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DEVELOPMENTS IN AGING: 1979

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

PURSUANT TO

S. RES. 65, MARCH 7, 1979

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

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., February 28, 1980.

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

DEAR MR. PRESIDENT: Under authority of Senate Resolution 65, agreed to March 7, 1979, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1979, Part 1.

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

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

Sincerely,

LAWTON CHILES, *Chairman.*

SENATE RESOLUTION 65, 96TH CONGRESS, 1ST SESSION [1]

Resolved, That the Special Committee on Aging, established by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from March 1, 1979, through February 29, 1980, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

SEC. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from March 1, 1979, through February 29, 1980, to expend $325,300 from the contingent fund of the Senate, of which amount (1) not to exceed $25,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such act).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 1980.

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

[1] Agreed to Mar. 7, 1979.

PREFACE

In the months prior to publication of this report, much was written about the decade that was drawing to a close. Analyzing the seventies became a temporary preoccupation for everyone from syndicated columnists to fashion experts. Much was written about the politics and policies of the seventies—about our national achievements, as well as our losses.

During the seventies, America felt economic pressures from a variety of sources. We were confronted with an oil embargo. Energy prices soared and, in the final year of the decade, inflation reached 13 percent. Unemployment was up; the consumers' buying power down. The decade, however, cannot be viewed in a vacuum. The seventies—and what the decade meant for the Nation's aging population—must be viewed in light of occurrences during the decade that preceded it.

In 1961, the first White House Conference on Aging helped bring information about the Nation's older Americans to the forefront. With the assistance of Federal grants, States and communities were actively involved in identifying issues to be discussed at the Conference. National awareness about aging issues was heightened through media coverage of the Conference, and post-Conference reports were issued in a period of reasonable economic growth. Conference recommendations were well received. In 1965, two of the major recommendations—medicare and the Older Americans Act—were enacted by Congress.

Well over a decade after their enactment, medicare and the Older Americans Act are still major factors in our efforts to help older people maintain their health and independence. But the climate that spawned these programs is far different from the climate that exists today.

With the seventies came increased public disillusionment with the lack of success of the war on poverty and other similar programs dating from the mid-sixties. Inflation began to take a bigger toll as the cost of basic necessities rose faster than other goods and services. Public interest in the efficient operation of programs funded with tax dollars was heightened and Congress became more intent on controlling Federal spending.

Members of Congress have expressed interest in limiting Federal spending since the 1870's; however, interest usually dwindled when there was a budget surplus and the national debt was being repaid. But, in the 1970's—when the Federal Government incurred a sizable deficit each year—interest in fiscal restraint intensified. In 1974, Congress enacted the Congressional Budget and Impoundment Control Act, which for the first time established a fiscal management process to set priorities and determine overall spending levels.

Given the increased emphasis placed on limiting Federal spending, fiscal restraint will likely be the watchword of the eighties. Unless a severe and imminent problem arises—such as the increasing need for energy assistance—emphasis will be placed on making more efficient use of existing programs. This does not mean, however, that fiscal restraint will be accomplished at the expense of the elderly. Instead, the emphasis on controlled Federal spending will require improved program administration and increased responsiveness to the needs of an aging population. Existing programs in education, housing, crime prevention, social services, employment, and other areas must more effectively serve our Nation's elderly population.

In the immediate future, the Nation and its Congress must concentrate on issues that pose the greatest problems. Inflation, which is devastating for retired people living on fixed incomes, is increasingly identified as the Nation's most pressing problem.

In light of recent inflationary trends, it is useful to note some of the reasons for convening the 1971 White House Conference on Aging:

> Inflation was continuing at such a rate that, while money incomes of millions of older people were raised through social security benefits, many persons were relatively poorer. Employment opportunities for retirees did not materialize to enable them to earn additional income. Taxes, especially property taxes, climbed to such levels that many older homeowners were forced to sell and move into cheap rented quarters. Production of new housing lagged. Health services remained fragmented and uncoordinated, resulting in poor delivery of services to the elderly. Institutional care was increasingly allocated by public agencies to the proprietary nursing homes, which admittedly needed stronger regulatory measures to improve their standards.[1]

Unfortunately, the problems identified almost a decade ago still exist as we approach the 1981 White House Conference on Aging. In recognition of the financial problems caused by inflation and factors such as taxes and housing, "Developments in Aging: 1979" contains for the first time a section discussing economic performance and the economic status of the Nation's elderly population.

As identified in the above statement made prior to the 1971 White House Conference, inflation is not the only factor significantly affecting the well-being of older people. Other factors include health services and long-term care. More must be done to assure that older Americans are not relegated to nursing homes or other forms of institutional care. As our population grows older and the demand on our limited alternative forms of care intensifies, the need for a national policy on long-term care becomes crucial. By working toward the development of such a policy, much could be done to assure that older people are able to live in dignity.

Further, experience is making it clear that in developing a policy on long-term care, the resources of existing social institutions and support systems should be tapped. In an era in which much attention is focused on problems facing the American family, government should reinforce families who want to care for an older person at home. Government disincentives for family care should be eliminated.

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[1] 1971 White House Conference on Aging, "Toward a National Policy on Aging, Final Report, Volume 1" (Washington, D.C.), p. 3.

But the family is not the only support system caring for older people in the community. Churches and private organizations also provide a variety of services to the elderly. Care should be exercised to assure that these services are encouraged and maintained—and not replaced by government programs. In a time of fiscal restraint, no legitimate provider of services for the elderly should be overlooked.

In retrospect, it appears that the optimism which spawned new programs in the sixties was tempered by the seventies and the realization that it takes more than money and good intentions to solve complicated problems. The seventies brought into focus the need for efficient and innovative program administration. At the same time, limited resources highlighted the importance of tapping all available resources.

There can be little doubt that the fiscal restraint of the eighties will pose new challenges to those who serve as advocates for older people. However, the 1981 White House Conference on Aging, the approaching reauthorization of the Older Americans Act, and an evolving national policy on long-term care offer opportunities for innovative people to demonstrate what can be accomplished through effective program development, equitable access to existing traditional programs and more efficient administrative practices.

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

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EVERY NINTH AMERICAN[1]

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

By the beginning of this century, the numbers of older persons had increased much more rapidly than the young and they represented every 25th American (3.1 million or 4 percent of the 76 million total).

At the beginning of 1980, the estimated 25 million older Americans made up over 11 percent of the population—"Every Ninth American."

But in recent years something uniquely different with new potentials for study and concern has become evident. In the past, the numbers of persons in all age groups increased even while the proportion of older persons in the population grew somewhat faster than did the younger age groups. Recent trends, however, have been different. Fertility rates since the end of the postwar baby boom have actually been below that necessary for zero population growth so that a continuation over a lengthy period of time will bring us an aging society with an increasing median age and eventual declining total population by the middle of the 21st century.

Even cursory consideration indicates the enormous implications for retirement and income policies, the role of technology, the shifting of product markets and advertising, clothing styles, social and recreational facilities, location and types of housing, health care facilities and personnel, entertainment, etc.

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

STATE HIGHLIGHTS

In mid-1979, the largest concentrations of older persons—13 percent or more of a State's population—occurred in six States: Florida (18.1), Arkansas (13.7), Iowa and South Dakota (13.1), Missouri and Nebraska (13).

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

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Texas). Adding five more States (Pennsylvania, Illinois, Ohio, Michigan, and Florida) brings the eight-State total to almost half the older population of the United States. It takes 12 more States (New Jersey, Massachusetts, North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, and Louisiana) or a total of 20 States to account for just over three-quarters of the older population. It requires an additional 10 States or a total of 30 to include 90 percent. The remaining

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

10 percent of the 65-plus population lives in the remaining 20 States and the District of Columbia. (See exhibit A for the actual figures and a detailed analysis of recent State trends.)

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold. The 65-plus population continues to grow faster than the under-65 portion: Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population; for 1970–79, the increase was 23.5 percent for the 65-plus group but only 6.3 percent for the under 65.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with significant numbers of older in-migrants. These five States and Alaska also had the fastest growth rates (over 50 percent) in 1970–79: Nevada (96.6 percent), Arizona (79.5), Florida (62.7), Hawaii (59.9), New Mexico (54.8), and Alaska (54.2).

Florida still has the highest proportion of older people—18.1 percent in 1979, 14.5 in 1970. Alaska remains the State with the smallest number and the smallest proportion of older persons—10,000 or 2.6 percent in 1979.

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 3,400 persons aged 65-plus die. The *net* increase is about 1,600 per day or almost 600,000 per year, but the 5,000 "newcomers" each day are quite different from and have experienced a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1979, most older Americans were under 75 (61.9 percent). Over half were under 73. And more than a third (35.2 percent) were under 70. Over 2.3 million Americans are 85 years of age or over. As a result of the significantly longer life expectancy for females, the preponderance of women over men increases with age. (See "Sex Ratios" and "Projections".)

Accurate data on the number of centenarians are not available, but 11,890 persons were receiving cash social security benefits in June 1978, after producing some "proof of age" that indicated that they were aged 100-plus. Further, a sample study of the file of persons covered by medicare produced an estimate of about 14,000 centenarians.

PERSONAL INCOME

Older economic units continue to have half the income of their younger counterparts. Retirement from the labor force usually brings a half to two-thirds cut in income and thrusts many older persons into a low-income category. Price inflation presents many difficulties to most older persons but hits hardest those who are truly on "fixed

incomes" which remain completely unchanged, such as most private pension plan payments, commercial annuities, certain investments (like old bonds), etc.

Families

In 1978, half of the 8.5 million families headed by an older person had incomes of less than $10,141 ($195 a week) as compared with $19,310 ($371 a week) for the 49.3 million families with under-65 heads. The skewing of the income distribution for older families toward the lower income levels is illustrated by the fact that the arithmetic average income, the mean, of $13,754 is more than $3,600 greater than the median ($10,141).

However, while the poverty rate for older families is high (see below), not all older families suffer low incomes. More than 550,000 or 6.5 percent of older families had 1978 incomes between $20,000 and $25,000, 820,000 or 9.6 percent had incomes between $25,000 and $50,000, and 168,000 or 2 percent had incomes in excess of $50,000. Thus, over 18 percent of the older families had higher incomes in 1978 than the median for the younger families.

The importance of income from work (earnings) is shown by the fact that the 750,000 (8.8 percent) of the older families whose heads were fully employed all year had double the income of all older families ($20,937 versus $10,141) and almost double the mean income ($26,278 versus $13,754).

Unrelated Individuals

The 1978 median income of the 7.6 million unrelated individuals aged 65-plus who were living alone or with nonrelatives was $4,303 ($83 a week) as compared with $8,530 ($164 a week) for those under 65. The mean income for the older individuals was $5,989 or almost $1,700 higher than the median.

One million or 13.2 percent of the older unreleated individuals had 1978 incomes of $10,000 or more; over 100,000 or 1.5 percent had $25,000 or more.

Poverty

(*This analysis is based solely on money income and excludes consideration of services or noncash benefits, and their impact on standard of living.*)

In 1978, 24.5 million persons of all ages (11.4 percent of the U.S. population) lived in households in which the total income was below the official poverty threshold for that size and type of household. Some 3.2 million older persons (14 percent or a seventh of the 65-plus population) were poor by this definition (for example, $3,917 for the household of an older couple or $3,116 for an older individual living alone).

Women and minority members are heavily overrepresented among the aged poor:

PERCENT BY PERSONS IN EACH CATEGORY

Sex	Total	White	Black	Spanish origin [1]
Both sexes	13.9	12.1	33.9	23.1
Male	10.0	8.3	26.7	20.9
Female	16.7	14.7	38.9	25.1

[1] May be of any race.

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Nevertheless, this is a significant improvement over the 4.7 million or a quarter of the elderly who lived in "poor" households in 1970 and results primarily from the increases in social security benefits. It must also be recognized that many of the aged poor became poor after reaching these age levels because of the half to two-thirds cut in income that comes with retirement from the labor force. Cost reductions after retirement are usually considerably less than the income loss.

Application of a somewhat more liberal standard of low-income status, 125 percent of the official poverty threshold in 1978, produces an estimate of 34.2 million persons of all ages (15.8 percent) and a disproportionately larger 5.4 million 65-plus (23.4 percent) who fall below that standard (for example, $4,896 for an older couple household and $3,895 for an older individual alone).

Adequacy—The Retired Couple Budget

In the early 1960's, the Bureau of Labor Statistics, with the help of a group of experts, developed a theoretic retired couple budget to provide a modest but adequate standard of living for a retired couple consisting of a 65-plus husband and his wife, assumed to be self-supporting and living in an urban area, to be in reasonably good health and able to take care of themselves, and to own a reasonable inventory of furniture and equipment.

Before 1969, the annual cost of the budget was calculated by actually pricing out all of the items in the budget and applying the appropriate "weighting." Since 1969, the cost of the budget is determined by applying to the cost for each division or component in the previous year the change in the comparable component of the Consumer Price Index for the urban wage earners and clerical workers. This procedure produces an approximation of unknown accuracy since spending patterns in the two measures are different as are the weights.

In 1978, the intermediate retired couple budget cost $7,846 ($151 a week). Of the 5.9 million two-person husband-wife families with 65-plus heads, about 2.2 million or 37.5 percent had less than this amount of income.

The cost of the lower budget ($5,514 or $106 a week), providing a reduced standard of living but well above the poverty level, could not be met by 1.1 million or 18.3 percent of these older couples.

The cost of a higher budget ($11,596 or $223 a week), providing some "luxury" items, gifts, contributions, and taxes, was beyond the income of 3.7 million or 62 percent of these older couples.

INCOME AND EXPENDITURES

In the past, the Bureau of Labor Statistics conducted interview and diary-type surveys of households at approximately 10-year intervals to gather data on income and expenditure patterns to serve the general need for this economic data and for the periodic updating of the content and weighting in the Consumer Price Index.

The surveys will now be conducted annually and the first new data are expected in 1981. The following presents the highlights from the last available survey, 1972–73.

(*Survey data are collected and tabulated for "economic units," consisting of both families (groups of persons related by marriage or blood living together in a single household) and unrelated individuals (persons living alone or with nonrelatives).*)

INCOME SOURCES AND FINANCIAL STATUS, 1972–73

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

[1] Under 65 equals 100.

The older units had about half the income of the younger, primarily because the larger amounts from retirement and investment income for the older units still did not balance out the loss of earnings from employment. As expected, the assets of the older units were greater than for the younger, but the net growth was not expected since it is known that older units tend to avoid new liabilities and have less credit potential but not that they have excess disposable income for investment.

EXPENDITURES, 1972–73

Category	Average annual amount			Distribution		
		65-plus			65-plus	
	Under 65	Amount	Index [1]	Under 65	Percent	Index [1]
Total	$10,059	$5,400	54	100.0	100.0	100
Insurance and pension	874	176	20	8.7	3.3	38
Gifts and contributions	410	490	120	4.1	9.1	222
Other consumption	8,775	4,734	54	87.2	87.7	101
Food	1,831	1,155	63	18.2	21.4	118
Alcoholic beverages	86	30	35	0.9	0.6	67
Tobacco products	146	60	41	1.4	1.1	79
Housing	2,619	1,559	60	26.0	28.9	111
House furnishings and equipment	438	174	40	4.4	3.2	73
Clothing	737	290	39	7.3	5.4	74
Transportation, excluding trips	1,801	689	38	17.9	12.8	72
Health care (out of pocket)	480	448	94	4.8	8.3	173
Personal care	105	82	78	1.0	1.5	150
Recreation, education, trips	712	336	47	7.1	6.2	87

[1] Under 65 equals 100.

Older Americans spend proportionately more of their income on gifts, contributions, food, housing, health, and personal care, and less on other items in a pattern generally similar to that of other low income groups. Persons living on fixed incomes are hit hard by price inflation and the elderly command little potential for personal improvement of income. Even formulas that provide for "indexing" (adjusting retirement payments for changes in price indices) are of only partial assistance since, at best, they provide for only a restoration of the previous living standard and only as a catch-up after the fact. This delay and its nonretroactive application creates special problems for older people who have little in easily available savings to carry them over.

INCOME MAINTENANCE

Old Age, Survivors, and Disability Insurance

In October 1979, cash social security payments were sent to 35 million persons of all ages for a total of $8,994 million. Of this total for the month, 4.8 million under-65 disabled workers and their dependents received $1,106 million paid from the disability insurance trust fund, 7.6 million persons of all ages received $1,826 million as survivors of deceased workers, 22.5 million persons of all ages received $6,052 million as retired workers or their dependents, and some 115,000 special 72-plus beneficiaries received $10.5 million.

Among the retired workers and dependents, the 18.9 million retired workers averaged $293.39 for the month (October 1979), the 3 million wives or husbands of the retired workers averaged $148.03, and the almost 700,000 children averaged $118.90. Some 60 percent of all retired workers are receiving "reduced benefits," since they started to draw benefit payments before reaching age 65.

Among the survivors of deceased workers, the 0.6 million widowed mothers or fathers with children averaged $211.87, the 2.7 million children averaged $204.91, the 4.2 million older widows or widowers averaged $269.11, the 129,000 disabled widows and widowers averaged $180.59, and the 16,000 aged parents (deceased workers' sole dependents) averaged $238.08.

Of the total 35 million beneficiaries in October 1979, 23.1 million or 66 percent were aged 65-plus: 16.9 million retired workers, 6.1 million survivors or dependents, and 115,000 special age-72 beneficiaries. About 3.5 million or 9.9 percent were aged 62 through 64 and 8.4 million or 24.1 percent were under 62.

At the end of September 1979, after the payment of $2.2 billion for that month's medicare vouchers ($1.6 billion for hospital and $684 million for supplementary medical), the old age and survivors trust fund had $27.7 billion, the disability insurance trust fund had $5.6 billion, the hospital insurance trust fund had $13.4 billion, and the supplementary medical insurance trust fund had $5 billion.

Supplementary Security Income

In October 1979, almost 1.9 million persons received SSI payments based on eligibility as needy and aged 65-plus, totalling $210.9 million, averaging $111.80. (In 1978, there were 3.2 million older people living in households below the poverty line.)

Practically all of the States provide SSI supplements to the recipients in their States since SSI replaced the Federal-State old age assistance in 1974. More than half of the States take advantage of the Federal provision which permits the Federal Government to write a single check for both the Federal payment and the State supplement and then collect the State's share from the State. Not counting the payments made by States directly to the recipients in their State, the Federal Government made payments in October 1979 to about 1.2 million recipients covering the Federal payment only, to about 275,000 recipients covering the State payment (recipient not eligible for Federal benefit), and to 442,000 recipients receiving both a Federal payment and the federally-administered State supplement.

In addition, an estimated 25,000 65-plus persons received SSI payments as "blind" and 347,000 as "disabled." These types of payments are higher than those for the "aged."

HEALTH

National Health Expenditures, All Ages

(*Includes personal health care expenditures, and costs of research, construction, and public health activities such as control of contagious diseases.*)

	Calendar year	
	1965	1978
Total expenditures:		
Amount (billions of dollars)	43.0	192.4
Per capita (dollars)	217.42	863.01
Percent of gross national product	6.2	9.1
Private expenditures:		
Amount (billions of dollars)	32.3	114.3
Per capita (dollars)	163.29	512.62
Percent of total	75.1	59.4
Public expenditures:		
Amount (billions of dollars)	10.7	78.1
Per capita (dollars)	54.13	350.40
Percent of total	24.9	40.6

Between the years 1965 (before medicare became effective), and 1978, the total health bill rose from $43 billion (6.2 percent of the GNP) to $192.4 billion (9.1 percent of the GNP). This more than tripling of costs results from technological changes, rapid price and labor increases, the "aging" of the population, and increased utilization made possible by increased resources, especially through public programs.

In this period, hospital care costs rose most rapidly, jumping from 32 percent to 40 percent of the total, nursing home costs rose from 3 percent to 8 percent of the total, while all other costs increased in amount but decreased proportionately.

Personal Health Care Expenditures

(*Excludes costs of research, construction, and public health activities such as control of contagious diseases.*)

These expenditures rose from $37.3 billion in 1965 to $149.1 billion in 1977 and $167.9 billion in 1978.

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

Older people represent 11 percent of the total population but account for 29 percent ($41.3 billion) of total personal health care expenditures. Of these $41.3 billion, only $13.6 billion or a third came from all private sources and $27.6 billion or two-thirds were paid by public programs, as follows: $18.3 billion or 44.3 percent from medicare, $6.9 billion or 16.7 percent from medicaid, and the remaining $2.5 billion or 6 percent from smaller programs at the Federal and State levels.

Comparison of levels and sources of payments on a per capita basis for 1966 (the year medicare became effective) and 1977 shows the following:

Age and fiscal year	Total	Direct out of pocket	Third-party payments			
			Total	Government	Private health insurance	Philanthropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1977	514	164	350	150	187	13
65-plus:						
1966	445	237	209	133	71	5
1977	1,745	462	1,283	1,169	101	12
Distribution (percent):						
Under 65:						
1966	100.0	51.1	48.9	19.4	27.3	2.2
1977	100.0	31.9	68.1	29.1	36.4	2.6
65-plus:						
1966	100.0	53.2	46.8	29.8	15.9	1.1
1977	100.0	26.5	73.5	67.0	5.8	0.7

This comparison shows both a significant increase in utilization as well as a doubling of health care prices, with a pronounced shift toward third-party payment arrangements, especially through public programs. The nominal dollar increase in out-of-pocket payments by older persons loses significance if allowance is made for the rapid price increases for the same amount of care plus the actual increase in utilization.

Health Status

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

Counting the approximately 5 percent of older people who live in institutions as being in poor health, a total of about a seventh (14 percent) of all older people consider themselves in poor health.

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

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

Utilization

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

Based on data for 1978, on the average a person aged 55–64 spends 1.9 days per year in a short-stay hospital. This increases to an average of 3.2 days for persons aged 65–74 and to 6 days for those 75-plus.

In 1976, on the average a person aged 55–64 spent a fraction of a day per year in a nursing home, with a jump to 4.4 days for persons aged 65–74, 21.5 days for those aged 75–84 and 86.4 days for those 85-plus.

Of the 1.1 million older people in nursing homes at the time of a 1977 study, 19 percent were aged 65–74, 41 percent were 75–84, and 40 percent were 85-plus—in the total older population, the comparable percentages were 62, 29, and 9. In the nursing home population, 74 percent were women (60 in the total older population), 69 percent were widowed, 14 percent were single, and 12 percent were married; 93 percent were white. Of every 100 residents in nursing homes, almost 40 came from their own residences (only 14 had been living alone), 32 came from general hospitals, 13 from other nursing homes or related facilities, and the rest (about 15) came from a variety of mental and other health facilities.

SELECTED DATA FROM 1978 HOUSEHOLD SURVEY OF THE NONINSTITUTIONAL POPULATION

	All ages	65-plus
Restricted-activity days per person per year	17.4	36.5
Bed-disability days per person per year	6.8	14.5
Number of acute conditions per person per year	2.2	1.0
Number of physician visits per person per year:		
Total	4.8	6.5
In doctor's office, clinic, or group practice	3.3	5.0
In hospital outpatient department	.6	.6
By telephone	.6	.6
Interval since last physician visit (percent distribution):		
Less than 1 yr	75.4	79.8
Under 6 mo	58.9	68.8
6 to 11 mo	16.5	11.0
1 to 2 yr	10.9	6.2
2 to 4 yr	9.3	8.1
5-plus yr	3.3	5.2
Never	.2	.1
Number of dental visits per person per year	1.6	1.2
Interval since last dental visit (percent distribution):		
Less than 1 yr	49.8	32.2
Under 6 mo	35.6	24.2
6 to 11 mo	14.2	8.0
1 to 2 yr	13.3	7.8
2 to 4 yr	12.8	13.9
5-plus yr	13.6	44.3
Never	9.1	.6
Short-stay hospital discharges per 100 persons per year	15.9	24.7
Average length of stay (days)	7.0	10.4
Number of hospital episodes per year (percent distribution):		
Total	100.0	100.0
None	89.6	82.0
1 episode	8.6	13.3
2 episodes	1.4	3.4
3-plus episodes	.5	1.3
Average length of stay for persons with hospital stays by number of episodes:		
Total, all episodes	9.7	15.6
1 episode	6.8	11.0
2 episodes	18.3	24.9
3-plus episodes	35.3	39.0

Death Rates

In the period between 1965 and 1977, annual death rates for older persons dropped about 13 percent from 6.1 per 100 to 5.3 per 100. Within the older population, there were these variations: The rate for persons 65–74 dropped 18 percent from 3.8 to 3.1 per 100; the rate for those 75–84 declined 12 percent from 8.2 to 7.2 per 100; while the rate for the 85–plus dropped 27 percent from 20.2 to 14.7.

The rate for deaths of older persons from heart disease dropped 18 percent, from 2.8 to 2.3 per 100 per year. The rate for deaths from stroke dropped 22 percent from 0.9 to 0.7. The rate for deaths from cancer, however, increased 11 percent, from 0.9 to 1.

While these three causes of death accounted for three-quarters of the deaths of older people in 1977 as they did in 1965, the total decline in death rates has resulted in an increase in life expectancy at age 65.

HOUSING

The 1976 annual housing survey showed 14.8 million elderly households (households with heads aged 65-plus) and they constituted 20 percent of the total 74.1 million households in the United States.

Broad measures of housing conditions showed many similarities between the elderly and the younger households but there were differences in many of the details arising from the somewhat lower proportion of the elderly living in metropolitan areas, their concentration in the inner city, their generally lower income level, the greater age of their homes and the accompanying maintenance problems and costs, the presence of excess space as maturing family members leave their parents' homes, etc. In general, about 90 percent of housing was evaluated as "adequate."

The traditional rule of thumb is that housing should not cost more than 25 percent of income. In the 1976 survey, it was found that 80.3 percent of all households and only 58.7 percent of elderly households could "afford" adequate housing if they spent under 25 percent of their income. For owners, the percentages were 84.3 percent for all and 62.2 percent for the elderly; for renters, 72.8 and 50.1 percent. In fact, in 1976, 32 percent of all households spent more than 25 percent of their income for housing while 35 percent of the elderly did so—65 percent of renters and 23 percent of owners.

Home ownership is more prevalent among the aged than the younger households (70.6 versus 63.3 percent) and an estimated 84 percent of the elderly had paid off their mortgages completely.

The elderly tend to live in much older structures than do younger families. Almost 60 percent of the elderly households live in structures built before 1950 as compared with 40 percent for the younger. Prewar housing is occupied by 47.1 percent of the older households and only 30.2 percent of the younger.

While the totals for flawed or inadequate housing were rather similar (about 10 percent in each case), older households had more problems with plumbing, kitchens, and sewage, while the younger had more problems with maintenance and toilet access (the latter because of the presence of children under 18).

As expected, household income, value of owned home, and monthly rental are considerably larger for all households than for the older households; moreover, it must be remembered that some other costs, like food and health care, absorb larger proportions of the incomes of older households.

While older households, like all households, have about one chance in ten of being inadequately housed, black and Hispanic families have only one chance in five of enjoying adequate housing. In the worst case, a poor Hispanic man aged 65-plus and living alone has less than one chance in two (a probability of 0.56 as compared with 0.43 for a poor elderly black man).

COMPARISON OF CHARACTERISTICS OF HOUSEHOLDS WITH UNDER-65 AND 65-PLUS HEADS, 1976

[Percent distributions]

Characteristic	Heads under 65	Heads 65-plus	Characteristic	Heads under 65	Heads 65-plus
Total households	100.0	100.0	Total households	100.0	100.0
Tenure:			Type of heating equipment:		
Homeowner	63.3	70.6	Central	54.6	43.5
Cash rent	34.5	26.4	Steam	17.8	20.6
No cash rent	2.2	3.0	Electric	6.6	6.0
Year structure built:			Floor, wall	8.5	9.4
After March 1970	17.5	7.7	Room heater	5.4	9.5
1965 to 70	13.1	8.9	Other/inadequate	7.1	11.0
1960 to 64	11.1	7.5	Air conditioning	53.8	46.6
1950 to 59	18.4	16.2	Alterations during year ($100 plus)	10.5	4.7
1940 to 49	9.6	12.6	Water source:		
1939 or earlier	30.2	47.1	Public or private	83.5	83.5
Units in structure:			Individual well	15.0	14.8
1	68.7	67.1	Other	1.5	1.7
2 to 4	12.4	12.8	Electricity:		
5 or more	13.9	15.1	Yes	99.8	99.8
Mobile home	5.0	4.9	No	.2	.2
Hotel or rooming house	.3	.5	Type of sewage disposal:		
Number of bathrooms:			Public sewer	73.1	73.2
None or shared	2.1	4.6	Septic tank/cesspool	25.9	24.4
1 but separated	.3	.6	Chemical toilet		
1	58.9	70.1	Privy	.9	2.0
1.5	14.9	11.9	Other	.1	.4
2	16.7	10.2			
3 or more	7.1	2.6			

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976

Characteristic	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Total households	14,827	9,301	5,525	100.0	100.0	100.0	62.7	37.3
Tenure:								
Homeowner	10,469	6,118	4,352	70.6	65.8	78.8	58.4	41.6
Cash rent	3,913	2,990	923	26.4	32.1	16.7	76.4	23.6
No cash rent	445	194	251	3.0	2.1	4.5	43.6	56.4

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976—Continued

Characteristics	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Year structure built:								
After March 1970	1,142	721	421	7.7	7.8	7.6	63.1	36.9
1965–70	1,318	820	498	8.9	8.8	9.0	62.2	37.8
1960–64	1,109	708	401	7.5	7.6	7.2	63.8	36.2
1950–59	2,399	1,583	815	16.2	17.0	14.8	66.0	34.0
1940–49	1,876	1,224	653	12.6	13.2	11.8	65.2	34.8
1939 or earlier	6,983	4,245	2,737	47.1	45.6	49.5	60.8	39.2
Units in structure:								
1	9,951	5,431	4,519	67.1	58.4	81.8	54.6	45.4
2 to 4	1,905	1,441	464	12.8	15.5	8.4	75.6	24.4
5 or more	2,243	2,027	216	15.1	21.8	3.9	90.4	9.6
Mobile home	729	402	327	4.9	4.3	5.9	55.1	44.2
Hotel or rooming house	76	59	17	.5	.6	.3	77.6	22.4
Number of bathrooms:								
None or shared	680	221	459	4.6	2.4	8.3	32.5	67.5
1 bath but separated	93	76	18	.6	.8	.3	81.7	19.3
1	10,390	6,532	3,859	70.1	70.2	69.8	62.9	37.1
1.5	1,760	1,123	637	11.9	12.1	11.5	63.8	36.2
2	1,511	1,060	451	10.2	11.4	8.2	70.2	29.8
3 or more	392	290	102	2.6	3.1	1.8	74.0	26.0
Type of heating equipment:								
Central	6,450	4,155	2,295	43.5	44.7	41.5	64.4	35.6
Steam	3,063	2,554	509	20.6	27.4	9.2	83.4	16.6
Electric	890	523	368	6.0	5.6	6.7	58.8	41.2
Floor, wall	1,394	874	520	9.4	9.4	9.4	62.7	37.3
Room heater	1,405	578	827	9.5	6.2	15.0	41.1	58.9
Other/inadequate	1,625	618	1,007	11.0	6.6	18.2	38.0	62.0
Air conditioning	6,914	4,565	2,349	46.6	49.1	42.5	66.0	34.0
Alterations during year ($100 plus)	699	441	258	4.7	4.7	4.7	63.1	36.9
Water source:								
Public or private	12,385	8,612	3,773	83.5	92.6	68.3	69.5	30.5
Individual well	2,188	644	1,544	14.8	6.9	27.9	29.4	70.6
Other	253	45	209	1.7	.5	3.8	17.7	82.3
Electricity:								
Yes	14,795	9,291	5,505	99.8	99.9	99.6	62.8	37.2
No	31	10	21	.2	.1	.4	32.3	67.7
Type of sewage disposal:								
Public sewer	10,848	7,935	2,913	73.2	85.3	52.7	73.1	26.9
Septic tank/cesspool	3,622	1,302	2,319	24.4	14.0	42.0	36.0	64.0
Chemical toilet	7	4	3					
Privy	294	45	249	2.0	.5	4.5	15.3	84.7
Other	57	15	42	.4	.2	.8	26.3	73.7

HOUSEHOLD INCOME, VALUE OF HOME, AND MONTHLY RENTAL, 1977

[Numbers in thousands]

Type of household	Owner occupied				Renter occupied			
	All ages		65-plus		All ages		65-plus	
	Number	Median	Number	Median	Number	Median	Number	Median
	Household income							
All households	48,765	$16,000			17,395	$10,000		
2-plus person households	42,088	17,600			10,748	12,100	1,119	$7,100
Husband-wife	36,274	18,500	5,551	$9,200	1,943	9,300	97	6,500
Other male head	1,775	15,400	390	9,700	4,705	5,800	384	5,000
Female head	4,039	10,100	952	7,800	9,119	6,300		
1-person household	6,677	5,800			4,048	8,600	724	4,100
Male head	1,988	9,800	748	5,100	5,071	4,900	2,080	3,700
Female head	4,689	4,900	2,989	4,300				
	Value of home				Monthly rental			
All households	38,754	$36,900			16,806	$197		
2-plus person households	34,058	38,200			10,239	201	1,069	$178
Husband-wife	29,459	39,100	4,013	$32,500	1,908	217	92	154
Other male head	1,344	36,400	301	28,900	4,608	184	374	149
Female head	3,254	30,500	739	26,200	9,010	160		
1-person household	4,696	27,100			3,967	159	698	98
Male head	1,321	28,500	528	24,000	5,043	160	2,063	153
Female head	3,375	26,700	2,168	25,700				

A SUMMARY OF HUD HOUSING UNITS FOR THE ELDERLY*

Section No.	Program	Status	Number of projects	Number of units	Value	Approximate number of elderly units	Percent of elderly units	Reporting period
Construction programs:								
3,4 title II	Low-income public housing	Active	9,812	1,177,556	NA	[1] 529,900±	45±	Cumulative through June 30, 1978.
202	Direct loans for housing for the elderly and handicapped.	Inactive[2]	330+	45,275	$574,580,000	45,275	100	Cumulative through 1972.
		Active[3]	760	67,866	2,133,300,000	64,964	96	Cumulative through Apr. 30, 1979.
231	Mortgage insurance for housing for the elderly.	do	463	62,746	1,035,632,314	62,746	100	Cumulative through December 1978.
221(d)3	Multifamily rental housing for low- and moderate-income families.	do	3,322	337,113	5,025,908,981	49,763	7	Do.
221(d)4		do	3,272	385,459	7,242,658,245			
235	Homeownership assistance for low- and moderate-income families.	Inactive[2]	[7] 457,630	458,234	8,225,030,654	NA	NA	Total program figure through revision.
		Active	12,547	12,551	354,355,937	NA	NA	Cumulative revised program through September 1978.
207	Multifamily rental housing	do	2,637	285,012	3,932,318,605	3,382	1.2	Cumulative through December 1978.
236	Rental and cooperative assistance for lower income families.	Inactive	4,052	434,645	7,479,970,182	53,799	12	Do.
202/236	202/236 conversions	do	182	28,306	482,032,750	28,306	100	Do.
232	Nursing homes and intermediate care facilities.	Active	1,241	141,505	1,495,653,888	141,289	100	Do.
Nonconstruction programs:								
8	Low-income rental assistance:							
	Existing[4]	do	7,589	700,234	NA	199,178	28	Cumulative through Apr. 30, 1979.
	New construction[4,5]	do	6,232	424,217	NA	251,034	59	Do.
	Substantial rehabilitation[4,5]	do	965	73,319	NA	28,253	39	Do.
312	Rehabilitation loans	do	63,933	NA	546,357,000	NA	([8])	Cumulative through Sept. 30, 1978.
23	Low rent leased housing	Inactive[2]	NA	163,267	NA	54,000+	35±	Cumulative through December 1975.

*All figures represent number of projects/units currently insured by FHA unless otherwise noted.
[1] Data does not indicate how many of these units are designed specifically for the elderly.
[2] Figures for original program reported through program revision.
[3] Figures for revised sec. 202/8 represent cumulative project reservations as of Apr. 30, 1978.
[4] Figures represent cumulative fund reservations through reporting date.
[5] Figures do not include sec. 8 commitments attached to sec. 202/8 fund reservations.
[6] Figures represent loan commitments only.
[7] Figures represent number of mortgages.
[8] Approximately 20 percent of the loans.

Source: This table was compiled by the Community Services Staff, NVACP, with the assistance of the Management Information Systems Division, Office of Management, in the Office of Housing and the Program Budget Development Division, Office of Budget, in the Office of Administration.

LIFE EXPECTANCY

Levels and Trends

Computed from death rates in 1977, average life expectancy (remaining years of life) at birth was 73.2 years. For males, it was 69.3 years but 7.8 years longer or 77.1 for females. At age 65, average remaining years of life were 16.3, but the 18.3 years for women was still 4.4 years longer than the 13.9 years for men.

The increase of 25 years in life expectancy at birth since 1900 (when it was 48.2 years) results from the wiping out of most of the killers of infants and of the young—much smaller improvement has occurred at the upper ages when chronic conditions and diseases become the major killers. Many more people now reach age 65 (76 percent versus 40 percent in 1900) but, once there, they live only 4.4 years longer (16.3 years versus 11.9) than did their ancestors who reached that age at the turn of the century.

Should recent decreases in death rates continue, especially from cardiovascular conditions, life expectancy in the later years may increase further.

SUMMARY: LIFE EXPECTANCY BASED ON DEATH RATES IN 1977, BY SEX AND COLOR

	Both sexes	Male	Female
At birth:			
Total	73.2	69.3	77.1
White	73.8	70.0	77.7
All other	68.8	64.6	73.1
At age 65:			
Total	16.3	13.9	18.3
White	16.3	13.9	18.4
All other	16.0	14.0	17.8

LIFE EXPECTANCY AT BIRTH, 1976, SELECTED COUNTRIES

	Male		Female		
Rank	County	Years	County	Years	Rank
1	Japan	72.3	Switzerland	78.3	1
2	Sweden	72.2	Netherlands	78.1	2
3	Switzerland	71.7	Sweden	78.1	3
4	Netherlands	71.6	France	77.6	4
5	Israel	71.0	Japan	77.6	5
6	Italy	69.9	Canada	77.1	6
7	England and Wales	69.7	United States	76.7	7
8	Canada	69.6	Australia	76.4	8
9	France	69.5	Italy	76.1	9
10	Australia	69.3	England and Wales	75.8	10
11	United States	69.0	German Federal Republic	74.7	11
12	German Democratic Republic	68.9	Israel	74.7	12
13	German Federal Republic	68.1	German Democratic Republic	74.5	13

SEX RATIOS

As a result of the yet unexplained longer life expectancy for females, most older persons are women—14.6 million as compared with 10 million men in mid-1979. Death rates are higher for males than for females at all ages (including the fetus) so that although there are approximately 105 boy babies born for every 100 girl babies, the numbers even out by the end of the teens and females outnumber males in ever larger numbers thereafter.

The average for the total 65-plus population is 146 women per 100 men—between ages 65 and 74 there are 130 women per 100 men, for 75-plus the ratio rises to 178 women to 100 men. In the 85-plus group, there are 224 women for every 100 men. (See "Projections" below.)

MARITAL STATUS

In 1979, most older men were married (7.4 million or 77 percent) but most older women were widows (7.1 million or 52 percent). There are 5.3 times as many older widows as there are widowers. Among the 75-plus women, almost 70 percent were widows. About 35 percent of the married 65-plus men have under-65 wives.

In 1977, among the 2.2 million marriages of persons of all ages, there were about 21,180 brides and 38,820 grooms aged 65-plus. For well over 90 percent of these, it was a remarriage after widowhood. Marriage rates for older men are about eight times that for older women.

EDUCATIONAL ATTAINMENT

In 1979, about half of all older Americans had less than a 10th grade education; the median for the 25–64 age group was high school graduation. About 2.1 million or 9 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates. The increasing educational attainment of the older population (an increase of more than a year of schooling in the median since 1970) results from a classic example of a cohort effect rather than the aging process; in the past, each succeeding generation has been given the opportunity to receive more schooling than did its predecessor—as each cohort with more years of schooling reaches age 65 and the oldest cohort with less schooling dies off, the median increases.

LIVING ARRANGEMENTS

In 1979, more than 8 of every 10 older men but less than 6 of every 10 older women lived in family settings. The others lived alone or with nonrelatives except for the one in twenty who lived in an institution (a figure that jumps to one in five in the 85-plus age group).

About three-quarters of the older men lived in families that included the wife but only slightly more than a third of the older women lived in families that included the husband. Four of every 10 older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1979, a slightly smaller proportion of older than of younger persons lived in metropolitan areas (63 versus 64 percent). Within the metropolitan areas, however, almost half of the older people lived in the central city while about 60 percent of the under-65 lived in the suburbs. The inevitable aging of the residents of the older suburbs, which began their rapid expansion in the post-World War II period, could bring a reversal of these proportions and the development of the same problems, lacks, and barriers faced by the inner city aged.

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes. Some 62 percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than older women voted, but the women voters still outnumbered the men. Voter participation falls off sharply after age 75.

In the 1978 congressional election, when, as usual, there is smaller total voter turnout, older people still made up 15 percent of the voting age population but cast 18 percent of the votes. Some 56 percent of the older population voted, a much higher proportion than the under-35, and about the same as the 35–64 group.

MOBILITY

In the March 1978 household survey, 13.7 percent or 3.1 million of the persons then aged 65-plus reported that they had moved from one residence to another in the 3-year period since March 1975. In a pattern that has remained constant for a long period of time, considering that most moves are made for occupational reasons and this is not important for older persons, some 8.4 percent of the elderly moved within the same county, 2.9 percent moved to a different county within the same State, and only 2.3 percent moved across a State line.

The impression that there is more extensive interstate migration of older people arises from the very visible (but small) flow that is concentrated in the direction of a very few States—Florida, Arizona, and Nevada.

EMPLOYMENT

In November 1979, 20.1 percent of 65-plus men (1.9 million) and 8.4 percent of 65-plus women (1.2 million) were in the labor force with concentrations in three low-earnings categories: Part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that in a period of some unemployment the discouraged older worker stops seeking a job and is not counted as being in the labor force at all. For those remaining actively in the labor force and counted as unemployed, the average duration of unemployment was much longer than for younger workers. Labor force participation drops off very quickly after about age 70.

AUTOMOBILE OWNERSHIP

As is true for major household appliances, automobile ownership by older households is well below that of households with younger heads but part of the difference depends on income level rather than age, health, or choice. A 1974 survey showed that 62 percent of older households owned at least one car as compared with 86 percent for the younger. There is, however, a strong relationship between income level and auto ownership at all ages so the lower income level of the

older households accounts in part for the lower ownership rate. Other factors are also present.

PROJECTIONS

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

These projections show a total population of 260.4 million by 2000 with 31.8 million or 12.2 percent aged 65-plus (11.2 percent in 1979). The number of 85-plus persons would almost double to 3.8 million and the ratio of 65-plus women to men would rise to 150 to 100 as compared with 146 to 100 in 1979.

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65-PLUS, 1980–2050

[Numbers in thousands]

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

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

The above projections represent averages for the whole 65-plus age group as if it were a homogeneous mass. Important differences by sex and age group within the 65-plus population are as follows:

PROJECTED TRENDS WITHIN THE 65-PLUS AGE GROUP, 1976–2050

[Percent change]

Sex and age	1976–2000	2000–2025	2025–2050
Both sexes, 65-plus	+38.8	+60.0	+9.0
65 to 74	+22.8	+77.5	−6.7
75 to 84	+56.9	+41.1	+14.9
85-plus	+91.1	+32.4	+91.6
Male 65-plus	+35.8	+64.0	+5.7
65 to 74	+24.4	+79.1	−6.3
75 to 84	+55.0	+44.1	+13.5
85-plus	+68.8	+29.9	+92.9
Female 65-plus	+40.8	+57.3	+11.2
65 to 74	+21.6	+76.2	−7.1
75 to 84	+58.0	+39.4	+14.3
85-plus	+101.4	+33.4	+91.1

Thus, comparison of the approximately 25-year time spans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the postwar babies reach the later years, then a sharp deceleration as the current low birth rates are reflected in a smaller cohort reaching 65. Significantly, the usually more rapid growth in the number of older women is reversed in the 2000 to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025 and return to the current trend after 2025 when all rates of growth will be much slower, especially in the "younger" aged.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young (under 18) and the old (65-plus) are dependent on the middle group, the so-called "productive age" population, tends to show a quite reasonable "burden" on the middle group under reasonable economic and labor force assumptions:

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

Exhibit A

Recent State Trends in the Older Population, 1970–79

Between 1970 and 1979, the Nation's older population (65-plus) increased from 20 million to 24.7 million or from 9.8 percent to 11.2 percent of the total population. As has been true for most of the 20th century, the older population grew considerably faster in 1970–79 (23.5 percent) than did the under-65 population (6.3 percent). These national trends, however, represent the averaging out of a variety of different State trends. Details and analyses are presented below.

PROPORTION OF THE POPULATION AGED 65-PLUS

For the Nation as a whole (50 States and the District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 11.2 percent in 1978. The proportion ranged from 2.6 percent in Alaska and 7.7 percent in Hawaii to 18.1 percent in Florida and 13.7 percent in Arkansas.

In Wyoming, the only State where the under-65 group grew faster than the 65-plus, the proportion of older persons actually dropped, from 9.1 percent in 1970 to 8.1 percent in 1979. In five States (Alaska Colorado, Idaho, New Hampshire, and Utah), the increase in the proportion of the State's aged population was 0.5 percentage points or less in the 9-year period. The remaining States had larger gains.

SUMMARY: STATES BY PERCENT OF POPULATION AGED 65-PLUS, 1979

18.1	1	Florida.
13.3 to 14.2	1	Arkansas.
12.3 to 13.2	10	Iowa, Kansas, Maine, Massachusetts, Missouri, Nebraska, Oklahoma, Pennsylvania, Rhode Island, and South Dakota.
11.3 to 12.2	11	Arizona, Connecticut, Minnesota, Mississippi, New Jersey, New York, North Dakota, Oregon, Vermont, West Virginia, and Wisconsin.
11.2 [1]	3	Alabama, Kentucky, and Tennessee.
10.2 to 11.1	9	California, District of Columbia, Illinois, Indiana, Montana, New Hampshire, North Carolina, Ohio, and Washington.
9.2 to 10.1	9	Delaware, Georgia, Idaho, Louisiana, Maryland, Michigan, South Carolina, Texas, and Virginia.
8.2 to 9.1	3	Colorado, Nevada, and New Mexico.
7.2 to 8.1	3	Hawaii, Utah, and Wyoming.
2.6	1	Alaska.
Total	51	

[1] National average.

DISTRIBUTION AMONG THE STATES

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

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.3	10.3	9.4	9.4
New York	8.0	18.3	8.6	18.0
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.6	47.9	31.1	49.1
New Jersey	3.3	51.2	3.4	52.5
Massachusetts	2.6	53.8	2.9	55.4
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee	16.1	69.9	15.5	70.9
Maryland, Minnesota, Louisiana, Washington, Alabama, Kentucky, Connecticut, South Carolina, Iowa, Oklahoma, Colorado, Oregon, Arizona, Mississippi, Kansas, Arkansas	22.7	92.6	22.3	93.2
West Virginia	.9	93.5	.9	94.1
Nebraska	.7	94.2	.8	94.9
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.8
Hawaii, Idaho, New Hampshire, Montana, Nevada, South Dakota, North Dakota, District of Columbia	2.8	99.1	2.7	99.5
Delaware	.3	99.4	.2	99.7
Vermont	.2	99.6	.2	99.9
Wyoming	.2	99.8	.1	100.0
Alaska	.2	100.0	----------	100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE. 1970 AND 1979

State	Number (in thousands)		Percent increase		Percent of all ages		State rank[2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1979	1960–70	1970–79	1970	1979	1970	1979	1960–70	1970–79	1970	1979
Total, 51 States	19,972	24,658	21.1	23.5	9.8	11.2	(X)	(X)	(X)	(X)	(X)	(X)
Alabama	324	421	24.7	29.7	9.4	11.2	21	19	16	16	30	25
Alaska	7	10	27.9	54.2	2.3	2.6	51	51	11	6	51	51
Arizona	161	289	79.0	79.5	9.1	11.8	35	30	1	2	34	16
Arkansas	237	300	22.0	26.6	12.3	13.7	28	28	21	22	3	2
California	1,792	2,316	30.9	29.3	9.0	10.2	2	1	9	18	36	34
Colorado	187	239	18.8	27.8	8.5	8.6	33	33	24	20	38	47
Connecticut	288	356	19.1	24.0	9.5	11.4	26	26	23	26	27	21
Delaware	44	57	22.6	30.0	8.0	9.7	48	48	20	15	42	37
District of Columbia	70	73	2.4	3.2	9.3	11.1	41	45	51	51	32	28
Florida	985	1,603	78.2	62.7	14.5	18.1	7	3	2	3	1	1
Georgia	365	488	26.4	33.6	8.0	9.5	17	16	15	11	42	40
Hawaii	44	70	51.3	59.9	5.7	7.7	47	46	4	4	50	50
Idaho	67	91	16.3	34.4	9.5	10.0	44	41	29	10	27	36
Illinois	1,089	1,220	12.2	12.0	9.8	10.9	4	6	40	47	24	29
Indiana	492	570	10.8	16.0	9.5	10.6	12	13	45	40	27	32
Iowa	349	381	6.9	9.2	12.4	13.1	19	22	49	49	2	4
Kansas	265	301	10.8	13.6	11.8	12.7	27	27	45	44	7	8
Kentucky	336	393	15.1	17.1	10.4	11.2	20	21	35	38	21	26
Louisiana	305	379	27.0	24.1	8.4	9.4	23	24	12	25	39	41
Maine	114	135	7.6	18.6	11.5	12.3	36	36	48	32	9	11
Maryland	298	380	32.3	27.3	7.6	9.2	25	23	8	21	45	44
Massachusetts	633	711	11.3	12.3	11.1	12.3	10	10	43	46	10	12
Michigan	749	887	18.0	18.4	8.4	9.6	8	8	25	34	39	39
Minnesota	407	470	15.4	15.4	10.7	11.6	15	18	33	41	14	19
Mississippi	221	276	17.0	24.8	10.0	11.4	30	31	27	24	22	22
Missouri	558	635	11.4	13.7	11.9	13.0	11	11	42	43	6	6
Montana	68	83	5.1	21.1	9.9	10.6	43	43	50	29	23	33
Nebraska	183	204	11.8	11.6	12.3	13.0	34	35	41	48	3	7
Nevada	31	61	70.4	96.6	6.3	8.6	49	47	3	1	49	46
New Hampshire	78	98	15.8	25.9	10.6	11.1	39	40	31	23	19	27

Footnotes at end of table.

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1979—Continued

State	Number (in thousands)		Percent increase		Percent of all ages		State rank[2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1979	1960–70	1970–79	1970	1979	1970	1979	1960–70	1970–79	1970	1979
New Jersey	694	843	24.4	21.6	9.7	11.5	9	9	17	27	25	20
New Mexico	70	109	37.7	54.8	6.9	8.8	42	38	5	5	48	45
New York	1,951	2,115	15.8	8.4	10.7	12.0	1	2	31	50	14	15
North Carolina	412	571	32.7	38.6	8.1	10.2	14	12	7	8	41	35
North Dakota	66	80	13.3	20.5	10.7	12.1	45	44	36	31	14	13
Ohio	993	1,142	11.2	15.0	9.3	10.6	5	7	44	42	32	30
Oklahoma	299	363	20.1	21.5	11.7	12.5	24	25	22	28	8	10
Oregon	226	294	23.5	30.3	10.8	11.6	29	29	19	14	13	18
Pennsylvania	1,267	1,491	12.7	17.7	10.7	12.7	3	4	37	37	14	9
Rhode Island	104	123	16.1	18.6	10.9	13.2	37	37	30	33	12	3
South Carolina	190	269	26.8	41.6	7.3	9.2	32	32	13	7	46	43
South Dakota	80	90	12.5	12.4	12.1	13.1	38	42	38	45	5	5
Tennessee	382	492	24.0	28.8	9.7	11.2	15	15	18	19	25	24
Texas	988	1,302	32.9	31.9	8.8	9.7	6	5	6	13	37	38
Utah	77	106	29.4	37.3	7.3	7.7	40	39	10	9	46	49
Vermont	47	56	8.6	17.9	10.6	11.3	46	49	47	36	19	23
Virginia	364	483	26.6	32.7	7.8	9.3	18	17	14	12	44	42
Washington	320	415	15.4	29.5	9.4	10.6	22	20	33	17	30	31
West Virginia	194	226	12.5	16.6	11.1	12.0	31	34	38	39	10	14
Wisconsin	471	556	17.4	18.1	10.7	11.8	13	14	26	35	14	17
Wyoming	30	36	16.6	20.6	9.1	8.1	50	50	28	30	34	48

[1] Corrected for errors in number of centenarians.
[2] States ranked in decreasing order; State with largest quantity is ranked 1.
[3] Not applicable.
Source: Based on published and unpublished data, Bureau of the Census.

RESIDENT POPULATION, TOTAL, ALL AGES, AND AGE 65-PLUS, STATES IN RANK NUMBER ORDER, 1979

Rank	Total, all ages: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	65-plus: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	Rank
1	California	22,694	10.3	10.3	California	2,316	9.4	9.4	1
2	New York	17,648	8.0	18.3	New York	2,115	8.6	18.0	2
3	Texas	13,380	6.1	24.4	Florida	1,603	6.5	24.5	3
4	Pennsylvania	11,731	5.3	29.7	Pennsylvania	1,491	6.1	30.6	4
5	Illinois	11,229	5.1	34.8	Texas	1,302	5.3	35.9	5
6	Ohio	10,731	4.9	39.7	Illinois	1,220	5.0	40.9	6
7	Michigan	9,207	4.2	43.9	Ohio	1,142	4.6	45.5	7
8	Florida	8,860	4.0	47.9	Michigan	887	3.6	49.1	8
9	New Jersey	7,332	3.3	51.2	New Jersey	843	3.4	52.5	9
10	Massachusetts	5,769	2.6	53.8	Massachusetts	711	2.9	55.4	10
11	North Carolina	5,606	2.6	56.4	Missouri	635	2.6	58.0	11
12	Indiana	5,400	2.5	58.9	North Carolina	571	2.3	60.3	12
13	Virginia	5,197	2.4	61.3	Indiana	570	2.3	62.6	13
14	Georgia	5,117	2.3	63.6	Wisconsin	556	2.3	64.9	14
15	Missouri	4,867	2.2	65.8	Tennessee	492	2.0	66.9	15
16	Wisconsin	4,720	2.1	67.9	Georgia	488	2.0	68.9	16
17	Tennessee	4,380	2.0	69.9	Virginia	483	2.0	70.9	17
18	Maryland	4,148	1.9	71.8	Minnesota	470	1.9	72.8	18
19	Minnesota	4,060	1.8	73.6	Alabama	421	1.7	74.5	19
20	Louisiana	4,018	1.8	75.4	Washington	415	1.7	76.2	20
21	Washington	3,926	1.8	77.2	Kentucky	393	1.6	77.8	21
22	Alabama	3,769	1.7	78.9	Iowa	381	1.5	79.3	22
23	Kentucky	3,527	1.6	80.5	Maryland	380	1.5	80.8	23
24	Connecticut	3,115	1.4	81.9	Louisiana	379	1.5	82.3	24
25	South Carolina	2,932	1.3	83.2	Oklahoma	363	1.5	83.8	25
26	Iowa	2,902	1.3	84.5	Connecticut	356	1.4	85.2	26
27	Oklahoma	2,892	1.3	85.8	Kansas	301	1.2	86.4	27
28	Colorado	2,772	1.3	87.1	Arkansas	300	1.2	87.6	28
29	Oregon	2,527	1.2	88.3	Oregon	294	1.2	88.8	29
30	Arizona	2,450	1.1	89.4	Arizona	289	1.2	90.0	30
31	Mississippi	2,429	1.1	90.5	Mississippi	276	1.1	91.1	31
32	Kansas	2,369	1.1	91.6	South Carolina	269	1.1	92.2	32
33	Arkansas	2,180	1.0	92.6	Colorado	239	1.0	93.2	33
34	West Virginia	1,878	.9	93.5	West Virginia	226	.9	94.1	34
35	Nebraska	1,574	.7	94.2	Nebraska	204	.8	94.9	35
36	Utah	1,367	.6	94.8	Maine	135	.6	95.5	36
37	New Mexico	1,241	.6	94.5	Rhode Island	123	.5	96.0	37
38	Maine	1,097	.5	95.9	New Mexico	109	.4	96.4	38
39	Rhode Island	929	.4	96.3	Utah	106	.4	96.8	39
40	Hawaii	915	.4	96.7	New Hampshire	98	.4	97.2	40
41	Idaho	905	.4	97.1	Idaho	91	.4	97.6	41
42	New Hampshire	887	.4	97.5	South Dakota	90	.4	98.0	42
43	Montana	786	.4	97.9	Montana	83	.3	98.3	43
44	Nevada	702	.3	98.2	North Dakota	80	.3	98.6	44
45	South Dakota	689	.3	98.5	District of Columbia	73	.3	98.9	45
46	North Dakota	657	.3	98.8	Hawaii	70	.3	99.2	46
47	District of Columbia	656	.3	99.1	Nevada	61	.3	99.5	47
48	Delaware	582	.3	99.4	Delaware	57	.2	99.7	48
49	Vermont	493	.2	99.6	Vermont	56	.2	99.9	49
50	Wyoming	450	.2	99.8	Wyoming	36	.1	100.0	50
51	Alaska	406	.2	100.0	Alaska	10		100.0	51

ECONOMIC PERFORMANCE AND ELDERLY ECONOMIC STATUS, 1979*

What has been the effect of 1979's rapidly rising prices on the economic status of the elderly? To what extent are the elderly "inflation proof"? How does overall economic performance—wages, profits, economic growth, employment—relate to the economic welfare of the aged?

Although 1979 has too recently ended to know the answers to these questions with certainty, this chapter attempts to provide information bearing on these issues. The 1979 performance of the U.S. economy is summarized, with particular attention to the inflation rate. The expenditures of the elderly are reviewed and the effects of energy and food inflation are discussed. Finally, the question of elderly incomes and inflation protection is addressed.

It is not surprising to learn that inflation appears to be having a very serious impact on the ability of retired persons to maintain their relatively modest standards of living. Furthermore, inflation threatens to erode the major income gains of the early 1970's.

I. ELDERLY INCOME STATUS

Comprehensive information on the 1979 income situation of the elderly will not be available until early 1981. In 1978, the median annual income for families headed by a person 65 years of age or older was $10,141, roughly 52 percent of that for families with younger household heads. Individuals €5 or older, living alone, had median incomes of $4,303; again about 50 percent of the income of their younger counterparts. In October 1979, the average social security benefit paid to all retired workers was $293 per month, while workers first retiring in that month received $318 per month.

Considering all income received by persons 65 or older in 1978, roughly 50 percent was obtained from social security, 10 percent from private pensions, and 10 percent from interest on retirement savings.

In 1976, the last year for which such a calculation has been made, 28 percent of all social security recipient households received 90 percent or more of family income solely from social security.

In 1978, 3.2 million persons 65 years of age or older had incomes below the official poverty line, roughly the same number of elderly poor as in 1977; 1.3 million of these persons were male and 1.9 million were female. The national poverty rate in 1978 for all elderly persons was 14 percent, for males 8.8 percent and for females 23.9 percent.

In summary, elderly persons entered 1979 with approximately one-half the income of the nonelderly. Roughly 3 million elderly persons

*Prepared by Thomas C. Borzilleri for the Special Committee on Aging. Dr. Borzilleri, a profesional consultant, has a doctorate in economics.

had incomes below the poverty level—$3,917 for a couple, $3,116 for a single person—and approximately 10 million elderly persons had 1978 incomes under $5,000 per year.

II. ECONOMIC PERFORMANCE IN 1979

A. Economic Growth, Wages, Profits, and Employment

By most historical standards, the performance of the U.S. economy over the past 12 months has been poor. Prices have increased by almost 13 percent and after adjusting for the effect of price increases, the value of all the goods and services produced by the people of the United States—real gross national product—advanced by only an approximate 2 percent. Average hourly earnings have increased from $5.69 to $6.34, an increase of 11.4 percent, and average weekly earnings have increased from $210.50 to $225.07, about 7 percent. In both cases, inflation has erased these gains.

Profits hardly fared better. In 1978, profits available for payments as dividends, for cost-of-living increases in private pensions or for retained earnings, totaled $83 billion. For 1979, profits will be approximately $88 billion, an increase of 6 percent before any adjustment for inflation-induced declines in the purchasing power of these dollars.

The unemployment rate averaged 5.8 percent over the year. Perhaps one of the brighter spots in the economic performance of 1979 was the creation of 2 million new jobs, an increase in the number of employed persons of 1.8 percent over 1978. Even though this percent increase is quite respectable by historical standards, it is quite a bit below what occurred in the 3 years following the 1975 recession. Over the 1976–78 period, employment increased by more than 3 million a year.

B. Fiscal Policy

Reflecting attempts by both the administration and the Congress to control inflation, the Federal Government deficit was reduced by more than 40 percent—from $49 billion in fiscal year 1978 to $28 billion in fiscal year 1979. The deficit for fiscal 1980 is expected to be in the same range, roughly $28 billion. In 1979, Federal spending increased from $451 billion to $494 billion, while tax collections rose from $402 billion to $466 billion.

It should be pointed out that although wage and earnings gains did not exceed the overall rate of inflation, these gains put workers into higher tax brackets and increased Federal tax collections. This occurs because of the progressive nature of the U.S. income tax system: Each dollar received as income is taxed at progressively higher and higher rates. Hence, a worker who succeeds in getting a wage increase just sufficient to keep his earnings up with inflation, finds his tax burden increased and his spendable income reduced, in spite of the wage increase. Congress explicitly recognized this problem in last year's tax legislation, reducing personal taxes by approximately $15 billion. This year's inflation, and increases in the social security payroll tax, have more than offset the tax reductions of 1978.

C. Social Security

It is also notable that roughly 45 percent of the $28 billion Federal deficit in fiscal year 1979 is attributable to the deficit in the social security system. The social security payroll tax raised $118 billion in fiscal 1979, and supplemental medical insurance taxes added another $2.6 billion to receipts. Total old age, survivors, disability, and hospital insurance outlays, however, exceeded these tax collections by $11.2 billion.

The deficit is not the result of a fundamental problem in the social security system itself. Rather, the deficit arises almost completely because of the overall poor performance of the economy in 1979. Social security revenues depend on the payroll tax and hence on employment and wage growth. Social security outlays depend in part on the inflation rate, since the program provides automatic cost-of-living adjustments. Even though these adjustments increased social security outlays by $5 billion in 1979, there would have been no social security deficit if the unemployment rate had averaged 5 percent instead of 5.8 percent over the year.

D. Monetary Policy

The monetary policy conducted by the Federal Reserve System also reflected, if belatedly, concern with inflation, and recognition that a slowdown in the rate of growth of money and credit is a necessary condition to a slowdown in prices. A complete discussion of how monetary policy affects the inflation rate is well beyond the scope of this chapter. In brief, however, some sales—for example homes or automobiles—depend critically on the ability of the purchaser to borrow money. If borrowing costs a great deal or if funds are simply unavailable, sales cannot be made, and further, prices cannot be raised and may even be reduced. As a direct result of Federal Reserve policy actions, the prime rate—the interest rate charged to the "best" corporate borrowers—rose to 15.75 percent in mid-November and is currently—January 1980—15.25 percent. For the month of November, the U.S. average home mortgage rate was roughly 12.5 percent. Average consumer loan rates exceeded 14 percent and automobile loan rates averaged more than 13 percent. In brief, monetary policy became quite "tight" in the latter half of 1979 and high interest rates reflected this relative scarcity of loanable funds.

In summary, both fiscal and monetary policy have moved in the direction of restraint over the past year. The Federal Reserve has significantly slowed the growth rate of the money supply and—relative to 1978—the Federal deficit has been significantly reduced. This past year has seen a fair increase in the number of employed, mediocre corporate profits, constant or declining real consumer income, relatively high unemployment rates and an abysmal rate of inflation.

E. Inflation

Table I presents 12-month-percentage changes for selected components of the Consumer Price Index (CPI). Overall, prices have increased by 12.6 percent over the past year. Energy price increases

have been incredibly rapid: Home heating oil is 62 percent more expensive than last year, gasoline is up 51 percent, and natural gas is up 20 percent.

There are also a number of other notable characteristics of this past year's inflation. First, even though the prices of a number of items generally considered to be "necessities"—medical care, food, and rent—did not increase as rapidly as the overall CPI, the past year's increases in these items have been significant and in the 9- to 10-percent range. Second, it should be noted that a number of other important goods and services increased only slightly over the past year and in some cases actually declined. For example, while beef prices increased 20 percent, mass transit is only 5 percent more expensive than last year, and poultry is 2 percent less expensive than 12 months ago.

TABLE I.—*Selected components of the Consumer Price Index*

[Percent change, November 1978 to November 1979]

All consumer price	12.6
Food	9.8
Cereals	10.0
All dairy products	12.0
Milk	11.9
Butter	12.4
Margarine	6.1
Pork and poultry	−9.7
Poultry	−2.5
Beef	20.0
Bacon	−16.0
Energy and utilities:	
Home heating oil	61.8
Natural gas	20.3
Electricity	9.7
Telephone	.2
Water and sewer	2.8
Gasoline	50.8
Rents	8.1
Intracity mass transit	5.4
Medical care:	
Doctors' services	9.0
Hospital rooms	10.2
Hospital and other medical services	11.0
Prescription drugs	7.9
Eyeglasses, nonprescription drugs, prescription drugs	7.3

Source: Consumer Price Index, U.S. Department of Labor, Bureau of Labor Statistics.

III. THE EFFECTS OF HIGHER PRICES ON THE ELDERLY

Given the aforementioned increases for 1979, to what extent have these price increases reduced the elderly's standard of living or economic well-being? A complete answer to this question is not yet available, but the evidence that is available indicates that both food and energy price increases are seriously affecting the aged.

A. ELDERLY EXPENDITURES

Table II shows how, on the average, elderly households spent their incomes in the 1972–73 period. Although this information is 7 years old, it was released in 1978 and is the most accurate, comprehensive expenditure information available. Food and shelter outlays were

particularly important, together absorbing approximately 29 percent of gross income in these years. Approximately 8 percent of the elderly's income was spent on each of the following: Health, transportation, recreation, taxes, gifts and contributions, and housing expenses other than rent, mortgage, and property taxes. Given the rapid rise in energy prices since 1973, it should be noted that the elderly's spending on household fuel and gasoline averaged 7 percent of income in the 1972–73 period.

TABLE II.—AVERAGE HOUSEHOLD CONSUMER EXPENDITURES, HOUSEHOLD HEAD AGED 65 OR OLDER, 1972–73

	Average dollar outlay	Percentage of gross income
Food	$1,039	16.5
Shelter, including property taxes	796	12.7
Household fuel and utilities	342	5.4
Other housing outlays	522	8.3
Clothing	242	3.8
Gasoline	155	2.5
Other transportation outlays	544	8.6
Health insurance premiums	197	3.1
Health outlays not reimbursed	252	4.0
Nonprescription drugs	59	1.0
Reading, recreation, education	446	7.1
Gifts and contributions	546	8.7
Other consumption spending	272	4.3
Income and other taxes	528	8.4
Retirement savings contributions	176	2.8
Other income not consumed	176	2.8
Household average gross income	6,292	100.0

Source: Consumer Expenditure Survey, Integrated Diary and Interview Survey Data, 1972–73, U.S. Department of Labor, Bureau of Labor Statistics, 1978.

B. Food Expenditures

What has happened to the share of household income spent on these goods and services since this earlier period? From 1973 to the present, food prices have increased by more than 60 percent and as mentioned above, fuel oil prices rose 62 percent in 1979 alone. Without more recent and comprehensive expenditure survey data, it is difficult to know how the elderly have responded to these higher prices. Murray [1] (1978) studied elderly food expenditures and found that, on average, the elderly did not cut back on food purchases when prices increased. Rather, they cut back on other goods and increased their total outlays on food by the same percentage as the increase in prices. These findings would imply a 1979 average dollar food outlay for elderly households in excess of $2,400 per year and an average income share spent on food in the 25- to 30-percent range.

C. Energy Expenditures

Table III presents more recent data on elderly household fuel consumption. Column 1 gives 1975 annual expenditures estimated by the Department of Energy, while column 2 simply updates these fuel expenditures by the changes in their prices which have occurred since 1975. Even allowing for some energy cutback in the face of sharply higher prices, it is clear that household fuel is far more important in

[1] Janet H. Murray, "Changes in Food Expenditures: 1969–1973—Findings from the Retirement History Study," Social Security Bulletin; July 1978.

the elderly market basket than it was in the 1972–73 period. An elderly homeowner using fuel oil to heat his home spent approximately $700 on that fuel alone in 1979. This would imply that more than 9 percent of income would have been spent on home heating and approximately 12 percent of all income spent on all home energy consumption in 1979.

TABLE III.—MEDIAN HOUSEHOLD EXPENDITURES ON ENERGY, BY TYPE OF FUEL, HOUSEHOLD HEAD 65 OR OLDER

	1975 [1]	1979 [2]
Gasoline	$313	$543
Electricity	160	215
Natural gas	145	266
Fuel oil	350	728
All home fuels	397	651

[1] Source: Energy Information Administration, "Household Expenditure Projections, Annual Report to the Congress, 1978," p. 356.
[2] Estimates, updating by price changes only.

Although a national average budget estimate for elderly energy consumption falls in the 12 percent of income range, Campbell [2] (1979) reported that in 1978, more than 1 million elderly households had energy consumption expenditures exceeding 25 percent of their total incomes, and 2 million elderly households had energy outlays that amounted to more than 14 percent of income. Given 1979 price increases, this situation could only have worsened. Clearly, the very rapid rise in energy price experienced in the past year has had negative effects on the living standards of the elderly and, like food price increases, has significantly reduced income available for the purchase of other goods and services.

IV. ELDERLY INCOMES AND INFLATION

To what extent are the incomes of the elderly "inflation-proof"? Although this issue has yet to be comprehensively investigated, it remains one of the most important policy issues in the field of aging.

A. Social Security

As discussed earlier, consumer prices increased on the average by 12.6 percent over the past 12 months. It should first be pointed out that social security benefits were increased in July 1979 by 9.9 percent to compensate for the loss of purchasing power experienced by social security retirees in 1978. The social security cost-of-living adjustment is based on a calculation of price changes from the first quarter of one year to the first quarter of the next. Hence, it will be March 1980 before the calculation is actually made and July 1980 before the adjustment is actually reflected in recipient benefit checks. Since the benefit increase in July 1979, fuel oil prices have increased 23 percent and natural gas prices 9 percent. It will be another 6 months before compensation is received for inflation suffered over the past 9 months. It should be noted that when the adjustments are made, the increases are not retroactive, no "catchup" checks are issued to social security recipients.

[2] Toby H. Campbell, "Emergency Energy Assistance Programs: SCIP and EEAP Service Relative to Need," Urban Institute working paper, October 1979.

