At the end of the year, nearly 1.6 million persons in the 45-plus age category were unemployed, almost 28 percent above the level for December 1974.

Once unemployed, the older worker runs a substantially greater risk of being without a job for a long period of time. A direct relationship between an increased length of unemployment and advancing age was again reflected in 1975. The average duration of unemployment for persons in the 45-to-54-age category was 15.8 weeks. For individuals 55 to 64, it increased to 17.8 weeks. And for workers 65 or older, the average duration jumped to 24.5 weeks—or nearly *6 months* on the average.[2]

In August 1975, the Subcommittee on Employment and Retirement Incomes began hearings in Chicago on "The Recession and the Older Worker." In his opening statement, Subcommittee Chairman Jennings Randolph pointed out that poverty among persons in the 45-to-59-age category increased by 200,000 during the preceding year, from 2.4 million to 2.6 million. He warned that our Nation may be witnessing the making of a new class of working poor. Senator Randolph then said:

> Who will compose this class? They are the labor force dropouts who have just given up after they have had prolonged and futile searches for jobs.
>
> They are persons who receive actuarially reduced social security benefits at an earlier age because in many instances they seemed to have no other choice, and those individuals who have exhausted their unemployment compensation.[3]

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[1] The Bureau of Labor Statistics (Department of Labor) has kept average unemployment figures since 1948.

[2] The average duration of unemployment for other age groups is as follows:

Age:	*Average duration (weeks)*
16 to 19	9.2
20 to 24	13.1
25 to 34	14.8
35 to 44	15.8

Source: Bureau of Labor Statistics, Department of Labor.

[3] "The Recession and the Older Worker," hearing before the Subcommittee on Employment and Retirement Incomes. U.S. Senate Special Committee on Aging, 94th Cong., 1st Sess., Chicago, Ill., August 14, 1975, page 3.

I. PROBLEMS CONFRONTING OLDER WORKERS

Witnesses in Chicago stressed that age bias—whether overt or covert—is still a real and serious obstacle, despite the enactment of the Age Discrimination in Employment Act in 1967. Mr. Clyde E. Murray, vice president of the Chicago Area Council of Senior Citizens Organizations, urged that the Age Discrimination in Employment Act be strengthened by removing the age-65 year limit for application of the law. He gave this rationale:

> . . . The chronological age of 65, or of any other arbitrary age, is a poor measuring stick for determining whether a person can carry on his or her work. No two persons have the same potential or ability at any age. One person may have gone past his potential on a job at 40 while another may do his best work at 75. I am very much attracted by the new GULHEMP theory developed by Dr. Leon Koyl, from Canada. It is an acronym using the first letters of seven words. These factors are: G for general appearance, U for upper extremities, L for lower extremities, H for hearing, E for eyesight, M for mentality or intelligence, and P for personality.
>
> It seems to me if we put all those factors together, we can determine the fitness of a person for a job whether he be 50 or 70.
>
> I am hoping that these factors, or other similar factors, taken in combination, can replace the sole factor of age.[4]

Elderly persons emphasized that they needed to work to supplement their social security benefits because inflation has greatly eroded their purchasing power. Mr. Raymond E. Hartstein, director of personnel and industrial relations for Brunswick Corp., considered the social security earnings limitation or "retirement test," to be a major barrier for employment of older workers. He said:

> This seems to knock them between the eyes. They want to work and save face, but do not want to work for nothing. These elderly are quite capable and want to do something and be constructive and helpful, but when they have to limit their earnings to $210 a month, it proves quite difficult. In addition, it discourages older people from working and from making their full contributions to society. It discriminates against those who want to be involved and denies the Nation the benefit of their abilities.
>
> It is a well-known fact that the pressures of inflation have squeezed the retirees harder than most any other segment of the population. This makes it a must that many of them attempt to seek out employment to stay above water.[5]

Technological advances also can pose problems by making skills of older workers obsolete. Moreover, relocation assistance—when available—can cause other difficulties. Mr. George Kanyok, assistant direc-

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[4] Page 45 of hearing cited in footnote 3.
[5] Page 24 of hearing cited in footnote 3.

tor of education for the Amalgamated Meat Cutters and Butchers, AFL–CIO, described some of the difficulties for the subcommittee:

> The problem here was that the emotional shock of uprooting an entire family and moving to a new location was too great for them to bear, especially when the move is being made to save a job. There was no increase in income and no advancement.
>
> I believe these problems are severe, in that one-third of the work force today is over 45 and if these trends are not reversed, the older worker will be obsolete in the next 10 to 15 years.[6]

Other witnesses pointed out that elderly women suffer multiple forms of jeopardy, particularly if they are members of minority groups. They are discriminated against because of age, race, and sex.

A. Manpower Efforts: The Chicago Experience

Despite the urgent problems confronting them, middle-aged and older workers continue to be underrepresented in our Nation's manpower efforts. *In fiscal year 1975, persons 45 or older accounted for only 8.8 percent of all participants in general manpower programs funded by the Federal Government.* Yet, they accounted for 20 percent of the average total unemployment throughout 1975, 26 percent of the average long-term joblessness (15 weeks or longer), and 31 percent of the very long-term unemployment (27 weeks or longer).

ESTIMATED ENROLLMENT OF PERSONS AGED 45 OR OLDER IN DEPARTMENT OF LABOR GENERAL MANPOWER PROGRAMS, FISCAL YEAR 1975 [1]

Program	New enrollment	45 yr and older	
		Number	Percent
Work incentive (WIN)	576,997	47,604	8.3
Comprehensive Employment and Training Act (CETA)	1,258,400	113,571	9.0
Title I—Manpower services	(886,500)	(55,850)	(6.3)
Title II—Public service jobs	(166,900)	(22,531)	(13.5)
Title VI—Emergency jobs	(255,000)	(35,190)	(13.8)
Total	1,835,397	161,175	8.8

[1] The Public Works and Economic Development Act (administered by the Department of Commerce) provides another potentially important source for employment opportunities—particularly the title X job opportunities program. Title X is directed primarily at labor intensive public works or public service projects. One example is the Pennyrile Allied Community Services, Inc., project in Hopkinsville, Ky., which began on Mar. 1, 1976. This project employs 60 persons aged 65 or older throughout a 9 county region in Kentucky. The older workers will be employed primarily in providing homemaker and home repair services.

Source: Bureau of Labor Statistics, Department of Labor.

Persons 45 or older are also underrepresented in activities conducted by the U.S. Employment Service offices throughout the Nation. In fiscal year 1975, the Employment Service helped place 3.1 million persons in jobs. Of this total, individuals 45 or older accounted for less than 11 percent of the placements (340,000). Nearly 7 million persons were referred for jobs. But only 666,000 were 45 or older, representing less

[6] Page 33 of hearing cited in footnote 3.

than 10 percent of the total. And 316,000 individuals were referred to training programs, including 16,000 in the 45-plus age category—or 5 percent of the total.

However, the city of Chicago plans to devote a much greater portion of its resources to mature workers.

Mr. Samuel C. Bernstein, assistant to the mayor for manpower, told the subcommittee:

> Instead of giving 6 percent of our resources to the unemployed in training programs alone, we will increase it to well over 20 percent in 1 year. This is the kind of thing that has to be done, it seems to me, across the country if we are going to be utilizing the resources that are presently available to provide for the senior worker, to the degree and in proportion to the need, that those older workers are now presenting to the country as a whole.
>
> Now, what else have we done in Chicago that may have particular pertinence in your deliberations as to what is the need nationwide. We have very definitely recognized with respect to the other aspects that CETA, I am talking about the Comprehensive Employment Training Act, which is the sum total of manpower programs today, represents what the Labor Department and the Office of Economic Opportunity used to administer, now delegated to State, local, and county governments; city and county governments are required to administer.
>
> In this area, we are saying with respect to such things as the employment programs, which, as you know, started with the Emergency Employment Act, and then—they were titles V and VI, and then there was a package of resources that, although markedly were inadequate, still represented something well over $1 billion. We are talking now of the greater utilization of those resources for older workers. For instance, we are moving for the first time, publicly announced today, into the field of funding private, nonprivate agencies with funds to bolster their activities in the community.[7]

B. Fiscal 1977 Budget Requests

Administration economists predict an improvement in the employment rate during the next 2 years. The administration expects the unemployment rate to decline to 7.7 percent in 1976 and to 6.9 percent in 1977. These rates, though, are well above acceptable levels. And many authorities believe that the projected levels are unduly optimistic.

Despite the expected high level of unemployment throughout 1976 and 1977, the administration proposes no increased funding for the title I (manpower services) and title II (public service jobs) CETA (Comprehensive Employment and Training Act) programs for fiscal 1977. A $1.98 billion appropriation is recommended for CETA: $1.58 billion for title I and $400 million for title II. For fiscal 1976, the administration requested a $1.7 billion supplemental appropriation to continue 310,000 public service jobs under title II (in areas with at

[7] Page 52 of hearing cited in footnote 3.

least 6.5-percent unemployment for 3 or more consecutive months) and title VI (emergency jobs program with funds distributed under a nationwide formula) through December 31, 1976. These jobs, though, will be phased out in 1977, by September 30. The Congress provided $1.2 billion for title II of CETA as an amendment to the emergency swine flu appropriations, which became law (Public Law 94–266) on April 15, 1976.

The fiscal 1977 budget requests a funding level of $2.54 million for enforcement and overhead operations for the Age Discrimination in Employment Act. This request would support 81 positions, the same number as this year.

II. STATUS OF COMMUNITY SERVICE EMPLOYMENT

Throughout 1975 and in early 1976, the administration continued efforts to phase out the senior community service employment program.[8]

The pattern was set in the fiscal 1975 budget when the administration requested no funds—for the third consecutive year—for the Title IX Older American Community Service Employment Act. In addition, the administration proposed to rescind the entire $12 million appropriation for fiscal 1975 for title IX.

A. Congressional Response

The Congress, however, rejected this attempt to terminate the title IX program. As the unemployment rate reached its highest level in 34 years, the Congress sought increased funding for the senior community service employment program.[9]

In the first continuing resolution for fiscal 1976 (through the end of the first session) the Congress provided an additional $30 million for title IX, above the $12 million previously appropriated for fiscal 1975. This combined funding level of $42 million provided approximately 12,400 community service jobs for low-income persons 55 or older.

No funding was included in the fiscal 1976 Labor-HEW appropriations bill (H.R. 8069) for title IX because the authorization legislation had not been extended when the Congress acted on H.R. 8069. (For further discussion, see introduction, page 5. Title IX, therefore, was maintained at a $42 million funding level through March 31, 1976, under the second continuing resolution.[10]

The program was sustained under another continuing resolution (Public Law 94–254) in April until Senators Eagleton and Brooke [11] won approval of a $55.9 million funding level as a rider to an emergency swine flu appropriation resolution. This measure became law (Public Law 94–266) on April 15. The new funding level will increase

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[8] The senior community service employment program is authorized under the Older American Community Service Employment Act, which is administered by the Department of Labor. The program provides job opportunities in a wide range of community service activities (e.g., antipollution control, health aides, community betterment activities, and others) for low-income persons aged 55 or older.

[9] Public Law 94–41, approved June 27, 1975.

[10] Public Law 94–159, approved December 20, 1975.

[11] Cosponsors of the Eagleton-Brooke Amendment included Senator Kennedy, the author of the title IX program. Other cosponsors included Senators Church, Williams, Tunney, Pell, Case, Abourezk, Hart (Mich.), Weicker McGovern, Hatfield, and Burdick.

participation in the title IX program from 12,400 to 15,000. Funding will be available from July 1, 1976, to June 30, 1977. Congress is expected to provide funding for the final 3 months of fiscal 1977 [12] for title IX—quite likely as a part of the Fiscal 1977 Labor-HEW Appropriations Act.

B. Title IX in 1975

Title IX came into existence in 1973 with the enactment of the Older Americans Comprehensive Services Amendments.[13] Legislation—the Older American Community Service Employment Act, S. 3604—first introduced by Senator Kennedy in 1970, led to the creation of the title IX program. It was designed to convert the Mainstream pilot projects—such as Green Thumb, Senior Aides, and others—into permanent, ongoing national programs. The Nixon administration, though, requested no funds for title IX during the first 2 years of its existence. But the Congress maintained the program with a $10 million appropriation in fiscal 1974 and $12 million in fiscal 1975.

In 1975 the Department of Labor engaged in a major effort to terminate all categorical programs for older workers. It announced that no CETA (Comprehensive Employment and Training Act) discretionary funds would be used after June 30, 1975, to support Mainstream older worker employment programs.

On July 1, 1975, Mainstream was merged with title IX. With this action, title IX provided the entire source of support for the senior community service employment program.

As of September 30, 1975, the title IX program reflected the following characteristics:

—51 percent of the enrollees were men and 49 percent were women.
—51 percent had an eighth grade education or less.
—More than one-half of the community service workers were over age 65; 18.8 percent were aged 55 to 59; 25.1 were 60 to 64; 27.9 percent were 65 to 69; 18.4 percent were 70 to 74; and 9.8 percent were in the 75-plus age category.
—More than one-quarter of all participants were members of minority groups: 73 percent were white; 21 percent Negro; 2.6 percent Indian; and 3.4 percent other races. The Spanish-American elderly accounted for 5.8 percent of the total enrollment.
—All of the participants were economically disadvantaged.

C. Older Americans Amendments of 1975

Congress reaffirmed its support for the title IX Older American Community Service Employment Act with the enactment of the Older Americans Amendments of 1975 (Public Law 94–135).[14] The new law extended the title IX program for 3 years, through fiscal 1978, with a $487.5 million, in new funding authority.[15] If fully funded at the $200 million authorized level in fiscal 1978, the Older American

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[12] Fiscal 1977 ends September 30, 1977. A 3-month transitional period will be necessary in 1976 because the end of the fiscal year has changed from June 30 to September 30.
[13] Public Law 93–29, approved May 3, 1973.
[14] Approved November 28, 1975.
[15] The authorized funding levels for the title IX Older American Community Service Employment Act are $100 million for fiscal 1976 (ending June 30, 1976); $37.5 million for the transitional quarter July 1, 1976 to September 30, 1976; $150 million for fiscal 1977; and $200 million for fiscal 1978.

Community Service Employment Act could provide nearly 59,000 jobs for older workers.

The 1975 amendments further emphasized that the national contractors would have major responsibility for administering the program. Specifically, the new law directed the Secretary of Labor to reserve a sufficient sum under each year's appropriation to continue older worker employment programs conducted by national contractors at least at the fiscal 1975 jobs level. Any remaining appropriations may be distributed to the States, taking into account the 55-plus population and a State's relative per capita income.

Another important change is the *requirement* (it was permissive under prior law) that the Secretary of Labor consult with both State and area agencies on aging concerning the locations and types of older worker projects to be operated within their jurisdictions under national grants and contracts. The Senate Labor and Public Welfare Committee report gave this rationale for the new requirement:

> In the past, these agencies have often been bypassed in making decisions regarding older worker projects. They are given the responsibility for coordinating activities for the aging; they should be given corresponding rights of consultation.[16]

D. Fiscal 1977 Budget Request

Despite these clear-cut expressions of congressional intent to continue title IX, the administration requests no funds in the fiscal 1977 budget. The budget said, "Similar activities are provided by the employment and training assistance account." [17] However, the administration requests no additional funds for the CETA title I (State and local manpower revenue sharing) and title II public service jobs programs (compared with the fiscal 1976 continuing resolution which maintained title I at $1.58 billion and title II at $400 million).

Senators Eagleton, Brooke, and Church are seeking $90.6 million for title IX (from July 1, 1977 to June 30, 1978). This amount would enable approximately 22,000 low-income persons 55 or older to participate in the program. Cosponsors of the Eagleton-Brooke-Church amendment include Senators Williams, Kennedy, Tunney, Case, Abourezk, Hart (Mich.), Pell, Weicker, McGovern, Hatfield, Burdick, and Scott (Pa.).

FINDINGS AND RECOMMENDATIONS

Our Nation still lacks a clear cut and effective policy to maximize job opportunities for middle-aged and older workers. Persons 45 and older continue to be underrepresented in our Nation's manpower programs.

Several actions are needed to provide greater employment opportunities for middle-aged and older workers. The committee recommends that:

—The Department of Labor insist that prime sponsors take concrete action to assure that mature workers are more

[16] S. Rept. 94–255 to accompany S. 1425, Older Americans Amendments of 1975, 94th Cong., 1st Sess., June 25, 1975, page 30.

[17] "The Budget of the United States Government, Fiscal Year 1977 : Appendix," page 515.

appropriately represented in CETA job and training programs.[18]

—Legislation be enacted to remove the age-65 year limitation for application of the Age Discrimination in Employment Act.[19]

—The Congress provide more adequate funding for the Age Discrimination in Employment Act and the Comprehensive Employment and Training Act.

—Legislation be approved to designate a particular week during the year as "National Employ the Older Worker Week" to promote job opportunities by Government and the private sector.[20]

—The social security earnings limitation be liberalized.

—Any new manpower legislation acted upon during the 94th Congress should include provisions designed to meet the special needs of the elderly.

Operation Mainstream and the Title IX Older American Community Service Employment Act have amply demonstrated the value of and the need for a national senior corps—not only for older workers but also the communities served.

Nearly 700,000 persons aged 55 or older were unemployed at the end of 1975—representing a 28-percent increase during the past year. For many of these older workers, title IX can provide a second career in fulfilling work. Senior community service employment also has another dividend: Elderly poor persons can work their way out of poverty in dignity while helping others in their communities.

The committee strongly urges that the title IX older American community service employment program be continued in fiscal 1977 and expanded to provide more jobs for older workers.

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[18] In February 1976, the Department of Labor published a guide entitled "Serving the Elderly, A Guide for Prime Sponsors." On February 19, 1976, Ben Burdetsky (Deputy Assistant Secretary for Employment and Training) wrote Senator Church, saying:

"In publishing this Guide, we hope to foster a deeper awareness and understanding of the employment problems and the employment potentials found within the elderly population. Additionally, the Guide will allow prime sponsors to gain a base of information upon which objective determinations may be made as to equitable levels of service on this group."

[19] Senator Fong introduced S. 871, which would remove the age-65 year limitation for application of the Age Discrimination in Employment Act.

[20] On February 23, 1976, the Senate passed S.J. Res. 35 which would designate the second full week in March 1976 as "National Employ the Older Worker Week." Senator Randolph introduced S.J. Res. 35 on February 19, 1975. S.J. Res. 35 became law (Public Law 94-275) on April 21, 1976.

CHAPTER X

AREAS OF CONTINUING OR EMERGING CONCERN

A wide range of issues—encouraging new developments or others clearly emerging as potential or actual problems—drew attention from this committee and other congressional units during the past year.

I. FEDERAL ISSUES AND EFFORTS RELATED TO NUTRITION

High food prices and other economic pressures on older Americans (see chapter I) caused intensifying interest during 1975 in federally assisted programs intended to help meet food needs of older Americans.

The nutrition program for the elderly authorized under title VII of the Older Americans Act reached a new peak of participation during the past year, and efforts were underway in 1976 to assure more adequate funding (see chapter I).

A long struggle over extension of the food stamp program reached a crescendo early this year, led by many Members of Congress who sought to cut back that program significantly. At the same time, other legislators tried to make food stamp participation more attractive and convenient to the elderly.

In addition, new action taken during 1975 was taken to promote greater coordination between the title VII and State commodities food distribution programs.

Special problems related to nutritional needs of the elderly have been mentioned often at Senate Committee on Aging hearings and in writings in professional journals and the press.

Dr. Jean Mayer, professor of nutrition at Harvard, recently wrote,[1] for example, that many older Americans "are reduced to subsistence on tea, toast, and jelly" because of meager income and by solitary living patterns.

Dr. Mayer also said:

> In addition, the problems associated with growing old can work against a proper diet. Dental problems and digestive disorders may restrict the foods that an older person can eat. Physical disabilities, such as arthritis or failing vision, may hamper the ability of the elderly to prepare meals. Many lack the means of transportation or strength to go to markets that offer the widest and most economical choice of food.

Studies by the National Institute on Aging have provided important evidence about the relationship of poor dietary habits to the aging

[1] In his syndicated column, "Food For Thought," 1975.

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process. One study revealed, for example, that caloric intake is closely associated with the ability to ward off disease.[2]

More direct testimony on the everyday problems of older Americans in today's food marketplace was provided to the Senate Committee on Aging by an elderly witness [3] who described problems he knows from firsthand experience in Ventura County, Calif. There, 13,000 of the 40,000 seniors in the county are "just below the poverty level." The witness said that many older persons are slowly starving, and he gave this example:

> One man told me he had to live on $1 a day after he paid his rent and utilities and so forth. His medicare insurance has gone up, of course—that $1 a day was not enough for a big man to live on. I asked how he could live on $1 a day and he said: "I taught my stomach to shrink." He said he had spent over a year slowly reducing the amount he ate. He said his stomach did shrink and he can live on less. But he said: "I go to bed every night hungry."

Dr. Mayer provides supporting evidence about widespread undernutrition among older persons:

> We have found that because of various factors, the elderly are the only segment of our population who have gained weight on an ordinary hospital diet.

But he adds that undernourishment is not the only problem—"a large percentage of the elderly are overweight or even obese."

In any case, it is clear that organized efforts to develop a national research program as part of a national policy on nutritional needs of the elderly is very much needed. Welcome as the food stamp and title VII programs are in helping to deal with immediate needs, a more clear-cut expression of long-term national direction and objectives is called for.

A. Congregate Meals Under the Older Americans Act

The nutrition program for the elderly (title VII of the Older Americans Act) has become a highly successful program in its short time of operation.[4] Currently, close to 250,000 elderly daily participate in programs throughout the Nation. Title VII offers a well-balanced, hot meal 5 days a week in congregate sites, or home-delivered meals to shut-ins. The program also provides ancillary social services such as information and referral, transportation, health, and recreation. Administered by the State agencies on aging, title VII has become so popular that many of the nutrition projects have had to place elderly on waiting lists for their programs. Elderly persons seek the benefits of the program not only for its nutritional services but also for its camaraderie, recreation, and education. Nutrition centers have become the social centers for elderly citizens in many locales of the country. (For further information on title VII funding, see chapter I, page 14; for

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[2] Studies in progress by National Institute on Aging.

[3] Anthony Lamb, Ventura County senior citizen coordinator, at hearing on "Future Directions in Social Security: Impact of the Cost of Living," May 16, 1975, Los Angeles, Calif., page 1255.

[4] Public Law 92–258, signed into law on March 22, 1972.

details on title VII operations, see appendix 2, item 4, report of the Administration on Aging.)

B. Commodities

Until 1973, the commodities or food distribution program was a major contributor to elderly nutrition programs. Most counties had commodity programs which supplied government surplus foods to food assistance programs. Such commodities significantly assisted program capabilities in providing services to more of the needy. However, in 1973 the commodity programs at the county level were phased out and replaced with the food stamp program.

The commodity program of today only exists at the State level, (every State but Kansas receives commodities from USDA). These commodities are of benefit to the elderly, specifically through title VII of the Older Americans Act. Recent amendments to title VII require the Secretary of Agriculture to purchase "high protein foods, meat and meat alternates on the open market" for distribution to title VII projects.[5] The amount of commodities is based on an annual program level of assistance of at least 15 cents per meal in fiscal year 1976 (approximately $10.5 million) and at least 25 cents per meal in fiscal year 1977 (approximately $22 million). The cost of such commodities is borne by the USDA under provisions of section 32 and 416 of the Agriculture Adjustment Act of 1937.[6]

C. Food Stamps

The elderly population's participation in the food stamp program increased substantially during 1975. Higher food prices, ability to use food stamps to purchase congregate meals, and automatic eligibility as SSI recipients, influenced many elderly to seek the benefits of food stamps. Approximately 74 percent of one-person households were determined to be 60 years of age and older and about 40 percent of two-person households were estimated to be 60 plus.[7]

As the number of elderly participants increased in the food stamp program, the administration attempted to advance several proposals which would have seriously jeopardized, and in many cases eliminated, benefits to the elderly under the program.

One of the first legislative acts of the 94th Congress was to block an attempt by the U.S. Department of Agriculture (USDA) to increase the purchase price of food stamps to 30 percent of the recipient's income. Such an increase would have affected nearly 15 million food stamp recipients, many of them elderly. The average purchase price for the recipients is currently about 24 percent, with the elderly's average price often lower. Therefore, to have increased their outlay for stamps by 6 to 10 percent would have caused many elderly to drop from the program. The House and Senate acted overwhelmingly to block such an increase by freezing the purchase price at January 1975

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[5] Public Law 94–135, signed into law on November 26, 1975.
[6] Public Law 75–137, signed into law on June 3, 1937.
[7] *Food Stamp Program*, a report in accordance with Senate Resolution 58, prepared by Food and Nutrition Service, U.S. Department of Agriculture for the Committee on Agriculture and Forestry, U.S. Senate, July 21, 1975.

figures. The President allowed this bill (H.R. 1589) to become law without his signature, therefore, without his approval.[8]

Later in the year, in response to a court order [9] directing it to upgrade the benefits of the food stamp program, the USDA proposed three plans which would have drastically reduced assistance for about 11 million recipients, including the elderly, particularly elderly women. The proposed regulations, specifically plans 1 and 2, would have decreased many elderly's allotment of stamps under the program while in many cases at the same time increasing their purchase price.[10] Therefore, they would be paying more for fewer stamps. Such proposals would have also seriously affected SSI recipients. In 19 States, for example, the SSI recipient would have had to pay increased prices for lower allotments while in some instances the purchase price would have exceeded the coupon allotments, thereby making it useless to participate in the program.

In response to the proposals, USDA received thousands of critical comments from the public, welfare organizations, and the Congress. In a letter to the President and the USDA, U.S. Senate Committee on Aging Chairman, Senator Frank Church, was joined by 49 Senators in deploring the proposed regulations. The Senators' comments were centered on the No. 1 and No. 2 proposals under which "the elderly will receive drastic cutbacks in aid if either of the first two proposals are adopted." The letter also criticized the proposals' potential to reduce program costs but increase the outlay for administrative costs. Therefore, Senator Church and the others condemned this as a most damaging form of policy, stating that "we should not take money out of the hands of the poor and put it into the hands of administrators for needless redtape."

To follow up on the written comments, the Senate Committee on Aging held a hearing [11] on the proposed regulations and their effect on the elderly. Elderly food stamp recipients, State administrators, national aging organizations, and the public interest legal firm which filed the original suit resulting in the court decision voiced their opinions about the administration's proposals. All agreed that the administration was attempting to curb inflationary costs of the program but at the expense of the most needy, including the elderly. Presiding at the hearing, Senator Church described the proposals as yet "another administration attempt to penalize senior citizens for economic conditions beyond their control."

On December 1, 1975, the administration responded to the many comments by publishing as final regulations, plan three—thereby rejecting the plans severely criticized in proposals Nos. 1 and 2.[12] Plan three is basically the same allotment formula as currently operating and is being studied by the Agriculture and Forestry Committee of the Senate and the Agriculture Committee of the House.

The legislative committees of both Houses have put many hours into hearings and meetings on the food stamp program, attempting to combat many of the so-called loopholes and frauds by those who many

[8] Public Law 94–4, February 20, 1975.
[9] *Miriam Rodway et al.* v. *The United States Department of Agriculture et al.* (No. 74–1303) U.S. Court of Appeals, District of Columbia Circuit, June 12, 1975.
[10] *Federal Register*, Vol. 40, No. 183, Friday, September 19, 1975.
[11] "Proposed USDA Food Stamp Cutbacks for the Elderly," Washington, D.C., November 3, 1975.
[12] *Federal Register*, Vol. 40, No. 231, Monday, December 1, 1975.

consider ineligible for the benefits. Six major bills have been introduced in the Senate to amend the program extensively.[13] Most deal with tightening the eligibility standards for the program, but differ with specific treatments of the recipient and income. To protect the particular needs of the elderly recipients, Senator Church introduced a bill (S. 2751) which would benefit all participants, but particularly the elderly. It would eliminate the purchase requirement for food stamps, increase the recipients' allotment of stamps, and allow for more efficient administrative methods to accommodate the elderly recipient.

On April 8, the Senate passed a compromise version of the National Food Stamp Reform Act of 1976 (S. 3136). The Senate bill includes a 25-percent of income purchase requirement which was a compromise between the Agriculture Committee's provision for a 27.5-percent price and efforts to eliminate the purchase requirement. S. 3136 also includes semiannual adjustments in accordance with the Consumer Price Index for the poverty line eligibility level (estimated at $5,500 for a family of four as of April 1) and the standard deduction which the bill allows to be $100 for each household with an additional $25 deduction for those households with a member who is 60 years of age or over or those households with an income above $150 per month. The bill also provides that eligibility be based on income received during the 30 days prior to application; regulates vendor payments far more restrictively than under current law and allows supplemental security income (SSI) recipients to apply for food stamps at local or district social security offices. This latter provision, sponsored by Senator Church, would allow for State food stamp personnel to be housed in SSI quarters in order to assist those elderly, blind, and disabled recipients who wish to apply for food stamps.

The Congress will continue to assess the program during the 94th Congress. With the number of participants in the food stamp program now standing at 19 million, it is vitally important that the eligibility basics for a sound program be secured. However, as Senator Church remarked on the Senate floor:

> I endorse the need for food stamp reform, but while the Congress is considering such reform I do not want the particular needs of the elderly to be overlooked. Without such attention, genuine reform simply would not be possible.[14]

II. TITLE XX—SOCIAL SERVICES

On October 1, 1975, the new title XX [15] social services program became operational. Title XX replaced title IV–A and title VI of the Social Security Act. Under title XX, services are made available by the States to the blind, disabled, elderly, and AFDC (aid for dependent children) families.

Title XX continues an overall ceiling of $2.5 billion installed by the Congress in 1972.[16] Funds under title XX are allotted to the States on

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[13] S. 2451 (Dole-McGovern), S. 2369 (Chiles-Nunn), S. 2537 (Talmadge-administration), S. 1993 (Buckley), S. 2840 (Javits) and S. 2751 (Church).

[14] From remarks made on the Senate floor by Senator Frank Church, December 5, 1975 (*Congressional Record*, S21234, December 5, 1975).

[15] Public Law 93–647, signed into law on January 4, 1975.

[16] Public Law 92–512 included a provision placing a $2.5 billion ceiling on the social services program.

the basis of population. The States have responsibility for administering the program and meeting the matching requirement of 75 (Federal) to 25 (State).

Congress enacted title XX after a 2-year struggle [17] which had begun when the Congress blocked implementation of administration regulations for the former title VI program on the grounds that such regulations would seriously restrict eligibility for free services and force strict cutbacks in several major areas.

On December 31, 1973, the President reluctantly signed a social security bill which imposed a congressional mandate to postpone the implementation of the administration's regulations until 1975.[18]

This delay gave the Congress and the administration time to reach an agreement on a new statute, which became title XX. However, the congressional compromise injected several new concepts into the social services program, including:

—A goal-oriented service program replacing the former "mandated" services concept (under former social services programs, several categories of services were "mandated" or required to be provided by the States. Under title XX, States must develop a service system which meets priority goals described in the law).

—Authority for States to spend 50 percent of their allotment for public assistance and medicaid recipients. States were also given the option to provide free services to those persons with incomes up to 80 percent of the State's median income with an income-related fee to persons with incomes between 80 and 115 percent of the State's median income.

—Allowing the States to count private funds or in-kind contributions in their matching requirement.

—Allowing more flexibility for the States but also providing for better coordination of title XX with the States' other human services programs. (States would be given more leeway in developing the service plan for their particular State with Federal requirements and restrictions. However, the States would be required to coordinate their title XX plan with other services plans of the States, e.g., the Older Americans Act, Vocational Rehabilitation Act, etc.).

—A requirement for individual eligibility certification of each participant with the States having some discretion as to the reporting requirements of this certification.

A. The Income Test Issue

In the interim before the new program began on October 1, questions arose about its effect on service delivery to the elderly. The major issue is the potentially adverse relationship between the title XX provision for individual eligibility determinations and the Older Americans Act programs' and senior centers' requirement for participation based only on age. The imposition of an income or "means test" [19]

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[17] For additional information about the events leading to enactment of title XX, see p. 99. *Developments in Aging: 1974 and January–April 1975*, and *The Rise and Threatened Fall of Service Programs for the Elderly*. Both publications were issued by the U.S. Senate Committee on Aging.

[18] Public Law 93–233, signed into law on December 31, 1975.

[19] Technically the title XX test is based only on income, whereas a means test is based upon income and the value of possessions and holdings. But despite the inaccuracy, the "means test" description was generally used in discussions of title XX.

details on title VII operations, see appendix 2, item 4, report of the would violate the intent of the Older Americans Act, particularly title VII, which prohibits any form of means test. Senior centers, many of which could have supplemented their programs with title XX funds, were especially hard hit. Just as it was beginning to appear that many advocates for aging would be successful in influencing their title XX State plans to include a greater percentage of services for the elderly, the complicated and expensive administrative procedures made necessary by the means test requirement, could cause some States to refuse to develop title XX coordination with other aging programs. Thus, the potential of services for the elderly could be damaged.

Foreseeing such complications, the administration issued regulations postponing the implementation of the means test determinations for 6 months. States that had been providing social services on a group eligibility basis could continue to do so until March 31, 1976.

B. Legislative Action

During this 6-month interval, elderly and service providers expressed their concern about the title XX means test to their congressional representatives and Senators, prompting legislative proposals in the Senate and House of Representatives which would exempt senior centers and/or aging services from the title XX individual eligibility certification.[20]

The House Subcommittee on Public Assistance (Ways and Means Committee) conducted several days of hearings and heard complaints from the elderly and others on the relationship of title XX and aging services.

Stephen Kurzman, Assistant Secretary for Legislation, represented the Department of Health, Education, and Welfare and said that the administration would issue regulations before the April 1 deadline in order to permit the States far greater flexibility in determining what form of eligibility determination they would administer under title XX. In addition, Mr. Kurzman requested an extension of the limited group eligibility provision which the States were currently using. However, he asserted that "this change can be effected only through a statutory amendment since our (HEW) regulatory changes of last October exhausted our discretion in this area.[21]

Following up on Mr. Kurzman's suggestion, the Ways and Means Committee recommended that the operating waiver be extended for 6 additional months in order that "the administration's proposals and other bills which have been introduced on the subject can be carefully considered." [22] In other words, those States currently providing services under title XX on the basis of a group eligibility certification could continue to do so for an additional 6 months. During this time, the Congress and administration would both be offering additional proposals to assist in solving this problem.

The House passed this measure (H.R. 12455) on March 16, which would allow those States who were providing services under a group

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[20] H.R. 7032 (Heinz, Pennsylvania), H.R. 9280 (Rosenthal, New York), H.R. 11385 (Green, Pennsylvania), H.R. 12014 (Corman, California), and S. 2157 (Javits, New York).

[21] Testimony before the Subcommittee on Public Assistance, Ways and Means Committee, by Stephen Kurzman, Assistant Secretary for Legislation, DHEW, March 4, 1976.

[22] "Continuation of Group Eligibility Determinations Under Title XX." House Report 94–903, Ways and Means Committee, March 15, 1976.

eligibility determination prior to October 1, 1975, to continue to do so until October 1, 1976.

Before the Senate acted to extend this waiver, the administration issued final regulations giving States greater flexibility in choosing the forms of eligibility determination for title XX social services.[23] Under such rules, the States would be allowed to do away with the frequently criticized "means test" by administering a less stringent form of eligibility determination. According to the regulations, "States may establish any method or methods, including a declaration method, for determining eligibility. . . ." The April 2 regulations also allow the States to opt to use a different form of eligibility determination for different services, different categories of individuals, and different geographic areas.

On May 20, 1976, the Senate Finance Committee reported out a committee substitute for H.R. 12455 which would give the States complete flexibility in determining title XX social services eligibility. The Finance Committee's bill would eliminate all current Federal eligibility requirements under title XX and place such responsibility in the hands of the States.

Conferees of the House and Senate will resolve the differences in the two bills in conference.

C. Administration's "New" Proposal

The first few months of title XX operation [24] became even more complicated with the announcement of an administration proposal for transforming title XX into a block-grant program. In his message to the Congress of February 23, 1976, President Ford described his intentions:

> This reform proposal will improve and strengthen the program of social services established under title XX of the Social Security Act. It will provide a $2.5 billion block grant annually to the States on a population basis. It will eliminate the requirement for State matching funds, as well as most Federal requirements and prohibitions on the use of Federal funds.

On face value, the block grant proposal appears to be an improvement. However, such a block-grant program, with its vague definition of services, could result in a severe cutback to "social" services. For example, it appears that educational and physician services and reimbursements for long-term care could be supported under such a "flexible" block grant program. Since Federal restrictions and matching requirements would be less demanding of the State under this proposal, many States might opt to support such nonsocial services with title XX allotments.

Other provisions of the block grant which will appear favorable to the States at first glance are the elimination of certain restrictive requirements on use of Federal funds; the decrease in Federal monitoring and oversight of State plan requirements; and allowing the States

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[23] *Federal Register*, Vol. 41, No. 65, April 2, 1976.

[24] For example of activities on aging funded under title XX, see chapter XI, page 210.

to have discretion on which form of eligibility determination, group or individual, they will administer. These provisions, coupled with the elimination of the State matching requirement, will make the administration's proposal tempting to State officials.

Therefore, the future of title XX is far from certain. The next year will include several regulatory proposals, further consideration of the legislative proposals, and the consideration of the administration's block grant proposal.[25] All will have a major effect on the future of title XX as an effective social services provider to the elderly.

III. LEGAL SERVICES

Hearings conducted by the Senate Committee on Aging have provided clear and convincing evidence that the legal needs of the elderly are oftentimes overlooked or largely ignored.[26] In far too many cases, they are forced to fend for themselves when a legal problem arises—whether it involves litigation, understanding the "technicalities" of Federal programs, or even planning their personal affairs.

Large numbers of older Americans—particularly moderate-income persons—now find themselves in a "legal limbo." They have too much income to qualify for legal services. But, they cannot afford to pay a private attorney at today's prices.

During 1975, important advances were made to improve legal representation for the aged. However, the administration threatened to undo much of what had been accomplished through inadequate appropriations requests when it submitted the new budget on January 21, 1976.

A. Background: The Tunney Amendment

The Fiscal 1975 Labor-HEW Appropriations Act[27] included a $9 million increase for the title III State and community programs under the Older Americans Act, raising the administration's budget request of $96 million to $105 million. When the Senate considered this measure in September 1974, Senator Tunney and Senator Magnuson (chairman of the Senate Labor-HEW Appropriations Subcommittee) had a brief colloquy—emphasizing that at least $1 million of the increased funding for title III be used to strengthen legal representation for older Americans.[28]

Despite this expression of congressional intent, some doubt remained whether the administration would actually spend the money for legal services projects. However, Commissioner Flemming informed the committee during a hearing on "Training Needs in Gerontology" that the Administration on Aging would "respect the legislative history relative to the $1 million."[29]

AoA has since used nearly $1.2 million of section 308 model project funds to support legal representation projects for the elderly. A major

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[25] The administration's proposal was introduced as S. 3061 by Senator Curtis on March 2, 1976 and as H.R. 12175 by Congressman Vander Jagt on February 27, 1976.

[26] "Legal Problems Affecting Older Americans," part 1, St. Louis, Mo., August 11, 1970; part 2, Boston, Mass., April 30, 1971. "Improving Legal Representation for Older Americans," Los Angeles, Calif., June 14, 1974.

[27] Public Law 93-517, approved December 7, 1974.

[28] *Congressional Record*, September 16, 1974, page S16686.

[29] "Training Needs in Gerontology," hearing before the U.S. Senate Special Committee on Aging, part 3, 94th Congress, 1st Session, March 7, 1975, page 181.

purpose is to make legal services more accessible to older Americans. In addition, the projects are intended to:

—Sensitize State and area agency on aging staff to the legal needs of the elderly.

—Develop instructional materials for professionals, paraprofessionals, and volunteers.

—Develop and demonstrate replicable models of interagency cooperation and coordination in providing quality legal services through attorneys, students, volunteers, law schools, local bar associations, and other community agencies.

Among the projects funded:

(1) Tolland Windham Legal Services, Willimantic, Conn. ($33,406).

(2) Presbyterian Senior Services, New York, N.Y. ($44,600).

(3) National Council of Senior Citizens (Legal Research and Services for the Elderly), Washington, D.C. ($249,607).

(4) National Paralegal Institute, Washington, D.C. ($150,000).

(5) National Retired Teachers Association-American Association of Retired Persons (Legal Counsel for the Elderly), Washington, D.C. ($85,000).

(6) University of Michigan, Ann Arbor, Mich. ($91,032).

(7) Louisiana Center for the Public Interest, New Orleans, La. ($70,432).

(8) University of Southern California (National Senior Citizens Law Center), Los Angeles, Calif. ($225,000).

(9) Senior Adult Legal Assistance, Palo Alto, Calif. ($47,322).

(10) California State Office on Aging, Sacramento, Calif. ($121,000).

(11) George Washington University, Washington, D.C. ($75,850).

B. Older Americans Amendments of 1975

The Older Americans Amendments of 1975 [30] represented another important victory in making legal representation more readily available for the elderly. Four key provisions were adopted for this purpose.

Priority Services.—Four priority services—including legal counseling, transportation, residential repair, and in-home services—are identified for funding under the title III State and community programs on aging. Beginning in fiscal 1977, States must commit at least 50 percent of the increase in their allotment for planning and social services (the difference between their allotment in fiscal 1977 compared with fiscal 1975) for the four enumerated services, but in no event can this be less than 20 percent of the title III State planning and social services funding. States assuring AoA that they would use one-third of their title III allotment to provide some or all of the four priority services would be exempt from either the 50-percent or 20-percent requirements.

Training of Lawyers and Paraprofessionals.—Title IV training is now expanded to include lawyers and paraprofessionals to (a) provide legal counseling or (b) monitor the administration of programs for older Americans. Training is also authorized to identify legal

[30] Public Law 94–135, approved November 28, 1975.

problems affecting older persons and developing solutions for their needs.

Social Services Definition.—The title III social services definition is broadened to include legal and other counseling services and assistance to older persons.

Title IX Community Service Employment Definition.—The title IX community service employment definition now applies to legal and other counseling services.

C. Support Centers

On other fronts, the House passed H.R. 10799 on March 24, 1976. H.R. 10799 would permit the National Legal Services Corporation to fund by grant or contract research, training, technical assistance, and clearinghouse activities. The Legal Services Corporation Act of 1974 (Public Law 93–355) requires that these activities be undertaken directly by the corporation. H.R. 10799 would also permit the Legal Services Corporation to use up to 10 percent of its appropriations for grants or contracts for these support activities.

D. Fiscal 1977 Budget Request

For fiscal 1977, the administration is recommending an $80 million funding level for the National Legal Services Corporation, $8 million below the fiscal 1976 appropriation (State, Justice, and Commerce Appropriation, Public Law 94–121) of $88 million. The Congress, however, provided an additional $4.33 million as a part of the Fiscal 1976 Second Supplemental Appropriations Act (Public Law 94–303). The administration's fiscal 1977 recommendation is more than $60 million below the $140.3 million sought by the Legal Services Corporation. The fiscal 1976 appropriation now supports 258 legal services programs, staffed by 3,300 attorneys. A cutback in legal services activities would probably be necessary if the administration's fiscal 1977 recommendation is adopted. But the extent of the reduction is not known at this time.

In addition, the administration plans to phase out the Older Americans Act model projects program in fiscal 1977. It would, therefore, be necessary for section 308 legal representation projects to seek alternative sources of funding. This may be difficult, though, because of the proposed cutback in funding for the Legal Services Corporation.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Far too many older Americans suffer needless anxiety and deprivation because they do not know what recourse is available when a legal problem develops.

Comprehensive efforts are needed to make legal representation more readily available for the elderly.

The committee strongly supports the Administration on Aging's efforts to fund legal services projects under the section 308 model projects program. The committee further urges that (1) section 308 be funded in fiscal 1977, and (2) AoA should continue its financial support of model projects to strengthen legal representation for older Americans.

Further, the committee recommends that the proposed funding for the Legal Services Corporation be raised to a more adequate level.

IV. NATIONAL INSTITUTE ON AGING

May 31, 1976, was the second anniversary of the signing of legislation which established a National Institute on Aging within the National Institutes of Health (NIH).[31]

But the National Institute on Aging (NIA), early in 1976, was laboring against major difficulties:

—After 20 months of authorization, the new Institute still did not have a permanent director[32] in April 1976. A designated search committee composed of seven members from various institutes within the NIH conducted the usual search and interviews, but to no avail. Without the leadership a director offers, the Institute and staff have lacked the stability and advocacy necessary to establish credibility within NIH, the Department of Health, Education, and Welfare, and the field of research.

—Initial staffing of the Institute in 1975 supported only six positions with five of them being transferred from other institutes.

—Insufficient staff was due to the lack of administrative funds in the 1975 operating budget. As most of these funds were transferred from the National Institute of Child Health and Human Development's (NICHD) Adult Development and Aging Branch, no set-aside administrative moneys were available. Most of the financial support was directed towards research grants and was specified for that same purpose under the NIA budget.

—Supplies, such as office furniture, typewriters, and other equipment—had to be borrowed or shared with other institutes. This again was attributed to the lack of specific set-aside moneys for the administrative purposes.

—In addition, the National Advisory Council on Aging[33] required by law did not meet at a formal meeting until April 1975. There-

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[31] Public Law 93–296, signed on May 31, 1974.

[32] This situation was rectified on May 1, 1976, when Dr. Donald S. Fredrickson, Director of the National Institutes of Health, announced that Dr. Robert N. Butler had been appointed the first Director of NIA. An NIH press release of that date said that Dr. Butler was in private practice in Washington, D.C., as a psychiatrist and psychoanalyst. He has also worked with and for the elderly for more than 20 years and is author and coauthor of several books on aging, including: *Aging and Mental Health* (with Myrna I. Lewis), *Human Aging* (coauthor), and *Why Survive? Being Old in America*. Dr. Butler has also served as a psychiatrist and gerontologist at the Washington School of Psychiatry and has been on the faculty of the board of the Howard and George Washington Schools of Medicine as well as the Washington Psychoanalytic Institute.

On the same day that his appointment to NIA was announced, Dr. Butler was informed that he had won the Pulitzer Prize for nonfiction for his book, *Why Survive? Being Old in America*.

Senator Frank Church, chairman of the Senate Committee on Aging, said in the *Congressional Record* (May 5, 1976) of Dr. Butler's NIA appointment: "Dr. Butler is an excellent choice. As a psychiatrist, he has continually urged greater attention to the mental health needs of the elderly, who are so often neglected in this area. As an advocate for action on matters of concern to older Americans, he has helped our citizens to become aware of the dangers of 'ageism,' of negative attitudes toward the aging and all that now goes with that process. As a consultant to the National Institutes of Health, the Senate Committee on Aging, and the Center for Law and Social Policy, Dr. Butler has helped shape national goals and actions on aging." Of Dr. Butler's Pulitzer Prize award, Senator Church said that "everyone concerned about aging should welcome the Pulitzer committee action."

[33] Current members of the Advisory Council are: Edwin L. Bierman, M.D., professor of medicine, School of Medicine (RG–20), University of Washington, Seattle, Wash. 98195; Harold Brody, Ph. D., chairman, department of anatomical sciences, State University of New York at Buffalo, 316 Farber Hall, Buffalo, N.Y. 14214; Ms. Maria Christian, physical and occupational therapist, Department of Physical and Occupational Therapy, Medical Sciences Campus, University of Puerto Rico, San Juan, P.R. 00936; Ms. Katherine Dunham, director, performing arts training center, Southern Illinois University, East St.

fore, the law's requirement to establish a research program plan for the NIA written 1 year from the enactment date could not be met. The Council requested and was granted a year's extension under the Older Americans Amendment of 1975 (Public Law 94–135) and, therefore, the plan is not due until May of 1976. The absence of this plan to "coordinate and promote research into biological, medical, psychological, social, educational, and economic aspects of aging" could be detrimental to the Institute's development. Such a policy is essential for the Institute's efforts in setting forth the operations of the Institute, its goals and research program.

Contributing to all obstacles encountered by the Institute's first year of operations was the inadequate budget. The total budget request and operating level for the Institute in fiscal year 1975 was $15.7 million. Such a budget was the smallest of all NIH institutes, with several institutes receiving as much as 20 times that of the NIA allotment.[34] The Institute requested a $3 million supplement for fiscal year 1976, but the request never made it out of the DHEW channels.

In response to the urgent need for increased funds for the new Institute, the Congress included additional moneys for the NIA in the Labor-HEW appropriations bill (H.R. 8069) for fiscal year 1976. The Senate appropriated $20.526 million for the Institute while the House of Representatives allotted only $15.526 million. The Senate and House conferees compromised upon a final request of $17.526 million. This Labor-HEW appropriations bill was vetoed by the President but successfully overridden by the House and Senate, and thus became law.[35]

No funding was provided for training because the authorization for the National Research Service Awards Act has not been continued when the House first acted on the Fiscal 1976 Labor-HEW Appropriations Act. Later $1.762 million was provided for training in a continuing resolution. In addition, NIA had $100,000 for standard level user charges to be paid to the Government Services Administration for building rental. All in all, the funding level for NIA amounted to $19.388 million in fiscal 1976.

It is estimated by the Institute staff that this small increase will enable the NIA to support approximately 10 additional grants and contracts and increase the staff.

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[34] The fiscal year 1976 operating level for the NIA was approximately $15.74 million while such institutes as the National Cancer Institute and the National Heart and Lung Institute received $687 million and $304 million respectively.

[35] Public Law 94–206, vetoed by the President on December 19, 1975, and overridden by the House on January 27 and the Senate on January 28, 1976.

The administration requested $26.22 million for the NIA for fiscal year 1977 which is almost $7 million over the fiscal year 1976 funding level. NIA staff members estimate that such an increase could allow for the additional support of 70 to 80 grants and contracts.

During its struggle to attain status within the research field, the National Institute on Aging continues to support research seeking more knowledge about the aging process. In 1975, the Institute supported grants and contracts numbering approximately 140 which included such studies as:

—The biological, molecular, and cellular relationships to the aging process.
—Senile dementia.
—The biochemical relationships of exercise and stress to aging.
—Neurochemical analysis which suggests that as certain chemicals of the brain decline, the memory declines.
—Comparisons of the restriction of caloric intake and its relationship to longevity and one's ability to ward off disease.
—The relationships of developmental psychology and the aging process; and
—Relationships of menopausal periods and estrogen levels with bone loss and cardiovascular diseases.

V. PRESCRIPTION PRICE DISCLOSURES

Acting upon findings from an investigation begun in 1974, the Federal Trade Commission issued a comprehensive report in 1975 proposing two trade regulation rules intended to give consumers easier access to price information about prescription drugs.

Impressed by the FTC recommendations and findings, Senator Frank Church, chairman of the U.S. Senate Special Committee on Aging, took action to express congressional support for the FTC proposals.

A. The Importance of Drugs to the Elderly

People over 65 comprise about 10 percent of the Nation's population, but purchase 23 percent of drugs sold.[36] Medicare does not cover drugs on an outpatient basis and neither do many health insurance policies. The result is that about 86 percent of expenditures for prescription drugs are from private sources.[37] This makes prescriptions the third highest personal medical expenditure for older Americans, behind hospital and nursing home care.[38]

B. Present Problems in Obtaining Price Information

Many older Americans are forced to buy needed prescription drugs without access to nominal price information. Verbal disclosure between the pharmacist and the consumer is the most prevalent form of price disclosure now. This form, however, may be unsatisfactory to older Americans with mobility restrictions and limited access to transportation.

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[36] Mueller, Marjorie Smith, and Robert M. Gibson, "Age Differences in Health Care Spending, Fiscal Year 1974." *Social Security Bulletin*, June 1975, page 4.
[37] Worthington, Nancy. "National Health Expenditures, 1929–74," *Social Security Bulletin*, February 1975, page 9.
[38] Mueller and Gibson, *supra*. at 5.

The most convenient method of comparison shopping is the sort that can be done from the home. This would include price lists printed by the store and retained by the consumer, newspaper, and other media advertisements, and telephonic disclosures. These forms are currently the least available.

Statutes, codes, regulations, and customs in many States not only prevent consumers from obtaining price information, but also prohibit pharmacists from making disclosures. In some cases professional sanctions are instituted against pharmacists for posting price lists. The overall view for the United States was a ubiquitous "lack of price information." [39] This is reflected in the FTC finding that 34 States presently have significant barriers to price advertising.[40]

Drug prices do vary greatly from store to store. Numerous surveys have documented the wide differences in drug prices across the country and even in the same town. A survey printed in the *Miami News* [41] showed how drastically prices can differ:

Drug	Strength (milligrams)	Quantity	Price		Percent difference
			High	Low	
Achromycin	250	50	$12.50	$1.20	1,041
Pentids	250	50	8.00	1.50	533
Tetracycline	250	50	14.95	1.20	1,245

C. The FTC Proposals

The Federal Trade Commission, in May 1975, proposed two trade regulation rules to eliminate barriers to drug price disclosure. Retail sellers would be free to take out newspaper ads, print price lists, or disclose price information in other ways. Restraints on retail sellers would be removed and consumers would be encouraged to seek price information.

The FTC is empowered to promulgate regulations to remedy unfair trade practices.[42] The nondisclosure of drug prices is seen as an unfair practice under the meanings of the FTC act.

D. The Church Resolution

Senator Church introduced legislation (S. Res. 357) on January 27, 1976, to put the Senate on record in support of the FTC's proposed regulations concerning prescription price disclosures. Senate Resolution 357 declares that there is a need for adequate price disclosures of prescription drugs. It also expresses the sense of the Senate that laws and private restraints against accurate prescription price disclosure and advertising are contrary to the public interest. In addition, Senate Resolution 357 states that the following acts are unfair trade practices within the meaning of the Federal Trade Commission Act:

—Prohibiting, hindering, or restricting—either directly or indirectly—the disclosure by any retail seller of accurate price information concerning prescription drugs.

[39] "Prescription Drug Price Disclosures," staff report to the Federal Trade Commission, January 28, 1975, page 4.
[40] Id. at 34.
[41] *Miami News*, April 13, 1974.
[42] 15 U.S.C. 45 (1970).

—Failure of a retail seller to disclose adequate retail price information upon request.
—Restricting or failing to make any disclosure of adequate price information because of any rule, regulation, or code of any non-Federal entity.

Senator Church gave this rationale for his resolution:

> I believe that it is also highly important for the Congress to go on record in support of a system of adequate price disclosure for prescription drugs, and I offer a Senate resolution for that purpose. It is critical to the senior citizens of our Nation that they get a fair shake in the purchase of prescription drugs, especially since medicare does not reimburse for out-of-hospital prescription drugs. I ask my colleagues to join with me in supporting all-out efforts promoting the fair advertisement of prescription drugs, and I hope that restrictive State laws will be struck down in the interest of justice for older Americans.

Senate Resolution 357 has been referred to the Senate Commerce Committee. Cosponsors include Senators Abourezk, Buckley, Pell, Haskell, Leahy, and Beall.

E. Other Activities

Other agencies and groups have taken steps intended to encourage greater drug price disclosure.

In November 1975, the Department of Justice filed a civil antitrust suit charging the American Pharmaceutical Association with conspiring to prohibit the advertising of prescription drugs. The suit contends that as a result of the conspiracy to prohibit price advertising, competition is suppressed and eliminated, and that purchasers of prescription drugs, "have been deprived of the benefits of free and open competition in the advertising and sale of prescription drugs." [43] This suit is pending in the U.S. District Court in Grand Rapids, Mich.

Virginia Citizens Consumers Council (a nonprofit Virginia corporation with a membership of approximately 150,000) brought suit for declaratory and injunctive relief against enforcement of a Virginia State statute regulating pharmacists. The contested statute describes as "unprofessional conduct" the advertising or promotion of any prescription drug price.[44]

A three-judge court in the Eastern District of Virginia held the statute unconstitutional. In reaching this conclusion, the court cited a first amendment "right to know." [45] The law was held to deny consumers this right without sufficient justification. The case has been appealed directly to the U.S. Supreme Court and arguments have been heard. A final decision is expected shortly.