When social security benefits are increased, the adjustment will be calculated using the overall Consumer Price Index. A number of studies have reported that use of the CPI, rather than a specific elderly consumer index, results in a small but systematic understatement of the price experience of older persons. Generally, this understatement is in the range of 5 percent. It must be emphasized, however, that none of the studies undertaken to date have been particularly sophisticated. Additionally, results appear to be sensitive to the period of analysis. In any event, failure to use a separate CPI for the elderly for social security cost-of-living adjustments may be resulting in an underadjustment of benefits.

B. Private Pensions

Only 5 percent of the private pension plans in the United States contain a provision for full, automatic cost-of-living increases. Gayle Thompson [3] used the retirement history study data to investigate what had occurred to the private pension benefits received by totally retired persons from 1972 to 1974. She found that 36 percent of the retirees received the same pension benefit in the 2 years; 20 percent were receiving less than they were receiving in 1972; and 28 percent had an increase that was less than the change in the Consumer Price Index. Only 16 percent of the retirees received increases in their pensions equal to or greater than the change in prices over the period. The clear conclusion that emerged from her analysis is that private pension benefits tend not to be indexed against inflation and were being severely eroded by the price increases of the period.

When pensions are not contractually adjusted, good corporate profitability is a necessary condition for ad hoc adjustments. Given the rapid rate of inflation experienced in 1979 and the weak performance of corporate profits during the period, profit-based ad hoc benefit increases will not have been great in 1979, and thus it seems likely that private pension benefits have been severely reduced in purchasing power over the past 12 months.

C. Interest Income

Earlier, mention was made of current and very high interest rates. Again, the prime rate is now in excess of 15 percent and all borrowing rates appear to be over 12 percent. At the same time, however, savers, by law, are only receiving 5.5 percent on their savings accounts with savings and loan institutions. The reason for this spread between what borrowers are willing to pay and what savers are permitted to receive, is a series of Government financial regulations collectively referred to as regulation Q.

Estimates by Prof. Edward Kane of Ohio State University indicate that elderly small savers have missed better than $20 billion in interest income over the past 10 years that they otherwise would have received if regulation Q did not exist. Clearly, when prices are rising at 12.5 percent a year and a saver is receiving only 5.5 percent in interest, the purchasing power of savings deposits declines over the course of the year.

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[3] Gayle B. Thompson, "Impact of Inflation on Private Pensions of Retirees 1970–74: Findings from the Retirement History Study," Social Security Bulletin, November 1978.

D. Employment Income

Slow employment growth and relatively high unemployment rates mean an increased chance that an employed older worker will lose employment and a reduced chance that the unemployed older person will find employment. As mentioned previously, real wages for the economy as a whole have been constant or declining over the past year. It is quite unlikely then, that older part-time workers received wage increases sufficient to keep their earnings ahead of the rate of inflation.

In summary, social security is the only major income source of the retired that appears to be even reasonably well protected from inflation. The long delays between adjustments, however, result in significant losses and there is evidence that using the overall CPI, rather than a specific older persons' price index to adjust benefits is also resulting in at least some income erosion. Private pensions and wage income all appear to increase by less than the inflation rate and, considering all these sources of income, it is clear that elderly incomes are not "inflation-proofed." Their incomes are quite vulnerable to significant inflation erosion in spite of the automatic cost-of-living provisions of the social security system.

V. SUMMARY

The high rates of inflation experienced in 1979 are having serious effects on elderly incomes. Inflation in specific goods and services, notably food and especially energy, is undoubtedly reducing the living standards and economic well-being of most retired people.

During the same year, economic growth has been slow, employment and profits only fair, and worker incomes hardly rose at all. In such an economic environment taxpayers are less willing and less able to provide support for improved or expanded Government programs.

Concern with inflation has produced restrained monetary and fiscal policies on the part of the Government. Private corporations find it difficult to finance ad hoc cost-of-living increases for their retirees and/or to commit themselves to special efforts to improve the employment picture for older workers.

In summary, social progress and additional economic justice for the elderly is easier to obtain in a world with strong economic progress than in a world without it. If the U.S. economy is ever again to generate the sort of economic conditions that made possible the major improvements in social security of the early 1970's, the control of inflation, strong economic growth and a generally more healthy economy are absolute requirements. Future economic gains for the aged demand a far better overall economic performance than that of 1979.

96TH CONGRESS 2d Session | SENATE | REPORT No.96-613

PART 1
DEVELOPMENTS IN AGING: 1979

FEBRUARY 28 (legislative day JANUARY 3), 1980.—Ordered to be printed

Mr. DOMENICI (for Mr. CHILES) from the Special Committee on Aging, submitted the following

REPORT

[Pursuant to S. Res. 65, 96th Cong.]

Chapter 1

RETIREMENT INCOME

CHAPTER HIGHLIGHTS

The Carter administration budget proposals announced in January set the tone for what turned out to be a very cost-conscious legislative year. Recommending major cutbacks in currently available social security benefits, the administration sought to save in excess of $500 million in fiscal year 1980. At year's end, however, only the limitation of disability benefits seemed to have any chance of favorable congressional action.

Nevertheless, the push by both Congress and the administration to reduce the Federal deficit coupled with a return to double digit inflation renewed concern about the financial stability of social security and about the "unfunded liability" of many troubled pension and retirement funds. In general, 1979 was marked by a relative dearth of completed legislation—particularly any action to expand or liberalize retirement benefit programs.

As the year progressed, a wide range of significant developments came to light as major groups and official organizations completed or continued their efforts on retirement income issues, including:

—An HEW report: "Social Security and the Changing Roles of Men and Women" (February 1979).

—Hearings on "universal coverage" by the Universal Social Security Coverage Study Group, including an interim report (June 1979).
—Continued hearings and the issuance of working papers by the President's Commission on Pension Policy.
—A Congressional Budget Office report questioning the short-range fiscal soundness of the social security system (July 1979).
—The final report of the National Advisory Council on social security (December 1979).

In past years, the recommendations of the Advisory Council have had a direct impact on congressional action. Significantly, this quadrennial report rejected most of the administration's January cutback suggestions and endorsed several controversial new directions including:

—Counting one-half of social security benefits as taxable income.
—Shifting the financing of medicare to general revenues.
—Considering the possibility of raising the basic social security retirement age from 65 to 68 after the end of the century.

In an effort to bring the many retirement income issues into better focus, the Special Committee on Aging commissioned the Urban Institute to undertake a major study which would, in part, identify and consolidate all the economic and public policy issues which should be considered by policymakers in establishing new directions in employment, pensions, and income maintenance for older Americans. In 1980, the committee intends to publish the results of this study.

I. 1979 DEVELOPMENTS IN SOCIAL SECURITY

As presented to the Congress on January 22, 1979, President Carter's fiscal 1980 budget included several legislative recommendations affecting social security. Specifically, in the current congressional and administrative spirit of fiscal restraint, these proposals were designed to reduce social security outlays in fiscal 1980 and in subsequent years. Eight major legislative initiatives were proposed:

(1) *Limit disability benefits.*—The maximum family benefit for a disabled person would be limited to 80 percent of the worker's average indexed monthly earnings (1980 savings: $21 million). This proposal was designed to preclude a disabled worker and his or her family from receiving more in benefits than the employee made while working prior to becoming disabled. Recent data indicate that as many as 6 percent of all disability awards exceed predisability earning levels.

(2) *Reduction in dropout years.*—In general, five low earnings years may be dropped out now in computing social security benefits for most eligible workers. The administration proposed to reduce the number of dropout years for younger disabled or deceased workers according to the following formula:

Age:	*Number of dropout years*
Under 27	0
27 to 31	1
32 to 36	2
37 to 41	3
42 to 46	4
47 and over	5

This proposal would reduce benefits (1980 savings: $14 million) for some younger disabled or deceased workers (and/or their families).

(3) *Proposals to increase work incentives.*—Four proposals were recommended to increase work incentives (1980 cost: $39 million) for disabled beneficiaries:

—An extension of the current 12-month trial work period to 24 months. Benefits would not be paid during this second 12-month period, but the disabled worker could be automatically reenrolled in the program if his or her attempt to return to work failed (thus avoiding a lengthy reapplication process).

—Continuation of medicare and medicaid coverage for 2 years after a disabled worker leaves the benefit roll.

—Require that only one waiting period for medicare protection (presently 24 consecutive months) must be met if a disabled worker fails at an attempt to return to work.

—Allow a deduction for impairment-related work and attendant care expenses in computing eligibility for disability benefits.

(4) *Phase out postsecondary student benefits.*—Benefits paid to dependent children (18 to 22 years old) who are attending postsecondary schools would be phased out over a 4-year period (1980 savings: $155 million).

(5) *End mother's or father's benefit when youngest child is 16.*—Benefits paid to an adult caring for children would end when the youngest child reaches age 16, instead of 18 as under present law (1980 savings: $23 million). The provision would be phased in over a 2-year period. Benefits for dependent children would still be payable until age 18.

(6) *Eliminate minimum for new beneficiaries.*—The regular minimum monthly benefit (now frozen at $121.80) would be eliminated for workers (and their survivors) who become entitled after May 1979 (1980 savings: $53 million).

(7) *Eliminate lump-sum death benefit.*—The $255 lump-sum social security death benefit would be eliminated (1980 savings: $221 million). The administration would replace it with a new SSI (supplemental security income) lump-sum death benefit (equal to 1 month's benefit or about $220 in 1980 and increasing each year thereafter according to cost-of-living increases). This would have the effect of limiting the lump-sum death benefit to low-income aged, blind, and disabled persons.

(8) *Federal pension offset.*—Social security benefits would be reduced by $1 for each $3 of pension income received from Federal employment which is not covered by social security (1980 savings: $14 million). The offset would not apply if the Federal annuity is less than the average social security benefit (estimated at $285 per month in 1980 for a retired worker without dependents). If the Federal pension exceeds the average social security benefit, only the portion above the average would be subject to the $1-for-$3 offset. The social security benefit, though, would never be less than 32 percent of the average indexed monthly earnings.

In spite of a storm of opposition from organizations representing the elderly, poor, labor, and others, the administration presented its legislative package to Congress in April. At year's end, with the exception of the recommended cutbacks in disability benefits (see discussion below), the proposals had received little or no action by Congress.

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A. Benefits

In a year of double-digit inflation, it came as no surprise that the Department of Health, Education, and Welfare (HEW) announced a record 9.9-percent cost-of-living increase in social security benefits starting July 3, 1979. The increase was the largest single automatic cost-of-living boost since such increases were mandated in 1972. The maximum social security benefit for a worker retiring in 1979 rose from $503.40 to $553.30. The average monthly benefit for an elderly couple rose from $439 to $482 and for an elderly widow from $243 to $267. The annual cost-of-living increase in 1978 was 6.5 percent. HEW estimated that the latest increase would cost the Government $10.2 billion in fiscal 1980.

B. Financing

With the Social Security Amendments of 1977, Congress took action to shore up the social security trust funds in the face of serious reports that without changes, the disability insurance fund (DI) would run out of reserves in 1979, and the old age survivors insurance funds (OASI) would have been exhausted by 1983. Consequently, on January 1, 1979, the payroll tax rate was increased to 6.13 percent on incomes up to $22,900. The amendments called for the following additional increases in the coming years: 6.13 percent on $25,900 in 1980; 6.65 percent on $29,700 in 1981; 6.7 percent on $31,800 in 1982; 6.7 percent on $33,900 in 1983; 6.7 percent on $36,000 in 1984; 7.05 percent on $38,100 in 1985; 7.15 percent on $40,200 in 1986; and 7.15 percent on $42,600 in 1987.

In spite of these major increases designed to bolster the revenue for social security, the threat of continued double-digit inflation and possible economic downturn through recession sparked a whole new chorus of serious concerns among traditional social security analysts. Mixed with these notes of concern were other voices extolling the soundness of the program. By year's end, the objective observer was left confused at best about the true status of the financial viability of the social security system.

C. Board of Trustees, Federal OASI and DI Trust Funds

The 1979 annual report of the Social Security Board of Trustees submitted to Congress on April 13, 1979, predicted that the OASI fund would develop serious cash flow problems by 1983 if a severe recession hits the country. By contrast, they reported that the DI fund would continue to grow even in harsh economic times. Members of the Board are the Secretaries of HEW, Labor and Treasury, as well as the Commissioner of Social Security. Their report makes 5-year (short-range), 25-year (medium-range), and 75-year (long-range) projections using three sets of assumptions: optimistic, intermediate, and pessimistic. Under the intermediate assumptions, only the long-range projections indicated a possible deficit.

At a news conference to announce the Board's findings, Commissioner Stanford Ross announced that the OASI and DI trust funds were in "sound" condition for the next 50 years.

D. Congressional Budget Office Report

On July 31, 1979, 3 months following the report from the Social Security Board of Trustees, Congressional Budget Office (CBO) Director Alice Rivlin stated in a letter to House Budget Committee Chairman Robert N. Giaimo that "recent inflation and anticipated economic slowdown have brought the short-run financial soundness of the social security system into question again." CBO claimed the problem could be handled by increasing the payroll tax or by allowing the OASI fund to borrow from the Treasury on a temporary basis or to borrow from the DI fund or the health insurance (HI) fund.

The CBO emphasized that it was going to take years (under the new payroll tax increases) for substantial extra money to pile up in the trust funds. Meanwhile, because of increases in automatic cost-of-living benefits (see above), inflation has kicked benefit levels up higher than earlier expected. As a result, the balance in the OASI fund, which at the start of 1979 was equal to 34 percent of anticipated outlays for the year, is expected to drop to 5.4 percent of anticipated outlays by 1984 which is not enough to insure cash flow to pay all benefits.

(In billions)

	1979	1980	1981	1982	1983	1984
Old age and survivors insurance (OASI):						
Outlays	$90.5	$104.0	$119.8	$135.7	$150.4	$165.3
Budget authority	86.7	99.4	113.1	131.7	147.3	163.8
Trust fund balance at end of year	27.2	22.7	16.0	12.0	8.9	7.4
Trust fund balance at beginning of year as a percent of outlays	34.3	26.2	18.9	11.8	8.0	5.4
Disability insurance (DI):						
Outlays	14.0	16.1	18.5	21.9	24.0	26.7
Budget authority	15.3	17.4	20.7	24.3	27.4	30.7
Trust fund balance at end of year	5.7	7.0	9.1	11.5	14.9	15.8
Trust fund balance at beginning of year as a percent of outlays	31.4	35.4	37.8	41.6	47.9	55.8
Combined OASDI:						
Outlays	104.5	120.1	138.3	157.6	174.4	192.0
Budget authority	102.0	116.8	133.8	156.0	174.7	194.5
Trust fund balance at end of year	32.9	29.7	25.1	23.5	23.8	26.2
Trust fund balance at beginning of year as a percent of outlays	33.9	27.4	21.5	15.9	13.5	12.4

E. HEW Campaign and Advisory Council on Social Security

Adding to the debate on the adequacy of social security financing, newly appointed Secretary of HEW, Patricia Harris, launched in October a nationwide public relations campaign to emphasize that "social security is the cornerstone of American social policy [and] a good buy for the American worker." Contrasting today's social security coverage with that of a private pension system, Harris pointed out several major advantages: (1) Higher return of a worker's earnings after retirement, (2) automatic cost-of-living increases, (3) portability from one job to another, (4) inclusion of hospital coverage, and (5) benefits not subject to tax.

Also in October in testimony before the House Ways and Means Subcommittee on Social Security, Henry Aaron, Chairman of the Advisory Council on Social Security, confirmed the opinion that current fears about the fiscal soundness of the social security system were not

justified. However, he also attacked the payroll tax system of financing as regressive and inflationary and said that alternative methods of financing must be found if social security is to function (see discussion below on Advisory Council recommendations).

PROSPECTS FOR 1980

In short, the fiscal soundness of the social security system was an issue frequently at the forefront during 1979. Although Congress took no specific action to adjust the financing picture either in the short or long run during the year, the issue is very much alive and could see action in 1980.

F. Universal Coverage

The issue of mandatory universal coverage of Federal employees under social security was closely considered during passage of the 1977 Social Security Amendments. However, the final bill called instead for a study of the feasibility of bringing those Federal and public employees not covered by social security into the system. The amendments established the Universal Social Security Coverage Study Group comprised of the Chairman of the Civil Service Commission (later the Office of Personnel Management), the Secretaries of the Treasury and HEW, and the Director of the Office of Management and Budget.

On November 22, 1978, the study group announced a series of eight hearings on the issue of universal coverage to be held around the country beginning in late December 1978 and ending in April 1979. On June 8, 1979, a "draft prospectus" was issued and the final report was expected by year's end.

The June 8 draft outlined the various aspects of the problems inherent in the feasibility and desirability of extending social security coverage to Federal and public employees not now covered. The issues and problems the study group is evaluating include:

—Ratio of benefits to contributions.
—Survivors' and spouse benefits.
—Length of service versus size of benefits.
—Disability benefits.
—Hospital, medical coverage, and life insurance benefits.
—Cost-of-living adjustments.
—Offset of pensions by outside earnings.
—Taxability of benefits.
—Vesting.

In considering these many complex issues, it is important to point out that there are many differences between the social security and civil service systems, as well as between social security and many other public pension programs covering non-social-security-enrolled State and local government employees. Social security was designed as a social insurance program of basic benefits for old age and disability to be supplemented by private pension programs and personal savings. Its replacement rate is progressive, meaning individuals with lower incomes receive proportionately greater benefits upon retirement—in relation to their contributions and lifetime earnings—than those with higher incomes. Civil service retirement, on the other hand, is a pension system intended to provide adequate sole support for former Federal workers. It is a defined-benefit, fixed-rate system,

which means one's annuity is based directly on length of service and size of contributions.

Other factors the study group is considering include:

—Ways to design a regressive public employee retirement system to supplement social security's progressive rate.

—Conformity with Internal Revenue Service and Employee Retirement Income Security Act regulations.

—Portability of benefits.

—Special retirement provisions for hazardous duty.

—Handling of unfunded liability of pension funds.

The June 8 draft also pointed out several options not being considered, or being given only cursory analysis. These particular areas have been of greatest concern to many Federal workers and their representative groups, all of whom have been strongly in opposition to the notion of universal coverage. These areas include:

—Merging the pension funds of civil service and other public employee retirement systems with those of social security.

—Adding social security to the existing noncovered retirement systems without any modifications in them.

—Substituting social security coverage for the existing noncovered retirement systems.

—Reducing the social security or pension benefits of persons who have already retired or are about to.

Thus, due to the complexity of the issues involved, it is inaccurate to say that the study group is merely considering ways to "merge" social security and civil service. However, Federal employee associations that have been following the study group's progress have expressed concern that too much attention has been focused on ways to integrate the systems and not enough consideration is being devoted to the question of the desirability of universal coverage.

The main options the study group is considering for universal coverage include:

—Mandating coverage for all on a specific date

—Mandating coverage for all nonvested and new employees after a certain date.

—Mandating coverage for all whose age plus length of service is less than a certain amount.

—Mandating coverage for all who are less than a certain age; and

—Mandating coverage for all who are hired after a certain date.

It should be stressed that the study group is also looking at ways to encourage voluntary participation in social security and has already determined that some of the above options for mandatory coverage would not be desirable.

While the study group has been examining the issues for the past year-and-a-half, some Senators and Representatives have proceeded to introduce bills to institute universal coverage. These proposals range from measures which would make coverage mandatory for people hired after a certain date, to ones which would cover all current Federal employees and/or Members of Congress and their staffs. The committees which must act on legislation in this area have expressed concern that it would be unwise to proceed on the bills until the study group's final report is in and all the options have been considered carefully.

Although the study group's final report was not yet issued as this report was written, it is expected that once it is completed, Congress will begin to consider the many bills that have been introduced. However, in light of the stiff opposition that has already surfaced concerning the concept of universal coverage, there is ample reason to predict that speedy progress on this issue is unlikely in the near future.

G. Earnings Test

The 1977 Social Security Amendments—Public Law 95–216—approved a gradual liberalization of the earnings limitation or earnings test which requires a $1 deduction in benefits for every $2 earned over certain amounts for beneficiaries under age 72. Beginning on January 1, 1979, the annual amount that beneficiaries could earn without losing any benefits increased from $4,000 to $4,500 for those aged 65–71 and to $3,480 for those under 65. The ceilings will rise to $5,000 and $3,720 respectfully in 1980, providing some $280 million in additional benefits to almost 1.6 million people. Beginning in 1982, the test will not apply to those over 70.

The 1977 amendments altered the earnings test in another way. Prior to the amendments, there was an annual test applied on a monthly basis. Regardless of annual income, a beneficiary could receive payments so long as his monthly income did not exceed one-twelfth of the annual ceiling. The 1977 amendments removed the monthly test and left a strict annual test, except for one "grace" year which allows persons retiring in the middle of the year to receive full benefits regardless of how high their earnings were before retirement. Several problems were created by this change, and legislation has been introduced to help correct the inherent inequities.

In October, the House Ways and Means Committee reported out H.R. 5295. This bill amends title II of the Social Security Act to allow a monthly earnings test to be applied to mothers, children, and students for the year in which they leave the benefit rolls. For these groups, under current law, the only year of exemption from the annual earnings test is the year during which benefits first were received. This provision is retroactive to January 1, 1978.

The bill also provides for a separate application for medicare at age 65, to protect those who wish to continue working from using their 1-year exemption from the annual earnings test until they are ready to stop working and retire. The provision, in effect, allows these workers to waive medicare benefits until they retire, and would allow them to collect higher benefits in the future.

The bill excludes from income, for earnings test purposes, all self-employment income that results from services performed in past years. Approximately 50,000 people are expected to be affected by this provision, mostly retired insurance salespersons and farmers.

In addition, the bill makes clear that the 1977 earnings test amendment should be applicable only to those who were entitled to benefits for the first time after 1977. This provision will require approximately $232 million in benefits, mostly retroactive to 1978, to be paid in fiscal year 1980.

H.R. 5295 passed the House on December 19, and was received by the Senate on December 20, 1979, where it was referred to the Finance Committee.

Several other bills were introduced to amend the earnings test:

—S. 1287, introduced by Senator Barry Goldwater, and S. 1418, introduced by Senator Roger W. Jepsen, would repeal the earnings test for all beneficiaries over age 65.

—S. 1498, introduced by Senator Spark M. Matsunaga, would exclude from countable earnings, income realized by retired farmers, insurance agents, and others similarly situated who receive income after retirement for work completed prior to retirement.

—S. 1554, introduced by Senator John A. Durkin, which would have the same result as S. 1498, but would only apply to retired insurance agents.

All these bills were referred to the Senate Finance Committee in June and July. The committee has requested comment on them from the Office of Management and Budget, and from the Departments of the Treasury and HEW. No further action was taken in 1979.

H. 1979 Advisory Council on Social Security

Following an 18-month study, the 13-member Advisory Council on Social Security, on December 7, 1979, released its recommendations to strengthen and improve the social security program. The Council's 400-page report was submitted to HEW Secretary Patricia Harris and to Congress. The report declared that social security was "the Government's most successful social program," and it emphasized that "all current and future beneficiaries can count on receiving all the benefits to which they are entitled."

In addition, the report cautioned that the system, which now has 35 million beneficiaries and pays $147 billion a year in benefits, needs both financial strengthening and improved benefits for certain classes of workers. In past years, Congress has paid very close attention to Social Security Advisory Council recommendations, many of which have been enacted into law.

In one of its more important recommendations, the Council unanimously declared: "The time has come to finance some part of social security with nonpayroll tax revenues." It recommended that medicare, which now uses 1.05 percent of the 6.13 percent payroll tax, be funded from corporation and personal income taxes. The social security tax could then be reduced to 5.6 percent each on employer and employee from 1980 to 2005, when it would rise to 7.25 percent. Present estimates indicate that this would be enough to take care of all old age and disability payments through the middle of the next century. The change to general revenue funding of medicare would reduce the social security tax burden, which is heaviest on low-paid workers, and pick up those costs from the progressive income tax. Up to now, however, Congress has resisted the use of general revenues for social security.

Other major recommendations of the Advisory Council included the following:

—Make one-half the social security benefit subject to Federal income tax. Benefits are currently tax free. In 1979, an aged couple would pay no additional tax unless their total income (including one-half of social security) exceeded $7,400 per year.

—Grant cost-of-living increases twice a year instead of once.

—Increase benefits for the lowest-paid, full-time workers to insure all workers with 30 years or more employment at minimum wage receive benefits higher than the poverty level.
—Increase benefits for the highest paid workers modestly so that they get a better return on the payroll taxes they pay.
—Seriously consider raising the basic social security retirement age from 65 to 68 some time after the end of the century.
—Make social security coverage mandatory for all newly hired Federal, State, local government, and nonprofit employees starting work after enactment of this provision.
—Allow the Treasury to contribute general revenue funds to social security when unemployment over 6 percent causes payroll tax revenue to fall.
—Pursue "earnings sharing" as the most promising approach to concerns of homemakers, working women, divorced women, and widows. This plan would compute benefits for both husband and wife on the basis of half the couple's combined earnings.

It is significant to note that the Council rejected several Carter administration recommendations made earlier in 1979 to eliminate: (1) The regular social security minimum benefit, (2) the lump-sum death benefit, (3) benefits for students age 18 to 22 who are children of beneficiaries, and (4) benefits for mothers of beneficiaries caring for children aged 16 to 18.

II. PENSIONS

This year's major legislative developments in pensions concern single and multiemployer plans. While single employer plans cover employees of only one employer, multiemployer plans cover the employees of two or more unaffiliated employers and are maintained under one or more collective bargaining agreements. Approximately 7.7 million workers are participants in about 2,000 multiemployer pension plans.

A. ERISA

1. TERMINATION INSURANCE PROGRAM

When Congress enacted the Employee Retirement Income Security Act (ERISA) in 1974, it created a federally operated pension plan termination insurance program for employees participating in defined benefit pension plans (title IV). The "termination insurance" program is administered by the Pension Benefit Guaranty Corporation (PBGC) which is governed by a Board of Directors consisting of the Secretaries of Labor, Commerce, and the Treasury. The program was one of several devices included by Congress in ERISA to insure that benefits defined for participants in pension plans would be paid.

While single employer plans have been insured since July 1, 1974, uncertainties about how best to provide termination insurance for multiemployer plans caused coverage of such plans to be deferred until January 1, 1978, while permitting the PBGC to provide benefit guarantees in the case of a multiemployer plan termination on a discretionary basis. The discretionary authority of the PBGC to insure plans that have been in existence for more than 5 years has

been used to assume the liabilities of a multiemployer milkmen's plan and for three millinery plans. Although the PBGC has authority to borrow up to $100 million from the U.S. Treasury, this borrowing authority may not be used to guarantee benefits in multiemployer plans that terminate before May 1, 1980; these payments made as a result of an ERISA guarantee must be made from the multiemployer fund.

Benefits under a PBGC insured plan are now insured up to $1,159.09 per month. However, pension benefits under terminating multiemployer plans at this time are insured only under the discretionary provisions of ERISA which also provide that Congress must be notified in case of an insured multiemployer plan termination.

Although mandatory termination insurance coverage was to begin on January 1, 1978, for multiemployer plans, it has been deferred twice to allow the PBGC sufficient time to study the problems in extending this coverage and to submit corrective legislation. In making the deferrals (the first to July 1, 1978, Public Law 95–214, and the second to May 1, 1980, Public Law 96–24), Congress was concerned that automatic coverage of multiemployer plans would encourage plans to terminate and to rely on the insurance program to pick up the pieces. This would place a heavier liability on the remaining contributing employers who would then have a greater "reason" to consider withdrawal themselves. The potential for disastrous consequences in this event is great.

The PBGC report of September 29, 1977, outlined the major problems of multiemployer plans and described the monetary implications for multiple multiemployer plan terminations. The PBGC reported that about 2 percent of the 2,000 title IV plans, covering 5 percent of multiemployer plan participants, were under difficult financial hardships with a high degree of potential terminations. The total unfunded but vested liabilities of these plans in 1977 exceeded $350 million. In addition, another 10 percent of all multiemployer plans, with 15 percent of all participants, were also in financial difficulty. Their unfunded vested liabilities were about $3.5 billion.

With an underlying fear of paying for a termination insurance program whose costs could easily be in the neighborhood of $4 billion, Congress is using the time before May 1, 1980, to consider legislation to modify the ERISA provisions dealing with termination insurance coverage.

Following its analysis of the termination insurance problem, the PBGC developed legislative recommendations which were submitted to Congress and which would change the way multiemployer pension plans are insured under title IV of ERISA. The recommendations reduce the incentives to terminate plans and they seek to distribute the costs of plan termination equitably. In presenting the administration's proposal to the Congress, Secretary of Labor Ray Marshall, who is also the Chairman of the PBGC Board of Directors, explained that:

> The bill has two primary objectives: (1) To make sure that plans have sufficient funds to pay benefits, and (2) to provide insurance only for involuntary events—plan insolvencies resulting from sustained declines in covered employment.

Secretary Marshall went on to explain that the key elements of PBGC's legislative proposal are:

(1) An employer that leaves a multiemployer pension plan would be required to pay its fair share of the plan's vested liabilities.

(2) The minimum funding standards for multiemployer pension plans would be revised to help insure that sufficient funds will be available to pay benefits.

(3) A program of plan reorganization would provide financially weak plans an opportunity to restore the balance between benefit promises and contributions. Reorganization would also provide relief from escalating costs.

(4) A multiemployer plan would terminate if it were amended to end the crediting of additional service for any purpose or if all employers withdraw. Employers would be required to continue funding vested benefits.

(5) Plan insolvency would be the only event insured by the PBGC. Financial assistance provided by the PBGC would be repaid by a multiemployer plan if and when its financial condition improved.

The Secretary concluded his testimony by affirming his belief that these elements "will make termination insurance work for multiemployer pension plans. Multiemployer plans may be the only way that millions of workers in the private sector can earn vested retirement benefits. Enactment of the proposed bill would be a significant step toward assuring those workers that they will receive pensions even if their pension plan fails." [1]

The proposal became S. 1076 when introduced by Senators Williams, Long and Javits on May 3, 1979, and seeks to improve ERISA's termination insurance program for multiemployer pension plans. Under current law, employers that remain in a plan until it terminates are liable to the PBGC for unfunded guaranteed benefits of up to 30 percent of each employer's net worth. For some employers 30 percent of their net worth may be less than the cost of continuing the pension plan. In such cases there may be an incentive for employers to terminate the plan and shift the cost to the insurance program, even though the company may be capable of continuing the plan. S. 1076 addresses this fundamental weakness of ERISA.

The bill was jointly referred to the Senate Committee on Finance and the Senate Committee on Labor and Human Resources. Hearings were held on June 26 and 27, 1979 by the Committee on Labor and Human Resources. A House companion bill, H.R. 3904, was also introduced May 3, 1979 and was jointly referred to the House Committee on Education and Labor and the House Committee on Ways and Means. On May 11, 1979, H.R. 3904 was referred to the Education and Labor Committee's Subcommittee on Labor-Management Relations where hearings were held on June 4 and 7, 1979. The subcommittee reported the bill on December 13, 1979 to the full committee for action. The Ways and Means Committee's Oversight Subcommittee held a hearing on the legislation July 25, 1979. Action is

[1] U.S. Congress. Senate. Committee on Labor and Human Resources. Multiemployer Pension Act Amendments Act of 1979. Hearings, 96th Congress, 1st Session on S. 1076. June 26 and 27, 1979. Washington, D.C., U.S. Government Printing Office, 1979, pp. 121–131.

anticipated in Congress before May 1, 1980 when mandatory termination insurance is scheduled to become effective under current law.

2. ERISA IMPROVEMENTS ACT OF 1979

The second major piece of legislation pending in the Senate affecting pension plans is S. 209, the ERISA Improvements Act of 1979. S. 209 was introduced by Senators Williams and Javits on January 24, 1979, and was referred to the Senate Finance Committee and the Committee on Labor and Human Resources. This act is a refinement of a previous bill, S. 3017 (95th Congress), and incorporates changes resulting from earlier hearings.

While S. 1076, discussed above, focuses on termination insurance for multiemployer pension plans, S. 209 is intended to simplify and clarify the administrative and regulatory mechanisms that govern all employee benefit plans. As Senator Javits pointed out, this "issue is particularly crucial when one considers the magnitude of pension assets and the importance of this pool of capital to the American economy." He went on to say:

> Private pension assets today total $280 billion. State and local governmental plans hold $130 billion more; and Federal retirement programs outside of social security have another $55 billion. By 1985, these assets are expected to aggregate $1 trillion, and within the foreseeable future will provide nearly one-half of all the external capital raised by U.S. enterprises.[2]

Senator Williams summarizes the provisions of S. 209 as follows:

> This legislation is designed to achieve four important objectives for our system of private employee benefit plans:
>
> To simplify, clarify, and improve certain ERISA and tax code provisions so that plans are improved from the standpoint of both plan sponsors and plan participants and beneficiaries;
>
> To stimulate the creation of more private sector retirement arrangements, so that a greater proportion of the work force does not place sole reliance for retirement income on the already overburdened social security system;
>
> To consolidate the administration and enforcement of ERISA and the corresponding tax code provisions in a single new Federal agency; and
>
> To adjust the application of the Federal securities laws and certain State laws as they relate to ERISA-covered plans.[3]

The establishment of a new and independent agency may be more difficult than theoretically proposed. The IRS, for example, would continue to perform its functions out of the Treasury Department, and the Department of Labor would maintain its interest in decisions affecting labor. In the words of Senator Orrin G. Hatch, "A new agency may well be counterproductive and result in triple jurisdiction

[2] U.S. Congress. Senate. Committee on Labor and Human Resources. ERISA Improvements Act of 1979. Hearings, 96th Congress, 1st Session on S. 209. Feb. 6, 7, and 8, 1979. Washington, D.C., U.S. Government Printing Office, 1979, p. 100.

[3] Ibid., p. 1.

instead of dual jurisdiction." Senator Hatch sees "no compelling need for the establishment of a new Federal agency which would require hiring additional Federal employees and opening field offices all over the Nation at what must be substantial costs." In short, his minority view is that the new agency may be "premature." [4]

Committee hearings were held by the Senate Committee on Labor and Human Resources on February 6, 7, and 8, 1979. On May 16, 1979, the committee favorably reported S. 209. The Subcommittee on Private Pension Plans of the Senate Finance Committee held hearings on April 3, 1979, and on December 4 and 5, 1979 to review S. 209 and other similar and related bills.

B. District of Columbia Retirement Reform Act

In a move that will have great impact on the financial condition of the District of Columbia for the rest of the century, Congress passed, and the President signed into law, H.R. 3939/S. 1937 (Public Law 96–122). A similar attempt that passed the House and the Senate in the 95th Congress was pocket-vetoed by President Carter.

When the District won home rule in 1975, it inherited the pension obligations imposed by Congress as a result of the "pay-as-you-go" financing nature of the pension program, previous commitments and new requirements. The 1978 liabilities for the police and firefighters retirement system were $1.5 billion, teachers' $800 million, and judges' $12 million, for a total of $2.312 billion in unfunded liability. Projections indicate that, without congressional assistance, the cost to the District to maintain police and fire pensions would be more than the salaries of active employees by the year 2000.

The new law:

(1) Establishes separate retirement funds for police officers and firefighters, teachers, and judges, but allows moneys in these funds to be commingled for investment purposes.

(2) Establishes an 11-member Retirement Board to manage the funds (five appointed by city, six elected by active and retired employees).

(3) Requires that these funds be managed on an actuarially sound basis to provide proper financing of benefits.

(4) Prohibits investment of funds in District of Columbia, Maryland, and Virginia bonds, real estate, and agencies.

(5) Gives the Retirement Board fiduciary responsibility over the funds.

(6) Requires the Retirement Board to comply with reporting and disclosure requirements similar to those imposed by the Employee Retirement Income Security Act of 1974 (ERISA).

(7) Provides for Federal payments into each fund to help finance, in part, liabilities for retirement benefits enacted and administered by Congress prior to home rule.

(8) Makes certain changes in benefits.[5]

The final bill authorizes total appropriations of $1.3 billion for fiscal years 1980 through 2004. The annual Federal payment will be $52.07

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[4] U.S. Congress. Senate. Committee on Labor and Human Resources. The ERISA Improvements Act of 1979: Summary and Analysis of Consideration. (Committee Print) November 1979. Washington, U.S. Government Printing Office, 1979, pp. 63–64.

[5] U.S. Congress. House of Representatives. Committee on the District of Columbia. District of Columbia Retirement Reform Act; Report to accompany H.R. 3939. Washington. D.C. Report No. 96–155, p. 2.

million with $34.2 million for police and firefighters, $17.7 for teachers, and $220,000 for the judges' retirement fund.

C. Employee Stock Ownership Plans (ESOP's)

While employee stock ownership plans (ESOP's) are not pensions as such, they do have a direct impact on retirement income, just like other forms of stock ownership. An ESOP enables an employee to acquire stock ownership in a company's future without—in most cases—putting up any money, and it provides new tax benefits for the employer.

By encouraging employees to be stockholders, there is the added incentive and interest that comes with being an owner. The major difference from traditional stock ownership is the method of paying for the stock. The corporation establishes a tax-exempt ESOP trust fund that borrows money from a bank or other lender. The loan is guaranteed by the parent corporation. The ESOP then uses the money to purchase stock in the company, thus giving the corporation funds to expand and/or modernize its operations. Each year the corporation makes a tax-exempt payment to the ESOP equal to the interest and principal payment due on the loan. Each employee accumulates a "vested interest" in the stocks held by the ESOP. When the employee leaves the firm or retires, he or she receives his or her share of the stock held in the ESOP. If an employee dies, his stock entitlement passes to his beneficiaries. (A more detailed explanation of ESOP's can be found in three publications available from the Senate Finance Committee: "ESOP's—An Explanation for Employees," published in March 1978; "ESOP's and TRASOP's—An Explanation for Employees," published in November 1978; and "Employee Stock Ownership Plan—An Employer Handbook," published in August 1979.)

Congress has encouraged the development of ESOP's by passing the following major pieces of legislation:

(1) The Employee Retirement Income Security Act of 1974 Public Law 93–406).

(2) The Tax Reduction Act of 1975 (Public Law 94–164).

(3) The Tax Reform Act of 1976 (Public Law 94–455).

(4) The Revenue Act of 1978 (Public Law 95–600).

These laws determine the parameters for ESOP's. As refinements and legal definitions evolve, ESOP's will change in detail, but not in basics. Since ESOP's provide a vehicle to allow employees to invest part of their earnings in their company's stock, corporations may look to these plans as a source of new capital for future expansions. Thus, ESOP's may grow in importance—not only in terms of improving retirement income—but also as a means to strengthen capital formation in our economy at large.

Several bills are currently pending before the Congress that would "fine tune" and expand ESOP's. H.R. 2797, the Technical Corrections Act of 1979, makes a number of adjustments in the tax code affecting ESOP's and other provisions affecting deferred compensation. H.R. 2797 was passed by the House (July 16, 1979), approved by the Senate Finance Committee on December 13, and placed on the Senate legislative calendar. Action on this legislation should occur early in the second session of the 96th Congress (S. Rept. 96–498—H. Rept. 96–250). The Employee Stock Ownership Improvement Act

of 1979—H.R. 4902—was introduced by Representative Bill Frenzel on July 23, 1979. H.R. 4902 would make permanent the credit against corporate income taxes for the employer's contribution to an ESOP. The proposal would also allow a special income tax credit to small businesses who establish an ESOP. H.R. 4902 was referred to the House Ways and Means Committee, which has taken no action to date. A similar bill, S. 1240, was introduced by Senator Russell Long on May 23, 1979. In addition to other changes, S. 1240 would allow the tax credit to be applied to either the corporation's assets base—as provided in current law—or its wage base which would encourage the development of ESOP's in labor-intensive industries. This measure was referred to the Senate Finance Committee which held hearings on the legislation on December 4 and 5. No further action has yet been scheduled.

D. Legislation Affecting Pension Benefits of Women

When the Congress acted in 1974 to pass the Employee Retirement Income Security Act (ERISA)—setting minimum vesting, funding and reporting requirements for private pension plans—it did not, however, require any particular company to have a pension plan. In fact, less than half the private work force is working for employers having pension plans. According to the latest data available, about 49 percent of male employees but only 21 percent of female employees work in private sector jobs which are covered by private pensions. Furthermore, simply because an employee is working in a company which does have a pension program is no assurance that the employee will receive a pension upon retiring. Since most plans require 10 years of service before pension benefits vest, many women never receive a pension because they do not work long enough with one employer.

The private pension system generally rewards a certain kind of work behavior—that is, a lifetime of steady work with relatively little job mobility and high earnings. Of those retired receiving pensions, male retirees receive pensions about 40 percent higher than female retirees. The disparity of pension benefits and coverage between men and women comes about because the type of work behavior conducive to receiving pension benefits is more typical of men than it is of women. Trends in women's work behavior over the past several years, however, suggests that relatively more women will receive relatively larger pension benefits in the future years. Nonetheless, a much larger proportion of men than of women still have this favored work pattern.

Besides vesting requirements, participation requirements can also result in problems for some women workers. ERISA provides that employees do not have to be included in pension plan coverage until age 25. This provision in particular works to the disadvantage of many women since women in the 20–24 age bracket have the highest labor force participation rate among women—68.3 percent in 1978 with a projected increase to 76.8 percent by 1985. Female participation in the work force is about equal to that of men until age 25, at which time it begins to drop off as women begin having children and drop out of the work force, at least temporarily.

Still another problem with pension plans is the fact that they utilize "sex-based actuarial tables" to compensate for the fact that

women as a group have greater life expectancy than men. As a result, women are sometimes required to contribute more to their pension in order to receive the same benefits as similarly situated men or receive lower pension benefits. Recent court decisions in this area, however, are correcting this inequity by prohibiting different benefits or contributions based upon such tables.

A number of legislative proposals have been introduced during the 1st session of the 96th Congress which, if enacted, would change the private pension system to react to some of these issues. The following section describes some of these proposals and discusses the kind of benefit that would be made available:

1. SPOUSAL IRA'S

If both husband and wife hold jobs where they are not covered by a pension plan, each may contribute up to $1,500 to an IRA—Individual Retirement Account. If one spouse does not work, the maximum contribution for the couple would be $1,750. If the working spouse is covered by a pension plan, the nonworking spouse cannot set up an IRA.

The following bills allow an individual a tax deduction for contributions to a spouse's IRA, even if the spouse has little or no earned income:

S. 94, introduced by Senator Lloyd Bentsen, amends the Internal Revenue Code, section 219, to allow a married individual with no income or with an income lower than that of his or her spouse to use the spouse's income to calculate the amount that the individual could contribute to an IRA, if other qualifications for an IRA are met. The bill allows a contribution of up to $1,500 to the IRA of each spouse who meets the IRA requirements. It also repeals section 220 which provides for a maximum contribution of $1,750 for married couples where one spouse could not qualify for an individual IRA.

H.R. 393, introduced by Representative Tennyson Guyer, is similar to the Bentsen bill, although it applies without regard to any community property laws.

H.R. 1542, introduced by Representative Paul Trible, is identical to the Bentsen bill except for a different effective date.

H.R. 2914, introduced by Representative Marilyn Lloyd Bouquard, and H.R. 3082, introduced by Representative Robert A. Roe, are identical to H.R. 393.

H.R. 3171, introduced by Representative Arlan Stangeland, contains a section—title IV—which is identical to H.R. 393.

H.R. 4547, introduced by Representative Sam Gibbons, permits married couples to compute the income tax deduction for contributions to retirement savings on the basis of one-half their combined income.

The aforementioned measures are presently pending before the Finance Committee in the Senate or the Ways and Means Committee in the House of Representatives. One day of hearings on S. 94 was held by the Senate Finance Committee's Subcommittee on Private Pension Plans on April 3, 1979. No action has been scheduled for any of the other bills referenced above.

2. LIMITED EMPLOYEE RETIREMENT ACCOUNTS (LERA'S)

Under current law, employees participating in qualified pension plans may not make contributions to an Individual Retirement Account. Many pension plan participants would like to contribute to an IRA as well, since there is no assurance that they will actually receive a pension benefit from the plan which covers them. Failure to receive pension benefits could result from a number of causes, such as frequent job changes, movement in and out of the labor force or working too little time to become vested in a pension benefit.

In 1978, Congress adopted the simplified employee pensions provision that permits employers to set up special employer-sponsored IRA's. Employers are allowed to contribute and deduct contributions equal to the lesser of $7,500 or 15 percent of each employee's compensation. If the employer contributes less than the employee could have contributed to a regular IRA, the employee may contribute the difference. The limits on contributions to a regular IRA are the lesser of $1,500 or 15 percent of compensation includable in gross income.

A number of bills have been introduced which would allow certain other individuals covered by a pension plan to make limited contributions to an IRA or other plan so that they might have an assurance of some pension coverage.

The IRA-Employer Plan Coordination Act of 1979 (H.R. 628), introduced by Representative James Corman, replaces section 219 of the Internal Revenue Code and provides that individuals whose employers do not contribute to qualified pension plans in amounts that are at least equal to the regular IRA limits may contribute the difference between the regular IRA limits and the employer contribution to an IRA or the employer plan. Employer contributions would not count against the regular IRA limits unless the employee was fully vested in the contributions.

S. 1428, introduced by Senator Alan Cranston, and H.R. 838, introduced by Representative Wolff, are identical to H.R. 628.

H.R. 962, introduced by Representative William Brodhead, is similar to H.R. 628, but it contains provisions for spousal IRA's which H.R. 628 lacks. In addition, H.R. 628 contains provisions for simplified employee pensions which H.R. 962 lacks.

H.R. 2049, introduced by Representative James Oberstar, amends section 219 of the code to allow individuals to deduct amounts contributed to an IRA, but the deduction would be reduced by the amount of the employer contributions to any of a number of qualified ERISA plans or plans established by the United States or a State. The bill makes a similar amendment to section 220(b) dealing with retirement savings for certain married individuals.

H.R. 3523, introduced by Representative Margaret Heckler, creates a new section 221 and redesignates current section 221 as 222. This bill allows employees who are active participants in certain ERISA plans (but not Federal, State, or local plans) to make tax-deductible contributions of up to the lesser of $1,000 or 10 percent of compensation to their employer-sponsored pension plan or to an IRA. In the case of an IRA, however, the deduction is limited to the excess of the $1,000 or 10 percent limit over any amounts paid to other types of ERISA plans.

S. 75, introduced by Senator Bob Dole, is similar to H.R. 3523. In addition to contributions to certain ERISA plans, the bill also allows contributions to a group retirement trust maintained by a labor organization meeting certain requirements. The maximum deduction is the same. This bill specifies that the contribution to an IRA is an alternative deduction to those allowed by sections 219 and 220 of the code (the regular IRA sections). The bill contains special rules which might limit deductions to highly compensated employees and special rules dealing with married individuals.

S. 557, introduced by Senator Lloyd Bentsen, amends section 219 to allow tax-deductible employee contributions to an IRA or to qualified plans in which the employee is an active participant for any part of the taxable year. The prohibition against a participant in a qualified plan making tax-deductible IRA contributions or contributions to a qualified plan is removed. The limits on the contribution and deduction are the same as the present IRA limits.

S. 1209, introduced by Senator John Durkin, is similar to H.R. 3523 and S. 75. In addition to contributions to the labor organization plans, this bill also allows contributions to Federal, State, and local plans. The maximum deduction is limited to the lesser of 10 percent of compensation or $200. The bill does not contain special rules for highly compensated employees or married individuals that are contained in S. 75.

S. 209, introduced by Senators Williams and Javits, also allows a deduction for contributions to an IRA, to a group retirement trust maintained by a labor organization, and to other specifically defined plans. Section 203 of S. 209 is identical to the provisions in S. 75 (see above) except that deductions are not allowed for plans in existence on January 1, 1978, if: (1) Employee contributions are mandatory, or (2) employer contributions are made *only* when contributions are also made by employees.

S. 209 has been ordered reported, as amended, by the Senate Finance Committee. The Senate Finance Committee's Subcommittee on Private Pension Plans held 1 day of hearings on Senate bills 75 and 557 on April 3, 1979. The other measures mentioned in this section are presently pending before the House Ways and Means or Senate Finance Committees with no action scheduled as of January 21, 1980.

3. MISCELLANEOUS IRA

H.R. 3250, introduced by Representative Jack Kemp, permits alimony payments to be included in computing the total allowable income tax deductions for contributions to retirement savings. H.R. 3250 is presently pending before the House Ways and Means Committee.

4. JOINT AND SURVIVOR ANNUITIES

Several bills would expand joint and survivor annuity coverage and protect surviving spouse's pension rights under ERISA. With the exception of S. 209, which was discussed previously, no action has been taken on any of the bills mentioned in the following section.

Currently, ERISA provides that plans do not have to provide for a joint and survivor annuity during the period between the day when the employee starts participating in the plan and the date of earliest retirement age or, if later, the date 10 years before normal retirement age (see Internal Revenue Code, sec. 401(a)(11)).

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H.R. 717, introduced by Representative Robert Roe, provides that an ERISA plan cannot be tax qualified unless the plan provides a survivor's annuity for the spouse of the participant who dies before the earliest retirement age. The annuity would begin on the annuity starting date, determined as if the participant had lived to the earliest retirement age, and the payments would be at least equal to payments that would have been made under a survivor's annuity to which the spouse would have been entitled if the participant had been separated from the service on the date immediately preceding his death.

Section 2 of H.R. 2049, introduced by Representative James Oberstar, and H.R. 3340, introduced by Representative Elizabeth Holtzman, are essentially the same as H.R. 717.

Section 127 of S. 209 proposes that if a plan provides for the payment of benefits in the form of an annuity, it must provide for the payment of a joint or survivor annuity. If the normal form of benefit is an annuity, then if the participant who is credited with at least 10 years of service for vesting purposes dies before the annuity starting date, the plan must provide that the spouse will receive a survivor's annuity similar to that described under H.R. 717. However, if the actuarial equivalent of the survivor's annuity does not exceed $2,000, then the plan can distribute the survivor's benefit in a lump sum.

Also, if the plan's normal benefit is not an annuity, if a participant dies before normal retirement age but after accruing 10 years of vested service, the surviving spouse would be entitled to the participant's benefit in a lump sum or in installments or as agreed in writing.

The legislation also provides for an election or nonelection of joint and survivor benefits by the participant on or before the date in which he or she completes 10 years of service for vesting purposes.

H.R. 5167, introduced by Representative Elizabeth Holtzman, provides that married couples will be deemed to have elected a joint and survivor's option, if available, unless both parties agree in writing that they do not want such coverage. The bill requires the survivor annuity to be at least 75 percent of the joint annuity and changes the marriage requirement.

5. ERISA—PROPERTY SETTLEMENTS

These bills provide that pension plans must obey court orders dividing benefits in community property settlements or attaching pensions for alimony or child support. With the exception of S. 209, no action has been taken on any of the measures mentioned in the following section.

ERISA sections 206(d)(1) and 514 prohibit assignment or alienation of plan benefits and preemption of ERISA by State law. The question has arisen whether State courts may order division of a participant's benefit in a plan without disqualifying the plan for tax purposes.

H.R. 1884, introduced by Representative John Seiberling, amends ERISA to provide that plans will not be disqualified for permitting assignments or alienations pursuant to a decree of divorce, separate maintenance, or court orders for child support, providing there is no requirement that the plan altered the timing or form of benefit payout. It also provides that the antiassignment provisions shall not be

construed to invalidate State community property laws governing distribution of marital property.

Section 128 of S. 209, the ERISA Improvements Act of 1979, provides that the antiassignment/alienation provisions shall not apply in the case of court order or property settlement pursuant to State domestic relations law, whether common law or community property type, which affects marital property rights of any person in any benefit payable under a pension plan providing the order does not require the plan to alter the timing or form of payments.

Section 155 of S. 209 provides that the preemption of ERISA will not apply to any court order of a State domestic relations court as described in section 128 above.

III. RETIREMENT INCOME AND THE TREATMENT OF WOMEN

The issue of unfair treatment of women under social security and other retirement programs received a great deal of attention during 1979. Extensive legislative activity, an important HEW report and numerous hearings accentuated the growing awareness and concern over past inequities that continue to exist requiring careful reexamination and movement toward change. In releasing the HEW report on social security and the changing roles of women and men, Secretary Joseph A. Califano captured the essence of this growing concern when he noted:

> The social security system as it now stands discriminates against women. It's not a question of whether but how to change the current structure to correct the inequities while retaining the strengths of the present system.

A. HEW Report—Men, Women and Social Security

Congress, through enactment of the Social Security Amendments of 1977, required HEW to study and report on proposals to eliminate dependency as a factor in entitlement to spouse's benefits and to eliminate sex discrimination under the social security system. On February 15, 1979, that report entitled "Social Security and the Changing Roles of Men and Women" was submitted to Congress. Although the report made no official recommendations, it did set out a comprehensive analysis of the manifold issues involved and specifically outlined a variety of options. In part, it concluded:

> Issues related to social security benefits for women have arisen primarily because of changes in American society, particularly the increased labor force participation of women and increased divorce and remarriage rates. The present social security structure has increasingly been questioned on the basis of whether it responds adequately to today's work patterns and family relationships.
>
> In summary, all of the concerns about social security protection for women relate to the fundamental goals of the system which are to provide benefits that are adequate to meet important social needs and at the same time are equitably distributed among different categories of beneficiaries and contributors to the program.

Questions of equity and adequacy are not new to the social security program. The original program was designed to combine goals of both equity and adequacy. For example, the basic program is equitable in that it scales benefits to past earnings; a high earner receives a higher basic benefit than a low earner. On the other hand, social adequacy is provided in the case of low earners, who have less margin for reduction in income, under a weighted benefit formula that produces benefits that replace a higher portion of their preretirement earnings. The social adequacy function is further served by the provision of dependent's and survivor's benefits for the families of workers.

In many cases, the goals of adequacy and equity are inconsistent; program changes that improve equity may reduce adequacy and vice versa. This tension has been with the system since its inception, and the appropriate balance between these two goals is often a source of controversy.

The issues identified have been raised in a number of quarters—the administration, the Congress, women's organizations, and the public. They are fundamentally tied to the social security program's twin goals of adequacy and equity and the conflicts between them. Reducing inequities for women workers while providing adequate protection for women with little paid work history will involve striking a new balance between the equity and adequacy of the social security system.

If present social trends continue, concern about the issues explored in this report will become more widespread in the future.

The options to deal with the various issues range from very small changes in the present system to comprehensive plans that would alter the basic structure of social security. The report has analyzed the various options to show how they would deal with the issues, how they would change the present system, what assumptions they are based on, and how much they would cost.

No specific recommendations are made. The broad-scale options represent significant changes in the basic social security system—both in the type of benefits payable and in the level of protection provided for future beneficiaries. Changes of this magnitude will require careful consideration and extensive public debate before they can be put forward as recommendations. This report is designed to provide a framework for the necessary consideration and debate.

The debate needs to focus first on the future role of social security and on what issues can and should be dealt with under the program. It is only after judgments are made as to what issues should be resolved through the social security program that attention can be turned to the appropriate ways of making the changes.

One of the major options analyzed in the report is the so-called "earnings sharing" approach under which a married couple's total annual earnings would be divided equally for each year of marriage.

Each spouse would have social security protection in his or her own name which could be added to any protection acquired as a covered worker while married or from another marriage. Neither spouse would be considered a dependent of the other.

In a November 28, 1979 hearing chaired by Senator Nancy Landon Kassebaum, the Special Committee on Aging heard testimony from several witnesses on the issue of earnings sharing as a preferred direction for reform. One witness, Mary C. Falvey, a member of the National Advisory Council on Social Security, endorsed the earnings sharing concept:

> The Council majority feels that the concept of earnings sharing needs to be thoroughly discussed and debated throughout the country before any such program can be endorsed.
>
> Communication and debate, however, need not and should not delay action. I personally believe that earnings sharing is the way to go, that its advantages in improving the treatment of women under social security are stronger than those of any other option that has been or is likely to be developed in the foreseeable future, and that its weaknesses are manageable and acceptable.

(See below for further discussion of the Council's recommendations.)

Although numerous bills were introduced in Congress during 1979 to effect better treatment of women under social security, the complexity of the issues and their need for better understanding by the Congress and the public at large has stalled any significant action during 1979.

The study presented a number of limited options for dealing with present adequacy and equity problems, as well as two comprehensive options—an earnings-sharing model and a two-tier model which employs some features of earnings sharing in the work-related tier.

1. MAJOR OPTION NO. 1—EARNINGS SHARING

Under earnings sharing, a couple's annual earnings would be divided equally between them for the years they were married for purposes of computing retirement benefits. The earnings would be divided when the couple divorced or when one spouse reached age 62. This would entitle each spouse to a primary benefit which would replace aged dependent spouse's and surviving spouse's benefits provided under present law.

The basic earnings-sharing idea has been modified in certain respects in order to pay benefits that are somewhat comparable to present law benefits. The modifications are:

—When one spouse dies, the survivor would be credited with 80 percent of the total annual earnings of the couple during the marriage, but not less than 100 percent of the earnings of the higher earner.

—For purposes of benefits for young survivors—children and young surviving spouses caring for children—earnings would not be transferred between the spouses with regard to a marriage in effect at the time of death. Benefits for young survivors would be based on any earnings credits the deceased person had from paid

work (while unmarried or during a current marriage), plus any credits acquired as a result of a prior marriage terminated by death or divorce.

—For purposes of disability benefits, earnings would not be shared with regard to a marriage still in effect at the time of disability. Disability benefits would be based on any earnings credits the disabled person had from paid work (while unmarried or during the current marriage), plus any credits acquired from a prior marriage.

2. MAJOR OPTION NO. 2—DOUBLE-DECKER BENEFIT STRUCTURE

Under the double-decker option, each U.S. resident would have retirement, survivors, and disability protection. This universal protection would be the first tier of a two-tier system. Tier I would be a flat-dollar payment of $122 for U.S. residents beginning at age 65 (or upon disability). Reduced benefits would be paid as early as age 62. Tier II would be a benefit equal to 30 percent of a person's average earnings in covered employment. Tier II benefits would be payable at age 62 (reduced if taken before age 65). The benefit for an aged or disabled worker would be equal to the sum of a tier I and tier II benefit.

Under the double-decker option, the adequacy and equity elements of the program would be separated—tier I generally would provide the the social adequacy element and tier II the equity element. Dealing with the goals of adequacy and equity under social security with separate benefit tiers should make it easier for the public to understand the unedrlying principles and for policymakers to develop proposals to fulfill specific goals.

A number of the features of this option are not an integral part of a basic double-decker system but were included to improve the protection of specific groups of persons. Such features include the 50–50 split of earnings at divorce, the inheritance of earnings by a surviving spouse for purposes of computing tier II benefits, and the provision of an adjustment benefit to a surviving spouse at any age. These features of the plan are generally the same as those under earnings sharing although the benefit amounts would be somewhat different due to the different benefit structure.

B. Legislation—Women and Social Security

Several bills designed to equalize the treatment of women and men under the social security program were introduced during the 1st session of the 96th Congress. The following is an outline of major legislative initiatives in this area for the year 1979. The bills have been referred to either the House Ways and Means or the Senate Finance Committees where they are pending further consideration.

1. PROPOSALS TO ELIMINATE THE OFFSET PROVISION IN PRESENT LAW

Current law provides that men entitled to a Federal, State, or local pension in their own right must experience a reduction in the amount

of social security benefits for which they are eligible. The amount of this reduction must be equal to the amount of their public pension. An identical offset provision will go into effect for women in 5 years. The following bills, either by amending title II of the Social Security Act or by amending section 334 of the Social Security Amendments of 1977, would eliminate entirely the offset provision for both sexes.

H.R. 398 (Tennyson Guyer).
H.R. 652 (Carl D. Perkins).
H.R. 801 (Richard C. White).
H.R. 1063 (Delbert L. Latta).
H.R. 2140 (Chalmers P. Wylie).
H.R. 2215 (Ronald M. Mottl).
H.R. 2687 (William H. Harsha).
H.R. 2853 (Jerry M. Patterson).
H.R. 3379 (Herbert E. Harris et al.).
H.R. 3802 (William H. Natcher).
H.R. 3941 (Majorie S. Holt).

H.R. 2501, introduced by Congressman James Quillen, would not eliminate the offset but would postpone its effective date for an extra 5 years.

2. PROPOSALS TO CONTINUE COVERAGE WHICH WOULD OTHERWISE BE TERMINATED

Present law provides that individuals eligible for social security old age benefits and dependent benefits may receive only one of these benefits. The following measures are designed to significantly liberalize this provision in current law.

H.R. 484, introduced by Representative Elizabeth Holtzman, would amend title II of the Social Security Act to provide that an individual may receive an old age or disability insurance benefit and a widow's or widower's insurance benefit simultaneously.

H.R. 658, introduced by Representative Frederick Richmond, would provide that the marriage of a disabled individual receiving child's insurance benefits under social security to a civil service retirement or survivor annuitant would not terminate entitlement to his or her social security benefits. This measure would overturn the decision in *Califano* v. *Jobst* which held that it was not unconstitutional to terminate a child's disability benefits upon marriage.

H.R. 1730, introduced by Representative Charles B. Rangel, provides that marriage or remarriage of a widow, widower, parent, child, or wife would not terminate entitlement to social security insurance benefits or reduce the amount of said benefits.

3. PROPOSALS TO ALLOW COURT-ORDERED GARNISHMENT FOR PROPERTY SETTLEMENT

Under present law, garnishment of payments made by the Federal Government is permitted in order to enforce alimony or child support obligations. However, in cases of property settlements or other divisions of property, garnishment is not permitted. The following measures are designed to permit garnishment in cases which involve property settlements or other divisions of property.

H.R. 2389, introduced by Representative Sam Hall, amends title IV of the Social Security Act to subject to garnishment as alimony any payment or transfer of property or its value between spouses or former spouses in compliance with a community property settlement, or other division of property directed by a court of competent jurisdiction.

H.R. 2473, introduced by Representative Whitehurst, amends title IV of the Social Security Act to permit, in addition to the enforcement of alimony payments under such part, the enforcement of any "other court-ordered payments or settlements" to or on behalf of a spouse or former spouse. The legislation also defines the term "other court-ordered payments or settlements" to include lump-sum or periodic payments of funds or transfers of property between spouses or former spouses under a decree of separation or divorce in compliance with any community property settlement, equitable division of property, or other division of property.

4. PROPOSALS TO LOWER AGE REQUIREMENTS FOR ENTITLEMENT TO SOCIAL SECURITY BENEFITS

Representatives James Quillen and James L. Oberstar introduced legislation during the 96th Congress which would lower the age requirements for entitlement to social security benefits. The Quillen bill, H.R. 2466, would amend title II of the Social Security Act to lower the age for entitlement from 65 to 50 for otherwise qualified women to receive widow's insurance benefits. The Oberstar bill—H.R. 5133—would amend title II to: (1) Eliminate the age requirements for disabled wives, husbands, widows, and widowers to obtain full benefits; (2) provide benefits for essential spouses of disability beneficiaries without regard to age or children in care, and (3) provide that all divorced spouses and former spouses (including husbands and fathers) may qualify for benefits.

5. PROPOSALS TO EXPAND SPOUSAL BENEFITS

Representative Margaret Heckler introduced H.R. 1039 during the 1st session of the 96th Congress. This measure, the "Homemakers Social Security Benefits Act," would amend title II of the Social Security Act and certain provisions of the Internal Revenue Code to provide coverage to homemakers. For purposes of the legislation, homemaker is defined as an individual who conducts the affairs of a household without remuneration, is between the ages of 18 and 65, and who is not already entitled to benefits under title II of the Social Security Act.

H.R. 2503, introduced by Representative Oakar, would accomplish the following by amending title II of the Social Security Act:

—Permit married couples filing joint tax returns to share their income for old age, survivors and disability insurance purposes as well.

—Allow certain recipients of spouses' or survivors' benefits to include such benefits as income in determining their average monthly wage.

—Lower the age of eligibility for such benefits to age 50.

—Eliminate the special dependency requirements for husband's and widower's benefits.
—Authorize children entitled to more than one child's insurance benefit to receive the total amount available.

An identical bill (H.R. 2912) to that introduced by Representative Mary Rose Oakar was introduced by Representative Marilyn Lloyd Bouquard.

6. PROPOSALS TO SHORTEN THE MARRIAGE REQUIREMENT

The "Comprehensive Social Security Reform Act of 1979" (H.R. 765), introduced by Representative Louis Stokes, would, among other things decrease to five the number of years a divorced woman must have been married to an insured individual in order to qualify for wife's or widow's benefits. Representative Sidney R. Yates introduced legislation (H.R. 874) similar to that proposed by Representative Stokes. Another measure, H.R. 3309, introduced by Representative Stephen J. Solarz, calls for the elimination of the duration-of-marriage requirements which are presently applicable in determining whether a person qualifies for benefits as the widow or widower of an insured individual.

7. PROPOSALS RELATING TO THE WORKING SPOUSE'S BENEFIT

Representative Barber Conable introduced H.R. 14 during the 96th Congress which would add a new subsection to the Social Security Act to provide a working spouse's benefit. If an individual is entitled to both old age benefits or disability insurance benefits and a wife's, husband's, widow's, or mother's insurance benefit, then the persons would be entitled to working spouses' benefit (WSB) equal to 25 percent of the amount of the smaller benefit plus the full amount of the larger benefit. The WSB cannot result in a payment greater than the maximum primary insurance amount and only one member of a married couple is entitled to the WSB in any month. With the exception of a differing effective date, H.R. 1851 (Bill Frenzel), H.R. 2650 (William Green), and H.R. 3158 (Norman F. Lent) are identical to the Conable measure.

8. PROPOSALS TO ELIMINATE GENDER-BASED DISTINCTIONS IN CURRENT LAW

H.R. 3171, introduced by Representative Arlan Stangeland, proposes to eliminate certain gender-based distinctions in the Social Security Act by providing benefits for divorced husbands, surviving divorced husbands, and widowers with minor children on the same basis as similarly situated women.

H.R. 4842, proposed by Representative John Burton, would eliminate certain gender-based distinctions in areas relating to treatment of divorced husbands, father's insurance benefits, and credit for certain military service. The bill would also equalize entitlement to certain benefits at age 72, allow illegitimate children to apply for children's benefits from either parent under certain conditions, allow married couples who are self-employed to divide the income and deductions between them if they each exercise equal management and

control, and redefine the effect of marriage on the termination of certain disability and other dependents' or survivors' benefits.

Legislation introduced by Senator Daniel Inouye (S. 907) would provide that benefits for husbands, widowers, and fathers would be available on the same basis as for wives, widows, and mothers.

Prior to the Social Security Act Amendments of 1972, the period used to determine the amount of covered work needed for retirement eligibility and for benefit computation purposes was shorter for women than for men. In 1972 this discrepancy was prospectively eliminated. However, the changes were not extended to men who had already reached age 62. H.R. 4772, introduced by Representative John F. Seiberling, provides that the 1972 revision in the social security benefit computation formula for men would apply to men who retired in or before 1972 as well as men retiring after that date.

C. House Select Committee on Aging Task Force on Women and Social Security

In order to insure a full and careful debate on the issues surrounding the treatment of women under social security, the House Select Committee on Aging's Task Force on Women and Social Security conducted a series of hearings on this topic beginning in May of 1979. The task force, which is chaired by Representative Mary Rose Oakar, has focused attention primarily on the following issues:

(1) Disparities in social security benefit levels for two-earner and one-earner couples.

(2) Duplication in protection for working married women.

(3) Differences in payments to the aged survivor of a two-earner couple as opposed to survivors of one-earner couples.

(4) Inequities in the system which adversely affect the single worker.

During the course of the hearings, the task force heard testimony from a broad spectrum of witnesses including representatives from women's groups, senior citizen organizations, economists, representatives from the Social Security Administration, and from individuals who had been adversely affected by the system's imbalances. The ultimate goal of the task force is to balance certain indisputable injustices with appropriate legislative action. A full task force report is presently in the preparation stage, and should be completed early in 1980.

D. Senate Hearings on Women and Social Security

The treatment of women under social security was a major focus of a Senate Special Committee on Aging hearing chaired by Senator Nancy Landon Kassebaum on November 28, 1979, in Washington, D.C. In her opening statement, Senator Kassebaum outlined the following instances of inadequacy and inequity in our present social security structure:

—Many married women who have worked and paid social security payroll taxes for several years find that they receive no more in benefits than they would have received had they never contributed to the system.

—Many two-earner couples receive lower total benefits than single-earner couples with identical average lifetime earning credits.

—Survivors of two-earner couples receive a lower benefit amount than survivors of one-earner couples with the same total average earnings.
—Divorced women experience severe gaps and duplication of social security protection.
—Married women workers find they have lost disability insurance protection if they drop out of the labor force to take on family responsibilities.

Witnesses at the hearing focused specifically on the pros and cons of the "earnings sharing" approach. (See major option No. 1, earnings sharing, above.) Although this concept had been generally acknowledged as the most promising means for minimizing social security's current inequities, the experts were by no means unanimous in endorsing earnings sharing. The following excerpts from the hearing reflect the diversity of opinion which surrounds the earnings sharing approach to social security equity:

Julia K. Arri, president, Business and Professional Women's Clubs, Inc., testified:

> Earnings sharing is the most comprehensive alternative to be offered and the most promising plan for achieving equity in social security. The problems that remain, however, are serious. We must continue to seek ways to alleviate them. We strongly believe that no reform should reduce retirement benefits. By raising or eliminating the maximum earnings allowed and continued refinement of the earnings sharing option, there is hope that the social security system can adequately and equitably meet the retirement needs of our older citizens.

Mary C. Falvey, National Advisory Council on Social Security, commented:

> The Advisory Council found earnings sharing to be the most promising approach to treating women equitably in today's world * * * I am among those in a minority on the council who would go further and state that the weaknesses in earnings sharing are manageable and acceptable and, although they need to be dealt with, discussion should be framed in the context of making earnings sharing work—not in an exploratory mode of evaluating the concept.

Martha Keys, special adviser to the Secretary, Department of Health, Education, and Welfare, added:

> The earnings sharing concept for work-related benefits responds positively to many of the inequities: it recognizes the economic contribution of the homemaker and thus solves the problem of zero-earnings years for averaging; it ends the gaps in protection for divorced spouses; it gives equal benefits to equal earnings couples and to the survivors of those couples; it helps women to meet the recency of work test for disability benefits; it reduces the difference in protection between single and married women workers: and it ends the duplication of tax paid by married women workers because the benefits are related to earned and shared credits.

James Hacking, assistant legislative counsel, National Retired Teachers Association/American Association of Retired Persons, testified:

> * * * we believe it makes better sense to revamp the system so that it becomes strictly a work-related program which is divested of most of its social adequacy objectives and emphasizes individual equity. If we are going to go through the lengthy and difficult process of reforming the system, we must be reasonably sure the end product of that process will be relevant to the socioeconomic context in which it must operate. We believe the only way to insure that contextual relevance is to have the system award benefits to individual workers and those benefits be based on that individual's contributions to the system.

Commissioner Stanford G. Ross, Social Security Administration, concluded:

> I would like to emphasize that a move to an earnings sharing system involves a basic trade-off—either the cost of the social security program must be increased and additional financing provided, or benefits must be reduced for some, or some compromise between these approaches must be struck * * * consideration must be given to seeking a middle ground between these two extremes * * * overall program cost and equity must be of major concern.