F. Price Disclosure of Eyeglasses

Similarly, the Federal Trade Commission voted unanimously to propose regulations to preempt State laws and professional trade regula-

[43] *United States* v. *American Pharmaceutical Association,* Complaint filed by U.S. Department of Justice, at 5.
[44] 1950 Code of Virginia, as amended § 54–524.35(3) (1972 Supp.). The United States Supreme Court, in a decision handed down May 24, 1976, found the Virginia advertising ban unconstitutional under the First and Fourteenth Amendments.
[45] *Virginia Citizens Consumer Counsel, Inc.* v. *State Board of Pharmacy,* 373 F. Supp. 683 (E. D. Va. 1974).

tions that restrict price advertising of prescription eyeglasses. Senator Percy expressed support for the proposed regulation, saying:

> I might add that I remain firmly convinced that the proposed rule should be adopted. Government has no right to impose restraints that artificially inflate, by some 25–40 percent, the price of an important health device such as prescription lenses. These State laws and professional restraints simply increase costs and have little redeeming social or health value.
>
> I was pleasantly surprised when I learned that on January 20, 1976, the FTC announced additionally that it will also investigate commercial restrictions in the prescription eyeglass industry that may be increasing costs. These restrictions, which include State laws precluding optometrists from practicing in discount houses, appear to be contrary to the public interest*.

FINDINGS AND RECOMMENDATIONS

In 1974, Americans spent almost $10 billion for drugs and drug sundries, and persons in the 65-plus age category accounted for $2.3 billion. Older Americans spend nearly 2½ times as much for prescription drugs as younger Americans.

One important reason is that 80 percent of the elderly suffer from one or more chronic conditions. About 15 percent have severe chronic conditions. Their prescription expenditures are more than six times as great as those for younger Americans. Some elderly persons spend 45 percent or more of their income on medication.

These facts underscore the importance of adequate price information in order for the elderly and their families to make an intelligent decision about the appropriate prescription to purchase at the most economical price. However, adequate information is not available now. Several barriers exist, preventing or hindering older Americans from obtaining the information they need to make an informed decision.

The committee urges that Senate Resolution 357 be approved expeditiously to encourage the disclosure of prescription prices for all consumers, the young as well as the old. In addition, the committee reaffirms its support for the FTC actions to stimulate adequate medication cost disclosures by retail sellers.

VI. TASK FORCE, FDA ACTIONS ON HEARING AIDS

Asked by the Secretary of Health, Education, and Welfare to examine issues raised at hearings [46] by this committee's Subcommittee on Consumer Interests and by a Retired Professional Action Group Report,[47] an HEW intradepartmental task force continued its work during 1975.

Congressional Record, February 17, 1976, page S1703.

[46] "Hearing Aids and the Older American", Subcommittee on Consumer Interests of the Elderly, September 10, 1973.

[47] "Paying through the Ear; A Report on Hearing Health Care Problems," Public Citizen's Retired Professional Action Group, 1973.

In a related activity, public hearings by the Food and Drug Administration (FDA) of HEW were held in May 1975 on both a preliminary report prepared by the task force in September 1974 and a supplementary report prepared by the task force in October 1974. At this hearing, testimony was presented by representatives of the Hearing Aid Industry Conference, the Greater Philadelphia Hearing Aid Guild, the National Hearing Aid Society, the American Speech and Hearing Association, the Retired Professional Action Group, the American Council of Otolaryngology, and various manufacturers and consumer interest groups.

After analyzing these comments, the task force transmitted its "Final Report to the Secretary on Hearing Aid Health Care."

The report acknowledges:

> Hearing impairment is a major public health problem requiring competent professional attention. Unfortunately, few hearing impaired people receive medical or other professional attention prior to the purchase of a hearing aid . . . approximately 70 percent of the people who buy hearing aids go to a dealer first rather than to a physician specializing in diseases of the ear, an audiologist, or to someone trained and supervised by these health professionals.
>
> The hearing aid industry estimates that there are slightly more than 7.5 million potential candidates for hearing aid use, at least half of whom are over 65. . . . Some individuals are sold the wrong type of hearing aid; but, most tragic of all, some individuals with remediable ear disease go undiagnosed, trying one hearing aid after another, until they reach the point where the disease is no longer remediable.[48]

The report recommends the following:

(1) That as a general practice, a medical examination be required within the preceding 6 months before being fitted for a hearing aid. Purchasers over the age of 18 would be permitted to waive this requirement provided certain warning signals are not apparent. These include: dizziness, ear deformity, fluid drainage, rapid onset of hearing loss, or a foreign body in the ear. In the event of any such conditions, a hearing aid will not be sold without the written approval of a physician.

(2) HEW should support the proposed Federal Trade Regulation Rules regarding the provision of a trial period, and adequate labeling.

(3) Hearing aid labeling should disclose the following material facts:

(a) A hearing aid will not restore normal hearing.

(b) A hearing aid will not prevent or improve organic conditions resulting in a hearing impairment.

(4) Efforts should be undertaken to develop plans for a national public education program for hearing health care.

(5) The cost of hearing evaluation tests and other hearing aid services should be separated from the cost of the device.

(6) The Secretary should consider the desirability and cost implications of coverage of comprehensive hearing health services to include the purchase of hearing aids, under all existing HEW programs.

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[48] "Final Report to the Secretary on Hearing Aid Health Care," page 14.

(7) Cooperative research programs should be established for the development of new and improved sensory aids for the deaf and the hearing impaired.

In September 1975, the Secretary approved the final report and asked for the development of regulations to implement the task force recommendations.

On April 21, 1976, proposed regulations appeared in the *Federal Register*.

The proposed regulations:

(1) Set forth the types of information that must be included in the labeling to provide hearing health professionals and patients with adequate directions for the safe and effective use of a hearing aids;

(2) Specify the technical performance data that must be included in the labeling to assure that hearing health professionals have adequate information to correctly select and fit a hearing aid; and

(3) Restrict the sale of a hearing aid to those patients who have undergone medical evaluation within the past 6 months, but with provision that fully informed adult patients may waive the medical evaluation if none of the designated conditions is present at the time of purchase.

Comments are currently being accepted by the Department on these proposals.

Senator Percy criticized the Food and Drug Administration proposal for medical clearance. He also pointed out that hearings conducted by the Permanent Subcommittee on Investigations of the Senate Government Operations Committee disclosed that many persons are sold hearing aids they do not need or cannot use.

> Unfortunately, this evidence did not appear to have much weight with the FDA, which has proposed that there be medical clearance for hearing aid purchasers which can be waived by persons over 18 years of age.
>
> The proposed rule also presumes that a hearing aid dealer can detect a medical pathology and will, when such a problem is noted, immediately refer the client to a physician. This proposal flies in the face of the pattern of evidence presented to the subcommittee showing that medical referrals very often are not made by hearing aid dealers when they clearly should be made.*

In efforts paralleling those of HEW, the Federal Trade Commission proposed trade regulations for the hearing aid industry in June 1975 concerning sale of hearing aid devices. These proposed regulations would do the following:

(1) Provide that the seller must give the consumer the right to cancel his hearing aid purchase within 30 days and get most of his money back;

(2) Require that certain information be disclosed to consumers, including the fact that many persons with hearing loss will not receive any significant benefit from the use of any hearing aid; and

(3) Prohibit the use of certain terms and selling techniques which might mislead or deceive consumers.

Congressional Record, May 19, 1976, page S7496.

FTC is currently conducting public hearings on these proposed changes.

VII. PROGRESS ON ERISA

A report by the Department of Labor on the operations of the Employee Retirement Income Act (ERISA)[49] appears in appendix 2, item 8 of this report. After describing the two major operating divisions of ERISA, the Department statement report concludes:

> While much more remains to be done in implementing ERISA, the bicentennial year will be especially significant to many thousands of Americans in private retirement plans as the vesting and related minimum standards provisions of the law become effective and create new rights to retirement income. The Department of Labor will continue to issue regulations and interpretations during 1976, and will also accelerate its enforcement efforts.

The Department of Labor is also continuing its review of terminations of pension plans, a matter which raised some concern during 1975. (See, for example, an article, "Backing Out of Private Pensions," in the *New York Times* on February 8, 1976).

Responding to comments made in that article and elsewhere, Senator Harrison A. Williams, chairman of the Senate Committee on Labor and Public Welfare, and Senator Jacob Javits, ranking Republican member on that committee, wrote an article which appeared in the *New York Times* of February 29. About terminations, they wrote:

> In 1973, the year prior to the enactment of the reform law, 4,130 pension plans were terminated, according to Employee Benefit Plan Review, a pension industry publication. While precise figures for 1974 are not available because of the changes in bureaucratic administration, we do know that the number of terminations in 1975 was smaller than the 5,000 that is commonly cited by the critics and was initially reported by the Pension Benefit Guaranty Corporation, the new Federal agency created by ERISA to insure private pension plans.
>
> In fact, administrative errors inflated the number of terminations last year. Those errors included double counting, mistaken filings and other mistakes that accounted for more than 700 false terminations.
>
> While less than 1 percent of the 600,000 pension plans affected by ERISA in 1975 were terminated, more than 33,000 applications for new pension plans were received by the Internal Revenue Service during the same period. It must be noted that the terminations of 1975 occurred during the longest and deepest of the post-war recessions.
>
> During recent hearings held jointly by the Senate Small Business and Finance Committees to investigate the causes

[49] Also commonly called the Pension Reform Act of 1974 (Public Law 93–406, signed September 2, 1974). ERISA was the product of 3 years of intensive action by the Subcommittee on Labor, Senate Committee on Labor and Public Welfare.

of terminations in 1975, Internal Revenue Service and Pension Guaranty Corporation officials testified that their studies indicate the vast number of pension terminations were caused by business mergers, the substitution and establishment of new pension plans, and the recession.

Bureaucratic burdens created by the initial administration of ERISA were not cited as an important cause.

They concluded:

> As we review the current outcry from pension reform critics, Congress must be careful not to let any controversy over regulations and administrative requirements serve as a smokescreen for those who would reverse the course of pension reform.
>
> We are concerned that ERISA be administered and enforced efficiently and effectively by the executive branch. And we do not condone the executive department's delay in promulgating regulations and exemption procedures in order to provide pension plans with appropriate guidance and administrative relief.
>
> But we should not conclude that criticism of administrative procedure warrants cutting back on the essential protection provided to the 35 million American workers for whom these reforms were intended.

VIII. UPDATE ON REVENUE SHARING

It is probable that an extension of general revenue sharing, the program of "no strings" fiscal assistance to units of local and State government, will be passed by the Congress early this year. The current program is due to expire at the end of 1976, and it has received widespread support from local and State governments. Revenue sharing's actual and potential impact on programs and services for older Americans, however, is still very much in doubt.

In last year's report on *Developments in Aging*,[50] examples of innovative and successful efforts at the local level to obtain revenue sharing funds for use in programs and services for older Americans were cited. The total amount of revenue sharing funds actually being spent on social services and aging-related programs, however, was very small during the early stages of the program, and there is little indication that this situation is changing.

As William R. Hutton, executive director of the National Council of Senior Citizens, concluded in testimony presented to the House Select Committee on Aging in November 1975:

> There are currently a number of studies underway which will provide further documentation of the efficacy of general revenue sharing. The data that is available now is often conflicting and inconclusive. One fact, however, is not in serious dispute: Older Americans are not receiving their fair share of

[50] *Developments in Aging: 1974 and January-April 1975*, a report of the Special Committee on Aging, U.S. Senate. Report No. 94–250, June 24, 1975.

programs and services supported by general revenue sharing funds.[51]

It is virtually impossible to accurately determine how much general revenue sharing money is being used specifically for aging-related purposes. Current reporting procedures are keyed to eight priority categories, one of which is social services for the poor or aged. Expenditures on services for the aged are not separated. To add to the confusion, money reported spent in other categories, such as health or transportation, may or may not reflect some support for aging-related programs.

A. Reports on Use of Funds

However, the first reports of actual use of revenue sharing funds issued by the Office of Revenue Sharing [52] showed less than 3 percent of total allocations had been used for social services for the poor and the aged together through June 30, 1973.

The most recent report on actual expenditure of general revenue sharing funds covering the period July 1, 1974, through June 30, 1975, showed that the priority given to services for the elderly by State and local units of government has not changed; it is even less. Only 2 percent of the total funds were spent for social services for the poor or the aged.[53]

An earlier, more detailed analysis of actual spending by 219 local governments solely on programs and services for older Americans was provided by the General Accounting Office at the request of Representative Claude Pepper of Florida. A GAO letter of February 13, 1974, to Representative Pepper provided the information that only 28 of the 219 governments authorized the expenditure of part of their revenue sharing funds in programs or activities specifically and exclusively for the benefit of the elderly. These authorizations totaled about $2.9 million, or about two-tenths of 1 percent of the total funds authorized by the 219 governments.

In testimony to the House Select Committee on Aging in late 1975, Treasury General Counsel Richard R. Albrecht pointed to what he called the success that State and area agencies on aging had had in utilizing revenue sharing funds allotted to them between July 1, 1974, and February 28, 1975.[54] During this period, he claimed, local advocacy activities had resulted in $6,083,293 of general revenue sharing funds being directed toward programs for the aging. This represents, however, only about eight one-hundredths of 1 percent of the more than $7 billion of general revenue sharing funds spent by State and local

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[51] *Government's Response to the Elderly*, hearing before the Select Committee on Aging. House of Representatives. November 18, 1975. One of the studies underway, funded by the Administration on Aging, is an attempt to develop a strategy for increasing the proportion of revenue sharing funds which are allocated to programing for the elderly by: (1) Identifying where and how revenue sharing money is now going for elderly programs; and (2) identifying where changes in strategy may increase present allocations. A preliminary report, *Revenue Sharing and the Elderly: A Case Study and Analysis of the Literature*, prepared for the Administration on Aging by Kappa Systems, Inc., Arlington, Va., December 22, 1975, notes that all past research efforts have concluded that it is an extraordinarily difficult task to document the fiscal impact of general revenue sharing on any particular target group.

[52] *General Revenue Sharing—The First Actual Use Reports*, issued by the Office of Revenue Sharing, Department of the Treasury.

[53] *Reported Uses of General Revenue Sharing Funds 1974-1975*, issued by the Office of Revenue Sharing, Department of the Treasury.

[54] Report cited in footnote 51.

governments on services and facilities for their citizens during the full period of July 1, 1974, through June 30, 1975.[55]

Our older Americans are still clearly not getting their fair share. Americans over 65 represent 10 percent of the population and 28 percent of Americans living below the poverty level.

B. Proposals To Increase Share for Aging

A number of proposals have been offered to increase the share of these funds for social services and, specifically, for programs and services for older Americans.[56]

Last year's report on *Developments in Aging* [57] suggested two alternative routes that the Congress could take to achieve more equitable distribution of general revenue sharing funds to benefit older Americans: To seek greater safeguards actually assuring earmarking of funds for the elderly under revenue sharing; or to encourage more aggressive action at the local level in channeling funds for such purposes.

As considerations of change in general revenue sharing advance, it appears unlikely that an extension of the program will contain any provision for setting aside revenue sharing funds for specific purposes, including programs and services for older Americans. It is more likely that an extended program will contain provisions to encourage more aggressive action at the local level.

C. Citizen Participation

Somewhat stricter local reporting procedures and other measures to encourage greater citizen participation in determining spending priorities for revenue sharing funds, if adopted, may serve to encourage more aggressive action by local aging groups in this decisionmaking process. But the history of citizen participation in determining how revenue sharing funds are to be spent has been poor. In its report to the Senate Subcommittee on Inter-Governmental Relations in July 1975, the GAO found that

> . . . a few local governments made a special effort to encourage the public to help decide how the (revenue sharing) funds should be used. However, public participation in most of the governments' budgetary processes did not change but remained at the same low level that existed prior to revenue sharing.[58]

Later, Elmer B. Staats, the Comptroller General of the United States, recommended to a House committee [59] that renewal of the rev-

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[55] *Case Studies of Revenue Sharing in 26 Local Governments,* report to the Subcommittee on Intergovernmental Relations, Committee on Government Operations, U.S. Senate, by the Comptroller General of the United States (GGD–75–77, July 21, 1975).

[56] In addition to the proposals for stronger citizen participation and elimination of matching prohibitions discussed here, Congress has considered proposals to require minimum spending in key priority areas, including social services and housing for the elderly; to rewrite the allocation formula, insuring that more funds are channeled to larger cities which are home for the greatest numbers of elderly poor; and to strengthen civil rights enforcement and add a prohibition against age discrimination in the use of funds.

[57] Report cited in footnote 50.

[58] Report cited in footnote 55.

[59] Report cited in footnote 51.

enue sharing program should require full reporting of fund use and provide a full and wide opportunity for local citizen participation and recommendations.

D. Matching Requirements

Another change being considered is elimination of the current prohibition on use of revenue sharing funds as part of the local share of matching funds for Federal categorical or block grants. Most of the current federally funded programs for the elderly require local matching funds, and the removal of this restriction could have the effect of providing another source of partial funding for these programs.

If adopted, both of these changes could help; but requirements for increased citizen participation and removal of the matching prohibition will not insure more equitable treatment for older Americans. Gaining access to revenue sharing funds will still require skillful, well-informed efforts at the local levels.

E. Questions for the Future

—Will State and area agencies on aging and local senior citizen organizations be able to successfully advocate for a fairer share for older Americans? There are a number of notable exceptions at the local level, but the experience to date does not suggest an optimistic answer.

—Will continuation of the general revenue sharing program have the effect of reducing funding levels for other federally funded programs? The evidence to date is mixed. Many critics of the program insist that this is the case. In a recent survey of State units on aging conducted by the Committee on Aging, about half of the 41 States reporting had no overall budget increases within the last 3 years.

In extending the Revenue Sharing Act, Congress should give special attention to incorporating strong provisions for citizen participation in the local decisionmaking process and provide for greater accountability in reporting procedures.

If funds for services for older Americans are not specifically set aside, then an extension of the general revenue sharing program should provide for reporting procedures which will allow determination of actual spending on programs for older Americans. Without this information, the questions cannot be answered.

IX. OLDER AMERICANS IN RURAL AREAS

A continuing drawback to the effectiveness of the Older Americans Act is insufficient financial support to serve all of the potential elderly participants. State offices on aging are continuously faced with having to choose "target areas" within their boundaries for aging programs. Often, major areas of the States are left relatively unserved. Frequently such areas are located in the rural territories of the States.

As pointed out by the first National Conference on Rural America, rural counties across the country have witnessed a steady decline in their number of services programs for all age groups—transportation, health, housing, and employment among them. With the steady flow

of the population to the urban areas, the rural areas have less and less population on which to base a claim for increased Federal assistance.

Approximately 5.4 million elderly reside in predominantly rural areas. According to the National Farmers Union,[60] 33 percent of the rural elderly live in poverty. In addition, 60 percent of all substandard housing is in rural areas and 25 percent of these substandard occupancies are lived in by elderly. From this description, it would appear that they would be the prime candidates for services made possible by the Older Americans Act. However, their geographical dispersion works against them.

A. The Older Americans Act: Does It Serve the Rural Elderly?

In hearings before the Senate Committee on Aging in April 1975, elderly service providers testified about the Older Americans Act's effectiveness in rural America. State directors, area agency personnel, and title VII project directors all agreed that the act could be significantly improved to reach the rural elderly resident.

Mary Ellen Lloyd, director of a title VII project in Christianburg, Va., pointed out that:

> Our (meals-on-wheels) program is reaching approximately 575 elderly persons a month with transportation, a nutritious meal, fun and fellowship, and other essential services. However, this comprises only 4 percent of the elderly in our planning district. We could reach many more, both on site and homebound, if more funds were available for food, transportation, and outreach workers.

Further improvements for the act were recommended by South Carolina's executive director of the commission on aging, Harry Bryan, when he stated that rural areas could be helped considerably "by mandating that the matching ratio for Older Americans Act funds be the same in areas not having an area agency on aging as it is in areas that do, that is, 90–10. Let's eliminate this particular discrimination."

Other witnesses concurred with Mr. Bryan's recommendation by stating that rural areas must often turn down services because of their inability to come up with their matching share.

Elizabeth Myers, director of the Georgia Mountain Area Program on Aging, said:

> It is urgently recommended, by all that I have talked to in rural areas throughout the Nation, that title III funding to established area agencies on aging be sustained at a level commensurate with the financial facts of our existence.

The hearing clearly showed that the practitioners view lack of funds and lack of State administrative flexibility as two of the major obstacles to an effective service system for the rural elderly.

B. Congressional Action

As a part of his comprehensive bill to amend and extend the Older Americans Act, Senator Frank Church emphasized the needs of the

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[60] In testimony before the Senate Committee on Aging, "The Older Americans Act and the Rural Elderly," April 28, 1975.

rural elderly. S. 1426 would have provided for the States to give emphasis to their rural areas by including language in section 308 of title III (model projects) which would provide for demonstration projects to improve the delivery of services and meet the special needs of the rural elderly. Senator Dick Clark introduced amendments which placed additional emphasis on the rural elderly resident under all service titles of the Older Americans Act.

The final Senate bill [61] included language which required that the relative distribution of older persons residing in urban and rural areas must be taken into account in developing and implementing title III (grants for State and community programs on aging) and title VII (nutrition program for the elderly). However, the House of Representatives bill (H.R. 3922) included no such language. A House-Senate conference committee then agreed upon a provision similar to the original language offered by Senator Church. The agreement read that the Commissioner shall give special consideration to projects designed to "meet the special needs of, and improve the delivery of, services under provisions of this act, with emphasis on the needs of low-income, minority, Indian, and limited-English speaking individuals, and the rural elderly." [62]

C. Increased Appropriations

With the congressional support of increased funds for title III and the administration's release of additional title VII funds,[63] it is possible that the States will receive significant increases for their aging services programs. The Administration on Aging specifically directed the States "that expansion of existing projects should be based on outreach activities designed to make sure that low income and minority persons within the project area who are oftentimes isolated and cut off from society, know about the program and have been given an opportunity to participate in it." [64] It is also projected that such increases be used by the States to develop and expand projects in those areas where few services are now available.

Such increases will enhance the Older Americans Act's capability to serve the rural elderly and enable the States to develop comprehensive service delivery systems in all areas of their boundaries.

X. ACTIONS RELATED TO MINORITY CONCERNS

Recent social security increases, the advent of the supplemental security income program, and improvements in other Federal income maintenance programs have helped considerably to improve the economic well-being of all older Americans.

But economic progress still tends to lag for minority aged groups: elderly blacks, the Spanish-speaking, American Indians, and Asian-Americans. And in some respects, the minority aged are worse off than in 1970 in comparison with elderly anglos.

At that time, the likelihood of being poor was almost twice as great for the minority aged. A 1975 Bureau of the Census survey

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[61] S. 1425 (H.R. 3922), approved by the Senate on June 26, 1975.
[62] Public Law 94–135, Older American Amendments of 1975, signed into law on November 28, 1975.
[63] For a detailed discussion of increased funding for titles III and VII, see chapter I, pages 3 and 7.
[64] Program Instruction, Administration on Aging (AoA–P1–76–14), March 27, 1976.

(based upon 1974 income) revealed that the minority aged are now 2.4 times as likely to be poor than other older Americans.

However, poverty has declined sharply for minority groups. In 1970, approximately 45 percent of the minority elderly lived in poverty. Latest census information discloses that about one out of every three (33.6 percent) minority elderly is poor.[65] The number living in poverty has also declined, from about 940,000 to 782,000. During this same period the total minority aged population has increased by 250,000, from 2,078,000 to 2,328,000. The net impact is that over 400,000 minority aged have escaped from poverty.

POVERTY BY RULE AMONG PERSONS 65 OR OLDER IN 1974

Minority aged	Number	Percent	Poor	Percent poor
Total aged	21,127,000	100.0	3,308,000	15.7
White [1]	19,206,000	90.9	2,642,000	13.8
Black	1,722,000	8.2	626,000	36.4
Spanish Speaking	407,000	1.9	116,000	28.5
Other races	199,000	.9	40,000	20.1
Total minority	2,328,000	11	782,000	33.6

Note: All figures based on current population survey data of March 1975.
Source: Bureau of the Census.

[1] Some Spanish-speaking elderly are included.

A. Administrative and Legislative Developments

Several legislative and administrative developments occurred in 1975 which offer the prospect of improving conditions for elderly members of minority groups. Other actions may provide vital information to facilitate systematic problem solving efforts. The need for information cannot be overstated because much of what now exists is outdated, incomplete, or simply inaccurate. And in far too many cases data are not available. Until this information gap is closed, it will continue to be difficult—if not impossible—to develop comprehensive and sound national policies to respond to the minority aged's pressing problems.

B. AoA Agreement To Assist Elderly Indians

On September 17, the Administration on Aging entered into a working agreement with the Office of Native American Programs designed to improve living conditions for elderly American Indians. The study would involve a four-prong approach to:

(1) Expand knowledge about the living conditions and needs of aged Indians and test alternatives for meeting these needs.

(2) Heighten awareness of the cultural needs and problems faced by older Indians, especially by governmental agencies with resources to serve this group.

(3) Increase the involvement of Indian tribes and organizations in the development of policy, planning, and programing for older Indians at all levels of government.

(4) Expand government resources to serve the needs of elderly Indians and increase the number of Indian tribes and organizations

[65] The official poverty threshold (on a weighted basis) is $2,352 for an individual aged 65 or older and $2,958 for a two-person family with a head aged 65 or older.

receiving funds directly for purposes of providing services for the aged.

American Indians account for about 0.4 percent of the total U.S. population. But the background paper to the "Statement of Understanding Concerning Improvement of Services to Elderly American Indians," points out:

> By any social or economic indicator commonly used to reflect conditions under which the people live, American Indians frequently fall into the lowest of categories.[66]

C. Asociacion Nacional Pro Personas Mayores

In addition, AoA awarded a model projects grant to Asociacion Nacional Pro Personas Mayores. The asociacion was legally incorporated on April 28, 1975 after considerable planning and organizing by Hispanic professionals, paraprofessionals, and senior citizens.

A major objective of the model project is to encourage greater participation by the Hispanic elderly in title III programs. The Asociacion plans to establish a national clearinghouse component to collect and disseminate information to service providers and area agencies on aging.

D. The National Conference of the Spanish-Speaking Elderly

Another important event was the first National Conference on the Spanish-Speaking Elderly which was held in Kansas City, Mo., from March 4 to 7, 1975. Over 300 persons throughout the Nation gathered to exchange program and legislative information relating to the Older Americans Act. This national conference was the outgrowth of the first statewide training conference held in Kansas in May 1973.

E. National Center on the Black Aged

The National Center on the Black Aged received funds under title X (job opportunities program) of the Public Works and Economic Development Act to provide jobs for the unemployed, particularly for the older black worker. The project is designed to provide escort and security services for senior citizens.

NCBA also testified before congressional units on issues of direct concern to aged blacks. Dr. Aaron Henry, president of the National Center on Black Aged, Inc., for example, testified before the Subcommittee on Housing for the Elderly of the Senate Committee on Aging on regulations implementing the section 202 housing program. He expressed support for the administration's proposed regulations to limit section 202 projects to 300 units, giving this rationale:

> . . . NCBA is primarily concerned that blacks and other minorities have the opportunity to develop, plan, own, and manage their own housing projects. Some members of the coalition believe that it is sufficient to provide housing units for minorities in housing projects that others own and manage. The reason NCBA believes that minorities should own and manage

[66] *Aging*, Nov. -Dec. 1975, Nos. 253–4, p. 3. One additional action taken by AoA was to join in sponsoring, with the National Tribal Chairmen's Association, a National Indian Conference on Aging in Phoenix, Ariz., June 15–17, 1976.

their housing projects, as explained in detail in our comments of June 13, 1975, is that NCBA wants to assure that minorities benefit economically from all aspects of housing and not just be given an apartment in which to live. Therefore, we have concluded that the proposed 300 unit restriction or some alternative method would be useful in order to prevent other established organizations from monopolizing housing opportunities for minorities.[67]

F. University of Michigan-Wayne State University Title IV Grant

Two preliminary manuscripts for practitioners working with minority older persons were prepared on elderly blacks and the Spanish-speaking aged under a title IV training grant to the University of Michigan-Wayne State University.

The 1974 Michigan Comprehensive Plan on Aging surveyed elderly Michigan residents to identify the major problems confronting the elderly. Aged blacks listed their five major difficulties as (1) income, (2) health, (3) crime, (4) nutrition and transportation (tied), and (5) housing. Nearly two out of three elderly blacks (68 percent) identified income as a serious problem. In contrast, 35 percent of elderly whites considered income to be a major problem.