IV. SUPPLEMENTAL SECURITY INCOME

Major developments in 1979 involving the supplemental security income (SSI) program began with early attention to administration budget announcements to cut Federal spending. SSI, like most programs, did not escape the push for fiscal restraint. In addition, the Department of Health, Education, and Welfare—HEW—proposed several significant new regulations affecting the SSI program.

A. Social Welfare Reform Amendments of 1979

Originally introduced as H.R. 4321 and later revised to H.R. 4904, the administration's welfare reform legislation was aimed in part at generating savings in SSI expenditures—estimated at $20 million for fiscal year 1980—by:

(1) Shifting the accounting system in SSI from quarterly prospective to monthly retrospective. (SSI benefits are now calculated on a quarterly period based on the recipient's estimate of the income he or she will receive in the quarter. Retrospective budgeting bases the current month's benefit on the income the claimant received in the past, whether or not that income is available to the claimant in the future.)

(2) Prohibiting the disposal of assets to qualify for benefits.

(3) Eliminating windfall benefits when an applicant receives retroactive social security benefits for the same time period.

(4) Increasing the responsibility of the sponsors of legally admitted aliens who become dependent on SSI.

In addition to these cost-saving proposals, H.R. 4321 proposed several other significant changes including:

(1) Cashing-out the food stamp program by allowing an individual (or couple) whose only income was SSI to receive a cash payment equal to the equivalent food stamp allotment.

(2) Providing that attorneys' fees, in cases of favorable judicial decisions, may be set by the court up to 25 percent of the past-due SSI benefits.

(3) Excluding burial plots and up to $1,500 for burial costs in counting of resources.

H.R. 4321 was introduced on June 5, 1979, by Representative James C. Corman, Chairman of the Public Assistance Subcommittee of the House Ways and Means Committee. Following hearings held in June, the subcommittee reported a similar but revised bill, H.R. 4904, to the full committee. The revised bill had been altered by several amendments including the following:

(1) An amendment which provides that transfer of resources would not result in ineligibility for SSI if the claimant could show that the transfer was not for the purpose of obtaining benefits; however, the claimant would bear the burden of proof.

(2) An amendment which states that eligibility and SSI payments would be determined prospectively rather than retroactively for each month rather than each quarter.

(3) An amendment reducing retroactive social security payments by the amount of SSI payments for the same time period was rejected.

On November 7, 1979, H.R. 4904 passed the House and was sent to the Senate where it was referred to the Finance Committee. No action was taken there before the end of the year. The bill may face serious opposition in the Senate due to the opposition from Finance Committee Chairman Russell Long who prefers giving block grants to States to run their own programs. In addition, several of the bill's cost-saving proposals have been added by the Senate to another measure, the child welfare bill (H.R. 3434). Separate passage of cost-cutting amendments might reduce pressure to take up the welfare reform bill in the Senate (H.R. 4904).

NEW REGULATIONS

During 1979, the Carter administration proposed several new regulations having a significant impact on the SSI program including:

(1) Regulations proposed by HEW to cover the "pass-along" of Federal SSI cost-of-living raises to individuals eligible for State supplementary benefits. These proposed rules will implement the pass-along provisions of the social security amendments enacted October 21, 1976 (sec. 2 of Public Law 94–585). States that make supplementary payments on or after June 30, 1977, must agree to continue making these payments and to keep them at certain levels. If a State does not agree, or if the State agrees but does not keep the payments at the required levels, the State is subject to loss of medicaid reimbursement under title XIX of the Social Security Act (Federal Register, Mar. 27, 1979);

(2) Final rules promulgated by the U.S. Department of Agriculture (USDA) to establish an eight-project demonstration program to find

out what happens when persons over age 65 who are recipients of SSI receive cash in lieu of food stamps. Proposals to participate in this program were due December 17, 1979 (Federal Register, Oct. 12, 1979);

(3) Regulations proposed by USDA allowing SSI recipients to apply for food stamps at social security offices and be certified as eligible on the basis of information already contained in social security files (Federal Register, Dec. 7, 1979); and

(4) Interim regulations issued by HEW which would allow more flexible redetermination of an individual's SSI eligibility. Current regulations require redeterminations at least once a year; under the interim regulations, the frequency of redetermination would vary depending on the type of case (Federal Register, Nov. 7, 1979).

B. Two GAO Reports Find $25 Million in Erroneous Payments and Failure of Title XX To Provide Needed Services To SSI Elderly

During 1979, the General Accounting Office (GAO) produced two reports dealing with the SSI program.

After a yearlong study of a 1-percent random sample of 39,075 SSI active records, the GAO concluded that computer system flaws, poorly worded field office manuals, and lack of supervision of field staff may have resulted in over $25 million in erroneous payments to SSI recipients. Several technical recommendations were made to help correct the situation.

Secondly, at the request of Senator Chiles, the GAO studied the way seven States spend their title XX social service dollars to meet the needs of SSI recipients and found that inadequate outreach and insufficient resources leave many of these needs unmet. Several suggestions were made to improve the delivery by services: (1) Improve coordination between the Older Americans Act and title XX by requiring State and local governments to make joint needs assessments, program development, and resource allocations; (2) encourage State and local governments to use more jointly funded projects to deliver common services; and (3) require the Social Security Administration to eliminate barriers that prevent outreach agencies from obtaining SSI recipients' names and addresses.

V. DISABILITY INSURANCE REFORM

When the President announced his budget proposal for fiscal year 1980, he recommended changes in several aspects of the social security program to reduce expenditures for 1980 and subsequent years. These recommendations included changes in disability benefits as follows:

—Limit disability benefits to 80 percent of the worker's average indexed monthly earnings.

—Reduce the number of years which may be dropped in computing benefits for a younger disabled or deceased worker from the current 5 to: zero for those under age 27, one for the 27–31 age group, 2 for workers between the ages of 32 and 36, 3 for those age 37–41, 4 for ages 42–46, and 5 years for those over 47.

—Increase the work incentives for the disabled by extending the current 12-month trial work period to 24 months, continuing medicare and medicaid coverage for 2 years after a worker leaves

the disability rolls, requiring only one waiting period if a worker fails in his attempt to return to work, and allowing a deduction for impairment-related work and attendant care expenses.[6]

To implement these changes, authorizing legislation was necessary, and the House Committee on Ways and Means reported the Disability Insurance Amendments of 1979 on April 23 (H. Rept. 96–100 to accompany H.R. 3236). The committee approved and the House passed on September 6, the provisions for changing the social security disability program in the manner recommended by the administration with minor differences.

Passage of H.R. 3236 met strenuous opposition from "Save Our Security," a coalition which included aging groups and several former Commissioners of Social Security. Concerns expressed about the legislation by the aging community focused on the potential threat to the elderly by the precedent of reductions in benefits and the hardship which would be created for the older disabled worker by the changes. As stated by Jack Ossofsky, executive director of the National Council on Aging, in his July 18 letter to Members of Congress:

> The social security system is an intergenerational compact which has served America well for three generations. Hastily constructed adjustments to the system, especially when a variety of expert panels will be reporting to Congress on the subject over the next 18 months, constitute a precipitous and unnecessary challenge to the soundness of the system. Any benefit changes should be made after complete consideration and then only to strengthen the long-term soundness of the system, not to provide a temporary boost to Federal budget cutting in a particular year.

When Representative Claude Pepper, Chairman of the House Select Committee on Aging, testified before the Senate Finance Committee on October 9, he asserted that the elderly would bear the brunt of the cutbacks, saying that 30 percent of those on the disability rolls are 60 years of age or older and that the average age of individuals receiving disability is 55.

The Department of Health, Education, and Welfare and proponents of the legislation maintain that 6 percent of all persons receiving disability benefits are receiving more than their previous net earnings and approximately 16 percent of the beneficiaries are receiving more than 80 percent of their average net earnings (H. Rept. 96–100, p. 6). By allowing workers of all ages to drop 5 years of low earnings in computing benefits, the proponents of H.R. 3236 argue that an inequity exists in permitting a 29-year-old worker to drop 71 percent, or 5 years out of 7, while for a worker over age 50 the 5-year exclusion for 28 years of work represents only 18 percent (H. Rept. 96–100, p. 6). The Social Security Administration estimates that the average replacement rate for earnings of newly disabled workers has increased from 60 percent in 1967 to over 90 percent in 1976, while the recovery rate has declined to only one-half what it was in 1967 over the same period. The agency concludes, "High benefits are a formidable incentive to maintain beneficiary status especially when the value of medicare and other benefits are considered" (H. Rept. 96–100, p. 4).

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[6] U.S. Congress. Senate. Special Committee on Aging. The proposed Fiscal 1980 Budget: What It Means for Older Americans. (Committee Print.) Washington, U.S. Government Printing Office, 1979, pp. 1–2.

After holding hearings on H.R. 3236 and a related House-passed measure (H.R. 3464 to be accompanied by H. Rept. 96–104) which provided work incentives in the SSI program, the Senate Finance Committee reported its version of both measures as the Social Security Disability Amendments of 1979 (S. Rept. No. 96–408 to accompany H.R. 3236). The Senate Finance Committee changed the House provisions as follows:

—Raised the family benefit limit from 80 percent of a worker's average indexed monthly earnings (AIME) or 150 percent of primary insurance amount (PIA), to 85 percent of the worker's AIME or 160 percent of his PIA; and like the House, guaranteed that no worker would receive less than 100 percent of his primary insurance amount; and

—Raised the "drop years" to 1 year for workers under age 32, 2 years for the 32–36 age group, 3 years for those ages 37–41, 4 for the 42–46 age group, and 5 years for age 47 and over.

The provisions for deduction of impairment-related expenses, extension of the trial work period and medicare coverage for disabled individuals who return to the work force, and eliminating subsequent waiting periods for disabled workers who had to return to the disability rolls were retained by the Senate committee.

The full Senate took up H.R. 3236 on December 5 but failed to complete action on it and did not return to consideration of the bill by the end of the 1979 session. Further action by the Senate on the legislation is anticipated early in 1980, and one of the amendments that may be offered is a proposal by Senator Howard Metzenbaum to strike the bill's sections 101 and 102 which contain the limitation on family benefits and changes in the years a worker may drop for computing his benefits (letter of December 12 from Senator Metzenbaum to his colleagues).

VI. OTHER PUBLIC RETIREMENT PROGRAMS

A. Civil Service Retirement

Three issues of major importance affecting civil service retirement were raised in 1979. Two of these issues, universal coverage and the $1 for $3 Federal pension offset, have been described above. In addition, a significant effort was made to reduce the number of cost-of-living increases for Federal retirees from two per year to one per year.

The Congressional Budget Office (CBO), in December 1978, published an option paper entitled "Options for Federal Civil Service Retirement: An Analysis of Cost and Benefit Provisions." This study was ordered by the House Budget Committee and discussed several major options (CBO is not permitted to make recommendations). The options were geared primarily to find ways to reduce Federal spending, a goal sought by the administration as well as both House and Senate Budget Committees. Currently, approximately 2.7 million Federal civilian employees are covered by civil service retirement (CSR), and despite the relatively high Federal employee contribution rate toward retirement and insurance (7.9 percent of total salary), the CSR fund is not paying its way. Presently, CBO estimates that the fund has an "unfunded liability" of about $130 billion, a figure that could rise to $160 billion by 1984. CBO also estimates that Government costs could be reduced by $3.1 billion per year if Federal

civil servants were covered by social security and a private pension plan. The major options presented were:

(1) Merger or integration of the civil service retirement sytem with social security.

(2) Increase the Federal employee contribution for retirement and insurance from 7.9 percent to 14.1 percent of pay.

(3) Toughen the standards Government now uses to determine disability retirements.

(4) Realine the CSR program to non-Federal standards by reducing annuities for workers who retire early.

(5) Eliminate or reduce cost-of-living raises now received automatically each March and September by Federal and military retirees.

The issues of tougher eligibility standards for disability and universal coverage have been discussed earlier in this chapter; however, considerable attention was also given by the Senate to reducing cost-of-living increases. Specifically, the Senate Budget Committee in both its first and second budget resolutions for fiscal year 1980 recommended that the Senate Governmental Affairs Committee report out legislation to reduce the present biannual cost-of-living adjustment for CSR annuitants to an annual adjustment.

Senator Chiles, a member of the Governmental Affairs Committee, has strongly opposed any reduction in the current approach to cost-of-living increases. His amendment in 1976 had originated the twice yearly increases as compensation for other cost-of-living mechanisms that were removed. At the close of 1979, the Governmental Affairs Committee had not taken any action on this issue.

B. Railroad Retirement

Under the provisions of the 1937 Railroad Retirement Act, former railroad employees and their dependents were eligible for railroad retirement benefits as well as social security annuities if they were vested under both systems. Usually these employees worked for at least 10 years in the railroad industry and later worked in other jobs accruing the required quarters of coverage to be eligible for social security benefits. The 1974 Railroad Retirement Act Amendments, however, altered this possibility. The amendments, whose purpose was principally to restore the program to a sound financial posture, required at least 25 years of railroad service in order for a worker to be eligible for full benefits.

The amendments, in seeking to insure the financial soundness of the system, illustrate the particularly unique manner in which the act and amendments to the act are handled. When Congress took over the railroad retirement system in the midst of the depression, it did so in order to insure the continued payment of pension benefits. Since that time, the benefit structure and levels, as well as the tax rate and its distribution between employers and employees have been negotiated at the bargaining table by rail labor and management and then periodically incorporated by Congress as amendments to the original Railroad Retirement Act of 1937.

As a result of the 1974 changes in the act, over 130,000 former railroad employees who contributed to the railroad retirement fund are ineligible for benefits they would have received prior to the 1974 changes in the law.

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1. LEGISLATIVE ACTION

On March 13, 1979, Senator Domenici introduced legislation, as he had in the 95th Congress, to amend the Railroad Retirement Amendments of 1974 (S. 635). The bill allows railroad employees who worked less than 25 years, but more than 10 years, prior to the 1974 amendments to be eligible for full benefits earned under both the railroad retirement program and the Social Security Act. The projected cost of the bill is approximately $83 million annually. The bill was referred to the Senate Committee on Labor and Human Resources, where no action was scheduled during the 1st session of the 96th Congress. Senator Domenici, as ranking minority member of the Senate Special Committee on Aging, has on several occasions expressed a keen interest in pressing for consideration of S. 635 before adjournment of the 96th Congress.

A measure identical to Senator Domenici's bill, H.R. 1690, was introduced in the House by Representative Manuel Lujan. Representative Joe Moakley also introduced similar legislation, H.R. 1870.

2. JUDICIAL ACTION

Judge Cole J. Holder of the U.S. District Court for Southern Indiana ruled in the summer of 1979 that the Railroad Retirement Act of 1974 changes the retirement rules and discriminates against a class of former workers. He found that the change prevents plaintiffs in the case from receiving certain benefits they had earned prior to the enactment of the 1974 act.

Judge Holder stated that benefits under the program were earned by the plaintiffs because they had been "making full employee contributions to the railroad retirement fund in compliance with the Railroad Retirement Act of 1937" which was the law during their early employment period. The judge ordered the Railroad Retirement Board to go back to the original requirement that anyone with at least 10 years of railroad work was qualified for some portion of a windfall benefit.

The judge's ruling and S. 635 offered by Senator Domenici are identical in purpose. The U.S. attorney filed a notice of appeal along with a motion for a stay of judgment. Actions on the judge's ruling are still pending.[7]

3. ADDITIONAL LEGISLATION

Senator Domenici has also introduced S. 393, a bill to amend the Railroad Retirement Amendments of 1974 to modify the survivor's benefits for widows and widowers of railroad employees. This bill is intended to increase the annuities of widows and widowers by the difference between what they get under current law and what the employee was getting prior to enactment of the 1974 law. The bill includes widows and widowers of employees who died before retirement who qualify for survivors benefits under the current law. The number of persons affected by the bill is approximately 300,000 with an annual cost of roughly $93 million. The bill was referred to the Senate Committee on Labor and Human Resources where no action had yet been taken by the end of 1979.

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[7] *Fritz et al.* v. *U.S. Railroad Retirement Board;* USOC SIND No. 1P76-49-C, July 27, 1979.

4. FISCAL OUTLOOK FOR RAILROAD RETIREMENT

Both the Railroad Retirement Board and the General Accounting Office have projected that the railroad industry pension fund will run out of funds by 1985. The industry pension is underfunded by at least 4 percent of current railroad industry payroll; that is, revenues have to be increased or benefits decreased by an amount equivalent to 4 percent of payroll to make the fund financially sound.

The administration is proposing action that would restore the solvency of the railroad industry pension fund, while protecting current beneficiaries. The proposal would increase revenues by 2 percent of railroad industry payroll—over $200 million in 1980—chiefly by eliminating the cap on the tier II tax levied against employers. The remaining 2-percent deficit will be eliminated by decreasing benefits for future retirees.

5. LEGISLATIVE OUTLOOK

The Senate Labor and Human Resources Committee is studying the administration proposal and is developing its own legislation which will likely be introduced soon after the 2d session of the 96th Congress begins in 1980.

Representative Harley Staggers, Chairman of the House Committee on Interstate and Foreign Commerce, has introduced H.R. 5144 which essentially reflects labor's interests in bringing the railroad retirement system into financial balance. The legislation calls for the same approach to dealing with the projected 4-percent deficit in the fund as does the administration proposal: reduce benefits by 2 percent and increase revenues by 2 percent through the removal of the cap on the tier II employer tax. Other legislative proposals are expected to be suggested during the next session which will reflect the thinking of rail management in dealing with the deficit problem.

C. VETERANS

On January 1, 1979, the new Veterans' and Survivors' Pension Improvement Act of 1978—Public Law 95-599—went into effect. As the year unfolded, it soon became clear that beneficiaries under the new act who were also recipients of supplemental security income (SSI) might face serious eligibility problems under medicaid and other "medically needy" programs.

On balance the new act was quite favorable, providing increased monthly benefits and more liberal financial eligibility criteria. In addition, whenever social security recipients are given a cost-of-living increase Veterans' Administration—VA—beneficiaries will receive a similar increase using the same percentage.

Significantly, however, many of the income exclusions which existed under the prior law have been eliminated, and individuals who benefited from those exclusions may not receive a higher benefit under the new pension plan. An important guarantee—the so-called "grandfathering provision"—is provided in the new law. Under this provision, any individual who was receiving a VA pension as of December 31, 1978, can opt to receive benefits under either the old or the new law. The "grandfathering provision" prevents his pension from being terminated or reduced because of changes in the new law.

More than 100,000 VA beneficiaries are also receiving SSI benefits. As a result, among those who could be hurt by the new law are persons whose medicaid eligibility depends on their receipt of an SSI payment since higher VA benefits may exceed the Federal SSI payment levels. Also hurt would be persons in States with "medically needy" programs. In these States, potential medicaid beneficiaries whose income exceeds allowable limits are permitted to "spend down"—in other words pay directly for medical services out of their own pockets—until their revised income level, now depleted by paid medical costs, reaches a level of eligibility. In many cases, opting to receive the higher VA benefits could result in a net loss of income after the "spend down."

Without notice or opportunity for comment, in February of 1979 the Social Security Administration took the position that all VA beneficiaries must accept the higher VA benefits or automatically lose their SSI eligibility—Claims Manual Transmittal No. 4636 (SSI–178) and Emergency Instruction DI No. SS–79–033(236). In a nationwide class action suit, *Jones* v. *Califano*, plaintiffs challenged this rule as being procedurally void for noncompliance with the Federal Administrative Procedure Act and in violation of the option provision in the new pension act.

On May 8, 1979, the U.S. District Court for the District of Columbia issued a temporary restraining order prohibiting the Social Security Administration from implementing its new rule. However, Judge Oliver Gasch later dismissed the action claiming the court lacked appropriate jurisdiction since no adequate "claim" had been filed with the Secretary of HEW, meaning that the plaintiff had not sufficiently pressed his grievance administratively before seeking assistance from the court.

In a legislative attempt to address this issue, Senator Alan Cranston introduced an amendment to H.R. 3434, the child welfare bill, which would require that veterans in States where medicaid eligibility is dependent on receiving SSI be notified that election of higher benefits may endanger their medicaid status. H.R. 3434 is now in conference where the Cranston amendment and other issues have not yet been resolved.

D. Military Pensions

Major efforts were initiated in 1979 to improve benefits for widowers and widows under the survivor benefit plan (SBP) established by Congress in 1972. Under this program, officers and enlisted personnel in the armed services were encouraged to take a reduction in retirement pay in exchange for an assured minimal income for their designated survivor, usually a widow. Problems arise when the widow reaches age 62 and is eligible for social security benefits, because the survivor benefit plan calls for a 100-percent, dollar for dollar, offset or reduction of SBP benefits for each dollar of social security. For many lower income widows of enlisted men, the offset frequently results in the total elimination of SBP benefits.

Legislation introduced in the House by Representative Bob Wilson (H.R. 3314) and in the Senate by Senator Strom Thurmond (S. 91) are designed to reduce the offset from 100 percent to 50 percent. These bills would also: (1) Remove the offset entirely for widows who receive social security benefits based on their own earnings; (2) eliminate the offset when there is one dependent child (no offset now

exists where there are two dependent children); and (3) modify the manner of applying cost-of-living adjustments to conform with the manner used for civil service retirees so that SBP participants would not continue contributing more for the same benefits.

Even though hearings had been conducted on S. 91, the bill had not been reported by the Subcommittee on Manpower and Personnel of the Senate Armed Services Committee at the year's end. H.R. 3314 had been referred to the Subcommittee on Military Compensation of the House Armed Services Committee, where it awaits further action.

VII. MANDATORY RETIREMENT: AGE DISCRIMINATION IN EMPLOYMENT ACT AMENDMENTS OF 1978 BECOME EFFECTIVE

Effective January 1, 1979, the 1978 amendments to the Age Discrimination in Employment Act (ADEA) extended coverage by raising the upper age limit in the act from age 65 to 70 for private employment and non-Federal public employment. In addition, the 1978 amendments included other major improvements:

—The maximum protected age for Federal Government employees was abolished totally.

—The right to a jury trial was added on issues of fact in private ADEA suits involving monetary damages.

—Section 4(f)(2) of the act was amended to make clear that involuntary retirement under either a bona fide seniority system or a bona fide employee benefit plan (such as a retirement, pension or insurance plan) cannot be required or permitted (for more detailed analysis of the 1978 ADEA amendments, see "Developments in Aging: 1978," pp. 186–187).

A. EEOC Takes Over Enforcement Responsibility

Effective January 1, 1979, enforcement of Federal sector age discrimination cases was transferred from the Civil Service Commission to the Equal Employment Opportunity Commission (EEOC). Similarly, responsibility for enforcing the ADEA in non-Federal employment was shifted to the EEOC from the Department of Labor, effective July 1, 1979.

Research functions required under the act will remain in the Department of Labor.

B. Developments: 1979 Labor Department Report

On July 12, 1979, the Department of Labor, as required by section 13 of the act, reported to Congress on its activities in enforcing the ADEA during 1978. ("Age Discrimination in Employment Act of 1967," a report covering activities under the act during 1978.) Several significant increases in activity and awards to workers were reported:

—Compliance actions under the ADEA rose from 5,600 in 1977 to 5,728 in 1978.

—Thirty-eight lawsuits were filed by the Department in 1978.

—Restoration of lost income: A record 1,363 older workers and job applicants received $4.8 million, the highest level of income ever restored in a year (compared to 744 persons receiving $2.7 million in 1977).

—Monetary compensation: A record 4,111 individuals in the 40–65 age group during fiscal year 1978 received damages totaling a record $14 million (compared to $10 million paid to 1,943 workers in 1977).

In comparing the growth of activities under the ADEA from its earliest enforcement in 1968 up through fiscal year 1978, the Department reported several other significant indications of activity:

—An estimated 27 million persons are now covered by the ADEA, or 7 out of every 10 persons aged 40 to 70 in the civilian labor force (employers with less than 20 employees are still exempt).

—Since 1968, 450 court actions were instituted by the Department, 305 of which were concluded with 267 wholly or partially resolved in the Department's favor.

—Out of a potential 58 jurisdictions covered by the act, the number of State age discrimination laws has increased from 23 in 1965 to 44 by the end of 1978.

—The number of complaints received by the Department increased from 1,000 in fiscal year 1969 to almost 4,300 in fiscal year 1978.

C. Court Action: Procedural and Substantive Developments

As court activity in the field of age discrimination increased in volume, important developments both in procedural law and in substantive issues occurred during 1979. Unfortunately, the progress was not all positive. Whereas significant breakthroughs in procedural law were obtained, setbacks on the substantive side were cause for concern.

Prior to the 1978 amendments, many aggrieved workers and job applicants saw their cases dismissed by courts before their claims could be heard on their merits. One major procedural problem involved the requirement of conciliation. Representatives for the Secretary of Labor were required to seek conciliation with the employer prior to court action. If the court felt that the efforts toward conciliation were inadequate, the case was simply thrown out of court. In November 1979, the Fifth Circuit Court of Appeals in *Marshall* v. *Sun Oil Co. of Pennsylvania*, 592 F. 2d 563 (1979), held that adequate conciliation was not a "jurisdictional" requirement. In other words, should the court feel that more concerted effort toward conciliation was required, the action would not be dismissed but stayed, thus allowing time for the EEOC to make further efforts with the employer. If conciliation was still inconclusive, the case could be resumed by the court.

In July 1979, in the case of *Bean* v. *Crocker Bank*, 600 F. 2d 754 (1979), significant progress was made in bringing class action suits under the act. Here the Ninth Circuit Court of Appeals held that there was no limit on the number of plaintiffs in similar circumstances who could join the suit. In addition, the court ruled that each plaintiff need not go through all the normally required procedural steps in order to "opt in."

Despite this progress in procedural case law, and despite the increasing number of successful plaintiffs winning damages and restored income (see above), many careful observers of ADEA enforcement are pessimistic about future chances for major gains. Significant court decisions decided on substantive (rather than procedural grounds) have greatly influenced this concern.

On November 8, 1979, the District Court of the District of Columbia in the *Murnane* v. *American Airlines* case, 21 F.E.P. 284 (1979), upheld American Airlines' policy of not hiring any pilots for training over age 30. The airline argued that the steps from flight engineer to copilot to captain took 16 years. The plaintiff was a 43-year-old retired military pilot, and the airline argued that he would be 59 before he could be promoted to captain. Since Federal Aviation Administration regulations require mandatory retirement of all commercial pilots at age 60 (see below), the airline would have expended much time and money to train a pilot who could perform in that capacity for only 1 year. In addition, the airline raised the issue of public safety, arguing that airline safety is compromised by having older pilots. The act permits an exception to its mandate in situations where an employer can show that age is a "bona fide occupational qualification" (BFOQ) reasonably necessary to the normal operation of a particular business. In this case, the court found that the BFOQ requirement was satisfied.

Another significant setback occurred in *Loeb* v. *Textron, Inc.*, 600 F. 2d 1003 (1979). Prior to *Loeb*, a plaintiff could prove age discrimination simply by satisfactorily showing that age was one of many factors used against him. In the *Loeb* case, the court held that the burden of proof was on the plaintiff to show that age was "the determining factor" in the alleged discriminatory action taken against him.

As a result of both the *Murnane* and the *Loeb* decisions, it will now be much more difficult for plaintiffs to prevail. Moreover, in cases involving some form of public safety, the courts to date seem to have adopted a "let's not take a chance" approach.

D. H.R. 3948: Experienced Pilots Act of 1979

Introduced on May 4, 1979, by Congressman Claude Pepper, Chairman of the House Select Committee on Aging, H.R. 3948 took aim at the 1959 Federal Aviation Administration (FAA) ruling requiring the mandatory retirement of commercial airline pilots at age 60. The ADEA specifically excludes pilots from its provisions. As reported out by the House Public Works and Transportation Committee, the bill prohibited discrimination against airline pilots solely because of age, if the individual is less than 61½ years of age. The provisions of the bill would take effect immediately upon enactment, terminate 18 months after enactment, and apply to pilots employed by airlines on the date of enactment who were less than 61½ years of age. The bill would:

—Prohibit any Government official from denying or limiting a pilot's airman certificate solely by reason of age.

—Prohibit any Government official from requiring an airline to terminate an individual as a pilot by reason of age or to discriminate against such an individual as to compensation and other terms of employment.

—Prohibit an airline from terminating the employment of a pilot or discriminating against the pilot with respect to compensation and other terms of employment solely because of age.

—Require a pilot 60 years of age or older to pass a medical examination at least four times a year.

In addition, the bill directed the National Institutes of Health (NIH) to conduct a study on the effect of aging on pilots. It requires

the study to be completed within 1 year. If the study determined that pilots over the age of 60 years cannot perform satisfactorily, the provisions raising the age limit to 61½ years would have been terminated. The study would determine whether:

—An age 60 limitation on pilots is medically warranted.
—Any age limitation on pilots is medically warranted.
—Current medical examination procedures for pilots are adequate to determine an individual's physical condition.
—Current medical examinations are frequent enough to assure that a pilot's physical condition is being satisfactorily monitored.
—Aging affects the ability of individuals to perform the duties of a pilot with the highest degree of safety.

Facing stiff opposition from labor and the airline industry, and confronted with the argument that the study should precede any increase in the age limit, the bill was passed by the House on December 5, 1979, with only the NIH study intact. The bill was immediately referred to the Senate where the Committee on Commerce, Science, and Transportation also approved the study. As amended by the Senate the bill cleared both Houses on December 19, 1979, and was signed into law on December 29, 1979 (Public Law 96–171).

E. Prospects for 1980

It appears more and more certain that the issue of age discrimination will receive increased attention and more vigorous enforcement by the EEOC. In addition, the likelihood of more private suits is enhanced now that a jury trial is available for issues of fact. Speaking to this very issue, the president of the American Bar Association, Mr. Leonard S. Janofsky, in a speech to the State Bar of Arizona on November 3, 1979, stated:

> My own view is that in the next decade, the Age Act will be the source of a great percentage of employment discrimination litigation, perhaps even eclipsing title VII (of the Civil Rights Act). There are at least two reasons for this.
>
> First, there is a trend toward use of the Age Act by the "executive plaintiff." An executive tends to be an older person, white and male. Very often the Age Act is the only basis upon which he can contest a termination or other adverse personnel action.
>
> Second, jury trials are available under the Age Act, whereas they are not under title VII. . . . The right to a jury trial is very significant . . . jurors tend to be older people. Often they are retired people who, unlike many others, have time to serve on a jury. . . . Coupled with the normal juror's prejudice against large corporations, and the bias in favor of an employee with many years of faithful service, you can see why the right to a jury trial is so important in an age case.

VIII. MAJOR STUDY BY URBAN INSTITUTE ON RETIREMENT INCOME ISSUES COMMISSIONED BY THE SENATE SPECIAL COMMITTEE ON AGING

The Senate Special Committee on Aging has contracted with the Urban Institute, a leading research organization in the area of economic analysis, to undertake a major study of retirement income issues. In a multifaceted yearlong study, the Urban Institute has been involved in the following tasks:

(1) The identification of all economic, budgetary, and public policy issues which should be considered by policymakers in establishing employment, retirement, pension, and income maintenance policies applicable to older workers and to the elderly not in the work force.

(2) The drafting of a summary of all information currently available concerning the impact of an aging population on the economy.

(3) The identification of all ongoing research, in both public and private institutions, relevant to the major issues identified in the first phase of the inquiry.

(4) The outlining of a research agenda which makes use of currently available data and ongoing research, identifies types of information needed but not currently available, and establishes priorities for future research efforts.

(5) The identification of various policy options and alternative solutions for committee consideration in the context of the sets of issues identified in the first phase of the inquiry.

A. Background to the Study

The basic demographic facts describing the aging of the U.S. population are, in the last year of the 1970's, now well known to scholars, policymakers, and the public. The postwar "baby boom" will, in the first decades of the 21st century, inevitably reappear as a "senior boom." Yet, while the facts of this dramatic change in the structure and composition of the American population are well known, the many and complex economic, social, budgetary, and human consequences of this demographic evolution are less well known.

The implications of these population pressures on the labor force, on retirement, on retirement income, and on consequent pension policy cannot be overstated. While the growing fiscal pressures on the social security system have been the focus of much attention, less well documented is the impact of demographic change upon both private pensions and public employee pension plans, and the interaction of these plans with the social security system.

One result of the aging of the American population on the pension system of the Nation is illustrated by the substantial amounts of unfunded pension liabilities that have been accumulated in Federal employee pension plans, in State and local government pension plans, and in private pension plans. Some estimates of the aggregate of these unfunded liabilities suggest that the amount may be greater than the national debt. While the ERISA legislation of 1974 (Employee Retirement Income Security Act) is bringing about reductions in the unfunded

amounts for the private plans (public employee pensions are not affected by ERISA), the liabilities nonetheless hold substantial importance for the American labor force, the economy, and patterns of retirement income for older Americans. In short, it is imperative that greater attention be paid to the issue of the ability of the American economy and work force to support the growing number of retirees through present or foreseeable pension arrangements.

B. The 12 Major Issues

In the first report of this project, titled "Major Policy Issues Affecting the Income and Employment of Older Americans," the Urban Institute identified 12 questions, each of which represents a general cluster of research and policy issues. Summarized below, these 12 issues as presented by the Urban Institute should be considered not as conclusions or recommendations but as a profile of major questions for further consideration.

1. ARE RETIREMENT INCOMES AND BENEFITS FOR THE AGED ADEQUATE?

While some economists argue that various noncash assets—for example, in-kind transfers such as medicare, medicaid, food stamps et cetera—represent substantial additions to pension income, others emphasize the increased financial need resulting from the eroding of fixed incomes by inflation. For current and new retirees, adequacy is affected by the different benefit formulas found in social security, public pensions, and private pensions—for example, computing benefits based on average lifetime earnings versus average of the few years prior to retirement. Within social security itself, furthermore, wide variation in wage-replacement rates results from differences in preretirement wages, work histories, and marital status. However, economic research on the future of social security has dealt more with the adequacy of the system's financing, than with its ability to adequately support retirees and their families in combination with private pension benefits and personal savings.

Of particular legislative concern to future as well as current retirees is the issue of inflation and benefit indexing. Research suggests that while indexing may mitigate the effects of inflation, it presents additional questions: (1) Adequacy and equity of retirement income in total may be problematic if different pension systems—for example, public versus private—use different indexing formulas or provide different degrees of protection; (2) the actual index used is critical: It has been argued that the Consumer Price Index does not accurately reflect the expenditure patterns of older Americans, and that a specialized price index is needed. Furthermore, middle-class elderly may be at particular risk in this context; there is little known about the income losses suffered by the nonpoor aged relative to their prior living standards.

At the other end of the debate concerning both adequacy and equity is the issue of "overpensioning." This is largely the result of the lack of integration of public and private pension systems with social security. Federal employee plans as well as many State/local plans are especially guilty of this lack of integration—with subsequent opportunity for combined pension income out of proportion to past wages or contributions.

2. EQUITY: ARE SUBGROUPS OF THE RETIRED AND AGED TREATED UNFAIRLY RELATIVE TO OTHERS?

Given the diversity of public and private pension plans, social security entitlements, and subsequent benefit adjustments and eligibility rules, different groups of retirees receive different benefits. The sources of such differential treatment are found in several kinds of factors, some of which may be more directly amenable to solution than others:

(1) *Family versus individual benefit rules.*—Rules granting social security benefits to divorced spouses have been liberalized, but with increased divorce rates and female labor force participation, inequities still exist between men and women and between one- and two-earner couples. The report recommends that consideration be given to the issue of how benefits are accorded to spouses independent of the primary earners' entitlements.

(2) *Private pension coverage.*—Women and blacks are less likely to be covered by private pensions. This is largely because these groups are concentrated in labor market sectors not broadly covered by pension plans; in addition, women and blacks are less likely to meet the long-term job continuity requirements of most pensions. Changes in ERISA rules could possibly alleviate some of the problems.

(3) *Longevity.*—Because of their greater average longevity, whites and women receive greater lifetime pension benefits than blacks and men. It may be argued, thus, that blacks and men are subsidizing the benefits of whites and women. Legislative interest in differential contribution and/or benefit rates would have to take into account recent and current litigation on the subject.

(4) *Private versus public pensions.*—Public pensions tend to be more generous than private pensions in some respects. Direct comparisons are difficult to make, however, due to public-private differences in: Employee and employer pension contributions, extent of social security coverage, and availability of profitsharing or other allied benefits provisions.

(5) *Generational cohort differences.*—(a) *Benefits:* The social security ratio of benefits to contributions is greater for many of today's elderly than for comparable future cohorts. (b) *Inflation:* Since future cohorts will be living longer, the real value of a fixed pension in the final years of a longer life will have been substantially reduced by inflation.

3. ARE RETIREMENT SYSTEMS AND PENSION PLANS ADEQUATELY FUNDED?

Long-run deficits for social security remain despite recent payroll tax increases and benefit modifications. When the baby boom age cohort of the 1940's and 1950's arrive at beneficiary age, the pay-as-you-go social security system will experience funding problems under current laws. In addition to proposals in the form of new taxes—such as a value-added tax—many proposals involve the use of general revenue funds to pay a major part of social security obligations.

State and local public pension plans are also typically unfunded pay-as-you-go systems; they are also experiencing escalating costs due to such factors as liberal use of disability retirements, expensive benefit provisions, low pension fund investment return rates, and increasing numbers of retirements. At the same time, local and State taxpayers have shown an increasing reluctance to approve taxes to pay

these increased costs. Passage of ERISA purposely excluded public pensions; legislative consideration was to await a special task force report. Since that report was published in 1978, such reconsideration of broadening the ERISA legislation may now be in order.

The high rate of private pension plan terminations which followed enactment of ERISA was said by some to have been caused by the law's too restrictive standards. Others said that the terminated plans were precisely those small and/or marginal plans which had led to Federal minimum standards. Research and analysis are currently underway. Future legislative interest in ERISA may deal with bringing public pensions into the law's jurisdiction, and with further consideration of ERISA standards, requirements, and issues pertaining to multiemployer pension plans.

The Pension Benefit Guaranty Corporation (PBGC), established by the ERISA legislation to insure future beneficiaries against plan failures and financed by insurance premiums paid for by the individual pension plans, may itself be financially unstable. In fiscal 1978, PBGC's annual expenses exceeded income by $35 million. As compared with fiscal 1978 trust fund assets of $438 million, a PBGC study recently estimated that plans representing $350 million in unfunded vesting liabilities have a "high potential for termination within the next 5 years."

4. HOW SHOULD THE COST OF PROVIDING FOR RETIREMENT INCOME BE SHARED?

Only a small proportion of pension beneficiaries actually receive the products of their own direct contributions (or their employer's contributions on their behalf). Rather, many pension plans are "underfunded," and thus current older retirees are paid from the contributions of current younger workers—hence the term "intergenerational transfer." Most Federal, State, and local employee pensions are based in part on such transfer payments, as is, of course, social security. Worker contributions may be especially inadequate at the beginning of the next century, as the number and proportion of retirees increase (when the baby boom generation retires), while simultaneously the number and proportion of workers is relatively low (when the current "baby bust" generation populates the work force).

General revenues are often suggested as a way of supplementing the contributions of current workers and their employers. Economic and philosophical arguments over such use of general revenues are well known. Politically, it has been argued that the political support for social security would be damaged if the link between (payroll) taxes paid and benefits received is weakened.

An alternative to general revenue or increased payroll taxes recently discussed is the development of a new tax resource—The value-added tax (VAT)—to be used primarily to finance social security benefits. The VAT is less visible than payroll taxes, and depending on what goods are taxed, it may be more or less regressive. On the other hand, like general revenues, there is no direct connection in the minds of the beneficiaries between benefits received and taxes paid.

A third issue regarding the sharing of the costs of providing retirement income concerns the proposed levying of the income tax on social security benefits. Currently, private pension income is taxed, but

social security income is not. Two consequences of taxing social security benefits should be noted: (a) The overall net cost to the Government of the social security system would be lowered; (b) those who are in greatest income need will not see their benefits reduced, as their income will not be high enough to be taxed.

5. DO PENSION PLANS DISCOURAGE SAVINGS AND INVESTMENT?

Recent attempts to restore the financial integrity of pension systems have emphasized increasing social security taxes and minimum funding standards (ERISA) for private pensions. Such changes have the effect of channeling increasing amounts of funds into public trust funds and private pension funds. While from the vantage point of the pension system these are positive events, there are possible negative effects—although in each of the three areas noted below, the research evidence is relatively tentative.

As contributions to social security and private pension plans are made (by the employee and/or the employer), the individual's own level of private savings is likely to go down. Despite the intergenerational transfer nature of most pensions, the individual's knowledge of the availability of pension resources tends to "reduce saving in other forms to compensate for promised pension benefits." However, the precise nature of this "substitution effect" has not been conclusively researched, nor is there any reliable study of how the age of the worker may affect such substitution. Additional research is required.

The question about the personal savings behavior of individuals can also be raised about the aggregate savings behavior of businesses and governments. That is, knowledge of accumulated pension and trust funds could either stimulate or depress such saving. "Based on past trends, the best evidence available, though far from conclusive, suggests that neither social security nor employer pension plans have had a significant net effect on the rate of aggregate savings." Even this tentative conclusion, however, is subject to change in response to changes in retirement behavior, inflationary expectations, and increased individual understanding of pension entitlements.

Finally, the accumulation of investment capital in pension funds could have adverse effects on capital formation and aggregate investment behavior, in at least two ways. First, as most pension fund assets are invested in stocks appearing on the New York Stock Exchange, and since the rate of investment portfolio turnover has been slow, opportunities for smaller companies to attract investment are diminished as pension assets become more predominant. Second, at the other end of the process, the large-scale capital accumulation of pension funds will begin to be liquidated in the 1996–2006 period, as the baby boom retires. The rapid liquidation of the investment portfolios into pension dollars could create downward pressures on stock market prices and upward pressures on interest rates.

6. WILL AN AGING POPULATION NECESSITATE AN INCREASE IN GOVERNMENT SPENDING?

If overall Federal spending is kept at the level of 20 percent of GNP, and current levels of old age programs are not changed, the dollar cost of these programs has been projected to rise from their current 25 percent of the Federal budget to 63 percent by 2025. In

addition to actual dollar costs, however, two additional issues are raised: Budget controllability, and scope of Federal Government activities.

About 75 percent of all Federal spending is classified by OMB as "uncontrollable" because it cannot be modified through the annual appropriations process. Most Federal benefits for the aged are in this category, and currently account for about 33 percent of all "uncontrollable" expenditures. As a consequence of population aging, this figure will rise such that uncontrollable expenditures will represent considerably more than 75 percent of the Federal budget.

Spending for aged benefits is dependent upon several factors, only some of which are directly amenable to congressional control: (1) Growth in the population entitled to various program benefits; (2) past earnings of the entitled population; (3) the rate of inflation; (4) decisions by individuals to retire; and (5) benefit entitlement and computation rules. Of these, it is primarily the fifth factor which is subject to legislative influence (which could, in turn, influence the fourth).

Increased spending as a percentage of the gross national product would not increase real Federal control of resources if the increase results from transfer payments as compared with increases in Federal spending in such areas as defense or environmental protection. For aged programs, the growing budget (health care is an exception) largely represents transfer payments through the Federal budget from younger workers to older retirees.

Whereas public spending for aged benefits has become essentially a Federal function, major expenditures of States and localities are aimed at the younger population—for example, public education, aid to needy families with children, employment and job training programs, social services, and family health care services. With population aging in the absence of significant policy changes, local/State expenditures will diminish as Federal spending (as noted above) will increase. Congressional sentiment in some quarters to discontinue revenue sharing, as well as local efforts to reduce property taxes, are indicators that such a shift in overall domestic Government spending may already be occurring.

7. SHOULD INDIVIDUALS' WORKING LIVES EXTEND TO OLDER AGES?

Although the Congress in 1978 raised the mandatory retirement age from 65 to 70 thereby extending the available working life for some individuals, many of the arguments against the age 65 limit are relevant to age 70, or indeed any mandatory age limit. Among the major policy questions, therefore, are the following:

Should there be any mandatory retirement age at all? Retirement deprives the economy of skilled workers, and deprives workers and their dependents of needed financial support. While it has been argued that an increased number of older workers would constrict job opportunites for others, especially youth, women, and minorities, it is far from clear that these groups in fact compete in large numbers for the same jobs which older persons hold if they are not mandatorily retired (for example, senior, highly experienced positions).

Despite the raised mandatory retirement age, social security and most retirement plans encourage early retirement. While in the past younger workers and immigrants filled the openings, new job entrants

will taper off significantly in future years. Thus, early retirement is no longer required as a labor force mechanism.

Finally, a critical issue concerns the mix of work and nonwork in old age: Postretirement work in general, and the availability of part-time work in particular. In discouraging postretirement work the social security means test is based on the premise that the system's main purpose is to provide a retirement income floor, and not to provide a kind of annuity regardless of need or work status. Nonetheless, many recipients find social security inadequate, and seek work anyway—often forced into taking low paying jobs which do not fully use their skills and experience.

One avenue of solution would be in the institutionalization of part-time work as a mechanism for job continuation into the later years. Although part-time work as a proportion of total employment has increased in the past 25 years, an increasing number of older persons who desire part-time work cannot find jobs. There is little solid research on the relative costs to employers of using part-time versus full-time employees in different occupations—although many employers may believe that the part-time worker is more costly. This is clearly an instance in which greater research efforts are needed, and could lead to major public and private policy changes of benefit to older Americans.

8. WILL CRITICAL LABOR MARKET SCARCITIES AND/OR SURPLUSES RESULT FROM PRESENT POLICIES AND TRENDS?

Changes in the age structure and composition of the labor force are caused largely by demographic trends. Such changes are also affected, however, by policies over which there is congressional control, and which can modify the effect of the demographic trends. One of the most important of these policy areas is that of retirement and pensions.

The aging of the American population also implies the aging of the work force. The debate over the desirability of an older work force is far from settled: While some argue that a more experienced work force would be more productive, others argue that an older work force would become dominated by people with obsolete skills and little enthusiasm for new training.

Despite the unsettled nature of this debate, and the clear need for more rigorous research on the subject, major aspects of current retirement and pension policy act to drive older workers from the labor force. First, despite the raising of the mandatory retirement age, pension "benefit formulas are usually designed to encourage earlier rather than later retirement. Thus, total labor force size is probably reduced, and the elderly labor force is reduced dramatically."

Second, the retirement tests used by social security and some private pension plans discourage work on the part of retirees.

Third, certain aspects of ERISA may inadvertently reduce employment opportunities for older persons. Despite new vesting privileges in ERISA, a mobile worker is likely to receive a smaller benefit from a given pension than the worker who stays in the same job. Since job mobility declines with age, this suggests that a pension plan will incur a smaller eventual liability for a younger worker since there is a greater chance that the younger worker will change jobs before the pension is paid. Although much more research effort needs to be devoted to this issue, it has been suggested that "this factor may cause

firms to favor younger workers over older workers in their hiring decisions."

9. SHOULD THE PRESENT MIX OF PUBLIC AND PRIVATE PENSION PROVISION FOR RETIREMENT INCOME BE CHANGED?

The dramatically lowered fertility of the past decade, with a concomitant decreased supply of young workers, and increasingly pessimistic expectations about economic growth in general, have raised doubts about the viability of private pension plans in particular. Since the funding of even current social security benefits has been a cause for public concern, any major decrease in levels of private pension availability is a cause for even greater concern.

In general, factors that increase costs of pensions to employers will discourage pension plan development, while tax incentives and a diminished social security role could stimulate growth. Additional research is needed, however, as "the ability of pension experts to predict the net result for pension offerings of all these forces is quite limited." Two specific issues, however, deserve special mention.

First, although data are limited on current use of Individual Retirement Accounts and Keogh plans, some firms may encourage them over pension plans to "avoid the burden of ERISA regulations and solve the problems of vesting and portability." More research is needed concerning the socioeconomic and attitudinal background of those eligible employees who have, and have not, chosen to establish such accounts.

Second, despite the integration of pension plans and social security benefits in the majority of major pension plans as required to qualify for tax exemptions under the Internal Revenue Code, many current integration formulas may be out of date in that they have not changed in response to recent and rapid increases in social security wage ceiling and benefit levels. Thus, the potential impact of these social security changes in the redesign of pension plan entitlement and contribution formulas suggests that integration remains as an important short-term issue.

10. SHOULD FEDERAL CONTROL BE EXTENDED OVER PUBLIC EMPLOYEE RETIREMENT PLANS?

Neither Federal workers—who are covered by civil service retirement—nor all State/local public employees—for whom coverage is optional—are covered by social security. Two basic issues are germane to further Federal intervention in public employee pension plans: The lack of universal social security coverage, and the application of IRS and ERISA rules to public plans.

First, employees who move between public and private employment might experience gaps in retirement benefits; for example, State/local pensions may not have the same cost-of-living adjustments as found in social security. However, the more politically sensitive problem is the potential of career public employees to pyramid pension benefits by taking private sector jobs after retirement from public employment. Not only does the retiree acquire two pensions, but: (a) The social security benefit is artificially high due to that system's weighting of small amounts of earnings, while (b) the public pension is high due to the weighting of the last few years of highest earnings.

It has been estimated that about 40 percent of U.S. civil service employees not covered by social security in their primary careers qualify for both public pension and social security benefits. Public concern here is heightened by the fact that 45 percent of civil service retirement costs are paid by general tax revenues.

Second, although neither IRS nor ERISA rules apply to public pensions, application of both is currently being considered by Congress. While the IRS has considered applying certain tax rules to public plans, Congress has considered legislating against such IRS action. Congress purposely deferred inclusion of public plans in ERISA until completion of a special study; the study by the House Pension Task Force has been completed, and legislation to establish Federal standards for public employee plans is about to be introduced. Among the issues: (1) Whether ERISA requirements for full funding can be applied, since most public plans are at least partially funded by local/State taxes, and (2) whether ERISA-type rules should apply uniformly without regard to level or size of governmental unit, or to type of employee.

11. SHOULD THE SOCIAL INSURANCE APPROACH TO OLD AGE INCOME SECURITY BE REVISED?

As is well recognized, in addition to its explicit retirement income function, social security performs a substantial welfare or social insurance function. Since the enactment of social security in 1935, however, a broad spectrum of explicit social programs have also been enacted—for example, food stamps, SSI, medicare and medicaid, federally subsidized housing, et cetera.

The fiscal squeeze on social security in recent years could be alleviated by the coordination or rationalization of social security with these other programs. This could be done either by greater reliance on needs-tested aid to the aged, or conversely, by much less reliance on needs-tested aid—that is, a program of universal or "per capita" grants.

Among the problems associated with a social security benefit more purely related to wage replacement would be: Negative effects for women not employed in the labor force; the need for amending private pension plans to reflect a low wage-replacement level for low-wage workers; inequities and gaps in existing Federal, State, and local welfare programs; questions of age eligibility; the positive value of the belief that benefits represent earned rights versus the social stigma of welfare—and consequent low participation rates of the elderly in welfare programs—and the problem of older persons being forced to cope with multiple Federal and State welfare programs which could be simplified only by sweeping reforms that Congress has considered but never acted upon.

Alternatively, elimination of needs tests, in the form of universal or per capita grants, could provide a basic income floor without regard to the recipient's other financial resources, and without the stigma of welfare needs tests. As with social security, however, this would be an expensive way to maintain an income floor, although making such grants taxable could reduce the overall cost of the system. Furthermore, given wide disparities in welfare benefit levels in current programs, it is unlikely that per capita grants would permit total elimi-

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nation of the various programs, with needs-tested State supplementation likely in States where SSI payments are high.

12. HOW SHOULD MAJOR CHANGES IN RETIREMENT POLICIES AND BENEFITS SYSTEMS BE IMPLEMENTED?

Policy change in the area of pensions is particularly complex since it affects the economic well-being of people in old age, and, consequently, the financial planning of one's retirement, which should be a lifelong concern. Since retirement policy is also of concern to all employers, public and private, and all unions, pension policy formation does not simply reflect a relationship between the Federal Government and individual beneficiaries.

In setting agenda for policy change, distinctions must be made between matters that can be handled relatively quickly, and those which can be more painlessly resolved if tackled years in advance. In turn, such distinctions require further research on such issues as the forward-planning time required by individuals and employers, by public and private pension plans, by social security, and by the legal/administrative issues concerned with the "grandfathering" of prior program benefits.

These considerations suggest that choosing the right times and priorities for political resolution of policy issues and the best means of transition may be equally as important as other aspects of deliberations over aged income and employment policies.

C. Study To Be Published

As stated earlier, these 12 clusters of issues represent the first phase of the Urban Institute study. The committee continues to work with the Urban Institute research staff as the subsequent phases of the inquiry are completed. The committee hopes to publish the Urban Institute reports in 1980 in order to share this important information with those segments of the general public concerned with pension and retirement income policy in the United States. In the longer run, however, the results of the study's overview of issues, frameworks for policy analysis, and research and information resources, will be used to assist the committee as it plans new hearings and policy initiatives in the early years of the new decade.

Chapter 2

HEALTH

CHAPTER HIGHLIGHTS

Health care costs continue to be of great concern to all older Americans. While Congress and the administration grapple with ways to slow steadily increasing inflation in health care costs, older Americans are becoming more vocal about their frustrations with medicare, the Federal health insurance program for social security beneficiaries.

A national conference was convened to assess mental health service needs of older Americans, and Congress began action to reauthorize Federal mental health programs with some additional emphasis on service to older Americans. The House Ways and Means Committee also approved some expansion of medicare's mental health benefits.

Both the House and Senate recognized special problems of alcohol and drug use among older Americans in reauthorizing Federal alcohol and drug abuse programs and in Senate passage of new legislation to regulate drug sales.

Special Committee on Aging hearings focused on ways to make service to medicare beneficiaries more attractive to health maintenance organizations and bills were introduced by the administration and Members of Congress to change reimbursement methods to federally qualified HMO's. New attention was also directed to improving the availability of geriatric training in the Nation's medical schools.

Hearings were held during the year on national health insurance proposals, an issue about which many older Americans have expressed strong interest, but it is unlikely that final decisions will be made soon.

I. HEALTH CARE COSTS FOR OLDER AMERICANS: FRUSTRATION MOUNTS

Out-of-pocket health care costs for older Americans continued to show steady increases, and legislation to contain hospital costs failed to pass Congress for the second year in a row. Special Committee on Aging hearings during the year raised questions about medicare's ability to reach all beneficiaries on an equitable basis, and revealed that more and more older Americans are voicing frustrations about the complexities of the program.

A. Cost of Health Care: 1978

National health spending reached $192.4 billion in 1978, 13.2 percent above 1977.[1] Hospital care accounted for the largest portion of this

[1] National statistics on health care costs are published annually by the Health Care Financing Administration, Department of Health, Education, and Welfare. The most current statistics available are for the calendar year 1978. U.S. Department of Health, Education, and Welfare. Health Care Financing Administration. National Health Expenditures, 1978. [Washington, summer 1979], Vol. 1, Issue 1.

spending: $76 billion, or 39.5 percent of the total national health bill, public and private. Medicare's portion of hospital payments was $18.3 billion, 24 percent of all hospital care payments in the Nation.

Physicians' services constituted the second largest category of expenditures: $35.2 billion, or 18.3 percent of total spending. Medicare's portion was $5.5 billion, 16 percent of all spending for physicians' services.

The third largest expenditure, and the fastest growing, was for nursing home services: $15.8 billion, or 8.2 percent of the total national health bill. Medicaid and medicare expenditures for nursing home care during 1978 were $7.6 billion, or 48 percent of all payments for nursing home care. Nursing home expenditures have increased an average of 16 percent each year since 1970.

B. Hospital Cost Containment Stalled

After Congress considered, but failed to enact, hospital cost containment legislation during 1978,[2] the administration again proposed legislation to establish voluntary limits on total annual increases in hospital expenses. The Hospital Cost Containment Act of 1979, H.R. 2626, was introduced by Representatives Charles B. Rangel and Henry A. Waxman in the House on March 6, 1979; and S. 570 was introduced in the Senate by Senator Gaylord Nelson and others on March 7, 1979. The legislation provides that if the voluntary goals were not met by hospitals, mandatory controls would be triggered.

Four committees in the House and Senate conducted extensive hearings on the legislation during the year. Modified versions of the administration's bill were approved by the Senate Labor and Human Resources Committee on June 13, 1979; rejected by the Senate Finance Committee on July 12, 1979; approved by the House Ways and Means Committee on July 17, 1979; and approved by the House Interstate and Foreign Commerce Committee on September 26, 1979.

The full House defeated a bill by a vote of 234 to 166 on November 15, 1979, agreeing to a substitute which would create a national commission on hospital costs to monitor price increases and study hospital inflation. No Senate vote was taken during the year.

Hospital cost containment legislation is strongly supported by the National Retired Teachers Association/American Association of Retired Persons and the National Council of Senior Citizens.

C. The Individual View: Out-of-Pocket Costs

Total per capita personal health care expenses for older Americans during calendar year 1978 were $2,026. This is an 11 percent increase over 1977, when per capita expenses were $1,821.

The personal share of this amount, those direct out-of-pocket payments made by the elderly themselves, was $608 in calendar year 1978, an increase of 15 percent over 1977, when the average out-of-pocket share was $530.

The public share of the total health care bill for the elderly comes primarily through medicare and medicaid. During calendar year 1978,

[2] See Developments in Aging: 1978, part 1, pp. 43–44, for summary and disposition of legislation considered last year. The Senate passed a hospital cost containment bill during the last days of the 95th Congress, but the House did not act.

medicare paid for about 44 percent of the total bill, or $21.775 billion. When medicare's cost-sharing amounts are deducted, the medicare share of personal expenditures was 40 percent, or about $19.695 billion. (During fiscal year 1977, this amount was 41 percent.) State medicaid programs paid for an additional 13.4 percent of total health care expenditures for the elderly in calendar year 1978.

The amounts each medicare beneficiary must pay out-of-pocket for medicare's hospital insurance (part A) increased by 12.5 percent on January 1, 1980. The initial deductible for part A hospital insurance was increased to $180, $20 more than the 1979 charge of $160. Daily coinsurance charges for long-term hospital stays and skilled nursing stays also increased by 12.5 percent on January 1, 1980.

The administration announced on December 31, 1979 that the basic monthly premium paid by medicare beneficiaries for medicare supplementary medical insurance protection (part B) will increase by 9.9 percent, from $8.70 per month to $9.60 per month, on July 1, 1980.

Part B is financed through beneficiary premiums and Federal general revenue funds. The medicare law requires that part B premium charges be reviewed each year. Premiums may be increased to cover rising costs, but annual percentage increases may not be more than corresponding cost-of-living increases in social security benefits. Social security beneficiaries received a 9.9 percent cost-of-living increase during 1979. According to the Department of Health, Education, and Welfare, medicare part B monthly premiums would have to be $16.30 per month as of July 1, 1980 in order to finance completely expected part B expenditures.

D. The Individual View: Frustration with Medicare

Hearings conducted by the Committee on Aging during 1979 demonstrated significant paperwork burdens faced by individual participants in the Federal medicare program and broad confusion over program benefits.

In an opening statement, Senator Lawton Chiles, chairman of the committee, summarized the repeated complaints from older Americans which led to the hearing:

> The burden of filling out medicare forms is an almost impossible one for way too many senior citizens. It has also caused many doctors to simply discourage medicare business or make senior citizens pay them, the doctors, before they treat them and then fill out the forms on their own.
>
> When Congress enacted medicare in 1965, it did not foresee the day when forms would be so complicated that the average older American would have trouble filling them out. It did not anticipate the day when doctors would charge just for filing the forms so they could get reimbursed. And it certainly did not think the day would come when the newspapers would have ads advertising for so-called medicare assistance bureaus which promise older Americans that they will fill out their medicare forms for a yearly payment of $50 or a percentage of their medicare reimbursement.[3]

[3] U.S. Congress. Senate. Joint Hearings before the Special Committee on Aging and the Subcommittee on Federal Spending Practices and Open Government of the Senate Committee on Governmental Affairs. Federal Paperwork Burdens, with Emphasis on Medicare. Hearings, 96th Congress, 1st Session. August 6, 1979. St. Petersburg, Florida.

Witnesses during the hearing cited numerous obstacles encountered before, during, and after attempted use of medicare benefits.

1. LOW ASSIGNMENT RATES

Very low rates of "assignment" (the number of physicians who agree to accept medicare payment for services provided without additional charge to the patient) make it difficult for many elderly to find physicians who will serve them.

During fiscal year 1978, only about 50 percent of all medicare claims for physician services were "assigned." The rate has been declining slowly, but steadily, since the program began in 1966. (In 1975, the rate was about 52 percent; in 1976, 51 percent, and in 1977, 50 percent.) The rates vary from area to area, however, with some local rates as low as 14 and 15 percent. A recent General Accounting Office study found that one-third of the States had assignment rates lower than 40 percent.[4]

2. PAYMENT DELAYS AND OBSTACLES

Although a detailed bill is needed by a patient to file a medicare claim, the refusal of some physicians to provide medicare patients with an itemized bill until it was paid was described as a common practice. Receipt of physician's bills without enough information to be acceptable for medicare payment was also described as routine.

Witnesses cited long waits—up to 10 months or more—for medicare payment once a claim was filed with the part B carrier. Great frustration resulted from perceived payment inconsistencies, discrepancies, and errors once claims were paid.

For example, two beneficiaires noted the same service, delivered by the same physician in the same city, resulted in two different payments. Other examples offered were: (1) Instances of routine denials of payment for certain services when claims were filed, with what appeared to be equally routine payment whenever the beneficiary questioned the first determination; and (2) errors resulting from carrier judgments that similar bills submitted by a single beneficiary were duplicates, when, in fact, two services had been performed. Beneficiaries also voiced a great deal of frustration with repeated requests for further information to verify a claim, when they felt that all information had been supplied on numerous previous occasions.

It is difficult to determine specific causes for these problems, as cases would vary from claim to claim. It appears, however, that frustrations mount as more and more utilization screens and limits are built into the medicare payment process as cost control mechanisms.

3. HIGH CLAIM REDUCTIONS

In addition to frustration with hard-to-understand forms and carrier communications, medicare beneficiaries experience an extremely high rate of reductions or denials on claims submitted. From 70 to 80 percent of the total volume of medicare part B claims submitted are either reduced or denied.

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[4] U.S. General Accounting Office. Comparison of Physician Charges and Allowances Under Private Health Insurance and Medicare. [Washington, 1979], (HRD-79-111, Sept. 6, 1979).

Nationally, the aggregate dollar figures for the *amount* that claims are reduced is about 50 percent: First 20 percent is subtracted in the form of beneficiary cost-sharing; and second, about 29 percent is further subtracted through outright denials and claim reductions. During fiscal year 1978, total medicare part B claims, as submitted by beneficiaries or by physicians on their behalf, were $10.576 billion. $1.226 billion (11.6 percent) were denied as noncovered services or not "necessary" services, etc. An additional $1.798 billion (17 percent) were subtracted through claim reductions as services beyond screening norms, charges above "reasonable," etc.

4. FEW APPEALS

According to recent surveys by the Health Care Financing Administration and the American Association of Retired Persons, however, few—from 2 to 3 percent—of the many medicare beneficiaries who feel they are being "cheated" by medicare reductions or denials ever question or appeal the carrier decision, even though those who do ask questions frequently receive an increase in reimbursement.

Hearing witnesses testified that very few beneficiaries question reimbursement because most believe that no adjustment will be made and the effort will not be worth the result, or because they do not understand the explanation for the reduction or denial. Studies have found, however, that of the 2 to 3 percent who do question their medicare payment, over 50 percent are judged in favor of the beneficiary with some increase in the reimbursement amount.

5. FAILURE TO FILE CLAIMS

Confusion about the medicare program itself, what services can be paid for, and how to file claims, means that some beneficiaries simply never file or file too late to receive benefits. Weltha Buxton, a volunteer medicare assistance counselor in Clearwater, Fla., told the committee:

> They come to us and they will open a shoebox and say, "Here are my claims," and spread them all over the desk. Or they have a suitcase or a "Publix's" bag full of claims, and you have to go through all of those. Sometimes you throw out more than three-quarters because they are outdated. . . . I think there were over $600 in expired bills that she could have been reimbursed for had she been better informed . . . so many people don't know that they can even file for medicare.

6. PAYING FOR THE "PAPERWORK"

The increasing complexity of the program has contributed to the decision by some physicians not to participate in medicare at all, with the result that more and more individual beneficiaries are forced to do the medicare "paperwork" themselves. Marjorie McEntyre, a staff officer for the Health Care Financing Administration in Atlanta, detailed some of the consequences:

> The ideal situation for a beneficiary is when the physician takes assignment. That is great. The doctor completes the paperwork and the patient saves money. A helpful condition

exists when the physician completes the claim form even if he does not take assignment, because those forms are cleaner and they process better. A problem often exists when the physician does neither, he does not fill out the form and he does not take assignment. It gets worse when he charges for filling out that form—anywhere from $1 to $5.

Some individuals are forced to pay even higher amounts to businesses to get help in having their forms processed. Examples cited at the hearing:

—A Florida business advertises a service to file up to three medicare claims per year for a fee of $25 a year for one person and $35 per year for a family. Additional bills will be processed for a charge of $1 per bill. Prior claims will be processed for 10 percent of the money collected. The advertising brochure suggests that the medicare beneficiary needs to be an "attorney, doctor, CPA, insurance agent, and mathematician to fill out medicare claims forms. . . ."

—A California business advertises a similar service covering filing of all claims for 1 year, including requests for reviews of questionable claim determinations and representation at hearings, as needed, for a yearly subscription fee of $120 for an individual and $220 for a couple. The same service will be offered for bills incurred prior to the subscription date (back claims) for a fee of 25 percent of the amount collected.

7. REMEDIAL ACTION

Simply stated, these and similar problems are likely to draw the increased attention of older Americans as long as the gaps between medicare payments and health care costs widen.

There are, however, a number of interim measures which have been proposed to improve beneficiary understanding of the medicare program and to make the "paperwork" process easier to control.

Some older American consumer groups have published lists of area physicians accepting assignment. These lists can help beneficiaries locate physicians and may encourage more physicians to participate fully in the medicare program. Local publication of lists of maximum charges allowed by medicare for the most commonly used services has also been proposed as a way to inform beneficiaries.

Experiments with a simplified claims form have suggested that the high error rates on claims filed by part B beneficiaries themselves can be reduced. The experimental use of a short Form SSA–1490 in Florida, with simplified language, larger printing, and larger writing spaces has resulted in a more rapid beneficiary response and better filing.

In a number of areas, specially-trained older volunteers have been able to reduce errors and improve claim handling substantially. Results of a demonstration program conducted in Florida indicate that claims filed with the assistance of specially-trained volunteers had an error rate of less than 5 percent, compared with a 67 percent error rate on claims filed by the beneficiary alone. Similar success has been obtained through a specialized program sponsored by the National Retired Teachers Association/American Association of Retired Persons at a number of sites throughout the country.

In December 1979, the Health Care Financing Administration created an Office of Beneficiary Services to evaluate the impact of new and proposed medicare legislation and regulations on beneficiaries and to identify and develop needed beneficiary services.[5] This new office will be responsible for development of simplified claims forms, and additional effort—working with national aging organizations—to mount a nationwide training program for medicare assistance counselors.

During consideration of H.R. 934, medicare and medicaid amendments, the Senate Finance Committee approved a provision intended to encourage more physicians to accept medicare assignment. (Section 231 of H.R. 934 was favorably reported by the Senate Finance Committee on December 10, 1979. H.R. 934 was not acted upon by the full Senate during the year; however, further action is expected early in 1980.) According to the proposed legislation, part B carriers would be instructed to give priority attention to claims submitted by "participating" physicians—those accepting full medicare assignment. The amendment would also authorize from 5 to 10 special demonstration projects to experiment with alternative ways of encouraging more physicians to accept medicare assignment. The Finance Committee's report (S. Rept. 96–471) cited the committee's concern "that the increasing reluctance of physicians to adopt assignment has resulted in a severe financial burden for many of the Nation's elderly."

II. MENTAL HEALTH AND THE ELDERLY

In 1978, three major studies, including the report of the President's Commission on Mental Health, documented that the mental health needs of the elderly are not being met by existing reimbursement and service programs. (See "Developments in Aging: 1978," pages 56–58.) Early in the 1st session of the 96th Congress, these needs, as well as recommendations for legislative action, were the focus of a National Conference on Mental Health and the Elderly sponsored by the House Select Committee on Aging.

First Lady Rosalyn Carter, the honorary chairperson of the President's Commission, described the special problems of older Americans in her opening remarks to the Conference:

> The harsh reality about our present system of mental health care is that for too many professionals and in too many programs the elderly do not exist . . . while as many as 25 percent of our older citizens may suffer from significant mental health problems, very few actually receive adequate treatment. For example, only 2 percent of all the patients seeing a private psychiatrist are elderly, and less than 3 percent of the budget of the National Institute of Mental Health has been spent on the plight of older Americans.
>
> The mental health problems of old age have many complex roots. Financial worries, unhappiness over the loss of social status, grief over the death of loved ones all can lead to depression, even suicide. Twenty-five percent of all suicides reported are committed by the elderly. The stigma of mental illness coupled with the stigma of old age can have devastating results.

[5] Federal Register, Vol. 44, No. 247, pp. 75719–20, December 21, 1979.

> Our Commission found a woeful lack of professionals, doctors, nurses, mental health practitioners, trained to address these special circumstances; and so we have more than 1 million people over the age of 65 leading lonely and unproductive lives in nursing homes.[6]

The recent trend toward "deinstitutionalization" in itself provides no benefit to the elderly if community support services and trained personnel are lacking. As stated by the Chairman of the House Select Committee on Aging, Representative Claude Pepper:

> . . . all over the country, various institutions, mostly State institutions, are pushing people, most of them elderly people, out of their State mental institutions and putting them out into boarding homes as they are called, so these people (boarding home proprietors) can get the benefit of SSI.[7]

Representative William R. Ratchford added:

> . . . I have seen too often patients come from mental hospitals or hospitals for the mentally retarded to a nursing home; or from a nursing home to a home health care program; or from a home health care program to a community-based program, and end up worse off. I think that the move toward getting the older patient out of the hospital or a nursing home, or a home for the aging and into the community is correct. But it is only correct in each instance if the proper training has been provided.[8]

Dr. Robert Butler, Director of the National Institute on Aging, presented the seven recommendations of the Task Panel on Mental Health of the Elderly of the President's Commission as a way to address these problems by building on existing programs in a cost-effective manner:

—Outreach to overcome the lack of accessibility to mental health services by the elderly.
—Home care as an essential component in the continuum of physical and mental health services.
—Medicare extensions to ease the reimbursement restrictions on mental health services.
—Geriatric training as part of the curriculum of educational programs for doctors, nurses, social workers, and psychologists.
—Research on organic brain disease, the most debilitating mental health problem of the elderly.
—Allocation of resources by the Department of Health, Education, and Welfare in a manner which reflects the needs and size of the older population.
—Revitalization of the Administration on Aging to carry out the intent of the Older Americans Act.[9]

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[6] U.S. Congress. House of Representatives. Select Committee on Aging. National Conference on Mental Health and the Elderly. (Committee Publication No. 96-186) Washington, U.S. Government Printing Office, 1979. p. 4.
[7] Ibid., p. 2.
[8] Ibid., p. 15.
[9] Ibid., pp. 21-2.

These seven issues were prominent among the recommendations of the various task forces that met at the National Conference. Some of the task forces' specific recommendations included:

—80 percent Federal matching for State support to community mental health programs.

—Comprehensive planning and coordination of many Federal programs, such as medicare, medicaid, title XX, the Older Americans Act, etc.

—Incentives for informal support systems—defined as friends, family, and neighbors—and linkages with the formal support network, as well as shared case management and monitoring on behalf of the elderly.

—A bill of rights for elderly patients receiving mental health services, including mutual agreement on plans for treatment between provider and client.

—Appropriation of $20 million per year for the study of "senile dementia" and $10 million per year for research on the causes and treatment of depression in the elderly.

—Establishment of a center for prevention in the National Institute on Mental Health, of which 40 percent of the total funds would be allocated to research and programs aimed at problems of the elderly.

—Eliminating discriminatory treatment of mental health services under medicare by: (a) Extending cost-related benefits to services of community mental health centers, (b) increasing the allowable reimbursement for outpatient services, (c) reducing the amount of copayment the beneficiary must pay for mental health services from 50 percent to 20 percent, (d) extending inpatient coverage to the equivalent of that for physical illness, and (e) providing payment for partial hospitalization.[10]

The conference set the stage for introduction of legislation to extend and improve existing mental health programs.

A. Reauthorization of Community Mental Health Programs

The current program of local mental health service delivery was originally established in 1963 and was most recently reauthorized through September 30, 1980, by the Community Mental Health Centers Extension Act of 1978 (Public Law 95–622, signed by the President November 9, 1978). The heart of the program is Federal funding for up to 8 years for the delivery of 12 basic services to a defined geographical area (catchment area) by a community mental health center (CMHC). There are approximately 745 grantees, 624 centers in operation, and 268 centers having completed the 8-year funding cycle.[11]

In his budget proposal for fiscal year 1980, the President requested $35 million for new mental health service grants (an increase of nearly $5 million over the amount appropriated for fiscal year 1979), over $195 million for continuation of the program reauthorized in 1978 (an increase of over $10 million above the fiscal year 1979 amount), and $49,584,000 for new initiatives contained in the administration's

[10] Ibid., pp. 53–71.

[11] U.S. General Accounting Office. Legislative and Administrative Changes Needed in Community Mental Health Centers Program. Report to the Congress by the Comptroller General of the United States [Washington, 1979], (HRD–79–38, May 2, 1979).

mental health systems proposal. Congress approved the President's request for new service grants and continuation of existing CMHC programs but refrained from appropriating funds for the new initiatives yet to be authorized (Public Law 96–123, signed into law November 20, 1979).

Mrs. Carter presented the findings of the President's Commission on Mental Health and plans for the new initiatives to the Subcommittee on Health and Scientific Research of the Senate Labor and Human Resources Committee on February 7, 1979. To implement these recommendations and initiatives, the administration proposed comprehensive legislation, the Mental Health Systems Act. President Carter's May 15 message to Congress,[12] which detailed the provisions of the bills (S. 1177 and H.R. 4156) emphasized the following problems the legislation was designed to address:

—Of the 20–32 million Americans who need some form of mental health services, many are denied access to appropriate care because of where they live, who they are, or the nature of their disability or economic circumstances.

—The 1.5 million chronically mentally ill adults who are institutionalized are particularly underserved, and in the move to return them to the community, appropriate support services are often lacking.

—There is not enough emphasis on prevention and early detection of mental illness in our programs.

—There is little coordination among Federal and State health and mental health policies, leading to fragmentation of services and lack of continuity of care for the mentally disturbed.

—Current Federal mental health programs lack flexibility, preventing communities from reaching their underserved populations, such as the elderly.

—Mental health research is underfunded, resulting in an erosion of our research capacity.

Thus, the major features of the President's proposal included:

—Grants to States for services to the chronically mentally ill, including demonstrations, training, and identification of barriers to care.

—One grant of up to $75,000 per catchment area for public or nonprofit private agencies to plan mental health services.

—Up to five grants each to private or nonprofit organizations to offer at least one service to an underserved group, such as the elderly.

—An extension of the CMHC program through up to 8 grants to facilities which agreed to provide 12 basic mental health services and through continuation grants for existing CMHC's. (See "Developments in Aging: 1978," p. 59, regarding the status of the elderly under the current program.)

—Grants to promote coordination of services between mental health facilities and outpatient health care clinics.

—Grants to States to fund prevention and public education programs, as well as funds for private nonprofit and public entities for similar nonrevenue producing activities.

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[12] Proposed Mental Health Systems Act—Message from the President PM 72. Congressional Record, vol. 125, May 15, 1979: S 5929–31.

—The requirement that States develop comprehensive mental health plans which would give particular emphasis to underserved groups, such as older Americans.
—Authorization of $347.7 million for these activities.

As introduced in the Senate (S. 1177), the legislation emphasized the role of the States in reviewing grant applications but left final approval to the Department of Health, Education, and Welfare. Only those applicants affiliated with the local CMHC could be awarded grants for services to underserved groups under the provisions of the bill.

The Senate Subcommittee on Health and Scientific Research met on October 18, to consider the provisions of S. 1177. The subcommittee reported the bill for consideration by the full Labor and Human Resources Committee with some of the following changes:

—The role of the States was enhanced by allowing them to change or delete proposals by public or nonprofit entities, as well as develop alternative proposals, before sending applications to HEW (States could comment on, but not modify, proposals by existing CMHC's and other applicants dissatisfied with the State's action could appeal to HEW.)
—The services to be provided to the chronically mentally ill were specified including identification and outreach, case management, and community support. (Similar provisions for needs assessment and coordination of services were included for the underserved groups, including the elderly.)
—State plans would have to include how the State intends to coordinate and deliver statewide community mental health services and increase outpatient, as opposed to inpatient, treatment for the mentally ill.
—$400 million for fiscal year 1982 and up to $550 million for fiscal year 1985 was authorized for the programs, as well as $87 million in fiscal year 1981 for existing CMHC's.

At the close of the 1979 session, S. 1177 was still pending before the Senate Labor and Human Resources Committee. Hearings were held on the companion measure in the House, H.R. 4159, by the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, but no further action was taken by the subcommittee by the adjournment of the 1st session of the 96th Congress.

B. Proposed Extension of Medicare Coverage

One of the central issues in the provision of mental health services to older Americans is the delivery mechanism; another is reimbursement. For several years, legislation has been introduced to extend medicare benefits for mental health services. Bills of this nature introduced in the Senate during 1979 include:

—S. 123, by Senator Daniel K. Inouye, to provide independent reimbursement for mental health services provided by psychologists.
—S. 458, by Senator Robert Stafford, to include community mental health centers among providers qualified under medicare.

—S. 1289, by Senator John Heinz, to eliminate medicare's 190-day lifetime limit for inpatient psychiatric care, reduce the 50 percent beneficiary copayment for outpatient mental health services to 20 percent, eliminate the $250 annual ceiling on outpatient mental health benefits, and include CMHC's as qualified providers.

Hearings held by the Senate Finance Committee in August 1978, highlighted the controversy over diagnosis, treatment, and appropriate level of care which has stalled action on legislation in previous sessions of Congress. A second impediment to passage of extensions in medicare for mental health services has been concern over the cost impact on the program. (See "Development in Aging: 1978," pages 58 and 59.)

Yet, in the 1st session of the 96th Congress, renewed impetus was given to expanding reimbursement for mental health care in some of the major national health insurance proposals. (See the "national health insurance" subsection of this chapter.) The House Ways and Means Committee approved additional medicare benefits in its report on the Medicare Amendments of 1979 (H. Rept. No. 96–588, part 1, to accompany H.R. 3990), as follows:

—Raised the ceiling on reimbursement of outpatient mental health services from $250 to $750 per year (section 21(a)).

—Reduced the beneficiary copayment from 50 percent to 20 percent for outpatient mental health services, the same amount required for physical health services (section 21(a)).

—Authorized payment for services performed by qualified clinical psychologists (section 21(b)).

—Authorized cost-related or other reasonable reimbursement for services provided by qualified community mental health centers (section 7).

The medicare amendments reported by the Senate Finance Committee (S. Rept. No. 96–471 to accompany H.R. 934) did not include similar provisions, nor did medicare legislation come before the full House or Senate. However, some Senators on the Finance Committee did begin exploring a possible long-range resolution to the question of which services should be covered by medicare. Legislation may be introduced early in 1980 to study the safety, effectiveness, and appropriateness of various mental health services for purposes of medicare reimbursement with panels of professionals to tentatively approve payment for certain services in the interim.

C. Extension of Alcohol and Drug Abuse Programs

It is estimated that one out of five Americans with an alcohol-related problem is elderly, and as many as 1.6 million of the Nation's population over age 65 may be alcoholics. The Institute of Medicine cites studies which show that alcoholism is the second most frequent cause for admitting older Americans to psychiatric facilities. A 1975 study by the National Institute of Mental Health shows that 16.2 percent of patients over age 65 who are admitted to State and county psychiatric hospitals are diagnosed as alcoholics (47 percent of the admissions are due to organic brain syndrome and 18.3 percent list depression as the diagnosis).[13]

[13] National Academy of Sciences. Institute of Medicine. Aging and Medical Evaluation. [Washington, 1978], p. 9.

Alcohol misuse among older Americans is often directly associated with factors related to advancing age, such as a decreased tolerance to alcoholic beverages, incompatibility of alcohol with prescribed medications, and increasing life stresses. Older Americans have received little attention in federally sponsored alcohol abuse programs and may not have their alcohol-related symptoms diagnosed for effective treatment. Since the cause and pattern of alcohol misuse by the elderly differs from that of the general population, older Americans are not being adequately served in existing prevention and treatment programs.

Similar problems exist for the elderly in the Nation's drug abuse programs. Unintentional drug misuse is common among older Americans, who consume 25 percent of all prescription drugs and take an average of 13 medications each for chronic and acute conditions. (See the subsection on "drug regulation reform" later in this chapter.) Drug interactions and individual metabolic changes in older persons, if not taken into account in dosage recommendations, can lead to overmedication, sometimes to the extent that the older patient becomes depressed or is incorrectly diagnosed as suffering from senility. As with alcoholism, older Americans who become drug-dependent usually do so for different reasons than the younger population and often do not receive appropriate outreach and help through conventional drug abuse programs.

In legislation to extend Federal alcohol and drug abuse prevention and treatment programs, Congress addressed some of the special alcohol and drug misuse problems of the elderly. The House Interstate and Foreign Commerce Committee reported their version of these measures in legislation to reauthorize both the alcohol and drug abuse programs through 1980 at roughly 1979 funding levels (H. Rept. No. 96–193 to accompany H.R. 3916). The bill, which passed the House of Representatives on October 16, contained provisions:

—Identifying the elderly as a special target population in award of grants and contracts by the Secretary of HEW to alcohol and drug abuse prevention programs.

—Requiring the appointment of representatives who are knowledgeable about the special alcohol and drug misuse problems of older Americans to State advisory councils.

The House committee also stressed the need for separate and specialized drug treatment settings for the elderly who are experiencing problems with overmedication and indicated that the National Institute on Drug Abuse should develop programs to inform health professionals about the unique problems of older Americans and furnish information in community settings (such as senior centers and nutrition sites) on the hazards of incompatible drug combinations, incorrect dosages, etc.

The Senate Human Resources Committee reported two separate pieces of legislation to extend and amend Federal programs to prevent and treat alcohol and drug abuse (S. Rept. No. 96–103 to accompany S. 440 and S. Rept. No. 96–104 to accompany S. 525). These bills passed the Senate on May 7 and contained provisions similar to those of the previously discussed measure reported by the House Interstate and Foreign Commerce Committee, such as identification of the elderly as an underserved population for special consideration in grant awards, increased representation of the aged on State advisory

councils, special attention to the unique problems of the elderly by the National Institute on Drug Abuse in research and project grants and contracts, and when appropriate, special treatment and prevention programs to meet the unique needs of older Americans.

After a conference committee met to resolve differences in the House- and Senate-passed versions of the legislation, the bills were signed into law by the President on January 2, 1980 (Public Laws 96–180 and 96–181).

Public Law 96–180 extends for 2 years the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and authorizes formula grants to the States in the amounts of $60 million in 1980 and $65 million in 1981. The law also authorizes $102.5 million in 1980 and $115 million in 1981 to be spent on project grants and contracts; $28 million in both 1980 and 1981 for research by the National Institute on Drug Abuse; and $8 and $9 million for 1980 and 1981, respectively, for National Alcohol Research Centers.

Public Law 96–181 reauthorizes the Drug Abuse Office and Treatment Act of 1972 and contains authorizations for $149 million and $20 million for treatment and prevention, respectively, in 1980 and $155 million and $30 million for these activities in 1981. Formula grants to the States are authorized at levels of $45 million for both 1980 and 1981

D. Outlook for Mental Health Legislation in 1980

Given the lack of a consensus on both the mechanism of service delivery and degree of medicare reimbursement for mental health care for older Americans, it is difficult to project exactly what the 1980 session of the 96th Congress will bring in terms of these areas. However, there is general agreement that our current mental health programs are not reaching the elderly, leaving unsettled the question of how best to meet these needs—through an expansion and revitalization of the existing CMHC structure or through a greater State role and service delivery by other private nonprofit or public entities. Congress also faces the dilemma of whether to authorize immediately expanded reimbursement for mental health services under medicare, or to opt for further study on the safety, effectiveness, and appropriateness of services offered by various types of professionals.

III. MEDICARE AND HMO's

As health care costs and out-of-pocket medical expenses for older persons continue to rise, the emphasis on developing alternative service delivery mechanisms has grown.

One such alternative to receive increased attention is the health maintenance organization—HMO. The HMO operates somewhat like a health insurance plan in that a specified monthly premium is charged for medical services called for in the subscriber's contract. Unlike Blue Cross, Blue Shield, and other commercial insurers, the HMO provides or arranges to provide the medical services specified in the contract.

In spite of the growing popularity and availability of HMO's as providers of medical care, few older persons have enrolled. According to the Health Care Financing Administration, medicare now has contracts with only 55 of the 225 HMO's and other prepaid group plans

now in operation. Only 492,000 medicare beneficiaries—2 percent of all such beneficiaries—are covered by these contracts, most having enrolled under an employee group plan prior to their retirement. The medicare participation rate is roughly half that of the general population.

During 1978, the Carter administration offered legislation (S. 2676 and H.R. 11461) to broaden use of medicaid and medicare funds to pay for elderly participation in HMO's. In so doing, the administration hoped to increase participation of elderly individuals in federally-approved HMO's. At the same time, the Federal Government was expected to realize a savings in the cost of medical care as a result of the relationship between increased participation rates and the lower cost of care—particularly hospitalization costs—which are associated with HMO's.

The legislation, however, was viewed as overly ambitious by some in Congress and too premature by others as HEW was still being criticized for inadequate administration of the current HMO program. Still others felt that the proposals would generate excessive profits for HMO's. The legislation, therefore, failed to get out of the Senate Finance Committee before the end of the 95th Congress.

At the beginning of the 96th Congress, the administration pressed again for its proposal aimed at increasing elderly participation in HMO's. Reforming the system by which HMO's are reimbursed by medicare for services provided elderly enrollees was the mechanism through which this goal was to be achieved.

A. Current Law

Under current medicare law, an HMO may participate in the medicare program in three ways:

(1) "Individual cost basis"—where the HMO is reimbursed for the reasonable cost or customary charges (whichever is less) for part A medicare services and for 80 percent of the reasonable cost of part B services (sections 1814 and 1833 of title XVIII of the Social Security Act).

(2) A "cost contract"—where an HMO enters into an agreement with HEW to provide part A and/or part B services to enrolled medicare beneficiaries in exchange for medicare reimbursement of reasonable costs actually incurred retroactively adjusted (section 1876 of title XVIII of the Social Security Act).

(3) A "risk contract"—where an HMO enters into an agreement with HEW to provide part A and/or part B services in exchange for medicare reimbursement based on HEW's retrospective estimates of what medicare would have paid had the services been provided outside the HMO (the "average adjusted per capita cost" or AAPCC). If the HMO's actual costs are below the AAPCC, it may receive and retain one-half of these "savings" up to a maximum of 10 percent of the AAPCC. Where actual costs exceed the AAPCC, the HMO must absorb them entirely.

Most HMO's choose either the individual cost or cost contract reimbursement options. The risk contract is particularly unpopular primarily due to the retrospective nature of the reimbursement procedure.

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B. Administration Proposal

With the problems of the current reimbursement system in mind, the administration advanced a proposal to deal with them. As presented, the proposal had three objectives: (1) To use medicare HMO payments to contain health care costs rather than fuel inflation; (2) to expand benefits for medicare beneficiaries who enroll in HMO's while generating long-term budgetary savings; and (3) to make available to medicare beneficiaries the same choice in health care delivery systems that the Federal Government mandates employers offer their employees.[14]

The administration proposal would:

—Eliminate the cost contract reimbursement option and phase out the options for individual cost reimbursement for part B services.

—Make HEW's reimbursement determination prospective for risk contracts under section 1876.

—Establish a new reimbursement level for medicare services at 95 percent of the AAPCC.

—Require the Secretary to calculate a community rate for medicare beneficiaries (i.e., the estimated amount the HMO would charge its medicare-eligible members under a community rating system). If the community rate were lower than the medicare reimbursement rate (at 95 percent of AAPCC), the HMO would have to spend the difference—"savings"—on benefit improvements for its medicare enrollees in a specified order of priorities: (1) reduced premiums for preventive care, such as immunizations and physical examinations; (2) reduced copayments, deductibles, and other charges, and (3) improved supplemental benefits.

—Require medicare enrollees to purchase preventive health services as defined in section 1302 (1)(H) of the Federal HMO act.

—Apply only to federally qualified HMO's.

The administration's proposal was introduced in the Senate as S. 1530 by Senator Abraham Ribicoff on July 17. He was joined by 21 of his Senate colleagues who cosponsored the bill. S. 1530 was referred to the Senate Finance Committee where it awaits further action.

The legislation was introduced in the House of Representatives on June 13 as H.R. 4444 by Representative Charles Rangel with Representatives Al Ullman, James Corman, and Claude Pepper joining as cosponsors. H.R. 4444 was jointly referred to the Ways and Means Committee and the Interstate and Foreign Commerce Committee.

Hearings on this and related measures were held by the Health Subcommittee of the Interstate and Foreign Commerce Committee on October 19, 22, and 23. The Health Subcommittee of Ways and Means approved the legislation with amendments as part of H.R. 4000 (a bill containing a broad range of medicare and medicaid amendments) on September 20, and the full Ways and Means Committee reported H.R. 4000 on November 5, to the House floor (H. Rept. 96–589, part 1).

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[14] U.S. Senate Special Committee on Aging. Hearings on Medicare Reimbursement for Elderly Participation in HMO's, Philadelphia, Pa., Oct. 29, 1979. Testimony of Dr. Peter Fox, for HEW/HCFA.

C. Alternatives to S. 1530/H.R. 4444

A proposal containing language very similar to the administration's bill was introduced by Senator David Durenberger on July 12 (S. 1485). The Durenberger bill opens reimbursement to State-licensed HMO's as well as to those which are federally qualified. In addition, it extends reimbursement to non-HMO entities which meet the definition of the term "health benefit plan." S. 1485 also provides that where medicare reimbursement levels (95 percent of AAPCC) exceed the community rate, the "savings" must go toward additional benefits that the Secretary finds to be equal in value to the savings; no specific ordering of benefits is provided.

A proposal drafted by Senator John Heinz and yet to be introduced incorporates many of the major features of the administration and Durenberger bills. This proposal also extends reimbursement to "health benefits plans"; sets reimbursement on a prospective basis; sets the reimbursement levels at 90 percent of AAPCC; provides that medicare enrollees shall work with the HMO in deciding how any "savings" are to be spent; and provides for out-of-area emergency medical benefits for medicare enrollees.

D. Senate Special Committee on Aging Hearings

On Monday, October 29, Senator John Heinz chaired a hearing of the Senate Special Committee on Aging in Philadelphia, Pa., to explore making HMO's more attractive to medicare beneficiaries and also to explore how the current HMO reimbursement system might be altered to make medicare beneficiaries more attractive to HMO's.

In his opening statement Senator Heinz set the tone for the hearing:

> We have spent a great deal of time developing one of the finest health care systems in the world, but we have done so without any particular concern for the cost involved or to those upon whom this cost will fall. Even worse, we have removed from the consumers of health care services the incentives to be prudent shoppers by taking them out of the direct line of payment for services rendered.

Using his proposal as points for discussion in addition to S. 1485 and S. 1530, Senator Heinz heard testimony from government officials, doctors, insurers, employers, HMO's and older people themselves. From this hearing and in his position on the Senate Finance Committee, Senator Heinz and his Aging Committee colleagues hope to direct even more attention in 1980 on developing alternative health care delivery systems for older Americans.

IV. STEPS TOWARD REFORM IN OTHER AREAS

A. National Health Insurance: Impact on Older Americans

The first session of the 96th Congress saw the introduction of a variety of proposals which would extend health insurance coverage to greater numbers of Americans and retain or expand medicare coverage for the elderly and disabled. Most of the plans fall between

the two basic types of coverage—comprehensive and catastrophic. None would expand coverage for long-term care. Each gives attention to the need for a mechanism to contain spiralling health costs, either through ceilings on national expenditures and set or negotiated fees, or through competition. On February 6, Senator Russell Long, Chairman of the Senate Finance Committee, introduced a catastrophic health insurance proposal (S. 350 and S. 351). The proposal was modified and reintroduced by Senator Long in March as S. 760. Hearings on Senator Long's bill and on another bill, S. 748 (introduced by Senators Robert Dole, John Danforth, and Pete Domenici), were conducted by the committee on March 27–29.

The momentum continued as Secretary of HEW, Joseph Califano, testified before the Senate Finance Committee on March 27 on the major features of the administration's national health insurance plan, which was introduced in the Senate (S. 1812) and the House (H.R. 5400) on September 25.

Senator Edward Kennedy, Chairman of the Health Subcommittee of the Senate Human Resources Committee, announced the basic components of his Health Care for All Americans Act on May 14, and the legislation was formally introduced in the Senate (S. 1720) and in the House (H.R. 5191) on September 6.

1. MAJOR PROPOSALS AS INTRODUCED

As introduced, the President's proposal, called "Health Care" (S. 1812, H.R. 5400), would assure payment for unlimited physician services, hospitalization, X-ray and laboratory tests once an annual deductible was met. State and Federal funds would pay for benefits to the poor, elderly, and disabled, although older Americans would be subject to cost-sharing similar to the current medicare program. The maximum they would be required to pay in out-of-pocket medical expenses would be set at $1,250 in deductibles and coinsurance. Other features of the program to benefit older Americans would include:

—Physicians participating in the program would have to accept the "Health Care" fee as payment in full for services rendered, thus, the 20 percent copayment under the current medicare part B would be eliminated (see section I, subsection D of this chapter, "The individual view: frustration with medicare," for a discussion of current physician participation in medicare part B program).

—The existing limit on fully-reimbursed hospital days under medicare part A would be removed to provide full coverage for hospitalization after the first day.

—Older Americans whose incomes are below 55 percent of the poverty standard would have no cost-sharing.

—The outpatient mental health benefit (now limited to $250 per year under medicare) would be raised to $1,000 per year (the current inpatient mental health benefit of 20 days per year would not be changed).

The "Health Care" plan would include system reforms to hold down the cost of medical services, such as an annual ceiling on total health expenditures, hospital cost containment, and physician fees set on a regional basis. The plan would be phased in over time. The first phase would not begin until 1983. It would not expand home health benefits

or long-term care coverage. Although the initial plan would not cover prescription drugs, the administration listed medications as a possible future expansion to the program.

The Kennedy-Waxman national health insurance proposal (S. 1720, H.R. 5191) seeks to establish the right of all Americans to quality health care and a choice of providers. The Health Care For All Americans Act would be administered jointly by a consortia of private health insurers and an independent National Health Policy Board. An annual ceiling on national health expenditures would be set, and full benefits would be phased in over time. Extensions of current medicare coverage would include:

—Unlimited hospitalization days with no copayment.
—Elimination of deductibles, copayments, and coinsurance for physician services.
—Full coverage for laboratory services, X-rays, ambulance services, and necessary medical equipment without cost-sharing.
—Coverage of prescription drugs for chronic conditions.
—Coverage for preventive health services, including immunization for the elderly against diseases to which they are particularly susceptible, such as influenza.
—Limited benefits for eyeglasses and eye exams, plus provisions for one audiological exam per year and purchase of one hearing aid every 3 years.
—Mental health outpatient coverage equal to 2 days for every inpatient psychiatric care day not used, and total yearly services by a community mental health center not to exceed the cost of a psychiatric visit times 20.

Current limits on home health services and long-term care would be retained. Medicare coverage would be expanded to all older Americans whether they are currently eligible or not, and part B participation for the elderly would be mandatory (under the current medicare program, participation in part A hospitalization insurance is dependent upon social security eligibility; participation in part B supplementary medical insurance is voluntary, with monthly premium).

The bill introduced by Senator Russell Long (S. 760) would supplement medicare with a catastrophic insurance plan. Eligibility would be extended by allowing noninsured elderly to enroll in part A of medicare by paying one-half of an actuarially-based premium. Premiums for medicare-eligibles for part B would be eliminated. Current medicare coverage for hospital and medical services would continue, but additional "catastrophic" coverage would be triggered once an individual had paid $2,000 in medical expenses and been hospitalized for 60 days. Older Americans would also have to pay $3 per visit for the first 10 visits to a physician per year.

Once the deductibles were met, mental health coverage would include inpatient hospital care, partial hospitalization, and visits to a community mental health center on an unlimited basis, plus five psychiatric visits per year. Although the current 100-day limit on skilled nursing home care would be retained, the Long bill would provide for unlimited home health benefits once the annual deductible was met. Coverage for prescription drugs would be expanded to include certain psychiatric drugs and immunizations.

A fourth major national health insurance proposal introduced in 1979 was sponsored by Senators Dole, Domenici, and Danforth (S. 748). The legislation would also amend medicare to provide catastrophic coverage to current medicare beneficiaries, who would continue to pay premiums for their insurance. Unlimited hospitalization and physician services would be provided after an annual deductible of $5,000 for certain covered services, or $1,000 in out-of-pocket expenses for coinsurance, were incurred over a 15-month period. No hospital copayment would be required after 60 days, and the current copayment for skilled nursing care after 20 days would be eliminated. In addition the annual limit on outpatient mental health benefits would be raised from the current $250 to $750, cost-sharing would be reduced from 50 percent to 20 percent for mental health services, and community mental health centers would be recognized as qualified providers. The legislation would expand home health benefits by removing the 100-visit limitation, liberalizing the definition of "homebound," eliminating the part A 3-day prior hospitalization requirement, and including occupational therapy as a primary home health service. The cost of prescribed medications could be counted toward meeting the annual deductible, and the cost of prescriptions for chronic illness would be covered once the annual deductible was met.

During the summer and fall, additional proposals were introduced to provide catastrophic coverage. The proposals focus on the concept of encouraging competition among health care providers to hold down costs by having employers offer a range of private plans to their employees. These include S. 1590 introduced by Senators Richard Schweiker, William Cohen, and others on July 26, and S. 1968 introduced on November 1 by Senators David Durenberger, John Heinz, and others.

S. 1590 would provide catastrophic coverage under medicare by replacing the current 150-day limit on inpatient hospitalization with its graduated system of copayments, unlimited hospital coverage and a uniform copayment of 20 percent once the individual's out-of-pocket expenses equalled 20 percent of his income. S. 1968 would expand coverage to workers but would make no substantive changes in medicare coverage or benefits.

2. COMMITTEE ACTION

The Senate Finance Committee met on June 18–20 to begin consideration of the basic elements to be included in a catastrophic health package. By November 7, the committee had made some basic decisions on extent of coverage for workers under employer-provided catastrophic plans, the degree of cost-sharing, and financing mechanisms. The committee also made the following decisions regarding extensions to the current medicare program:

—The total annual amount of deductibles and copayments would be limited to $1,000 under parts A and B of medicare combined. (After the beneficiary had reached this amount, the program would pay 100 percent of reasonable costs or charges for all covered services.)

—Once the annual deductibles were met, medicare would pay part of the cost of certain drugs, listed in a formulary, needed for the treatment of chronic illness.

The Senate Finance Committee tentatively plans to return to consideration of catastrophic health insurance measures in late February 1980.

Hearings were held during 1978 by the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee, which also is considering national health insurance proposals. The subcommittee plans to hold further hearings during the 1980 session of Congress. The House Ways and Means Committee held hearings jointly with the Interstate and Foreign Commerce Committee on national health insurance on November 29 and further hearings are planned for 1980.

B. Drug Regulation Reform

On September 27 the Senate passed the Drug Regulation Reform Act of 1979 (S. 1075, S. Rept. 96–321), which would make the first major changes since 1938 in the way drugs are approved, regulated and removed from the market. The National Institute on Aging estimates that 11 percent of the population over the age of 65 purchases approximately 25 percent of the prescription drugs sold in this country. Older Americans often react very differently to drugs than younger adults, due to differences in metabolism, rate of absorption and excretion, and interaction with other medications they might be taking. Thus, the provisions of S. 1075 regarding testing and approval of drugs, distribution of patient and physician information, labeling and promotional advertising, and removal of potentially dangerous drugs from the market are particularly important to the elderly.

As passed by the Senate, the legislation included the following provisions:

—*Generic drugs* that are identical in color, size, and shape to brand name products, or so similar in appearance that the consumer could not tell them apart, would have to show clearly the name or trademark of the manufacturer to be marketed.

—*Labeling and package inserts* as well as promotional materials would have to include a summary of the benefits and risks of the drug, dosage recommendations, storage and handling instructions, contraindications and side effects of the medication, and the name and address of the manufacturer and distributor.

—*A Federal drug index* of information for practitioners would be developed by contract with a private organization within 3 years, or by the Food and Drug Administration (FDA) itself, if no private entity could develop the index. The index would be a comprehensive guide on all prescription drugs, containing the same type of information required for labeling and inserts to physicians.

—*Pharmacies* would be required to see that patients received the necessary labeling and inserts on drugs purchased, as well as list the 100 most frequently prescribed drugs and the prices of the 50 most frequently sold drugs.

—*The Secretary of HEW would determine which drugs are widely used by certain segments of the population, such as children, pregnant women, or the elderly and require that all labeling, inserts, advertising, and information for the Federal drug index clearly state whether or not the drug had been tested in such segments of the population.* Because of the ethical and practical problems involved, the bill

did not go so far as to require that drugs primarily used by one segment of the population, such as the elderly, be specifically tested in that group.

—*The FDA could immediately suspend approval for any drug if it were determined that the medication poses an unreasonable risk to any segment of the population.* Special provisions were also added to get "breakthrough" drugs to the market more quickly.

—*An Office for Drug Science* would be established within HEW to conduct and support research relating to the safety and effectiveness of drugs and the development of new drugs, as well as carry out a program of ongoing drug policy research.

When the legislation was before the full Senate for debate, Senator Chiles sought to clarify how specific dosage recommendations and contraindications discovered when drugs are tested on the elderly would be disclosed in labeling and information to patients, doctors, and pharmacists. Senator Chiles expressed his concern for the need for this information to reach the consumer:

> We know that genetic factors play an important part in how any individual reacts to a drug. When you couple this with the changes in body chemistry, rate of absorption, and flow of blood to the heart and liver which come with the normal aging process, you have a very real dilemma in trying to find the right medication at the right dose for the older patient. In addition, an elderly individual often suffers from one or more chronic conditions and may be taking several drugs, prescribed by different physicians, for high blood pressure, glaucoma, etc. Individualizing the routine drug regimen, as well as choosing over-the-counter remedies or prescribing drugs to treat an acute illness, becomes an extremely complex matter for the physician and patient alike. Most drugs on the market are inadequately tested for effect on the elderly * * *. This situation leaves physicians, and their older patients alike, playing "Russian roulette" with medications.[15]

Senator Chiles also noted that the bill's provisions for review and comment by the public and interested parties would be a vehicle for getting important information on a drug's effects and optimum dosage to the elderly and their physicians. Clinical pharmacologists, geriatric specialists, and advocates for older Americans would have an opportunity to comment when the FDA develops regulations to implement the law. Information could then be obtained on which drugs should be tested on the elderly, how drug tests should be designed to determine dosages and effects on the elderly and how test information on different reactions and special dosages for older patients should be disclosed in labeling and advertising.

S. 1075 is pending before the Health Subcommittee of the House Committee on Interstate and Foreign Commerce, as are two similar House measures: H.R. 4258 introduced by Representative Henry Waxman and H.R. 2217 introduced by Representative John M. Murphy. At the close of the year, no action had been taken by the subcommittee on either the Senate-passed or House companion bills. Any legislation considered in the House during 1980, if considered at all, may be subject to the concerns of some that drug prices might be increased to reflect the additional cost to manufacturers of the proposed labeling and information requirements.

[15] Chiles, Lawton. Remarks in the Senate. Congressional Record, vol. 125, Sept. 26, 1979: S 13469.

C. Geriatric Medicine

In September 1978, the Institute of Medicine of the National Academy of Sciences issued the final report of its study, "Aging and Medical Evaluation." The study focused on "the effectiveness with which knowledge of aging is currently being incorporated in medical education." Based on its investigation, the Institute recommended:

—That medical schools' basic and clinical science courses include content on aging and problems of the elderly.

—That preparation for care of the aged be included in medical traineeships and examinations for certification and licensure.

—That nursing homes and other long-term care facilities be included in the rotations for medical students and other medical staffs.

—That teaching about aging receive increased emphasis in continuing medical education programs.

—That medical schools develop faculty to teach geriatrics and gerontology.

—That geriatrics not be developed as a formal practice specialty, but rather that gerontology and geriatrics be recognized as academic disciplines within relevant medical specialties.

—That medical schools and skilled nursing facilities jointly assume responsibility for the educational needs of nursing home medical directors.

—That funding be expanded for aging research in basic biological and behavioral sciences, clinical medicine, and health services research.

The National Institute on Aging (NIA) reaffirmed the need for increased attention to geriatric patients and the special medical needs of the elderly in its August 1979 report, "Recent Developments in Clinical and Research Geriatric Medicine: The NIA Role" (NIH 79–1990). NIA outlined five "compelling" reasons for systematic attention to geriatrics in medical school training:

—There is already a substantial body of knowledge about the aging process and symptoms of disease are often different for the elderly, frequently leading to incorrect diagnoses.

—Our population has dramatically shifted to cause the "graying of America."

—The burdens of illness—particularly the majority of disorders which develop or accumulate in later life—on individuals, their families, and society are staggering.

—The cost of health care for the elderly is remarkably high.

—Many physicians have negative, or even hostile, attitudes toward the elderly.

NIA recommended that the first 2 years of medical school include the "mainstreaming" of knowledge about aging into relevant coursework, followed by targeted, specialized lectures or whole courses on geriatrics in the next 2 years of medical school. The Institute further states:

> To develop realistic attitudes toward the old which reflect both positive and negative experiences, medical students should see older people in a range of training settings. After all, if students saw only children with irreversible conditions such as Down's syndrome, cerebral palsy, or Ewing's sar-

> coma, how many would go into pediatrics? Therefore, medical students should see older people who cope and get well, and they should see them in a family context as well as in a new type of "health promotion and disease prevention clinic for older adults" that could be created.

The Committee on Aging recognizes that there is still a long way to go toward implementing recommendations like the ones presented by the Institute of Medicine and the NIA. As stated by Dr. Robert Butler, Director of NIA, in a July 2 press release:

> We have some 330,000 practicing physicians in this country, many of whom are not equipped to meet the needs of today's 23 million old people—a situation which is likely to grow worse as the number of older people increases by almost 50 percent in the next 3 decades.

Early in 1979, Senator Quentin Burdick introduced legislation (S. 711) to provide grants to schools of medicine and osteopathy for establishing educational programs in geriatrics. The bill would authorize $3 million each year for fiscal year 1980 through 1984 for such grants. The measure is pending before the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee. Congress is expected to take up the issue when it considers comprehensive legislation to reauthorize health manpower programs, possibly during 1980.

D. Older Workers—Industrial Hazards in the Workplace

During the 1st session of the 96th Congress, the Special Committee on Aging explored the health problems of older uranium miners who had been overexposed to radiation prior to the implementation of adequate Federal controls on exposure. This section examines the committee's action in this area.

1. BACKGROUND

In the late 1940's the Atomic Energy Commission (AEC) was faced with the task of obtaining the uranium needed for defense purposes. The AEC, in the role of a buyer of uranium, encouraged exploration for uranium and its subsequent production at prices adequate to bring out the needed supplies. The Commission's regulatory authority stemmed from the Atomic Energy Act of 1954, and was limited to materials which were defined as source, byproduct and special nuclear material. The actual mining of uranium was not subject to regulation by the Commission. From the outset, the AEC proceeded on the principle that the regulation of mine safety was traditionally a responsibility of the individual States.

A Government-wide review of radiation hazards and radiation protection responsibilities conducted in 1959 by the Director of the Bureau of the Budget, the Chairman of the Atomic Energy Commission and the Secretary of the Department of Health, Education, and Welfare resulted in the establishment of the Federal Radiation Council (FRC) by Executive order of President Eisenhower on August 14, 1959. The primary function of the FRC was to advise the President with respect to radiation matters directly or indirectly

affecting health, including guidance for all Federal agencies in the formulation of radiation standards and in the establishment and execution of programs in cooperation with the States. The Federal Radiation Council completed a report of radiation risks among uranium miners in May 1967.[16]

The epidemiological data upon which the FRC, and subsequently the Joint Committee on Atomic Energy, relied in reaching their conclusions originated with the 1950 Public Health Service (PHS) study designed to delineate the carcinogenic hazards occurring in uranium miners. Periodic medical research surveys were conducted during the period 1950 through 1960 by a PHS research team. Before 1954, selected uranium miners and mill workers were examined, but no effort was made to examine all workers. During a 1954 through 1970 survey, however, an attempt was made to examine as many miners as possible.

As early as 1961, analyses demonstrated that white underground uranium miners were experiencing a significantly increased incidence of lung cancer mortality.

By 1962, from approximately 3,500 white underground miners, 12 lung cancer deaths had been observed as contrasted with only 2.8 such deaths expected. These analyses further demonstrated that factors other than radiation were not responsible for this excess of malignancies. By 1963, analyses demonstrated 22 lung cancer deaths observed as contrasted with 5.7 expected. These analyses also demonstrated an exposure response relationship between airborne radiation and the incidence of respiratory cancer.

In the early Public Health Service studies, a similar excess of lung cancer mortality was not clearly demonstrated among American Indian uranium miners who were known to use little or no tobacco. However, analyses of the lung cancer mortality rate among Indian uranium miners through 1974 has demonstrated a significant excess of lung cancer—11 observed versus 2.6 expected. This excess is independent of cigarette smoking.[17]

2. COMMITTEE HEARING

On August 30, 1979, Senator Domenici chaired a hearing in Grants, New Mexico to discuss the health problems of older uranium miners.[18] During the hearing, testimony was received from several older miners who had become afflicted with cancer and various respiratory diseases as a result of their mine work during the 1950's and 1960's when the Atomic Energy Commission was the sole procurer of uranium. Senator Domenici also received testimony from the families of the afflicted miners, local government officials, representatives from the unions and the uranium mining companies, health experts knowledgeable about the effects of overexposure to radiation, and attorneys familiar with the problems older workers encounter in their attempts to secure compensation for these occupationally-related diseases.

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[16] U.S. Congress. Joint Committee on Atomic Energy. Subcommittee on Research, Development and Radiation. Hearings on Radiation Exposure of Uranium Miners. May, June, July, and August, 1967 Washington, U.S. Government Printing Office, 1971.

[17] Testimony presented by Joseph K. Wagoner before the Senate Special Committee on Aging, Aug. 30, 1979.

[18] U.S. Congress. Senate. Special Committee on Aging. The Impact on Older Workers of Occupational Health Hazards: What is Being Done to Address the Health Needs of Older Workers, Aug. 30, 1979, Grants, New Mexico (not available at time of this printing).

3. LEGISLATION

Subsequent to the August hearing, on September 27, 1979, Senator Domenici introduced S. 1827, legislation which would establish a fully federally-financed mechanism for providing compensation and medical benefits to the early afflicted miners and survivors of miners. The Domenici bill, which is a substantially revised version of a measure he introduced during the 95th Congress, defines as eligible for benefits an afflicted miner who worked for 3 years or more in uranium mines prior to the implementation of adequate Federal standards in mid-1971. Compensable diseases include lung cancer, bronchial cancer, lymphatic cancer, pulmonary fibrosis, silicosis and other diseases which the Secretary of Health, Education, and Welfare deems are radiation or dust-induced. Underground miners, surface miners, millers and any other individual who worked in or on the premises of a uranium mine or milling facility are potentially eligible for compensation.

S. 1827 is presently pending before the Senate Labor and Human Resources Committee. Senator Domenici is actively working with the chairman and members of that committee in an attempt to secure hearings on the legislation sometime in 1980.

Senators Kennedy and Hatch also introduced legislation on behalf of fallout victims and uranium miners during the 1st session of the 96th Congress. This measure, S. 1865, proposes to strengthen the Federal Tort Claims Act by establishing legislatively the right of a private individual to sue the U.S. Government for damages incurred as a result of exposure to fallout or employment as a uranium miner.

Chapter 3

ISSUES IN LONG-TERM CARE

CHAPTER HIGHLIGHTS

Progress continued during 1979, though at a halting pace, toward an emerging definition of long-term care to include a broad spectrum of home and ambulatory care services closely linked with institutional care.

An administration report on recommendations for action in federally-financed home care services, required by Congress in 1977, was rejected by Congress, but later resubmitted by the Department of Health, Education, and Welfare (HEW) with additional recommendations.

A new demonstration initiative in community-based comprehensive long-term care programs was launched by HEW, along with an Administration on Aging initiative to establish specialized university training and research centers in long-term care.

Congressional committees approved amendments to expand medicare home health programs, and the Federal Council on Aging and the General Accounting Office produced important analyses of new directions for long-term care policy.

Initiatives begun by HEW during 1977 and 1978 to revise and improve Federal regulations governing nursing home standards of care, which had been expected to be issued during 1979, were stalled, but the rights of nursing home patients received renewed attention in Congress.

The rising cost of nursing home care was also the subject of continuing concern. Limits on Federal reimbursement were issued by HEW and further discussed by congressional committees.

Significant expansion in access to federally-financed long-term care services, both institutional and home- and community-based, has been hindered for years by fears of potential provider abuse and waste of Federal funds. Even though Congress passed significant antifraud and abuse legislation in 1977, the Special Committee on Aging has been concerned about its slow implementation. Some of these concerns were focused on during Special Committee on Aging hearings, and both HEW and Congress concentrated a new effort to fight abuse in the medicare home health program.

I. TOWARD A NATIONAL POLICY IN LONG-TERM CARE

During the past several years, advocates for older Americans have called increased attention to mushrooming needs for long-term care services. They have criticized the ability of medically-oriented Federal programs (primarily medicare and medicaid) to meet long-term

care needs without further development of noninstitutional home care and ambulatory care arrangements. Emphasis has also been placed on improving the ability of existing Federal programs to meet a wider range of needs.[1]

Much of the legislative focus in recent years has been on attempts to improve and expand the availability of home health care services through the Federal medicare program.[2] Even though congressional committees have approved amendments to modestly expand these services in both 1978 and 1979, this legislation has still not been finally approved. In 1979, Congress placed increased pressure on the Department of Health, Education, and Welfare to formulate additional policy alternatives for federally-financed home care services. A new research and demonstration initiative was launched to develop comprehensive community-based long-term care programs, utilizing the resources of a number of Federal agencies with an interest in long-term care.

The Federal Council on Aging outlined a series of "key issues" for consideration in the development of a comprehensive long-term care policy, and the General Accounting Office called for significant reform in medicaid policies toward long-term care services.

A. HEW Submits, and Resubmits, Home Health Report to Congress

As part of Public Law 95–142, passed in 1977, the Department of Health, Education, and Welfare was mandated to provide Congress with a full analysis of all issues, and recommendations for change, in home care programs funded under medicare, medicaid, and title XX of the Social Security Act. The report, which many members of Congress hoped would provide the basis for long-needed legislative reforms to increase access to home health care services, was delivered to Congress in April 1979.[3]

Disappointed with the report's failure to present broad policy alternatives and legislative recommendations, Senators Lawton Chiles, Chairman of the Special Committee on Aging, and William Cohen, Committee on Aging member and original sponsor of legislation calling for the report, expressed their frustration at a committee hearing:[4]

Senator Chiles said:

> We have been struggling for some time now to find efficient ways to make sure that our Nation's elderly will have a solid base of both institutional and home health care services they can turn to when support is needed. We still do not have our problems with nursing homes solved, but the most frequently

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[1] U.S. Congress. Senate. Special Committee on Aging. Developments in Aging: 1977, part 1, pp. 63–74. Developments in Aging: 1978, part 1, pp. 44–54, reports No. 95–771 and 96–55 for a more thorough discussion of these concerns and previous actions.

[2] Medicare's hospitalization insurance (part A) provides up to 100 visits during a benefit period of skilled nursing care in the home, as well as the services of a home health aide, physical or speech therapist, and medical social worker, as needed, for a "homebound" patient, after at least 3 days of hospitalization. Treatment must be for the same condition for which the patient was hospitalized and is available if prescribed by a physician. Medicare's supplementary medical insurance (part B) provides up to 100 visits in a calendar year of the same service, without the requirement for prior hospitalization. The part B benefit, however, is subject to the overall part B $60 deductible per calendar year.

[3] Department of Health, Education, and Welfare, "Home Health Services Under Titles XVIII, XIX, and XX." Report to the Congress pursuant to Public Law 95–142, April 1979. See Developments in Aging: 1977, pt. 1, cited in footnote 1, for a discussion of this legislation.

[4] U.S. Congress. Senate. Special Committee on Aging, "Home Health Care Services for Older Americans: Planning for the Future," May 7 and 21, 1979, Washington, D.C.

missing element is home care. The intent of our request was to enlist the expertise of the administration to help us set some directions and goals in home health care. The report which was delivered to us does not do that. We have no recommendations. We have no discussion of optional policy directions and goals. . . . We don't have any policy. We don't have any focus. We don't have any responsibility.

Senator Cohen stated:

> The best assessment that I can give this report is that it is a complete disregard for congressional intent. A simple reading of the law tells me that the report should develop methods to assure the quality of services provided, improve efficiency of program administration, curb fraud and abuse, and provide for coordination between Federal in-home service programs particularly with regard to reimbursement and provider qualifications. Outside of some action on fraud and abuse . . . I fail to see that any of these issues have been addressed.

Subsequently, Senators Cohen and Chiles and all members of the Committee on Aging introduced a resolution to return the report to the Secretary of HEW with directions to resubmit the report with further recommendations, as originally mandated.[5]

A revised version of the report was received by Congress on November 1, 1979.[6] The report noted:

> Available data suggest there may be a substantial need for in-home personal support services. Three to five percent of the total noninstitutionalized population (12 to 17 percent of the elderly) are either bedridden or require assistance in the basic functions of daily living. Yet, significantly, only about one-third of the functionally disabled receive some form of governmental assistance. Further, the elderly population, with the highest level of functional disability, will more than double between 1977 and 2035.
>
> When in-home personal support needs are met, there is considerable evidence that more costly and debilitating institutionalization can be avoided. In fact, figures indicate that assistance from family and friends is the major alternative to institutional admissions.[7]

Problems with existing programs were discussed, including:

—Overlapping program constituencies.
—Substantial differences in service definitions and the range and duration of services covered.
—Distinctions made between "health" and "social" services which reinforce fragmentation of service provision to those in need.
—Varying program regulations and reimbursement methods.
—Different Federal, State, and local relationships between programs.

The Department concluded:

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[5] S. Res. 169, passed by the Senate on July 11, 1979. A similar resolution, H. Res. 357, introduced in the House by Representatives Waxman, Rangel, and Pepper, was passed by the House on Aug. 2, 1979.

[6] Department of Health, Education, and Welfare. "Home Health and Other In-Home Services: Titles XVIII, XIX, and XX of the Social Security Act." A report to Congress, Nov. 1, 1979.

[7] The report estimates that 70 percent of the elderly disabled live with others. The proportion of aged individuals in nursing homes is 9 times greater among the unmarried than those who are married.

In the longer run, extensive and perhaps fundamental changes may well be required in the way we organize, deliver and finance care for persons with long-term disability. However, the current state of our knowledge does not yet permit us to identify with certainty those structural changes which would reconcile the sometimes conflicting objectives of individual options. It also does not permit us to recommend at this time some of the incremental benefit expansions that may alter the nature of the financing programs.

The report discussed the Department's future plans to answer "critical" policy questions,[8] and commented on a number of options for long-range broad reform:

—An expanded entitlement program, modeled on medicare.

—Establishing fixed grants to States for a single program of long-term care services.

—Use of "channeling agencies" to organize and manage long-term care delivery, predicated on the assumption that any future major expansion of in-home services is contingent upon the demonstrated ability of States and local communities to coordinate, manage, and control the utilizaton of an array of services.

The report, however, did recommend that Congress consider the following legislative changes:

—Removing the 3-day prior hospitalization requirement for home health services under part A of medicare.

—Allowing States the option of providing medicaid coverage for certain low-income aged, blind, and disabled individuals who need in-home services on a regular basis and who are not "categorically-eligible" for medicaid because their incomes exceed the cash assistance standard.

—Adding occupational therapy as one of the primary skilled service needs which may establish an individual's eligibility for home health services under medicare.

—Permitting reimbursement for physician's assistants and nurse practitioners, under the general supervision of a physician, to approve and review patient plans of care for medicare and medicaid home health care services in rural, medically-underserved, or health manpower shortage areas.

—Authorizing the Secretary to establish minimums on reimbursement of home health benefits under medicaid.

The Department also said it would consider administrative actions to:

—Conduct demonstration projects on eliminating the distinction between homemaker services and in-home services performed by home health aides in medicare.

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[8] The report defined the in-home services provided under these 3 entitlement programs as: (1) the "skilled" home health benefit available to medicare beneficiaries under medicare part A and part B; (2) the federally-required "limited" home health benefit available to low-income individuals under State medicaid home health services offered by some States at their option; (3) optional State medicaid personal care services; and (4) optional State Title XX programs of homemaker, chore, home management, personal care, home-delivered meals, and home health aide services.

Combined program expenditures for these in-home services totaled $1.1 billion in fiscal year 1977: $458 million from medicare; $179 million in Federal and State Medicaid funds; and $491 million in combined Federal, State, and local title XX funds. During fiscal year 1977, in-home services were provided to 690,000 Medicare beneficiaries and approximately 300,000 medicaid beneficiaries. About 500,000 title XX beneficiaries received in-home sercices.

—Inform States that they may not require medicaid beneficiaries to exhaust medicare home health benefits as a precondition of medicaid home health coverage where State medicaid programs cover services unavailable under medicare.
—Upgrade skills requirements for all homemaker/home health aides as a condition of participation in medicare and medicaid.
—Promote the development of quality assurance mechanisms for title XX in-home services.
—Initiate coordinated planning activities for medicare, medicaid, and title XX social services programs at the Federal, State, and local levels to provide for more efficient and cost-effective use of providers.[9]

B. New Demonstrations and Focus in HEW

Appropriations bills approved by Congress for fiscal years 1979 through 1980 contained $20.5 million for "special initiative" long-term care demonstration projects to be conducted by the Department of Health, Education, and Welfare.[10] The amount was derived from a special set-aside of $10.5 million from the Health Care Financing Administration's overall research and demonstration authority and an additional $10 million of the total $25 million appropriated for the Administration on Aging's title IV model projects program. (A special authorization for these demonstration projects was contained in Public Law 95–478, The Comprehensive Older Americans Act Amendments of 1978, which contained long-term care provisions originally introduced in the Senate by Senators Chiles, Church, Domenici, and Heinz; and by Congressmen Cohen, Pepper, and Brademas in the House.)

Concerned about the need for a coordinated focus on long-term care issues within the Department, the Senate Appropriations Committee recommended that the demonstrations be planned and carried out under the overall policy direction of the Secretary's office, specifically the Office of the Assistant Secretary for Planning and Evaluation. (See S. Rept. No. 96–247, p. 149.)

In a letter to HEW Secretary Patricia Harris (September 8, 1979) Appropriations Committee members Magnuson, Chiles, and Eagleton provided additional direction to the Department, further affirming the committee's intent that all long-term care activities be fully coordinated, and that demonstration priority be given to development and testing of new models of comprehensive community long-term care programs. The committee also suggested to the Secretary that the Department establish a long-term care policy unit, responsible for broad policy initiatives in medical and social service long-term care programs.

Secretary Harris later notified the committee that an interdepartmental steering committee had been created to coordinate and oversee the long-term care demonstration initiative. The committee is chaired

[9] A number of these recommendations were approved by congressional committees earlier in the year. A number of other legislative and administrative options, both for program expansion and improved administration, are identified in the report. Those listed here are only those given more immediacy by the Department.

[10] Public Law 96–38, which provided supplemental appropriations for programs administered by the Departments of Labor, and Health, Education, and Welfare for fiscal year 1979 and established funding for programs for fiscal year 1980, through continuing resolution, on the basis of committee-approved amounts for 1980.

by the Assistant Secretary for Planning and Evaluation, and has membership from the Health Care Financing Administration (responsible for administration of the medicare and medicaid programs), Administration on Aging (Older Americans Act programs), Public Health Service (Government-wide public health programs, including community health and mental health centers, health screening and disease prevention programs, etc.), and Office of Human Development Services/Social Services (title XX program). The primary purpose of the demonstrations would be to test the effectiveness of community "channeling" agency approaches to the organization and financing of community, in-home, and institutional long-term care services.[11]

1. DEMONSTRATIONS TO BEGIN IN 1980

A notice of intent to initiate a long-term care "channeling agency" demonstration program was published by HEW on December 21, 1979.[12] Three "key expectations" for the demonstration initiative were:

—To stimulate system level changes in the organization of the delivery system, the relationship among service providers, and in the way existing long-term care dollars are allocated.

—To create at the community level the structures that are necessary to coordinate, manage and arrange for the provision of appropriate and efficient long-term care services on behalf of the clients who need such services.

—To collect comparable information across the demonstration projects that will assist HEW in the development of a comprehensive long-term care policy including the legislative and administrative specifications required to implement policy objectives.

Each demonstration project would include a central component to screen potential clients for eligibility for service; assess service needs; develop a plan of care, or service plan; provide a mechanism to acquire or coordinate the provision of needed services for each client; monitor the quality and effectiveness of services being provided to each client; and reassess each client's need at regular intervals. A program must also provide access to a broad range of additional services, such as homemaking, chore services, and transportation.

The principal target population for the program will be functionally-impaired elderly. Approximately $18 million to $20 million will be made available during fiscal year 1980 to State or local government agencies and existing or new nonprofit agencies and organizations.

The Department expects to issue a final solicitation for proposals in March 1980, after receiving comments on the proposed outline. A second round of awards is planned in the first half of fiscal year 1981. It is expected that 20 to 25 national demonstration sites will be funded initially, with a total demonstration period of 5 years.

2. ADMINSTRATION ON AGING: LONG-TERM CARE GERONTOLOGY CENTERS

Commenting on the plans for long-term care "channeling agency" demonstrations, Commissioner on Aging Robert Benedict said:

[11] Letter, HEW Secretary Patricia Harris to Senator Lawton Chiles, Nov. 27, 1979.
[12] Federal Register, vol. 44, No. 247, Dec. 21, 1979, 75720-23.

> The task of developing a comprehensive service system [for long-term care] is, of course, no simple matter. Rather, it is one of the most massive and complex challenges any society can take on. As I see it, we are now in the midst of a crucial transition to a new and better way of ordering our human services programs generally, and in particular our health care and social services for the aging. . . . While we are on the one hand developing specific programs, on the other we need to focus on how access to these programs is gained.[13]

Parallel to the Departmentwide demonstration program, the Administration on Aging announced a program of grants to develop comprehensive long-term care gerontology centers in university settings to provide needed training, research, continuing education, and technical assistance to community long-term care service planners and providers. In the first phase of the program, planning grants (of approximately $96,000 each) were made to 22 academic institutions throughout the country. A second round of awards is planned for April 1980.

3. LONG-TERM CARE POLICY UNIT

In a letter to Senate Appropriations Committee members, HEW Secretary Patricia Harris said she believed long-term care was "emerging as one of the most critical policy areas of the next decade," and that she intended to make policy development in this area a high priority.[14]

A Departmentwide task force on long-term care policy has been formed under the direction of the Assistant Secretary for Health to develop policy goals, coordinate research and demonstration activities, and review *and initiate legislative proposals intended to alter significantly the structure of long-term care or the Federal role in providing services.*[15] (This task force is similar to the group formed to direct the special demonstration projects referenced above, with membership from the same agencies, but at a higher policy level.)

C. Other Congressional Action

Early in 1979, Senators Domenici and Bob Packwood, along with Senator Chiles and other members of the Committee on Aging introduced a bill (S. 489) to make a number of benefit changes in medicare's home health program,[16] including removal of the requirement under medicare (part A) that a patient be hospitalized for at least 3 days before becoming eligible for home health services; eliminating all restrictions on the number of home health visits allowed under both part A and part B; and adding occupational therapy as a primary service for home health eligibility. The bill also proposed a number of administrative modifications to the medicare home health program to help control wasteful program practices.

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[13] Speech by Robert Benedict, Commissioner, Administration on Aging, Department of Health, Education, and Welfare. "Policy and Program Developments in Long-term Care," Dec. 10, 1979.
[14] Letter, HEW Secretary Patricia Harris to Senator Lawton Chiles. Nov. 27, 1979.
[15] Ibid. Italic added.
[16] U.S. Congress. S. 489. Medicare Home Health Amendments of 1979. Introduced in the Senate on Feb. 26, 1979, by Senators Domenici, Packwood, Chiles, and a number of other Senators.

Hearings on home health care held by the Senate Finance Committee during May resulted in committee approval of a number of home health amendments before the end of the year. ("Medicare and Medicaid Home Health Benefits," hearings before the Subcommittee on Health of the Committee on Finance, U.S. Senate, on S. 421 and S. 489, May 21 and 22, 1979. Committee on Aging members Chiles, Domenici, and Cohen testified in favor of S. 489 and proposed additional committee action at the hearing. The Finance Committee amendments, offered in the committee by Senator Packwood, were favorably reported by the committee as part of H.R. 934 on December 10, 1979.)

The House Ways and Means Committee also completed action on home health amendments and favorably reported a bill to the House floor on November 5, 1979. (H.R. 3990, "The Medicare Amendments of 1979," H. Rept. No. 96–588.)

Both House and Senate versions would provide for unlimited home health visits under medicare part A and part B, and would repeal the current requirement for a prior 3 days of hospitalization for home health benefits under medicare part A.

Additional provisions included in the Senate bill, but not in the House bill, would change the designation of home health aide under the medicare home health program to "homemaker/home health aide," allow medicare reimbursement for home health services provided in a title XX-funded adult day care center, and allow physician's assistants and nurse practitioners to establish home health plans of care in rural areas.

Included in the House bill, but not in the Senate bill, is the elimination of the $60 deductible for home health services under medicare part B, addition of occupational therapy as a qualifying benefit for home health services, and a requirement that home health aides complete a training program approved by the Secretary of HEW.

Also included in both bills is a provision which would authorize special demonstration projects in up to 12 States for training and employing AFDC recipients as homemakers and home health aides. Projects would be eligible to receive 90 percent Federal funding under State medicaid programs for a period of up to 4 years.

Neither bill saw floor action before the end of the year, but both are expected to be considered early in 1980. Differences between the two bills will then have to be resolved in a House-Senate conference.

D. Federal Council on Aging: "Key Issues in Long-Term Care"

The Federal Council on Aging, authorized under the Older Americans Act to advise the President, the Congress, and HEW on issues affecting older Americans, identified what it called "key issues" in long-term care in its 1979 annual report.[17]

These issues are described by the Council as those upon which there is widespread agreement among policymakers and are intended, according to the Council, to serve as a basis for policy discussion at the 1981 White House Conference on Aging:

—The present fiscal orientation in the planning and delivery of long-term care services should be changed to a person-oriented

[17] Federal Council on Aging. Sixth Annual Report To The President, 1979, Jan. 15, 1979. See "Developments in Aging: 1978," part 1, pp. 46–47, for discussion of earlier work and recommendations of the Federal Council on Aging's Long-term Care Committee.

focus. Understanding the at-risk individual with a multiplicity of health and social needs is basic to any consideration of long-term care.

—Within the framework of an overall governmental obligation to at-risk persons whatever their age, individual programs which are age- or condition-related can be appropriate.

—Many at-risk individuals are functionally impaired and, as a consequence, are dependent physically on others for regular assistance in the performance of essential activities associated with normal maintenance of life. This inability to cope with the requirements of daily living, rather than a particular diagnosis, triggers involvement with long-term care. In this approach to long-term care, it becomes apparent that both mental and physical health be recognized and professional resources be involved. The overall life situation must be supported and enhanced—calling for the close coordination of the medical and social services systems.

—Family care should be the primary or first level of assistance to sustain the at-risk person. The second level of support should come from people helping each other through neighborhood and voluntary efforts. Availability of public and professional services should be based on the lack of informal supports and not only on the disability of the individual.

—A social care system parallel to the health care system is essential to the delivery of long-term care. Social care should be linked to the health care system and available to all who need long-term care.

—Voluntary agencies are essential to the delivery of long-term care and their participation should be encouraged.

—If the poor and vulnerable are to be served, then various entitlement and categorical program benefits must be coordinated around the individual at the local level. Although the pooling of funding for long-term care services in the Social Security Act programs of supplemental security income, medicare, medicaid, and social services (title XX), and title III of the Older Americans Act is a desirable goal, there is no consensus on how to accomplish it. The dilemma is to permit more flexibility at the local level and to use the medical/social entitlements more creatively, while seeking to ensure that no one is unserved.

—The evolution or development of long-term care should ensure its availability to persons of all economic levels.

—Three basic long-term care services are: an assessment which is primarily psycho-social in nature; eligibility determination; and case management which assists the individual in all areas where disability interferes with functional capacity.

—In order to coordinate responses to the multiple health and social needs of at-risk persons, a single unit should be established which has responsibility for developing a system of long-term care, overseeing its implementation, gathering data, and allocating resources. There is general consensus that local communities should have the responsibility for developing long-term care units, but there are many unanswered questions about the most desirable specific local auspice.

—Quality assurance is essential to the provision of appropriate, effective and efficient services to the at-risk elderly. Quality care

should provide the degree of care needed by the individual to remain as independent as possible, and should conform to minimum standards of care.

The Council plans to develop recommendations for financing long-term care during the coming year.

E. GAO Cites Medicaid Contradictions and High Costs

The General Accounting Office (GAO) has made a number of contributions to the debate on long-term care policy in recent years. In its most recent report, GAO cites a number of policy anomalies within the Federal/State medicaid program which contribute to excessively high medicaid costs while denying appropriate services to many older Americans and others in need of long-term care.[18]

Many elderly, who represent 86 percent of the nursing home population, neither need nor prefer nursing home care, and admission to a nursing home is regarded as avoidable for those residents who could have remained in the community if the necessary long-term care services had been available. (It is difficult to arrive at any consensus of the degree of "overinstitutionalization" of older Americans and other chronically disabled individuals, because there has been no agreement on what constitutes overinstitutionalization, and no attempt has been made to arrive at national estimates. Various focused studies, however, indicate that the range is between 15 and 40 percent of all older nursing home and hospital residents.)

Inappropriate medicaid policies which stress nursing home placement are reflected in program expenditures: Nursing home care accounted for $7.6 billion (or 41 percent) of the total 1978 Federal and State medicaid expenditures of $18.6 billion. Less than 1 percent of medicaid expenditures were for home health care services ($179 million in 1977).

GAO reported that medicaid eligibility policies and assessment procedures, as well as barriers encountered by older Americans and their families as they attempt to find and use community services, create incentives to use nursing homes rather than community services.

In summary:

—Medicaid and other public financing programs for long-term care provide little or no coverage for community services while medicaid offers full or partial coverage for institutional care. Medicaid-eligible elderly who cannot obtain community services because of restrictive State benefit packages receive full long-term care coverage under medicaid if they enter a nursing home. Low-income elderly who are not eligible for medicaid in the community but cannot afford to purchase appropriate long-term care services may become eligible for medicaid if they enter a nursing home, because many States have a different income standard for nursing home residents. They may also transfer their assets to relatives and become eligible for nursing home care only, or enter a nursing home and become eligible for medicaid after their assets have been depleted.

[18] U.S. General Accounting Office. Entering a Nursing Home—Costly Implications for Medicaid and the Elderly; Report to the Congress by the Comptroller General of the United States. [Washington, D.C., 1979], (PAD-80-12, Nov. 26, 1979). Earlier reports on long term care issues issued by the GAO include: Conditions of Older People: National Information System Needed. GAO report No. HRD-79-95, Sept. 20, 1979; Home Health—The Need For a National Policy to Better Provide for the Elderly. GAO report No. HRD-78-19, Dec. 30, 1977; and "The Well-Being of Older People In Cleveland, Ohio." GAO report No. HRD-77-70. Apr. 19, 1977.

—The same is true for the family and friends of at-risk elderly, who are frequently the caretakers of older individuals in the community. Often, the only way they can receive relief from the financial and psychological strain of caring for older members is by placement in a nursing home, since little or no assistance is available for community care. (Home health care, home-delivered social support services, adult day care, and other services such as nursing home "respite care" are often cited as effective ways to provide needed support to family members and other community "caretakers." Education and training for certain caretaker skills and services aimed at lessening psychological strains are also indicated.)

—This lack of essential community services is further hampered by a lack of information about community options that may be available and how they can be accessed. This not only is confusing for those in need of long-term care services, but also contributes to the tendency of professionals to recommend nursing home care because they do not have the expertise and time to arrange for alternatives.

—Medicaid policies for review of nursing home placement are not adequate to prevent unavoidable nursing home admissions because they usually take place after admission, when it is difficult to discharge a patient. Preadmission reviews focus primarily on medical conditions, without providing information about other conditions (such as living arrangements, availability of community support, etc.) which might suggest alternative long-term care services.

GAO concluded that as long as medicaid's nursing home coverage is the only readily available source of financial assistance for long-term care, many chronically impaired elderly will be placed in nursing homes even though this is a more intensive care level than is needed. Medicaid cannot adequately control avoidable nursing home utilization because of inadequate assessment mechanisms and lack of authority to screen all applicants for admission.

At the same time, State and local efforts to reduce medicaid support for avoidable institutionalization are impeded by the fragmentation and gaps in Federal long-term care funding and the current structure of the medicaid program.

GAO recommended that Congress establish a preadmission screening program before nursing home placement for all applicants, to: Make a comprehensive needs assessment; help obtain community services, coordinate and monitor the community care provided; make payment for community long-term care services; and act to control costs and utilization. A series of communitywide demonstrations could first be implemented, however because complete costs for such a program cannot now be determined. According to the General Accounting Office, not enough information is now available to accurately predict the number of older persons and other chronically disabled persons who would participate or the duration of their participation.

Representatives Claude Pepper and Henry Waxman introduced H.R. 6194 in the House of Representatives on December 19, 1979, which would (1) require comprehensive assessments under medicaid prior to nursing home admission, and (2) increase the Federal matching amount for certain medicaid community-based long-term care services.

II. NURSING HOME ISSUES

Issues of nursing home cost and quality of care both received attention during the year. House hearings focused on the quality of care in nursing homes and criticized the lax enforcement of existing Federal standards for care. Initiatives by the Department of Health, Education, and Welfare to strengthen Federal regulations governing the quality of care in nursing homes, begun during 1978, were expected early in 1979 but have not yet been issued. Some members of Congress showed renewed interest in legislation to establish certain basic rights for nursing home patients.

Regulations were implemented to help control the rising public costs of nursing home care, but some concerns have been raised about their effect on the availability of nursing home beds.

A. House Hearings Criticize Nursing Home Standards

Witnesses at a hearing before the House Select Committee on Aging charged that standards of care in federally-financed nursing homes were still not adequate to protect the basic dignity of nursing home residents, and that existing standards were not being adequately enforced.[19]

Advocates for nursing home patients described continuing instances of indiscriminate drug therapy, inadequate food, severely limited nursing care and physician attention, little or no supportive social or mental health services, and inadequate rehabilitative therapy. Advocates said that nursing home patients were still being denied basic rights, including refusals to allow them visitors, manipulation of patient's personal funds, and discriminate and hasty transfers from one nursing home to another without sufficient notice or preparation.

State enforcement of existing standards of care for nursing home patients was criticized for inadequate and unqualified staff and a lack of authority to ensure correction of deficiencies. Significant problems in deterring fraud and abuse of medicaid funds in some publicly-funded nursing homes was also cited.

At the end of the hearings, committee Chairman Claude Pepper summarized some of the underlying issues presented by witnesses: Criteria for Federal standards not defined clearly enough; inadequate compensation for good patient care in some nursing homes; and lack of adequate supervision and inspection by State and Federal governments.

B. New Nursing Home Regulations Still in Drafting Process

In 1978, the Federal Health Case Financing Administration began a review of Federal requirements for nursing homes participating in medicare and medicaid. The initiative was characterized as an attempt to shift the focus of standards and compliance activities from the physical characteristics of nursing homes to the quality of care actually given to residents.[20]

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[19] U.S. Congress. House of Representatives. Subcommittee on Health and Long Term Care, Select Committee on Aging, Oct. 17, 1979. "Special Problems in Long-term Care." See also a series of reports, U.S. Congress. Senate. Special Committee on Aging. Nursing Home Care in the United States: Failure in Public Policy, 1974-77.

[20] U.S. Congress. Senate. Special Committee on Aging. "Developments in Aging: 1978," pt. 1, pp. 76-87, for a discussion of this development and other nursing home issues.

Proposed revisions in medicare and medicaid conditions of participation for nursing homes were initially expected in early 1979, but are not now expected until sometime in 1980. New regulations are expected to further define protections for nursing home patient rights, to require comprehensive assessment of nursing home patients before admission to a medicare or medicaid facility, and to make some modifications in nursing home staffing requirements.

Nursing home patient advocates have commented favorably on HEW's efforts to strengthen patients' rights and require comprehensive patient assessment upon entry to a nursing home. Concern, however, has been voiced that the new rules may actually represent a weakening of existing requirements for staff levels and training and overall enforcement authority.

1. NURSING HOME FIRE SAFETY

HEW issued a notice of intent to consider new regulations on automatic fire extinguisher systems for nursing homes in late 1978, asking for public comment on a number of alternatives for expanding automatic sprinkler systems to more medicare and medicaid nursing homes.[21] Regulations have not yet been issued, although proposed rules requiring installation of systems in all new nursing homes are expected in early 1980.