Health also ranked high on the list; 65 percent of elderly Michigan blacks identified health as a serious problem. The preliminary manuscript gave this assessment:

> Too frequently the minority person may lack the money to pay the deductible so that he or she can utilize the medicare plan. Insufficient income results also in few visits to the doctor and less followthrough with prescribed medications. In addition to those facts, the black elderly often are victims of poor service from the medical profession. It appears that most doctors would prefer to treat the young or middle aged white woman than the older black woman, even though the black elderly appear to encounter more serious health problems.[68]

Inadequate income also intensifies other major problems of the minority aged: transportation, nutrition, and housing.

The preliminary manuscript[69] on the Spanish-speaking elderly pointed out that the elderly constitute a much smaller proportion of the Hispanic population than among anglos. Persons 65 or older, for example, account for only about 4 percent of the total Mexican-Americans population and 2 percent of all Puerto Ricans living in the United States. Several reasons were cited, including:

(1) Most recent Spanish-speaking persons immigrating to the United States are young; few are elderly.

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[67] "Examination of Proposed Section 202 Housing Regulations," hearing before the Subcommittee on Housing for the Elderly of the U.S. Senate Special Committee on Aging, part 2, Washington, D.C., June 26, 1975, page 117.

[68] "Manuscript A: The Black Elderly," prepared by Joseph Dancy, Jr., for the Institute of Gerontology, the University of Michigan-Wayne State University, with the assistance of title IV–A grant from the Michigan Office of Services to the Aging, pages 40–1.

[69] "Manuscript B: The Spanish-Speaking Elderly," prepared by Armando Rivas for the Institute of Gerontology, the University of Michigan-Wayne State University, with the assistance of a title IV–A grant from the Michigan Office of Services to the Aging.

(2) Some Mexican-Americans choose to return to Mexico after they become older.

(3) The higher incidence of poverty among Spanish-speaking persons may lead to ill health and inadequate health care.

(4) The life expectancy for Spanish-speaking persons is considerably lower than among anglos.

The manuscript also reported that a substantially smaller percentage of Spanish-speaking families receive social security benefits than among anglo families. Among the reasons cited:

(1) Many Spanish-speaking persons were not working in covered employment (e.g., farm labor) until several years after social security became law.

(2) Some Hispanic aged are unfamiliar with social security or other Federal income maintenance programs.

(3) Employers have not reported social security wage credits, even when Spanish-speaking individuals worked in covered employment.

G. Legislative Developments

Several measures (already described in other chapters and sections of this chapter) were acted upon in 1975 and early 1976 with potentially important implications for elderly minority groups.

The Older Americans Amendments of 1975 (Public Law 94–135) for example, authorizes the Commissioner on Aging to fund Indian tribes directly under title III, provided he determines that (1) Indian tribe members are not receiving benefits equivalent to other older persons in the State, and (2) they would be better served through direct funding. The listing of priority services for funding under the section 308 model projects program was expanded to include improvements in the delivery of services for low-income, minority, Indian, and limited English-speaking individuals.

Nearly 34 million social security, railroad retiree, and supplemental security income beneficiaries received a one-shot $50 payment ($100 for couples) under the Tax Reduction Act of 1975 (Public Law 94–12). This special payment provided an additional $1.7 billion for these individuals. The one-shot payment is nontaxable and is disregarded in determining eligibility for any public assistance program.

Social security beneficiaries also received an 8 percent cost-of-living adjustment in July under the automatic escalator provision initially enacted in July 1972 (for further details see chapter III, pages 64–66). The Federal SSI income standards also rose by 8 percent—from $146 to $157.70 a month for qualifying individuals and from $219 to $236.60 a month for eligible couples—since the SSI escalator provision is pegged to the social security cost-of-living adjustment mechanism.

Food stamp eligibility was extended for 1 year (through June 30, 1976) under Public Law 94–44.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

As a group, older Americans share many common concerns; but these problems—such as inadequate income, failing health, malnutrition, transportation difficulties, inflation, and others—are frequently much more intense among elderly members of minority groups.

Nowhere is this more evident than in the area of income. Nearly one out of three elderly members of minority groups lives in poverty. Additionally, many are marginally poor. In sharp contrast, one out of seven aged whites is classified as poor under Bureau of the Census definitions.

The Older Americans Act and the Older American Community Service Employment Act have been helpful in responding to the special needs of the minority aged. The minority elderly receive about 44 percent of the gap-filling services under the title III State and community programs on aging and 21 percent of the supportive services. Almost one-fourth (23 percent) of all participants in the title VII nutrition program for the elderly are members of minority groups. And one-third (32.8 percent) of older workers in the title IX senior community service employment program are minority aged members.

Several actions are needed to provide dignity and retirement security for elderly minority members.

The Committee on Aging plans to devote special attention to their needs during hearings on "Future Directions in Social Security." The committee will also explore several alternatives to provide job opportunities for aged and aging minority members.

The committee further recommends that the following actions be taken:

—The income standards under the SSI program should be raised to a level to abolish poverty once and for all for all older Americans.

—The Administration on Aging should take prompt steps to implement the provision authorizing direct funding of Indian tribes under the Older Americans Act. In addition, AoA should make funds available to improve the delivery of services for the minority aged under the section 308 model projects program.

—The Department of Labor should make funds available for the National Center on the Black Aged, as well as other minority groups, to finance a senior community service employment program.

—Federal agencies should improve outreach efforts to seek out and find isolated elderly members of minority groups who are eligible for Federal benefit programs.

—The Administration on Aging should work with other Federal agencies to improve the accuracy and availability of information about aged members of minority groups.

XI. ADVANCES FOR SENIOR CENTERS

Congress recognized the present and potential value of senior centers when it wrote in a new title V into the Older Americans Act Amendments of 1973.

That new title, "in order to provide a focal point in communities for the development and delivery of social services and nutritional serv-

ices designed primarily for older persons," authorized the Commissioner of Aging to:

. . . Make grants to units of general purpose local government or other public or nonprofit private agencies or organizations and . . . make contracts with any private agencies or organizations and . . . make contracts with any agency or organization to pay not to exceed 75 per centum of the cost of acquiring, altering, or renovating existing facilities to serve as multipurpose senior centers (including the initial equipment of such facilities).

But even though authority for such appropriations existed, the administration did not request, and the Congress did not allot, any funds for title V purposes during 1974 and 1975. In 1976, however, title V* would finally become operational as funds were approved for the transitional quarter (June 30 through September 30, 1976). (See introduction for details on appropriations.)

This funding action took place as multipurpose senior centers reached new heights in terms of numbers and services offered.

The NCOA Report: A comprehensive analysis [70] of center operations appeared in 1975 and summed up a great deal about center activities.

Discussing the growth of senior centers and clubs, the report said:

> A growing number and increasing variety of senior group programs are developing in communities throughout the United States. The first club for older persons was organized in Boston in 1870; the first senior center was established in 1943. These organizations number in the thousands today.

In an earlier survey,[71] 4,870 senior centers and clubs meeting at least once a week were listed.

The latest study says:

> From our experience, we know that these . . . programs run the gamut from complex multisite, multipurpose senior centers, meeting 6 or 7 days a week, to simple club structures meeting biweekly or monthly.
>
> The significance of senior centers in the lives of older persons was clarified by the study. Participants viewed the senior center as a program of services and activities and also as a place to go, a place to gather for friendship and fellowship, or a place to sit, observe, and just be near other people. For example, though few of the individuals interviewed had participated in specific services or activities within the past week or even month, the overwhelming majority stated they attended the center several days a week, and a substantial portion (27 percent) attended daily.

The report added:

> Contrary to common perception, today's centers serve the poor and the not-so-poor persons with less than eighth grade

*Congress, in May 1976, appropriated $5 million for title V for the July 1–Sept. 30 transitional quarter. The supplemental appropriation bill was signed on June 1, 1976.

[70] *Senior Centers, Report of Senior Group Programs in America.* Prepared by the National Institute of Senior Centers, a program of the National Council on the Aging, Inc., under an Administration on Aging grant, December 1975.

[71] *Directory of Senior Centers and Clubs: A National Resource,* National Council on the Aging, 1974.

educations plus those with graduate degrees: retired blue-collar workers as well as older professionals and persons of various ethnic and racial backgrounds.

Additional Developments: Another indicator of the growth of senior centers was an announcement [72] from Los Angeles Mayor Tom Bradley this year that nearly a dozen "one-stop" senior citizens model multipurpose centers were to open during late March and April.

"At last," said the Mayor, "we're able to offer a city-wide one-stop center program to the senior citizens of Los Angeles. This will eliminate the need for senior citizens to travel to a dozen places for a dozen different services."

Funded through the local area agency on aging, the program will offer these services: information and referral, health screening, transportation, recreation, services for the homebound, nutrition counseling, hot meals in many cases, food services, buyers clubs, education, legal aid, volunteer services, and social action services. Center sites include churches and storefronts.

Another Los Angeles center was established by the Andrus Gerontology Center which will offer, with the help of a foundation grant, free services to all senior residents of the community surrounding the University of Southern California, at which the center is located. Among those programs planned or in service are: adult counseling, legal services, geriatric screening and evaluation, day care to enable the older adults to bring children to the center, an exercise physiology program, and a weekly nutrition program.[73] (For additional discussion of senior centers, see chapter I, part VII.)

FINDINGS AND RECOMMENDATIONS

Multipurpose senior centers already are making a major contribution toward the development of badly needed services for many older Americans, and—with funding through title V of the Older Americans Act—can make an even greater one.

Intensive efforts should be made, from the very beginning of title V funding, to: (1) Recognize the independent and proud tradition of centers, many of which were established before there was an Older Americans Act and which also have won support of many of their activities through private means (this can be done only through sensitive and understanding appreciation of the unique place that existing centers already have in many communities); (2) make every effort to link center activities to ongoing planning and coordination efforts of area agencies on aging and State offices on aging, also supported in part by the Older Americans Act; (3) evaluate the range of services made possible through title V funding, and the numbers of people enrolled through outreach or other measures to reach the low-income and isolated elderly; and (4) assure close communication between Federal officials responsible for funding under title V of the Older Americans Act and title XX of the Social Security Act.

[72] Press Release from the Office of the Mayor, March 26, 1976.
[73] From "Gerontology Topics," newsletter, Andrus Center, March 1976.

XII. PARTICIPATION BY OLDER AMERICANS IN PROGRAMS ON AGING

What is the appropriate role of older persons in programs meant to serve them? Are they to be active, but often unheeded, members of advisory units? Are they to be paid employees who influence or even direct those programs? What is the proper mix between "consumer input" on one hand and the policymaking responsibilities of professional staff members, many of whom are relatively young and of whom have received formal training in gerontology and management of public programs.

Those questions were among those discussed at a symposium [74] planned in response to growing concern about citizen participation in federally assisted programs on aging.

One of the participants, Gray Panther convenor Margaret Kuhn, expressed deep dissatisfaction with present requirements and practices in such programs. She called for greater self-direction by older Americans.

Among the other points made:

W. Ray Smith of the Denver Regional Office for Administration on Aging programs said the critical issue "revolves around advisory councils as advisory bodies versus policymaking bodies" in Older Americans Act programs.

He added:

> The regulations governing the functions of advisory councils to State and area agencies on aging are not specific as to function and responsibility. The Older Americans Act of 1965, as amended, under title III and VII requires that both State agencies on aging and area agencies on aging, and nutrition programs establish advisory councils and project councils respectively to assure citizens input.

Mr. Smith said that additional research is needed to analyze the role of such units throughout the United States, but that in the six States of his region:

> The degree of success of impact of advisory councils of a State or area agency on aging or nutrition project is restricted by several factors: the Administration on Aging's undefined policy relating to the functions of advisory groups, staff attitude toward advisory council members, lack of knowledge on proper utilization of advisory councils, and the administration location of the area agency on aging or a nutrition project at the local level . . . (for example) When an area agency is located within a Council of Governments structure, a nonelected governmental body made up of locally elected officials within a geographic region of a State, then the advisory council of the area agency becomes simply another advisory body to the Council of Governments. . . . This limited advisory role meets the requirements of the Administration on Aging; however, in order for older people

[74] "Self-Determination by the Elderly on Programs Meant to Serve Them," October 29, 1975, at 28th Annual Scientific Meeting of the Gerontological Society.

to have some degree of control over programs affecting their lives, councils must be involved in policy decisions.

He added that South Dakota had established an advisory council in 1973 which, "as a policymaking council," had developed "an excellent record in not only fulfilling the regulations of the Older Americans Act, but in directly answering the needs of the local communities throughout the State."

But Mr. Smith also said that the Administration on Aging had taken the position that the Executive order which established the council must be revised "to limit their role to strictly that of an advisory body." He asked for "legislation and regulations . . . that would allow and insist that older persons on advisory councils be allowed to make policy decisions in programs designed to benefit the older population."

Carroll L. Estes, Ph. D., associate professor of sociology at the University of California in San Francisco and a member of the California Commission on Aging, said the issue of self-determination extends far beyond Older Americans Act programs.

She said:

> For example, new federalism programs created under general and special revenue sharing enactments provide an opportunity for participatory roles (and perhaps even some degree of self-determination) for older persons "if they play their cards right." However, these new federalism enactments also provide the distinct *possibility* (and probability) that *no such participatory roles will be forthcoming for older persons.*

Dr. Estes said also that the role of the older person in Older Americans Act programs is likely to be confined to "citizen involvement" as opposed to "citizen action." She described the AoA interpretation of the South Dakota advisory council's responsibilities as "devastatingly narrow" and also criticized policy ambiguities in present policy on the rights and responsibilities of older persons in advisory roles, and also on criteria used to name members of such units. She also said:

> If one believes in the principle and merit of self-determination by the elderly, what is called for is a national policy and commitment to meaningful citizen involvement in all programs which affect older persons—beginning with employment and including legislative mandates for (and specification through Federal regulation of) an *action role* for older persons which includes (but is not limited to) assuring the representation and participation of those most affected by the "condition" and problems of aging, while also discouraging the dominance of other types of citizen participants who are involved in the enterprise for other reasons.

Kay Pell, coordinator of the Comprehensive Employment and Training Act for the State of Idaho, said that area councils in aging had a voice in determining CETA priorities and contributed to an overall emphasis on older worker hiring in other State employment programs.

Richard W. Michaud, director, Bureau of Maine's Elderly in that State's Department of Human Services, said that senior citizens in western Maine have created "a model of national significance" in dealing with the problems of the rural elderly.

He added:

> The model is a federally funded program entitled Project Independence. Its goal is to increase the independence of older people by developing social services which allow them to remain in their own homes, thus avoiding costly and often unnecessary institutionalization in hospitals and nursing homes . . . at the very beginning, the elderly had initial input into the design of what has now become a State system of advisory committees made up of older people setting priorities and public policies for senior action.

Robert Ahrens, Director of the Chicago Mayor's Office for Senior Citizens (MOSC), said that between 1,250 and 1,500 citizens serve on various MOSC committees and that "senior citizen caucuses" are held monthly in each of the five service areas within the city:

> There is discussion on any and all issues, feedback by MOSC on the questions raised at prior caucuses, and consumer evaluation of services MOSC and the city offer directly as well as those that MOSC purchases.

For the title VII nutrition program, advisory committees of senior citizen participants have been established at each of the 72 community dining sites. Mr. Ahrens gave other examples of "consumer input" and added:

> We think we now know the problems before us in achieving successful . . . citizen participation by older people. It will be some time before we find the answers to these problems if, indeed, we ever do. But we mean to try. Perhaps the real significance is in this effort.

FINDINGS AND RECOMMENDATIONS

A clear statement of Federal policy in regard to citizen participation and advisory unit functions is needed, either in legislation or through regulations. To aid toward that effort, the Administration on aging should examine what appear to be inconsistencies in practice and policy in regard to advisory body functions. Findings from this research should be shared with the Congress, with State and local area agencies on aging, with organizations on aging and with those older persons now attempting to serve on advisory councils of one kind or another.

XIII. FTC ACTIONS ON FUNERALS

As part of what is described as "a broad (Federal Trade) Commission program which is examining anticompetitive State law restraints which injure consumers," [74a] the Commission in August 1975

[74a] From Federal Trade Commission news release, August 28, 1975.

proposed new trade regulation rules affecting the funeral service industry.

The FTC said:

> Each year millions of families are forced by the death of a relative to make one of the largest consumer purchases under severe handicaps of time pressures, emotional distress, and lack of information of experience. As an FTC hearing examiner noted long ago, there are few, if any, industries where the ultimate consumer is so disadvantaged or where his normal bargaining is so diluted in a situation of such immediate need.[75]

The proposed rule would prohibit funeral directors from:

—Picking up or embalming corpses without permission from the family;

—Requiring those who opt for an immediate cremation to purchase a casket, and from refusing to make available inexpensive containers suitable for cremation;

—Profiting on cash advance items (amounts paid out by the funeral home for obituary notices, cemetery charges, flowers, and the like which are reimbursed by the family);

—Misrepresentations of the legal public health necessity for or preservative utility of embalming, caskets or burial vaults;

—Untruthful and unsubstantiated claims of watertightness or airtightness of caskets and burial vaults;

—Bait-and-switch tactics;

—Disparagement of a consumer's concern for price;

—Restrictions or obstructions to advertising or other disclosure of price information;

—Interferences with the offering of low-cost funerals, direct cremation services or other alternative modes of disposition pre-need arrangements; and memorial society activities.

The rule would also require mortuaries to furnish to customers.

—A fact sheet about legal requirements for embalming, caskets and burial vaults;

—A casket price list;

—An itemized list of prices for the services and merchandise offered for sale, with conspicuous disclosure of the consumer's right to select only the items desired;

—A memorandum, at the time funeral arrangements are made, which records the items selected and their respective prices.

The rule also would require funeral homes which advertise to include in their advertisements a notice that price information is available and the telephone number to call to obtain such information.

The Commission has invited comments and its conducting hearings before deciding whether to adopt the regulation rule as final, when it would become legally binding.

Taking sharp exception to many of the criticisms made of present funeral home practices, the National Funeral Directors Association said in April 1976 that it had filed suit asking for a temporary re-

[75] Pages 3–4, *Funeral Industry Practices, Proposed Trade Regulation and Staff Memorandum*, Division of Special Projects, Bureau of Consumer Protection, FTC, August 1975.

straining order to enjoin the Commission from taking further action on the proposed rule.[76]

Specifically, the suit complained that funeral directors had been denied the right to present oral testimony at public hearings and that they had been denied cross-examination of other witnesses.

Another complaint was made by Thomas H. Clark, counsel for the association, at an FTC hearing in New York City. He accused the FTC of staging a prejudiced attack on the Nation's 22,000 funeral directors.[77]

Dr. Harry Wienerman, representing members of the National Retired Teachers Association and the American Association of Retired Persons in the New York and surrounding area, said at the same hearing:

> . . . our associations, since 1974, have taken a long hard look at the funeral and crematory industry. In the course of our investigation, we have obtained a great number of membership letters and expressions of interest, both pro and con. As a result, we have arrived at the following conclusions:
>
> Our members are not making informed decisions with respect to arrangements for funeral services.
>
> There is an alarming lack of information relating to this transaction.
>
> Emotionally distressing circumstances prohibit our members from making a fair and balanced purchase of a relatively costly item.

XIV. CONSUMER PRODUCT SAFETY AMENDMENT

Up for extension in 1975, the Consumer Product Safety Commission Improvements Act became the subject of an amendment intended to make that legislation more responsive to the needs of the elderly and handicapped.

Senator Frank Church offered the amendment which said:

> The Commission shall also consider the special needs of the elderly and handicapped persons to determine whether they would be adversely affected by the promulgation of any rule.

Giving his reasons for the amendment, Senator Church said he had been impressed by testimony before the Senate Committee on Aging. He said:

> That committee has taken testimony describing, sometimes in gripping detail, the waning of physical powers which quite often accompanies the aging process.
>
> At hearings on architectural barriers, for example, the committee learned of the special problems that glass partitions or doors can cause persons who have failing eyesight. Even certain colors can be misconstrued by older persons who have fairly common vision problems. Hearing loss can cause other difficulties, in buildings and in streets.
>
> It is no wonder, then, that older persons quite often retreat to their own homes in the face of an outside environment they

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[76] *Wall Street Journal*, page 13, April 15, 1976.
[77] *New York Post*, April 21, 1976, page 12.

regard as hostile. Society can fight that fear to a limited degree by designing more hospitable buildings and by recognizing the special needs of the elderly and the handicapped in other ways.

But the older or handicapped person in his own home can face hazards from the very products meant to provide convenience. An electric fan, for a person with limited vision, can be a hazard. Wall-heaters and can openers can cause difficulties. For some time now, I have also been concerned about the new "child-proof" packaging regulations ordered by the Product Safety Commission. The intent is to protect children from opening prescription drugs and swallowing potentially dangerous substances. But sometimes an older person, particularly one who has an arthritic condition, can be thwarted to the point of desperation.

I remember one particular elderly constituent of mine. This woman was ill and required medication regularly. When she could not budge the "child-proof" lid, she actually smashed the bottle with a hammer.

It is true that the Commission has made it possible for consumers to have their choice of the "child-proof" lid or a traditional one. But I think it is also true that many consumers do not know this, nor do many pharmacists. My amendment would, in effect, instruct the Commission to be more sensitive to this and other matters of special concern to the elderly.

I think my amendment will help the Commission perform its important functions more responsively and I urge its adoption.[78]

Senator Frank Moss, chairman of the Consumer Subcommittee for the Senate Committee on Commerce, accepted the amendment and said, "I think it improves the bill."

As approved by House and Senate conferees on March 11, 1976, the legislation included the Church amendment (advanced in the House by Representative John H. Heinz).

The Consumer Products Safety Commission Improvements Act became law (Public Law 94–284) on May 11, 1976.

XV. DISASTER PLANNING FOR THE ELDERLY: A STUDY[79]

No section of the Nation is immune from natural disaster. In June 1972, the Susquehanna River, fed by torrential rains of tropical storm Agnes, flooded Wilkes-Barre, Pa., and surrounding Luzerne County. (The county has a high proportion of older residents; in 1970, 19.2 percent of the population was aged 60 or over; 12.9 percent was over 65.)[80]

The disaster produced what has been described as the first societal response in the Nation's history in which the problems of the older

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[78] Page S13020, *Congressional Record*, July 18, 1975.

[79] *The Impact of a Major Natural Disaster on the Elderly and Societal Response to Their Needs, Wyoming Valley, Pa., 1972*, Department of Community Medicine, School of Medicine, University of Pennsylvania, Philadelphia, 1976, 3 volumes; final report funded through Grant No. 93–HD–57357/3–03. U.S. Department of Health, Education, and Welfare, Office of Human Development, Administration on Aging.

[80] Ibid., vol. I, page 9.

population were identified as sufficiently significant to warrant special organizational response.[81] Partly due to this unique aspect of the Wilkes-Barre experience, a study was undertaken by the University of Pennsylvania's Department of Community Medicine under a grant from the Administration on Aging (AoA).[82] The report was designed to ascertain why the elderly were singled out for special attention, and what form this increased assistance took.

A. Federal Resources for Disaster Action

More than 20 Federal agencies administering more than 100 programs provide various forms of assistance in time of disaster.[83]

At the time of the Wilkes-Barre flooding, the Office of Emergency Preparedness (OEP) was responsible for directing and coordinating all aspects of this assistance. OEP was abolished under Reorganization Plan No. 1 of 1973, and its disaster role was placed within the newly-formed Federal Disaster Assistance Administration (FDAA) in accord with the Disaster Relief Act Amendments of 1974.

FDAA is a division of the Department of Housing and Urban Development (HUD) and reports directly to the HUD Secretary, as opposed to OEP, which was within the White House. Aside from that difference, FDAA functions in almost exactly the same manner as OEP did.

When a State Governor requests a national declaration of a State emergency, FDAA conducts a damage survey and then makes its recommendation to the President. It is when the President declares the emergency that the Federal relief effort begins. FDAA determines the stricken area's needs and then makes "mission assignments" to the various Federal agencies. During an emergency, HUD becomes subordinate to and is directed by FDAA; it may receive a "mission assignment" if circumstances dictate.

The FDAA effort is orchestrated, not by the head of the regional office which serves the afflicted locale, but by an appointed Federal coordinating officer. The State government designates a similar functionary. The aim of FDAA is to direct a coordinated Federal relief effort, and the goal of that effort is to supplement State and local self-help.[84]

The Department of Health, Education, and Welfare's (HEW) disaster functions are generally limited to the reduction of health hazards. It is the Red Cross which has been designated by Congress as the Nation's dominant emergency social welfare agency.[85]

The Administration on Aging, which is part of HEW, has not been active in past disasters. The study concludes that "at best, AoA acted as a neutral intermediary providing office space and arranging for some meetings" [86] in the Wilkes-Barre emergency. At present, AoA is developing a "memo of understanding" with FDAA, under which it will develop special outreach projects and assist FDAA in identifying older victims' special needs.[87]

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[81] Ibid., vol. III, pages 7–8.
[82] Report cited in footnote 79.
[83] Ibid., vol. II, page 32.
[84] Conversation with Jean Freeze, disaster program specialist, HUD, May 7, 1976.
[85] Ibid., vol. II, page 29.
[86] Ibid., vol. III, page 27.
[87] Source cited in footnote 84.