2. PATIENT FUND PROTECTIONS

A third area under consideration by HEW is the expansion of standards for protection of personal funds of nursing home patients. In September 1978, the Health Care Financing Administration proposed new rules to implement provisions of Public Law 95–142 and Public Law 95–292 which required all nursing homes participating in medicare or medicaid to establish accounting systems for patient's personal funds, prohibited comingling of patient funds with nursing home funds, and required HEW to define the costs which may be charged to the personal funds of patients.[22]

As proposed, the rules would require a nursing home to provide patients with an explanation of rights and a list of services included in the basic daily nursing home rate. All funds in excess of $50 would have to be deposited in an interest-bearing account, and the nursing home would be required to keep a written record of all transactions from the patient account. Final regulations are expected early in 1980.

C. Congress to Look at Patient's Rights?

Members of both the House and the Senate have introduced a "Long-Term Care Resident's Rights Act" which would establish an extensive list of basic rights for all nursing home patients, and provide an enforcement mechanism through a private right of action in the courts.[23]

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[21] Federal Register. Vol. 43, No. 235. Dec. 6, 1978: 57166–67.

[22] Federal Register. Vol. 43, No. 171. Sept. 1, 1978, pp. 39154–56. Public Law 95–142, Medicare-Medicaid Anti-Fraud and Abuse Amendments, passed in 1977. Public Law 95–292, End Stage Renal Disease Programs Amendments, passed in 1978.

[23] S. 1546. Introduced in the Senate by Senators Cohen, Williams, and Javits on July 20, 1979; and H.R. 5609, introduced in the House by Representative Waxman on Oct. 16, 1979.

About 20 States have taken action to enact some form of patients rights or "quality of care" legislation. Analyses of these trends are available from the National Citizens' Coalition for Nursing Home Reform, Washington, D.C.

The rights would apply to patients in all nursing homes receiving Federal assistance, in contrast to existing Federal standards which apply only to nursing homes certified to participate in medicare and medicaid. The bill also significantly differs from existing law in its enforcement mechanism, which would give individual patients access to the courts. Currently, the only enforcement of patient rights is through Federal and State decertification of nursing homes from participation in medicare or medicaid and Federal withdrawal of funds from States.

In other related legislative action, bills to allow the Federal Government to sue to protect the rights of "persons confined in State institutions" was passed by the House and approved by the Senate Judiciary Committee.[24] Both bills would allow the U.S. Attorney General to file suit in Federal court to protect the rights of persons confined in State prisons, mental institutions, juvenile facilities, and nursing homes if the Attorney General found a pattern and practice of deprivation of rights.

The bills, however, exempt privately-owned and operated institutions without a substantial relationship with the State. As currently drafted, they would affect only about 10 percent of the Nation's nursing homes (primarily those operated directly by county and State governments). These bills, which may receive further action during 1980, do not mandate any additional rights for nursing home patients.

D. Steadily Increasing Costs

The fastest-growing category of all health care spending in the Nation is nursing home care. During 1978, a total of $15.8 billion was spent on care provided in skilled nursing facilities, intermediate care facilities, and personal care homes. The rate of increase, averaging 16 percent per year since 1970, is expected to continue to increase because of the growing older population and continued increases in the costs of wages, food, and fuel, which constitute the bulk of nursing home costs.

Over half (53 percent) of all nursing home care is financed by Federal, State, and local public sources with the bulk of this amount (46 percent of all national expenditures on nursing home care) coming from medicaid.

Total public expenditures during fiscal year 1978 were $8.4 billion: $7.25 billion from combined Federal and State medicaid payments; $396 million from Federal medicare payments; and about $716 million from other Federal, State, and local public sources such as the Veterans' Administration and State public assistance programs for individuals not eligible for medicaid.[25]

Most of the remaining bill for nursing home care ($7.2 billion, about 46 percent) is paid for directly by nursing home residents, or their families, from private resources.

Many individuals are admitted to nursing homes as private-pay patients, but later have their care financed through public sources as their own resources are used within a short period of time. For example, the average monthly charge for nursing home care during 1977 was

[24] H.R. 10. Passed by the House on May 23, 1979. S. 10. Approved by Senate Judiciary Committee on Nov. 2, 1979; S. Rept. No. 96-416.

[25] Health Care Financing Administration, Department of Health, Education, and Welfare. National Health Expenditures, 1978, "Health Care Financing Review," summer 1979

$689, but 25 percent of all residents were charged from $800 to $1,000 a month. The median stay for all nursing home residents, according to a 1977 national survey of nursing home residents, is 20 months. Although estimates vary, about one-third of all nursing home residents may have entered a nursing home as private pay patients and received medicaid eligibility within 1 year or less.[26]

There are also increasing concerns about the excess cost to public programs related to forced payments for unneeded, higher levels of care (such as acute care hospital beds) when lower-cost nursing home beds are not available. The General Accounting Office reported during the year that about $73 million in Ohio and about $216 million in New York is being spent on hospital services for patients who could be served by nursing homes but remain in more costly hospital beds because nursing home beds are not available.[27]

E. Implementation of Nursing Home Cost Limits

Concern over the rising cost of health care, and the effect on public financing programs in particular, led to congressional approval of legislation to give the Secretary of the Department of Health, Education, and Welfare authority to set upper limits on the reimbursable costs of health care providers participating in medicare and medicaid—including nursing homes, home health agencies, and hospitals. The authority was first implemented for hospitals, and final regulations were issued during 1979 by HEW to set limits for both nursing homes and home health agencies.[28]

Late in the year, as the nursing home cost limits were being implemented, reports began surfacing from some States that some nursing homes would have to discontinue participation in the medicare and medicaid programs, electing to serve private-pay patients only. Some public homes, such as county-operated facilities serving primarily medicare and medicaid patients—which are often affected by higher, negotiated wage rates for staff than some other homes—would have to close or change ownership. Bankruptcy proceedings were threatened in some public and private nonprofit homes, primarily in States which have set relatively high medicaid nursing home rates. New York State, for instance, anticipated that over 110 public and private nonprofit nursing homes would face losses averaging $20 per day per patient. At the end of the year, court action to delay implementation of the limits in the State was in process. Reports have also been received from Wisconsin that public, county-operated, nursing homes are threatened by the new limitations.

It is too early to gage the total effect of the implementation of these cost limits, but the Senate Special Committee on Aging will follow progress during the coming year.

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[26] U.S. General Accounting Office. Entering A Nursing Home—Costly Implications for Medicaid and the Elderly; Report to the Congress by the Comptroller General of the United States. GAO Report No. PAD-80-12. Nov. 26, 1979. Department of Health, Education, and Welfare; National Center for Health Statistics. July 1979, DHEW Pub. No. (PHS) 79-1794.

[27] U.S. General Accounting Office. Health Costs Can Be Reduced By Millions of Dollars If Federal Agencies Fully Carry Out GAO Recommendations. Report of the Congress by the Comptroller General of the United States. GAO Report No. HRD-80-6. Nov. 13, 1979.

[28] Authorized by section 223 of the 1972 Amendments to the Social Security Act, Public Law 92-603. In Aug. 1979, HEW published a schedule of limits on nursing home routine service costs, Federal Register, vol. 44, No. 171. Aug. 31, 1979. 51542. The limits were to be effective in Oct. 1979. (Proposed limits were originally published, for public comment, on May 18, 1979. 44 CFR 29326.)

III. ABUSE AND WASTE IN FEDERAL PROGRAMS SERVING THE ELDERLY

The Committee on Aging has long been concerned about actual and potential fraud, abuse, and waste in major Federal programs, because they so significantly affect many important services intended to improve the lives of all older Americans. (For instance, committee members have conducted over 10 hearings on medicare and medicaid and title XX fraud and abuse since 1975 and have sponsored and supported legislative efforts to curb program abuses, primarily through the "Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977," Public Law 95–142.)

The rising costs of health care, including that portion which can be attributed to program abuse and inadequate administrative control of program expenditures, ultimately penalizes the beneficiaries of the programs themselves.

Federal concern and attention to these problems continued in 1979. A Justice Department report warned about the extent of fraud and abuse in Federal programs and concluded that Federal efforts to control them were "weak and reactive," at best. Hearings by the Committee on Aging focused on efforts to curb abuse in the medicare home health program, and both Congress and the administration took new initiatives during the year to prevent wasteful program practices.

A. Justice Department Report

A Justice Department report, detailing the "state-of-the-art" in Federal program controls against abuse, concluded that enforcement "has suffered from an ad hoc and reactive posture." The Department cited a number of weaknesses, including general lack of definition for and quality of data on fraud and abuse, legislative priorities for enforcement, alternatives to criminal justice enforcement, and overall enforcement planning and incentives for enforcement.[29]

The prognosis was not good:

> The meager evidence currently available supports the finding that fraud and abuse extends into all types of benefit programs and is committed by a large cast of actors whether singly or in collusion. Truly staggering is the fact that if current trends are extrapolated, losses to fraud and abuse in the 15 programs reviewed in this study could amount to between $80 and $100 billion over the next 10 years. With such an outlook for the future, Federal, State, and local governments can no longer turn their backs on the problems of enforcement.

B. A Focus on Home Health

Hearings and reports by the Committee on Aging and others[30] have documented significant abuse of medicare's home health program.

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[29] Department of Justice. Law Enforcement Assistance Administration. National Institute of Law Enforcement and Criminal Justice, "Fraud and Abuse in Government Benefit Programs." Nov. 1979. Medicare and medicaid were included in the study; title XX programs were not.

[30] U.S. Congress. Senate. Special Committee on Aging, Subcommittee on Long Term Care. "Medicare and Medicaid Frauds, and Proprietary Home Health Care. 1975–79;" Committee on Government Operations. Subcommittee on Federal Spending Practices, Efficiency, and Open Government. 1975–76 hearings and report; U.S. House of Representatives. Committee on Ways and Means. Subcommittee on Oversight. 1978 hearings.

A number of controls on medicare abuse were enacted by Congress in 1977, but implementation has been slow. The General Accounting Office concluded during the year that excessive home health reimbursement and program abuse was continuing.[31]

Voicing concern over the GAO findings, Senator Chiles called a hearing to question administration officials on progress being made to curb home health fraud and abuse.[32] Chiles outlined his concerns for home health programs:

> This hearing is one I really wish we didn't have to hold. More than 3 years ago I held a hearing right here on the same subject—the efficiency of the medicare program in disbursing funds to home health agencies. I said then that I fully supported the concept of home health care—that I believed care in the home was a valuable and needed service. I am even more convinced of that today. I also said then that I couldn't understand how the Congress could continue to encourage the development of home health programs while there were so many inefficiencies in the program and so many examples of outright abuse of the taxpayer's dollar. . . . I am not able to come back and tell you that everything is working all right and that we can now take the next steps and expand this kind of care to more of those in need. Instead we are here to find out why, 11 years after the beginning of this program, we are still hearing about the same problems.

HEW's Deputy Inspector General, Richard Lowe, told the committee he agreed not all that could be done to address medicare home health problems and correct system defects had been acted upon. He said:

> We have tried to patch holes in the regulations that are often loosely constructed and afford insufficient guidance for effective monitoring. What has actually been created is a vehicle within which fraud and abuse can flourish. The result is a prosecutor's nightmare and an intermediary's frustration.

1. HEW INITIATIVES

Witnesses confirmed that abuses found in the past, such as promotion fees, startup costs, personal expenses and duplicate bills charged to the medicare program continue to exist, and outlined a "major investigative and audit initiative" for home health agencies.

Investigations of 140 home health agencies are either under active investigation and consideration for prosecution by the Inspector General, have been referred to the Attorney General for prosecution, or are under active full-scale investigation by the Health Care Financing Administration. In a parallel thrust, audits will evaluate the ability of current reimbursement procedures and guidelines to ensure proper payments. Special audit consideration will be given to agency salaries and fringe benefits, startup and consultant costs, fees for administrative and management services, and "double charging" of costs to the medicare program. Reviews made by the Health Care Financing

[31] U.S. General Accounting Office. Home Health Care Services—Tighter Fiscal Controls Needed. Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. Report of the Congress by the Comptroller General of the United States. Washington 1979 (HRD-79-17, May 15, 1979).

[32] U.S. Congress. Senate. Special Committee on Aging. Abuse of the Medicare Home Health Program Miami, Fla. Aug. 28, 1979.

Administration will focus on detailed audits of home health agency cost reports and high rates of utilization of home health services in some agencies.

Other steps taken during the year, or anticipated during 1980, are:

—Publication of limits on medicare reimbursement for home health visits, which HEW estimated would save $20 million during 1980.

—Development of a new cost reporting system for home health agency costs.

—Additional intermediary guidelines for determining allowable costs for medicare home health agencies in the areas of management consultant services, patient solicitation, administrative salaries, and transportation costs.

The Department also reported plans to assign regional or areawide fiscal intermediaries in an attempt to deter home health abuse.[33]

2. CONGRESSIONAL ACTIONS

A number of provisions to strengthen safeguards against medicare home health abuse received favorable action by congressional committees during 1979, and it is likely that a number of these proposals will be approved by the Congress during 1980.[34]

Amendments being considered would:

—Require the Department of Health, Education, and Welfare to place cost limitations on medicare reimbursement for specific home health agency line-item administrative costs, rather than overall per visit costs, as now proposed.

—Establish regional intermediaries for home health agencies to improve program management.

—Bar physicians with significant ownership or financial relations with a home health agency from certifying service need and from establishing plans of care for patients served by that agency.

—Authorize the Secretary to establish bonding and escrow requirements for home health agencies participating solely in the medicare program in order to assure their ability to repay overpayments.

—Prohibit medicare reimbursement for home health agency contract services costs when a contract term exceeds 5 years or is based on a percentage of a home health agency's reimbursement from medicare.

C. State Medicaid Fraud Units

Section 17 of Public Law 95–142 authorizes 90 percent Federal matching funds for a period of 3 years (fiscal years 1978 through 1980) for the costs of establishing and operating special State medicaid fraud

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[33] Federal Register. Final notice, Vol. 44, No. 107. June 1, 1979. Effective July 1, 1979. Cost limits authorized by Section 223 of 1972 Social Security Amendments, Public Law 92-603. Limits were differentiated by metropolitan/non-metropolitan areas.

A new cost reporting system (USHHAR—Uniform System for Home Health Agency Reporting) is undergoing extensive testing and revision. Expected to be issued during 1980.

Patient solicitation: HCFA issued intermediary letters nos. 79-20 and 79-22 in May, 1979 clarifying distinctions between allowable costs for "advertising" and "solicitation." Fringe benefits: intermediary letter 79-14, issued Apr. 1979, sought to clarify allowable reimbursement for some fringe benefits. Related organizations: a proposed rule to expand definitions of allowable reimbursement of "costs to related organizations" was published in the Federal Register, vol. 44, No. 19, on Jan. 26, 1979.

HEW's intent to assign regional intermediaries was contained in its report to Congress on home care services, report cited in footnote 6.

[34] Proposals have been favorably reported as part of H.R. 934 and/or 3990, cited in footnote 39. Many of them were included in S. 489, the "Medicare Home Health Amendments of 1979," introduced in the Senate by Senators Domenici, Packwood, Chiles, and others on Feb. 28, 1979.

control units. By the end of 1979, the second year of the program, 27 States had established a unit. The HEW Inspector General reported to Congress that the proficiency of the units was increasing, with significant impact on medicaid fraud. Approximately 2,400 cases were under investigation, 160 indictments or charges of multiple offenses had been obtained, and 125 convictions had occurred. The Inspector General estimated that the total potential monetary recoveries of the existing units would be about $14 million in 1 year (or about 70 percent of unit operating costs), even though a typical unit was less than 1 year old.

In addition to the recovery of public funds through investigation and prosecution, a number of established fraud units have recommended improved program procedures to State legislatures and medicaid agencies. Adopted recommendations have resulted in additional cost savings and improved patient care in nursing homes, including changes in nursing home operating procedures and prosecution of some nursing home personnel for violations of patients' rights.[35]

The Inspector General noted, however, that unless the period of Federal funding at 90 percent was extended, establishment of additional State units was doubtful and continuation of existing units was questionable.

Slow response by some States, and certification delays for others, had resulted in only 19 certified State units by the end of 1978. Senator Frank Church, then Chairman of the Committee on Aging, introduced legislation to extend the period of 90-percent Federal funding for start-up of State units until October 1, 1982, to ensure that States making a good faith effort toward certification would have a full 3 years of funding, as intended by Congress.

The Church amendment was approved by the Senate late in 1978, but action was not taken by the House. The amendment was approved the second time by the Senate Finance Committee during 1979, but had not received final action by the end of the year. It is expected to be acted upon early in 1980.[36]

D. Additional Actions

1. REGULATIONS ON INFORMATION DISCLOSURE

Final regulations for disclosure of information by medicare and medicaid providers were issued by the Department of Health, Education, and Welfare in July 1979, effective immediately for medicare providers and effective in October 1979 for medicaid providers.[37]

New procedures are required:

—For disclosure of certain information about owners, employees, subcontractors, and suppliers as a condition of participation in medicare, medicaid, title XX, and some other federally-funded health programs.

—For termination of new or renewal agreements with providers if any of its owners, officers, directors, agents, or managing em-

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[35] U.S. Department of Health, Education, and Welfare, "Quarterly Report of the Inspector General," July-September 1979. Nov. 30, 1979.

[36] U.S. Congress. Senate. Special Committee on Aging. "Developments in Aging: 1978," Part 1. Page 70-72, for a discussion of these problems, reviewed at a hearing of the Special Committee on Aging, "Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units," July 25, 1978. The amendment was favorably reported to the Senate floor as Section 260 of H.R. 934 on December 10, 1979.

[37] Federal Register, vol. 44, No. 138. July 17, 1979. The regulations implemented sections 3, 8, 9, and 15 of Public Law 95-142.

ployees are convicted of a criminal offense against medicare, medicaid, or title XX programs, or if any provider fails to fully disclose the identity of such officers.

—For notification to the Secretary of a medicare provider's employment of anyone who worked for that provider's intermediary during the previous year.

—For providing the Secretary with access to medicaid provider records.

Nursing homes and home health agencies, as well as other providers, would be affected by the new requirements.

2. PROPOSED LEGISLATION FOR CIVIL PENALTIES

Legislation proposed by the administration to authorize the Secretary of the Department of Health, Education, and Welfare to impose a civil monetary penalty of up to $2,000 for a fraudulent claim for reimbursement under medicare and medicaid was favorably acted upon by the House Ways and Means Committee during the year. A similar bill was introduced in the Senate by Senators Chiles, Melcher, and Pryor, but had not been considered by the end of the year.[38]

3. MEDICAID MANAGEMENT INFORMATION SYSTEMS

The Senate approved a bill introduced by Senator Richard Schweiker to encourage States to install medicaid managment information systems, require HEW to provide technical assistance to States in system operation, and require that information on medicaid and medicare providers terminated or suspended from program participation be exchanged between medicare and medicaid administrators. The provision had not emerged from a House-Senate conference by the end of the year.[39]

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[38] Section 16 of H.R. 4000, favorably reported by the House Ways and Means Committee on Nov. 5, 1979. S. 1662, introduced on August 2, 1979.

[39] As an amendment to H.R. 3434, "The Adoption Assistance and Child Welfare Act of 1979," approved by the Senate on Oct. 29, 1979.

Chapter 4

ENERGY ASSISTANCE PROGRAMS

CHAPTER HIGHLIGHTS

On April 5, 1979, the President announced, as part of his energy policy, the gradual decontrol of domestic oil prices to encourage conservation and stimulate development of domestic oil and other energy resources.

In June and December of 1979 the Organization of Petroleum Exporting Countries (OPEC) announced substantial increases in the price of oil. In November 1979, oil imports from Iran were ordered to be discontinued by the President in response to the Iranian students' takeover of the American Embassy in Tehran and the holding of the embassy staff as hostages.

Even before the major impact of these unprecedented price hikes would affect American's energy bills, the Bureau of Labor Statistics (BLS) estimated that between 1972 and 1979 the average American household had experienced: A 293 percent increase in fuel prices, a 155 percent increase in the price of natural gas and a 75 percent increase in electricity costs. The total effect of these price increases meant that the average American household spent 25 percent of its incomes on energy last year and would be paying approximately 50 percent during 1980.

Americans were not only paying higher prices for fuel oil and gasoline as a result of decontrol and OPEC price hikes, but were also paying higher prices for plastics, prescription drugs and other products that are derived from petroleum.

According to a November 27 HEW factsheet, between 1978 and 1981, the poor will spend a total of $10 billion more for energy than they would have in the absence of decontrol and the OPEC increase. Of this amount, about one-fifth will be caused by decontrol while the OPEC increase will be responsible for most of the rest.

Elderly households suffered—and will suffer—even more. Estimates by Department of Energy show that they spent an average of 30 percent of their incomes on energy bills last year, projections for 1980 surpass 50 percent.

Even though some of the retirement and pension programs on which the elderly depend for income—including social security—are indexed to the Consumer Price Index (CPI), the adjustments will not come close to matching the increases in energy costs. For example, during the past 5 years, social security benefits increased 42.7 percent and supplement security income (SSI) benefits increased 24 percent. These increases did not begin to compare with energy price hikes, let alone with increases in the cost of food, medical care, shelter, and other expenses which most elderly people must meet with limited incomes.

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According to the Fuel Oil and Marketing Advisory Committee (FOMAC) of the Department of Energy, approximately 16.2 million households suffered a loss of $4 billion in purchasing power in 1978 alone, due primarily to escalating fuel prices. According to FOMAC, over 7 million of these households are headed by an elderly person.

Congress responded to these unprecedented price increases by significantly expanding and amending in 1979 the existing energy assistance and weatherization programs. These programs, thought by many to be subordinate in the past, were now considered essential assistance for the low-income and elderly.

Congress also realized that, for at least several years, low-income households would be in need of assistance to meet rising energy costs and for assistance to conserve energy by weatherizing and insulating their homes. Hence, the programs discussed in this chapter are the beginning of a major new component of the existing network of Federal, State, and local social services and energy programs.

I. CONGRESSIONAL RESPONSE

A. Special Committee on Aging Actions

On August 2, 1979, responding to grave concern by constituents about energy prices for 1980 and the future, the Senate Special Committee on Aging agreed to a committee resolution proposed by Senator Charles H. Percy, which stated:

> In the development of a national energy plan, the President and the Congress shall assure that an adequate program of assistance to meet the particular needs of elderly persons is enacted.

The committee defended the special needs of the elderly by describing the high impact of cost increases on elderly persons' incomes compounded by the fact that many elderly reside in substandard housing which is poorly insulated and costly to heat and cool.

On August 30 and September 13, 1979 the Senate Special Committee on Aging held hearings on "Energy Assistance for the Elderly" in Akron, Ohio, and Washington, D.C., to explore the various methods of providing energy assistance for low-income elderly households. Senator John Glenn, who presided at the earlier hearing in Ohio, and Senator Lawton Chiles, who chaired the hearing in Washington, D.C., pointed out that the Special Committee on Aging has, over the past 5 years, documented the fact that elderly people are financially and physically affected by rising energy costs to a greater degree than other age groups. ("Impact of Rising Energy Costs on Older Americans," parts 1–7, hearings of the U.S. Senate Special Committee on Aging.)

In Ohio, Senator Glenn pointed out that the Special Committee on Aging had learned from the National Institute on Aging and other medical experts that "elderly persons are far more susceptible to temperature-related health problems such as hypothermia and heat prostration. Often, their good health depends on adequate heat and air conditioning."

In Washington, D.C., Senator Chiles pointed out that during 1978, "There were numerous elderly persons who actually froze to death,

and in Dallas alone, 20 elderly persons died from heat prostration due to lack of air conditioning."

In Washington, Senator Percy commented:

> The energy crisis has rendered a severe blow to the poor and the elderly on fixed incomes—the very people who are least able to resist this attack. We have been told that low-income persons spend an average of 25 percent of their income on household energy costs—the average household spends 5 percent. In many cases, the low-income and elderly have already cut back on their use of energy to the point where it is questionable whether they are living in a healthy environment.

Senator Pete Domenici, a member of both the Special Committee on Aging and the Energy and Natural Resources Committee, pointed out that "social security benefits had risen 30 percent between 1973 and 1976 but, during that same period, the cost of electricity rose 42 percent, natural gas 58 percent and fuel oil 83 percent." He went on to stress the importance of Aging Committee members working with committees that have authority on energy legislation to assure that meaningful and responsible solutions to energy related problems are reached.

The administration, represented by Deputy Assistant Secretary for Planning and Evaluation of HEW, John Palmer, stated:

> The President shares the committee's concern that the elderly receive adequate energy assistance, and the low-income energy assistance program reflects our commitment to this goal.

Mr. Palmer added that the President's proposal originally called for an authorization of $800 million for fiscal year 1980. After the OPEC price increases, however, Mr. Palmer noted that the President increased the amount requested for energy assistance in the administration's plan from $800 million to $1.6 billion. HEW Secretary Patricia Roberts Harris, at a later hearing of the Senate Labor and Human Resources Committee, explained:

> We are sending forward this additional supplemental request because time is short, and it is imperative that both the Congress and the Executive branch move quickly to ensure that resources are made available to help poor people this winter. Whatever else we may do, we cannot delay the onset of winter, we cannot bring back low-cost energy. Therefore, we must make certain that poor people do not suffer from the effect of higher energy prices.

Representative Dennis Eckart, a member of the Ohio State Legislature, defended the need for prompt enactment of a program for 1980 at the committee's hearing in Akron:

> Many consumers now have both the incentive and the means to manage their energy uses and make decisions that can cut energy costs. But the fixed income, the elderly and the disabled, will continue to need assistance not only to offset the high prices of energy, but also to use energy more efficiently. A program to address this major omission in our Nation's energy policy must include both the Federal resources and the best the States have to offer.

B. 1980 Energy Assistance Program

Responding to the urgent need for energy assistance during the winter of 1980, Senator Jacob Javits proposed an amendment on the Senate floor to the 1980 Interior Appropriations bill (H.R. 4930). In addition to the previously appropriated $250 million for energy crisis intervention administered by the Community Services Administration, Senator Javits' amendment made an additional $1.35 billion available for energy assistance purposes—for a total of $1.6 billion in fiscal year 1980. This measure was signed into law on November 27, 1979 (Public Law 96–126).

The 1980 program will be substantially implemented under previously issued CSA regulations (45 CFR, part 1061, vol. 44, No. 198, October 11, 1979 and 45 CFR, part 1061, vol. 44, No. 247, December 21, 1979) for the energy crisis assistance program (formerly crisis intervention) with several major changes. The first change mandates that $400 million of the $1.6 billion will be distributed to recipients of SSI by the Department of Health, Education, and Welfare. All current SSI recipients except those in medicaid institutions are eligible. The amount of the benefit received will be determined by the following formula: One-third on the number of heating degree days squared in the State (number of days with an average temperature below 65 degrees) times the number of the State's households with incomes below 125 percent of the poverty level, one-third on the difference in home heating energy expenditures in the State between 1978 and 1979, and one-third on the number of SSI recipients in the State compared to the total number of SSI recipients in the Nation. The individual benefit in each State, as determined by the above formula, is a maximum of $250 and is a one-time payment. The following table reflects the approximate SSI/energy assistance payment in each State:

ALLOCATION OF THE $400 MILLION FOR SSI RECIPIENTS

[In dollars, $250 maximum]

	Individual benefit level		*Individual benefit level*
Alabama	44	Montana	250
Alaska	250	Nebraska	222
Arizona	55	Nevada	117
Arkansas	48	New Hampshire	250
California	44	New Jersey	185
Colorado	156	New Mexico	76
Connecticut	250	New York	150
Delaware	166	North Carolina	73
District of Columbia	102	North Dakota	250
Florida	39	Ohio	151
Georgia	46	Oklahoma	58
Hawaii	34	Oregon	218
Idaho	250	Pennsylvania	157
Illinois	170	Rhode Island	190
Indiana	229	South Carolina	53
Iowa	250	South Dakota	250
Kansas	131	Tennesse	58
Kentucky	69	Texas	45
Louisiana	39	Utah	250
Maine	226	Vermont	244
Maryland	140	Virginia	106
Massachusetts	144	Washington	180
Michigan	177	West Virginia	88
Minnesota	250	Wisconsin	204
Mississippi	41	Wyoming	250
Missouri	97	All States	97

Approximately $800 million of the $1.6 billion will be distributed by HEW to the States to assist low-income persons not receiving the one-time SSI payment. These funds will be allocated to the States based on a formula under which 50 percent of the funds are weighted by the number of heating degree days squared in the State times the number of State households with incomes below 125 percent of poverty. The other 50 percent is weighted by the difference in State home heating energy expenditures between 1978 and 1979. Approximations on each State allotment are as follows:

TENTATIVE STATE ALLOCATIONS FOR ENERGY ASSISTANCE PROGRAMS UNDER 1980

State	Amount (in millions)	Percent of total
Alabama	$4.37	0.551
Alaska	3.11	.392
Arizona	1.89	.238
Arkansas	3.31	.418
California	21.01	2.650
Colorado	10.45	1.319
Connecticut	21.23	2.679
Delaware	2.67	.337
District of Columbia	3.04	.384
Florida	2.61	.329
Georgia	5.78	.730
Hawaii	0	0
Idaho	5.16	.651
Illinois	45.60	5.753
Indiana	21.99	2.774
Iowa	15.25	1.924
Kansas	5.18	.654
Kentucky	9.60	1.212
Louisiana	2.11	.266
Maine	12.53	1.580
Maryland	14.66	1.850
Massachusetts	40.72	5.137
Michigan	47.58	6.003
Minnesota	36.20	4.568
Mississippi	2.46	.311
Missouri	16.05	2.025
Montana	5.36	.677
Nebraska	6.84	.863
Nevada	1.56	.196
New Hampshire	7.77	.980
New Jersey	36.54	4.610
New Mexico	3.17	.399
New York	117.94	14.880
North Carolina	16.27	2.053
North Dakota	7.07	.893
Ohio	40.19	5.070
Oklahoma	4.62	.583
Oregon	11.32	1.429
Pennsylvania	59.38	7.492
Rhode Island	6.58	.830
South Carolina	4.84	.611
South Dakota	5.78	.730
Tennessee	9.35	1.180
Texas	8.18	1.032
Utah	4.29	.541
Vermont	5.45	.688
Virginia	16.71	2.108
Washington	18.66	2.354
West Virginia	6.84	.863
Wisconsin	31.41	3.963
Wyoming	1.92	.242
All States	792.60	100.000

The States can use its share of the $800 million to make payments to recipients of AFDC or to develop an alternate plan to serve those households that are below 125 percent of the poverty level ($3,913 for aged individual, and $4,925 for an aged couple). States are given considerable flexibility in choosing the administering agency, the level of benefits and the method of distribution. For example, a State may make a direct payment to the low-income household or may implement

a vendor approach in which the payment is made to the vendor or energy supplier, who in turn reduces the low-income household's utility bill.

The remaining $400 million made available to the States will be used to implement a larger crisis intervention program. This program, which is significantly guided by the October 11 and December 21, 1979, CSA regulations, allows persons with incomes under 125 percent of the poverty level to apply to the State for assistance in meeting household energy costs. The crisis intervention program can complement the assistance provided under the payments made to SSI and AFDC recipients. Thus, an elderly person could receive his or her one-time payment from HEW through the SSI program and still be eligible in a "crisis situation" for extra aid from the State. Crisis assistance can take the form of direct payments, payments to vendors, and/or the provision of goods and services such as heaters, blankets, food, medicines, or supportive services.

The CSA regulations, in accordance with congressional intent as expressed in the 1980 Labor/HEW Appropriations Conference Report (H. Rept. 96–400), emphasize that the highest priority should be placed on serving the low-income elderly.

The 1980 funds were released to the States at the end of 1979 and are expected to be made available to recipients by February 1980. The date of implementation will vary among the States depending on previous experience in implementing such a program, the State's timetable in developing and securing approval for the required State plan and the method of delivery.

The one-time SSI payment to blind, disabled and elderly individuals is scheduled to be made by HEW in January 1980. The payment will be a supplement to the recipients routine SSI check and will be accompanied with a notice explaining the one-time supplement's purpose as energy assistance.

C. The Future Energy Assistance Program

On December 17, 1979, the Senate passed the Crude Oil Windfall Profit Tax Act of 1979 (H.R. 3919). The major focus of this bill is to tax certain revenues received by domestic oil producers. In addition, the legislation specifies how the additional tax revenues generated by the tax may be used by the government.

The Finance Committee's crude oil windfall profits bill included a provision establishing a low-income energy assistance program. However, in a floor maneuver the Senate substituted another bill, S. 1724, the Home Energy Assistance Act, introduced by Senator Harrison Williams, which was approved by the Senate Labor and Human Resources Committee on October 25, 1979, and earlier debated as a

separate measure by the full Senate. In substituting S. 1724 as an amendment to the windfall profits bill, the Senate agreed that the new energy assistance program would be tied to the revenues generated by the windfall profits tax.

The new energy assistance program provides for a 2-year authorization for fiscal years 1981 and 1982 at levels of $3 billion and $4 billion, respectively. Major provisions of the Senate approved program include:

—Eligibility level of 100 percent of the Bureau of Labor Statistics (BLS) lower living income standard (approximately $5,514 for a retired couple). This standard is currently used by the Comprehensive Employment and Training Act (CETA) and varies by region and metropolitan and nonmetropolitan area. (The poverty level, on the other hand, does not vary by region.)

—Automatic eligibility for recipients of SSI, AFDC, food stamps, and certain veterans benefits.

—Flexibility for the States in determining method of distribution (direct cash assistance, vendor payments, vendor line, etc.), and in selecting the State and local agencies to administer the program.

—Priority for low-income households and households having at least one elderly or disabled member. This priority resulted from a floor amendment proposed by Senator Chiles and the entire Senate Special Committee on Aging. It was amended by Senator Alan Cranston to include certain disabled individuals.

—An allowance for States to provide assistance for cooling purposes, when it is determined to be a medical necessity.

—An administrative allowance of up to 15 percent of the States allocation, with the State required to match 50 percent of the cost.

—A provision for direct grant awards to be made to Indian tribes and tribal organizations, if the Secretary of HEW determines that a State is not meeting the needs of its Indian population.

—A provision which allows for assistance under this program to be disregarded as income when determining eligibility or assistance levels for other federally assisted programs.

The most debated aspect of the 1981–82 program was the allocation formula. Led by a New England contingent, an amendment was proposed that would have given more emphasis in the formula to heating degree days, thus permitting States with colder temperatures to receive a larger allocation. Eventually, a compromise was worked out which weights 50 percent of the funds by the number of heating degree days squared, times the BLS lower living income population of the State. The remaining 50 percent is weighted on a State's total residential energy expenditures. Under these combined weightings, each State would receive approximately the following percentages of the appropriations that will later be approved for the program:

PERCENTAGE DISTRIBUTION FOR 1981–82 ENERGY ASSISTANCE PROGRAM

State:	*50 percent degree days squared × low-income population; 50 percent energy expenditures, $120 minimum*
Alabama	1.06
Alaska	.47
Arizona	.58
Arkansas	.78
California	4.44
Colorado	1.48
Connecticut	1.88
Delaware	.24
District of Columbia	.28
Florida	1.72
Georgia	1.30
Hawaii	.15
Idaho	.58
Illinois	6.21
Indiana	2.88
Iowa	1.87
Kansas	1.00
Kentucky	1.55
Louisiana	1.30
Maine	1.15
Maryland	1.52
Massachusetts	3.89
Michigan	5.55
Minnesota	3.60
Mississippi	1.05
Missouri	2.58
Montana	.63
Nebraska	.92
Nevada	.24
New Hampshire	.70
New Jersey	3.80
New Mexico	.56
New York	11.60
North Carolina	1.94
North Dakota	.64
Ohio	5.66
Oklahoma	.97
Oregon	1.00
Pennsylvania	6.84
Rhode Island	.63
South Carolina	.85
South Dakota	.58
Tennessee	1.50
Texas	3.10
Utah	.65
Vermont	.49
Virginia	1.85
Washington	1.52
West Virginia	.95
Wisconsin	3.28
Wyoming	.27
Total	100.00

By the end of the 1st session of the 96th Congress, the House had not approved an energy assistance bill for fiscal years 1981 and 1982. It was anticipated that the House would accept most of this provision in the Senate bill during the joint House-Senate conference on the crude oil windfall profits legislation. However, major changes in the measure are possible. Therefore, final approval of the future energy assistance program cannot be realized until the 2d session of the 96th Congress.

D. Relief for the Moderate Income

As described above, the low-income energy assistance programs are directed at persons who are at or below either the BLS lower living income standard or the poverty level. These levels for a retired couple are currently about $5,514 (lower living income standard) and $4,925 (125 percent of poverty level). Therefore, there will be a considerable number of older persons with low and moderate incomes who will not be eligible for this assistance.

Recognizing the impact of rising energy costs on the moderate to middle income, the Senate Finance Committee added a tax credit to the crude oil windfall profits bill (H.R. 3919), which is not included in the original House version of H.R. 3919. The credit would be a nonrefundable tax credit for taxpayers with incomes less than $22,000. The taxpayer would be responsible for determining the amount of the credit by multiplying his or her cost for heating energy by the relative

energy price percentage to be determined by the Department of the Treasury. The credit may not exceed $200 and may not be less than $30.

The future of this tax credit will have to be determined in the joint House and Senate conference on the windfall profits legislation.

II. OTHER ENERGY ASSISTANCE FUNDING SOURCES

At the end of 1979, Federal departments and agencies recognized that States and localities would be needing additional instruction and guidance to implement the new, expanded energy assistance programs. An interdepartmental task force comprised of the Administration on Aging, the Social Security Administration, the Community Services Administration, and the Office of Human Development Services (HEW) was formed to discuss the new programs and the type of information that would prove helpful. In developing this information, the agencies and departments involved summarized the major service programs—other than direct energy assistance—which can be tapped to support different forms of energy assistance.

The major programs, the support of which will vary by specific State programs and allowances, include:

A. HEW—Title XX Social Services Program

HEW makes formula grants to States under title XX of the Social Security Act to reimburse 75 percent of State expenses for providing social services to public assistance recipients and other low-income and lower-middle-income persons. (At the option of each State, members of households with incomes up to 115 percent of their State's median income are eligible for services. The title XX program is available in all States.) A State must publish a comprehensive annual services plan before it can receive any funds under title XX. (This plan can, of course, be revised or amended.) For fiscal year 1979, there was a $2.9 billion legislative ceiling on Federal funds for title XX grants. The fiscal year 1980 ceiling has reverted to $2.5 billion, but it is anticipated that further congressional actions will probably restore it to the fiscal year 1979 level. Current regulations permit the use of title XX funds for a number of purposes including the payment of utility bills, and some States have actually used title XX funds for this purpose.

B. HEW—State and Community Programs on Aging

HEW makes formula grants to States (at matching rates of 75 percent for administration and 90 percent for services) under title III of the Older Americans Act of 1965 (as amended) to provide social services, including nutrition services and senior centers, for persons aged 60 or older. Beginning with fiscal year 1981, a State must submit a 3-year plan and have it approved by HEW before it can receive any of these funds. (This plan is to be revised annually if necessary, and may also, of course, be revised or amended at other times.) Services are funded at the local level through area agencies on aging which receive funds from the States. Funds under this program may be used

to provide emergency services for older persons; the Administration on Aging (AoA) specifically advised State units on aging several years ago that available funds may be used for emergency payment of utility bills. AoA is currently developing program instructions concerning the use of title III funds. The amount of money available for emergency services is subject to statutory limitations. State officials on aging, area agencies on aging, and AoA-funded senior centers have been instructed to be cooperative with other agencies and organizations on energy assistance and weatherization.

C. HEW—Native American Programs

HEW makes project grants under title VIII of the Community Services Act of 1974 to governing bodies of Indian tribes and other appropriate public or private nonprofit agencies to promote the goal of economic and social self-sufficiency for Native Americans. Possible uses of these grants include projects aimed at increasing the capabilities of Indian tribes to provide services previously provided by the Federal Government and other non-Indian organizations; projects designed to provide needed services to promote individual and family self-sufficiency; and projects to establish and operate urban centers serving Indians living off-reservation. In case of a disaster or other emergency, it is possible to reprogram grant funds under this authority to provide needed assistance, which might include payment of utility bills for households experiencing energy crises.

D. HEW—Aid to Families With Dependent Children (AFDC)

HEW makes formula grants to States under title IV–A of the Social Security Act to reimburse 50 percent or more of State expenses for aid to needy families with dependent children. Under this program, a State must submit a plan and have it approved by HEW before receiving matching funds. (This plan can, of course, be revised or amended.) Single-parent needy families are eligible for AFDC payments in all States, as are two-parent families with one parent who is incapacitated. Two-parent families with one parent unemployed are eligible for AFDC payments under limited circumstances in about half of the States. Benefit levels are set entirely by the individual States, and only one or two States (down from three several years ago) index AFDC benefit levels to the Consumer Price Index.

E. State- or Local-Funded General Assistance

Except for Arkansas, all States (plus the District of Columbia) have nonfederally assisted income maintenance programs of one kind or another which are generally lumped together under the heading of general assistance. Authorization and funding for these programs is entirely under State and/or local legislation. Beneficiaries may include households not eligible for federally aided income assistance, but restrictions on eligibility vary widely. Benefits are often lower than AFDC benefits in the same State for a family of the same size. Many of the programs provide continuing (short term or temporary) financial assistance, but 16 States (as of 1977) provide only emergency or

short-term assistance. For households in crisis situations, some States could presumably provide assistance for paying high energy/fuel bills through their emergency or short-term assistance programs.

F. Department of Agriculture—Food Stamps

The Department of Agriculture provides free food stamps to needy households to be used to purchase food. The amount of food stamps provided to a household varies with household size and income. The basic food stamp benefit amount is adjusted for food inflation every 6 months—which compensates for food inflation but not for other price increases. To determine countable income for the program, households may deduct from gross income the portion of their shelter costs (including utilities as billed—even if the bill has not yet actually been paid) which exceeds 50 percent of household income. The excess shelter deduction (plus a dependent care deduction) is subject to a $75-per-month statutory limitation. To the extent that rising utility bills drive total shelter costs above 50 percent of household income, affected households may receive a larger allotment of food stamps, which may in some cases release cash previously used for food to be used for a portion of the increased utility bills. (For each $10 decrease in countable income, food stamp benefits are increased by about $3.)

G. Federal Emergency Management Administration

This agency provides assistance only to areas of Presidentially declared natural disaster or other general emergency (such as a blizzard). This assistance may include cash payments, emergency shelters, blankets, clothing, and food, but it does not include direct grants to low-income households to pay outsized utility bills.

III. WEATHERIZATION PROGRAMS

A. History and Problems

During the winter of 1973, community action agencies in Maine and Wisconsin began the first weatherization programs designed to help low-income persons conserve energy and pay their fuel bills.[1]

A national program was created in 1975 with the enactment of the emergency energy services conservation program through section 222 (a)(5) of the Economic Opportunity Act (Public Law 93–644). From 1975 through 1978, the Community Services Administration (CSA) operated a nationwide weatherization program primarily through its network of local community action programs (CAP's). During its 3 years of operation, the CSA used appropriations of $192.2 million to weatherize 372,911 dwellings.

Through other legislation, specifically the Energy Conservation and Production Act (ECPA) enacted in 1976, the Department of Energy (DOE) also obtained the authority to operate a weatherization program. In fiscal year 1978, DOE used combined appropriations of $27.5 million from 1977 and $65 million from 1978 to weatherize

[1] U.S. Congress. Senate Committee on Labor and Human Resources. Report to accompany S. 1725 (Washington, S. Rept. No. 96–434), p. 7.

approximately 72,500 dwellings. In fiscal year 1977 and 1978 both the CSA and DOE programs operated concurrently under separate statutory authority and separate regulations. However, since the Department of Energy had no nationwide network of local counterpart agencies, many of the community action agencies conducted DOE-funded, as well as CSA-funded, programs.

As of fiscal year 1979, the total appropriation of $200 million for the weatherization program was transferred to the Department of Energy. The Office of Management and Budget prohibited CSA from using any of its funding for such purposes. The DOE with its 1979 appropriation of $200 million weatherized about 111,800 dwellings of low-income persons.

Both the CSA and DOE programs have been criticized for delays, performance, and management problems. One of the key obstacles to program success was the requirement that the weatherization funds be used primarily for materials leaving inadequate funds for labor and program administration.

Inadequate sources of labor, lack of skills and training and problems of coordination with public employment programs such as the Comprehensive Employment and Training Act (CETA) compounded the problems of community action agencies in implementing the weatherization program.

And now, following the 1978 CETA amendments, several CAP directors have told the Special Committee on Aging that even if CETA workers were trained to perform the required weatherization tasks, their use and availability is severely limited since CETA job slots have an 18-month limit.

Another significant problem, according to local program administrators, is the limit on assistance per household. Often this restriction meant that only marginal or temporary improvements could be made. DOE's 1979 regulations restricted the amount of cost per dwelling to $800.

Further, since the program was focused on homeowners, many potentially eligible persons were neglected due to difficulties in dealing with landlords and property owners.

B. Congressional Action and Changes

The Congressional Office of Technology Assessment (OTA) in its report on, "Residential Energy Conservation" in 1979, summarized the need for assistance in energy conservation for the low-income and elderly. The OTA report cited:

> The poor and elderly are usually not in a position to lower fuel bills by reducing consumption. Available data show that the average low-income household in 1975 used 55.4 percent less electricity and 24.1 percent less natural gas than the average middle-income U.S. household. In the aggregate, low-income households used only 11 percent of total U.S. residential energy, although they accounted for 17 percent of the population. These figures are especially significant because at least 43 percent of low-income households have no storm doors or storm windows—factors that drive up the amount of home fuel use required to maintain minimum conditions of health and comfort. Moreover, 39 percent of low-income households have no thermostat or valve with

> which to control their heat, and among low-income renters 49 percent lack such control. Given these circumstances, recent increases in utility and fuel bills severely penalize poor people who cannot significantly cut consumption without enduring health hazards in their drafty, uninsulated homes.

In justifying the need for the reauthorization and expansion of the weatherization program, the Senate Subcommittee on Employment, Poverty and Migratory Labor of the Labor and Human Resources Committee in the committee report (S. Rept. 96–434) stated:

> Both the Congress and the Carter administration have recognized that energy conservation is an essential and primary element of our national energy policy. Low-income and near-poor Americans have no other choice but to conserve energy in order to cope with today's high energy prices. Further conservation and reduction of consumption is certainly possible for this segment of our society, but they alone do not have the financial resources required to make further progress. This is why the committee believes that a long-term commitment by the Federal Government is necessary to pursue the goal of further conservation. By doing so the disproportionate energy price burden now borne by the low-income and near-poor can be relieved and the Nation's energy consumption and foreign oil bills can be reduced.

With this report, the committee sent to the Senate on November 29, 1979, S. 1725, the Economic Opportunity Amendments of 1979, which substantially expand the weatherization program. Major provisions of S. 1725, sponsored by Senator Gaylord Nelson, include:

—Reinstatement of the program's full authority within the Community Services Administration and the Economic Opportunity Act. However, S. 1725 does not strike section 413 of the Energy Conservation and Production Act and, therefore, a low-income weatherization program could also still be administered at DOE.

—Authorizations of $500 million, $750 million and $950 million for fiscal years 1981–83.

—An eligibility level equal to 85 percent of the BLS lower living income standard, which for a retired couple on a national average is approximately $4,687 annually.

—An allocation formula to the States identical to the one approved by the Senate for the energy assistance program (described above).

—Greater flexibility in utilizing weatherization funds for labor costs while still requiring a substantial participation by CETA workers.

—A slight increase in the allowed labor cost per dwelling but with clear congressional intent that this not be a home repair program.

—A mandate that homeowners, renters and owners of rental property be treated equitably in the provision of weatherization services.

—Direct funding for Indians and migrant workers if the director of CSA determines such groups are not receiving benefits that are equivalent to the weatherization benefits being provided to the other income eligible population.

—A required outreach program, with priority attention to the elderly and severely handicapped.

The future of this reauthorization bill will be determined in the 2d session of the 96th Congress.

The interdepartmental task force on energy described in section B of this chapter, also provided States and localities with a summary of Federal and State assistance programs which could support various forms of weatherization and insulation. The summary includes:

1. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—COMMUNITY DEVELOPMENT BLOCK GRANTS

The Department of Housing and Urban Development makes formula grants to cities in standard metropolitan statistical areas and to urban counties under title I of the Housing and Community Development Act of 1974 to help these jurisdictions develop visible urban communities, including decent housing and a suitable living environment, and expand economic opportunities, principally for persons of low and moderate income. (Some project grants are also made to States and to smaller local governments.) Cities may undertake a wide range of activities directed toward neighborhood revitalization, economic development, and provision of improved community facilities and services. One possible use of funds under this program is to provide low-interest loans and/or grants for home improvements and renovation including weatherization. It is believed that only a small proportion of total program funds are used for weatherization.

2. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—SECTION 312 REHABILITATION LOANS

The Department of Housing and Urban Development makes direct loans to property owners in community development block grant areas and certain other urban areas under section 312 of the Housing Act of 1964 to support the rehabilitation of residential, commercial, and other properties. Applicants must have ability to repay the loan, and security offered for the loan must be adequate. Loans of up to $12,000 are available for home improvements including insulation and weatherization. It is not known what proportion of total loans are used to provide insulation and weatherization, or what proportion of beneficiaries are below the poverty threshold.

3. DEPARTMENT OF AGRICULTURE—VERY LOW-INCOME HOUSING REPAIR LOANS AND GRANTS (SECTION 504)

The Agriculture Department's Farmers Home Administration makes loans and grants to certain lower-income rural homeowners under section 504 of the Housing Act of 1949 to give them an opportunity to make essential minor repairs to their homes to make them safe and remove health hazards to the family or the community. Applications are made to county farmers home offices.

Section 504 loans for urgent need are made to low-income rural homeowners with some ability to repay the loan. Loans may be up to $5,000, and are at low interest (repayable in 5 years); they may be used for home improvement, including but not limited to weatherization. In fiscal year 1979, funding for these loans was $24 million.

Section 504 grants for urgent need are made to low-income rural homeowners aged 62 years or older. Grants may be up to $5,000 per unit; they may be used for home improvement, including insulation and weatherization. In fiscal year 1979, funding for these grants was $19 million.

Chapter 5

SOCIAL SERVICES

CHAPTER HIGHLIGHTS

Congress made significant changes in the delivery of social services under the Older Americans Act in 1978. Social service grants, congregate meals, home-delivered meals, multipurpose senior centers, and legal and ombudsman services were all placed under one administrative structure. Funding for all of these services was directed to State agencies on aging which in turn made awards to area agencies on aging for the coordination and provision of services to older Americans. Congress had decided that combining all service programs under one title and administrative structure would eliminate duplicative and overlapping functions such as outreach, advocacy, needs assessments, staff training, and various other administrative functions. It was also expected that consolidation would increase the visibility, political strength and significance of area agencies and provide for more effective coordination of community resources for the elderly.

In 1979, Older Americans Act resources were directed into the area of long-term care for the first time. In order to fulfill the mandates of the act, States were required to provide ombudsman services for older persons residing in long-term care facilities, and the Administration on Aging was directed to fund special projects in comprehensive long-term care.

The network of State and area agencies, which provide the administrative structure to deliver all Older Americans Act services, along with a number of other social services, operated throughout 1979 and entered 1980 without final regulations necessary to implement fully the new mandates of the act. These programs were funded under a continuing resolution for fiscal year 1979 and received small increases in the fiscal year 1979 supplemental appropriation to cover deficits caused by inflation, energy costs or mandates in the 1978 amendments.

The older Americans volunteer programs, reaffirmed as a part of the ACTION agency in the Domestic Volunteer Service Act Amendments of 1979, received increased stipends for the volunteers in the fiscal year 1980 appropriations. New programs to benefit older Americans were authorized in these amendments. Appropriations for the programs will be considered in the fiscal year 1981 budget.

There were no increases in the title XX program of grants to States to support social services for individuals and families in 1979. Consideration of changes in the national title XX ceiling, in both the Senate and the House of Representatives, was affected by the overall spending limitations set forth in the budget resolutions for fiscal year 1980. The two bodies differed as to the amount by which the ceiling should be raised and a reconciliation of this difference is not expected until 1980.

In the area of transportation, bus manufacturers decided not to bid on Transbus, after almost a decade of study and development. Final regulations implementing section 504 of the Rehabilitation Act of 1973 were adopted by the Department of Transportation and legislation requiring Amtrak to institute reduced fares for senior citizens was enacted. In addition, the insurance industry made substantial progress in the area of rating and classification of vehicles used to provide transportation for social service programs.

I. THE OLDER AMERICANS ACT OF 1965, AS AMENDED

The Older Americans Act (OAA) was first enacted in 1965 (Public Law 89–73) to support a State agency on aging in each State and to provide grants to these agencies to initiate community-based social service projects for older Americans. The act established within the Department of Health, Education, and Welfare an operating agency, the Administration on Aging, to be the principal agency for carrying out the mandates of this act. The act was amended seven times between 1965 and 1978.

A chronology of the most significant amendments is as follows:

—In 1972, a new title VII authorized a nutrition program with funds awarded to local community projects to provide nutrition services to older persons.

—In 1973, the title III social service program was revised to improve organization at the State and local levels. The 1973 amendments also authorized a new title V, which provided direct grants to local community agencies to pay part of the cost of acquiring, renovating, altering and initial staffing of facilities for use as multipurpose senior centers.

—In 1975, the amendments required State plans to include four priority services: Transportation, home services, legal services and residential repair and renovation.

—In 1978, the act was substantially revised when, in October, the President signed the Comprehensive Older Americans Act Amendments of 1978 (Public Law 95–478). These amendments restructured and reorganized the OAA programs by consolidating the separate social services, senior centers and nutrition services into one title—title III. The 1978 amendments also enacted a new title VI to provide direct grants to Indian tribal organizations to develop services for older Indians.

The following table of appropriations under the OAA since its enactment in 1965 clearly demonstrates the large expansion of Federal funding for programs for the elderly in recent years:

1966	$7, 500, 000	1974	$217, 800, 000
1967	10, 275, 000	1975	245, 000, 000
1968	18, 450, 000	1976	354, 300, 000
1969	23, 000, 000	1977	492, 250, 000
1970	28, 360, 000	1978	696, 700, 000
1971	33, 650, 000	1979	819, 320, 000
1972	101, 700, 000	1980	965, 120, 000
1973	253, 000, 000		

A. Older Americans Act Funding

The programs for aging received significant increases in both the supplemental appropriations for fiscal year 1979 and in the fiscal year 1980 appropriations legislation. The Senate Appropriations Committee described the increases (S. Rept. 96–247) as:

> . . . expressing its continued support . . . for all aging programs throughout the Labor-HEW appropriation bill. Aging programs are and must continue to be of growing importance not only to the Congress, but to the United States as a whole because of the change in our population mix.

1979 SUPPLEMENTAL APPROPRIATIONS

The fiscal year 1979 supplemental appropriations (Public Law 96–38) contained an increase of $68.87 million for OAA programs.[1] Funding for specific titles was increased as follows:

—Title III–B, social services: $3.97 million increase for area agency services and senior centers to meet increased responsibilities for implementing State plans and to assure maintenance of current program levels; $3.5 million increase to prevent a reduction in State allotments resulting from population shifts and application of the new allocation formula.

—Title III–C, nutrition: $22.5 million increase for States to cover deficits or service reductions.

—Title V, community service employment: $8.9 million increase to cover increase in minimum wage for 47,500 enrollees for July 1, 1979, to June 30, 1980 (this program is forward-funded).

—White House Conference on Aging: $3 million (total for fiscal years 1979 and 1980) to meet cost of planning and conducting the conference.

—Food commodities program: $27 million increase to provide cash in-lieu-of commodities for nutrition projects.

Fiscal year 1980 appropriations (Public Law 96–123) provided an increase of $150 million, a 16-percent increase over the 1979 funding level for OAA programs. Additional funding was necessary for States to comply with the expanded mandates of the 1978 amendments. These new mandates include direct grants for Indian tribes, the federally funded home-delivered meals section of the nutrition program, and the prohibition on the use of nutrition funds for supportive services effective in fiscal year 1981. Highlights of the fiscal year 1980 funding increases are:

—Title III–B, social services: $50 million increase to maintain social services at the present level, to provide transportation services, senior centers, and other supportive activities to the nutrition program, and to begin to compensate for the fiscal year 1981 prohibition on the use of nutrition funds for supportive activities.

—Title V, community service employment: $57 million increase to expand job slots from 47,500 to 52,250 for the period July 1, 1980, through June 30, 1981, and to synchronize funding with other OAA programs.

[1] A chart showing total appropriations for fiscal year 1979 is on a later page.

—Title VI: $6 million in first-time funding for grants to Indian tribes to promote the delivery of social services to Indians.

OAA appropriations by title are outlined in the table below. This table provides the funding level under the continuing resolution for fiscal year 1979, the increases allowed under the supplemental appropriations for fiscal year 1979 and the final funding levels under the continuing resolution for fiscal year 1980 (Public Law 96–123). Although the OAA programs are operating under a continuing resolution for the second year, the fiscal year 1980 appropriations legislation allowed program expansion for home-delivered meals, the congregate meals program, and the long-term care demonstrations under the model projects program.

SUPPLEMENTAL APPROPRIATIONS FOR FISCAL YEAR 1979 AND 1980

[In millions of dollars]

	Fiscal year 1979 continuing resolution	Fiscal year 1979 supplemental	Total, fiscal year 1979	Fiscal year 1980 continuing resolution
Title II:				
Federal Council on Aging	$0.45	0	$0.45	$0.45
National Clearinghouse	2	0	2	2
Title III:				
State administration	19	$3.5	22.5	22.5
Social services	193	3.97	196.97	246.97
Congregate meals	250	22.5	272.5	270
Home-delivered meals	0	0	0	50
Title IV:				
Training	17	0	17	17
Research	8.5	0	8.5	8.5
Multidisciplinary centers	3.8	0	3.8	3.8
Model projects	15	0	15	[1] 20.5
Title V: Community service employment	211.7	8.9	220.6	266.9
Title VI: Direct grants to Indian tribes	0	0	0	6
Sec. 311—surplus commodities	30	27	57	[2] 50.5
White House Conference on Aging	0	3	3	0
Total	750.45	68.87	819.32	965.12

[1] Included in the $20.5 million is a set-aside of $10 million for AoA demonstration projects in long-term care. Another $10.5 million was included in the Health Care Financing Administration (HCFA) budget for related long-term care demonstrations.

[2] Contains authorization for continuation of the agricultural commodities program directed to nutritien projects. AoA is directed to analyze and report to the Appropriations Committees by Dec. 1, 1979, on the advisability and feasibility of continuing to operate commodities as a separate program or combining the cash payment portion of the commodity program into the title III–C nutrition authorization.

B. The New Title III

The 1978 amendments became effective on October 1, 1978. The Administration on Aging (AoA) began to involve the public in developing proposed regulations in November 1979. However, 1979 came and went, and 1980 began, without regulations necessary to implement fully the major provisions of these amendments—title III, grants for State and community programs on aging.

Proposed regulations for this title were published by AoA on July 31, 1979 (44 FR 45032). Consideration was given to comments received by October 1, 1979. AoA distributed over 100,000 copies of the proposed regulations and held 11 public hearings—one for each of the 10 Federal regions and an additional hearing in the State of Hawaii.

The level of public response to the proposed regulations was unusually high. Over 407 statements were presented in public hearings. After the hearings. AoA received an additional 1,600 separate comments on the proposed rules.

The issues which emerged as areas of concern included:

—Single organizational unit (to administer the OAA program at State/substate levels).
—State and area agency resource allocation plan.
—State plans review, and the roles of the State advisory council and the A–95 review agency.
—Hearing procedures.
—The types of agencies that may be designated as area agencies.
—Service requirements for multipurpose senior centers.
—The relationship between providers of home-delivered and congregate meals programs.
—The options for defining "greatest economic need," "social need," "rural areas," etc.
—Congressional intent relative to the establishment of community focal points.
—Redesignation of State units on aging, program and service areas (PSA's) and area agencies on aging (AAA's), etc.

There was consensus among interested persons that the proposed rules were clearly written from a grammatical and stylistic viewpoint, easily read and in a format superior to the existing title III regulations. Questions arose, however, over whether AoA followed the intent of the law in drafting the rules, portions of which were so ambiguous as to leave the reader unclear as to how the rule would be implemented.

In view of the questions raised by the proposed regulations, a joint hearing of the Senate Subcommittee on Aging of the Committee on Labor and Human Resources and the Special Committee on Aging was convened on October 18, 1979—the anniversary of the signing of the 1978 amendments. The purpose of the hearing was to examine fully the concerns of the aging community, clarify congressional intent, and work toward devising the most effective delivery of needed services for older Americans.

Since the responses by the Commissioner on Aging, Robert Benedict, failed to clarify key issues, or answer questions posed by committee members, Senators Thomas Eagleton and David Pryor, who cochaired the joint hearing, proposed that another hearing be conducted to hear "precise and specific" proposals as to how the Commissioner planned to review unclear or controversial areas. This followup hearing was to be conducted before the proposed regulations are published in final form.

As of this writing (December 1979) AoA could not provide a definite date for publication of the final regulations. Thus, the hearing on the final regulations is pending.

Although promulgation of final regulations for title III appeared to be the major area of concern throughout 1979, State and area agencies on aging were implementing the provisions of the amendments and moving toward the consolidation of service titles. In recognition of the major changes required at each level of program operation, the amendments provided a transition period of up to 2 years for State and area agencies to be in full compliance with the new requirements of the act. Under the provisions of the act, the Commissioner for fiscal years 1979 and 1980 may waive any new requirements for a State agency, if he determines that the State agency cannot meet the required consolidation, or because meeting the requirements would reduce or jeopardize the quality of services under the act. A waiver

may be granted only if the State agency shows that it is taking steps to meet the requirements. The State agency also has the authority to grant waivers to area agencies.

Although title III, grants for State and community programs on aging, provides the administrative framework for all of the OAA service programs and generates considerable attention and discussion, there are other OAA titles which also deserve equal attention. These titles are implemented either by separate guidelines developed by AoA or by regulations promulgated by other Federal agencies, and consequently are not affected by the absence of final title III regulations.

C. Title IV—Training, Research and Discretionary Projects and Programs

In addition to authorizing training, research and multidisciplinary centers, this title provides for all demonstration projects, including special demonstrations for long-term care, legal services, and national impact demonstrations. All provisions of this title are implemented by AoA guidelines rather than HEW regulations. The Commissioner on Aging may not, however, make a grant or contract under this title in any State without prior consultation with the State agency on aging.

1. TRAINING (IV–A AND IV–E)

Since enactment of the OAA in 1965, AoA has used its training and education program for general development efforts appropriate to an emerging field such as gerontology. The title IV–A training program and more recently the title IV–E multidisciplinary centers of gerontology have been directed toward the planning and development of career and in-service training. Program guidelines have been broad and adaptable and have accommodated a diversity of activities and interests. Grantees under these guidelines, primary institutions of higher learning or State agencies on aging have had considerable latitude in carrying out projects to train and educate people for service in the field of aging.

Beginning in the mid-1970's, there was an expansion of the IV–A program functions beyond that of preparing persons for careers in the field of aging through undergraduate and graduate training or education. This expansion of IV–A functions was stressed in the 1978 amendments whereby AoA was given an important role in developing community-based health and social services responsive to the varying needs of older individuals. AoA was also mandated to develop and implement a national manpower policy in the field of aging.

As a result of the legislative focus, AoA introduced significant changes in the direction and structure of its education and training program in 1979, and emphasized:

—The development and implementation of comprehensive and coordinated community-based service systems, with special emphasis on providing special services to the vulnerable elderly.

—Advocacy by AoA and State and area agencies on aging to tap the resources of other support systems that can advance the well-being of the elderly.

AoA's 1979 education and training guidelines were actually a 3-year plan (fiscal years 1979–81) and an announcement to the aging com-

munity of new initiatives. These initiatives reflected the mandates of the 1978 amendments and strategic changes in AoA policy and program priorities.

The new training initiatives began a systematic process of background studies, analyses, draft formulations, and consultation which are required for the development of the national manpower policy. AoA anticipates that the process will be completed in fiscal year 1981.

The training guidelines announced six program initiatives to be started in 1979 or early in 1980. Five programs are governed by grant competition. These five programs are:

—Title IV–A gerontology career preparation program.
—Title IV–A minority research associate program.
—Title IV–E long-term-care gerontology centers program.
—Title IV–A geriatric fellowship program.
—Title IV–A national continuing education program.

The sixth program initiative provides for the establishment of aging policy study centers under the title IV–E multidisciplinary centers of gerontology. The purpose of these study centers is to encourage the development of organizational personnel and other resources for the performance of activities that will solve, or help to alleviate social, economic or health-related problems of older persons.

In the selection of subject areas for proposed national aging policy study centers, an applicant may choose from among the priorities identified by AoA, or they may initiate a subject area of their own interest. AoA identified eight priority areas. These eight areas are:

—Income maintenance.
—Housing and living arrangements.
—Employment and retirement.
—Education, leisure, and continuing opportunities for older persons.
—Older women.
—Aging in the future society.
—Aging and attitudes, values and ethics.
—Health.

AoA has taken steps to comply with the broad mandates of the 1978 amendments by restructuring its education and training program and by developing initiatives which may be implemented over the next several years. The initiatives outlined above will be completed in fiscal year 1981 and culminate in a national manpower policy on aging. This national manpower policy will then provide the basis for AoA's education and training program plans for the period beginning with fiscal year 1982.

2. RESEARCH (IV–B)

The research and development program authorized in this title is the foundation of AoA's knowledge-building efforts. Part B of this title provides for the awarding of grants and contracts to support research that will contribute to the well-being of the elderly by:

—Identifying and studying patterns and factors that impact upon the lives of older persons.
—Developing, demonstrating, and evaluating approaches and methods for improving the lives or quality of life of older persons.

The research supported by these grants and contracts gives special attention to the needs of the very old and impaired whose problems are compounded by social isolation, low income, minority and/or rural

status. Emphasis is also focused on public and private policies that impact on the lives of older persons relative to employment, retirement, income, health, housing, social, and/or volunteer services.

A major legislative mandate for AoA is advocacy in relation to other support systems. Therefore, research strategies must be designed which will suggest new, or modifications of existing public and private policies to improve the lives of older people.

AoA's fiscal year 1979–80 research guidelines are based on a multiyear plan which when fully developed will coordinate research, demonstration, and program evaluation studies. The guidelines reflect input from the research community, researchers, and program officials from other Federal agencies, and representatives of major national organizations—including groups of minority elderly, State and area agencies on aging. The development of research guidelines predicated on substantial input from "outside" AoA was first accomplished in 1979. The research priorities, outlined in the guidelines, also reflect AoA's concern that future research should be useful to public and private officials.

The guidelines present researchable questions within nine strategy areas, and in addition identify certain special projects. The nine strategy areas are:

—Characteristics, needs, and resources of older people.
—Family, neighborhood, and community.
—Societal conditions.
—Economics of aging: Employment, retirement, and income.
—Continuing opportunities: Work, education, and leisure.
—Living arrangements: Housing and environment.
—Health care and social services.
—Services with an emphasis on the vulnerable elderly.
—The network on aging.

The special projects identified in the guidelines, for which AoA will solicit proposals are:

—Assessment studies of groups of recent AoA demonstrations.
—Codification of research on minority older people.
—National research conference on technology and aged.
—Small grants program.
—Gerontological research institutes.

AoA recognizes that a number of demonstrations have been conducted in areas in which there is considerable current interest. The results of individual demonstration projects typically find their way to interested parties through publications, circulation of reports, conference presentations and/or word of mouth. It has not been the case, however, that the results of multiple demonstrations dealing with the same general problems, system, or issue have been directly compared and assessed in terms of the overall demonstration experience. Such comparative assessment is particularly important in terms of information and knowledge which could be used by policymakers or practitioners.

The purpose of these assessment studies, consequently, is to develop and disseminate practical knowledge for policymakers, program administrators, and practitioners through the assessment of prior AoA demonstrations on:

—Community care system.
—Social and community services.

—Care for the homebound.
—Family, friends, and other informal support systems.

The updated codification of research findings on minority older people will assimilate the findings of a number of AoA-supported projects which specifically focused on minorities, as well as all other projects which, to the extent feasible, have included minorities in their study design. For purposes of this special codification, the four recognized minority groups are: Hispanic, blacks, Pacific Asians, and Native Americans.

Only a minute portion of the country's technological capabilities have been explored for potential use in aiding the physically impaired and aged persons in our society. Successful transfers of technology to the area of human services would involve the sharing of expertise across a wide range of disciplines. Since there are few avenues available which allow for interdisciplinary knowledge-sharing and communication, AoA will support a national conference which will provide a forum for sharing/exchanging knowledge and further develop the state-of-the-art of research in this area.

Historically under AoA's research program, a small number of large awards have been made to experienced gerontologists. Between the intense competition for awards and the infrequent receipt of an award by a less experienced researcher or an institution with a small research budget, few bids were made for small grants. Therefore, by offering small grants in the 1979 guidelines, AoA provided a special incentive to attract less experienced professionals who might, without support, select fields other than gerontology.

Research institutes have been supported in many diverse fields. The most notable example within HEW is the Rehabilitation Services Administration which has demonstrated that such an institute can produce quality research products. A gerontology research institute can provide AoA with a resource for assessing research products and knowledge, assessing the utilization of such knowledge and address, in a timely manner, gaps which may appear in the existing knowledge base.

3. DISCRETIONARY PROJECTS AND PROGRAMS (IV–C)

Guidelines for a multiyear model projects program were published by AoA in April 1978. The only change or addition to these guidelines during 1979, was in the form of guidance for the national aging organizations projects program (title IV, sec. 424), which was published in July 1979, with awards expected by early 1980.

The broad model projects program is predicated on a social systems approach. The older person is viewed as one actor among others (family members, friends, associates, etc.). A social system may contain two or more persons such as husband and wife, or a social system may be nationwide such as a long-term care system.

When the social systems approach is applied directly to the aging, it becomes apparent that the Nation's social, economic, and political efforts to give older Americans equal access to the privileges and opportunities accorded others becomes a national social system. Such a national social system consists of many subsystems at the Federal, State, and local levels. Thus, the model projects program is an attempt to improve that system, clarify its mission, increase the quality of performance of its staff, and educate potential clients to the appropriate and efficient use of available or developing services.

The identified priorities and special emphasis areas in support of the systems concept, outlined in more detail in the Federal Register (43 FR 16648) are: Community care systems and services (State level) and family and community supports (local level).

Projects in support of community care systems are expected to demonstrate ways to improve systems of comprehensive and integrated services for the elderly, particularly those elderly at risk of losing their ability to maintain self-sufficiency and independent living arrangements. The special needs of individuals who are of advanced age, on low income and/or suffering from chronic or recurrent physical or mental disabilities may require special consideration under this section.

Special projects in comprehensive long-term care were also authorized (title IV, sec. 422) in the 1978 amendments. This section will be discussed in detail in the health chapter of this report.

Special demonstration projects on legal services for older persons (title IV–C, sec. 423) was a new provision in the 1978 amendments. The purpose of this section is to support training, technical assistance and information dissemination to agencies, organizations and private law firms that are providing or supporting pro bono or reduced-fee services to older persons. Funds are also available to support demonstration projects to expand or improve the delivery of legal services to older individuals with social or economic needs.

In AoA's expenditure plan for the use of fiscal year 1980 model project funds, the legal services provision of this title was combined with the long-term care ombudsman provision to form an older Americans' advocacy assistance program. This combined program is both a national and State program of technical assistance for the network on aging to assist in expanding advocacy and in developing a range of advocacy activities to help institutionalized and noninstitutionalized older persons with the greatest social or economic needs secure their rights, benefits and entitlements.

The focus of this program is on both advocacy for individual older persons (personal advocacy) and advocacy that affects large numbers of older persons (issue advocacy) with special attention to older persons who are abused or exploited in both institutions and in their communities.

As part of the advocacy assistance initiative, AoA also announced its intention to award contracts to support a network of biregional centers and a national center to assist the States and area agencies on aging and other community agencies and organizations in carrying out their advocacy functions. Biregional centers will be responsible for providing training and technical assistance to the professional staff of the State agency older Americans advocacy assistance programs. Awards for the establishment of a national resource center and centers in HEW regions IX–X, III–IV, and V–VII, were made late in 1978. Awards for Federal regions I–II and VI–VIII are expected in mid-1980.

During 1979, advocacy assistance awards were made to each State agency on aging to assist them in carrying out the purposes of this program and to augment State and local efforts to implement the new provisions of the 1978 amendments. Both the State and biregional advocacy assistance programs are supplements to the mandated legal services and ombudsman activities of the OAA and are not intended to serve as a replacement for the title III-supported activities in these two areas.

The authority for the national impact demonstrations (title IV–C, sec. 424) was the result of recognition by both Congress and AoA of the need to develop partnerships with national organizations to achieve maximum implementation of the OAA. The purpose of the program is to enhance at the national level the capacities of State, substate (area agency) and local network on aging agencies to plan and administer programs in aging.

AoA placed special emphasis on the development of organizations that represent underserved and underrepresented groups within the aged population (minorities, rural elderly). Organizations eligible to apply under this program must be nonprofit, private agencies and meet the following requirements:

—Are national in scope and/or membership.
—Focus on the administration of programs and services to meet the needs and interests of older Americans.
—Are heavily committed to helping their members and/or constituents carry out the purpose of the OAA.
—Have a record of leadership in the development of nationwide efforts in aging.

Organizations which represent elderly persons of minority groups must, in addition, be national level representatives of elderly persons in one of the following groups: American Indian/Alaskan Native, Asian/Pacific, black, and Hispanic.

AoA expects to make up to five awards to nonminority aging organizations and up to five awards to minority aging organizations. Approximately $1.8 million will be available for the first year (1980). The project period of the awards may not exceed 3 years.

D. Title V—Community Service Employment for Older Workers

Title V promotes part-time job opportunities in community service activities for unemployed, low-income persons who are 55 years old or older and who have poor employment prospects. The law provides 90 percent Federal funding (up to 100 percent in disaster or economically depressed areas) for this program.

Regulations for this title are the responsibility of the Department of Labor (DOL). DOL is also responsible for determining eligibility which they have defined as any member of a family which receives regular cash welfare payments or whose annual income, adjusted for family size, does not exceed 125 percent of the poverty level. The poverty level is determined and updated by the U.S. Office of Management and Budget (OMB). Effective in mid-1979, the OMB poverty guidelines were $4,250 for a single nonfarm person and $5,625 for a nonfarm family of two.

Participants in this program are placed in part-time public service jobs, for which their wages are subsidized by the Federal Government and assisted where possible, to obtain unsubsidized jobs in the private or public sector. Trainees are paid at least the minimum wage ($2.90 in 1979 and $3.10 effective January 1, 1980). Upon placement in a job, enrollees receive either the prevailing wage for work or the Federal minimum wage, whichever is higher. Enrollees are limited to 1,300 hours in any 12-month period.

Prior to fiscal year 1977 appropriations, all title V programs were administered by national contractors under the auspices of DOL. In

1977, the State offices on aging received 20 percent of the title V funding and the 1978 amendments to the OAA directed that any additional funding in succeeding fiscal years will be allotted at 55 percent for the States and 45 percent for the national contractors. National contractors will, however, retain at least the number of job slots they had during fiscal year 1978.

The fiscal year 1980 appropriation provided for program expansion to 52,250 jobs, a 10-percent increase over the current level of 47,500 jobs. The higher job level became effective October 1, 1979, and will continue through June 30, 1981.

The Senate Committee on Appropriations (S. Rept. 96–247):

> . . . directed that where appropriate, the highest priority be given to employment activities making home repairs and energy saving improvements to minimize heat transfer and improve thermal efficiency of dwellings in both cold and hot climates.

In establishing this priority, the committee also expressed concern that while other Federal programs assist communities in purchasing weatherization materials, there is often insufficient manpower to install these materials within the homes of the elderly and the poor. Therefore, the title V sponsors were strongly encouraged to coordinate their manpower with other agencies' resources to accomplish the desired results of all weatherization programs.

The Senate Appropriations Committee, in reporting the fiscal year 1980 funding level, also expressed concern that minority contractors in the title V program (Asociacion Nacional Pro Personas Mayores, National Center on Black Aged and Urban League) received less than 3 percent of the available funds. In view of the severity of poverty among the minority elderly, this appears to be a disproportionately low figure. As a result of this disparity, DOL was asked to review its funding policy with a goal toward achieving proportionate funding for minority contractors.

During 1979, DOL, utilizing information from a task force composed of representatives of both State agencies on aging and national contractors, drafted regulations to implement the title V mandates of the 1978 amendments to the OAA. As of this writing (December 1979) DOL indicated that all major issues relative to the proposed regulations have been resolved and that they expect to publish draft regulations in February 1980.

As has been the situation with respect to title III of the OAA, title V has operated since October 1, 1978, without benefit of final regulations necessary to implement the program fully.

E. Grants for Indian Tribes (Title VI)

The 1978 amendments also enacted title VI, a new direct grant program to Indian tribal organizations. The purpose of the new program is to assure that older Indians receive social services, including nutritional services, comparable to services provided through grants for State and community programs on aging. Eligible tribal organizations may apply for direct funding to pay the costs of providing social and nutritional services to Indians age 60 and older, and to acquire, alter, construct, or renovate multipurpose senior centers.

This new title was a result of the congressional response to the initiatives of national Indian organizations which were concerned about the lack of services being received by older Indians under the OAA. Under the new legislation, Indian tribes and tribal organizations may now choose between being funded directly by the Commissioner on Aging (title VI) or funding through the State and area agencies on aging under title III.

Direct funding to Indian tribes was addressed in the 1975 amendments to the OAA with a section authorizing the Commissioner to withhold a portion of a State's allotment and to grant it directly to an Indian tribe, if the Commissioner determined that the State had failed to provide benefits to older Indians that were equivalent to those provided to non-Indian older persons, and further, that the Indians would be better served by a direct grant. This provision, however, was never used.

The 1978 amendments require that at least $5 million be appropriated for title VI before it can be implemented. In fiscal year 1979, however, all OAA programs operated under a continuing resolution which contained no funding for new programs.

The $6 million in first-time funding for this title was the result of an amendment, introduced by Senator Harrison "Jack" Schmitt and cosponsored by Senator Pete V. Domenici, to the fiscal year 1980 Labor/HEW appropriations measure (Public Law 96–86).

To be eligible for direct funding a tribal organization must meet the following requirements:

—Represent at least 75 or more older Indians.
—Demonstrate its ability to deliver social and nutritional services.
—Assure that older Indians it represents for the purpose of title VI do not receive services under title III for the duration of the title VI grant.

A tribe may authorize a tribal organization to represent a distinct part of the tribe for purposes of title VI, while the other members of the tribe remain eligible to receive services under title III. Under title VI it is the tribal organization, and not the tribe, that applies for and administers the grant. Likewise, it is the tribal organization that is prohibited from receiving funds under title III for the duration of the grant under title VI. Congress did not require that an entire tribe choose between titles, but title VI offers the advantage of furthering the concept of tribal sovereignty and developing tribal administrative capacity while title III may offer a more adequate funding level. The proposed regulations would permit a tribe to authorize one tribal organization to represent a specified group of older Indians for purposes of title VI. Older Indians belonging to that tribe and who are not represented by the tribal organization would remain eligible for services under title III.

Although title VI received $6 million in October 1979 (for fiscal year 1980), the program will not be implemented until mid-1980, since AoA has not promulgated program regulations necessary to implement the title.

On January 31, 1979, AoA published a notice (44 FR 6155) of its intent to develop regulations for title VI. Proposed regulations were published on December 5, 1979 (44 FR 70064) with February 4, 1980, designated as the closing date for receipt of comments. This notice of proposed rulemaking contains all the program regulations necessary

to implement title VI. Many of the provisions of the proposed title VI regulations are similar to those in the proposed title III regulations. As a result of this similarity and overlap, and since there is no cross-referencing of the regulations, the proposed title III regulations should be read together with title VI regulations for clarity and understanding of the full scope of the OAA's social service program.

The act establishes the general relationship between title VI and title III in the statements of purpose for each title. The objectives of title III relative to assuring maximum independence and well-being for all older persons are equally valid objectives for title VI. The noteworthy quality of title VI is that it is designed to accomplish these same objectives for older Indians through direct Federal grants to Indian tribal organizations, rather than through State and area agencies.

In the introduction to the proposed rulemaking for these regulations, AoA noted the unique cultural differences of the Indian population and the necessity, in some instances, to provide for choices which facilitate what is most suited to the special needs of older Indians living in the context of their own culture.

There are points where title VI and title II intersect rather than run along parallel lines. The distinction made in the proposed regulations between "tribe" and "tribal organization" has a direct bearing on title III programs because of the responsibility area agencies have for older Indians who are members of a "tribe" but are not represented by a "tribal organization" under title VI.

From the standpoint of funding, there are also important points where title VI and title III intersect. Title VI does not become operational unless it receives an appropriation in each fiscal year of at least $5 million ($6 million was appropriated for fiscal year 1980). This has a direct impact on the title III program especially on the decisions that State and area agencies must make in the development of their State and area plans. State and area agencies must be aware of whether there is an appropriation for title VI, and whether the individual Indian tribal organizations in their planning and service area will apply for title VI funding or continue to require service under title III. State agencies on aging need to be aware of this information since title VI authorized a reallotment of State title III funds in an amount equal to the Indians served under title VI who were also counted for purposes of the State's title III allotment.

Final regulations to implement this title are not expected before mid-1980. There will be no direct grants or expenditures made from the fiscal year 1980 appropriation of $6 million until final regulations are promulgated.

F. Proposed Amendments to Older Americans Act

During the 1st session of the 96th Congress, several bills to amend the OAA of 1965 were introduced and referred to the House Committee on Education and Labor. The provisions of the bills are as follows:

—H.R. 2565, introduced March 1, would amend the act to provide expanded counseling assistance for the elderly.

—H.R. 5273, introduced September 13, would amend the act to provide relief for older Americans who own or rent their own homes (property tax relief program).

—H.R. 6150, introduced December 14, would amend the act to require States to provide assistance to older persons with limited English-speaking ability for the purpose of enabling such older persons to participate in programs and receive benefits under the act.

—H.R. 6148, also introduced on December 14, would amend the act to provide that area agencies on aging shall have authority to award funds to providers of home-delivered meals for older persons without requiring that such providers also furnish meals to older persons in a congregate setting.

II. TITLE XX ISSUES

A. Indexing the Title XX Ceiling: 1980 and Beyond

In 1972 Congress established a $2.5 billion annual ceiling, beginning in fiscal year 1973, on the amount of Federal funding for social services programs under the Social Security Act. Prior to fiscal year 1973, Federal matching for social services under titles IV–A and VI was open-ended: Every dollar a State spent for allowable social services under these titles was matched by 3 Federal dollars.

In 1974 Congress passed legislation which substantially revised the statutes governing the social services program under the Social Security Act, and transferred the provisions relevant to these programs to a new, separate services title, title XX.

Title XX represented a major reform in that several categorical social services programs were consolidated into a block grant approach. The new legislation established certain broad goals, such as assisting individuals in becoming economically self-supporting and preventing inappropriate institutional care. The overall national ceiling of $2.5 billion allocated among the States on a population basis was incorporated in the new title XX legislation.

When the title XX program began in 1975, many States were already spending at their individual ceilings. Such factors as the increased real cost of professional and supervisory personnel and the erosion of purchasing power by inflation have resulted in substantial sentiment for raising the national ceiling.

In 1978, Congress passed a one-year-only increase in the ceiling to $2.9 billion for use during fiscal year 1979. HEW estimates that States have used all, or close to all, of their 1979 title XX funds. In fact, a substantial number of States are spending more than their allotments on services which would qualify for title XX funding and are paying for them out of State and local funds.

This is the context in which the Congress, during 1979, has considered increasing the $2.5 billion ceiling placed on the title XX program. Consideration of changes, in both the Senate and the House of Representatives, has also been affected by the overall spending limitations set forth in the first and second concurrent budget resolutions for fiscal year 1980 (H. Con. Res. 107 and S. Con. Res. 53, respectively), which reflect a spirit of fiscal restraint.

Present differences between the Senate and the House in the amount by which the national title XX ceiling should be raised for fiscal 1980 reflect their differing interpretations of the second budget resolution (S. Rept. 96–336). The House Committee on Ways and Means, in

reporting H.R. 3434, the Adoption Assistance and Child Welfare Act of 1979, recommended the amount of $3.1 billion to replace the current permanent ceiling of $2.5 billion, commencing with fiscal year 1980 (H. Rept. 96–136).

In its consideration of H.R. 3434, however, the Senate Finance Committee recommended a 1980 increase in the ceiling to $2.7 billion. In describing the difference between the amounts proposed by the Senate and the House, the Finance Committee report did not cite major philosophical differences concerning the nature of the social services programs, but stated that "the committee believes that it cannot, in the light of the Senate budget resolution, recommend a fiscal 1980 title XX level in excess of $2.7 billion at this time." (S. Rept. 96–336.)

The Senate passed the Finance Committee version of H.R. 3434 on October 29, 1979; the House of Representatives passed its version on August 2, 1979. A joint conference committee has been named to work out differences between the House and Senate-passed versions of H.R. 3434—including the setting of a new permanent title XX ceiling. The conference committee is expected to complete its deliberations in early 1980.

In addition to the controversy over the 1980 ceiling, the Senate expressed (in S. Rept. 96–336) serious concern:

> . . . about the impact of inflation on the programs operated under title XX and particularly so in view of the fact that the permanent ceiling has been reached by all States. For this reason, the Finance Committee believes that it is appropriate at this time to consider indexing this program over the next several years, in order to provide some assistance to States in meeting the impact of inflation on high priority service programs, and to provide States with advance knowledge of the amount of funding they can expect for these programs.

Toward this end, the Senate recommended an indexing formula in which the permanent ceiling of $2.5 billion will be adjusted for inflation on an annual basis using the percentage change in the Consumer Price Index during the preceding year. This indexing approach is patterned on the one which has been used to determine cost-of-living increases under the social security program. Using current economic forecasts of both the administration and the Congressional Budget Office, the Senate proposal specifies the following title XX national ceilings: Fiscal year 1980, $2.7 billion; fiscal year 1981, $2.9 billion; fiscal year 1982, $3.1 billion; fiscal year 1983, $3.2 billion; fiscal year 1984, $3.2 billion; and fiscal year 1985, $3.3 billion.

In order to assure a reevaluation of both the appropriateness and the effectiveness of these indexing provisions, the Senate version of H.R. 3434 also provides that increases beyond the $3.3 billion level cannot take place in the absence of subsequent legislation to extend the provisions.

An amendment was proposed during Senate consideration of H.R. 3434 that would have substituted a fixed national title XX ceiling of $2.9 billion starting in fiscal year 1981 for the indexing provisions. This amendment was defeated. As noted previously, the Senate

version of H.R. 3434, with a proposed 1980 ceiling of $2.7 billion and the proposal for indexing the ceiling through 1985 is now pending in a Senate-House conference committee.

B. GAO Report, State Title XX Programs

At the request of Senator Chiles, the General Accounting Office (GAO) conducted a review of social service programs in selected States funded under title XX to determine the extent to which programs were serving elderly supplemental security income (SSI) beneficiaries (Rept. No. HRD–79–59). GAO also reviewed the coordination and delivery of social services by States under title XX with services provided under title III of the Older Americans Act (OAA).

GAO assessed services in seven States and determined that only between 3 and 33 percent of the SSI beneficiaries received social services under the title XX program during fiscal year 1978, even though services are mandated for all SSI beneficiaries. Those States with the largest SSI elderly populations are also the States which serve the lowest percentage of SSI elderly with title XX social services. State and local officials in the States under review reported that inadequate resources prevented agencies from providing all services needed by clients and from expanding services to include more clients. Reasons cited for inadequate resources include the absence of State supplemental funds (funds in excess of match requirement), State expenditures below those required to earn the full title XX allocation and the expenditure of existing title XX allocations on clients presently being served. Therefore, under the existing appropriations, any expansion of services to SSI elderly can only be provided by reducing services to other client groups or by the reallocation of title XX resources to meet the needs reflected in States needs assessments. The impact of inadequate funding, according to local program officials, fell most heavily on homemaker/chore and transportation services.

The report revealed that, nationwide, States spend 5.1 percent of their title XX funds on elderly SSI recipients, while spending a much higher percentage on persons receiving aid to families with dependent children (29.3 percent). While one State in the study earmarked over 16 percent of its title XX funds for the elderly, three States did not earmark any title XX funds for older people.

In addition to inadequate resources, the absence of outreach as a program component was another reason the elderly had significant unmet needs. The usual outreach method under title XX programs is that of informally advising elderly persons about social service programs when they apply for SSI and medicaid aid. The study determined that this informal method did not effectively reach this group.

Coordination between agencies providing social services under title III and title XX occurred in only one of the seven States reviewed in the study. State and local officials in other States agreed that more program coordination was needed. However, effective program coordination is hindered by the fact that the two programs have different eligibility requirements and different organizational structures. Title XX legislation requires elderly persons to be either SSI recipients or meet the States' income criteria to be eligible for title XX services.

Under title III, however, all elderly persons are eligible for services regardless of income. Therefore, in all States some persons eligible for title III programs (age 60 years and over) become ineligible for title XX services because their income exceeds the States' eligibility requirements.

According to GAO, the differences in program eligibility requirements may be minimized by using the group eligibility provision of title XX. Under this provision, States are given the option of making eligibility determinations on a group basis rather than an individual basis. The option may be implemented for any group if the State can reasonably determine that substantially all persons receiving services are members of families whose monthly gross income is not more than 90 percent of the State median income.

The organizational structures of the title XX and the title III programs are different. The title XX program generally has an agency in each county of a State. The title III program is organized on an area basis, and almost all areas encompass more than one county. Therefore, the title III agency must coordinate with several separate county-run title XX agencies.

The GAO report recommended that the Department of Health, Education, and Welfare (HEW) instruct the Office of Human Development Services to implement the following recommendations:

—Encourage States to operate outreach programs for the elderly to assure that they are aware of and can compete for available social services.

—Improve coordination between the title III and title XX programs by adopting policies that encourage State and local governments to make joint (1) needs assessments, (2) program development, and (3) assessment of allocation of resources and to use more jointly funded projects to deliver common services.

III. TRANSPORTATION ISSUES

A. Transbus

Early in 1979, a consortium of three major U.S. cities—Miami, Los Angeles and Philadelphia—requested bids for 530 buses built according to Transbus specifications developed by the consortium and the U.S. Department of Transportation (DOT). However, no bids were received by the May 2 deadline for submission. The two U.S. companies that were most likely to bid—General Motors Corp. and Grumman-Flxible Corp.—indicated that they could not bid because of issues relating to technological and commercial aspects of the Transbus procurement requirements (TPR) and other business considerations.[2] The U.S. Secretary of Transportation, Brock Adams, immediately called for an independent scientific review of the procurement requirements and associated issues to assist him in establishing policies and guidelines for future use of Federal funds for bus procurement. The Mitre Corp. was retained to conduct the review and issued its report in July 1979.[3]

[2] National Academy of Sciences, Commission on Sociotechnical Systems. National Research Council. NRC Transbus Study. Washington, 1979. p. v.

[3] The Mitre Corp. Transbus: An Overview of Technical, Operational, and Economic Characteristics (McLean, Va., 1979).

To assure the objectivity of the study, the Secretary of DOT asked the National Research Council (NRC) to review the Mitre report and to advise DOT as to those specific findings that were either supported or unsupported by evidence presented.

The NRC, the principal operating agency of the National Academies of Science and Engineering, and the Mitre Corp. agreed on the following points:

—The decisions of the U.S. bus manufacturers not to bid were reasonable and understandable business judgments. Considerable financial risk would have been involved in accepting a fixed-price contract to provide the specified Transbus with its unproven tandem axle, smaller tires and the required warranties.

—The Transbus mandate should be delayed until DOT has re-examined the options to achieve the Transbus goals.

—The bus defined in the TPR could not be procured, nor can it be procured with only modest changes in the TPR.

—Transbus would represent a major advance over "New Look" buses in terms of passenger comfort and convenience, accessibility, safety, operating speed, and environmental impact. The NCR review panel noted that the advanced design bus (ADB) also provides substantial improvement over the basic "New Look" bus. ("New Look" buses are those built by U.S. and Canadian manufacturers from 1959 until the late 1970's.)

—Transbus would be more expensive than the ADB to produce and operate and more expensive than previous government estimates of its cost.

—No existing wheelchair lift is completely satisfactory, but the lift may be inherently better than a ramp since the slope of any ramp of practical length is too steep for efficient, safe operation, particularly away from curbs or where curbs do not exist.

The NRC, however, took issue with one significant finding of the Mitre study that centered on whether Transbus could be produced in the specified timeframe. Mitre indicated that, from a purely technical point of view, Transbus could be produced in the specified timeframe. The NRC panel, however, did not believe that there is sufficient evidence that Transbus could be produced in the specified time.

The NRC indicated that, while both points of view are based on professional judgment (since neither government actions nor corporate decision could be predicted with certainty), "the time needed for component development and proof testing and the adverse corporate climate for such development led the (NRC) panel to its view." [4]

The NRC further concluded that functional performance specifications for procurement generally are preferred to technical design specifications because they require the contractor to meet the specific technical objectives and at the same time allow latitude in the choice of options in technology.

Following the decision of manufacturers not to bid on Transbus, the Acting DOT Secretary, W. Graham Claytor, announced on August 3, 1979, the indefinite postponement of the September 30, 1979, deadline, after which all buses purchased with Federal funds were to meet Transbus specifications. An issue paper on future options for Transbus is currently being prepared by DOT for submission to the Secretary.

[4] National Academy of Sciences. Commission on Sociotechnical Systems. National Research Council. NRC Transbus Study, p. 5.

B. Section 504 Regulations Issued

On May 31, 1979, DOT issued final regulations implementing section 504 of the Rehabilitation Act of 1973. These regulations require that transportation systems receiving Federal funds from DOT be accessible. (49 CFR part 27: "Final rule—nondiscrimination of the basis of handicap in federally-assisted programs and activities receiving or benefiting from Federal financial assistance," Federal Reg., vol. 44, No. 106, May 31, 1979, pp. 31442–31483.) Briefly, the regulations provide that:

1. *Public transit buses,* the most widely used means of public transit, for which solicitations are issued after the effective date of the rule, must be wheelchair accessible. While the rule contemplates that Transbus will ultimately become the core of the public transit bus system, it does require that new buses before Transbus be accessible. Within 10 years, half the buses used in peak hour service must be wheelchair accessible, and these buses must be utilized before inaccessible buses during off-peak hours so as to maximize the number of accessible buses in service.

2. Under existing regulations all new *rapid rail* facilities must be accessible. This rule would also require that all existing rapid rail systems be made accessible to the handicapped over time, subject only to a limited waiver provision. The rule adopts a systemwide approach to rapid rail and mandates that key stations be made accessible in 30 years if station accessibility involves extraordinary costs, with less costly changes in 3 years.

3. *Commuter rail* systems must be made accessible, also subject to a limited waiver provision. On the basis of key station criteria similar to those applied to rapid rail, all key stations must be made accessible within 3 years, with an extension to 30 years if station accessibility involves extraordinary costs.

On a system basis, one vehicle per train must be accessible no later than 3 years after the effective date of the rule, whether by replacement or retrofit, but up to 10 years is allowed if extraordinary costs are involved.

New vehicles for which solicitations are issued on or after January 1, 1983, must be accessible.

4. *Light rail* (trolley and streetcar) systems must be made accessible, also subject to a limited waiver provision. Using similar key station criteria as apply to rapid rail, all key stations must be made accessible within 20 years, with less costly changes to be made in 3 years.

On a system basis, within 3 years after the effective date (up to 20 years may be allowed if extraordinary costs are involved), half the vehicles used in peak hour service must be wheelchair accessible, and these vehicles must be utilized before inaccessible vehicles during off-peak hours so as to maximize the number of accessible vehicles in service. New vehicles for which solicitations are issued on or after January 1, 1983, must be accessible.

To assist urbanized areas prepare transition plans for program accessibility as required by the final rule, DOT has prepared an "advisory guidance for urbanized areas with fixed-route bus and/or paratransit systems." A similar document to assist rural areas is currently being prepared. (For a background discussion of DOT regulations to implement section 504 of the Rehabilitation Act of 1973, see "Developments in Aging: 1978," pt. 1, p. 146.)

It is noteworthy that the House report accompanying the 1980 DOT appropriations bill, H.R. 4440 (H. Rept. 96–272), included the following language regarding section 504 regulations:

> The committee is concerned that the regulations issued pursuant to section 504 of the Rehabilitation Act of 1973 might require the expenditure of vast sums with only minimal benefits to handicapped persons. Section 321 of the Surface Transportation Assistance Act requires a study of this issue. Pending the completion of that study, the committee is recommending language which would prohibit the use of funds to retrofit any existing rail transit system to comply with the section 504 regulations.
>
> The committee believes the Department of Transportation should also evaluate the costs and benefits associated with equipping all regular route buses with lifts. In addition, the committee believes that the Department should ensure that any lifts which are currently being purchased with UMTA assistance, are reliable, maintainable, and operable.

While language with regard to equipping buses was not included in the Senate report (S. Rept. 96–377) nor the conference report on H.R. 4440, the conference report (H. Rept. 96–610) prohibits the use of urban discretionary grants for retrofitting fixed-rail systems to comply with section 504.

The 321 studies referenced in House report language were mandated by section 321 cf the Surface Transportation Assistance Act of 1978 and are scheduled to be submitted to Congress in March 1980. Two separate studies are being conducted: One deals with the cost of making fixed-guideway public mass transportation systems accessible to and usable by handicapped persons (i.e., retrofitting the systems); the other deals with the feasibility of retrofitting light-rail systems (including trolleys, streetcars, cable cars, etc.) and commuter rail public transportation systems.

C. Reduced Amtrak Fares

The Amtrak Reauthorization Act, signed by the President on September 29, contains a provision requiring Amtrak to institute reduced fares for senior citizens. Amtrak officials announced on December 18 that the new discounts—which were included in the reauthorization act largely through the efforts of Senator Jim Sasser and Representative Claude Pepper—will become effective January 1, 1980. The 25 percent discounts will apply to any trip made by a senior citizen or handicapped person at any time and on any train when the regular one-way coach fare is $40 or more.

D. Insurance Problems of Transportation Service Providers

Vehicle insurance has become a major problem for social agencies providing transportation services. Commonly encountered problems include high rates, policy cancellation, vehicle use restrictions, and the inability to purchase insurance. The genesis of this problem stems from State laws and regulatory practices which were written to cover such vehicles as private cars, commercial vehicles or school buses, but made no explicit provision for social service vehicles.

Until late 1979, a classification or rate-setting schedule for "service" vehicles did not exist. As a result, underwriters considered these "unclassifiable" vehicles as high risks, rather than as manageable risks, and as a consequence, insurance was unobtainable or offered at a prohibitive cost. The only classification of risks known to underwriters were vehicles which were "for hire" (taxi, bus) or "private carriage" (car), as contrasted with "service" vehicles. Furthermore, while traditional classification gave immunity to governmental and some charitable organizations, this immunity did not extend to the varied private, nonprofit social service agencies which have emerged as the providers of transportation services in the last decade.

Recent attention has been directed to the insurance problem through a hearing of the Senate Special Committee on Aging, concentrated staff work by the National Association of State Units on Aging (NASUA), an indepth study by the Transportation Center of the University of Tennessee and a White House meeting on insurance problems of social service agencies and public transportation vehicles. The National Governors' Association (NGA) also organized a task force of relevant State agencies, representatives from the Insurance Services Office (ISO), and the Department of Health, Education, and Welfare to develop and review model State legislation. As a result of the interest and concern generated by the groups mentioned above, the insurance industry agreed to give priority attention during 1979 and 1980 to the development of insurance initiatives which would begin to alleviate problems faced by social service agencies as transportation providers.

The first initiative undertaken by the industry was the development of a new classification for vehicles used in social service transportation programs. This new classification or rating schedule, which became effective in all States (except Texas, Massachusetts, and Hawaii) on October 1, 1979, provided the operating flexibility needed by underwriters to offer coverage for a new category of transportation: Service vehicles. Information on this new classification was provided to all underwriters by the ISO, a national organization which renders a wide range of advisory, actuarial, rating, statistical research, and other types of service to the insurance industry.

The industry fully expects that the introduction of the ISO's classification structure, along with its class definitions, rating factors and codes, will facilitate the writing of insurance for most, if not all, social service vehicles. The availability of information from ISO to local underwriters will help eliminate the unfamiliarity associated with the term "service" vehicle. As a result, underwriters will be more willing to offer initial or continued coverage.

The classification or rating schedule for social service vehicles will also allow the industry to assure the collection of needed statistics

on this type of transportation and provide a basis for reasonable insurance rates (rate setting). The traditional vehicle use classification system will also be modified to provide for the sharing of vehicles by different programs or agencies.

The insurance industry has placed special emphasis on the need for careful selection and training of paid and/or volunteer drivers. The absence of a carefully planned and executed selection process to screen out drivers with recent traffic violations has been a deterrent when social agencies applied for vehicle coverage.

The industry has indicated that they will undertake an initiative, in cooperation with the Departments of Transportation and Health, Education, and Welfare to develop driver selection and training manuals, and other risk management assistance materials, which will be available to nonprofit organizations providing transportation services. The special training needs of employees of the Comprehensive Employment Training Act (CETA) program, and senior citizens who volunteer as vehicle drivers, have also been identified by the industry. Both stringent selection criteria and generic training courses are being developed to meet the needs of special categories of drivers, such as the two identified above.

The model legislative initiative undertaken by the NGA task force in late 1979 is scheduled for completion in June 1980. This undertaking will provide drafts of model State laws to address regulatory and liability issues facing volunteers and governmental or charitable transportation. These draft statutes will be evaluated to determine if a Federal legislative solution is possible, and/or desirable, or if remedial legislation is needed on a State-by-State basis.

The seriousness of the insurance problems encountered by transportation providers was further underscored by a provision in the 1978 amendments to the Older Americans Act (title IV, training, research and discretionary projects and programs) which gave the Commissioner on Aging the authority to make grants to any public or nonprofit agency, organization or institution for the purpose of:

> . . . conducting a study related to the problems experienced by State and area agencies on aging and other service providers in operating transportation services, with particular emphasis on the difficulties of continually rising insurance costs and restrictions being placed upon the operation of such services by insurance underwriters.

IV. ACTION

A. New ACTION Programs

In the final days of the 1st session of the 96th Congress, President Carter signed a 2-year renewal of the Domestic Volunteer Services Act (Public Law 96–143), which included two new urban initiatives designed to benefit the elderly: Fixed income counseling and the helping hands programs.

The helping hands program, which was a provision from a Senate bill, S. 239, is a special volunteer program designed to reduce the institutionalization and isolation of older persons and persons with various handicaps. Volunteers, acting on a person-to-person basis, will be assigned in a manner that will emphasize interactions between

persons of all age groups. They will work to assure program coordination with the appropriate State system for the protection of persons with developmental disabilities.

The fixed income counseling provision establishes a program to utilize volunteers with specialized or technical expertise in providing personal and group financial counseling to low- and fixed-income individuals.

Funding for the two new provisions which provide benefits for older persons was explained in H. Rept. 96–606:

> Of the funds appropriated for each of the fiscal years 1980 and 1981 for the purpose of carrying out the special volunteer programs section of the Domestic Volunteer Service Act Amendments of 1979, which are in excess of $2.5 million but not in excess of $10 million, not less than 50 per centum for each fiscal year shall be available for carrying out the fixed income counseling and helping hands programs.

B. Older Americans Volunteer Programs

The ACTION agency's older Americans volunteer programs (OAVP)—foster grandparents, senior companion, and retired senior volunteer program—were reauthorized in 1978 for 3 years as part of the Comprehensive Older Americans Act of 1978 (Public Law 95–478).

During the reauthorization process, there was an attempt to transfer OAVP from the ACTION agency to the Administration on Aging. However, Public Law 95–478 retained the programs within ACTION through fiscal year 1981. Conferees approved this provision pursuant to an agreement that an oversight hearing would be held early in the 96th Congress by the Subcommittee on Child and Human Development of the Senate Committee on Labor and Human Resources. Such a hearing was conducted on October 27, 1979. No recommendations to change the status of the OAVP resulted.

The OAVP appropriations for fiscal year 1980 was substantially above the President's budget request and $21.3 million over fiscal year 1979. The OAVP received increased funding to provide program expansion as follows:

—Foster grandparents, $56.9 million—four new projects and 240 new slots for foster grandparents.

—Senior companions, $19 million—four new projects and 240 new slots for senior companions.

—Retired senior volunteer program, $26 million—expanded volunteer opportunities for approximately 17,000 older persons in 170 existing projects and funded 22 new projects, enabling another 7,700 older persons to serve.

In addition, the fiscal year 1980 appropriations increased stipends for foster grandparents and senior companions from $1.60 to $2 per hour. This increase became effective in November 1979. Effective on the same date, transportation reimbursement for older volunteers was increased to a maximum of $1.85 per day.

V. OTHER PROPOSED LEGISLATION

Early in 1979, several legislative proposals which would affect the lives of older Americans were introduced and referred for appropriate committee action. The provisions of these bills are as follows:

—S. 392, introduced on February 8, and S. 597, introduced on March 8, would provide that polling and registration places for Federal elections be accessible to physically handicapped and elderly individuals.

—S. 691, introduced on March 15, would prohibit the use of appropriated funds to lobby members of State legislatures and legislative bodies of political subdivisions.

—H.R. 2751, introduced on March 8, would provide specific statutory authority for the Veterans Administration to meet the demand for geriatric health care posed by record numbers of elderly veterans.

—H.R. 4015, introduced May 9, and S. 1523, introduced on July 16, would amend title 38 of the U.S. Code to establish demonstration centers of geriatric research, education and clinical operations within the Veterans Administration. This legislation is referred to as the "Veterans Senior Citizens Health Care Act of 1979."

Chapter 6

HOUSING

"Housing is a major variable physically, socially, and psychologically, in the lives of older people. It is an integral part of the trinity that perks up one's quality of living, the other two being sufficient income and good health." [1]

CHAPTER HIGHLIGHTS

During 1979, housing took on more significance in the lives of older persons as they were forced to combat rising costs in the housing market, escalating rents, a growing number of abandonments and conversions of apartment buildings, and the steady decrease in the availability of low- and moderate-income rental units.

Efforts by the Congress and the administration were orchestrated in 1979 to assist the elderly in meeting the housing challenge.

The Housing Act was reauthorized for 3 additional years and includes some increases in programs which benefit the elderly.

Federal initiatives were begun to demonstrate new and better ways of providing housing and services to elderly in congregate facilities.

And, efforts for home care—social services, health care, and energy assistance—grew as Congress responded to the demand by older persons to remain in their own homes and to the recognition of the cost-effectiveness of such programs.

I. HOUSING FOR THE ELDERLY IN THE SEVENTIES: AN OVERVIEW

How well were the elderly housed in the seventies? According to the Department of Housing and Urban Development (HUD), the elderly were housed "no differently from all Americans," with one major exception—the elderly, on the average, must pay a larger proportion of their income for housing than do other age groups.

[1] Federal National Mortgage Association, Housing for the Retired, 1979.

Based on a 1976 annual housing survey, HUD published a report in 1979, "How Well Are We Housed? The Elderly." This report revealed the following facts:

—14.8 million households (30 percent of the total households) are headed by a person 65 years or older;
—10.9 million households (71 percent of elderly households) own their own homes;
—3.9 million elderly households rent their dwelling units;
—6.65 million households (45 percent of the elderly households) consist of two people headed by a male 65 years of age or older;
—465,000 households (3 percent of the elderly households) include no wife;
—1.36 million households (9 percent of the elderly households) include no husband;
—1.43 million households (10 percent of the elderly households) consist of men living alone;
—4.92 million households (33 percent of the elderly households) consist of women living alone;
—63 percent of elderly households live in standard metropolitan statistical areas (SMSA's);
—37 percent of elderly households live in non-SMSA, rural areas;
—9 percent of elderly households with "families" have income below poverty with a median income of $8,720;
—30.7 percent of elderly households with a woman living alone are below poverty with a median income of $3,640;
—24.4 percent of elderly households with a man living alone are below poverty with a median income of $3,640;
—47 percent of the elderly households living in dwellings built before World War II; and
—9 percent of the elderly households have "flaws" or physical inadequacies (as judged by HUD) based on the availability of heating and plumbing, on the availability of sewage-disposal systems, and on the maintenance of the living units, its design, electrical system, and kitchen.

Table 1, "Elderly Households and How they Live, 1976," depicts in more detail the number of elderly households with various characteristics by geographical distribution (SMSA/non-SMSA).

Table 2, "The Housing of the Elderly Closely Matched the National Average in 1976," provides a specific breakdown of the flaws—physical inadequacies—in the 14.8 million elderly occupied housing units.

Both of these tables are based on data gathered by the 1976 annual housing survey reports, "How Will We Be Housed? The Elderly," published in 1979 by the HUD Office of Policy Development and Research. Data in this section was also compiled from 1976 current population reports:

TABLE 1.—ELDERLY HOUSEHOLDS AND HOW THEY LIVE/1976 [1]

	SMSA	Non-SMSA	All locations
A. Geographic distribution:			
Percentage	63	37	100
Number	9, 301, 000	5, 525, 000	14, 827, 000
B. Tenure:			
Homeowner	6, 118, 000	4, 352, 000	10, 469, 000
Cash rent	2, 990, 000	932, 000	3, 913, 000
No cash rent	194, 000	251, 000	445, 000
C. Physical characteristics:			
1. Year structure built:			
After March 1970	721, 000	421, 000	1, 142, 000
1965 to 1970	820, 000	498, 000	1, 318, 000
1960 to 1964	708, 000	401, 000	1, 109, 000
1950 to 1959	1, 583, 000	815, 000	2, 399, 000
1940 to 1949	1, 224, 000	653, 000	1, 876, 000
1939 or earlier	4, 245, 000	2, 737, 000	6, 983, 000
2. Units in structure:			
1	5, 431, 000	4, 519, 000	9, 951, 000
2 to 4	1, 441, 000	464, 000	1, 905, 000
5 plus	2, 027, 000	216, 000	2, 243, 000
3. Mobile home	402, 000	327, 000	729, 000
4. Hotel, rooming house	59, 000	17, 000	76, 000
5. Number of bathrooms:			
None or shared	221, 000	459, 000	680, 000
1 bath, but separated	76, 000	18, 000	93, 000
1	6, 532, 000	3, 859, 000	10, 390, 000
1.5	1, 123, 000	637, 000	1, 760, 000
2	1, 060, 000	451, 000	1, 511, 000
More than 2	290, 000	102, 000	392, 000
6. Type of heating equipment:			
Central	4, 155, 000	2, 295, 000	6, 450, 000
Steam	2, 554, 000	509, 000	3, 063, 000
Electric	523, 000	368, 000	890, 000
Floor, wall	874, 000	520, 000	1, 394, 000
Room heater	578, 000	827, 000	1, 405, 000
Other/inadequate	618, 000	1, 007, 000	1, 625, 000
7. Air-conditioning	4, 565, 000	2, 349, 000	6, 914, 000
8. Alterations during year ($100 or more)	441, 000	258, 000	699, 000
9. Water source:			
Public or private	8, 612, 000	3, 733, 000	12, 385, 000
Individual well	644, 000	1, 544, 000	2, 188, 000
Other	45, 000	209, 000	253, 000
10. Electricity:			
Yes	9, 291, 000	5, 505, 000	14, 795, 000
No	10, 000	21, 000	31, 000
11. Type of sewage disposal:			
Public Sewer	7, 935, 000	2, 913, 000	10, 848, 000
Septic tank/cesspool	1, 302, 000	2, 319, 000	3, 622, 000
Chemical toilet	4, 000	3, 000	7, 000
Privy	45, 000	249, 000	294, 000
Other	15, 000	42, 000	57, 000

[1] These figures are derived from computer tapes and may vary from those published in "Annual Housing Survey" Reports, 1976, Department of Housing and Urban Development.

TABLE 2.—HOUSING OF THE ELDERLY CLOSELY MATCHED THE NATIONAL AVERAGE IN 1976

Type of flaw	Units without flaw	Units with flaw	Percent of all units with flaw	Inadequate units by number of flaws				
				1 flaw	2 flaws	3 flaws	4 flaws	5 plus flaws
Plumbing	14, 146	680	4.6	181	214	189	88	7
Kitchen	14, 391	435	2.9	86	92	165	84	7
Maintenance	14, 336	490	3.3	325	59	30	69	7
Public hall	14, 792	34	.2	21	8	3	3	0
Heating	14, 588	238	1.6	170	26	14	22	7
Electrical	14, 812	14	.1	7	4	1	2	1
Sewage	14, 475	351	2.4	0	84	175	85	7
Toilet access	14, 814	12	.1	11	2	0	0	0
Total (in thousands)	13, 494	1, 332	[1] 9.0	801	244	192	88	7

[1] The 90 percent confidence interval for the summarizing average (9 percent) is plus or minus 0.7 percentage points. The 90 percent confidence interval for the percentage of units with individual flaws is smaller. What this means is that, in theory, we can say with 90 percent certainty that the results differ by no more than 0.7 in either direction—if we had surveyed every household.

Source: "Annual Housing Survey Reports," 1976, Department of Housing and Urban Development.

This is the picture of the elderly in independent living arrangements which, according to the Bureau of the Census, breaks down to 63 percent living with families and 30 percent living alone. The other 6 percent of the elderly population are, according to the Bureau of the Census, "institutionalized" in various group care facilities such as intermediate and skilled nursing homes, boarding and foster homes.

II. FEDERAL HOUSING FOR THE ELDERLY

Housing and congregate living facilities for the elderly are varied in size and form. High rise and low rise facilities ranging from single unit apartments, duplexes, residential hotels, personal care homes, and mobile homes are sponsored and supported by private organizations, churches, local and State governments, and the Federal Government.

Housing assistance for the elderly is directly and indirectly provided through various housing programs which fall into four basic categories: Homeownership assistance programs, nursing home and intermediate care facilities, rental housing programs, and rent subsidy programs.

The Federal housing programs fund a substantial number of units for the elderly. A brief sketch of the construction and rental housing programs of the Department of Housing and Urban Development is shown in the following chart:

SUMMARY OF HUD HOUSING UNITS FOR THE ELDERLY *

Section No.	Program name	Status	Projects	Units	Value	Approximate number of elderly units	Percent elderly units	Reporting period
			Construction programs					
3, 4 (title II)	Low-income public housing [1]	Active	[3] 8,550	1,147,000	[5] $261,000,000	[3] 519,857	[2] [6] 43±	Cumulative through July 1976.[6]
202	Direct loans for housing for the elderly and handicapped [1].	do	330+ [2] 285	45,275 [2] [7] 29,000	580,000,000 750,000,000	45,275 29,000	100	Through 1972 fiscal year 1976 funding.
231	Mortgage insurance for [1] [4] housing for the elderly.	do	291	44,668	600,000,000	44,668	100	Cumulative through fiscal year 1976.
221(d)3	Multifamily rental	do	1,507	124,000	1,600,000,000	[3] 12,400	[6] 10	Cumulative to April 1976.
221(d)4	Housing for low- and moderate-income families [1] [4].	do	1,726	215,000	3,200,000,000	[3] 21,500		
235	Homeownership assistance [1] for low- and moderate-income families.	do	NA	475,353	8,500,000,000	Not currently available. Coming 4th quarter fiscal year 1977.[3]		Current cumulative total.
207	Multifamily rental housing [1]	do	2,234	282,064	3,600,000,000	[3] [6] 10,000	Under 5	Cumulative through April 1974.
236	Rental and cooperative assistant for lower income families.[1] [4]	Inactive	4,134	[2] 456,958	7,600,000,000	50,833	[3] [6] 9	Cumulative through October 1976.
202/236	202/236 conversions [3]	do	182	28,305	481,812,750	28,305	100	Do.
232	Nursing homes and intermediate care facilities [1].	Active	1,069	[8] 119,265	1,100,000,000	119,265	100	Cumulative through April 1976.
			Nonconstruction programs					
8	Low-income rental assistance [1] [4]	Active	NA	[3] [9] 233,022	NA	[3] 91,979	35	Fiscal year 1976 only (approved through March 1977).
312	Rehabilitation loans [1]	do	NA	NA	352,000,000	[3] NA	[10] 23 Loans [11] 17	Cumulative through July 1976.
23	Low-rent leased public housing [1]	Inactive	NA	163,267	NA	[3] 54,500+	[3] [6] 35±	Cumulative through December 1975.

[1] All statistics from "HUD Programs, 3/77". unless otherwise noted.
[2] 1976 report to the Senate Special Committee on Aging.
[3] CPD, H, MIS, PD & R staff.
[4] May be double-counted in sec. 8 or vice versa.
[5] Fiscal year 1974–76, funds for new starts only.
[6] Data does not indicate how many of these units were actually designed for the elderly.
[7] Funds for units approved for construction fiscal year 1976.
[8] Beds.
[9] All types.
[10] Loans.
[11] Funds.

*This table was compiled by the Office of the Assistant Secretary for Neighborhood Voluntary Associations and Consumer Affairs as of March 1977. It is a preliminary compilation and is, therefore, subject to revision.

A. Section 202 Housing for the Elderly and Handicapped

Section 202 of the Housing Act of 1959, as amended, provides for direct Federal loans for a maximum of 40 years to private nonprofit sponsors for the development of new or substantially rehabilitated housing for the elderly, physically handicapped, or developmentally disabled. It is the only housing program under HUD which provides 100 percent construction loans. It is the only HUD program which is mandated to have all sponsors classified as private nonprofit organizations, corporations or consumer cooperatives. During the program's history, over half of the sponsors have been religious institutions with the remaining half composed of nonprofit union groups, community based organizations, cooperatives, and fraternal organizations.

1. SECTION 202 UNITS

Section 202's history is broken into two periods—the "old" program, 1959–68, and the "new" program, 1974-present. Under the old program, 330 projects containing approximately 45,000 units were built. Under the new program (through fiscal year 1979), HUD has made reservations for 1,100 projects containing about 90,000 units. Of these projects, 465 with 50,670 units are under construction and 145 projects with 15,241 units are completed and occupied.

In addition to the living units, the section 202 projects are required to "provide the necessary services for the occupants, which may include among others, health, continuing education, welfare, informational, recreational, homemaker, counseling, and referral services, as well as transportation, where necessary to facilitate access to these services." [2] These services can be provided in the community spaces of the facility including cafeterias or dining halls, community rooms or buildings, workshops, adult day health facilities and other outpatient facilities. These community spaces are utilized in every 202 project, especially laundry rooms, community rooms and recreational areas. According to a sampling by HUD of 202 projects, the following facilities and services were found in 202 buildings:

	Percentage of 202 projects
Space:	
Laundry facilities	91
Community rooms	94
Dining rooms	22
Infirmaries	3
Recreation facilities	86
Services:	
Air conditioning	54
Meals	7
Physical therapy	3
Medical care	4
Nursing care	4
Maid and linen service	4

Eligibility for 202 projects is limited to persons 62 years of age or older. There are no income limitations; however, most 202 projects are linked to section 8 rent subsidies which restrict eligibility to 80 percent of the local median income for the household. Section 8 is discussed later in this chapter.

[2] 43 CFR, part VI, subpart A, § 885.1(a), Mar. 1, 1978.

2. SECTION 202 RESIDENTS

Tenants in 202 projects have traditionally been white, elderly females with middle socioeconomic status. This has been chiefly attributed to the placement of 202 buildings in predominantly white, middle class neighborhoods. Most applications came from sponsors in such areas. In the past, these sponsors were most often religious groups and fraternal organizations which attracted residents from their own memberships or from the same social and ethnic backgrounds. HUD's analysis of the 202 projects under the "old" program (1959–68) revealed that in the 45,000 units, only 6.9 percent of the occupants were minority; 5.3 percent black, 0.6 percent Hispanic, and 1 percent of other minorities.[3]

This trend has been substantially altered under the "new" 202 program (1974–79). This is chiefly attributed to the efforts of HUD and minority housing organizations who have supported efforts to comply with congressional intent for greater participation by minorities in the 202 program. Through workshops and technical assistance, HUD has attempted to inform and educate potential minority sponsors about the 202 program and encourage applications from such sponsors. These efforts began to pay off with minority applications for 202 projects comprising approximately 25 percent of the total applications in both fiscal years 1978 and 1979. However, a noticeable increase in minority residents of 202 projects will not be as dramatic for several years since most 202 buildings sponsored by minority and ethnic organizations are in early stages of construction.

3. 1979 REAUTHORIZATION

Public Law 96–153, the Housing and Community Development Amendments of 1979, was signed into law on December 21, 1979. Included in these amendments, which extend the Housing Act of 1964, was the reauthorization of loan authority for the 202 program for 3 additional fiscal years, 1980–82. The amount of loan authority was increased to approximately $870 million for 1980, $990 million for 1981, and $1.015 billion for 1982. The $870 million for 1980 was later decreased to $830 million in the Housing and Community Development appropriations bill for fiscal year 1980 (Public Law 96–103). By the first of 1980, HUD has made available to its local field offices 80 percent of the $830 million which would support approximately 17,635 units of 202 housing. If the additional 20 percent is released for new units, the total supported in 1980 could reach around 20,000 units.

During the reauthorization of the 202 program, support for this popular program was evident. Senator Lawton Chiles, referred to the program as "the most effective and efficient program we have had. Certainly in section 8 and certainly for subsidized housing, it has been a boon for the elderly. . . ."[4]

Senator Pete Domenici described section 202 as:

> . . . one of the Department of Housing and Urban Development's most successful programs. The success of section 202 is, in large part, because nonprofit sponsors have made

[3] Department of Housing and Urban Development, Office of Policy Development and Research, Housing for the Elderly and Handicapped (January 1979).

[4] Chiles, Lawton, Remarks in the Senate. Congressional Record, Vol. 125, July 27, 1979, p. S10757.

> a long-term commitment to provide housing and services to the elderly. It should be noted that the 202 nonprofit sponsors have not experienced a single default in this program. The section 202 financial record has been excellent with a foreclosure rate of less than 1 percent after 20 years of operation. Tenant turnover in existing projects is extremely low, indicating that this is one Federal program that is meeting a real need in a cost-effective manner.[5]

Senator Harrison Williams, Chairman of the Senate Subcommittee on Housing and Urban Affairs, stated:

> There is wide agreement that the 202 program may well be HUD's finest. The quality of the housing built is exceptional, and there have been virtually no sponsor defaults in its entire history. This exemplary record is largely due to the high degree of community participation which is guaranteed through the sponsorship of dedicated, expert, nonprofit organizations.[6]

Other changes in the 202 program were included in the 1979 amendments.

a. Office of Elderly Housing

From 1961 to 1977, the Department of Housing and Urban Development (HUD) had an office that dealt directly with matters affecting the elderly. The office was responsible for overseeing policy, program, advocacy, and coordination of housing services for the elderly and was located within the Department's Loan Division. Since May of 1977, however, there has been no focal point for the integration of elderly housing services, policy, and program evaluation within HUD.

Over the next 30 years, as the elderly population continues to grow at a much greater rate than the general population, the demand for HUD-financed new housing, as well as rehabilitated housing and rental assistance for the elderly will increase. This demand for HUD-financed housing emphasizes the need for a coordinated approach within HUD to oversee developments and programs affecting the elderly.

Organizations serving the elderly, such as the Ad Hoc Coalition on Elderly Housing, have frequently argued that effective intervention at HUD is essential in the formation of policies and procedures affecting the development, management, and design of elderly housing programs.

The American Association of Homes for the Aging called for the re-establishment of a HUD office to deal with matters affecting older Americans, pointing out that with the elimination of the loan division—the principal point of contact for housing sponsors—there appeared to be no effective, single office in the reorganization for problem solving, technical assistance or advocacy for elderly housing issues.

Senator Domenici introduced an amendment to the Housing and Community Development Amendments of 1979 to establish a special Office of Elderly Housing under the direction of an Assistant to the Secretary. The Assistant to the Secretary for Elderly Housing would:

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[5] Domenici, Pete. Remarks in the Senate. Congressional Record, July 13, 1979. p. S9380.
[6] Williams, Harrison. Remarks in the Senate. Congressional Record, Vol. 125, July 27, 1979. p. S10755.

(1) Be responsible for the Department's implementation of the Age Discrimination Act of 1975 as amended.

(2) Participate in the formulation of policies and procedures affecting the development and management of housing and other related programs for the elderly.

(3) Coordinate interdepartmental and intradepartmental activities with respect to housing programs serving the elderly.

(4) Provide technical assistance and facilitate access to appropriate agencies within the Department responsible for the planning, development, and management of programs for the elderly.

(5) Participate in the planning and budgeting of Department programs with respect to elderly housing and related programs.

(6) Serve as an ombudsman within the Department on behalf of consumers of housing for the elderly and related services.

(7) Assist in the evaluation of Department programs directed toward serving the elderly.

(8) Make an annual report to the Secretary on the adequacy and effectiveness of the Department's efforts with respect to serving the elderly.

Such an office within HUD would help to ensure sensitivity to the needs and problems of the elderly residing in federally assisted housing. Senator Domenici was joined by 14 cosponsors, including Senator Chiles and Senator Harrison Williams, Chairman of the Housing and Urban Affairs Subcommittee of the Senate Committee on Banking, Housing, and Urban Affairs.

Upon introducing this amendment, Senator Domenici stated that he felt it necessary "to strengthen the management capabilities for elderly housing within the Department of Housing and Urban Development." The amendment was agreed to by the Senate on July 13 and included in the Housing and Community Development Act Amendments of 1979 (H.R. 3875). The measure was referred to a conference committee charged with resolving differences in the House and Senate-passed versions of the bill.

When conferees met in August, one of the major items of disagreement was the amendment establishing the Office of Elderly Housing within the Office of the Secretary. While House conferees argued that this provision would strip the Secretary of his prerogative to organize and manage the Department, Senate conferees stressed that the legislation was needed in order to ensure that such an office was established in the face of HUD's resistance.

After several days of debate on this issue, and after the conferees had communicated their concern to HUD, the conference committee agreed to accept a compromise submitted by Assistant Secretary for Housing, Lawrence B. Simons, in his letter to Senator Williams dated August 17, 1979. Secretary Simons stated his fundamental opposition to a congressionally-mandated Office of Elderly Housing on the grounds that "such matters of internal departmental organizational structure and coordination should be at the discretion and prerogative of the Secretary." However, Simons went on to note that he was sympathetic to the intent of the amendment and announced his plans to assign responsibility for coordination and technical assistance in matters relating to elderly housing to a special assistant reporting directly to him. Simons expressed his hope that this arrangement

would further enhance the internal coordination of elderly housing programs—an effort begun by the recent reorganization of the Office of Housing—and that a special assistant reporting directly to the Assistant Secretary would also "increase the visibility of this important area of concern within the Department."

b. Capital Investment Waiver

The Secretary of HUD was given the authority to waive the $10,000 escrow amount required of sponsors. This change, proposed by Senator Pete Domenici, was intended to allow sponsors in rural areas and minority sponsors, unable to come up with the capital investment, to be able to continue participation in the program. Senator Domenici warned:

> This amendment is not intended to discourage small and minority nonprofit sponsors from making every effort to raise the minimum capital investment requirement, nor does it attempt to change the present law. It does make the law flexible by allowing the Secretary to give greater consideration to potential small minority nonprofit sponsors, and just as important, allows them an equal opportunity to participate in competitive bidding for Federal contracts.[7]

c. Adult Day Health Facilities

The 202 statute, before the 1979 housing amendments, did allow community space to be used as infirmaries, outpatient and inpatient facilities. However, HUD discouraged this use of community space for health units by deleting reference to such space in the 202 regulations and handbook. In an effort to alter this policy, Senator Lawton Chiles proposed an amendment which would encourage HUD to permit community space to be used for adult day health facilities. The emphasis of the Chiles amendment was on adult day health services and outpatient facilities. It was not his intent that 202 projects offer "institutional medical care" as found in skilled and intermediate care facilities, but that such projects be allowed to house health clinics within their building. Senator Chiles stated:

> I can understand HUD's concern that the 202 program not become a type of skilled care facility or nursing home for the elderly and the handicapped. I share their concern. In fact, my amendment is intended to retain the independent living character of the 202 project by allowing community space to be used for adult day health services which means that the residents can walk from their apartments to the health center, receive the necessary care, and return to their apartments. Such outpatient health care is instrumental in keeping elderly persons from being prematurely institutionalized.[8]

d. Technical Assistance for Minorities

The new amendments also permit the Secretary of HUD to make available appropriate technical assistance and training assistance for potential applicants who have limited resources, particularly minority

[7] Domenici, Pete. Remarks in the Senate. Congressional Record, vol. 125, July 13, 1979, p. S9381.
[8] Chiles, Lawton. Remarks in the Senate. Congressional Record, vol. 125, July 13, 1979, p. S9384.

applicants, who would be unable to participate in the program without such assistance. This provision coupled with the Secretary's ability to waive the required capital investment, is intended to persuade more minority and limited income sponsors to compete in the application process. As discussed earlier, participation by minorities in the program has been exceedingly low.

B. Section 8 Rent Subsidies

Section 8 of the Housing and Community Development Act provides housing subsidies to low- and moderate-income families to assist them in making up the difference between the cost of housing the family can afford and the cost of standard housing in the area. Section 8 provides rental assistance under which moderate and low income persons pay no more than 25 percent, and as low as 15 percent, of their incomes for rent in newly constructed or substantially rehabilitated dwellings.

In testimony before the Subcommittee on Housing Appropriations of the Senate Appropriations Committee on May 2, 1979, the American Association of Homes for the Aging (AAHA) told the Congress that:

> Out of the 1.2 million people who have received section 8 assistance, 500,000 have been elderly or handicapped. Out of the section 8 funds going for new construction, approximately 360,000 elderly individuals have received assistance, out of a total of 550,000 people, or 60 percent. Out of the section 8 funds going for existing housing, only 20 percent of the 700,000 units were inhabited by elderly persons.

According to a HUD sampling, the mean income of section 8 households with heads 62 years of age or older is approximately $3,155 and these households have an average gross rent of $150 per month.[9]

The Housing and Community Development Amendments of 1979 (Public Law 96–153) amended section 8's requirement for contribution by the renter. Specifically, the law was changed to allow *very* low-income families to pay between 15 percent and 25 percent of their income for rent. The remainder would be subsidized by section 8. Very low-income families are those with incomes at or *below* 50 percent of the local median income.

For families with low-income (*above* 50 percent of the local median income) the required percentage was increased to "not less than 20 percent but not more than 30 percent of such family income."

These required contributions would most often apply to elderly households. However, the 1979 amendments also provided for new contribution rates for large households. Public Law 96–153 requires that "a large *very* low-income family" pay 15 percent of their income for rent. In addition, the law requires "a very large low-income family" to pay 20 percent of their income for rent.

The Housing and Community Developments of 1979 conference report (S. Rept. 96–496) points out that the new contributions "will not be implemented until January 1, 1980, and that tenants residing in section 8 units as of December 31, 1979, are exempted from this amendment."

[9] Department of Housing and Urban Development, Office of Policy Development and Research, "Lower Income Housing Assistance (Section 8), Nationwide Evaluation of the Existing Housing Program" (November 1978).

In addition, the Housing Act's selection criteria for public housing and section 8 programs was amended to require that preference be given to families occupying substandard housing or who are involuntarily replaced. However, the conferees point out:

> The priority is intended to guide the owner or PHA (public housing authority) in determining which potential tenants to select. The priority is not intended nor should it be used to allow the Department to direct an owner or PHA to select certain tenants. . . . This provision is not intended to alter the basic responsibility over tenant selection which, under current law, rests solely with the PHA and owner. It is simply intended to have owners and PHA's give priority to meeting the urgent housing needs of those families living in substandard conditions or being involuntarily displaced.[10]

The Department of Housing and Urban Development Appropriations Act for fiscal year 1980 (Public Law 96–103) provides for approximately $5.3 billion for rent subsidies for fiscal year 1980. At the time of passage (November 1979), it was estimated that this would support approximately 265,000 section 8 units. However, inflation and escalating rents dropped this number to about 250,000 in revised HUD estimates. According to the Low Income Housing Coalition, 225,000 units is a more realistic total. Therefore, the number of section 8 units available for reservations in fiscal year 1980 will be substantially lower than the earlier made HUD estimates for section 8 for fiscal year 1979.

C. Congregate Housing Services Program

During the 95th Congress, the Congregate Housing Services Act, title IV of the 1978 Housing Act, was introduced by Senators Williams, Church, and Domenici. Passed by the Congress as Public Law 95–557, it authorizes HUD to make grants to section 202 housing projects and local public housing agencies (PHA's) for the purpose of helping to provide meals and supportive services to frail, impaired elderly, nonelderly handicapped, or temporarily disabled residents in need of such services. The intent of these demonstration grants was expressed by Senator Williams, who stated: "Its purpose is to assist those with decreased mobility or energy to retain the capacity for independent living to the greatest extent possible." [11]

Although enacted in 1978, it was not until November 1979, that HUD announced competition for the $10 million appropriated for fiscal year 1979 for congregate housing services. In December 1979, HUD approved 38 applications from PHA's and 202 projects. Only 14 of the 38 approved awards went to 202 projects with the remaining 24 going to PHA's. The low number of 202 projects receiving congregate housing services demonstrations was, according to HUD, due to the few number of applications received from 202 projects.

The first congregate housing services awards will be disbursed over a 3-year period at a rate of approximately $3 million a year. HUD

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[10] U.S. Congress. Senate. Committee on Banking, Housing, and Urban Affairs. Conference Report 96–496, December 13, 1979, U.S. Government Printing Office, 1979.

[11] Williams, Harrison. Remarks in Senate. Congressional Record, Vol. 124, Mar. 8, 1978, p. S3256.

estimates that approximately 80 percent of the funds will be going to existing PHA and 202 projects and the other 20 percent to projects not yet completed.

As intended, not every resident of a PHA project or 202 building will be eligible for these services. Only those considered by the housing managers as frail and impaired will participate. In the 38 awards made in 1979, the largest number of persons served in one facility will be 247 in a PHA in the District of Columbia. The smallest number of persons served will be nine in a small 202 project in Illinois. The grantees are:

Grantees	Project designation	Number served
Housing Authority, city of Old Town, Old Town, Maine	Marsh Island Apartments	20
Rutland Housing Authority, Rutland, Vt	Templewood Court	12
Housing Authority of the city of Woonsocket, Woonsocket, R.I	Morin Heights	45
Manchester Housing Authority, Manchester, N.H	Project No. 1-15	68
Bethany Homes, Inc., Haverhill, Mass	Merrivista	40
Methodist Conference Home, Inc., Rockland, Maine	Methodist Conference Home	16
Roncalli Health Center, Inc., Bridgeport, Conn	Roncalli Apartments	20
New York City Housing Authority, New York, N.Y	Palmetto Gardens	30
Housing Authority of Plainfield, Plainfield, N.J	Richmond Towers	52
Congregation Brothers of Israel, Trent Center Apartments, Inc., Trenton, N.J.	Trent-Center Apartments	50
Richmond Redevelopment and Housing Authority, Richmond, Va	1611 Bldg	38
Philadelphia Housing Authority, Philadelphia, Pa	Germantown House	60
Baltimore City Housing Authority, Baltimore, Md	McCulloh Homes	33
Wilmington Housing Authority, Wilmington, Del	Compton Towers	36
District of Columbia Department of Housing and Community Development, District of Columbia.	Garfield Terrace	247
St. Mary's Association for Retarded Citizens, Leonardtown, Md	Group Home	27
Housing Authority of the city of Fort Pierce, Fort Pierce, Fla	Lawnwood Terrace	25
Mississippi Regional Housing Authority No. 5, Newton, Miss	No. MS-030-020	40
Orange Grove Center for the Retarded, Inc., Chattanooga, Tenn	Group Home	48
Diocese of Memphis Housing Corp., St. Peter Manor, Inc., Memphis, Tenn.	St. Peter Manor	60
Housing Authority of the city of Bloomington, Ill	No. IL-51-5	24
Cincinnati Metropolitan Housing Authority, Cincinnati, Ohio	Redding Apartments	25
Housing and Redevelopment Authority of Duluth, Minn	Tri-Towers King Manor	80
The Lambs, Inc., Libertyville, Ill	Group Home	9
Housing Authority of New Orleans, La	Guste Homes	70
Cherokee Nation of Oklahoma, Telequah, Okla	Tsa-la-gi	50
Greater Jerusalem Baptist Church, Houston, Tex	W. Leo Daniels Towers	20
Greater Muskogee Christian Churches, Inc., Muskogee, Okla	New construction project	15
Council Apartments, Inc., University City, Mo	The Delcrest	45
Murphy-Blair Resident Housing Corp., St. Louis, Mo	Murphy-Blair Senior Commons	32
Tabitha Home, Inc., Lincoln, Neb	The Walter	35
Northern Cheyenne Housing Authority, Lame Dear, Mont	Wendell Turkey Shoulderblade Center	39
Episcopal Management Corp., Kaysville, Utah	St. Marks Gardens	15
Renew, Inc., Sheridan, Wyo	Group Home	64
Housing Authority of the County of Los Angeles, Calif	Nueva Maravilla	36
Housing Authority of the County of Marin, San Rafael, Calif	Kruger Pines	30
Hale Mahaolu, Inc., Kahului, Hawaii	Hale Mahaolu	30
Housing Authority of Portland, Oreg	Northwest Tower	15

The Department of Housing and Urban Development Appropriations legislation for 1980 (Public Law 96-103) again provided for $10 million for congregate housing services for fiscal year 1980. These funds will be awarded to additional grantees for additional 3-year demonstrations. Although the administration did not request any funding for congregate housing services in fiscal year 1980, HUD did project that announcements for competition for the second $10 million would be made in the Federal Register early in 1980. The program is considered an interagency effort. The Office of Neighborhoods, Voluntary Associations and Consumer Protection, and the Office of Housing, Policy Development and Research of HUD are taking the lead. The Administration on Aging and the Office of Rehabilitation Services of HEW are coordinating the services to be provided.

Most States will probably use State economic opportunity offices to administer the program and delegate program operations to a combination of community action agencies, area agencies on aging, unemployment insurance offices, and district welfare offices [49]

(For further information on energy assistance, see chapter 4.)

[49] U.S. Department of Health, Education and Welfare. Office of the Assistant Secretary for Planning and Evaluation. Fact Sheet—Low-Income Energy Assistance Program for Fiscal Year 1980 (Washington, D.C.. Nov. 28, 1979).

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propriation for these activities nor did the Office of Management and Budget (OMB) permit CSA to use any of its funds for weatherization in fiscal year 1979. Instead weatherization funds for fiscal year 1979 were awarded to the Department of Energy. Local operation of the program, however, was still carried out largely by community action agencies.[48]

An exceptionally cold winter during 1976–77, increases in the cost of home heating oil, and inflation prompted Congress in 1977 to make a special appropriation of $200 million (Public Law 95–26) for the special crisis intervention program (SCIP) to be used to assist the poor in paying high fuel bills. The Community Services Administration administered this program through community action agencies and other local providers. In fiscal year 1978, Congress passed a supplemental appropriation of $200 million (Public Law 95–482) with special emphasis on the distribution of funds to the low-income elderly.

In anticipation of even higher fuel costs in 1980, the Congress and the administration developed an expanded program of energy assistance to low-income persons. A total of $250 million for the CSA energy crisis assistance program was approved under the Labor-HEW appropriations continuing resolution (Public Law 96–86).

In October 1979, the Senate and House of Representatives approved an additional $1.35 billion for an expanded energy assistance program. The $1.35 billion is divided as follows: $150 million for the Community Services Administration, $400 million for supplemental security income recipients, and $800 million to the States for distribution by the Governors. States must submit plans for the use of their allocation of the $800 million funds for approval by HEW.

Both the Senate energy assistance measure (Javits amendment to H.R. 4930, the Interior appropriations bill) and the House measure (H.J. Res. 430 emergency supplemental), used existing authority under the Economic Opportunity Act (section 222) to expedite the funding for the 1979–80 winter months.

The $250 million (continuing resolution) and the $150 million (H.R. 4930) will add up to $400 million for the Community Services Administration's energy crisis assistance program (ECAP) for fiscal year 1980.

ECAP provides emergency assistance to households with incomes no higher than 125 percent of the CSA poverty guidelines or to households whose heads receive supplemental security income. The funds must be used for the payment of energy-related costs, but may not be used for weatherization. Not more than $400 may be spent on a household unless a State wants to spend more. Funds may be used only for the following forms of assistance: (1) Payments to vendors and suppliers of fuel, goods, and other services; (2) the establishment of lines of credit with fuel/utility vendors for the benefit of eligible households; (3) direct assistance to a person who has paid a fuel bill; and (4) short-term emergency assistance in the form of goods or services such as emergency fuel deliveries, warm clothing, blankets, temporary shelter, emergency repairs, food, medicines, or other supportive services.

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[48] U.S. Congress. Senate. Committee on Labor and Human Resources. Economic Opportunity Amendments of 1979; report to accompany S. 1725 (Washington, D.C., S. Rept. 96–434).

stimulate a better focusing of all available local, State, private, and Federal resources upon the goal of enabling low-income individuals of all ages, in rural and urban areas, to attain the skills, knowledge, and motivation and to secure the opportunities needed for them to become self-sufficient." The CAA's, therefore, provide a wide-range of services to low-income individuals, including the low-income elderly. These services include senior opportunities and services, food and nutrition, crisis intervention, weatherization, health, housing, rural transportation, manpower training, and job development.[44]

As reported in "Developments in Aging" part 1, last year, the 1978 amendments took a number of steps to strengthen and expand community action agency services in rural areas.

Community action against poverty was carried out by a nationwide network of 878 CSA-funded community action agencies in 1979. CSA estimates there will be close to 900 CAA's by the end of 1980.[45] CSA attempts to ensure the economic self-sufficiency of the poor by promoting involvement of the poor in carrying out a policy of local flexibility and initiative in implementing its programs.

The CSA estimates that in 1979, over 2 million persons 50 years of age and older were beneficiaries of the programs and projects administered by community action agencies.