In Wilkes-Barre, the county bureau of aging was unable to render immediate assistance; its office was under water. When it reopened at a new location it functioned as a center for receiving inquiries and directing older individuals to the agency best suited to respond to their specific need.[88]

B. The Demand for Services

The major service demand emanating from Wilkes-Barre's senior population was for "hard" benefits such as housing, loans, nursing home care, and debris removal.[89] Such "soft" items as casework, counseling, and psychotherapy was not widely requested, apparently because of a strong support network of family and friends and a high degree of resiliency and self-reliance amongst the older population. The observation was also made that public assistance was not widely utilized by the elderly population while food stamps were. This may be due to a stigma attached to welfare which apparently does not transfer to food stamps, possibly because they require a cash purchase and are disseminated in a bank rather than a welfare office.[90]

Housing: The Greatest Need.—Temporary shelter was the immediate need following the flood. As the report said:

> Particularly for the elderly, more than any other segment of the population, displacement from their homes was clearly the focal event and source of problems ensuing following the impact of the flood.[91]

This need was primarily met through mobile homes, which were provided on a rent-free basis for 1 year through the President's disaster fund. (Under reorganization legislation, the provision of temporary housing is now entrusted to HUD.)[92] The local waiver of all zoning ordinances facilitated this program; however, it was hindered in effectiveness by inadequate data resulting in constantly shifting estimates of need.[93]

Long-term, low-interest loans for the repair of disaster-damaged dwellings are provided by the Small Business Administration (SBA), part of the Department of Commerce, and by the Department of Agriculture's Farmer's Home Administration (FmHA). The bulk of the relief in this instance was provided by SBA, as FmHA's effort is directed at rural areas.[94]

The extension of aid to affected homeowners was aided by the passage of the Flood Disaster Relief Amendments of 1972. This legislation authorizes 30-year loans at 1 percent interest; principal payments are suspended for the initial 5 years for all victims whose homes sustained at least 30 percent damage or who relied on retirement or disability pensions for their income.[95] SBA regulations stipulate that "the age of any applicant will not be considered" in determining eli-

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[88] Report cited in footnote 79, vol. III, pages 36–37.
[89] Ibid., vol. III, pages 46–47, 68.
[90] Ibid., vol. III, pages 65–66.
[91] Ibid., vol. III, page 73.
[92] Source cited in footnote 84.
[93] Report cited in footnote 79, vol. III, pages 80–83.
[94] Ibid., vol. III, page 84.
[95] Ibid., vol. III, pages 15–16.

gibility.[96] While this provision enables the elderly to receive Federal benefits, the process is considerably slowed by sections of the Small Business Administration Act of 1953 which forbid SBA from disregarding its credit and lending procedures in granting disaster loans. Thus, SBA determines the borrower's credit rating, an action in direct contradiction to OEP's reading of the housing loan provisions of the Disaster Act of 1970.[97]

The study asserts that the home loan procedure in Wilkes-Barre was deficient in a number of respects. Widespread ignorance of the very existence of these attractive loans helped necessitate two deadline extensions.[98] Frequent complaints were received concerning the length of time taken to process applications, delays inherent in SBA's refusal to abandon its normal procedures. At first, SBA refused also to give any sort of priority to persons whose homes had been destroyed and who wished to obtain new housing in the same neighborhood rather than relocate. Eventually, SBA relented and began dealing with this problem on a case-by-case basis.[99]

The study asks for greater flexibility rather than radical restructuring of the loan mechanism. It states that the traditional Federal funding model (in which authority and funds flow from the national government to the States and from the State to the localities) is neither relevant or effective in such widespread emergency situations. Rather, it argues that a central, on-the-scene coordinating agency like SBA, communicating and working with banks, information centers, task forces, and redevelopment authorities, represents the most desirable solution. Finally, it notes that OEP was irrelevant to this primary disaster need; SBA had no interaction with OEP, primarily because its programs can operate even in the absence of an officially declared disaster.[100]

The Flood's Impact Upon Health Care.—Because of sufficient prior warning, very few deaths are directly attributable to the flood.[101] However, neither Civil Defense nor any other public authority took the responsibility to order the evacuation of nursing homes or other health facilities. Civil defense reported that only county officials had the necessary authority. Finally, when communications were disrupted, civil defense did advise these facilities that they should seriously consider evacuation. In all but one instance that course was taken and safely implemented, with patients transferred to temporary quarters or to facilities outside the flood area. The one nursing home that chose not to evacuate at once operated for several days without sanitary supplies or electricity, with 5 feet of water covering the first floor, and with waste disposal effected by tossing plastic bags of excrement into the surrounding waters. Further, the potential for gas line rupture and explosion was ever-present for the home's 150 charges.[102] It appears that this 5-day delay in evacuation resulted in abnormally high death rates for these patients in the months following the flood.[103]

Aside from the flooding of nursing homes, hospitals, and physicians' offices, older persons were affected by the loss of drugs, medical records,

[96] Ibid., vol. III, page 85.
[97] Ibid., vol. II, pages 37–38.
[98] Ibid., vol. II, pages 37–38.
[99] Ibid., vol. III, page 116.
[100] Ibid., vol. III, pages 130–132.
[101] Ibid., vol III, page 139.
[102] Ibid., vol. III, pages 142–143.
[103] Ibid., vol. III, page 149.

and pharmacies. Although many of these persons were not certain of what medications they were taking, in what dosage, or for what disease, the situation appears to have been dealt with successfully by immediate diagnostic measures taken in the emergency health care facilities.[104]

Longer-term effects of the disaster were an increase above the norm in the number of deaths due to heart disease in the subsequent 4 months,[105] and some mental trauma. This psychological damage seems to have been contained at a low level through the traditional support of friends and family and the counseling efforts of numerous paraprofessional aides.[106]

Summing up on health issues, the report declares:

> One would have to conclude that the health care system was extraordinarily resilient, both as a whole and in terms of its component parts. Hospital service was relatively uninterrupted in the valley. To be sure fewer elective procedures were carried out, but essential functions proceeded smoothly as they had before. A steady state returned to the health care system within 100 days with perhaps the singular exception of the nursing home bed shortage. However, in some ways that was not significantly unlike that which had existed prior to the flood.[107]

This resilience was due largely to county and State efforts; HEW did not respond to requests in meeting the nursing home and community care needs of the elderly.[108]

C. The Special Federal Interest in Elderly Flood Victims

Two question arise: (1) Why did this situation receive special treatment, and (2) what form did this effort take?

The "why" cannot be ascribed to any demands emanating from the older population, as this simply did not occur. In fact, its existence would have been surprising considering the overall disorganization and disorientation following the flood.[109] Rather, the unique situation arose from the interest of two key advocates with access to the Governor of Pennsylvania and the President. These advocates were Robert Benedict, the newly appointed head of Pennsylvania's Bureau of Services for the Aging, and Frank Carlucci, President Nixon's personal representative and flood relief coordinator, and a native of Wilkes-Barre.[110]

The official form of the special Federal effort was the President's Task Force on Aging. This organization, headed by Ms. Alice McFadden, enjoyed a special kind of power because she was a member of the staff of the flood relief coordinator.[111] Ms. McFadden presided over a group of both paid and volunteer workers and functioned as an advocate for the elderly in daily meetings chaired by Carlucci and attended by all involved Federal agencies. The task force identified

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[104] Ibid., vol. III, pages 137, 139.
[105] Ibid., vol. III, pages 140–141.
[106] Ibid., vol. III, pages 153–154.
[107] Ibid., vol. III, page 156.
[108] Ibid., vol. III, page 149.
[109] Ibid., vol. III, pages 33–34.
[110] Ibid., vol. III, pages 17, 28–29.
[111] Ibid., vol. III, page 39.

elderly victims and their needs, referred them to the appropriate agency and, most importantly, followed up to assure that their problems had been dealt with. To find the older population and to determine their needs, a questionnaire was mailed to every household in the affected area,[112] under the auspices of a Project Search.

D. The Study's Conclusions

The results of the study can be paraphrased as follows: [113]

The societal response to the needs of Wilkes-Barre's elderly was massive, appropriate, and effective.

While Project Search was a dramatic innovation, "examination of the ultimate results are less impressive." Its main benefit may have been a psychological boost to the older population.

The President's task force focused attention and sensitized officials to elderly needs, but did not exercise a coordinating function.

The most effective "hard" services are provided by agencies taking on duties most similar to those they perform in nonstress periods.

The most crucial period for meeting victims' needs is the first 100 days.

OEP was unable to coordinate interagency cooperation. Moreover, the functional overlap between the coordinating agency and the service providers tended to delay and reduce assistance because of resultant ambiguity and confusion.[114] The study questions whether coordination, aside from the avoidance of service duplication, is even necessary. In Wilkes-Barre, a focal organization emerged naturally to coordinate activities within each sphere of need.

Due primarily to the support of family and friends, the elderly proved stronger and more resilient than the investigators had expected. For most, reliance on disaster-related social assistance was terminated within 6 months.

The flood had some positive aspects. Many persons were relocated to housing they found superior; community awareness was fostered; family ties were strengthened. Thirty-seven percent of the elderly felt they were "better off" after the flood.

The more vulnerable elderly (female, poorer, living alone) did not utilize social services to a greater extent than their less vulnerable peers, with the sole exception of SSI assistance.

It was neither efficient nor effective to deal with nonsurvival issues in the first week to 10 days following the calamity.

E. Improving the Federal Disaster Response for the Elderly

As noted above, reorganization has placed disaster relief coordination within the FDAA. At the disaster scene, FDAA establishes a "one-stop" center where victims can meet with representatives of all Federal agencies providing assistance. The FDAA also delineates the jurisdictions of agencies performing the same functions, such as SBA and FmHA.

No special FDAA program exists for the elderly. However, all their projects are covered by a nondiscrimination rule and every effort is

[112] Ibid., vol III, pages 38–39, 42–44.
[113] Ibid., vol. I, pages 1–45.
[114] Ibid., vol. II, page 36.

made to contact all eligible older persons. If necessary, FDAA will provide transportation and counseling. And, as mentioned, this agency is developing a working agreement with AoA which should do much to guarantee that elderly victims are not overlooked.

HUD, in its separate function as the provider of temporary shelter, designates an individual in its emergency field office to look after the needs of the elderly.[115]

The SBA still follows its normal credit approval policies; the director of their disaster operation staff asserts that the General Accounting Office (GAO) demands this. Presently, SBA loans carry a 6⅝ percent interest rate and have no forgiveness provision. However, SBA will generally allow 4–6 months to elapse from the time of disbursement to the first payment. These are 30-year loans but most, in fact, are paid back within 12 years.

SBA makes every effort to expedite the loan process. During the Wilkes-Barre situation, they requested that the Treasury Department set up a check cutter in nearby Harrisburg so that victims could receive their money on the same day as approval. In other situations a telecopier is used to speed loans up.

Another SBA option which exists for disaster aid are the section 408 welfare/disaster grants authorized by the Disaster Relief Act Amendments of 1974. While technically State grants, they are funded 75 percent by the Federal Government. These grants are available only for a Presidentially declared disaster, and then only if the State has opted to participate. At present, 27 States have enacted such a program.

Aside from its home loan function, SBA also acts as a screening agent, designated by FDAA, to determine eligibility for Federal grants covering personal property losses suffered by individuals with limited incomes.[116]

It appears that Federal programs have been coalescing into a more coherent and coordinated form. But progress can still be made. Aside from finalizing its understanding with FDAA, AoA should consider developing a small corps of professional "advocates" who can be dispatched to a given disaster and articulate elderly needs to other Federal administrators. And AoA's parent agency, HEW, should be more willing to assist in health care restoration. Finally, the present Federal scheme should be trimmed to yield a smaller number of agencies, each responsible for a specific "hard" need.

The Wyoming Valley study makes clear that older disaster victims need a government response that recognizes their special needs and responds to those needs in a well-organized and nondiscriminatory fashion.[116a]

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[115] Source cited in footnote 84; conversation with Judy Barrows, program support specialist and legislative liaison. FDAA. May 7, 1976.

[116] Conversation with Donald J. Marvin, director, disaster operation staff, SBA, May 7, 1976.

[116a] Special attention was given to the needs of older persons in June 1976, when the north wall of the Teton Dam collapsed, causing extensive flooding in a five-county area of southeastern Idaho. The U.S. Administration on Aging sent two field representatives to the scene. The Idaho State Office on Aging and the area agencies in the flooded areas coordinated their efforts in attempting to find elderly victims, counsel them, and provide needed services and assistance. Many of the elderly affected by the disaster were SSI recipients. Senator Frank Church introduced legislation which would exclude any disaster assistance as income under SSI statute and allow the SSI recipient to have a 6-month grace period while living in the household of another before the SSI benefit is reduced by one-third.

XVI. ARCHITECTURAL BARRIERS: GAO REPORT

As enacted in 1968, the Architectural Barriers Act was intended to insure that federally financed public buildings would be designed and constructed to be accessible to the physically handicapped. This goal is also of concern to older Americans, many of whom are partially disabled or unable to deal readily with inconvenient steps, steep ramps, or other building features which deny accessibility.

A General Accounting Office report [117] submitted to the Congress on July 15, 1975, concluded that: "the Architectural Barriers Act has had only a minor effect on making public buildings barrier free." Based on its inspection of 314 buildings or building plans, the GAO determined that buildings currently being designed and constructed are "only slightly more barrier free than buildings designed and constructed within the years immediately after the passage of the act." The report also said:

> Major barriers found from the parking lots to the building entrances included streets to cross, high curbs to negotiate, and steps to climb. Inside the buildings, major barriers included restrooms with unusable toilet stalls, water fountains that were too high, and elevators with controls beyond the reach of the physically handicapped.

GAO recommended that the Congress should amend existing legislation to:

—Impose a clear statutory mandate that Federal agencies named in the Architectural Barriers Act insure that public buildings are made accessible to the physically handicapped.

—Include within the coverage of the act all Government-leased buildings and facilities intended for public use or in which the physically handicapped might be employed as well as all privately owned buildings leased to the Government for public housing.

—Require that agencies named in the act establish a system of continuing surveys and investigations to insure compliance with prescribed standards.

—Remove the present exemption of the U.S. Postal Service from coverage by the Architectural Barriers Act.

Discussing its recommendation as to the Postal Service, GAO explained that the Service was established after passage of the Architectural Barriers Act and is exempted. It added:

> The Postal Service has issued a regulation requiring compliance with the . . . standard. This administrative action is commendable; however, because post offices are so frequently used by the public, they should be subject to a statutory, rather than merely a regulatory, requirement.

During oversight hearings before the Handicapped Subcommittee of the Senate Labor and Public Welfare Committee, the Architectural and Transportation Barriers Compliance Board was questioned by Senator Jennings Randolph concerning their implementation of the

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[117] *Further Action Needed To Make All Public Buildings Accessible to the Physically Handicapped,* by the Comptroller General of the United States.

act. It is expected that corrective legislation will emerge as a result of this dialog.

Another analysis of the effectiveness of the Architectural Barriers Act was offered by the House Public Works and Transportation Committee based on hearings conducted last autumn.[118]

XVII. WHAT FUTURE FOR SOS?

From the very beginning, the war on poverty focused primarily on the needs of the young. But in 1967—with the passage of the Economic Opportunity Amendments—the Congress made it clear that the Office of Economic Opportunity was to direct increased attention to the problems of the aged poor.

Earlier hearings conducted by the Committee on Aging in 1965 and 1966 on "The War on Poverty as It Affects the Elderly" provided impetus for older persons programs. Expert witnesses agreed that OEO had a special responsibility for the elderly poor. At that time, persons 65 or older accounted for about 20 percent of all Americans living in poverty, although they constituted less than 10 percent of the total U.S. population.

SOS (senior opportunities and services program) was established in 1967 to identify and meet the special needs of the elderly poor. Specific program objectives included development of new employment and volunteer opportunities; establishment of gap-filling services; and modification of program structures to facilitate greater utilization of public services by the elderly poor.

A. Highlights of SOS Programs

Throughout its existence, SOS has developed innovative approaches for meeting the needs of the elderly poor—oftentimes in tailor-made ways for the target population. SOS has assisted many aged poor to become self-sufficient through creative programs—some of which have broken new ground in providing essential services. One noteworthy area is assisting elderly persons in winterizing their homes. SOS has provided a valuable advocacy function for the older poor and has assisted them in becoming their own spokesmen.

Perhaps even more important, SOS has provided an effective network of services to enable elderly persons to live independently in their own homes. Major services include: outreach and referral, home health, homemaker, home repair, handyman, transportation, consumer education, meals-on-wheels, friendly visitor, and telephone reassurance.

B. Developments in 1975

With the enactment of the Community Services Act (Public Law 93–644) on January 4, 1975, the Office of Economic Opportunity acquired a new name and a new status. OEO is now known as the Community Services Administration, and it is an independent agency. The Community Services Act extended basic poverty programs through fiscal 1977, including SOS.

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[118] For discussion of S. 662, a bill including provisions dealing with barriers in transportation systems, see part II, chapter VII, of this report.

However, the administration failed to request any funds to continue SOS for fiscal 1976. Two continuing resolutions[119] kept the program alive during fiscal 1976, until the Congress overrode the President's veto of the Fiscal 1976 Labor-HEW Appropriations Act, H.R. 8069.[120] The Fiscal 1976 Appropriations Act provides $10 million for SOS.[121]

In addition, the Administration on Aging and the Community Services Administration entered into an agreement on November 5, 1975, to conduct joint funding of service, delivery, research, and demonstration programs.

C. Fiscal 1977 Budget Request

For fiscal 1977, the administration recommends a $10 million appropriation to continue SOS. This represents the first time the administration has requested funding for a community action categorical program within the Office of Economic Opportunity-Community Services Administration since 1973.

Nearly 300 Community Service Administration programs serve 1 million older persons, providing 7.9 million services or activities. These projects have been funded with $22.6 million in Federal funds, including $10 million from SOS. SOS has funded 198 projects.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Independent evaluation [122] of SOS has demonstrated the value and worth of the program in identifying and meeting the needs of the elderly poor. SOS has enabled many elderly persons to continue to live independently in their own homes, instead of being institutionalized at a much higher public cost.

The Committee on Aging strongly urges that SOS be continued and expanded. Additional funding is needed to provide services for the elderly poor who are not now served by SOS. In addition, inflationary pressures during the past 3 years have greatly strained the operating budgets of SOS grantees.

XVIII. CRIME AND THE ELDERLY

Concern about the impact of crime and violence upon the elderly was mingled during the past year with encouraging news of intensified efforts at prevention. [123]

Among the developments:

—What was described as the first "national meeting to focus attention on the problem of crime against older persons and on ap-

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[119] Public Law 94–41 (approved June 27, 1975) continued SOS at a $10 million level through the end of the first session of the 94th Congress. Public Law 94–159 (approved December 20, 1975) provided continuation authority through the end of March 1976.

[120] The House voted to override the President's veto of the Fiscal 1976 Labor-HEW Appropriations Act by a vote of 310 to 113 on January 27, 1976. The Senate voted to override by a vote of 74 to 24 on January 28, 1976.

[121] Public Law 94–206, passed over the President's veto on January 27, 1976, in the House of Representatives and on January 28, 1976, in the Senate.

[122] "Evaluation of Selected Senior Opportunity and Services Programs," Kirschner Associates, Inc., prepared for Office of Economic Opportunity in February 1970.

[123] This committee's Subcommittee on Housing turned its attention to crime victimization of older persons with hearings conducted in 1971: Parts 5, 6, 7, 8 and 9, "Adequacy of Federal Response to Housing Needs of Older Americans."

proach to reducing criminal victimization" [124] was conducted in Washington, D.C. The 3-day conference brought together practitioners and planners in the fields of aging services and criminal justice. Heavy emphasis was placed upon positive crime prevention efforts already underway in many communities.

—Additional recognition of the magnitude and complexity of the crime problem was provided by the International Association of Chiefs of Police in the February 1976 issue of their journal, *The Police Chief*. Articles by eight authors explored issues related to law enforcement and the older citizen. Philip J. Gross, a research associate with the association, described a model project—funded through the Administration on Aging—intended to reduce the vulnerability of the older citizen to criminal victimization.

Dr. Jack Goldsmith, associate professor at the Center for the Administration of Justice at the American University, wrote:

> There are no specific types of crime that are committed exclusively against older persons. In fact, older persons are victimized by the same crimes as are younger persons, although at different rates and with different consequences . . . there is a differential impact of crime upon the older victim. Crime tends to have a more profound and lasting effect on the older victim than on the younger adult victim.

—The Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging held six hearings in the spring of 1976 on elderly crime victimization. [125]

—A number of crime prevention programs were underway. Mayor Tom Bradley of Los Angeles announced in February 1976 that the city was establishing a campaign which will have as a primary feature training sessions to instruct seniors in ways to protect themselves against crimes which have traditionally victimized the elderly.[126] This program was held in conjunction with an interagency task force directed by State Attorney General Evelle Younger, who had announced in January that the State office on aging and his crime prevention unit "have joined together in a team effort for planning and training in the areas of crime and consumer fraud prevention for senior citizens." [127] Another example was provided in Multnomah County, Oreg., where the county government and the U.S. Law Enforcement Assistance Agency are funding an older Americans' crime prevention re-

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[124] From statement by Jack Goldsmith, Ph. D., conference chairman, in program on National Conference on Crime Against the Elderly, June 5–7, 1975, Washington, D.C., under a grant from the U.S. Administration on Aging.

[125] The hearings, all held in Washington, D.C., were as follows: (1) March 15, Mr. Charles J. Orlebeke, Assistant Secretary for Policy Development and Research, HUD; accompanied by Dr. Morton Leeds and Mr. Charles Julet. (2) March 29, Dr. Booker T. Yelder, Jr., project director, National Center on Black Aged; Mr. George Sunderland, Coordinator of the Crime Prevention Program of NRTA–AARP. (3) April 12, Mr. Henry F. McQuad, Deputy Administrator for Policy Development, LEAA. (4) April 13, Mr. Clarence M. Kelley, Director, FBI. (5) April 28, Chief John Holihan, Alexandria, Va., Police Department; Ms. Bonnye F. Cohen, Crime Prevention for Seniors, Police Department, Montgomery County, Md. (6) May 6, Capt. Stanley Friedman, crime resistance program, Bureau of Police, Wilmington, Del. The subcommittee anticipates that printed transcripts of the hearings will be available at some future date.

[126] News release from mayor's office, February 4, 1976.

[127] From "Senior Crime Preventers' Bulletin," issued by the Consumer Information Protection Program for Seniors, January–February 1976.

search project. In St. Louis, the area agency on aging is cooperating with the Metropolitan Police Department in funding a senior home security program "designed to hire elderly workers to install security devices in the homes of other elderly citizen residents." [128]

—In New York City, the police department has established a special senior citizens robbery unit [129] in the Bronx. "What was needed," said a newspaper report, "was one unit to which reports of all robbery assaults against the elderly in buildings would be made and which would build the confidence of the old in the police."

—Interest in legislation related to crime and the elderly appeared to be on the rise. Senator Beall introduced S. 1875, which would require State plans for Law Enforcement Assistance Administration grants to include provisions for the prevention of crimes against the elderly. This measure was adopted in modified form by the Senate Judiciary Committee as a part of S. 2212, the Crime Control Act of 1976. S. 2212 would authorize the Law Enforcement Assistance Administration to fund programs to combat crimes against the elderly. Representatives Matsunaga and Scheuer won approval of an amendment (similar to the Beall proposal) to a bill (H.R. 13636) to continue the Law Enforcement Assistance Administration. In addition, the House Judiciary Committee approved another provision advanced by Representatives Matsunaga and Scheuer to permit funding of crime prevention programs for the elderly.

On November 6, 1975, Senator Williams introduced S. Res. 297 to request Federal agencies administering programs for older Americans to study the causes of crime against the elderly and to reduce the incidence of crimes. The resolution would request Federal agencies administering programs for older Americans to:

—Collect information concerning the causes, types, and frequency of crimes against the elderly.

—Conduct studies to develop programs to reduce the frequency of crimes against older Americans.

—Develop recommendations to protect the elderly from crime.

NCOA Proposals: The National Council on the Aging, in the public statements issued by its board of directors in November 1975, said that in a Harris poll conducted for the NCOA, people over age 65 rated crime or the fear of crime as their most serious personal problem. The NCOA board recommended that a "number of steps must be taken immediately, at both the national and local levels to make America safe for its nearly 21 million older citizens," among them:

(1) A national senior citizens crime index should be developed to monitor the growth and delineate the development of offenses against older people.

(2) The Law Enforcement Assistance Administration (LEAA) of the Justice Department should undertake studies to determine how localities may best cope with the problem of crime against older people and to use its resources to fund programs which protect the elderly.

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[128] From, "The Center Line," May 1976, published by the St. Louis Mayor's Office for Senior Citizens.

[129] *New York Daily News*, November 11, 1975.

(3) Local police authorities should be encouraged to set up strike forces to prevent attacks on the elderly and to pinpoint the locations and modus operandi of the attacks.

(4) Local police should undertake regular visits and liaison to facilities used by the elderly such as senior centers, housing projects, etc.

(5) Self-help programs which train the elderly themselves in crime-prevention procedures should be developed.

(6) Senior center leaders should be trained to train their members in crime prevention.

(7) Community watch programs, involving community groups of all ages (teen patrols, radio-dispatch cab drivers, police hookups, high school student escorts, etc.) should be established to be alert to threatening or suspicious activities.

(8) Patrol of streets (perhaps by retired policemen or police cadets) and areas older people use that have high incidences of criminal activities should be encouraged, and escort services to and from transportation services to housing projects, shopping malls, senior centers, clubs, clinics, etc., should be set up.

(9) The police should train and assign the elderly stay-at-homes or home-bound to observe streets or sections of their neighborhoods, and to report suspicious behavior to police.

(10) Regular police security checks of buildings and sites housing the elderly should be made (just as the fire department makes regular fire prevention inspections).

(11) Housing for the elderly should have installed (on government subsidy or as tax-deductible expense) burglar-proof photoelectric beams on windows and doors, one-way glass, TV monitors in elevators and corridors, and central alarm buzzer systems linked to police dispatchers or patrol units.

(12) Since crime against the elderly is reduced in specific housing as compared to intergenerational housing, more housing especially for the elderly should be encouraged and built.

(13) Government checks should be mailed to banks for individual deposit; banks should provide free checking accounts for the elderly.

(14) An offense against an older person should be made a Federal crime if committed in federally funded facilities such as housing projects, centers, etc.

FINDINGS AND RECOMMENDATIONS

The most recent National Crime Panel survey report reveals that the victimization rate for crimes against the elderly is 31.6 per 1,000 persons. Applying this ratio to the 22.4 million persons in the 65-plus age category means that almost 700,000 older Americans are victimized each year.

Freedom from fear is a high priority for the aged. In many cases, it is their No. 1 concern, whether they live in the central cities, the suburbs, or rural communities. It is no wonder that millions may now live under a form of house arrest, barricaded from the outside world.

Older Americans are tempting prey for perpetrators of violent crimes. Several factors may make them especially vulnerable: poor vision, slowness of foot, and perhaps a weakened condition.

The elderly, though, are victimized in other ways. Large numbers are bilked by con artists, swindlers, and others out to make a fast dollar. Here again, several conditions may make them vulnerable for the unscrupulous: loneliness, fear of dying, poverty, and other factors.

The committee recommends a comprehensive program to combat crimes against the elderly. For immediate actions, the committee urges that:

- **—Legislation be enacted into law to add a requirement that State plans for Law Enforcement Assistance Administration grants include provision for the prevention of crimes against the elderly.[130]**
- **—Prompt action be taken to implement the recommendations of the board of directors of the National Council on the Aging to make America safe for the elderly (see page 202 for discussion of the specific recommendations).**
- **—Federal agencies administering programs for older Americans study the causes of crime against the elderly and develop recommendations to reduce the incidence of crimes, as recommended in Senate Resolution 297.**

XIX. ACTION AGAINST CREDIT DISCRIMINATION AND NO-FAULT INSURANCE

Under terms of the Equal Credit Opportunity Act Amendments of 1976 as enacted in March 1976 (Public Law 94–239) no creditor may discriminate against applicants in a credit transaction on the basis of age. If credit is denied, the applicant may request a written statement giving the reasons.

This victory was the result of several years of effort on the part of consumer advocates, including representatives of national organizations on aging.

The National Council of Senior Citizens, for example, took a stand in 1967 before the House Banking and Currency Committee on the Consumer Credit Protection Act and related bills. Testimony at that time urged enactment of the truth-in-lending law to require lenders to state the full cost of credit simply and clearly before any credit contract is signed.

Summing up the reasons for concern about age discrimination in credit, Legal Research and Services for the Elderly recently said:

> In 1973, only 1.4 percent of all personal loans went to persons over 64 years old even though they made up 10.2 percent of the population. Yet many statistics show that older persons are in fact among the best credit risks. Credit granting institutions have also discriminated against retired persons, despite the fact that retirement income, such as social security, pensions, and annuities, is in many ways more regular and dependable than employment income. . . . In addition, elderly purchasers have often been the victims of fraudulent credit schemes, severely depleting their already low, fixed incomes. Many would benefit greatly from pro-

[130] Senator Beall has introduced legislation (S. 1875) for this purpose. Representative Matsunaga has sponsored a companion bill, H.R. 12366.

grams on how to understand credit terms, what the truth in lending law requires, how to watch for and avoid unscrupulous creditors, and how to plan for and use credit wisely.[131]

The LRSE also asked the Federal Reserve Board to develop regulations for the new law which "are thorough and effective," "widely publicized and understood," and "vigorously enforced."

John B. Martin, legislative consultant to the National Retired Teachers and the American Association of Retired Persons, sounded a similar theme when he testified before the Board of Governors of the Federal Reserve System on April 27, 1976.

First, he offered for the record a number of letters from members about credit denial. These responses, said Martin, established "a clear pattern of discrimination against older persons by certain national credit card companies, department stores, gasoline companies, banks, and other credit granting institutions."

One letter cited by Mr. Martin was from a 67-year-old physician with an annual income of $30,000 and no previous difficulty obtaining credit. He wrote that he was turned down for a mortgage loan on the grounds that he was "too old." At another bank where he had been doing business for 37 years, he was turned down unless he could obtain a "young" cosignor.

Commenting about implementation of Public Law 94–239, Mr. Martin asked the Board to carefully consider issues including: credit scoring systems "which employ age as a factor" and thus "might prove discriminatory to older persons"; clear and specific explanations if a request for credit is denied; and disclosure of "the source of any information used in denying credit," in order to permit the applicant to have "an opportunity to clear his credit record of any erroneous or incorrectly recorded data."

Setback on No-Fault: A similar advocacy effort on another consumer issue—no-fault automobile insurance—was centered during early 1976 on a bill, S. 354, to establish nationwide minimum no-fault standards for prompt, adequate payment for personal injury caused by automobile accidents. Advocates of the legislation said it promised reduced minimum premiums for older persons.