D. Energy

The Community Services Administration's energy conservation and solar energy policies are designed, as part of its legislative mandate, to ". . . enable low-income individuals and families, including the elderly and the near poor, to participate in energy conservation programs designed to lessen the impact of the high cost of energy and to reduce individual and family energy consumption." [46]

During the 1973 energy crisis, it became apparent that the poor and elderly poor were the most vulnerable. That year, the Maine State Economic Opportunity Office, using a special $478,000 OEO grant began "project fuel," which combined weatherization, crisis intervention, and energy assistance activities into one project, which became the prototype for future weatherization projects. Using section 222 local initiative funds, many CAA's quickly mobilized local projects. Congress recognized the program's value and made it a national program in 1974 by adding a new section 222(a)(12)—Emergency Energy Conservation Services [now section 222(a)(5)]—to the Economic Opportunity Act.

Under this authority, CSA operated a national weatherization program from fiscal year 1975 through 1978. CSA made grants directly to local agencies to implement weatherization programs. During those 3 years of operation, the CSA program expended $192.2 million to weatherize 372,911 [47] dwellings. Even though section 222(a)(5) of the Economic Opportunity Act as amended, retains the CSA authorization of a winterization program CSA did not receive a specific ap-

[44] Community Services Administration, Office of Community Action, Program Policy Statements, Fiscal Year 1979, p. 10.
[45] Ibid.
[46] Community Services Administration, Office of Community Action Program Policy Statements, Fiscal Year 1979, p. 10.
[47] Community Services Administration, CSA Fact Sheet for Energy Conservation (Washington, D.C., January 1979).

outreach networks which seek out the poor for assistance, provide information on where they can obtain services and complement senior center services funded by the Administration on Aging. During 1979, approximately 1 million elderly persons 60 years of age and older were served by SOS which expended approximately $9.5 million. In addition, the programs provided support to a number of statewide elderly advocacy organizations.

B. Community Food and Nutrition

The community food and nutrition program (CFNP), now authorized under title II of the Community Services Act, began in 1968 as the emergency food and medical services program (EFMS). The medical component of the program was dropped when CSA was created in 1974.[42]

The purpose of the CFNP is to fight hunger and malnutrition among the poor. Although CFNP services are available to all low-income individuals, a primary emphasis has traditionally been given to poor older persons. CSA's community food and nutrition policy statement of 1979, stated that CFNP ". . . provides assistance in those areas not emphasized in other Federal food and nutrition programs, such as mobilization of resources, self-help, technical assistance, crisis relief, and consumer education activities."

The main objective of CFNP is to link the poor with opportunities provided by existing food and nutrition programs, not to create duplicative or competing services. In order to meet its stated objectives, CSA has outlined the following strategy areas: (1) Access and improvement of service delivery, (2) self-help, (3) nutrition consumer education, (4) crisis relief, and (5) coordination of antihunger efforts.

The community food and nutrition program spent over $28.5 million on 520 grants throughout the country. It distributed its grants to: 370 community action agencies, 74 nonprofit community organizations, 62 Indian projects, 7 migrant groups, and 6 national support groups. CSA does not have statistical data on the number of elderly persons served under CFNP. They did state, however, that they will have data available in 1980.

Previously, the administration of the CFNP was limited by statute to local community action agencies. The 1978 amendments made public and private nonprofit agencies eligible for program grants.

CFNP funds are flexible and may be used in a variety of ways depending upon needs and resources of the communities in which they are used. Priorities are established locally in accord with CSA policies and instructions. Funds may not be obligated for long term commitments or for duplicative programs.[43]

C. Community Action Agencies

Title II of the Economic Opportunity Act provides for the establishment and funding of community action agencies (CAA's). The basic purpose of title II, as stated in section 201(a) of the act, is "to

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[42] Community Services Administration, CSA Fact Sheet for Food and Nutrition (Washington, D.C., January 1979), p. 2.
[43] Ibid.

(3) To undertake research and experimentation designed to expand the knowledge base about poverty problems and to develop and test innovative solutions.

(4) To develop and support local programs which meet the critical services needs of the poor and provide permanent improvements in living conditions.

In order to accomplish these objectives, the CSA mission requires a coordinated and comprehensive approach in which the poor themselves participate to the fullest extent possible in decisionmaking and implementation of programs which have a direct impact on their lives. The CSA's mission and objectives are carried out at the local level by the community based organizations.

The 1978 reauthorization of the Economic Opportunity Act of 1964 emphasized specialized services to the elderly through programs such as: Senior opportunities and services, community food and nutrition, emergency energy conservation and crisis intervention, and local initiative programs through community action agencies.

In a 1979 policy statement, CSA noted:

> Policy on the older poor will focus on the goals of promoting the highest possible level of independent living, preventing or delaying institutionalization, providing supportive services especially for the functionally dependent, increasing the access of the elderly poor to services, and overcoming and eliminating discrimination on the basis of age.

In order to implement this strategy, CSA identified the following areas of emphasis for its services programs for older persons: (1) Outreach and follow-through, (2) access and advocacy, (3) innovative programing and integrated services, (4) income maintenance and employment, (5) elderly victimization, (6) independent living/housing, (7) nutrition, (8) transportation, and (9) discrimination.

A. Senior Opportunities and Services

In its early years, the Office of Economic Opportunity (OEO) placed little emphasis on programs for older poor persons. Unfortunately, assumptions had been made that social security, medicare, medicaid, and other programs would serve the elderly poor along with other groups. However, OEO research projects and outreach efforts clearly demonstrated the need for additional services for the Nation's elderly.[41]

The senior opportunities and services (SOS) program, authorized by section 222(a)(3) of the Economic Opportunity Act of 1964, as amended, provides services to low-income elderly, primarily individuals not being served by other programs for the elderly. SOS also gives preference to the employment of low-income elderly as service providers. The 1978 amendments reauthorizing the Economic Opportunity Act (Public Law 95-568) added new language to require that SOS programs, when feasible, utilize the direct services of other agencies serving the elderly poor. Many of the SOS grantees are community action agencies (CAA's) that subcontract with local elderly service provider organizations. These SOS projects maintain information and

[41] Community Services Administration. CSA Fact Sheet for Senior Opportunities (Washington, D.C., January 1979), p. 1.

this end, the committee accepted an amendment offered by Senator Chiles which requires the Department to report to the Congress by January 1, 1980 on how prime sponsors have developed programs for older workers.

Still concerned that success of section 215 efforts hinged on proper implementation of section 308, Senator Domenici introduced an amendment to H.R. 4389 when it reached the Senate floor. The Domenici amendment, accepted on the floor without objection, set aside $5 million of title III funds for section 308 middle age and older workers programs.[40] In conference action to resolve differences between the House-passed and Senate-passed versions of the legislation, conferees deleted this provision but inserted language in the conference committee report (H. Rept. 96–400) directing DOL "to utilize a significant portion of CETA title III resources to fund projects for middle-aged and older workers under section 308 of the act."

Title III, "special national programs and activities," also include a mandate for the development of employment opportunities and appropriate training services for displaced homemakers. Since a significant number of displaced homemakers are older women, this program is especially relevant to the older population. In fiscal year 1979, the Department of Labor set aside $5 million of title III funds for displaced homemaker activities. While there will be some emphasis on using CETA title II and title VI public service employment positions for displaced homemakers, the bulk of the allocated funds, $3.25 million, will be used to fund proposals for regional displaced homemaker demonstration projects.

No separate funding has been provided for older displaced homemakers. However, in the Department of Labor's announcement of the displaced homemaker grants (Federal Register, October 26, 1979, pp. 61932–61934), the following were designated as priority subgroups within the national displaced homemaker population: (1) 40 years of age or older; (2) minority; or (3) rural residents. Furthermore, according to the announcement, applicants will be judged in terms of several kinds of prior service provision experience; the list includes experience in serving middle-aged or older individuals.

VIII. COMMUNITY SERVICES ADMINISTRATION

The primary goals of the Community Services Administration (CSA), which was created by the Economic Opportunity Act of 1964 are twofold: (1) To provide the necessary assistance to the poor to become self-sufficient, and (2) to promote sensitivity and responsiveness to the needs of the poor.

In working toward these goals, CSA has four major objectives:

(1) To act as the representative of the poor within the Government, make their needs and aspirations known to the Nation's decisionmakers, and mobilize both public and private sector resources on their behalf.

(2) To promote the development and strengthening of community-based institutions which represent the interests of the poor on the local level and carry out a range of programs and developmental activities responsive to their needs.

[40] Domenici, Pete V. Remarks in the Senate. Congressional Record, vol. 125, July 20, 1979: S10023.

another within the labor force and to facilitate the transition of such workers from nonparticipation to participation in the labor force...

(3) Conduct research on the relationships between age and employment and insure that the findings of such research are widely disseminated in order to assist employers in both the public and private sectors better understand and utilize the capabilities of middle-aged and older workers.

(4) Develop and establish programs to develop methods designed to assure increased labor force participation by older workers who are able and willing to work but who have been unable to secure employment or who have been discouraged from seeking employment.

To fund the projects set forth in section 308, the Congress provided that the Secretary shall reserve not more than 5 percent of the amount available for all of title III.

Early in 1979, during the budget and appropriations process, the House Select Committee on Aging's Subcommittee on Retirement Income and Employment was informed by the Department of Labor that without new moneys added to title III, it would not consider implementing the new section 308 projects for middle-aged and older workers.[38] Subsequent conversations between the Department and the Senate Special Committee on Aging revealed that once funding for the other programs mandated in title III was apportioned—for Native Americans, migrant and seasonal farmworkers, etc., there were few if any funds left over for implementing section 308. (Included in the programs to receive mandated funds was the public service jobs for older Americans program originally authorized and funded under title X of the Public Works and Economic Development Act of 1965. In transferring this program to CETA, the Congress required DOL to continue its funding until it could be phased out.)

As the Labor-HEW appropriations bill for fiscal 1980 (H.R. 4389) worked its way through the legislative process, efforts were made to set aside a specific amount of title III funds for implementation of section 308. Although the House Appropriations Committee reported the bill with no specific set-aside for section 308, Representative John Burton, Chairman of the House Select Committee on Aging's Retirement Income and Employment Subcommittee, received assurances on the House floor from Appropriations Committee Chairman William Natcher that the committee expected the Department to allocate "a substantial amount of title III funds for section 308 programs, since over $27 million could be used for that purpose." [39]

During the Senate Appropriations Committee consideration of the 1980 Labor-HEW appropriations bill, Senator Chiles raised his concern that only 2 percent of CETA enrollees are over age 55, despite clear congressional mandates that more effort needs to be focused on employment problems of older workers. In reporting the bill to the Senate floor, the committee reflected this concern in its report (S. Rept. 96–247) and further directed DOL to make a vigorous effort to implement the older workers initiative found in section 215 of CETA. To

[38] Burton, John L., Remarks in the House of Representatives. Congressional Record, vol. 125, June 27, 1979 : H5239.
[39] Ibid.

their usefulness and limitations in research. The conference brought together approximately 150 specialists and considered the several issues involved with the uneven usefulness, availability, and exploitation of the various Federal data sets.

VII. COMPREHENSIVE EMPLOYMENT AND TRAINING ACT (CETA)

CETA is the primary program in the United States for providing training, employment, and other services leading to unsubsidized employment for economically disadvantaged, unemployed or underemployed persons. While individuals of all working ages who qualify can participate in this program, historically CETA has devoted few of its program resources to addressing the employment problems of the middle-aged and older worker.

In the 1978 amendments to the Comprehensive Employment and Training Act (Public Law 95-524), the Congress acted to correct this oversight. Prime sponsors—those receiving CETA funds—were required by the act to take the needs of the older worker into account in the development of their comprehensive employment and training plans, and were required in their annual plans to describe specific services which would be made available to individuals who were experiencing severe handicaps in obtaining employment—including persons who are "55 years of age or older." In the 1978 amendments, the Congress went even further to guarantee that older workers would no longer be ignored by the CETA program.

Noting the substantial underrepresentation of older workers among CETA participants, Senators Chiles and Domenici authored an amendment which became section 215 of the act, "Services for Older Workers." The new section 215 provides that services for older workers shall be designed in order to assist eligible participants to overcome "the particular barriers to employment experienced by older workers." Although separate funding for older workers was not provided in this section, the Congress did require the Secretary of Labor to insure that each prime sponsor's plan include provisions for activities and services for older workers and that these services be coordinated with other programs and services provided by senior centers, area agencies on aging, and State units on aging. Further, the Congress added a linkage between section 215 and section 308 of the act, "Projects for Middle-Aged and Older Workers," by providing that services utilized under section 215 might include activities described in section 308.

Section 308 was also added by Congress in the 1978 amendments to draw further attention to older worker employment needs. As part of title III-A "Special National Programs and Activities," section 308 directs the Secretary of Labor to:

> (1) Develop and establish employment and training policies and programs for middle-aged and older workers which will reflect appropriate consideration of these workers' importance in the labor force and lead to a more equitable share of employment and training resources for middle-aged and older workers.
>
> (2) Develop and establish programs to facilitate the transition of workers over 55 years of age from one occupation to

of the life course; attitudes, self-image, and life satisfaction; sex role differences in aging; economic implications of biological losses; social and cultural factors in health maintenance and function.

(3) Older people and social institutions: Linking the first two research categories, this area refers to research on relations of aging individuals to the several social institutions within which they grow old. The Institute supports age-related research on such topics as the family and kin networks; friendships and peer groups; and economic, political, religious, health, and leisure institutions.

In addition to these three major categories of research topics, the social and behavioral research program has developed four major emphases which are applicable to most research proposals: (1) The dynamic, rather than static, character of aging as a process, and of social and historical change which affects both the ways individuals age and the age structure of society; (2) the interrelatedness of old age with earlier ages, as later life is interconnected with the full life course; (3) the cultural variability of age and aging, both within a single society and across societies; and (4) the multiple facets of age and aging, as social and psychological aging processes are in continuing interplay with biological and physiological aging.

As part of its continuing development and respecification, the social and behavioral research program has prepared a substantially revised program announcement detailing the several content categories, program emphases, award selection criteria, and profile of available mechanisms of support. The program announcement appears in the NIH "Guide for Grants and Contracts," volume 8, No. 15, December 4, 1979, and is available from NIH's social and behavioral research program office.

E. The Epidemiology, Demography, and Biometry Program

During 1978 the Institute established the position of associate director for epidemiology, demography, and biometry. Under the direction of Dr. Jacob Brody, this largely intramural program focuses on research on the epidemiology of health and disease as well as the interaction of demographic, social, and economic factors as they affect the health of the elderly. The overall mission of the program is to serve as the Institute's focal point for quantitative population base research on health and disease in the aging, including the broad disciplines of medicine, biostatistics, epidemiology, economics, sociology, and demography.

The program is developing two sets of research emphases which, it is hoped, will evolve into separate branches of the program. The population and clinical research analysis group is involved primarily with clinical applications of population research using mainly primary data sources. The population dynamics and research analysis group focuses on demographic and economic research and relies largely on secondary data analysis.

Among the projects of the program, one which may have the broadest impact on research on aging in general was a conference on "Demographic and Health Information for Aging Research: Resources and Needs." The conference emphasized, identified, and began the process of inventorying the immense volume of Federal data, and examined

(1) The basic aging program encourages fundamental molecular and genetic research and research training on the biology and mechanisms of aging. The four research areas which comprise this program are genetic and cellular aging, genetics and comparative aging, theoretical gerontology, and dermatology.

(2) The molecular and biochemical aging program supports research activities in the four areas of immunology, intermediary metabolism, pharmacology, and diabetes.

(3) The biophysiology and pathobiology of aging program supports five interrelated areas of research: Neuroscience, nutrition, endocrinology, geriatric medicine, and exercise physiology. In addition, this program develops and manages the supply of aging animal models essential for research on aging.

A substantial and detailed report of the recent major findings of the biomedical research and clinical medicine program is included in part 2 of "Developments in Aging: 1979."

D. The Social and Behavioral Research Program

One of the major developments of the Institute in 1979 was the expansion and reorganization of the social and behavioral research program, an activity which will continue in 1980. As noted above, Dr. Matilda White Riley was named to head this program. In general, the program is concerned with the social, cultural, economic, and psychological factors that affect both the process of growing old and the place of older people in society.

The program is coordinated with related programs on aging within NIA (e.g., biological research and clinical medicine) as well as with such other organizations as the National Institute of Mental Health, the National Institute of Child Health and Human Development, and the National Institute of Neurological and Communicative Disorders and Stroke. Yet the social and behavioral research program views health and well-being not narrowly within the framework of biological aging alone, but as the outcome of intricately interacting biological, psychological, social, and environmental processes.

The newly reorganized program includes three broad, overlapping categories of research projects:

(1) Older people in the changing society: This area focuses on research on age as a structural feature of society, both in the population and the organization of social roles. Research topics include the age composition of the population; demographic patterns of migration, morbidity, and mortality; and research on such age-related societal structures as labor force participation opportunities, political opportunities, age-based conflict, environmental design, and age integration versus age segregation.

(2) Psychological and social components of the aging process: This area focuses on the psychological and social aspects of aging as a process and includes studies of constancy and change in social and psychological characteristics, behaviors, and environmental responses of individuals as they grow old. It also includes biopsychological and cognitive components of the aging process such as the physiological bases of aging behavior, psychomotor skills, memory, learning and attention, creativity, and wisdom. Additional research areas include such social psychological and social factors as subjective views

While all categories of grants demonstrated an increase, the largest increase was in the area of clinical research and training, which increased by 200 percent. This reflects in part the initiative of the NIA's Director, Dr. Robert Butler, who in 1979, accelerated NIA's concern over the lack of clinical medical training in geriatrics in American medical schools. Dr. Butler has noted that although 40 percent of all persons who come into contact with a doctor are older people, few medical schools have provided specialized training in geriatrics for medical students. Responding to this need, the Institute is now supporting geriatric training to 11 medical schools across the United States.

While the President's proposed budget for the fiscal year 1980 would have resulted in a cut in Institute funding, appropriations approved by the Senate and House of Representatives increases the Institute's budget by $13.1 million, or 23 percent over fiscal year 1979. While not as dramatic as the 1978–79 increase, the appropriated funds will provide for a significant number of additional research and training awards. In their respective appropriations committee reports, both the Senate and the House specifically mentioned the importance of expanding NIA's research and training programs.

The Senate (S. Rept. 96–247, pp. 61–62) stated that "nearly 100 new and competing research grants, and new initiatives such as geriatric initiative grants, clinical investigation awards, and special initiative awards for aging research will take place within the increased amount . . ." In its report (H. Rept. 96–244, p. 44), the House stated that "of the increase . . . $5,400,000 is for new grants and competing renewals for investigator-initiated projects."

B. The National Academy of Sciences' Committee on Aging

In response to the growing importance of both the aged in society and research on aging as a preface to understanding the processes of aging, the Committee on Aging was established by the Assembly of Behavioral and Social Science of the National Academy of Sciences. A major activity of the Committee on Aging, with support from NIA, was a series of three workshops held in March, May, and June of 1979.

One of the major goals of the workshops was the discussion and development of multidisciplinary as well as disciplinary agenda for social and behavioral research on aging. Another major goal was the capturing of the research attention of scholars who were new to aging research. Toward these ends, the workshops were purposely designed to facilitate the interaction of established gerontological researchers with researchers who had not focused their research specialties within a gerontological context. The workshops were devoted, respectively, to stability and change in the family, the elderly of the future, and the biology and behavior of the elderly. The papers from the workshops are currently being edited into a three-volume set.

C. The Biomedical Research and Clinical Medicine Program

The program of biomedical research and clinical medicine supports research to further the goals of understanding the aging process and improving the ability of the individual and the health practitioner to respond to the diseases and other clinical problems of the aged. The program is divided into three separate areas of research:

The Research on Aging Act mandated that the Institute and its advisory council develop "a plan for a research program on aging designed to coordinate and promote research into the biological, medical, psychological, social, educational, and economic aspects of aging." This plan, "Our Future Selves: A Research Plan Toward Understanding Aging," was presented to Congress in December 1977. A supplement to the plan was presented in 1978, and contained the reports of three expert panels of the National Advisory Council on Aging in the areas of biomedical research, behavioral and social science research, and research on human services and delivery systems. These reports, specific program announcements for research and research training, as well as other documents and publications of the Institute, can be obtained directly from the NIA Information Office, National Institutes of Health, Bethesda, Md. 20205.

During the year, NIA announced a major addition to its senior staff with the appointment of Dr. Matilda White Riley as associate director for social and behavioral research. Dr. Riley is an internationally recognized pioneer in the sociology of aging and came to the Institute after many years of research and teaching experience at New York University, Harvard, Rutgers, and most recently at Bowdoin College in Maine, where she was Fayerweather professor of political economy and sociology. During the 1978–79 academic year she was in residence at the Center for Advanced Study in the Behavioral Sciences at Stanford. Earlier in 1979, Dr. Riley was one of four scientists to be elected to senior membership in the Institute of Medicine, National Academy of Sciences.

A. Research Grants and Budgets

NIA's research program made substantial gains in 1979 over previous years, measured in terms of both budget and number of research and research training awards made. The overall Institute budget, which was $37.3 million in 1978, increased to $56.9 million in 1979—an increase of 52.5 percent. As in previous years, the largest proportion of the Institute's budget supports the extramural programs of research, training, and contracts; the growth in this area was even greater than for the overall Institute budget. Compared to the 1978 extramural program of $26.3 million, the 1979 extramural program accounted for $43.1 million, an increase of 63.9 percent.

Similar growth has been seen in the number of awards made. The number of research and training awards for the past 3 fiscal years was: 266 in 1977, 325 in 1978, and 552 in 1979. While the 1977–78 increase was 22 percent, the 1978–79 increase was 70 percent. The distribution of 1978 and 1979 is as follows:

Area of awards	1978		1979	
	Number of awards	Percent of total	Number of awards	Percent of total
Biomedical/biological	209	64	347	59
Social/behavioral	79	24	120	19
Clinical	23	7	69	13
Multicategory	14	4	16	9
Total	325		552	

adequate support to appropriate and effective education programs for the increasing numbers of older Americans. . . . I believe we will have taken an important first step toward the kind of advocacy and accountability we need if you would designate an individual at the policy level to take charge of this area.

C. 1980 Appropriations

The President's budget for 1980 requested $90,750,000 for the adult education program. The House of Representatives and the Senate approved $100 million for the program, as well as $5 million for adult refugee education.

Despite the authorization of an expanded community schools program in the 1978 Education Amendments (Public Law 95–561), community schools were appropriated $3,138,000 for fiscal year 1980, $52,000 less than in 1979. This program encourages cooperation among providers of human services in the community by allowing resources to be pooled under title XX, the Older Americans Act, and a number of other Federal programs to provide adult education, health screening and referral, job information and counseling, recreation, and a number of other social services at local school buildings.

The Fund for the Improvement of Postsecondary Education, which is the source of support for such innovative projects as elderhostel, received $500,000 more in appropriations than in fiscal year 1979, bringing the 1980 funding to $13.5 million.

VI. THE NATIONAL INSTITUTE ON AGING

The National Institute on Aging was established as part of the National Institutes of Health by Congress in 1974 through the Research on Aging Act (Public Law 93–296). In response to mandates of the act, the NIA has established programs in biomedical research and clinical medicine; behavioral and social science research; and epidemiology, demography, and biometry. These three programs comprise the Institute's extramural research activities which are its largest set of responsibilities. In addition, substantial biomedical and behavioral research activities are conducted as part of the intramural research program of the Gerontology Research Center. The epidemiology, demography, and biometry program has also begun to develop a significant research program.

Support for research and research training is provided primarily through the award of investigator-initiated research grants. Research contracts are sometimes used but are generally reserved for the development and support of research resources, particularly animal and cellular resources.

Although researchers initiate their own research proposals, the Institute develops program emphases which are encouraged by means of program announcements, requests for applications (grants), and requests for proposals (contracts). In addition, stimulation of research on aging is accomplished through cooperative and collaborative agreements with other agencies, such as other NIH institutes, the Administration on Aging, the National Institute of Mental Health, and the National Academy of Sciences.

> thereby enabling the Federal Government to improve its contribution toward the betterment of American education."
>
> —Senate Report No. 96–49, to accompany S. 210.

Congress passed the Department of Education Organization Act (Public Law 96–88, signed into law on October 17, 1979) with the stated objectives of increasing the visibility and status of education, providing a Cabinet-level official to work with Congress and the President on Federal education programs, streamlining and coordinating the Federal education effort, and making Federal education programs more accountable and responsive to the States, local education agencies, and the American people.

Nowhere is the fragmentation and lack of coordinated effort in education more evident than in programs for adult and older Americans:

> Looking over the total Federal lifelong learning effort for older adults, it is possible to identify at least 50 Federal programs which provide some education or training activities in which older adults can participate. But this number is misleading. The activities are fragmented, relatively narrow in scope, and probably represent funding levels of less than 1 percent of the over $14 billion the Federal Government spent on education and training for all persons past compulsory school age in fiscal year 1976.[36]

Compounding the problem is the fact that reliable data on the educational attainment, needs, and participation in Federal programs by older Americans is not available. As stated by Ms. Christoffel:

> . . . the majority of Federal programs do not maintain statistics identifying their participants by age. There were more than 270 Federal programs providing lifelong learning in 1976, dispersed throughout 29 Cabinet-level departments and agencies, and few can tell how many older adults they are serving.[37]

(See the discussion of House-passed amendments to the Higher Education Act earlier in this section.)

To insure that the educational needs of the elderly receive sufficient attention in the new Department, Senator Chiles wrote the new Secretary of Education, Shirley M. Hufstedler, on December 13 to urge her:

> . . . to appoint an official, at the policy level, to be responsible for seeing that the educational needs of the elderly are met and that programs the Department administers in which older Americans can participate are effective and coordinated.

He also indicated that the individual should be able to oversee the aging education activities of the offices within the Department, as well as serve as liaison with other Federal agencies which have responsibility for such programs. Senator Chiles concluded by saying:

> I am not requesting that a whole new bureaucracy be created. However, I am vitally concerned that Congress target

[36] Pamela Christoffel, The Older Adult and Federal Programs for Lifelong Learning (Washington: The College Board, 1977), pp. 6–7.
[37] Ibid., p. 6.

—Provided in sections 102 and 103 that the funds to the States would be distributed through a formula of: (a) 20 percent on the basis of adult population for comprehensive planning for continuing education; (b) 70 percent for State services, of which: (1) 25 percent would be for educational information services, (2) 25 percent would go to continuing education programs and grants, (3) the remaining 50 percent would be distributed on the basis of population for continuing education programs; (c) 10 percent for Federal initiatives, such as national demonstrations.

—Provided in section 105 that the States would have substantial flexibility in setting the priorities for spending and specifically mentioned older persons and women reentering the work force among the possible target groups for continuing education activities and information.

—Required in sections 102 and 104 the States to coordinate their planning activities and information services with a number of other Federal education and employment programs, including the Older Americans Act.

—Reauthorized the National Advisory Council on Extension and Continuing Education, but renamed it the National Advisory Council on Continuing Education.

During consideration of H.R. 5192 by the House of Representatives, two amendments were adopted which are also related to the educational needs of older Americans. The first, offered by Representative Mario Biaggi, provided for a study of the remaining barriers to adult postsecondary education.[34] The second was offered by Representative Paul Simon, and required that evaluation reports of education programs include tabulations of data to indicate the effectiveness of programs by age, race, and sex of the participants.[35]

The education amendments of 1979 are currently pending before the Subcommittee on Education, Arts, and Humanities of the Senate Committee on Human Resources, where reauthorization hearings were held between October 2 and November 9. Consideration of the House-passed legislation and alternative measures introduced in the Senate is anticipated early in the 2d session of the 96th Congress.

B. The Department of Education

> ". . . . there is a significant, but carefully restrained Federal role in education. Total Federal spending is more than $25 billion annually. That Federal effort, however, is severly hampered by its burial in HEW . . . its confusing lines of authority and administration, its fragmentation, and its obvious lack of direction. A hampered and deficient Federal education effort places an adverse strain on States, localities, and public and nonpublic educational institutions. The committee believes the establishment of a Cabinet-level Department of Education will go far towards remedying these problems,

[34] Biaggi, Mario. Amendment No. 1098 to the Higher Education Act Amendments, Congressional Record, vol. 125, Nov. 2, 1979 : H10159–60.
[35] Simon, Paul. Amendment No. 1103 to the Higher Education Act Amendments, Congressional Record, vol. 125, Nov. 2, 1979 : H10192.

> The difficulty we have experienced in getting funding for title I is not, in my view, a negative judgment on the merits of Federal support for lifelong learning, community service and continuing education. It is plain for all to see that the dramatic changes in the clientele of postsecondary education justify, and indeed, demand a Federal role in assisting postsecondary education to effectively serve the "new" student of the last quarter of the 20th century. . . . The problem of attracting adequate funding is not the goals but the mechanism we have created to achieve those goals. Title I, as it currently exists, does not seem to effectively articulate these goals in a way that will attract support in the budget and appropriations process.[33]

However, the 1st session of the 96th Congress found no clearcut consensus with respect to exactly what the Federal role in lifelong learning should be and what changes should be made to meet the needs of the new population of older students.

The administration proposed in S. 1840, separating the community service and continuing education components of title I into two distinct parts. To eliminate the confusion between the goals and activities of the continuing education and lifelong learning sections, the President's proposal would combine the two in the continuing education section.

The consolidated program would be aimed at meeting the needs of the growing adult population through expanded programs of institutions of higher education. Funds, allocated to the States, would be authorized on a "such sums as are necessary" basis (that is, allowing the President and Congress to determine the amount each year in the budget process). Under the administration plan, funds would flow through a single State agency to institutions whose applications fit into the comprehensive statewide plan for continuing education.

Representative William R. Ratchford worked with a coalition of educators, administrators of postsecondary institutions, business and labor organizations, and aging groups to draft a new approach to meeting the educational needs of nontraditional students. As introduced, H.R. 4531 was designed to develop a core of Federal support which would marshal a coordinated effort toward retraining programs and continuing education for adult Americans. The bill would:

—Focus on adults who have been educationally disadvantaged due to their age, race or national origin, sex, a handicapping condition, or economic circumstances.

—Use institutions of higher education, business and industry, labor organizations, and other public and private entities as resources.

The House Education and Labor Committee adopted many of the major premises of H.R. 4531 in its version of the Education Amendments of 1980 (H. Rept. No. 96–520 to accompany H.R. 5192). The legislation, which passed the House of Representatives on November 7, contained the following provisions in title I:

—Authorized $100 million for fiscal year 1981 and $200 million by fiscal year 1985, 90 percent of which would be allocated to the States for "education outreach" programs.

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[33] Ibid.

missions policies which favor younger students, inadequate transportation, poor health, inconvenient scheduling of courses, as well as the biggest barrier of all—apathy on the part of older people themselves, partially resulting from a lack of understanding of educational options.[31]

Awareness of the "graying of America," changing economic and social conditions, the learning needs of adults, and the Nation's need to fully utilize our vast human resources were all reflected in the way the 96th Congress approached the reauthorization of the Higher Education Act. The 1979 session saw an impetus to revitalize title I, which includes continuing education and lifelong learning programs, in a way that would make recurrent education available to those who have been deprived of such opportunities due to age, race, sex, a handicapping condition, or previous educational experience.

A. The Higher Education Act

> "The typical student is no longer young, no longer full-time, no longer just out of high school, no longer a stranger to the world of work, no longer necessarily seeking either a set of skills, or an educational credential. And to be certain, he is no longer overwhelmingly 'he'." [32]

One of the main issues in the reauthorization of lifelong learning programs is that the proportion of nontraditional students has been growing in relation to the numbers of traditional learners. In spite of this phenomenon, the majority of Federal support to postsecondary education continues to be geared to the traditional student—the 18 to 22 age group. Some postsecondary institutions have recognized and moved to accommodate the needs of this changing student population. Private organizations, business, labor unions and other agencies which operate in noninstitutional settings are becoming interested in developing adult learning programs as well. However, Federal efforts for adult learners have been piecemeal and fragmented, thus doing little to promote coordination and planning. This situation points to a second major problem with the continuing education, lifelong learning and community service programs in the Higher Education Act—that of funding and the funding mechanism. While continuing education and community service programs (title I–A) saw their funding consistently reduced, the lifelong learning program (title I–B) was never funded at all.

Testimony at House and Senate hearings on title I of the Higher Education Act (HEA) addressed the need to refocus postsecondary programs to meet the demands of the new student population as well as the problem the existing title I program has experienced in the funding process. Representative William D. Ford, Chairman of the House Postsecondary Education Subcommittee, summarized the situation by saying:

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[31] The Lifelong Learning Project. Lifelong Learning and Public Policy. (Washington, February 1978), p. 43.

[32] U.S. Congress. House of Representatives. Subcommittee on Postsecondary Education of the Committee on Education and Labor. Reauthorization of the Higher Education Act and Related Measures. Hearings, 96th Congress, 1st session. Part 2—Lifelong Learning. June 21, 1979. Washington, U.S. Government Printing Office, 1979, p. 120. (Opening statement of Representative William D. Ford, Chairman.)

in adult education, compared to 20.6 percent of the 25- to 34-year-old population.[26]

The National Advisory Council on Adult Education stated in its report to the President:

> In 1977 a change (in adult education enrollment) began. The 16–44 enrollment decreased, while the 45–65 plus enrollment went up with the 65 and over enrollment doubling.[27]

While this increased enrollment is impressive, the over-55 population will grow from 45 million people in 1980 to 55 million by the year 2000, an increase of 19 percent.[28] Should current enrollment trends hold through the year 2000, then an even greater percent of older adults will comprise our student population in institutions of higher education.

Adult and continuing education encompasses much more than basic skills improvement. Traditional and nontraditional, formal and informal learning opportunities range from participation by older Americans in academic coursework on college campuses through programs such as elderhostel, to dissemination of practical knowledge of first aid, crime prevention, nutrition, and exercise at senior centers and community schools. (For a detailed discussion of elderhostels, see "Developments in Aging: 1978.") Educators have found that the learning needs and interests of the over-65 population are as diverse as the individuals themselves. There are, however, some common factors that lead adults of any age to further their education, as well as unique barriers to learning opportunities which particularly affect the elderly.

Kjell Rubenson in his paper on participation in recurrent education stated that "One powerful reason for participating is the desire to make practical use of the knowledge acquired." [29] He cites studies which have shown most people who take part in adult education do so, not because of a long-standing plan to further their education, but in response to a new situation requiring study, such as a family crisis, illness, job change, etc. "Retirees look for courses where they could acquire knowledge which would help them adjust to their new role in society." [30] For those who are nearing traditional retirement age, preretirement counseling and, where appropriate, second career training can ease the transition from one life phase to another. Similar counseling and training activities can be crucial to the middle-aged or older woman who is entering the work force for the first time or approaching the job market after years of nonparticipation. For many others who have limited opportunities for social interaction, hobby-oriented courses can play an important role in their lives.

The low rate of participation by older Americans in formal education programs has been shown to be attributed to a variety of barriers they face. These include lack of financial aid, discrimination in ad-

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[26] U.S. Department of Health, Education, and Welfare, National Institute of Education, Adult Learning Needs and the Demand for Lifelong Learning. (Washington, November 1979), p. 9.
[27] National Advisory Council on Adult Education. A report to the President of the United States. (Washington, August 1979), p. 2.
[28] Older Americans: An Untapped Resource, p. 14.
[29] Adult Learning Needs, p. 23.
[30] Ibid.

who are 65 and older desire work or volunteer opportunities. The survey showed that:

—2.8 million Americans over age 65 are working;
—4 million indicated they wanted to work;
—2.2 million said they felt they had specific skills but no opportunity to use them;
—3 million expressed interest in learning new skills;
—4.5 million were serving as volunteers; and
—2.1 million wanted to do volunteer work but had not done so.[22]

The desire of the elderly to remain active and productive members of society is only one side of the coin. NCCOA also asserted that we, as a Nation, need to effectively utilize the vast human resource our 46 million Americans over age 55 represent. This should be accomplished through policies:

> . . . that would bring the skills, interests, and experience of older people to bear in dealing with the many individual and community problems made worse and more costly by neglect and inadequate attention . . . resulting from discrimination, functional illiteracy, unemployment and underemployment, crime, alcoholism and drug abuse, poor housing, inadequate transportation, alienation and isolation.[23]

Educational opportunities play a key role in the ability of middle-aged and older Americans to achieve their personal goals, as well as in the capacity of society to benefit from their skills and knowledge. Thus, NCCOA recommended that:

> . . . educational and other cultural institutions help the Nation stop wasting its resource of older people by making it unmistakably clear that they are ready and willing to help people meet their creative needs, including assisting them in continuing to work or to reenter the workforce on a paid, self-employed, or volunteer basis.[24]

The aged, however, are not a homogeneous group. Their educational and training needs are as varied as each individual's life experience and chronological timetable of aging.

The most crucial need of some middle-aged and older Americans is basic education to attain functional literacy. While over 65 percent of the population between the ages of 25 and 29 have completed 4 years of high school, the percentage of high school graduates declines to slightly over 56 percent for the 55 to 64 age group, and drops to 37 percent in the 65 and over population.[25] The failure to graduate from high school is certainly not synonymous with functional illiteracy, and some older Americans with less than 8 years of formal education are competent in reading and math skills. Other older persons, however, are finding their early schooling inadequate in their efforts to cope with the demands of our highly technological society and bureaucratic governmental structure. Yet in 1975, only 2.3 percent of all Americans age 65 and older and 5.8 percent of the 55 to 64 age group, participated

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[22] National Committee on Careers for Older Americans. Older Americans: An Untapped Resource. (Washington: Academy for Educational Development, 1979), pp. 6 and 29.
[23] Ibid.
[24] Ibid., p. 77.
[25] U.S. Department of Health, Education, and Welfare. National Center for Education Statistics. The Condition of Education. (Washington, 1979), p. 225.

and cost effectiveness of crime prevention and victim assistance programs for the elderly by reallocating moneys from areas of duplication into areas of need.

During 1980, the Special Committee on Aging is planning to hold a Washington based hearing on crime and the elderly in an effort to ascertain the effectiveness of Justice Department, FBI, and LEAA programs. In addition, field hearings are being proposed to examine the outreach of these programs.

Background information on programs concerned with crime and the elderly has been gathered by the committee during 1979. Federal, State, and local agencies and private organizations concerned with aging and crime issues were requested to submit the following applicable information:

—Nature of crime prevention services presently being offered.
—Nature of future projects now in the planning stage.
—Source of funding for these programs.
—Information and statistical data on the problem and/or the impact of present projects designed to combat crimes against the elderly.

The information received is being cataloged for evaluation and will serve as a foundation for the hearings to be scheduled in 1980.

Legislative initiatives will emphasize educational programs, crime prevention assistance, victim's assistance, and senior volunteer programs.

Preparation for the 1981 White House Conference on Aging will also concentrate on the above-mentioned programs and on the collection of substantiating background information.

V. EDUCATION AND THE ELDERLY

The educational needs of older Americans received increased attention during the 1st session of the 96th Congress, as legislation was introduced to extend and expand the Higher Education Act. The heightened interest was due, in part, to growing economic pressures on older Americans to either stay in or reenter the work force. As retirees watched inflation erode the buying power of their savings, pensions, and social security checks, many desired—or found it necessary—to return to active employment. The 95th Congress acted to provide this opportunity by raising the mandatory retirement age to 70 for nongovernmental workers and to eliminate it entirely for most Federal workers. In turn, the December 1979 report of the Social Security Advisory Council would further encourage the continuation of older persons in the work force, if Congress accepts one of their recommendations to raise the primary age of eligibility for social security retirement benefits to 68. (See retirement income chapter, social security section.)

In addition to these economic factors, many individuals facing 10, 20, or 30 years of retirement "leisure" feel a psychological and social need to engage in full- or part-time work, self-improvement activities, or volunteerism.

A report by the National Committee on Careers for Older Americans (NCCOA) cites a 1974 Harris survey as evidence that despite a trend toward early retirement, many of the 21 million Americans

official, and a program host, to discuss live on radio/TV shows crime prevention and related criminal justice matters at the local level.

(7) Other activities addressing the following subjects are under way: Older persons reporting or nonreporting victimization, victim/witness advocacy for the elderly, roles for retired persons in support of the criminal justice system, elderly abuse, prevention of suicide among the elderly, realistic interpretation of victimization data, the nature and impact of fear, and the increasing violence with purse-snatching.

M. International Federation on Aging

The International Federation on Aging's (IFA) most recent publication is "Crime Against the Elderly: Implications for Policymakers and Practitioners," by Robert J. Smith. This publication deals with an issue of increasing importance in many of the developed countries. However, since most of the work on this subject so far has been done in the United States, the monograph draws mainly on information sources from the United States, although they were carefully chosen for possible application to other countries as well.

This monograph also served as a basic working document for the conference on crime against the elderly held recently in Rome, Italy, which was cosponsored by the Federazione Nazionale Pensionati and the IFA.

N. Initiatives for the Future

James Q. Wilson has made a very important distinction between social science research and public policy research [19] and his ideas are fundamental in evaluating the studies and programs relevant to crime and the elderly. He has defined "causal analysis" as seeking the ultimate explanation for criminal behavior, often the goal of the criminologist and the social scientist.

On the other hand, according to Robert Smith, "policy analysis" begins from a different perspective. It does not ask "what is the cause?", but "what can be done?", and is concerned with the social situation desired. The policy analyst seeks to understand what effect such tools as money, education, and the police can have on a situation and at what cost.[20]

The problem in dealing with crime, however, is that when policymakers have turned to the experts in criminology and gerontology for data concerning elderly victimization, the bulk of the "causal" information explaining human behavior, while important, is insufficient to initiate policy. Obviously, more study is necessary in order to achieve a better understanding of the total problem. This should not, however, be an excuse for inaction at the present time.[21]

Although the efforts of many worthwhile projects have been considerable, the tendency for each to be an isolated entity still exists. In looking ahead, the first task of the Committee on Aging is to investigate possible reductions in the duplication of already available community services. The second task is to fill gaps. "Eliminating overlaps" and "filling gaps" could serve to increase both program

[19] James Q. Wilson, Thinking About Crime. (New York: Vitage Books, 1975.)
[20] Robert J. Smith, Crimes Against the Elderly: Implications for Policymakers and Practitioners. (Washington: The International Federation on Aging, 1979), p. 7.
[21] Ibid., p. 26.

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

Since the early 1970's, the associations have been developing and implementing a number of programs and activities aimed at alleviating the problems of crime, and the fear of crime for older Americans. In addition, the associations have conducted periodic major surveys.

The crime prevention activities of the associations are briefly described below:

(1) The unit/chapter crime prevention program was developed and implemented to quickly provide members with practical, realistic ways to reduce criminal opportunities and to avoid victimization. An important objective is to alert the elderly to the real dangers while at the same time reducing needless fears to more rational levels. The program is structured in four parts: Street crime, residential burglary, criminal fraud, and community/police relations. The program is free, as a public service, to members and to interested community and service organizations. The same subject matter is available through the communitywide crime prevention program which reaches beyond the association membership.

(2) Seminars for law enforcement officers and other criminal justice professionals were developed to help law enforcement officers and others understand and deal more effectively with the elderly. The goals of this program are to impart specialized knowledge about victimization, the process of aging, how to communicate and carry out programs with the elderly, and how to utilize the tremendous resources presented by retired/older persons. In more recent years, these seminars have expanded to include social service workers, professionals in the field of aging, and others in governmental service as participants.

(3) A police training course was developed in 1976 when NRTA/AARP were funded by LEAA to develop the experience gained in more than 250 seminars into a training course for the use of law enforcement and other training institutions. Published in November 1977, "Law Enforcement and Older Persons: A Training Manual," is the first major training curriculum in this subject area designed for national implementation. The course has been received by law enforcement trainers and administrators, institutionalized by a number of States, translated into three foreign languages, and introduced in 11 foreign countries. Revisions and expansions of the manual, based upon independent evaluation, trainer response, and student critiques, are anticipated for publication by early 1980.

(4) A crime prevention cartoon series, delivering specific crime prevention information, was published in the associations' news bulletins. The current series, introducing Thelma Thwartum and crime prevention Sgt. "Tip" O'Leary as the principal continuing characters of a set of 25 four-frame cartoons, is offered free, as a public service in NRTA/AARP publications and to the print media and organizations interested in delivering crime prevention tips to their readers.

(5) Slide/cassette presentations on specific topical areas such as residential burglary, criminal fraud, how to testify in court, and jury duty have been made available on loan to association members and to other users.

(6) Radio and TV discussion guides have been developed to provide necessary materials to enable a member, a local law enforcement

The program has three major goals:

—To provide the public with information on the harmful effect of crime on the elderly and offer possible solutions. The quarterly CJE newsletter and the CJE resource center, which answers some 50 information requests each month, are two ways of accomplishing this.

—To offer training to local projects in the crime prevention/victim assistance field. Training will be based on earlier CJE studies and will attempt to upgrade and broaden services to project clients, especially senior citizens.

—To maintain an active research program. Research will continue into restitution programs nationwide and their potential benefits to the victim. A new research project on the elderly's use of neighborhood-based dispute resolution centers will examine the effectiveness of these centers in resolving common offenses against the elderly.

K. National Council on Crime and Delinquency (NCCD)

The National Council on Crime and Delinquency, a preeminent citizens organization in the criminal justice field, is a nonprofit agency funded by LEAA grants. NCCD is working to prevent and control crime and delinquency and to improve the system of justice by combining the resources of professionals and citizens. The NCCD gathers, processes, stores, and disseminates critical data on crime and prevention and has a staff that advocates a variety of philosophies and actions to fulfill the agency's mission.

The Council is currently involved in a national citizens crime prevention campaign, a major national effort to involve all Americans in the practice of common sense crime prevention. The effort is funded by the LEAA and by private contributors. In October 1979, a wide-scale public service advertising campaign designed for NCCD by the Advertising Council was launched in an attempt to raise the public's awareness of crime and methods they can take to protect themselves and their communities. In conjunction with the media campaign, NCCD is conducting a series of training sessions for leaders of citizen groups, businesses and labor organizations at their organizational annual meetings and at special State level forums for citizen leaders. This is done in order to teach the practice of crime prevention to leaders who can pass along these techniques to members of the organizations they represent.

NCCD recognized that many population groups, notably the elderly, are confronted with special crime problems. The Council is working with the National Retired Teachers Association/American Association of Retired Persons and the National Council of Senior Citizens in this campaign. Additionally, the NCCD is assisting the National Association of Colored Women's Clubs to develop a program on crime prevention for the elderly members of their various clubs and the communities the clubs serve.

As part of the national citizens crime prevention campaign, LEAA will publish a booklet on crime prevention for the elderly. This booklet will be available from the National Criminal Justice Reference Service.

NCCD's own information center maintains a complete file of information and statistical data on a variety of problems and programs.

LEAA's complementary comprehensive crime prevention program seeks to achieve similar goals by funding coalitions of public and private agencies in midsized cities.

THE LEAA PLAN

The victim assistance activities of LEAA are being revived and expanded by the agency's new Administrator, Henry S. Dogin.

Among the features of the new victim program created by Administrator Dogin are:

(1) An agency-wide task force to inventory all LEAA programs to see if they can meet victim concerns more effectively.

(2) A Government-wide task force, including agencies such as the Department of Housing and Urban Development and the Community Services Administration, to promote victim services throughout the Federal Government. Dogin cited as an example LEAA's expected participation in HUD's new crime prevention program targeted on public housing.

(3) The convening of a national coalition of private organizations—such as the National District Attorneys Association, the National Organization of Victim Assistance, and the American Probation and Parole Association—to help formulate a strategy for responding to victim and witness needs in every phase of the criminal justice process.

LEAA's information arm, the National Criminal Justice Reference Service, is responsible for a detailed compilation of all State and local crime prevention programs into a master directory for professionals in the field and for the general public. It is entitled "Criminal Justice and the Elderly—A Selected Bibliography."

J. National Council of Senior Citizens: Criminal Justice and the Elderly

As announced in an October 25, 1979 news release of the National Council of Senior Citizens (NCSC), the criminal justice and the elderly (CJE) program of NCSC has received a $223,867 grant from LEAA for its third year of operations. With matching funds from the Ford Foundation and the Edna McConnell Clark Foundation, the CJE program, a research and technical assistance center, established to reduce the traumatic effects of crime on the elderly, will continue through August 1980.

The CJE program began in 1977 with the backing of four Federal agencies. Its original purpose was to help coordinate and learn from seven crime and the elderly projects located in New York City, Milwaukee, Los Angeles, Chicago, New Orleans, and Washington, D.C. The staff was also charged with conducting research into criminal justice policies affecting the elderly.

The news release quotes CJE's director, Victoria Jaycox, as saying:

> The experiences of CJE and the seven projects have convinced us that comprehensive programs combining crime prevention and victim assistance are essential to the survival of many of our urban elderly. In our third year, we intend to use our knowledge to improve existing programs and to help those just getting a start.

The problem of criminal acts committed against the elderly has been and currently is of concern to the Community Services Administration. The Older Americans Program Office of CSA has funded for the last 2 years three coordinated projects on criminal justice and the elderly. A final report on these projects is being prepared by the National Council of Senior Citizens.

The New York City project entitled "Senior Citizens Crime Assistance and Prevention Program" targeted its services to the elderly residing in the Brownsville and Crown Heights areas of Brooklyn and the Central and East Harlem areas of Manhattan. This project has received approximately $465,000 from the Community Services Administration over the last 2 years. This project has enabled the elderly victims of crime to be assisted in the following ways: Counseling, medical followup, mental health referral, housing relocation, emergency financial help, victim compensation, legal assistance, transportation/escort, home care services, operation identification, home repair, security survey, early alert/direct deposit, and lock installation.

The Milwaukee, Wis., project is entitled the "Crime Prevention/Victim Assistance Program." Since July 1977, the Community Services Administration has contributed approximately $500,000 to the project operation. This project has provided for over 200 crime prevention education presentations to over 5,000 elderly. It has provided for a wide-range of security devices to be installed in approximately 500 homes. It has provided assistance to 15 percent of Milwaukee's elderly crime victims. The project organized a network of 56 block clubs which involve 1,000 elderly.

The New Orleans project is entitled the "Elderly Anti-victimization Prevention and Assistance Program." The Community Services Administration has contributed approximately $500,000 over the past 2 years toward the operation of the program. The project has provided for the dissemination of crime prevention packets to elderly crime victims and crime prevention education for over 2,000 elderly. Locks were provided for 100 households and the valuables in 366 households were engraved.

I. Law Enforcement Assistance Administration (LEAA)

As the primary Federal source of crime prevention and victim assistance programing among the general population, LEAA claims to have had a beneficial impact on the older subpopulation as well.

LEAA's crime prevention activities are focused in the Office of Community Anticrime Programs. Created by the Congress to assist local communities in combating crime, the office has funded anticrime grants proposed by nearly 150 nonprofit groups. However, increasing criticism of LEAA's neighborhood programs and their effectiveness has raised levels of congressional scrutiny with the result being a reduction in funding for the program from $15 million to $7 million for fiscal year 1979.

F. Program Overview

A number of programs concerning crime prevention for the elderly have been initiated or continued during 1979. Aspects of victimization addressed, range from physical protection (renovation of homes; installation of security locks and peepholes; better lighting; block clubs; transportation; direct bank deposit of social security, public assistance, and pension checks; and increased police patrol) to prevention through education (films, meetings, and sensitivity training to those attending to older victims). The successful trend to involve senior citizen volunteers in educational, crime prevention, and victim assistance programs is of great potential.

Senator Domenici emphasized the committee's concern in this area by stressing the importance of older Americans learning what they can do to reduce their chances of becoming crime victims:

> Through the continuation and expansion of educational programs on crime and crime prevention techniques, we can help to reduce older persons' fear of crime and free them from subsequent hardships and isolation.[18]

G. Department of Housing and Urban Development (HUD)

The Department of Housing and Urban Development (HUD) has spent over a year designing a major, new crime prevention program to be tested in selected public housing projects around the country. The effort, a part of President Carter's national urban policy is congressionally mandated by the Public Housing Security Demonstration Act of 1978 (title II of Public Law 95–557). The competitive grant program, drawing resources totaling $32 million from several Federal agencies, including the Department of Labor and LEAA, and $8 million in matching local funds, was open to competition among public housing agencies. The urban initiatives anticrime program selected 39 finalists which maintain projects with 1,250 or more Federal housing units, while 12 awards were granted to projects with fewer than 1,250 units.

The programs are meant to focus on locally proposed solutions to match community needs, linking crime prevention with urban redevelopment. Those areas to be covered include: (1) Public housing authority management of public safety, (2) physical redesign to improve security, (3) tenant anticrime organization and activity, (4) tenant employment, (5) youth and drug abuse services, (6) victim/witness services, (7) increased and more sensitive law enforcement, and (8) local and Federal public/private partnerships to cotarget resources on housing projects and their surrounding neighborhoods. A specific concern for elderly public housing tenants is integral to the program.

H. Community Services Administration (CSA)

In an August 31 response to this committee's inquiry into agency programing for crime and the elderly, CSA Director Graciela Olivarez described CSA's involvement in the following terms:

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[18] Pete V. Domenici, Crime and the Elderly. Remarks in the Senate. Congressional Record, vol. 125, July 19, 1979: S9903.

The Justice System Improvement Act of 1979 (S. 241) sponsored by Senator Edward Kennedy, was signed into law by President Carter on December 27, 1979 (Public Law 96–157). This act restates and amends in its entirety title I of the Omnibus Crime Control and Safe Streets Act of 1968 (Law Enforcement Assistance). The bill retains within the Department of Justice the Law Enforcement Assistance Administration (LEAA), and within LEAA, the Office of Community Anticrime Programs, with special priority to be given to funding program grants which will assist the elderly.

The Victims of Crime Act of 1979 was introduced by Senator Kennedy on January 23, as S. 190, and by Representative Peter Rodino on February 8, as H.R. 1899. The legislation directs the Attorney General to make grants to qualifying State programs for compensating victims of crime, with special attention given to the elderly. S. 190 was referred to the Senate Judiciary Committee. On March 2, the Judiciary Committee requested Executive comment from the Department of Justice. No further action on the legislation has been taken at this time.

On May 30, a new House bill, H.R. 4257, was referred to the House Judiciary Committee having been forwarded from the Subcommittee on Criminal Justice in lieu of H.R. 1899. This bill, H.R. 4257, was ordered reported from the full committee on June 5 and is awaiting floor action.

Another bill pending in the Judiciary Committee's Subcommittee on Criminal Justice, which has special importance for older Americans, is H.R. 980, the Senior Citizens Protection Act of 1979. The legislation, introduced on January 18 by Representative Cardiss Collins, amends title XVIII of the U.S. Code to provide penalties for assaults against the elderly that result in medical expenses which are paid by the United States.

Among the bills introduced to provide assistance for the installation of security devices in the homes of the elderly are:

—H.R. 1124, introduced January 18, 1979, by Representative Edward Roybal, to provide assistance for the installation of security devices in the residences of elderly persons. It includes projects to assist older persons to install home security devices in the list of projects eligible for grants from the Department of Housing and Urban Development. The bill was referred to the House Committee on Education and Labor where it awaits further action.

—H.R. 1136, introduced on January 18 by Representative Roybal, and H.R. 1380, introduced on January 24, by Representative John Paul Hammerschmidt, amend the Community Services Act of 1974 to permit the Community Services Administration to furnish assistance for the installation of security devices in the residences of older persons. Both bills were referred to the House Committee on Education and Labor where they await further action.

—H.R. 1134 introduced on January 18, 1979, by Representative Roybal, and H.R. 1344, introduced on January 24 by Representative Hammerschmidt, amend title XX of the Social Security Act to include among the services provided by that title, the installation of security devices in the homes of elderly people. Both bills have been referred to the House Ways and Means Committee where they await further action.

(12) Older people have the highest rates of crime of personal larceny with contact (theft of purse, wallet, or cash directly from the person of the victim, including attempted purse snatch).

(13) Awareness of increased vulnerability to criminal behavior has a chilling effect upon the freedom of movement of older Americans. Fear of criminal victimization causes self-imposed "house arrest" among older people who may refuse to venture out of doors. Furthermore, even in those situations where the fear of being victimized may be somewhat exaggerated or unwarranted by local conditions, the effect on the older person is just as severe as when the fears are justified.

(14) Because of the loss of status and decreased sense of personal efficacy associated in American culture with being old, older people may be less likely to process complaints through the criminal justice bureaucracy and to draw upon available community resources for protection and redress.[16]

Thus, although the elderly generally may not experience abnormally high victimization rates, the effect of such victimization—financial, physical, and behavioral—can be far more devastating to the older adult than to younger members of society.

What is needed is to change the concept of criminal victimization of the elderly. The physical, economic, behavioral, and environmental consequences associated with the older victim make such special attention necessary. Due in part to their special vulnerability and the differential impact of crime, fear of criminal victimization can be particularly pervasive among older persons. The crime problem has two aspects: The actual victimization and the fear of victimization.

Many experts believe that the fear of victimization and its behavioral ramifications are even greater problems than victimization itself. The psychological effects of victimization for victim and nonvictim alike, include a great increase in fear and anxiety, and a decrease in morale, ultimately resulting in a restriction of activities.

The social and psychological costs to a community of the victimization of its elderly residents are inestimable. If older people are prevented from participating in community life because of the effects of victimization itself or the fear of it, the community loses the contributions of many individuals who have much to give.[17]

E. Focus: Legislative Activity—Victim Assistance and Crime Prevention

The active participation of older people in advocating breakdown of traditional stereotyping has resulted in the older person being portrayed with greater dignity and more realism. This trend, when combined with recent citizen action to prevent crime before it happens, has resulted in Federal legislation raising the crime prevention needs of the elderly to a higher priority.

Legislative activities during the past year have included both preincident (prevention) and postincident (victim assistance) innovations. Though the future of most of the newly introduced legislation remains uncertain, the new policy of giving formal recognition to the once-forgotten victims of crime in the Federal Government's anticrime programs has been established.

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[16] Jack Goldsmith and N. E. Thomas. "Crimes Against the Elderly: A Continuing National Crisis." Aging (June–July 1974), 236: 10–13.

[17] Ibid., p. 22.

D. Impact of Victimization

Robert J. Smith's "Crime Against the Elderly: Implications for Policymakers and Practitioners" (pp. 17–18) contains a comprehensive overview of the quantitative and qualitative aspects of victimization experienced by older persons.

The physical, financial, psychological, and behavioral scars suffered by the elderly victim are often profound, and the cost to society is multifaceted and immense. Until recently, the impact of crime on the victim had not been a major consideration of the criminal justice system. The individual suffering most from crime, the victim, has been called "the forgotten element of the criminal justice system." Of all persons who, in one way or another, become targets of a criminal act, many contend that the elderly usually suffer most. Many reasons are offered as to why the impact of a crime on an older adult should be viewed differently in comparison to a similar victimization of a younger person. Jack Goldsmith, author of several publications dealing with crime and the elderly, has offered 14 reasons why a special approach should be taken toward victimization of the elderly:

(1) There is a high incidence of reduced or low income among the elderly. Thus, the impact of any loss of economic resources is relatively greater.

(2) Older people are more likely to be victimized repeatedly, often by the same crime and the same offender.

(3) Older people are more likely to live alone. Social isolation increases vulnerability to crime.

(4) Older people have diminished physical strength and stamina; hence they are less able to defend themselves or to escape from threatening situations.

(5) Older people are more likely to suffer from physical ailments such as loss of hearing or sight, arthritis, and circulatory problems which increase their vulnerability.

(6) Older people are physically more fragile and more easily hurt should they opt to defend themselves. For example, bones are more easily broken and recovery is more difficult. Thus, they are less likely to resist attackers.

(7) Potential criminals are aware of the diminished physical capacity and the physical vulnerability of the elderly and thus are more likely to seek out an elderly target (whose aged status is easily visible).

(8) There is a greater likelihood that older people will live in high crime neighborhoods, rather than in suburbs as a result of diminished income and of being rooted in central cities. Thus, they find themselves in close proximity to the groups most likely to victimize them—the teenage dropouts.

(9) The dates of receipt by mail of monthly social security and other benefit checks (and hence the dates when older people are most likely to have cash on their person or in their dwelling) are widely known.

(10) Dependency on walking or on public transportation is more likely among older people who, for physical, financial, or other reasons, are less likely to drive or own a private automobile.

(11) There is evidence that older people are particularly susceptible to fraud and confidence games.

Although it is the brutal and often sensational acts of violence that receive the most publicity and generate the most fear, these crimes are not numerically the most important. This quantitative conclusion should not diminish attempts to prevent such offenses. However, focus is now being directed to the less sensational, but numerically more important and often socially, psychologically, and physically more damaging nonviolent crimes [12] against older persons.

C. Social and Physical Environment

Several factors combine to render older persons particularly susceptible to the incidence and aftermath of crime. The most potent factor accounting for victimization, however, is the composition of the neighborhood in which the older person resides. The tragedy in American cities that have been studied is that older citizens tend to be concentrated in the inner city, where crime rates in general are higher.

This fact raises the question of why older Americans live in these high crime areas; it is obviously more than a matter of simple choice. Many are original residents of the neighborhood, regard it as their home, and are reluctant to leave. Others come there because of their need for low-cost housing and for the services which are available in densely concentrated housing. Still others may wish to leave, but their low incomes prevent them from resettling in outlying safer areas.[13]

The concentration of older people in the inner city could be a causative factor in the increase in crime because they are often trapped into close and unavoidable contact with that element of society most likely to attack or steal from them—young unemployed males who also tend to inhabit the inner city. The irony is that high rise, low-cost housing has been actively sought in the past by senior groups, churches, and organizations for older people, but the problem of security was not carefully reviewed at the planning or building stage. As a result, apartments, homes, and the immediate neighborhood surrounding the older people's dwellings often become high crime areas, if they were not so before.[14]

It might be noted that according to the aforementioned Kansas City study, in 80 percent of the serious crimes studied, the elderly victims were in their own homes or in the immediate vicinity. It might additionally be assumed that the greater percentage of instances of fraud also take place in or near the home of the victim. The fact that so much of the victimization of the elderly usually takes place in or near the home add to the trauma of victimization, since the home is usually regarded as a refuge. This situation undoubtedly contributes to the great fear of victimization expressed by many older people.

A perceived threat can be just as debilitating to the general well-being of the individual as a real threat—in some cases even more so. Even in the cases where fears may be largely unwarranted, the effect is just as severe on the older person's behavior as when the fears are objectively justified.[15]

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[12] Smith, p. 11.
[13] Ibid., p. 12.
[14] Ibid.
[15] Ibid., p. 21.

ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY SEX, RACE, AND AGE OF VICTIM, AND TYPE OF VICTIMIZATION, UNITED STATES, 1976[1]—Continued

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization and race of victim	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
SEX OF VICTIM: FEMALE							
Base:							
White	6,721,800	7,016,700	8,286,100	13,975,600	15,428,900	14,988,400	11,726,300
Black and other races	1,289,800	1,278,800	1,435,700	2,218,400	2,321,300	1,713,200	1,171,500
Rape and attempted rape:							
White	190	295	402	204	8	0	0
Black and other races	340	965	536	306	0	96	0
Robbery:							
White	332	518	593	350	313	296	141
Black and other races	303	812	1,964	1,068	556	571	458
Robbery and attempted robbery with injury:							
White	87	162	244	136	149	148	85
Black and other races	193	293	332	411	267	220	329
Serious assault:							
White	18	73	105	43	71	40	53
Black and other races	0	179	0	48	110	65	0
Minor assault:							
White	69	89	139	93	78	108	32
Black and other races	193	114	332	364	158	155	329
Robbery without injury:							
White	120	146	212	154	93	73	57
Black and other races	0	519	1,313	603	289	291	129
Attempted robbery without injury:							
White	125	210	137	60	71	74	0
Black and other races	110	0	319	54	0	61	0
Assault:							
White	3,103	3,708	3,174	2,075	1,220	505	195
Black and other races	3,221	4,205	3,973	2,980	1,046	1,060	821
Aggravated assault:							
White	691	1,209	863	632	338	178	43
Black and other races	1,749	1,770	1,723	1,597	598	492	556
With injury:							
White	175	421	272	195	93	47	22
Black and other races	656	845	642	662	216	245	0
Attempted assault with weapon:							
White	516	788	590	437	246	131	21
Black and other races	1,093	925	1,081	935	382	247	556
Simple assault:							
White	2,412	2,499	2,311	1,443	882	326	152
Black and other races	1,472	2,435	2,249	1,383	449	568	265
With injury:							
White	693	855	720	402	173	41	53
Black and other races	284	929	815	412	0	126	127
Attempted assault without weapon:							
White	1,718	1,644	1,591	1,041	709	286	99
Black and other races	1,187	1,506	1,435	971	449	442	139
Personal larceny with contact:							
White	105	331	355	287	203	308	351
Black and other races	0	174	771	798	663	698	935
Purse snatching:							
White	17	89	104	68	47	119	117
Black and other races	0	174	323	251	336	263	214
Attempted purse snatching:							
White	0	51	78	53	70	49	86
Black and other races	0	0	86	124	208	68	0
Pocket picking:							
White	88	191	173	166	86	140	148
Black and other races	0	0	362	422	119	367	721
Personal larceny without contact:							
White	14,575	14,235	13,148	10,245	7,869	5,078	1,789
Black and other races	9,621	9,108	8,582	9,247	6,413	3,337	2,185

[1] Subcategories may not sum to total because of rounding.

Source: Table constructed by Sourcebook staff from data provided by the National Criminal Justice Information and Statistics Service of the Law Enforcement Assistance Administration.

ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY SEX, RACE, AND AGE OF VICTIM, AND TYPE OF VICTIMIZATION, UNITED STATES, 1976[1]

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization and race of victim	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
SEX OF VICTIM: MALE							
Base:							
White	7,037,700	6,985,300	8,109,100	13,808,700	14,834,200	13,655,600	8,151,200
Black and other races	1,300,500	1,206,200	1,201,800	1,797,600	1,894,900	1,468,200	877,100
Rape and attempted rape:							
White	0	21	78	27	0	9	13
Black and other races	B	B	B	B	B	B	B
Robbery:							
White	1,508	1,198	1,135	711	582	409	545
Black and other races	2,375	1,972	2,186	1,772	1,505	2,304	999
Robbery and attempted robbery with injury:							
White	239	469	289	230	190	169	131
Black and other races	680	417	428	529	239	772	463
Serious assault:							
White	136	292	190	130	67	141	63
Black and other races	190	114	295	259	239	421	463
Minor assault:							
White	103	177	99	100	123	29	68
Black and other races	490	304	133	270	0	351	0
Robbery without injury:							
White	722	384	422	236	212	146	269
Black and other races	1,109	965	1,171	792	902	1,262	537
Attempted robbery without injury:							
White	546	344	425	245	180	94	145
Black and other races	586	589	587	450	364	270	0
Assault:							
White	5,215	7,623	5,918	4,342	1,867	948	681
Black and other races	3,988	5,212	5,712	5,281	1,244	1,282	316
Aggravated assault:							
White	1,624	3,456	2,622	1,773	758	447	219
Black and other races	1,798	3,065	3,219	2,782	847	907	316
With injury:							
White	633	1,393	1,019	521	265	101	31
Black and other races	872	1,217	1,309	977	296	281	0
Attempted assault with weapon:							
White	991	2,063	1,603	1,251	493	346	189
Black and other races	926	1,848	1,910	1,805	550	626	316
Simple assault:							
White	3,591	4,167	3,296	2,569	1,109	501	462
Black and other races	2,191	2,147	2,493	2,499	397	375	0
With injury:							
White	1,146	1,317	1,081	466	187	63	93
Black and other races	438	351	390	325	0	80	0
Attempted assault without weapon:							
White	2,445	2,850	2,215	2,103	922	438	369
Black and other races	1,752	1,796	2,103	2,174	397	295	0
Personal larceny with contact:							
White	356	441	222	155	143	148	180
Black and other races	325	917	1,219	487	306	609	520
Purse snatching:							
White	0	0	0	0	0	0	0
Black and other races	0	0	0	0	0	0	0
Attempted purse snatching:							
White	0	0	0	0	0	0	0
Black and other races	0	0	0	0	0	0	0
Pocket picking:							
White	356	441	222	155	143	148	180
Black and other races	325	917	1,219	487	306	609	520
Personal larceny without contact:							
White	16,498	15,895	16,347	12,052	8,559	6,263	2,970
Black and other races	10,006	10,759	14,330	11,693	7,448	6,978	2,470

See footnotes at end of table.

ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY AGE OF VICTIM AND TYPE OF VICTIMIZATION, UNITED STATES, 1976 [1]

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
Base	16,349,800	16,487,000	19,032,700	31,800,200	34,479,300	31,825,400	21,926,100
Rape and attempted rape	105	209	259	123	4	9	5
Robbery	998	935	1,028	637	510	452	342
Robbery and attempted robbery with injury	208	321	281	218	179	190	130
Serious assault	81	177	145	93	81	102	70
Minor assault	127	144	136	125	98	88	60
Robbery without injury	448	336	445	257	202	171	159
Attempted robbery without injury	342	278	302	162	130	91	54
Assault	4,092	5,515	4,563	3,303	1,488	761	414
Aggravated assault	1,264	2,340	1,826	1,316	564	344	147
With injury	465	924	684	414	187	92	23
Attempted assault with weapon	799	1,417	1,142	903	378	252	124
Simple assault	2,828	3,175	2,737	1,987	924	416	267
With injury	836	1,019	860	426	158	57	70
Attempted assault without weapon	1,992	2,155	1,877	1,561	766	360	198
Personal larceny with contact	222	408	384	277	214	274	326
Purse snatching	7	51	70	47	44	70	74
Attempted purse snatching	0	22	40	32	45	27	46
Pocket picking	215	335	274	198	125	177	206
Personal larceny without contact	14,648	14,286	14,241	11,042	8,045	5,580	2,277

[1] Subcategories may not sum to total because of rounding.

Source: Table constructed by Sourcebook staff from data provided by the National Criminal Justice Information and Statistics Service of the Law Enforcement Assistance Administration.

A. General Status/Background

Although it has generally been advanced that senior citizens are especially vulnerable to crime, the rate of criminal victimization of older adults, as compared with the entire population, is still a matter of debate.

Victimization studies conducted by the Law Enforcement Assistance Administration (LEAA),[5] the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP),[6] and the National Crime Survey (NCS)[7] all generally agree that older persons are not disproportionately represented as crime victims when all serious crimes and all age groups are considered. The pattern would, at first glance, indicate that the young are more likely to be victimized than the old. A closer inspection, however, reveals that while the young are indeed more prone to becoming victims of personal crimes such as rape and homicide, it appears that the rates of personal larceny, robbery, and fraud are as high or higher for the elderly when compared with younger groups. In fact, it is contended that the elderly who live in the inner city are victimized out of proportion to their relative numbers.[8]

According to one study, the aggregate data of official statistics and victimization surveys is often misleading as to the true extent of the problems and underestimates seriously the impact of the problem on many individuals and communities. "What little information is available would substantiate the impression of many that such victimization is on the increase." [9]

B. Types of Crimes

The nature of crimes against the elderly are primarily of the predatory type, rather than the violent type. One of the best studies of traditional crime categories, conducted in Kansas City, found that among the elderly burglary was the most frequent crime (55.9 percent), followed by robbery (24.6 percent), larceny (13.9 percent), assault (2.5 percent), and fraud (2.3 percent) with rape, homicide, and all other crimes under (0.52 percent).[10]

The following tables, taken from the Department of Justice's national crime survey report, illustrate the frequency of elderly victimization in comparison to other age groups.[11]

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[5] U.S. Department of Justice. Law Enforcement Assistance Administration. Criminal Victimization Studies in the Nation's Five Largest Cities. [Washington, 1975.]