As Senator Frank Church said during Senate discussion of the bill:

> No-fault's prompt settlement of claims, together with the health and economic benefits mandated under S. 354, are certainly compelling arguments for institution of the no-fault concept. But in addition, S. 354 will permit insurance policies to reflect, to a far greater degree, the insurability of policyholders. For example, the medicare coverage of the elderly and disabled would be reflected in lower rates. As chairman of the Senate Aging Committee, I am particularly aware of the problems senior citizens have in obtaining and affording automobile insurance, which is often crucial to their mobility and health care. This is a primary reason why I have supported the no-fault concept.
>
> Although S. 354 provides that medicare and other Federal programs will furnish coverage when they and no-fault both

[131] In a supporting paper prepared for use at the 13th Constitutional Convention of the National Council of Senior Citizens, June 2–5, 1976, Chicago.

apply on a given claim, the question of no-fault's relationship to other insurance companies remains, and is complicated by possible congressional action on national health insurance. Traditionally, this question of primacy of insurance coverage has been left to the States and insurance companies themselves, and S. 354 would preserve that responsibility. How no-fault may be viewed in conjunction with any proposal for national health insurance will be a matter for the Congress to review as that debate continues, and should not present any impediment for prompt action on no-fault itself.[132]

Senator Frank Moss, a prime sponsor of S. 354 and Chairman of the Consumer Subcommittee of the Committee on Commerce, also strongly urged enactment and said that in Michigan—where the no-fault plan "comes closest to meeting Federal standards, and exceeds them in many instances"—the experience "shows that unlimited medical, hospital, and rehabilitation benefits and generous wage loss protection can be provided to all accident victims without regard to fault, and without increasing bodily injury insurance premiums, so long as auto accident lawsuits are confined to the most serious cases." [133]

Other supporters of the bill said that States have, in general, failed to take adequate action in regard to no-fault.

S. 354, however, was not approved by the Senate. By a vote of 49 to 45 it was recommitted on March 31, 1976.

XX. FTC ACTION ON EYEGLASS SERVICES

In January 1976, the Federal Trade Commission issued for comment a proposed trade regulation rule pertaining to the advertising of ophthalmic goods and services.[134] Along with the rule, the FTC issued a staff report with their findings on conditions existing in the ophthalmic industry.

The FTC found that 48.1 percent of the population aged 3 years or older has glasses [135] and that 93 percent of the population 65 or over has glasses. Glasses are provided to the public by three forms of dispensers: ophthalmologists, optometrists, and opticians.[136]

Price advertising was found restricted to some degree in all 50 States.[137] This includes 40 States which prohibit any form of price advertising by optometrists.[138]

The FTC staff concluded that prices for eyeglasses may be inflated because of a lack of price competition caused by the restrictions on advertising. A study of the effect of advertising on eyeglasses estimated that great savings may accrue if these restrictions are lifted. The proposed trade regulation rule would eliminate the laws and regulations that hinder price advertising.

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[132] *Congressional Record*, March 31, 1976, page S4733.
[133] *Congressional Record*, March 31, 1976, page S4725.
[134] 16 CFR Part 456.
[135] Characteristics of Persons with Corrective Lenses—United States, July 1965–June 1966. DHEW Public Health Service, National Center for Health Statistics, Series 10, No. 53, 1969, 14.
[136] Id. at 3183, note 14.
[137] Advertising of Ophthalmic Goods and Services, staff report to the Federal Trade Commission, January 1976, p. 15.
[138] Id.

CHAPTER XI

ACTIVITIES AT THE STATE LEVEL

State activities related to aging are developing a broader and broader base.

Part of the growth is caused by the Older Americans Act (see chapter I, page 11) and the Federal-State working relationship on which the major part of that act is based.

But State initiatives—through legislatures and through State agencies either directly or indirectly concerned with aging—are making increasingly substantial contributions.

A full account of State actions is difficult to assemble at present, although earlier studies [1] have indicated the value of such compilations.

To obtain current information, the Senate Committee on Aging recently asked State agencies on aging to report on significant developments in State programs and by State legislatures.

The questionnaire was necessarily brief, and replies were also concise at committee request. Time did not allow for intensive interpretation of many of the items reported to the committee. Nevertheless, the State officials' own reports on their activities provide timely and helpful information about lively interest and actions in a number of States.

Additional material has been provided to the committee by reports and other publications from State agencies or legislative units. Selected examples of innovative State actions drawn from these reports are also briefly summarized in this chapter.

I. THE COMMITTEE SURVEY

State agencies on aging in 39 States, the District of Columbia, and the Virgin Islands had responded to the committee survey in time for the publication of this summary.

Of primary interest were State developments during 1974 and 1975 which might be taken as indicators of trends in the development of State agencies on aging, in the interest in and priority given to problems of older Americans by State legislatures, and in programing for older Americans at both the State and local levels.

The survey asked for information on changes in organizational status and funding within the last 3 years, whether or not a State legislative unit had been established since 1974, for reports of new State projects and programs for the elderly, examples of uses of title

[1] The Senate Committee on Aging, in November 1974, issued a report, *Developments and Trends in State Programs and Services for the Elderly* (Cat. No. Y4 Ag4 :ST1) which proved so popular that the supply was soon exhausted. Another report, *Developments and Trends in Aging: A Survey of Programs, Legislation, and Information Systems in a Sample of States*, was published in July 1975 by the California Commission on Aging. Prepared by C. L. Estes, Ph. D., Maureen Shaw, MSW, and Edith Stunkel, MSW, the survey reported on developments in 15 States. But the supply of this document, too, was limited.

XX and revenue-sharing funds, and of coordination of Older Americans Act title III programs with other programs in the State.

A. Developments in State Agencies on Aging

This committee's 1974 report on developments and trends in State programs and services for the elderly [2] identified three trends at the State level during the period 1971 to 1973:

(1) Establishment of State departments on aging;

(2) Strengthening of State agencies on aging located in the office of the Governor; and

(3) Placement of State agencies on aging as major operating offices of divisions within large "umbrella" type State departments of human resources, human services, or health and social services.

These trends have continued during the last 2 years.

Of the 41 units of State government reporting at the time of the publication of this report, 19 indicated that their State agency on aging had either been placed in a new organizational position which enhanced its responsibilities or that their programing responsibilities had increased within the last 3 years. Twenty-three States reported that their budgets had increased during this same period.

DEPARTMENTAL OR CABINET STATUS

In 1973, three States—Connecticut, Massachusetts, and Illinois—had established separate State departments on aging. Since then:

Connecticut: The department on aging reports increased responsibility for advocacy for older Americans, assigned to the department by the Connecticut General Assembly, and increased responsibility for coordination with other programs in the State. The department gained a full-time commissioner on aging in 1975.

California: In January 1974, legislation enacted by the California Assembly [3] established an independent office on aging with departmental status within the California health and welfare agency. Further legislation is now pending to change the name of the unit to the California Department on Aging.[4]

Pennsylvania: In November 1975, a bill was introduced in the Pennsylvania Legislature proposing to establish a new Pennsylvania Department of Aging.[5] The bill was introduced in response to testimony by Pennsylvania senior citizens during hearings held by the legislature's committee on aging and youth indicating their desire for a separate department.

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[2] Report cited in footnote 1.

[3] California Assembly bill 2263, approved October 1, 1973.

[4] California Assembly bill 2285, introduced May 5, 1975. The original legislation which created an independent office on aging with departmental status also created the California State Commission on Aging to act as the principal advocacy body in the State on behalf of older persons and advise the office on aging concerning basic policies and priorities, and a statewide advisory council of senior consumers. The commission and the advisory council are also the subject of new legislation (California Assembly Bill 4009) which would eliminate the statewide advisory council and restructure the commission on aging and increase its membership from 15 to 25.

[5] Pennsylvania Senate bill 1203. This bill is part of a package of five major pieces of legislation under consideration in the Pennsylvania Legislature dealing with reorganization of the structure of the State agency on aging and mandating by law Pennsylvania's programs for older Americans. The additional bills are senate bill 613 and house bill 1079, creating a Pennsylvania Council on Aging to act as a citizen's advisory group; and senate bill 614 and house bill 1088, creating the Older Pennsylvanians Act which would mandate programs for the elderly.

Maryland: The office on aging, created in 1974, merged with the Maryland Commission on Aging in 1975 and gained cabinet status.

INCREASED RESPONSIBILITY

Other evidence of the continuing trend to strengthen State agencies on aging and assign them more planning, programing and evaluation responsibilities follow:

(1) The Virginia Office on Aging was given independent status in 1974 within the new umbrella department of human affairs. The director of the office on aging is a gubernatorial appointee.

(2) North Dakota Aging Services of the Social Service Board of North Dakota reports that the State agency on aging was elevated to unit standing under the director of community services.

(3) In 1975, the New Mexico Commission on Aging gained new membership in the State's manpower subcabinet, giving it increased responsibility and access to the State's manpower resources for use in programing.

(4) The District of Columbia government created the division of services to the aged in 1975 as part of the department of human resources in the executive office of the mayor.

(5) The Bureau of Maine's Elderly was created in 1975 as a major operating unit within the department of human services.

(6) In 1975, New Jersey elevated the State office on aging to a separate division within the department of community affairs. (This move is actually a reestablishment of division status, as the agency was originally a division in 1957 and remained as such until 1972, when it was given office status within the division of human resources during a reorganization of the State government.)

(7) Legislation has recently been passed in the State of Washington which would greatly increase the responsibilities of the Washington State Office on Aging. (A description of this legislation is included in a following section of this chapter, "Reports from State Legislative Units.")

INCREASES IN BUDGETS

A number of States reported increases in their overall budgets for programs and services for the elderly during the last 2 years. Some States report that significant new money from State general funds was appropriated for use as Federal match and to fund new State programs for the elderly.

(1) Alabama reported an overall increase in State and Federal funding for the Alabama Commission on Aging of about $4 million between 1971 and 1976.

(2) Illinois reported an overall increase in funding of about $5 million since 1974, and the Maryland Office on Aging and Massachusetts Department of Elder Affairs also reported overall budget increases of close to $4 million during the last 2 years. The Tennessee Commission on Aging experienced an overall budget increase of $3.8 million to plan, develop and administer aging programs.

(3) California reported an increase of about $1.3 million in State funds during the last 2 years with an increase in Federal funding for

programs and services for older Americans of $18.4 million during the same period.

(4) The Ohio Commission on Aging reports that in addition to an increase in State funding for use as matching money for programs for the elderly under title XX,[6] they received $1 million from the State for their aid for independent living program.

(5) Kentucky reported an increase in State funding of close to $1.2 million.

(6) Alaska and North Dakota reported 100 percent increases in State general funds for matching purposes. Delaware, Georgia, Louisiana, Minnesota, New Mexico, Oklahoma, Rhode Island, South Carolina, Virginia, and West Virginia also reported increases in State funds to be used as matching money for federally funded programs.

B. Use of Title XX Funds

Twenty of the 41 State agencies on aging reporting indicated they had been able to put title XX funds [7] to what they considered "innovative" uses, and some agencies succeeded in getting sizable allocations of this social services money for programs and services for the elderly.

MOST COMMON USES

Older American programs most often funded through title XX include supplemental funding for the Older Americans Act title VII nutrition projects; establishment of areawide and, in Nevada, statewide transportation for the elderly; information and referral services; outreach; home health programs; homebound meal programs; and day care programs.

Wyoming reports that title XX enabled adult day care to be established for the first time and, in Delaware, title XX funded three adult day care centers.

The State title XX agency in Alabama has committed at least $5.4 million of Alabama's title XX allocation to be used for in-home services to the elderly. A significant portion of title XX contract funds have also been committed to services for the elderly.[8]

RELATIONSHIPS WITH STATE TITLE XX AGENCIES

The survey responses suggest that State agencies on aging in a close working relationship with the State agency responsible for developing and administering the State title XX plan have more success in bargaining for these scarce social service funds for programs for the elderly.

Maryland: A letter of agreement between the office on aging and the department of human resources assigned special title XX funds for community home care purchase of services contracts, allocated at the local level. The two State agencies then agreed to seek recommendations within the local jurisdictions as to whom the most satisfactory contractors might be.[9]

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[6] See the following section and chapter X, page 157 for additional discussion of title XX.
[7] See chapter X, page 157, for additional discussion of title XX.
[8] Report of activities from Emmett W. Eaton, State of Alabama Commission on Aging, March 18, 1976.
[9] Report of activities from Dawn F. Thomas, Maryland Office on Aging, March 19, 1976.

Louisiana: The bureau of aging services developed the adult services portion of the State plan for title XX and allocated State matching funds to four top priority services: transportation, nutrition, homemakers, and adult day care. An agreement was made with the division of family services, which administers title XX, for area agencies on aging to sign off on all adult service contracts developed in their specific areas. The area agencies on aging and area offices of the division of family services work together to provide technical assistance to service providers who are developing contracts.[10]

Pennsylvania: The Pennsylvania Office for the Aging prepares the State plan for social services for the aging provided under title XX. The office develops policies, regulations, and standards for social services; provides technical assistance to regional offices; monitors and evaluates field operations; and approves the annual program plans for area agencies on aging. Pennsylvania's title XX State plan estimates making $17,777,000 in title XX money available for area agency on aging programs in 1977. Approximately 43 percent of the total State and Federal money available to Pennsylvania for services to the elderly are title XX funds.[11]

EFFECT OF STATE AGENCY POSITION [12]

Resources available to an independent, high-level State agency on aging can also contribute to increased success in obtaining and monitoring the expenditure of State title XX money.

New York: The New York State Office for the Aging reported conducing extensive research prior to implementation of the title XX plan in order to provide useful data to county offices for the aging to influence their local title XX plans. The office reports that this kind of vigilance and advocacy was most effective in securing title XX funds for services for the elderly.

Subsequent to development of the State title XX plan, a title XX monitoring committee in various parts of the State focused on learning "how the service delivery system affects older persons; how older persons learn about services and what happens when they try to get services; and what the links are between income needs (such as supplemental security income) and service needs." [13]

Connecticut: The Connecticut Department on Aging anticipates being allocated funds under the fiscal year 1977 title XX State plan to develop central elements of a comprehensive coordinated home care

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[10] Report of activities from Louisiana Bureau of Aging Services.

[11] This information is reported in *Serving Older Pennsylvanians in '77: A Pre-Plan Summary of Proposals for the State Plan on Services for Older People,* prepared by Office for the Aging, Pennsylvania Department of Public Welfare, April 1976.

[12] One study recently examined the impact creation of a State unit on aging with cabinet level status could have on overall State funding for programs for the elderly. The study, which compared funding levels for aging programs in the State of Massachusetts prior to attainment of cabinet level status and creation of the department of elder affairs and after this change, concluded that ". . . prior to achieving cabinet level status, the Massachusetts Office on Aging achieved almost imperceptible growth in both State appropriations and responsibilities for elderly programs. After gaining cabinet level status, the department of elder affairs achieved very dramatic growth in State appropriations and in responsibilities for administering State programs for the elderly." The author suggests that one of the major causes of the growth of the department was its new mandate to plan, develop, and implement a home care program for the elderly; but without the power and the direct access to the Governor and to the legislature that cabinet status gave to the Department, the home care program would never have grown as fast and as large as it did. (*The Massachusetts Department of Elder Affairs: Can Cabinet Level Status Make a Fiscal Difference?* Prepared by James A. Bergman, Legal Research and Services for the Elderly, 2 Park Square, Boston, Mass. 02116, February 10, 1976.)

[13] Report of activities from Warren G. Billings, New York State Office for the Aging.

delivery system in each of the State's five planning and service areas. The system will provide assessment of service needs and case management for those receiving services, as well as expand existing services and introduce missing ones to insure the availability of full home care.[14]

Illinois: The Illinois Department on Aging succeeded in getting agreement on a request for $1.2 million of title XX money to be included in their budget.[15]

BARRIERS TO USE

In other cases, State agencies on aging reported experiencing barriers in the use of title XX funds for programs for the elderly. These included high match ratios, excessively strict regulations, and State statutes which prevented local units of government from allocating title XX money to area agencies on aging.

C. Use of Revenue-Sharing Funds

As reported in chapter XII of this report (page 173), the experience of State and area agencies on aging in obtaining revenue-sharing funds for programs and services for older Americans has not been highly successful. Only 11 States responded with any enthusiasm when asked about applications they had been able to make of these funds.

In six States, general revenue-sharing money was used for construction of senior centers. Other uses of revenue-sharing funds were reported for transportation programs, and as supplemental funds for nutrition programs and title III projects.

Illinois: The Illinois Department on Aging reported that large sums had been obtained from general revenue-sharing funds in two locations for construction of new buildings:

> In Springfield, Ill., $450,000 was obtained from the city of Springfield for construction of a new building to be used as a multipurpose service center for the aging. In Piatt County, the county board appropriated about $300,000 of general revenue-sharing funds for the construction of a new county nursing home.[16]

Florida: In 1974–75 the city of Miami used 15 percent of its revenue sharing for additional meals under title VII. Other counties have used small parts of their revenue sharing to augment programs under title III.[17]

Colorado: A city and county jointly used revenue-sharing funds to build a senior center.[18]

South Carolina: Local governments in Charleston, Rock Hill, and Greenville have made revenue-sharing funds available for new facilities for senior centers.[19]

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[14] Report of activities from Connecticut Department on Aging, March 23, 1976.
[15] Report of activities from Kenneth W. Holland, State of Illinois Department on Aging, March 17, 1976.
[16] Report cited in footnote 15.
[17] Report of activities from Margaret H. Jacks, Aging and Adult Services, Florida Department of Health and Rehabilitative Services, March 10, 1976.
[18] Report of activities from Robert B. Robinson, State of Colorado Division of Aging.
[19] Report of activities from South Carolina Commission on Aging.

Oklahoma: Approximately $500,000 in special revenue-sharing funds were made available for services for the elderly in Tulsa for fiscal year 1975 for the first time.[20]

D. Developments in State Legislatures

Perhaps one of the most significant recent developments at the State level has been the increase in legislative committees with full responsibility for initiating legislation for the elderly.

Two years ago, only a handful of States had established joint legislative committees on aging or other legislative units which could give overall direction and attention to the needs of the elderly. Now, 14 States report the development of aging units within their State legislatures.[21] Ten of these units have been created within the last 2 years.

In addition to these 14 States, the Colorado Division of Aging is recommending creation of a joint committee on aging within the Colorado Legislature.

California, Louisiana, Oregon, and South Carolina report active legislative committees on aging for a number of years. The 10 committees created during the last 2 years:

Arizona: The Arizona Legislature formed a Joint Senate/House Committee on Aging in February, 1975, which held 11 public hearings on the needs of Arizona's older population and drafted and advanced five pieces of legislation.

Georgia: The Georgia House created a human relations and aging committee in 1975 which conducts studies and drafts legislation. The Georgia Senate Services for the Aged Study Committee, created in 1976, is charged with the responsibility of making legislative recommendations to the general assembly in 1 year.

Nevada: The Nevada Legislature created a Special Subcommittee on Aging Problems in 1974, and the subcommittee recently has held hearings throughout the State on nursing home conditions.

New Hampshire: The joint committee on elderly affairs, created in 1975, is to make a report and legislative recommendations to the New Hampshire General Assembly in 1976.

New Mexico: An Interim Subcommittee on Aging of the Interim State Legislative Study Committee on Health and Aging was recently created in the New Mexico Legislature. This subcommittee has legislative authority.

New York: The New York State Assembly created a Standing Committee on Aging in 1975 with full legislative authority and responsibility. In 1976, a Senate Committee on Problems of the Aging was established. These committees supercede the work of the New York Legislature's Joint Committee on Problems of the Aging, which had been in existence for a number of years.

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[20] Report of activities from Special Unit on Aging, Oklahoma Department of Institutions, Social and Rehabilitative Services.

[21] The survey did not ask specifically whether a legislative committee on aging existed within the State legislature; rather, whether a new unit had been established after 1974. The figure of 14 States cited here, therefore, cannot be taken as a completely accurate assessment of the number of committees on aging in State legislatures. Only 16 States, however, reported that there was no legislative committee specifically considering the problems of the State's elderly.

Ohio: The Ohio Commission on Aging reports that a house subcommittee on aging considers many pieces of legislation during the year, and there are currently many bills pending.

Other new committees are the Indiana House Committee on Aging, the Delaware House and Senate Committees on Aging, and a Joint Committee on Aging in Wisconsin.

E. Programing for the Elderly

Even though the survey only asked for concise reports of coordination of title III with other State programs and examples of innovative State programing for the elderly, the number of examples and amount of information returned by State agencies on aging are too numerous to be reported in full here. What follows is a report on the program areas most often cited as being coordinated with title III programs and a sampling of program descriptions in a number of areas.

COORDINATION OF TITLE III WITH OTHER PROGRAMS

The range of State programs and services which are being coordinated with title III programs is very broad, but the most prevalent examples in a number of States are:

(1) Use of personnel funded under the Comprehensive Employment Training Act (CETA) and other manpower programs in a wide range of program support roles.

(2) Coordination of Older Americans Act title III programs with title VII nutrition projects very often providing information and referral and other services from meal sites.

(3) Coordination with the Retired Senior Volunteer Program (RSVP).

(4) Preventive health programs in cooperation with State health departments.

(5) Agreements with community schools to provide meals for seniors in cafeterias.

(6) Agreements with local and State housing authorities for use of buildings as senior centers, as nutrition sites, and as social service centers.

(7) Agreements with departments of transportation for senior buses and vans.

(8) Training programs with universities to train managers for elderly housing projects.

(9) Cooperative development of gerontology curricula at local universities and other training programs for those working with the elderly.

REPORTS OF INNOVATIVE PROGRAMING

State agencies on aging reported innovative programs for the elderly in a number of areas. All of the following examples are taken from the activity reports submitted to the Special Committee on Aging by State agencies.

OMBUDSMAN AND LEGAL SERVICES

Massachusetts:

> The function of the Nursing Home Ombudsman project is to serve as an advocate for service recipients and service

providers in order to coordinate the existing resources and regulatory agencies involved in the improvement of patient care.

The ombudsman project solicits the complaints, opinions, and viewpoints of three groups—patients, their families and friends, and professional persons; nursing home owners and administrators; and governmental regulatory agencies. The scope of the problem is then interpreted and a response given. The resolution of the problem is achieved through the utilization of administrative action, litigation, and/or legislation.

The legal services program for elders is operated in conjunction with the State Nursing Home Ombudsman project. This is a title III demonstration project designed to provide legal assistance to nursing home residents. The areas in which primary guidance will be offered are incompetency, right of access to nursing homes, deinstitutionalization, and home ownership.

The specific objectives of the program include a review of Massachusetts laws and regulations relative to the provision of care to nursing home residents and the elderly spouse remaining in the community, the development and maintenance of an effective working relationship with existing legal services projects, the utilization of services currently rendered by the Massachusetts Bar Association, and the training of Home Care Corporation and area agency on aging staff in the dissemination of legal guidance materials to the elderly.

INFORMATION AND REFERRAL [22]

Illinois:

Our project, "Ethnic Find," undertakes to provide information and referral services to the foreign-speaking residents of many different ethnic groups. A network of cooperation has been established with ethnic civic organizations, churches, national societies, foreign language newspapers, and TV and radio programs. A large corps of volunteers has been recruited and trained from each of the ethnic groups in the Chicago area. This program is particularly necessary and effective for large cosmopolitan cities. It has used statewide ethnic groups, headquartered in Chicago, to carry the program to other parts of the State as well.

REDUCING TAXES

Alabama:

In 1973, Alabama's Legislature passed significant legislation which better assists older people to remain in their own homes. This act exempts all persons 65 and older from the payment of ad valorem taxes for their homesteads if their

[22] The Administration on Aging has funded a number of research and development projects in information and referral. Perhaps one of the most useful sources of guidance in planning for statewide information and referral services for the elderly is *I & R Program Configuration: A Guide for Statewide Planning,* prepared by C. L. Hohenstein and Associates, Atlanta, Ga., under contract with the South Carolina Commission on Aging, October 1975. The publication is available from the Administration on Aging, DHEW Publication No. (OHD) 76–20114.

income is $5,000 or less. This exemption includes city, local, and State ad valorem taxes. The significance of this legislation is that it insures that fixed income older people will not be forced from their homes because of increased ad valorem taxation which occurs in so many instances because of taxation based on "property best usage." The State of Alabama is currently . . . reevaluating all property throughout the State. We anticipate ad valorem tax increases of 3 to 10 times the present rate. Thus, Alabama's eligible older people will not receive any tax increase as a result of this property reassessment. For example, in 1975, over $4 million of ad valorem taxes were not paid by Alabama's older people. The Alabama Commission on Aging has and will continue to advertise and encourage older people to take advantage of this "tax break."

VOLUNTEER SERVICES

Maine:

Project Independence was designed to identify and provide the services which the elderly householder needed in order to remain in his own home as long as he was able, in other words, to retain his independence. It was designed to be run for the elderly by the elderly, a revolutionary idea which worked out to become the keystone of the entire program. In fact, it has been called the biggest independence movement since 1776. The first step was a survey of the elderly, by the elderly in their centers, to find what services were needed. These were identified as transportation, health care, need for information, and recreation. These were the first components of the Project Independence program. Today it has added nutrition outreach, a handyman service, and paralegal service under the supervision of the Bureau of Maine's Elderly. It also sponsors the RSVP. The entire program is carried on by the elderly themselves on a strictly volunteer basis, and members also provide many hours of volunteer service to nursing homes, shut-ins, and neighbors in their communities on a regular basis.

SUPERMARKET ON WHEELS

New Jersey:

A 45-passenger bus was remodeled into a mobile food store in Monmouth County to bring daily groceries to low-income elderly at reduced prices. The program is modeled on a similar program successfully established in Denver, Colo., and is supported by a grant from the New Jersey Division on Aging of the Department of Community Affairs with matching funds provided by the Monmouth County community action program and Jaycees. The Jaycees are also contributing volunteer services to the project.

STATEWIDE DISCOUNTS

Vermont:

The Green Mountain passport can be purchased by any Vermont resident 65 years of age or older for $1. The passport

entitles the bearer to utilize the State parks and State college systems without fee. Merchants can use the Green Mountain passport as a basis for offering discounts to senior citizens.

Ohio:

The Golden Buckeye program provides a statewide discount card for senior citizens aged 65 years and older.

TRAINING NEW TALENT, BETTER USE OF EXPERIENCE

Oklahoma:

In coordination with Oklahoma State University, Division of Home Economics, a field work class has been developed for graduate students in food, nutrition, and institutional administration. The students are serving as consultants for six nutrition sites in southeastern Oklahoma. They will monitor the food service component of the program including sanitation, menu planning, nutrition education, and staff development. In addition to the obvious benefits to the students and the nutrition program, this experiment also offers the potential development of qualified persons in the field of elderly nutrition.

Florida:

We jointly funded, with the department of community affairs, training for managers of public housing for the elderly, using title III funds. This training was most successful and has subsequently been repeated and is now being made part of the ongoing work of the housing division of the department of community affairs. Our staff works with them on housing for the elderly and to plan for meeting the energy crisis.

Arizona:

Under contract from the National Council on Aging, the bureau on aging operates the older workers program under the Older Americans Act, title IX. The program is conducted statewide with the cooperation of Arizona's six area agencies on aging. . . . The program has afforded many struggling community based agencies with valuable part-time assistance while enabling the area agencies on aging to establish linkages with these agencies at virtually no cost to them or to the title III program. Area agencies on aging have also gained considerable skills in understanding Department of Labor procedures, which have resulted in a dramatic increase in the number of CETA and other positions being applied for and secured. During fiscal year 1975, some 93 persons were enrolled—over 50 percent were later placed into unsubsidized employment.

FUEL CRISIS INTERVENTION

New York:

In the winter of 1974–75, the State office organized a six-county program via an interagency agreement with the State

fuel allocation office, involving area agencies on aging and local fuel providers to insure provision of necessary home-heating fuel supplies to elderly households in the face of limited supplies and rising costs.

STATEWIDE TRANSPORTATION

Kansas:

The current proposal to correlate with the State department of transportation to provide a statewide rural transportation system is noteworthy. The State agency on aging applied for a $500,000 grant under section 147 of the Highway Transportation Act. The proposal was formed in cooperation with the State department of transportation. The State agency on aging will contract with the State department of transportation to administer and implement the proposal.

INCREASED OPPORTUNITIES FOR THE BLIND

District of Columbia:

The project for the blind-extended services for the blind and visually impaired older Americans . . . is a joint effort between the District of Columbia Public Schools and the District of Columbia Department of Human Resources. It is designed to demonstrate the value of extended social and educational services to the blind and visually impaired older Americans in the District of Columbia.

The program provides services to persons who are 60 years of age or older for whom presently available services are not adequate. The program provides a full agenda of training and activities in communication skills, typing, music, sewing, arts and crafts, physical education, cultural enrichment, adventure tours, field trips, and homebound consultation.

II. REPORTS FROM STATE AGENCIES

Valuable information on activities at the State level is available on a regular basis from those State agencies on aging which publish annual reports or regularly issue newsletters. For example, a very brief review of reports made available to the Special Committee on Aging produced the following information:

A. Pennsylvania

The Pennsylvania Office for the Aging has prepared a report on the office for the aging's proposed plan to provide services to the aging during 1977 in Pennsylvania.[23]

The plan identifies community services to which the State intends to give priority during the coming year, including the allocation of 25 percent of each area agency on aging's budget to in-home services; increased emphasis on specialized transportation services; the devel-

[23] Report cited in footnote 11.

opment of protective services staff units by area agencies on aging, supported by the State office on aging's activities in development of generic guardianship legislation; and a technical assistance plan for supporting services. The status report on current activities says:

> In terms of service impact, the efforts of the 1976 year of activity means significantly more services to more individuals than ever before. Information and referral service is becoming readily accessible through walk-in locations and toll-free telephone numbers. Specialized transportation services will be available. Expanded programing is occurring in the multi-service and neighborhood service centers. Individuals who need multiple services can now get assistance in making these arrangements through service management workers. Legal services, chore, day care and foster care services are now available for the first time in many areas.[24]

B. Louisiana

In Louisiana, the first Governor's Conference on Aging served to identify priority objectives for Louisiana's older Americans. Subsequently, the Louisiana Legislature appropriated more than $11 million for adult service programs for the elderly.[25] A number of resolutions adopted at the conference also produced legislative action, as described in the State report:

ACTION STATEMENT	LEGISLATION
Priority Resolution. Requesting the expansion of home delivered services.	Act 701 (W. D. Brown) Adult Day Care Centers. Authorizes the Louisiana Health and Human Resources Administration (LHHRA) to develop standards for adult day care centers and provides a system for voluntary licensing of such centers. Act 669 (W. D. Brown) Social Services; Title XX. Authorizes LHHRA to develop and implement a program of social services for children, families and adults in conformity with the provisions of Title XX of the Social Security Act.
Health. Requesting establishment of Geriatric Assessment Centers within the state hospital system.	HCR 25 (Humphries) Geriatric Assessment Centers. Directs the LHHRA to study the feasibility of establishing such centers in the state.
Requesting the extension of medical benefits provided under Title XIX (Medicaid) to the medically needy.	SCR 47 (Barthelemy) Medically Needy. Directs LHHRA to undertake a comprehensive study of the feasibility of implementing such a program. Act 534 (Breaux) Charity Hospital. Expands criteria of eligibility for admission to Charity to cover the medically needy.

[24] Report cited in footnote 11.
[25] *Report of the First Governor's Conference on Aging*, Baton Rouge, La., April 7–8, 1975.

ACTION STATEMENT	LEGISLATION
Senior Involvement. Requesting a waiving or reducing of tuition in state schools for elderly.	Act 525 (Scogin) Free Tuition. Exempts those over 65, who register for courses in public colleges or universities, from payment of tuition or registration fees.
Requesting that the state foster the social and recreational involvement of older persons.	Act 235 (Humphries) Free Admission to Parks. Citizens 62 or older shall be exempt from payment of admission to any state park. HCR 9 (Toca) Transportation. Requests firms providing public transportation to provide reduced rates for elderly.[26]

C. West Virginia

The West Virginia Commission on Aging reports on a number of State implemented and supported programs and services for the elderly:[27]

LEGAL SERVICES PLAN

> Many older West Virginians are now eligible to participate in the West Virginia legal services plan program . . . designed to provide low-income residents with free legal representation by private lawyers who have agreed to participate for less than their regular fees. . . . As the elderly are usually the most reluctant to seek legal assistance, the plan is making a special effort to reach them. . . . The West Virginia Bar helped develop the program to provide attorney services in a wide variety of civil matters. . . . Approximately 50 percent of the attorneys in the State have agreed to participate in the program. Each of the State's 55 counties has at least one lawyer working with the plan. The plan has also established seven regional offices around the State to provide assistance.

HOME CARE STUDY

> A joint committee of the West Virginia State Medical Association and the West Virginia Nurses Association recently formed a subcommittee, chaired by the executive director of the commission on aging, to study the availability of home care in the State, and to develop strategies to increase the availability of this type of care.

HOUSING DEVELOPMENT FUND

> Funded by a grant from the commission on aging, the West Virginia Housing Development Fund's Senior Housing Opportunity Program (SHOP) is designed to provide a more comfortable living environment for the elderly living in federally assisted housing. Training and technical assistance is being provided to managing agents and resident managers of 50 percent of HUD-assisted housing in West Virginia,

[26] Report cited in footnote 25.
[27] *Off Our Rockers,* West Virginia Commission on Aging annual report, 1975.

to increase their ability to meet the special needs of the elderly.

The fund is also providing special assistance to groups in southern West Virginia in obtaining Farmers Home Administration section 515 funds to expand rural rental housing opportunities in areas which cannot support a large housing development, where only a small number of units are involved with each development.

III. REPORTS FROM STATE LEGISLATIVE UNITS

A number of State offices on aging and committees on aging also regularly publish reviews of new and ongoing State legislation. These reviews and copies of bills can be of great value to other States wishing to share in innovative legislative strategies for improving living conditions for all older Americans.

A. New York

The New York State Office for the Aging reports that prior to the 1975 legislative session, the office distributed 14 legislative issue papers on the problems confronting older persons that could be eased by legislative action.[28] As a result of this effort, 12 bills were introduced and 5 were passed and enacted into law.

Selected examples of some of these new legislative efforts include public utility deposit exemptions for the elderly, inclusion of home health care coverage in insurance policies, and registration of hearing aid dealers and fitters:

> Chapter 191—An act to amend the public service law, in relation to public utility deposit exemption for certain people.
>
> This law would protect older persons of good credit standing from arbitrary deposit requirements which may prohibit them from subscribing to public utility services which are often necessary for their health and well-being.
>
> Under its provisions, the Public Service Commission must require gas, electric, and telephone companies to exempt from cash deposit requirements the dwelling units of subscribers who are aged 62 or older. An exception is made when the company can show that the older subscriber is a bad credit risk according to standards to be established by the Public Service Commission. . . .
>
> In its support of the bill, the Office for the Aging maintained: "The requirement of proof that an older public utility subscriber is a bad check risk is reasonable. We believe the Bill should be signed into law in order to negate the general misconception that older persons are bad credit risks due to their

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[28] *Summary: 1975 New York State Legislation Affecting the Elderly,* New York State Office for the Aging, 855 Central Avenue, Albany, N.Y. 12206, September 1975. The office reports, however, that the 14 legislative issue papers were in such demand most are now out of print—another indication of the demand for information across the country as awareness of the special needs of older Americans grows. The 1975 legislative summary cited here describes and cites over 30 new laws of specific interest to older persons. Requests for information and copies of any chapters of the laws of 1975 should be directed to New York State Department of State, Election and Law Bureau, 162 Washington Avenue, Albany, N.Y. 12210.

generally low and fixed incomes. While it is true that many older persons must live on limited and fixed incomes, it does not necessarily follow that they are bad credit risks. It is precisely because of their income that many older persons are in need of the protection proposed by this Bill."

Adds sec. 76-b and 92-b, Public Service Law. Approved: June 10, 1975. Effective: September 1, 1975.

Chapter 799—An act to amend the general business law, in relation to the registration of hearing aid dealers and fitters.

The goal of this law is to end growing widespread abuses in the hearing aid industry. It provides that no hearing aid shall be sold to any person unless, within the previous six months, he has been examined by an otolarnygologist or a licensed audiologist and a written recommendation for a hearing aid has been made.

The law also requires that hearing aid dealers provide a written 30-day money back guarantee and that dealers be registered with the Department of State.

In its comments to the Governor in support of the Bill, the Office for the Aging noted some additional benefits: "Because the Bill requires an examination by an audiologist or an otolarnygologist, the older person will know if his ears are healthy and a hearing aid is necessary or if he has a disease which without treatment may cause additional harm. The preventive aspect to the Bill is very important."

Adds Article 37, General Business Law. Approved: August 9, 1975. Effective: June 1, 1976.

Chapter 647—An act to amend the insurance law, in relation to group or blanket accident and health insurance policies and individual accident and sickness policy provisions.

This law mandates the inclusion of home health care coverage in insurance policies and was advocated by the Office for the Aging in Legislative Issue Paper Number 14.

The mandate does not apply to policies which cover persons employed in more than one state and policies which are collectively bargained and affect persons who are employed in more than one state, because of the practical problems in attempting to provide different levels of benefits for employees of the same employer depending upon their place of residence.

The definition of "home health agency" in the Public Health Law includes only voluntary non-profit and public home health care agencies. This law does not change that definition; therefore the coverage it mandates would apply only to non-profit agency services, consistent with existing practices under optional coverage.

By increasing the availability of health insurance coverage for home health care, the law encourages the use of home services when, in a physician's judgment, such care is unnecessary. Thus, it would lessen the impact of health care insurance coverage as a factor in determining the appropriate form of health care.

Amends sec. 162, 164, 250, Insurance Law. Approved: August 7, 1975. Effective: April 1, 1976.

B. Washington

A bill to provide a comprehensive program of community-based services for the elderly throughout the State of Washington was signed into law by Gov. Daniel J. Evans in April 1976.[29] The Senior Citizens Services Act provides $7.5 million ($1.9 million from the State to be supplemented by $5.6 million in Federal funds from section 308 model projects of the Older Americans Act) to meet the care needs of persons age 60 or over through the development of alternative care services. The act directs the office on aging, through area agencies on aging, to develop an annual plan for coordination, expansion, and development of the following community services:

—Access services, including information and referral, outreach, transportation, and counseling;
—Day care offered on a regular basis, including general nursing, rehabilitation, personal care, nutrition, social casework, mental health, and transportation services;
—Night services offered on a regular basis;
—In-home care, including health care and chore services;
—Counseling on death for the terminally ill, and care and attendance at the time of death;
—Health services, including screening and evaluation, in-home health services, health education, and health appliances to promote independence;
—Low cost, nutritionally sound meals in the home or at meal sites, and nutrition education, diet counseling, and shopping assistance;
—Housing services including counseling, repair and maintenance, and moving assistance; and
—Civil legal services in the areas of housing, consumer protection, public entitlements, property, and related fields.

C. Activities by Council of State Governments

Assisted by a grant from the U.S. Administration on Aging, the Council of State Governments began, in 1975, a project on aging intended to develop model State statutes.

The council met with an advisory council in September and also consulted with State officials before offering draft statutes at a National Symposium on Suggested State Legislation in Washington, D.C., on February 26, 1976.

The 17 statutes under discussion dealt with: generic drug substitution; prescription drug price posting; nursing home bill of rights; nursing home ombudsman committee; long-term care health, safety, and security; hearing aid dealers; age discrimination in employment; senior citizens community workers; energy lifeline; life care contract regulation; adult protective services; public guardianship; elderly housing authorities; retirement community full disclosure; local relocation assistance; boarding homes; multiservice senior centers, and community care.

Final decisions on the proposed statutes will be made by the council's committee on suggested State legislation at a meeting in Washing-

[29] Second Substitute House Bill No. 1316, by Committee on Ways and Means, State of Washington, 44th legislature, 2d Extraordinary Session, enacted April 1976.

ton, D.C., on June 11–12, 1976 (Sheraton-Park Hotel). The approved volume of suggested State statutes will then be published [30] and distributed to State legislators and a number of other officials. A final report will also be made to the Administration on Aging.

At the February symposium, Illinois Lt. Gov. Neil Hartigan described a report [31] which he said provided a foundation for objective analysis of the usefulness of State programs on aging to older citizens of Illinois. He also described followup action which he said can result in improved services for the elderly on a State level.

IV. PROGRAMING CASE STUDIES IN CITIES AND STATES

In addition to increasing volumes of useful information being generated by State and local units on aging, other Federal and privately sponsored research and development activities continue to provide insight into recent developments in aging programing and produce information which can assist those planning services for the elderly.

A. Survey by the U.S. Conference of Mayors

A Conference of Mayors Task Force on Aging—chaired by Mayor Wesley C. Uhlman of Seattle, Wash., and Mayor Janet Gray Hayes of San Jose, Calif.—recently undertook a 1-year program to create an awareness among city officials of the problems and needs of the urban elderly and to develop an understanding of the intergovernmental systems and service providers in relation to the elderly in cities.

Thus far, the task force has sponsored national workshops of public officials, developed articles about programs serving the elderly, and, under a grant from the Administration on Aging, developed a matrix of services available to the elderly in 56 cities.

In order to describe and analyze the intergovernmental systems and service providers affecting programing for the elderly in urban areas, the task force has also been conducting studies in six selected cities. Case studies on priority programs for the urban elderly and basic guidelines for coordinating the provision of these services are now being readied for publication.[32]

B. Federal Council on Aging Case Studies

A recent report issued by the Federal Council on Aging,[33] part of a study of the impact of combinations of programs serving the elderly throughout the country, also provides case studies of programing for the elderly.

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[30] For additional information about availability of this report and summaries on State legislation, write to: Brevard Crihfield, executive director, Council of State Governments, Iron Works Pike, Lexington, Ky. 40511.

[31] *A Matter of Dignity*, a report to Lt. Gov. Neil Hartigan by the Lieutenant Governor's Commission on Aging, Springfield, Ill.

[32] The matrix of services in 56 cities is now available from the task force. A handbook for mayors based on case studies with chapters on transportation, crime victimization, housing, health care, economic security, employment, organizing an aging program, public sector relationships, the role of the mayor, and intergovernmental relations will be available from the U.S. Conference of Mayors, Task Force on Aging, 1620 Eye Street NW., Washington, D.C., 20006, in early August 1976.

[33] *The Interrelationships of Benefit Programs for the Elderly: Appendix II, Programs for Older Americans in Four States.* A case study of Federal, State, and local benefit programs, prepared for the Federal Council on the Aging by the human resources and income security project of the Urban Institute, December 29, 1975. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The study, conducted for the Council by the Urban Institute, presents a general description of the services which might be available to an elderly person in Wisconsin, Georgia, Massachusetts, and Washington. The case studies include profiles of services available, their funding sources, and program enrollments.

A number of general observations are made through comparison of these four State programs:

(1) The level of program activity varies considerably from State to State, as do methods of planning, coordinating, and providing services to the elderly.

(2) The types of programs offered in all four States are considerably alike, even though the level of activity differs substantially. All four States have a common major objective—to provide an alternative to institutionalization through diverse offerings of social services.

(3) Those State agencies on aging operating as major offices or divisions within the State government structure with some statutory authority have more extensive program activity.

(4) All four States face budget constraints which severely limit their ability to provide services to all elderly persons who are in need. This is particularly true of services meant to alleviate the problems of isolation, poor health, and reduced physical ability, and anxiety, such as homemaker and chore services, transportation, nutrition, and legal and advocacy services. In the four States profiled, these services are available to and utilized by very small numbers of the elderly who are potentially eligible for them.

(5) A number of administrative problems are also consistent from State to State: Long delays and frustrating procedures in eligibility determination are often experienced by the elderly; complexity and frequent change in Federal regulations make it costly and time-consuming to administer programs for the elderly, and potential funds for programs are being eaten up by administrative costs; and a great need exists for more effective information systems which would make it possible to improve outreach efforts and reorder service priorities.

FINDINGS AND RECOMMENDATIONS

As these selected examples of new State programing and legislative initiatives show, a wealth of information on new ideas and strategies for improving life for older Americans is being generated by State and local agencies on aging throughout the country.

The cooperative network of agencies on aging is still in its youth. Any new venture needs new ideas and any cooperative network needs shared experiences in order to grow and strengthen.

As action at the State level increases, and as common problems and solutions begin to appear, the Committee on Aging recommends that an organized, regular summary of State activities and experiences be made available to all State or local agencies on aging in order to facilitate the development of a genuine nationwide network for information exchange and, where feasible, cooperative action for identification of and action on mutual concerns.

CHAPTER XII

A PROPOSAL FOR 1977

The Senate Committee on Aging, in the final chapter of its annual report last year, noted that 1976 was the mid-point between the White House Conference on Aging of 1971 and a similar conference likely to be held in 1981.

It recommended that a "Mid-Way White House Conference on Aging" be conducted in 1976 and added:

> It would appear that little would be gained by conducting a miniature version of the 1971 conference; it would seem, instead, that it should be directed at one key issue related to many others.[1]

Instead of making a specific proposal as to the possible theme of a scaled-down conference, the committee invited advice before making a final recommendation.

Senator Frank Church, committee chairman, on May 13, 1976, reported that he had received a suggestion which he had incorporated into legislation:

> I am introducing today a resolution (Senate Joint Resolution 195) calling for coordinated action by the executive branch—in consultation with the Congress, national organizations concerned with aging, individual older Americans, and appropriate members of the academic or service provider communities—to prepare for and then implement a midway, interim conference on a carefully selected theme related to overall progress in aging since 1971.
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> As to the "carefully selected theme," I am proposing in my resolution that this theme shall be: "Toward Longer Independent Living in Aging." My reasons for suggesting this thrust are as follows:
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> In last year's annual report of the Senate Special Committee on Aging—on which I serve as chairman—I wrote in a preface that I would welcome suggestions for the appropriate means of marking the 5th anniversary of the 1971 Conference.
>
> I added:
>
> "It seems to me that a miniature or repeat version of the 1971 conference would do little good at this point; we still have a long way to go before we come anywhere near fulfilling recommendations made then. But some form of stock-taking could be useful. The questions are: what form

[1] Page 128, *Developments in Aging: 1974 and January–April 1976*, U.S. Senate Special Committee on Aging, June 24, 1975.

should it take, and how can it take place without diverting energy and resources from other important activities?"

My invitation for suggestions resulted in challenging and encouraging replies strongly endorsing the concept. For example, Dr. Robert Butler, psychiatrist, gerontologist, Pulitzer prize-winning author, and recently named Director-designate of the National Institute on Aging, said last year that a continual audit of White House Conference recommendations is essential. He recalled a statement he made at the 1971 Conference calling for continuing scrutiny.

Among the other replies was one written by Mr. James Pennestri, director of the New Jersey Division on Aging. He said that the key issue of a midway conference should be "Longer Independent Living," because this theme covers such important matters as physical and mental health, housing, social services, outreach, energy, transportation, nutrition, day-care centers, nursing homes, and so on.

I agree heartily with Mr. Pennestri, and I would amend his suggestion only slightly by adding the words "Toward" and "in aging." [2]

Senator Church also called for a number of innovations which would distinguish the Mid-Way Conference from the 1971 conference:

My resolution is written in such a way as to give the executive branch considerable leeway in achieving the objectives set forth, but I believe that the work plan should include these features:

First. The Secretary of HEW would have responsibility for conducting the Mid-Way Conference on Aging. The Secretary would, however, consult with other Federal agencies—such as the Department of Labor and the Department of Housing and Urban Development.

Second. In addition, the Secretary would appoint working groups of leaders in the field of aging, experts on independent living, Members of Congress, and elderly persons themselves. These working groups would advise the Secretary on a wide range of issues.

Third. The working groups will be given allotted sums for first, the commissioning of technical papers; second, the hiring of consultants, where necessary; and third, if deemed essential, the conduct of public hearings.

Fourth. The working groups will issue reports for distribution 1 month before the Mid-Way Conference.

Fifth. The Mid-Way Conference would be conducted in 1977. The Secretary of HEW would nominate delegates to the Conference, after consulting with the working groups, the Congress, and directors of State offices on aging.

I have called for congressional participation in the work groups because I believe that the Mid-Way Conference calls for joint concern by the Legislative and executive branches. In addition I am aware of the proposal made by Representa-

[2] *Congressional Record*, May 13, 1976, page S7157.

tives Edward R. Roybal and Thomas J. Downey for a conference organized and implemented solely by the Congress. Impressed as I am by their initiative and ingenuity, however, I believe that the executive branch must have the primary role in any such effort.

As to cost:

My resolution names no specific amount of funding required for the Mid-Way Conference. I believe that the administration should make a budget request in early 1977 or seek congressional approval of a supplementary appropriation before that time, if needed.

I should point out, however, that the total sum appropriated by the Congress for the entire 1971 White House Conference on Aging and the extensive work which preceded it was $1.9 million. I believe, therefore, that the Mid-Way Conference should cost no more than $300,000 to $400,000; but I think Congress should seek recommendations from the executive branch on the final amount.

RECOMMENDATION

The Senate Special Committee on Aging supports Senate Joint Resolution 195 and urges early action in order to assure calling of the Mid-Way Conference at the earliest possible date in 1977, thus permitting a review of progress made since 1971 and building a base for action at a White House Conference on Aging now contemplated for 1981.

MINORITY VIEWS OF MESSRS. FONG, HANSEN, BROOKE, PERCY, STAFFORD, BEALL, DOMENICI, BROCK, AND BARTLETT

Introduction

Challenges in developing a national policy on aging responsive to needs of the Republic's third century, as emphasized in previous minority reports, are massive and complex.

Achievement of our goal to accord older Americans full social and economic status offering dignity, honor and unlimited opportunity for personal fulfillment calls for action both to produce and to reflect changed attitudes by the people as a whole. One such necessary action is elimination of negative bias relating to age, race, sex, and other personal denominators of prejudice, all of which, in varying degrees, create difficulties for older persons.

There must be recognition that America's 23 million persons over 65 have an endless variety of personal needs and abilities: economic, physical, social, mental and spiritual—no less than do small children, teenagers, young adults, and those of middle age. Above all, there must be new awareness of the fact that the vast majority of older Americans have desire and capacities for full life participation. They have interests, skills, talents, and appetites—an undiminished zest for living. They deserve fullness of opportunity.

There are many unmet needs in income, housing, job opportunities, health care, nutrition, recreation, education, and transportation to which the power of this Nation's resources, in and out of government, should be directed—always to the purpose of ending the patterns of rejection or discrimination which too often characterize society's attitude toward older persons.

Complete delineation of older America's needs, and current efforts to meet those needs, would require many volumes. We are, of necessity, limiting our statement to selected highlights, good and bad, from the 1-year period with which this report is concerned. We hope that these observations, together with information set forth elsewhere in the report and its appendixes—including summaries of work by Federal agencies—will be helpful in setting new priorities for action on behalf of older Americans.

INFLATION—STILL PUBLIC ENEMY NO. 1

As detailed elsewhere in this committee report, the past year has seen forward steps for older Americans on a number of fronts if not all. Gains have been made in average income levels, in housing, and in the developing network of service activities. *The most important progress, however, has been in the Nation's fight against the spiral in rising costs of living.*

In assessing recent progress against inflation, it should be understood that the level of prices has not been falling. Except in severe depressions, it rarely does. Inflation control objectives are to keep rises in living costs to a minimum—to keep them within manageable bounds.

While month-to-month declines in the rate of inflation, as measured by the Consumer Price Index, have not been too noticeable, when progress over the past 15 months as a whole is examined, the change is dramatic.

In December 1974, the Consumer Price Index was 12.2 percent higher than in December 1973. In March 1976, the Consumer Price Index was 6.1 percent above the level in March 1975. The rate of inflation had thus been cut in half.

This shift from an accelerating to a decelerating inflation rate is encouraging, as are indications that further progress may be made concurrent with a generally improving economy. The Nation still has a long way to go, however, in this crucial battle.

It is equally evident that the road to stability in the dollar's purchasing power will rarely be smooth. April's sharp rise in wholesale prices, usually a precursor of Consumer Price Index levels, gives warning that progress in control of inflation will at best follow an uneven pattern, no less than has been the case during the recent 15 months of progress.

Every minority report of the Senate Special Committee on Aging since its inception in 1961 has recognized the special injury suffered by older Americans as a result of rising costs of living. This inflation has been produced, at least in good measure, by excessive spending, extravagance and waste by the Federal Government. We have repeatedly emphasized the failure of recent Congresses to exercise prudence in conserving the taxpayer's dollar and have called for an end to deficit spending as a persistent governmental habit.

We reiterate our view that inflation is older America's No. 1 public enemy, and that this enemy can only be brought under control through a new congressional commitment to sound and reasonable priorities for Federal spending programs.

The United States has been fortunate that its President, who came into office in times that were difficult for the economy as well as troubled in other ways, has had the courage and foresight to resist a temptation to start a new spending spree to buy the Nation out of recession—an accelerated spending pattern which would only have aggravated the inflation problem and invited a new, perhaps deeper, recession in days to come.

The present national administration is rightfully proud that its efforts for economies in Government have been a factor in reducing the annual rate of inflation during the first quarter of 1976 to 2.9 percent. Predictions by economists, in and out of Government, that inflation during the coming months will be at levels of from 5 to 7 percent, however, indicates that the war is not won. Even such levels, nonetheless, are a far cry from the double-digit inflation which faced the President when he took office.

The business world may be able to accommodate itself to inflation at a fairly stable 6 percent annual rate. The same cannot be said for older Americans. For them, as well as others on fixed incomes, it is essential that efforts by the executive branch to hold down unnecessary

spending and waste be continued. They must be reinforced by a strong sense of fiscal responsibility in Congress.

We are somewhat encouraged by the new budget-making process instituted by Congress last year. Now in its first full-scale test, we will watch with interest how effective the process will be in holding down spending levels.

The seriousness and universality of rising costs of living as a problem for older Americans have been well documented by extensive hearings by this committee during the past 20 months. These hearings have shown clearly how the hidden tax of inflation creates almost insurmountable hardship for many retirees in their daily lives as they try to meet increasing costs of food, clothing, rent, home maintenance, property taxes, heating fuels, utilities, medical care, and other goods or services necessary for comfort and survival.

Influence of Government on the rate of inflation goes beyond the impact of budgetary deficits and beyond higher taxes which show up in increased costs of producing goods and services. Influence of Government is manifested also by the manner in which such spending is carried out—even for the most commendable and worthwhile programs and projects. There is need for greater efficiency in administration.

At hearings by this committee, questions have been raised about lack of coordination in programs of clear benefit to older Americans. Witnesses have pointed to unnecessarily higher costs of such programs resulting from noncoordination and duplication of effort. The point has likewise been made that excessively rigid administrative rules, which frequently ignore local realities, have increased unit costs of delivering needed services.

There is also growing concern throughout our society about excessive costs to individuals, business firms and nonprofit organizations produced by the mass of regulations imposed on them. These costs inevitably are passed on to the consumer.

Unquestionably the regulative responsibilities of the Federal Government are proper and necessary. It too often appears, however, that the demands by the Government on private producers and distributors of goods and services impose unjustifiable burdens and costs. It has been estimated that the expense of compliance with regulations adds as much as $60 billion a year to the costs of American business. This is reflected in higher prices it must charge. Excesses of Federal regulations have also caused nonprofit institutions, such as a number of colleges and universities, to withdraw from programs funded by HEW because there is too much paperwork.

It should be noted that while part of these problems are the result of excessive zeal within the bureaucracies, part are the result of congressional mandate. In either event, they contribute to the higher costs of goods and services in the private sector over and beyond the inflationary pressures attributable to Federal deficits.

It is obvious that nothing Government can do will be of greater help to all older Americans than to pursue vigorous policies aimed at bringing inflation down to manageable levels. Nor is there any easy road to this goal of dollar stability.

The inflationary spiral of the past 10 years is a product of long-term Federal spending abuses, including domestic excesses simultaneous

with a long drawn out no-win war in Vietnam. It is unreasonable to expect that the damage can be undone overnight.

Despite rising average incomes for older persons—in part due to automatic cost-of-living adjustments in social security first urged by minority views, Special Committee on Aging report, "Developments in Aging, 1965," and enacted in 1972, there is no way retirees can achieve and maintain the economic independence they deserve without victory in the war against inflation. Nor can we assume that recent progress will continue unless there is a determined effort at the Federal level to bring spending within limits that the Nation can afford. No group better understands this fact of life than do older Americans.

Even with a most enlightened posture of fiscal prudence in Government, setbacks will almost certainly occur in achieving the stable American dollar so essential to the economic well-being of older Americans.

As in the past, it is reasonable to expect that from time to time there will be conditions or events over which Government can exercise little or no control which will lead to rising costs of living, such as the crop failures here and abroad in recent years, and the rising worldwide demand for food.

We have learned, too, how serious can be the impact of arbitrary foreign actions, such as the late 1973 quadrupling in prices of foreign oil on which this Nation is so dependent. Clearly new efforts must be made to give the United States a higher level of self-sufficiency in fuels than it now has.

This in no way minimizes the importance of the primary area in which Government policy and practices have a clear relationship to inflation—the level of governmental spending and the size of the national deficits.

SOLVING SOCIAL SECURITY'S FINANCIAL PROBLEMS SHOULD BE THE FIRST CONGRESSIONAL PRIORITY

As emphasized in last year's minority views, the first specific legislative priority by Congress on behalf of older Americans should be action to solve the financial problems faced by social security's OASDI (Old-Age, Survivors, and Disability Insurance) program—the Nation's primary source of retirement income.

Reassurances, which go beyond lip service, should be given now to retirees that this essential cash program will continue to provide payments to them, and to younger Americans when they reach retirement age.

Continued delay in meeting both the immediate and the long-term deficits of OASDI can only serve to undermine further the confidence of the American people, already shaken, in the social security system.

The seriousness of the OASDI financing problems has been discussed widely in the press, it has been a concern of the social security trust fund trustees, and it has been recognized by the President in his messages to the Congress, and in proposals he has offered for correction of the deficits.

It is a grievous and unwarranted error to charge, as some have done, that public expression of concern about OASDI's financial difficulties is an attack on the system. On the contrary, a strong commitment to

tackle such problems head-on and without delay, is a genuine demonstration of concern for the people served by social security and the importance of keeping it effective on their behalf.

No one is more aware of this than informed older Americans to whom social security is so vital. They are concerned no more for themselves than for retirees who will follow them in years to come. They understand that failure to respond promptly to needs of the system is a disservice to the principle that social security must remain strong as a cornerstone of retirement income in America.

OASDI Questions Requiring Prompt Answers

Questions in the minds of the people about the social security cash benefits program are the same today as they were in 1975:

—How can the financial integrity of OASDI be assured?
—What changes in methods of financing and/or benefit levels should be considered?
—More money is needed; where will it come from?
—Have we expected to do too much too fast through OASDI?
—Will the workers, whose taxes provide current and future benefits, be willing to accept more increases in payroll deductions big enough to meet OASDI's financial deficits?
—Should general revenues be used to meet shortages in the trust funds? If so, how much money should be taken from general treasury funds for this purpose? What effect would this have on income taxes imposed on both young and old? How would it be reflected in higher prices through indirect taxes on purchases made?
—Are there other alternatives which could meet the short-term and long-term dimensions of the OASDI financial crisis?
—How do answers to these and similar questions interrelate with other legislative proposals—such as those for national health insurance?

We cannot afford, as a Nation, to approach these questions on a haphazard or piecemeal basis. Congressional actions on social security should also recognize serious implications which such action may have on our whole socioeconomic system and the long-range needs which must be met. OASDI is too important to the American people to be given casual treatment.

How Serious Are OASDI's Immediate Problems?

Currently more money is being paid out in OASDI benefits than is being received in social security taxes. During 1975, expenditures exceeded income by $1.5 billion. According to latest estimates by the Social Security Administration, deficits of outgo over income for OASDI operations during 1976 will be $4.3 billion.

In view of sharp increases in employment during the past year, the 1976 estimate is slightly below the deficit estimated by the Board of Trustees of the Federal Old-Age, Survivors, and Disability Insurance Trust Funds in their 1975 annual report. The fact remains that it is a dangerous shortage.

If no corrective action is taken, there is a strong probability that deficits will continue to grow in future years, even with growing employment, compounding a problem which has already reached unacceptable dimensions. Under present financing arrangements the OASDI trust funds will continue to pay out more than they take in from now on until they are exhausted early in the next decade.

Although originally promoted with the idea that a large reserve fund was to be created from employer/employee taxes so that it would provide interest earnings to meet a large part of the benefit cost, we have now come to the point where, unless changes are made, in the near future there will be no assets in the fund, and payroll tax contributions will be insufficient to meet payments pledged under social security.

For a number of years, since the expected large income producing reserve did not materialize, it has been the accepted view that assets in the OASDI trust funds at the beginning of each year should roughly equal expected benefit obligations payable for the year to follow.

Persistence of the current and anticipated deficits will destroy this safeguard to OASDI's integrity and viability. How serious is the trend in recent years is shown by the following table prepared by Robert J. Myers, who was Chief Actuary of the Social Security Administration from 1947 to 1970, and is currently professor of acturial science, Temple University. It describes the relationship between trust fund assets and expected annual outgo for selected years.

EXPENDITURES IN YEAR RELATED TO FUND BALANCE AT BEGINNING OF YEAR, U.S. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

[Dollar figures in millions]

Calendar year	Expenditures for benefits and administrative expenses	Fund at beginning of year	Fund as percent of expenditures
1940	$61	$1,724	2,82[c]
1945	304	6,005	1,975
1950	1,022	11,816	1,155
1955	5,087	20,576	404
1960	11,798	21,866	186
1961	13,389	22,613	169
1962	15,155	22,162	146
1963	16,217	20,705	128
1964	17,021	20,715	122
1965	19,187	21,715	110
1966	20,913	19,841	95
1967	22,471	22,308	99
1968	26,015	26,250	101
1969	27,892	28,729	103
1970	33,108	34,182	103
1971	38,542	38,068	99
1972	43,281	40,434	93
1973	53,148	42,775	80
1974	60,593	44,414	73
1975	69,184	45,886	66
1976	[1] 78,151	44,342	57

[1] Estimated.

The importance of normally maintaining a fully adequate reserve in the trust funds is the inevitability that there will be ups and downs in the economy which will be reflected in outgo occasionally exceeding social security income. The last time this occurred prior to the present period was in 1965. Prudence demands that social security be fully recession proof, or as nearly so as we can make it.

Whatever current reserve level is regarded as acceptable, the need for early action is shown by the latest available estimates from the Social Security Administration for the next several years as to the probable percentage relationship of OASDI *assets at year's beginning to expected outgo* in benefits and administrative expenses for that year. For calendar year 1976 estimated assets in the funds represent 57 percent of expected outgo:

	Percent
For 1977	46
For 1978	37
For 1979	29
For 1980	21
For 1981	14

and early thereafter in the 1980's the funds will be exhausted and unable to meet their commitments.

What Legislative Action Is Needed Now?

We call upon the Congress to give highest priority to meeting the serious shortfall in the OASDI trust funds as it threatens the system now and throughout the next 5 or 10 years. At the same time, we understand the complexities of the issues involved. We recognize that development of fully equitable changes in the system, which the problem demands, are beyond the province and expertise of the Special Committee on Aging. We therefore urge those committees with legislative jurisdiction in this field to take action now.

In his February 9 message to the Congress on older Americans, the President has responded to the need by enumerating five changes in OASDI which he believes to be necessary, and on which he has or will submit specific proposals. There should be no delay in careful attention to them by the Congress.

One of the changes, on which there appears to be little or no disagreement, and which was discussed in last year's report of this committee, is the "decoupling" of OASDI cost-of-living benefit increases for those already retired and prospective benefit levels for those still in the work force. It may be assumed that such legislation would follow the recommendation of the 1974–75 Advisory Council on Social Security.

The Council recommended retention of the current cost-of-living adjustment for retirees, a position with which we strongly concur, but it called for elimination of this procedure as applied to the benefit formula used for those still in the work force, *limiting the initial benefit formula increases to an index based on average increases in wages.*

With reference to this, the President said:

> The current formula which determines benefits for workers who retire in the future does not properly reflect wage and price fluctuations. This is an inadvertent error which could lead to unnecessarily inflated benefits.
>
> The change I am proposing will not affect cost of living increases in benefits after retirement and will in no way alter the benefit levels of current recipients. On the other hand, it will protect future generations against unnecessary costs and excessive tax increases.

We are informed that adoption of this proposal could eliminate current OASDI deficit prospects by as much as 50 percent. This elimination of "doubled" increases for those still in the work force would be fair to all participants in the system.

It was never intended that cost-of-living adjustments should be applied independently to the benefit schedule for those who are still working. Their increases should be taken care of solely on the basis of rising wages.

Action along these lines could offer a response to criticism of the rationality of the law's present language on automatic adjustments which the Finance Committee's special panel on social security financing expressed early in 1975. The panel said:

> Unless material changes are made in the benefit formula, Congress will not have the appropriate control over the reasonableness and consistency of benefits and it will be difficult, if not impossible, to finance the system on a satisfactory actuarial basis.

While the other proposals by the President are more controversial, they also deserve prompt consideration. They include: *a social security tax rate increase* of 0.3 percent for employers and employees in 1977 and of 0.9 percent for self-employed persons; *phasing out social security benefits for full time students aged 18 to 22* over a 4-year period; *changing the retirement test* so that it will be based only on annual income, and *eliminating retroactive payment of actuarially reduced benefits when this would require a permanent reduction in the beneficiary's future monthly benefits.*

These proposals should receive careful review along with a study of alternative methods of improving OASDI financing which might be superior to them.

Greater Long-Term OASDI Problems

Despite the seriousness of immediate OASDI deficit problems, long-term projections of the system's operations show even greater problems in social security financing.

The even more sizable deficits predicted by experts for OASDI during the next 50 to 75 years and beyond, unless changes are made, are primarily due to new predictions regarding three major factors:

(1) Inflation and wage level expectations;

(2) Anticipated continued early retirement trends; and

(3) Predictions that the percentage of the elderly in the population will rise substantially, due to low birth rates which will result in reduced total population growth.

How large the dollar shortages in OASDI will be, depends on the relative accuracy of differing assumptions made by various experts, on the one hand, as to probable rates of inflation and wage level increases, and, on the other, what will be future trends in retirement patterns and the birth rate.

The general range of estimates, however, indicates that unless corrective action is taken, the deficit in terms of present dollars will be somewhere between $1.5 trillion and $2.7 trillion over the next 75 years.

There is a tendency in some circles to brush off both short-term and long-term financial problems with the "reassurance" that there is "plenty of time" to solve these problems and that Congress will not fail its obligation to raise the money in some way. We believe the problem is too serious and the social security system is too important to America's people for such a position to be acceptable.

We share the view that Congress will meet its responsibility to see that obligated payments of social security benefits will be made. We do not share the view that there is a lot of time for developing appropriate lines of action.

The individual citizen tries to plan ahead for his own future, such plans often looking 40 to 50 years into the future. By the same token, we believe it is the responsibility of Government and national leaders to also look far into the future. In the larger time framework in which a Nation must live, this means 75 to 100 years, not just 5 or 10. This is the principle on which the whole social security system was based and which has been followed in the past. It must not be abandoned now.

No matter how we obtain money necessary to solving both immediate and long-term financing problems, the fact remains that the money must be raised somehow.

The Nation must also give serious and early thought to a review of current retirement patterns. This should relate to effects of continued trends both on OASDI's ability to continue as a program acceptable to the workers who pay the taxes on which it depends and on how current practices affect the lives of individual older Americans.

This becomes critically important with the prospect that, unless new approaches are developed, within 40 years the number of workers supporting each OASDI beneficiary will fall from more than three workers for one beneficiary to less than two for one.

Need for Constant Social Security Overview

If the past several years have offered any lesson to the Nation, it should be that the social security system is not only our most immense domestic business operation, but that the elements which enter into its success or failure are extremely complex.

Both the current OASDI financial shortages and the administrative problems with the supplemental security income program, SSI (discussed at some length elsewhere in this committee report), underscore the dangers in the way various programs under the Social Security Act have been approached in the past. We need a mechanism, totally independent of the bureaucracy which administers social security, to provide us with the kinds of information and overview that will give highest possible reliability to the decisions made in the future by the Congress and the executive branch.

Observations in this regard made in last year's minority report bear repetition here. The need and arguments for a constant, highly qualified review remain unchanged.

Last year, trustees for the social security trust funds, the 1974–75 Advisory Council on Social Security, and the Senate Committee on Finance Panel on Social Security Financing indicated that more study of social security and its problems is needed.

The logical conclusion to be drawn from any of the three reports is that there should be a continuous overview of social security by a permanent, continuing council or commission with no other responsibilities.

The 1974–75 Advisory Council on Social Security said, in part:

> Major aspects of social security that deserve attention, but that the Council did not have time to analyze thoroughly, included: full reserve funding vs. current cost financing; the effects of social security on productivity, capital formation, and private savings; the relationship between private pensions and social security; and the appropriate size of the trust funds. . . . Comprehensive study of these and related issues should be conducted by a full-time nongovernment body. . . .

The Committee on Finance Panel on Social Security Financing said:

> In view of limitation of time, the panel concentrated its study on the structure of the retirement benefits and its impact on the financing of the program. Other benefit formulas such as survivor benefits deserve an equally thorough study.

These observations reinforce the validity of the minority recommendation in the Special Committee on Aging report filed May 5, 1972, and reaffirmed in minority views since that time, that there should be a review agency for social security capable of serving a continuing ombudsman role for the people.

Specifically, the recommendation was that the Congress enact legislation to create a permanent, independent, bipartisan commission to maintain constant surveillance of social security, and to provide the President, the Congress, and the people with sufficient information to give maximum assurance that all decisions related to social security are well taken. Such a commission should have responsibility also for constant overview as to the social security system's adequacy and performance in meeting needs of the country and might well include a mechanism for adjustment of grievances against the system.

One way of implementing this would be through enactment of Senate Joint Resolution 5, a joint resolution to establish a National Social Security Commission, introduced early in this Congress by Senators Fong, Fannin, Tower, Thurmond, Brock, Domenici, and Hansen.

Responsibilities of the National Social Security Commission, as proposed in Senate Joint Resolution 5, would be the same as those now assigned by law to the Advisory Council on Social Security. Operational and structural changes to be made would be as follows:

(1) Members of the Commission, instead of being named by the Secretary of Health, Education, and Welfare, would be named on a bipartisan basis, with appointment power divided between the President, the President pro tem of the Senate, and the Speaker of the House of Representatives.

(2) The Commission would be permanent, functioning on a continuing basis with regular reports to Congress and the people, in contrast to current provisions for appointment of a new Advisory Council every 4 years with a tenure of approximately 1½ years.

(3) The Commission would have its own professional staff rather than having to rely on the Social Security Administration.

The National Social Security Commission would be an appropriate instrument for the numerous studies suggested by the temporary panels which have worked on various aspects of social security.

A CONTINUING PROBLEM: LONG-TERM CARE FRAUD AND ABUSE

An area of concern to which the Committee on Aging has directed concentrated effort during the past year has been the continuing investigation by the Subcommittee on Long-Term Care into fraud under the medicaid programs.

This inquiry, stepped up last year through the temporary addition of special investigators to the subcommittee staff, has been directed at *dollar fraud* and at *human fraud*—the mistreatment and personal abuse of patients for whom institutions were being paid to provide decent care.

Noteworthy in this investigative effort have been the personal on-site visits of hospitals, nursing homes, boarding homes, pharmacies, clinical laboratories, and doctors' offices by Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care; Senator Charles H. Percy, ranking minority member of the subcommittee, and Senator Pete V. Domenici.

Commendation is also due Mr. Val Halamandaris, associate counsel of the Committee on Aging and director of the Subcommittee on Long-Term Care staff. Mr. Halamandaris and the special staff have performed a distinguished service in ferreting out wrongdoing in the medical care field as it relates to older persons.

A summary of the subcommittee's findings and various legislative proposals for congressional consideration are to be found in chapter V of this report and do not require repetition here.

One visible result of recent inquiries by the Subcommittee on Long-Term Care, and by other agencies at State and local levels, appears to be a new sense of responsibility by the Department of Health, Education, and Welfare.

Secretary of Health, Education, and Welfare David Mathews announced, March 26, the initiation of a new joint Federal-State effort to curb abuse in medicaid.

Acknowledging that losses due to fraud and abuse could exceed $750 million annually, Secretary Mathews indicated that a team of medicaid examiners, composed of Federal and State personnel, would begin the campaign in Massachusetts in April and in Ohio in June in response to invitations from the Governors of those States.

Objectives of the effort, Secretary Mathews said, would be (1) to identify the kinds of abuse and fraud; (2) to assist the States in developing a management system which will insure efficient program control, and (3) to proceed with investigations and prosecutions.

If the campaign announced by Secretary Mathews is but a beginning in a serious effort, it is an encouraging development.

A most disturbing element in the problem of patient abuse and fraudulent billing in medical care of the elderly is its persistent character. One of the principals in the subcommittee's New York

nursing home investigation, for example, was also an object of inquiry in 1959 by the Kaplan Commission long before medicaid came into existence. That this individual has now been indicted, however, does offer some encouragement.

The long period of time that the Subcommittee on Long-Term Care has been pursuing such inquiries in itself underscores the difficulties in bringing a high level of professionalism into a field which should, above all others, be dominated by the loftiest motivation and most exemplary conduct, particularly as it relates to institutional care.

It is true that only about 5 percent of the persons past 65 are institutionalized. It is equally true that many of these persons are being well cared for. But the large number of the chronically ill aged who are being victimized by unscrupulous profiteers is a national disgrace. Mistreatment of even but one of this most vulnerable part of our population is inexcusable.

This problem's challenge to America's humanity is serious. To meet it will require involvement of persons from many walks of life at all levels of society and vigorous action on numerous fronts.

The Congress and executive branch of the Federal Government have a major responsibility, as do public officials at State and local levels. The professional health care societies should be called upon to do their part in policing the unscrupulous individuals or institutions which bring such professions into disrepute. Particularly in the case of nursing homes, boarding homes and other long-term care institutions, there is serious need for volunteer community leadership to protect the sick and enfeebled aged and to bring comfort to them. Such leadership can follow the lines urged through precept and example by the American Association of Retired Persons, the National Council of Senior Citizens, the National Retired Teachers Association, and other organizations interested in needs of older Americans.

The Subcommittee on Long-Term Care deserves our full support in the work it has been doing and is doing on behalf of those older persons least able to care for themselves.

THE GROWING OLDER AMERICANS ACT NETWORK

A continuing plus in efforts to improve quality of life for older persons has been the strengthening of a national services network through the imaginative leadership of Dr. Arthur Flemming under authority given him as Commissioner on Aging by the Older Americans Act, and the dedicated commitment of professionals in aging at State and local levels. While details of this effort to make maximum use of all kinds of programs, regardless of funding source, are presented elsewhere in this report, it is worthy of special note here.

While fully operative for only 2 years, this national network on aging, composed of 56 State agencies on aging, 489 area agencies on aging, and 733 title VII nutrition projects, has already begun to have an important impact on the lives of older persons. This has been achieved through improved coordination of existing services in such areas as health, manpower, education, and transportation. State and area agencies on aging operating under title III of the Older Americans Act have initiated new services, and strengthened existing services by tapping public and private resources other than those provided

under that act and not specifically earmarked for the elderly, and directing them toward serving older persons. During 1975 more than $100 million of Federal, State, and local funds (exclusive of title III and title VII) were made available in this manner.

Examples of such State and local action include:

$400,000 in community development funds were obtained to support nutrition programs, senior centers, and an RSVP program, and to initiate a homemaker program (Tulsa, Okla.).

$100,000 in general revenue sharing funds were contributed to support nutrition programs; $350,000 has been committed for next year (San Diego, Calif.).

$6 million in housing authority funds were allocated to services for older persons (Prince Georges County, Md.).

An additional $2.4 million in title XX funds were made available for older persons (Montana).

The title VII nutrition program for the elderly now provides approximately 300,000 meals a day, 5 days a week at more than 4,900 local sites throughout the country.

The interagency efforts of the Administration on Aging have helped the national network on aging to bring available resources to bear to serve the elderly. For example:

An agreement between AoA and the Department of Transportation led to DOT's release of $20.8 million for capital assistance in the provision of transportation services to the elderly and handicapped.

More than 27,000 older volunteers supported through ACTION program participate in titles III and VII programs under an AoA/ACTION agreement.

AoA and the Community Services Administration formally entered into an agreement designed to help meet the energy-related needs of older persons. It has been estimated that more than half the homes winterized through CSA's winterization programs belong to older persons.

LONG-RANGE CHALLENGES IN AGING

If the past is but prologue to the future, there is need for serious review of the direction that our society is going in responses, negative and positive, to needs of older Americans, and their implications for the years ahead.

Essential in any long-range assessment are answers to two questions:

(1) *What will be the challenges for individuals and the Nation in an "aging" society?—What social and economic changes will be required as the average age of our population and the percentage of older persons rise substantially?*

(2) *In meeting the new challenges to our society, how can and should responsibility and opportunity be divided among Government, private organizations, and individuals?*

The financial problem which faces the social security system in the period 25 or 30 years in the future, discussed earlier in this statement, is one manifestation of the need for policy reevaluation generated by the combination of lower birth rates and longer life expectancy

which is expected to produce a new mix of young and old in America during the early part of the 21st century.

Vital as this social security financing problem is, it is only one aspect of the impact of lengthening life which may see normal life expectancy of 85 to 90 years as further progress is made in medicine and average American standards of living. The whole role in society of persons past 65 may very well require updating to assure that individuals shall have maximum purpose and meaning throughout increasingly long lives.

Valid new and positive policy development in aging obviously will require serious attention by all elements of society, public and private.

America does have concern for older persons. This is reflected in summaries of activities by various Federal agencies which appear in the appendix of this report. Examination of them reveals effective progess during the past year on a wide range of programs of benefit to older persons.

More dramatic evidence of America's concern is seen through any review of the 15 years since the Eisenhower White House Conference on Aging. That period has seen enactment of medicare, medicaid, automatic cost-of-living adjustments in social security benefits, a new national supplemental security income program (SSI), new housing programs for the elderly, and the establishment of the National Institute on Aging.

During that period special impetus was given to improvements in quality of life for older persons through enactment of (without a single dissenting vote in either the House of Representatives or the Senate), and improvements in, the Older Americans Act with its provision for senior centers, a national hot noon meal program, community service employment opportunities, the Foster Grandparent program, the Retired Senior Volunteer program (RSVP), training of personnel to work with older persons, special transportation services, legal counseling, home repairs, and supporting services to the home.

We believe that efforts thus begun and continued should be strengthened at every opportunity. Nonetheless, we fear the very proliferation and growth of such programs under Federal subsidies may encourage a spirit of complacency which is dangerous to the future of other kinds of action essential to the well-being of older Americans of today and years to come.

Even as we continue our support for special Federal programs on behalf of the elderly, we recognize that there is a serious risk that the American public will assume that increased governmental expenditures are solving the problems of older persons, and that efforts to assure dignity, honor and independence in later years can just be left to government. This is simply not so.

As we have repeatedly pointed out in the past, some of the most serious questions for any aging American are those which call for major actions outside of the legislative field. Two years ago, the minority report of this committee called attention to literally hundreds of questions for which intelligent answers must be found if the best possible policies on aging are to be implemented. Many of them were questions which can be answered only through effective decisionmaking within the private sector of our society.

Most compelling among such questions is the one related to rigid retirement practices based on chronological age. Unless and until nongovernmental leaders, and the public as a whole, face up to the risks in current trends which force earlier and earlier retirement on America's workers, the future of aging in America will be far from bright.

Freedom of Choice Essential

The aim of any worthwhile response to the needs of older America should be fullness of life with dignity, honor, and independence.

To the maximum level of his or her ability to function as a human being, every older American should have freedom of choice.

Interference with this right to freedom of choice based on any artificial standard such as sex, race, or chronological age, without regard for the capacity of the individual to perform, is a direct violation of the American heritage of freedom.

To the extent that there is interference with the rights of older Americans, as in fact there is, solely because of age, it involves imposition on them of a second-class citizenship which is unacceptable today and will be intolerable in the future.

One of the most serious obstacles to first-class citizenship by older Americans is to be found in the prevalent practice in both public and private enterprise of forced retirement from employment solely on the basis of chronological age. A companion to it is the age discrimination in new employment. To the extent that either of these practices disregards the desires and the abilities of the individual, they represent a violation of what should be our national position on aging.

Older Americans themselves, whether still employed, voluntarily retired, or forced into retirement by such rules, have made it unmistakably clear that they resent such artificial interference with their right to participation in the economic processes of society. They have pointed out correctly, as have experts on the biological aspects of aging, that the imposition of such forced retirement at age 65 (or 60 or 70) has no basis in the ability of people to do a job.

In saying this, we are neither expressing opposition to voluntary retirement by individuals, which quite properly is elected by many persons, nor are we ignoring the problems faced by employers, including those related to insurance and pension plans. We recognize that the problems involved are complex and require imaginative leadership of the highest order. We recognize, too, that the solution to this problem is largely outside of the legislative field. We would be remiss in our duty as members of the Special Committee on Aging, however, if we did not express our serious concern about the continued failure of the private sector, in its varied fields of operation, to recognize the seriousness of the problem.

It may be that part-time retirement may be an answer for both employer and employee in the future. Even as many older persons who have retired want to accept part-time jobs rather than those on a full-time basis, so it may be the future should see development of similar accommodations within the framework of jobs long held. Whatever may be the precise formula, it does appear necessary, in both human and economic terms, to bring a new degree of flexibility

into the labor market. This should apply both to retirement rules and hiring practices.

While "new career" opportunities at low-pay scales under Government subsidies, such as in the old Operation Mainstream under the Department of Labor, are helpful, the real answer will only be found through new private leadership initiatives.

To do otherwise is to ignore the wealth of experience, skill, productivity that is now being lost to the Nation through forced idleness based on age alone. To do otherwise is to ignore the health and personal satisfaction values which many individuals find—at every age—in doing productive work.

Recognition to this has been given by every President beginning with Eisenhower and since his administration. We have reiterated it, sometimes in greater detail, in previous reports of the Special Committee on Aging. It is time that industry, labor and other elements in the private sector take the ball.

Essential as a new attitude by employers is, there are some areas in which the need for greater flexibility in retirement practices and employment policies can be helped through congressional action, including legislative prohibition of age discrimination. Most important in the legislative field is action on elements in public programs which discourage employment during later years. One major step needed is a change in the social security system's limitation on earnings by beneficiaries.

There is widespread and justifiable opposition among older persons to this earnings test as now devised. There is reason to believe that many who are now totally out of the work force would like to take jobs—full time or part time—who do not do so because of the double taxation the test imposes on them. They just feel they cannot afford to take a job, even though they would enjoy the work and need the money. They do not see why they should work and receive so little in return.

It is impossible to estimate accurately how many productive workers would be added to the labor force, contributing to the Nation's wealth and their own satisfaction, if the test were changed. In our judgment, however, based on testimony by retirees, the number would be considerably larger than usually appears in Government estimates which have been offered in the past.

One improvement, which we have long advocated, would be major liberalization or total elimination of the earnings test. Another would be through provision of more equitable increases in benefit levels for those who choose to defer retirement after 65.

The latter approach, which has been discussed at length in previous minority reports, is to be found in a bill, introduced by Senator Fong, to provide a 6⅔-percent increment in OASDI retirement benefits for each year retirement is deferred after age 65. This bill, S. 829, is cosponsored by every Republican Member of this committee and by a number of other Senators, including the committee chairman and the chairman of the Subcommittee on Employment and Retirement Income.

Employment is not the only area, of course, in which age discrimination interferes with full citizenship rights of older Americans. Housing is another. Discrimination sometimes even extends to limita-

tion on volunteer leadership roles. None of these, or others which could be named, is acceptable.

Granting of credit has long been denied to the elderly because of age alone. The new Equal Credit Opportunity Act will help. As a practical matter, however, the success of this effort requires a change in attitudes by lending institutions and other providers of credit.

Freedom of choice also involves a simple but often forgotten right—the right to be left alone.

It is evident that above all else in the field of aging, there is a need for development of new attitudes toward aging and older persons—attitudes which recognize that the 19th century stereotypes of older persons are not valid today; attitudes which recognize that older Americans have a zest for living, a level of appetites, and the right to their full satisfaction comparable to that of their younger counterparts; attitudes which fully recognize the rights of older persons to freedom of choice as first-class American citizens.

HIRAM L. FONG,
CLIFFORD P. HANSEN,
EDWARD W. BROOKE,
CHARLES H. PERCY,
ROBERT T. STAFFORD,
J. GLENN BEALL, JR.,
PETE V. DOMENICI,
BILL BROCK,
DEWEY F. BARTLETT.

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