[6] NRTA/AARP. Crime Prevention Program. [Washington : NRTA/AARP, 1977.]

[7] John J. Gibbs. Crimes Against Persons. [Washington : LEAA, 1979.]

[8] Robert J. Smith. Crimes Against the Elderly : Implications for Policy-Makers and Practitioners. [Washington : The International Federation on Aging, 1979], p. 7.

[9] Ibid.

[10] Ibid., p. 9.

[11] U.S. Department of Justice. Law Enforcement Assistance Administration. National Criminal Justice Information and Statistics Service. Service Book of Criminal Justice Statistics—1978 (Washington, 1978) p. 380, pp. 382, 383.

Senators Lawton Chiles, Pete V. Domenici, Frank Church, John Melcher, David H. Pryor, Bill Bradley, Quentin N. Burdick, and John Glenn of the Special Committee on Aging introduced S. 1060, which provided elderly households with a special medical deduction for allowable medical expenses above $35 a month.

Senator Chiles, upon introducing the bill on May 2, explained:

> Those people with relatively low medical bills would be able to deduct such expenses within the allowable $65 standard deduction. But those people with high medical expenses, who have received no deduction under the new law, would be able to deduct these expenses when computing their net income which determines their coupon allotment.

The Senate Committee on Agriculture, Nutrition, and Forestry combined this medical deduction provision with a provision that eliminated the $80 ceiling on shelter deductions for households with an elderly member. This measure, approved by the full Senate, was amended in conference to include severely disabled persons among those eligible for the special deductions. This measure was signed into law on August 14, 1979 (Public Law 96–58).

Realizing the need to implement this measure promptly, USDA promulgated final rulemaking regulations expeditiously on September 25, 1979 (7 CFR, parts 272 and 273, vol. 44, No. 187). These final regulations allowed the States to implement the new deductions between the issuance date of the regulations and January 1980. Most States planned implementation for January 1980 with several putting the new regulations into effect in December 1979.

In a related matter, the USDA issued proposed regulations on December 7, 1979 (7 CFR, part 273, vol. 44, No. 237), to implement a provision in the 1977 amendments to the food stamp program regarding application procedures. Specifically, the proposed rules carry out the change in the 1977 law to allow SSI households to apply for food stamp benefits at local or district social security offices and to be certified on the basis of information contained in the social security files. This would simplify the application process for aged, blind and disabled persons by allowing a "one-stop" application and certification process, instead of the current process which requires personal visits to at least two administrative offices.

Final promulgation of these regulations is expected in February 1980.

IV. CRIME AND THE ELDERLY

The increasing political activity of senior citizens in combination with the present trends towards crime prevention is resulting in higher priorities for legislative issues concerning crime and the elderly. Although available statistics have not substantiated claims of greater senior citizen victimization as compared to younger persons in all the traditional categories of crime, the elderly have been shown to suffer a disproportionate number of predatory crimes (robbery, larceny, fraud) for their numbers.

The physical, psychological, and economic aspects of victimization and the even more debilitating effects of fear of crime, are beginning to be addressed. National programs and Federal legislation are presently directed towards victim assistance, crime prevention, and education programs.

Senator Lawton Chiles, at a hearing conducted by the Special Committee on Aging in April 1979, detailed why the elimination of the medical deduction placed older persons at a serious disadvantage:

> It is common knowledge that elderly have far greater medical expenses than most other age groups. Medicare and medicaid often help to alleviate this burden, but there are numerous health services which are not reimbursable under either program and must be paid out-of-pocket by the patient. Therefore, those elderly faced with high medical bills are receiving a double blow when faced with extreme medical expenses and a reduction in food stamps because there is no longer a deduction for their medical costs above $65 (the standard deduction).

Several elderly witnesses at the hearing gave evidence of the provision's true impact on their economic situations. An elderly woman from Florida who resides with an elderly, disabled sister received notice that their food stamp benefits would be cut from $90 a month to $30. Her response: "How can we live with $30?"

An older woman from South Dakota told the committee that she and her husband had medical bills totaling approximately $1,300 last year that were not covered by medicare. Because a great percentage of these expenses were no longer deducted from their income in determining their food stamp coupon allotment, their monthly allotment was being reduced from $83 to $10. When asked how they were making ends meet, she responded:

> We are not making it. We are begging money from our children—we have to in order to live, to eat. Like this month, there won't be any money for food.

The second provision resulting in cutbacks for elderly food stamp participants is the restrictive changes in the shelter deduction. In the past, participants were able to deduct housing and utility costs that exceeded 50 percent of their income. Under the 1977 amendments, a ceiling of $80 was established for this deduction. Therefore, persons were limited in deducting shelter expenses in excess of 50 percent of their incomes to not more than $80. Members of the Special Committee on Aging and the USDA agreed that individuals in one- and two-person households, often the elderly, would be particularly hard hit by this restriction. However, the USDA also stated that the standard deduction would probably compensate for many of the decreases.

B. Legislative Action

Contrary to USDA's contention that only a small percentage of elderly persons would be negatively affected by the medical and shelter deduction restrictions, thousands of letters were received by congressional members from elderly persons who had been notified that their food stamp allotment had been severely cut back or discontinued. In response to these concerns, several bills were introduced in the House of Representatives and the Senate to provide a medical deduction for elderly households and/or to eliminate the $80 cap on shelter expenses for elderly residents (H.R. 2126, H.R. 2663, S. 632, S. 807, S. 872, S. 1060 and S. 1346).

are readily available to conference participants in advance, as should be information needed to evaluate Federal programs and/or policies relating to older Americans. In order to carry out these mandates, the Secretary may award grants to, or enter into contracts with, public agencies and/or nonprofit private organizations.

III. FOOD STAMPS

A. Background

In the 1977 Food and Agriculture Act (Public Law 95–113), the Congress significantly amended the food stamp program. Major changes included eliminating the purchase requirement (amount previously paid for the coupons) and replacing the numerous itemized deductions with four deductions: (1) A standard deduction indexed in accordance with the Consumer Price Index (CPI); (2) a shelter deduction for housing and utility costs; (3) a dependent care deduction; and (4) an earned income deduction.

Several of the changes benefit elderly persons who participate in the food stamp program. In testimony before the Senate Special Committee on Aging in April 1979, Carol Foreman, Assistant Secretary for Food and Consumer Services, U.S. Department of Agriculture (USDA), described some of these positive provisions. Of major significance was the removal of the purchase price. According to Secretary Foreman, "Informal evidence indicates that a significant number of elderly poor are entering the food stamp program as a result of the change in the program."

In addition, Mrs. Foreman stated:

> There are other provisions of the new food stamp program that benefit the elderly. The age at which an individual is exempt from the work registration requirement has been lowered from 65 to 60 years. A 12-month certification period may be assigned to households consisting entirely of elderly persons. The use of authorized representatives for those unable to get to certification offices will be encouraged. Mail service, telephone interviews, and/or home visits will also be used to certify those persons who, because of age, disability, or transportation problems, are unable to reach a certification office.

However, all results were not positive. Several provisions were only implemented at the first of 1979 after promulgation of regulations implementing the 1977 law. Among the changes were provisions which substantially reduced the amount of food stamps received by elderly households, and restricted household eligibility.

First, a standard deduction set at $70, but indexed with the Consumer Price Index, was substituted for numerous itemized deductions, including the former deduction for medical expenses. This change seriously hurts those older persons with high medical bills. In the past, all persons were able to deduct allowable medical expenses above $10, thus resulting in a smaller net income and larger coupon allotments. With the absence of the medical deduction the access of elderly persons to food stamps will be much more restricted.

ever, complaints under the ADA are being received and referred to the Federal Mediation and Conciliation Service. The FMCS can take the necessary steps to resolve the complaint between the two parties. If no agreement is reached, the complaint will be referred back to the appropriate agency where some steps can be taken. Although final rulings cannot be made until the agency issues its final regulations, certain courses of action are available to the agency based on its standards and mechanisms for other civil rights statutes.

II. 1981 WHITE HOUSE CONFERENCE ON AGING

The 1979 supplemental appropriations bill (Public Law 96–38) contained $3 million for the planning and operation of the next White House Conference on Aging, which was authorized by Congress in 1978 (Public Law 95–478). Although the conference will not be conducted until late 1981 (November 30 through December 4, 1981), HEW estimates that planning and preconference activities must be started at least two and a half years in advance.

The first major preconference activity was President Carter's December 1979 announcement naming the six key individuals who will lead the 1981 conference. Sadie T.M. Alexander, 81, a Philadelphia attorney was appointed chairperson. At the swearing in ceremony conducted at the White House, President Carter also appointed Arthur S. Flemming, chairperson of the 1971 White House Conference on Aging, as Chairperson Emeritus. Three deputy chairpersons were also appointed: Bernice Neugarten of Chicago, Lupe Morales of California, and Ellen Winston of North Carolina. Jerome R. Waldie, a former Congressman from California, will serve as executive director for the conference.

In responding to the appointments, HEW Secretary Patricia Harris, under whose direction the conference will be planned, reconfirmed her commitment to the conference. She underscored this commitment by stating that the development of a national policy to help older Americans maintain their economic, physical, and social independence is an attainable goal.

The authorizing legislation for the conference sets forth several requirements including:

—Providing Federal financial assistance to State and area agencies to help them hold local and State conferences prior to the White House Conference.

—Appointing and supporting an advisory committee for the conference and such technical committees as may be needed to insure the success of the conference.

—Conducting the conference in such a way that the broad participation of older persons, including low-income older persons, is assured.

—Issuing a final report to the President and the Congress within 6 months of the conclusion of the conference. (HEW will submit its recommendations for legislation and administrative action implementing the final report of the conference within 90 days.)

The Secretary of HEW is mandated under the authorizing legislation to assure that current and adequate statistical data and other information on the well-being of older individuals in the United States

With these definitions and instructions, the scope of the ADA was defined. Other parts of the regulations addressed administrative and enforcement procedures by the agencies and departments involved. Briefly, the required responsibilities of the agencies and departments providing Federal assistance include: (1) Publishing the proposed and final specific regulations; (2) publishing an appendix to the regulations listing all age distinctions present in the statutes and regulations over which they have authority; (3) submitting to HEW an annual report describing all actions taken to ensure effective implementation of the ADA; (4) notifying each program or activity receiving Federal assistance of their obligations under the ADA; and (5) providing technical assistance to aid those agencies and departments receiving Federal assistance in complying with the law.

The programs and activities receiving Federal assistance, which therefore fall under the authority of the ADA, are required by the regulations to: (1) Conduct a self-evaluation of the age distinctions within their programs and eliminate those which cannot be justified, and (2) provide sufficient data to justify compliance with the act.

The regulations provide for a unique complaint process which does not exist in any other form of civil rights enforcement. This process begins with all complaints being referred to the agency alleged to have discriminated on the basis of age. If the matter cannot be settled, the agency would refer the allegation to the Federal Mediation and Conciliation Service (FMCS) which would attempt to resolve the complaint by negotiating with the parties involved. If an agreement is not reached between the parties, then FMCS would resolve the matter. The FMCS approach was devised by the Department of Health, Education, and Welfare to cut down the time involved in settling such disputes. One central Federal Mediation and Conciliation Service will be responsible for managing and attempting to resolve the complaints of all agencies.

If the complaint is not resolved by the mediation process, then the case will be sent back to the agency where the complaint was filed. If the agency is unable to resolve the complaint by informal investigation, the matter will proceed to formal investigation. This could include administrative hearing, referral to the Department of Justice or referral to any Federal, State, or local government enforcement agency for corrective action.

If the person alleging discrimination is not satisfied with any of the administrative remedies, then he or she has 180 days to bring a civil action in the appropriate U.S. District Court.

C. Toward Implementation

The June 12 regulations required each agency and department providing Federal assistance to programs and activities to issue proposed regulations no later than 90 days after the publication date of the general regulations (therefore, rules were to be issued by September 12, 1979). The agencies and departments were then required to submit to HEW their final regulations not later than 120 days after the issuance of the proposed regulations.

At the end of 1979, only half of the appropriate agencies had issued proposed regulations and not one agency had issued final rules. How-

and awareness of the needs and concerns of older Americans." However, many aging organizations and advocates for the elderly did not "herald" the regulations as did the Secretary. Their concern was based on the Department's interpretation of the law's exemptions.

The ADA statute is different from other civil rights statutes because it does not prohibit all forms of age discrimination. There are exceptions. These exceptions, the focus of controversy between HEW and aging advocates, include:

—Permitting age distinctions which reasonably take into account age as a factor necessary to the normal operation or the achievement of any statutory objective.

—Permitting actions that have a more severe effect on one age group than another if those actions are based on reasonable factors other than age, i.e., agility and strength.

—Permitting age distinctions established "under authority of any law."

The latter exemption, permitting age distinctions established under the authority of "any law" has been the most controversial. The ADA statute does not define "any law." Some feel that the Congress meant only Federal laws by this phrase. Others, including HEW, interpret "any law" to mean any Federal, State, or local statute. In defending HEW's position in the June 5 press release, Secretary Califano stated:

> In light of this legislative history, I am compelled to follow congressional intent and exempt distinctions explicitly contained in Federal, State, and local laws from coverage by the act.
>
> But I believe it makes little sense to permit State and local governments to establish age distinctions, when federally funded programs are involved.
>
> But, no matter how strongly I feel, I cannot—and I should not—attempt to do by bureaucratic means what the Congress has explicitly refused to do by legislation.
>
> I do not believe, however, that the exemption should be eliminated for State and local laws involved in the administration of federally funded programs.

The Secretary pointed out that the Federal agencies and departments would not have their regulations in place for at least 7 months and this would give the Congress time to consider defining "any law" more precisely. In short, the Secretary placed the burden of defining "any law" back on the Congress. The final regulations interpreted "any law" to mean Federal statutes, State statutes, or local ordinances, adopted by elected, general purpose legislative bodies.[4]

In carrying out the meaning of the other specified exemptions, the regulations also had to define "normal operation" and "statutory objective."

"Normal operation," according to section 90.13, "means the operation of a program or activity without significant changes that would impair its ability to meet its objectives."

Section 90.13 also defined "statutory objective" as "any purpose of a program or activity expressly stated in any Federal statute, State statute, or local statute or ordinance adopted by an elected, general purpose legislative body."

[4] Department of Health, Education, and Welfare, 43 CFR, part 90, vol. 44, No. 114, section 90.3(b)(1), June 12, 1979.

Chapter 10

ISSUES OF CONTINUING AND EMERGING CONCERN

I. SLOW ADVANCEMENT OF THE AGE DISCRIMINATION ACT (ADA)

A. Toward Implementation of ADA

The Age Discrimination Act of 1975 (Public Law 94–135) has not yet been implemented. The act provides that "no person in the United States, shall on the basis of any age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance." The Age Discrimination Act does not cover the employment programs which fall under the authority of the Age Discrimination in Employment Act of 1967 (Public Law 90–202) but does apply to the Comprehensive Employment and Training Act (CETA).

The ADA was passed in 1975 with a proviso which delayed implementation until completion of a study of age discrimination by the U.S. Commission on Civil Rights and the issuance of regulations by the agencies and departments providing Federal assistance to programs and activities.[1] The law stated that the implementation date would not be before January 1, 1979. However, in 1978, the Congress delayed implementation further by amending the act to read "not before July 1, 1979" (Public Law 95–478).[2]

On June 12, 1979, the Department of Health, Education, and Welfare promulgated the final Government-wide regulations on the ADA.[3] These regulations, referred to as the "general regulations," were intended to guide all agencies and departments providing Federal assistance in the issuance of their "specific regulations" on the ADA.

B. The Controversial "General Regulations"

As required by the ADA, the Department of Health, Education, and Welfare was charged with developing the general Government-wide regulations for the ADA which were to be used by the agencies and departments in developing their specific regulations for enforcement of the act.

In a June 5, 1979 news release, HEW Secretary Joseph Califano stated, "These regulations do herald a new era of *public sensitivity*

[1] For a detailed description of the age discrimination study by the U.S. Commission on Civil Rights, see: U.S. Congress. Senate. Special Committee on Aging. Developments in Aging: 1977. Washington. U.S. Government Printing Office. 1978.

[2] For a description of the 1978 amendments to the Age Discrimination Act, see: U.S. Congress. Senate. Special Committee on Aging. Developments in Aging: 1978. Washington, U.S. Government Printing Office. 1979.

[3] Department of Health, Education, and Welfare. 45 CFR, part 90. vol. 44, No. 114. June 12, 1979.

According to PAERC, in 1979 the organization focused on conducting workshops in region II and IX jointly with the Administration on Aging's regional offices. One- and two-day workshops were held in Chicago, New York, Honolulu, and San Francisco. Participants were local service providers, community leaders and Pacific-Asian elderly from that community or area of the country. Service providers were given an overview of needs of Pacific-Asian elderly, and strategies to address those needs. Providers discussed services available in their areas. Specific recommendations related not only to the National Resource Center and national policy, but also to strategies that can be used locally and regionally in generating services. The center staff coordinated their efforts with HEW, AoA, State units on aging, and area agencies on aging in order to develop annual plans which identify target service areas to address the needs of the Pacific-Asian elderly. PAERC activities resulted in the establishment of their main office in Seattle, Wash., with a regional office in Washington, D.C. PAERC established its national advisory committee which is comprised of Asians of nearly every nationality including the Pacific Islands.

VII. RECENT DEVELOPMENTS AFFECTING ELDERLY MINORITIES

The National Center on Black Aged, Asociacion Nacional Pro Personas Mayores, National Indian Council on Aging and Pacific-Asian Coalition were concerned about the funding level for their proposals for fiscal year 1980 with the Administration on Aging. The Administration on Aging reviewed the proposals and negotiated the grant awards with these organizations and made the following awards:

	1980 funding level
Asociacion Nacional Pro Personas Mayores	$349, 052
National Center on Black Aged	349, 857
National Indian Council on Aging	336, 398
Pacific-Asian Elderly Resource Center	284, 692

Asociacion Nacional Pro Personas Mayores and National Center on Black Aged received the same funding as their 1979 level. The Administration for Native Americans, working with the Administration on Aging through an interagency agreement, has supplemented the above award to the National Indian Council on Aging in the amount of $85,000. The Pacific-Asian Coalition received an increase over their last year's level of $132,561 because it is a new program which received only startup funds in 1979.

The awards to minority aging organizations were made as a part of the national aging organizations projects program. This program is one of several new programs made possible by the national impact demonstrations authority of the 1978 Amendments to the Older Americans Act. A cooperative agreement funding mechanism is used rather than a grant. Prior to the initiation of this program, national organizations received grants from model project funds.

country in their various fields. A slide-tape presentation on the ceremony, and a book, "The Elders," will be completed in 1980.

The center compiled and published a "Topical Annotated Bibliography on the Black Elderly," containing listings for 200 publications in aging, and a directory of national aging organizations. The "Curriculum Guidelines in Minority Aging" is a resource manual for instructors to facilitate their teaching in the various aspects of minority aging. An upcoming project of the NCBA is the development of an annotated bibliography of employment opportunities for middle-aged and older women. Policy and position papers on selected issues affecting employment opportunities for this segment of the population are being prepared. As an adjunct to this project, NCBA has established a multiracial commission to research the barriers to employment opportunities and to develop recommendations for corrective actions.

VI. PACIFIC-ASIAN ELDERLY

As with other ethnic minority groups, the Pacific-Asian elderly have unique needs stemming from their cultural heritages that require sensitivity on the part of service providers. Bicultural and bilingual considerations are deemed essential for participation by Pacific-Asian elderly in Federal programs.

Pacific-Asian Elderly Resource Center

The Pacific-Asian elderly research project (PAERP) developed out of the Asian-American Mental Health Research Center's ad hoc task force on aging. The Mental Health Research Center was started by Asian-American social service workers and community representatives, and was governed by an advisory board composed of elected representatives from the nine national regions. The center received its initial funding from a 1974 National Institute on Mental Health grant.

On September 1, 1976, the Pacific-Asian elderly research project was awarded a $131,561 grant from the Administration on Aging for its initial year of operation.

In 1979, the Pacific-Asian elderly research project moved its offices to Seattle, Wash., and is now known as the Pacific-Asian Elderly Resource Center (PAERC).

The primary focus of the PAERC is to improve the delivery of services to the Pacific-Asian elderly community. To accomplish this goal the PAERC will compile and assess information, conduct workshops for service providers, provide technical assistance to Pacific-Asian communities, form a national advisory committee and regional task forces to develop needs data and policy recommendations.

poverty level. Older black women, particularly those living alone, have an even more disadvantaged economic situation.[1]

The National Center on Black Aged

The National Center on Black Aged (NCBA) was established in 1973 under a title IV research grant from the Administration on Aging. The center serves as an arm of the National Caucus on the Black Aged, which is a membership organization responsible for developing policy proposals concerning the needs of the elderly blacks. The National Center on Black Aged fulfills several functions, including collecting of data, engaging in research activities, disseminating information, encouraging the development of service programs, advocating on behalf of the elderly black, and working with other organizations in the field of aging.

According to the National Center on the Black Aged, it was involved in the review of the following draft regulations and programs of concern to the black elderly during 1979:

(1) Older Americans Act regulations: Of major concern was the elimination of the assurances for services and resources for the minority elderly and for contracts for minority contractors.

(2) Social security and supplemental security income programs: The detrimental effects on the poor and the minority elderly resulting from proposed cutbacks and reductions in disability benefits, were submitted to President Carter and to the Commissioner of Social Security.

(3) Senior community service employment program: 1979 was the first full year of NCBA's administration of a contract under the Older Americans Act title V program in which over 300 older persons were employed in the rural areas of five southern States.

(4) Pennsylvania research: Data gathered by various governmental agencies in Pennsylvania was reviewed to examine the utilization of social services by the minority elderly. The research revealed that black and other minority elderly are not being adequately served by the full range of programs which are available either through the Older Americans Act or through title XX of the social security legislation. NCBA's goals are to find ways area agencies and their contractors can encourage and improve minority elderly participation in these social service programs.

(5) Title IV Older Americans Act educational program: Under this program, the center worked with 60 black colleges to develop an interest in aging. Through NCBA's assistance in preparation of proposals, approximately $100,000 has been awarded to black colleges to conduct gerontology programs.

Other 1979 activities reported by the NCBA to the committee included testimony before the President's Commission on Pension Policy regarding the inadequacy of pensions and retirement income for blacks. Views on the President's budget for aging were presented to the Office of Management and Budget.

NCBA sponsored a "living legacy awards" program in which the President honored 17 black Americans for their contributions in the

[1] U.S. Department of Commerce, Bureau of the Census. Current Population Reports. Series P-23. Number 85 (Washington, August 1978), table 1, pp. 2-33.

California, Texas, Louisiana, Oklahoma, and Kansas. Senior enrollees work in schools, at nutrition sites, community agencies, and other service organizations.

(5) In September, the Asociacion cosponsored a conference with the Mexican/American Cultural Center in Oklahoma City, and the Associated Catholic Charities in New Orleans to promote job development for the "Project Ayuda" older workers.

(6) The Asociacion cosponsored the midwest leadership training conference for Hispanic elderly, held in Chicago in July, and sponsored participation by 10 "Project Ayuda" enrollees at the National Council on Aging conference.

(7) The Asociacion regional offices also provided local training and technical assistance. The Miami office involved older Hispanics in local crime prevention and energy conservation programs; the New York office activities included sponsorship of cross-cultural workshops for and about the Hispanic elderly.

(8) Throughout 1979, the Asociacion disseminated information on legislative issues affecting older persons, especially the minority elderly. This was accomplished through publication of newsletters and legislative bulletins and other special mailings. The Asociacion's Washington, D.C. liaison office conducted an indepth analysis of the draft regulations for the 1978 Older Americans Act amendments. This analysis focused on the regulations' potential effect on minority older persons. The Asociacion disseminated information regarding the regulations through their regional offices.

(9) The Asociacion participated in many national and regional aging conferences in 1979, including meetings of the National Council on the Aging, the Gerontological Society, the Western Gerontological Society, and the San Diego State University Institute on Minority Aging. They also presented testimony about the Hispanic elderly before Federal Council on the Aging hearings in May and June.

At the end of the year, the Asociacion Nacional entered into a 3-year "cooperative agreement" with the Administration on Aging to conduct a national impact project. Through this agreement, project "mano a mano," the Asociacion will undertake activities similar to those described above. They will focus on assisting the aging network reach the Hispanic elderly.

(10) The Asociacion in cooperation with the National Indian Council on Aging and the University of New Mexico submitted a proposal to the Administration on Aging to establish a national policy center on Hispanic and Indian elderly.

V. BLACK ELDERLY

In 1978, blacks 65 years of age and over numbered around 2 million and made up about 8 percent of all persons 65 and over. Between 1900 and 1978, the elderly black population increased 7 to 8 times which was comparable to the increase of the over age 65 population as a whole. Since 1970, however, the black population in this age group has risen by 28 percent as compared to a 19 percent increase in the white population for that same period.

The incidence of poverty among aged blacks, however, is still disproportionately high, twice that of the total population over the age of 65. One in every three black older persons has an income below the

IV. HISPANIC ELDERLY

Usually the Hispanic elderly, both rural and urban, belong to one culture, Mexican, Spanish, Puerto Rican, Cuban or Latin, and are accustomed to speaking only one language. Since many did not have educational opportunities available to them, they remain poorly educated. These two factors combined to result in language barriers that, in many cases, limit their participation in overall Federal programing. They are confronted with the same severe socioeconomic problems as other elderly minority groups.

Asociacion Nacional Pro Personas Mayores

The Asociacion Nacional Pro Personas Mayores was established in 1975, with the assistance of an AoA model project grant, to promote greater involvement of the Hispanic elderly in city, State and Federal aging programs, and to assist researchers and legislators to better understand the culture and specialized needs of the elderly members of the Hispanic ethnic groups.

The Asociacion furthers these goals through its participation in congressional hearings and aging conferences. It has established a national office and a number of regional centers in the following locations:

—Southeastern center in Miami, Fla.
—Eastern center in New York.
—Western center in Los Angeles.
—National office in Washington.

Unfortunately for the southwestern part of the United States, where there are large concentrations of Hispanic elderly, the southwestern center was closed in 1978. The southwestern center had been very active in Texas, New Mexico, Arizona, and Colorado and had provided valuable information to the Special Committee on Aging on the rural Hispanic elderly.

The Asociacion Nacional Pro Personas Mayores reported the following activities during 1979:

(1) The Asociacion continued to expand its role as the only national organization serving all segments of the Hispanic elderly in the United States. It provided increased awareness of the needs of Hispanic older persons and attempted to fill those needs.

(2) Asociacion projects during the year involved scientific research and analysis, monitoring of existing social service delivery systems, training and technical assistance, and dissemination of information.

(3) In the area of research, the Asociacion's AoA-sponsored research survey, "A National Study to Assess the Service Needs of Hispanic Elderly," came close to completion in 1979. The Asociacion administered questionnaires to 1,875 older Hispanic respondents nationwide. Respondents gave information about their status and needs in housing, medical care, transportation, education, and other service-related categories. Their Los Angeles office research staff has nearly finished the data analysis on this study. A final report on the study's findings will be published in the spring of 1980.

(4) The Asociacion continued to employ over 300 older persons through "Project Ayuda." This project, part of the Department of Labor's senior community service employment program, operates in

(e) Published the proceedings of the second National Indian Conference on Aging that dealt specifically with the health needs of the Indian elderly. The conference attracted 3,000 conferees with a large percentage being Indian elderly. There were approximately 20 issues identified in the form of resolutions that were subsequently submitted to appropriate agencies and departments for their action and/or response. The highlight of this document is the summary and findings of four studies commissioned by the Indian Health Service.

(f) Initiated a planning meeting with various tribal aging program directors as a preliminary step toward implementing a national training effort by NIOCA. This resulted in the first National Training Institute for Tribal Aging Program Administrators in November 1979. The Institute drew approximately 87 program administrators to Denver, Colo. During the course of the Institute, other training needs were identified which will be the subject of future training efforts. It is expected that by early spring, a "how to" manual will be developed for use by tribal aging program administrators.

(g) Provided testimony on the programmatic aspects of the section 202 elderly housing program, and provided several administrative and legislative recommendations that will increase the opportunity for Indian participation.

(h) On a quarterly basis, provided the Indian and non-Indian community with aging-related information through its newsletter NICOA News. Currently, there are over 1,500 subscribers that include congressional members, the aging network, Indian tribes, universities, libraries, and other interested individuals.

(i) Implemented the planning process necessary to sponsor the 1980 National Indian Conference on Aging. The thrust of the conference will be the preparation for the 1981 White House Conference on Aging. It will include the identification of issues, delegates, and development of strategies to ensure that the input provided by the Indian community is acted upon.

(j) Initiated contact, with postsecondary institutions that had ongoing gerontology programs. Through these contacts, NICOA has created the foundation necessary to recruit Indian students into the field of aging and thereby increase the number of qualified personnel in the field. Contacts have been made with Arizona State University, the University of Arizona, University of New Mexico, University of San Diego, and the University of Western Michigan at Kalamazoo.

(k) Provided training and technical assistance to Indian tribes and organizations in the development of their aging programs. This effort included: the Navajo Tribe, the Oklahoma Indian Tribes, the Creek Nation, the Idaho Indian Tribes, the Gila River Indian Community, the California Indian Tribes, the Standing Rock Indian Reservation, the Seminoles, Oneidas, the Great Lakes Intertribal Council, the Hopi Tribe, Southern Ute Indian Tribe, the New Mexico Pueblo Indians, the Seneca Nation, the Northwest Affiliated Tribes, the Yakima Indian Nation, the Chickasaw Indian Nation, the Phoenix Urban Indian Center, the Yaqui Tribe, the Coushattas of Louisiana, the Choctaws of Mississippi, the Eastern Band of Cherokees, and the Fort Mohave Indian Reservation.

(l) Make progress on its efforts to develop a comprehensive needs assessment and services profile of the Indian elderly. It is expected that a final report on council activities will be published in late summer of 1980.

grants to Indian tribes. On Monday, July 30, 1979, the Senate and House conferees agreed to provide $6 million for title VI.

Even with these limited funds, it should be possible to lay a solid foundation for the development of a comprehensive Indian aging program, including social and nutritional services for those tribes who elect to participate in title VI.

National Indian Council on Aging

The National Indian Council on Aging was created in 1976 as a result of the National Indian Conference on Aging in Phoenix, Ariz., which was held during that same year. The objectives of the National Indian Council on Aging are as follows:

(a) Communication and cooperation with services provider agencies and advocacy organizations in the field of aging nationwide.

(b) Dissemination of information on available service resources to the national Indian community.

(c) Intercession with the appropriate agencies, where necessary, to provide access to these resources.

(d) Technical assistance to and training of Indian tribal/organization staffs to the extent of available resources.

(e) Provision of relevant information and expert testimony requested by Members and staff of Congress.

(f) Service as a national clearinghouse for issues affecting the Indian and Alaskan Native elderly.

(g) To promote the flow of information to and from the national Indian community through a newsletter, local activities, and by holding Council and board meetings in different geographic locations throughout the United States.

The National Indian Council on Aging has provided the Senate Special Committee on Aging the following information on its activities since the Council's inception in 1976:

(a) Advocated and provided background information to both Indian and non-Indian communities regarding title VI of the Older Americans Act and reported on the status of appropriations bills as they progressed through the legislative process.

(b) In November 1978, NICOA and other Indian organizations met with staff members of the Administration on Aging to provide recommendations on the general format and direction of the title VI rules and regulations.

(c) The Administration on Aging signed a cooperative agreement with NICOA, signaling an end to the NICOA's status as a model project and ushering in a new formal relationship. It is expected that the National Indian Council on Aging will assume a significant role in the implementation of the title VI program by providing timely technical assistance and the training where necessary.

(d) Received a grant from the Administration on Native Americans to develop and implement more efficient outreach techniques resulting in an increase in the number of Indian elderly participants in entitlement programs. The grant grew out of a meeting with the Social Security Administration, Administration for Native American Programs, Indian Health Services, Bureau of Indian Affairs, the Department of Health, Education, and Welfare, the Interdepartmental Council on Indian Affairs, the Administration on Aging, and the National Indian Council on Aging.

According to the 1970 census revised statistics there are approximately 800,000 American Indians in the country today. Of the approximately 800,000 American Indians, there are about 64,000 elderly American Indians who are 60 years of age and older, constituting 8 percent of the total Indian population. The poverty rate among the Indian elderly has not been statistically documented. However, according to the National Indian Council on Aging and the Bureau of Indian Affairs, the unemployment rate for the Indian labor force was approximately 37 percent.

II. MINORITY ELDERLY AVERAGE MEDIAN INCOME

The following data was compiled by the Census Bureau from their current population survey in March of 1978 and March 1979. Aside from increases due to inflation, no significant changes in the median income for persons 65 years and older were observed in 1978. It may be noted that the average median income for the black and Hispanic elderly remained below that of the entire 65 and over population.

AVERAGE MEDIAN INCOME

	1977	1978
65 and over/all races	$3,856	$4,172
White 65 and over	4,004	4,381
Black 54 and over	2,694	2,825
Hispanic 65 and over	2,688	3,105

While no current data is available for the Indian elderly, the Census Bureau was able to determine a median income for the Indian elderly 65 years and older using information compiled in the 1970 census.

AVERAGE MEDIAN INCOME—1970

Indian elderly 65 and over (male and female)	$1,408
Indian elderly male 65 and over	1,654
Indian elderly female 65 and over	1,162

III. INDIAN ELDERLY

The Nation's elderly population has continued to receive increasing attention. However, until 1978 and 1979, the Indian elderly population had been essentially neglected. Significant steps were taken to improve the delivery of social and nutritional services to this group with the enactment of the 1978 Older Americans Act. The act established a separate title VI, direct funding for American Indian programs. Upon introducing the title VI legislation on February 28, 1978, Senator Pete Domenici, the ranking minority member of the Senate Special Committee on Aging, stated that: "The need for an expanded program of supportive services for older Indians is irrefutable." The Congress passed the legislation in the fall of 1978 authorizing "such sums as may be necessary" for fiscal years 1979–81 to carry out title VI. The administration did not include any funds for title VI in the proposed fiscal year 1980 budget. These actions set the stage for congressional debate on an amendment introduced by Senator Harrison Schmitt of New Mexico, and Senator Domenici to H.R. 4389, the Labor-HEW appropriations bill, to provide funding for direct

1970	17,484	3,984	13,323	3,708	6,138	3,477	4,161	9.9	22.5	8.1	8.0	10.5	5.9	30.8
1969	16,659	4,062	12,623	3,575	5,667	3,381	4,036	9.5	23.3	7.8	7.7	9.7	5.8	32.1
1968	17,395	3,939	13,546	3,616	6,373	3,557	3,849	10.0	23.1	8.4	8.0	10.7	6.3	32.2
1967	18,983	4,646	14,851	4,056	6,729	4,066	4,132	11.0	27.7	9.2	9.0	11.3	7.2	36.5
1966[1]	19,290	4,357	15,430	4,106	7,204	4,120	3,860	11.3	26.4	9.7	9.3	12.1	7.4	36.1
1966	20,751	NA	16,732	4,481	7,649	4,602	4,019	12.2	NA	10.5	10.2	12.8	8.2	37.3
1965	22,496	NA	18,508	4,824	8,595	5,089	3,988	13.3	NA	11.7	11.1	14.4	9.2	38.1
1964	24,957	NA	20,716	5,258	9,573	5,885	4,241	14.9	NA	13.2	12.2	16.1	10.8	40.7
1963	25,238	NA	21,149	5,466	9,749	5,934	4,089	15.3	NA	13.6	12.8	16.5	11.0	42.0
1962	26,672	NA	22,613	5,887	10,382	6,344	4,059	16.4	NA	14.7	13.9	17.9	12.0	42.7
1961	27,890	NA	23,747	6,205	10,614	6,928	4,143	17.4	NA	15.8	14.8	18.7	13.3	43.2
1960	28,309	NA	24,262	6,115	11,229	6,918	4,047	17.8	NA	16.2	14.9	20.0	13.3	43.0
1959	28,484	4,744	24,443	6,185	11,386	6,872	4,041	18.1	33.1	16.5	15.2	20.6	13.3	44.1
BLACK														
1978	7,625	662	6,493	1,622	3,781	1,094	1,132	30.6	33.9	29.5	27.5	41.2	15.7	38.6
1977	7,726	701	6,667	1,637	3,850	1,181	1,059	31.3	36.3	30.5	28.2	41.6	17.4	37.0
1976	7,595	644	6,576	1,617	3,758	1,201	1,019	31.1	34.8	30.1	27.9	40.4	17.8	39.8
1975	7,545	652	6,533	1,513	3,884	1,136	1,011	31.3	36.3	30.1	27.1	41.4	16.9	42.1
1974[1]	7,182	591	6,255	1,479	3,713	1,063	927	30.3	34.3	29.3	26.9	39.6	16.4	39.3
1974	7,467	626	6,506	1,530	3,819	1,157	961	31.4	36.4	30.3	27.8	40.7	17.6	41.0
1973	7,388	620	6,560	1,527	3,822	1,211	828	31.4	37.1	30.8	28.1	40.6	18.7	37.9
1972	7,710	640	6,841	1,529	4,025	1,287	870	33.3	39.9	32.4	29.0	42.7	20.0	42.9
1971	7,396	623	6,530	1,484	3,836	1,210	866	32.5	39.3	31.2	28.8	40.7	19.1	46.0
1970	7,548	683	6,683	1,481	3,922	1,279	865	33.5	48.0	32.2	29.5	41.5	20.5	48.3
1969	7,095	689	6,245	1,366	3,677	1,202	850	32.2	50.2	30.9	27.9	39.6	20.0	46.7
1968	7,616	655	6,839	1,366	4,188	1,285	777	34.7	47.7	33.7	29.4	43.1	21.7	46.3
1967	8,486	715	7,677	1,555	4,558	1,564	809	39.3	53.3	38.4	33.9	47.4	27.1	49.3
1966[1]	8,867	722	8,090	1,620	4,774	1,696	777	41.8	55.1	40.9	35.5	50.6	29.4	54.4
1959	9,927	711	9,112	1,860	5,022	2,230	815	55.1	62.5	54.9	48.1	65.5	44.1	57.0
SPANISH ORIGIN[2]														
1978	2,607	125	2,343	559	1,354	429	264	21.6	23.2	20.9	20.4	27.2	12.3	29.8
1977	2,700	113	2,463	591	1,402	469	237	22.4	21.9	21.9	21.4	28.0	13.5	29.8
1976	2,783	128	2,516	598	1,424	494	266	24.7	27.7	23.8	23.1	30.1	15.3	37.2
1975	2,991	137	2,755	627	1,619	508	236	26.9	32.6	26.3	25.1	33.1	16.5	36.6
1974[1]	2,575	117	2,374	526	1,414	435	201	23.0	28.9	22.4	21.2	28.6	13.7	32.6
1974	2,601	116	2,394	527	1,433	434	207	23.2	28.5	22.6	21.3	29.0	13.7	33.7
1973	2,366	95	2,209	468	1,364	377	157	21.9	24.9	21.5	19.8	27.8	12.6	29.9
1972	2,414	NA	2,252	NA	NA	NA	162	22.8	NA	22.3	NA	NA	NA	33.2

[1] Based on revised methodology.
[2] Persons of Spanish origin may be of any race.

Source: U.S. Department of Commerce, Bureau of the Census. Current Population Reports. Consumer income series P-60, No. 120, table 18 (Washington, November 1979), p. 28.

Note: For the year 1959, data for persons 65 yr and over and for blacks are based on 1-in-1,000 sample of the 1960 census. For the years 1969 to 1978, data are based on 1970 census population controls.

PERSONS BELOW THE POVERTY LEVEL, BY FAMILY STATUS, SEX OF HEAD, RACE, AND SPANISH ORIGIN: 1959 TO 1978

[Numbers in thousands. Persons as of March of the following year. For meaning of symbols, see text]

Year, sex of head, race, and Spanish origin	Number below poverty level							Poverty rate						
	Total		In families				Unrelated individuals	Total		In families				Unrelated individuals
	All persons	65 yr and over	Total	Head	Related children under 18	Other family members		All persons	65 yr and over	Total	Head	Related children under 18	Other family members	
ALL PERSONS—ALL RACES														
1978	24,497	3,233	19,062	5,280	9,722	4,059	5,435	11.4	14.0	10.0	9.1	15.7	5.7	22.1
1977	24,720	3,177	19,505	5,311	10,028	4,165	5,216	11.6	14.1	10.2	9.3	16.0	5.9	22.6
1976	24,975	3,313	19,632	5,311	10,081	4,240	5,344	11.8	15.0	10.3	9.4	15.8	6.0	24.9
1975	25,877	3,317	20,789	5,450	10,882	4,457	5,088	12.3	15.3	10.9	9.7	16.8	6.4	25.1
1974 [1]	23,370	3,085	18,817	4,922	9,967	3,928	4,553	11.2	14.6	9.9	8.8	15.1	5.7	24.1
1974	24,260	3,308	19,440	5,109	10,196	4,135	4,820	11.6	15.7	10.2	9.2	15.5	6.0	25.5
1973	22,973	3,354	18,299	4,828	9,453	4,018	4,674	11.1	16.3	9.7	8.8	14.2	5.9	25.6
1972	24,460	3,738	19,577	5,075	10,082	4,420	4,883	11.9	18.6	10.3	9.3	14.9	6.6	29.0
1971	25,559	4,273	20,405	5,303	10,344	4,757	5,154	12.5	21.6	10.8	10.0	15.1	7.2	31.6
1970	25,420	4,709	20,330	5,260	10,235	4,835	5,090	12.6	24.5	10.9	10.1	14.9	7.4	32.9
1969	24,147	4,787	19,175	5,008	9,501	4,667	4,972	12.1	25.3	10.4	9.7	13.8	7.2	34.0
1968	25,389	4,632	20,695	5,047	10,739	4,909	4,694	12.8	25.0	11.3	10.0	15.3	7.8	34.0
1967	27,769	5,388	22,771	5,667	11,427	5,677	4,998	14.2	29.5	12.5	11.4	16.3	9.1	38.1
1966 [1]	28,510	5,114	23,809	5,784	12,146	5,879	4,701	14.7	28.5	13.1	11.8	17.4	9.5	38.3
1966	30,424	NA	25,614	6,200	12,876	6,538	4,810	15.7	NA	14.2	12.7	18.4	10.5	38.9
1965	33,185	NA	28,368	6,721	14,388	7,249	4,827	17.3	NA	15.8	13.9	20.7	11.8	39.8
1964	36,055	NA	30,912	7,160	15,736	8,016	5,143	19.0	NA	17.4	15.0	22.7	13.3	42.7
1963	36,436	NA	31,498	7,554	15,691	8,253	4,938	19.5	NA	17.9	15.9	22.8	13.8	44.2
1962	38,625	NA	33,623	8,077	16,630	8,916	5,002	21.0	NA	19.4	17.2	24.7	15.1	45.4
1961	39,628	NA	34,509	8,391	16,577	9,541	5,119	21.9	NA	20.3	18.1	25.2	16.5	45.9
1960	39,851	NA	34,925	8,243	17,288	9,394	4,926	22.2	NA	20.7	18.1	26.5	16.2	45.2
1959	39,490	5,481	34,562	8,320	17,208	9,034	4,928	22.4	35.2	20.8	18.5	26.9	15.9	46.1
WHITE														
1978	16,259	2,530	12,050	3,523	5,674	2,852	4,209	8.7	12.1	7.3	6.9	11.0	4.5	19.8
1977	16,416	2,426	12,364	3,540	5,943	2,882	4,051	8.9	11.9	7.5	7.0	11.4	4.6	20.4
1976	16,713	2,633	12,600	3,560	6,034	2,906	4,213	9.1	13.2	7.5	7.1	11.3	4.7	22.7
1975	17,770	2,634	13,799	3,838	6,748	3,213	3,972	9.7	13.4	8.3	7.7	12.5	5.2	22.7
1974 [1]	15,736	2,460	12,181	3,352	6,079	2,750	3,555	8.6	12.8	7.3	6.8	11.0	4.5	21.8
1974	16,290	2,642	12,517	3,482	6,180	2,855	3,773	8.9	13.8	7.5	7.0	11.2	4.7	23.2
1973	15,142	2,698	11,412	3,219	5,462	2,731	3,730	8.4	14.4	6.9	6.6	9.7	4.5	23.7
1972	16,203	3,072	12,268	3,441	5,784	3,043	3,935	9.0	16.8	7.4	7.1	10.1	5.1	27.1
1971	17,780	3,605	13,566	3,751	6,341	3,474	4,214	9.9	19.9	8.2	7.9	10.9	5.8	29.6

poverty level in 1978, poverty rates of the various subgroups deviated widely from this figure.

The following table points out the differences between the elderly and the minority elderly. Although there were no significant changes, the poverty rate for persons 65 and over showed a slight decrease in 1978 (14.1 percent in 1977 to 14 percent in 1978). Particularly noteworthy is the increase in the poverty rates for Hispanics (21.9 percent in 1977 to 23.2 percent in 1978) and white (11.9 percent in 1977 and 12.1 percent in 1978) populations, and a decrease (36.3 percent in 1977 to 33.9 percent in 1978) in the black population poverty rate. These fluctuations are due, for the most part, to the increase and decrease in the number of persons 65 years or older that are below the poverty level.

Chapter 9

MINORITIES

CHAPTER HIGHLIGHTS

The poverty rate for the elderly (those over 65 years of age), at 14 percent of the elderly population, is much higher than the rate of 11 percent for the population as a whole. The minority elderly are even more disadvantaged with a disproportionately high percentage of incomes below the poverty level. For example, in 1978, 33 percent of the black elderly and 23.2 percent of the Hispanic elderly had incomes below the poverty level. Although recent statistics are not available on the poverty rates for Indians, in 1970 the average annual median income for Indians over 65, according to the Bureau of the Census, was only $1,408.

In response to the unique needs for advocacy and visible representation for older members of these minority groups, four national organizations have developed since 1973: the National Center on the Black Aged, the Asociacion Nacional Pro Personas Mayores, the National Indian Council on Aging, and the Pacific Asian Elderly Resource Center. During 1979 these organizations have reviewed legislation, developed needs analyses, and made policy recommendations on behalf of the minority elderly they represent. They have also provided information and technical assistance as well as implementing special projects to assist their respective constituencies.

During 1979 the Congress appropriated, for the first time, funds specifically for direct grants to Indian tribes for the provision of social and nutrition services to elderly Indians. This appropriation of $6 million was authorized by title VI of the Older Americans Act Amendments of 1978.

I. INTRODUCTION

The elderly as a group have much higher poverty rates than other age groups. The minority elderly, as a subgroup, however, have a disproportionately higher average poverty rate.

For the second consecutive year no significant change in the size of the poverty population was noted. In 1978, there were 24.5 million persons below the poverty level, essentially the same as the 1977 figure of 24.7 million.

Although 11.4 percent of the total U.S. population were below the

A letter initiated by Senator Domenici with the endorsement and signature of Senator Chiles, was sent to seven Federal agencies requesting information on rural programs with a statutory set-aside or component for rural recipients. The purpose of the letter was to find out what these agencies have done to comply with legislation specifically targeting resources to meeting rural needs. The questions asked dealt with funding set-asides, research or demonstration grants, rural characteristics deserving special consideration, and any other statutory components drawing attention to the needs of rural residents.

The Special Committee on Aging will be studying the agency responses with a view toward evaluating the extent to which executive agencies have complied with congressional intent in implementing those laws which contain a rural focus. The committee plans to assess agency responsiveness to rural concerns through the hearing process sometime in 1980.

In November 1978, the Federal Council on Aging convened a task force on rural elderly which included 11 national organizations concerned with the plight of older Americans living in rural areas. On January 28, 1979, a National Rural Strategy Conference to improve service delivery to the rural elderly was held in Des Moines, Iowa. The Senate Special Committee on Aging staff has been meeting with national leaders and organizations to discuss the unique needs and special problems faced by the rural elderly. Topics of these discussions include the lack of advocacy and consistent Federal strategies, untapped resources, unequal dollar distribution, the special interest of the minorities, as well as overall needs such as transportation, income, health, and housing. This dialog is expected to continue in 1980.

Section 307(1)(b)(2)_____	Waiver provision. The Commissioner, in approving any State plan under this section, may waive section 307(3)(B) if the State agency demonstrates to the Commissioner that the service needs of older individuals residing in rural areas in the State are being met, or that the number of older individuals residing in such rural areas is not sufficient to require the State agency to comply with the requirement.
Section 411(b)(3)_____	A study shall be conducted to determine the difference in unit costs, service delivery and access between urban and rural areas for the services assisted under this act and the special needs of the elderly residing in rural areas.
Section 421(a)_____	The Commissioner shall give special consideration to the funding of rural area agencies on aging to conduct model projects devoted to special needs of rural elderly. Such projects shall include alternative health care delivery systems, advocacy, outreach and transportation programs.
Section 421(b)(7)_____	The Commissioner in making any grants shall give special consideration to projects designed to meet special needs of older individuals residing in rural areas.

VII. RURAL DEVELOPMENT OUTLOOK

Rural development is a basic concern which will affect all of the services and program issues discussed above. It involves the activities of Federal, State, and local governments as well as the private sector. The coordination and orchestration of these activities so that they impact on rural areas in a mutually supportive way has been a continuing concern of rural development advocates in both the administration and the Congress.

In recent years, it has become increasingly clear that rural development and urban development policies and programs may interact in ways unforeseen by their original designers. For this reason, some people believe that rural and urban development problems should be dealt with together as integral parts of the national effort to achieve balanced growth and equal quality-of-life opportunities between rural and urban areas. Others believe that rural development efforts must remain separate (including a separate organizational structure) in order to avoid being overshadowed by urban needs.

Several studies by the executive branch, as well as pending legislation and reports by public and private organizations highlight the issues associated with the content, development, and administration of a national rural development policy. The following issues will undoubtedly be addressed as these studies, reports and legislative proposals are considered:

—The relationship of rural and urban development policies, and whether there should be separate policies for rural areas.

—The organization of the Federal Government as it relates to rural programs.

—The Federal aid package for rural areas, which some charge is inefficient and inequitable because of the duplication and overlapping of programs, the "redtape" associated with the programs, and urban bias in the design of some programs.

lation, rural areas have 58 percent fewer physicians, 38 percent fewer dentists, and 29 percent fewer nurses on a per capita basis than other areas.[14]

In 1973, the ratio of population to physician nationally was 1 to 768. However, the ratio in rural areas varied from 1 to 1,432 in the larger rural towns, to as much as 1 to 2,512 in isolated rural areas.

Another compelling problem which compounds the dilemma rural people face in obtaining access to health resources is the lack of available and adequate transportation services. The lack of adequate transportation services prohibits people from reaching health care services when they are actually ill, and as a result, many people are not seen until their condition reaches a critical point.

Compounding these health problems is the fact that rural Americans are served by less than one-fourth of the federally funded community health centers and receive less than one-fourth of the current medical benefits.

The largest Federal health program for the elderly is medicare. With a budget of over $20 billion, medicare serves 25 million elderly and disabled citizens. In 1975, 31.5 percent of the medicare recipients lived in rural areas. However the average payment for a rural beneficiary in 1972 was $296 compared with $425 for an urban recipient.[15] This differential could be reflective of a number of factors which merit further examination including the lack of accessibility to health care providers, lower charges by physicians in rural areas, unwillingness of rural people to go to a doctor or hospital or less actual need for reimbursable services.

VI. LEGISLATION—THE OLDER AMERICANS ACT

The 1975 amendments to the Older Americans Act contained few references to the "rural" elderly or to rural areas themselves. This contrasted sharply with the 1978 amendments to the act which include several provisions—many authored by Senator Domenici—intended to draw attention to the plight of elderly persons residing in rural areas. This deeper emphasis on rural needs resulted from the intensified lobbying efforts of organizations and individuals representing rural constituencies and interests and the efforts of those members in both the House and Senate who represent rural constituencies.

The following is an outline of those amendments to the Older Americans Act of 1978 which had a rural focus:

Section 205(a)----------	There shall be both urban and rural representation on the Federal Council on Aging.
Section 306(a)(5)(B)-----	Area plans must assure the use of outreach efforts that will identify individuals eligible for assistance under this act, with special emphasis on rural elderly, and inform such individuals of the availability of such assistance.
Section 307(3)(B)--------	State plans must provide assurances that the State agency will spend in each fiscal year, for services to older individuals residing in rural areas in the State assisted under this title (title III) an amount equal to not less than 105 percent of the amount expended for such services (including amounts expended under title V and title VII) in fiscal year 1978.

[14] White House Policy Statement, Small Community and Rural Development Policy, p. 3.
[15] Rural America Factsheet, p. 3.

Although the need for improved housing for the rural elderly is an urgent and readily identifiable one, initiatives in this area are falling far short of meeting the need. Furthermore, those programs which do exist appear to be serving primarily older rural persons who desire to live in multiunit dwellings.

In terms of needed programs, the 1971 White House Conference on Aging's special concerns session on rural elderly recommended legislation establishing and funding a major home repair program for older people in rural areas. It was recommended that legislation include funding for home repair loans, larger home repair grants for welfare recipients, and the use of manpower training funds to perform the work. The response from the Federal Government has been minimal thus far.

Between fiscal year 1975 and 1977, the Department of Housing and Urban Development (HUD) financed the construction of approximately 600,000 housing units. About 34 percent of these units are inhabited by elderly people. Of all these elderly units, some 64,000 (20 percent) are in rural areas.

The Farmers Home Administration (FmHA) subsidized approximately 260,000 housing units between 1975 and 1977. Of these, about 24,000 (9 percent) are for elderly people. About two-thirds of FmHA's elderly housing units are in rural areas.

Between FmHA and HUD, about 260,000 housing units for the elderly were started between fiscal year 1975 and 1977. This represents about 27 percent of all federally subsidized housing starts. About 31 percent of these elderly housing units are located in rural areas. Although this proportion corresponds to the proportion of rural elderly in the Nation, it does not reflect the poorer housing conditions in rural areas.[12]

The housing and community development amendments of 1979 require the Secretary of HUD to provide a report to the Congress on the housing needs of elderly and handicapped in rural areas. Specifically, the study will analyze the existing housing programs in rural areas and the needs of elderly residents in such areas. This study, proposed by Senator Domenici, was in response to the urban emphasis in the program. Senator Domenici pointed out:

> Between 1959 and 1974, less than 8.5 percent of the section 202 funds went to towns of less than 10,000 persons. In the revised programs since 1974, there has been some movement to correct this urban emphasis but the rural share continues to be inadequate. Overall approximately 15 percent of the units are reserved for nonmetropolitan locations and as before, many rural parts of States have yet to receive a single approval.[13]

V. HEALTH

The inadequacy of health services in rural areas is a critical problem for older persons, 87 percent of whom suffer from some form of chronic illness. Over 84 percent of the areas lacking an adequate supply of physicians, dentists, and other health personnel are in rural counties. While rural America contains roughly 41 percent of our national popu-

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[12] Rural America Factsheet, RAF No. 5 (Washington, D.C.), p. 3.
[13] Domenici, Pete. Remarks in Senate. Congressional Record, vol. 125, July 13, 1979, p. S9380.

Another major component of the White House initiatives on rural transportation is a series of interagency agreements designed to increase cooperation between Federal agencies and to reduce administrative burdens on rural transportation providers. One such agreement between the Department of Labor (DOL) and DOT, addresses the previously mentioned application of the section 13(c) labor protection provisions to transportation projects funded under section 18. Section 13(c) provides, in general, that as a condition of financial assistance under the Urban Mass Transportation Act, fair and equitable arrangements are made—as determined by the Secretary of DOL—to protect the employees affected by the assistance. The agreement between the two departments—which provides for a State warranty or certification of compliance with section 13(c) requirements—has eliminated the need for prior DOL review of applications for section 18 funds. While this warranty provision is designed to save time and reduce redtape (and was used in the approval of all 125 projects thus far authorized to receive section 18 funds), it should be noted that the congressionally mandated application of section 13(c) requirements of section 18 funds often met with resistance from projects seeking rural transportation funds.

Still another key element of the Carter administration's initiatives for improving social service and public transportation is an effort to increase the availability of resources. This is to be accomplished largely through increased attention to rural areas under existing programs. The DOL, for instance, is to provide up to 1,500 Comprehensive Employment and Training Act (CETA) slots during fiscal years 1979 and 1980 for placement in rural transportation systems in 14 demonstration States. Participating States are: Missouri, Alabama, Arkansas, North Carolina, West Virginia, Kentucky, Vermont, New Hampshire, Iowa, Michigan, Colorado, Oregon, Florida, and Washington.

IV. HOUSING

Sixty percent of the Nation's substandard housing is found in rural America and one out of four of such units is occupied by an older individual. More than one-half of the rural elderly live in homes built prior to 1915. Since a majority of all homes in which the rural elderly reside were built before 1950, they are uninsulated and costly to heat. The following data describes the dwelling conditions faced by many rural elderly persons:

(1) Three times the proportion of rural housing units lack complete plumbing as urban units.

(2) Over 2 million rural Americans do not have running water in their homes.

(3) Over 4 million have inadequate sewage disposal systems or none at all.

(4) Many rely on sources of drinking water that fail to meet safe drinking water standards.

The Rural Housing Alliance has reported that in 1970 there were 1,190,959 poverty-level older households in nonmetropolitan areas of low population density. The Gerontological Society, in a paper entitled "Rural Environments and Aging," reported that in 1970 one in five older rural Americans lived in housing which lacked complete plumbing facilities.[11]

[11] Gerontological Society. Rural Environments and the Aging, p. 107.

A. Toward Coordinated Transportation Systems in Rural and Small Urban Areas

Congress demonstrated a commitment to expand and coordinate transportation in rural and small urban areas when it enacted the "formula grant program for areas other than urban areas," section 18 of the Surface Transportation Assistance Act of 1978 (Public Law 95–599). The section 18 program moved rural transit out of the research and demonstration phase, which had been established under the Federal Highway Administration's rural public transportation demonstration program and which had funded over 100 2-year demonstration projects at a total cost of $25 million.

The new section 18 program received appropriations of $75 million in its first year (fiscal year 1979) to provide operating as well as capital assistance. Report language specified that the States must allocate funds on a "fair and equitable" basis, including the State's Indian reservations, and that up to 15 percent of the apportionment could be used for planning, administration, coordination, and technical assistance. As of this writing, 125 projects have been approved for receipt of section 18 funds. For fiscal year 1980, Congress appropriated a total of $85 million for the section 18 program.

Federal officials responsible for the section 18 program indicate that initial implementation of the program was somewhat hampered by a number of factors, including: (1) The need to establish a mechanism for implementing the new program; (2) a lack of public knowledge about the program and possible sources of local match; and (3) confusion as to the manner in which the labor protection provisions of section 13(c) of the Urban Mass Transportation Act should be handled by projects seeking section 18 funds (see below).

As State and local government officials become more familiar with the program and administrative mechanisms are established, the number of projects applying for and receiving section 18 funds is likely to increase. In addition, questions with regard to the labor protection provisions are being addressed by a special section 13(c) warranty that is included in grant contracts for section 18 funds. (This will be discussed in the following section on White House rural transportation initiatives.) Further, the Department of Transportation (DOT) is in the process of compiling a list of unrestricted Federal funding sources that may be used as local match for section 18 funds. This list should be distributed to States and all relevant Federal field offices early in 1980.

B. Addressing Transportation Problems Through Local Priorities: The White House Rural Development Initiatives

The stated purpose of the White House rural transportation initiatives is to help rural and small town residents overcome problems of isolation, to gain full access to essential human services, and to meet the transportation requirements of healthy, growing economies. In accomplishing this objective, the White House report on rural transportation initiatives emphasized the need for improvements in the coordination and delivery of Federal transportation programs, and the need to make these programs more accessible and more workable for the more than 50 million people living in nonmetropolitan areas.

lower than that for metropolitan poor families—a good indication of underemployment.[10]

Inflation is as severe a problem in rural America as it is everywhere else. Its effects are felt in the increasing costs of utilities (fuel usually being purchased on an individual and small scale basis), gasoline (for essential transportation to work and necessary services), health care (it is no cheaper in rural areas), agricultural and food preservation supplies ("home grown" food is not free), and food itself (rarely is all food raised on the farm).

III. TRANSPORTATION

Limited access to adequate transportation services is often mentioned by the elderly as their most acute concern. For the rural elderly in particular, mobility difficulties create hardships as they seek access to health care, social services, shopping facilities, recreation and friends. The problem is compounded by the simple fact of distance and, consequently, high travel costs. A lack of adequate transportation in rural communities translates into greater isolation, which in turn produces poorer physical and mental health for the rural elderly.

The rural transportation problem is even more strikingly portrayed by these additional statistics that were identified in a report on rural transportation initiatives issued by the White House in June 1979. The report was issued as part of the White House Rural Development Initiatives, which are designed to address the problems of smalltown and rural Americans. Among the unique problems of rural America that were highlighted in the report, entitled "Improving Transportation in Rural America," are:

(1) Only 31 percent of the Nation's 20,000 towns with a population of 50,000 or less are served by a public transit system.

(2) Less than 1 percent of rural persons working outside the home use or have access to public transportation to get to work.

(3) Intercity bus lines serve only about half of the Nation's towns of 50,000 or less. Since 1972, 1,800 small towns have lost intercity bus lines.

(4) Regulated air service carriers have dropped nearly 200 service points—30 percent of the total served in 1960—in the last 20 years.

(5) An estimated 60 percent of areas with less than 2,500 population have no taxi service.

(6) Fifteen percent of rural households, 57 percent of the rural poor, and 45 percent of the rural elderly do not own an automobile; 52 percent own only a single automobile, which means that other family members are "left behind" when the breadwinner uses the family car to travel to and from work.

(7) Rural residents must travel farther than their urban counterparts to gain access to medical care and essential social services—for example 30 percent of rural residents as compared to 10 percent of urban residents must travel more than half an hour to obtain medical care.

The lack of private and public transportation services prevents the elderly from gaining access to the federally funded services which they need and are eligible to receive.

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[10] The Rural Stake in Public Assistance: Information and Analysis to Guide Public Policy, The National Rural Center (Washington, D.C., December 1978), p. 36.

II. INCOME AND EMPLOYMENT

Despite changes in the patterns of migration of younger persons into and out of rural areas and the considerable attention being paid to rural economic development, the incidence of poverty continues to be significantly higher in rural areas than in urban. According to the U.S. Census Bureau in 1977, 18.7 percent of those persons over 65 years of age in nonmetropolitan areas had incomes below the poverty level compared to only 11.4 percent of those in metropolitan areas. A 1979 report by the National Rural Center found that the greatest incidence of poverty among the aged is still in rural areas.[6]

For the nonwhite population living in rural areas, the economic picture is even bleaker. A disproportionately large number of the rural poor are blacks, Hispanics, and Native Americans. Approximately 27 percent of rural Hispanic people and 38 percent of rural blacks live on incomes below the poverty level (compared to 11 percent for rural whites).[7] Black unrelated older persons (65 years of age and older) have two times the incidence of poverty as white unrelated persons living in rural areas. Of all aged black women living as "unrelated individuals," 61.3 percent are in poverty compared to 37.9 percent for whites.[8]

About 40 percent of all Native Americans were living below the poverty level in 1970. Women in both the rural and the urban work force do not share equitably in the economic rewards of their labor. In 1977, the average annual income of women working full-time in rural areas was only 54 percent of the income of rural men. Also, households headed by females made up almost 35 percent of all nonmetropolitan households living in poverty.[9]

This disproportionate poverty in rural areas may be attributed to a number of factors. In the rural agricultural economy, earnings are often lower and consequently social security and pension payments are smaller.

For those who are able and wish to work, the number of job opportunities in the public and private sectors are limited. Unemployment and underemployment are a major problem. In economically depressed rural areas, the limited availability of jobs for the entire population and lower than average wage rates impact with particular severity on older persons who need to and want to work. The problems of transportation to distant places of employment, new skills required by industrialization, and competition for scarce jobs combine to intensify the employment problem for older rural persons.

Despite the fact that they are poorer, older, more disabled and less educated, rural poor heads of households have higher involvement in the labor force than do their urban counterparts. For example, 57.5 percent of poor nonmetropolitan family heads are involved in the labor force, compared to 45.3 percent in metropolitan areas and the national average of 50.3 percent. Even with their high rate of involvement in the labor force, the mean income for these persons is still

[6] The National Rural Center, The Rural Stake in Public Assistance. Information and Analysis to Guide Public Policy (Washington, D.C., December 1978).
[7] White House Policy Statement, Small Community and Rural Development Policy (Washington, D.C., Dec. 20, 1979), p. 3.
[8] The National Rural Center, p. 41.
[9] Ibid.

TABLE 2.—PROPORTION OF TOTAL OLDER POPULATION THAT IS RURAL BY STATES: UNITED STATES, 1970

State	Total population age 60 and over	Percent of total 60 and over		
		Rural	Rural nonfarm	Rural farm
Alabama	477,918	43.7	37.6	6.1
Alaska	11,872	55.5	54.6	0.9
Arizona	235,145	20.8	19.8	1.1
Arkansas	335,695	51.9	42.2	9.7
California	2,579,744	10.1	9.0	1.1
Colorado	265,640	23.0	18.7	4.3
Connecticut	417,618	18.9	18.1	0.8
Delaware	63,719	31.4	28.2	3.3
District of Columbia	103,892			
Florida	1,353,044	18.2	17.3	0.9
Georgia	544,419	41.8	36.4	5.4
Hawaii	67,075	23.2	21.7	1.5
Idaho	98,630	43.5	30.8	12.6
Illinois	1,572,418	18.6	14.0	4.6
Indiana	703,511	34.9	24.9	10.0
Iowa	478,597	44.5	30.5	13.9
Kansas	367,114	40.5	28.3	12.2
Kentucky	478,429	49.7	34.7	15.0
Louisiana	450,131	34.8	30.7	4.1
Maine	160,133	48.0	45.7	2.3
Maryland	445,390	24.4	21.9	2.6
Massachusetts	890,198	12.5	12.1	0.4
Michigan	1,093,475	26.5	22.6	3.9
Minnesota	564,456	37.6	27.2	10.4
Mississippi	320,854	58.5	46.1	12.3
Missouri	787,046	33.8	24.7	9.0
Montana	97,237	47.3	37.0	10.3
Nebraska	251,329	45.2	31.6	13.6
Nevada	48,470	20.9	18.6	2.2
New Hampshire	109,418	43.2	42.0	1.3
New Jersey	1,015,220	11.3	10.8	0.6
New Mexico	105,388	32.2	27.4	4.8
New York	2,829,353	12.7	11.7	1.0
North Carolina	614,093	55.8	44.3	11.4
North Dakota	93,864	63.6	43.9	19.7
Ohio	1,428,477	23.2	18.6	4.6
Oklahoma	423,442	37.0	28.5	8.4
Oregon	321,931	30.9	25.5	5.4
Pennsylvania	1,834,896	25.0	23.3	1.7
Rhode Island	147,026	9.8	9.5	0.3
South Carolina	287,634	52.6	46.5	6.2
South Dakota	109,973	60.0	41.9	18.1
Tennessee	558,387	43.4	31.7	11.8
Texas	1,441,563	27.8	21.9	5.9
Utah	113,388	22.0	19.0	3.1
Vermont	66,889	64.8	60.0	4.8
Virginia	540,072	42.6	34.8	7.7
Washington	459,137	27.0	23.8	3.2
West Virginia	280,206	57.5	52.9	4.6
Wisconsin	662,284	35.7	28.2	7.4
Wyoming	44,260	38.1	29.3	8.8
United States	28,750,100	27.2	22.4	4.8

Source: Gerontological Society Conference Report, Rural Environments and Aging, Lexington, Ky.: March 1975.

TABLE 1.—PERCENT DISTRIBUTION OF THE RURAL POPULATION AGE 60 AND OVER BY CENSUS DIVISIONS AND REGIONS: UNITED STATES, 1970

	Rural	Rural nonfarm	Rura farm
Total number	7,822,629	6,438,549	1,384,080
Census divisions	100.0	100.0	100.0
Northeast	4.8	5.5	1.7
Middle Atlantic	12.0	13.5	4.5
East north-central	17.7	16.9	21.2
West north-central	13.8	11.8	22.0
South Atlantic	19.1	20.0	14.1
East south-central	11.2	10.4	15.7
West south-central	11.3	11.1	12.4
Mountain	3.5	3.6	3.7
Pacific	6.5	6.9	4.5
Regions	100.0	100.0	100.0
Northeast	16.8	19.0	5.8
North-central	31.5	28.7	44.2
South	41.6	41.5	41.6
West	10.0	10.5	8.2

Source: Gerontological Society Conference Report Rural Environments and Aging, Lexington, Ky.: March 1975.

Table 2 shows that 21 of the 50 States have at least 40 percent of their older populations in rural areas, and, in 8 States, more than half of the older population is rural. Thirteen States have more than 10 percent of their older populations living on farms. These statistics have important policy implications since so many Government programs developed to serve the elderly are presently geared to serve an urban-based population.[5]

[5] Ibid.

I. BACKGROUND

A majority (62 percent) of Americans 65 and older reside in metropolitan areas. The remaining 38 percent (8.4 million persons aged 65 and over) reside in nonmetropolitan areas—in small towns, on farms or generally in rural settings.[2] The following chart illustrates, by age, the population distribution between metropolitan and nonmetropolitan areas.

METROPOLITAN-NONMETROPOLITAN RESIDENCE OF PERSONS 55 YR AND OVER, BY SEX AND AGE: MARCH 1978

[Numbers in thousands; noninstitutional population]

Residence	Both sexes				Male				Female			
	Total, 55 and over	55 to 64	65 to 74	75 and over	Total, 55 and over	55 to 64	65 to 74	75 and over	Total, 55 and over	55 to 64	65 to 74	75 and over
Number												
Metropolitan	27,557	13,557	8,984	5,016	12,019	6,471	3,726	1,822	15,536	7,086	5,257	3,193
Central city	12,580	5,880	4,234	2,466	5,304	2,732	1,689	883	7,276	3,149	2,545	1,582
Outside central city	14,977	7,677	4,750	2,550	6,715	3,739	2,037	939	8,260	3,937	2,712	1,611
Nonmetropolitan	15,418	6,951	5,284	3,183	6,920	3,297	2,355	1,268	8,502	3,655	2,930	1,917
Total (number)	42,977	20,509	14,269	8,199	18,939	9,769	6,080	3,090	24,038	10,740	8,189	5,109
Percent												
Metropolitan	64.1	66.1	63.0	61.2	63.5	66.2	61.3	59.0	64.6	66.0	64.2	62.5
Central city	29.3	28.7	29.7	30.1	28.0	28.0	27.8	28.6	30.3	29.3	31.1	31.0
Outside central city	34.8	37.4	33.3	31.1	35.5	38.3	33.5	30.4	34.4	36.7	33.1	31.5
Nonmetropolitan	35.9	33.9	37.0	38.8	36.5	33.7	38.7	41.0	35.4	34.0	35.8	37.5
Total (percent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: U.S. Department of Commerce, Bureau of the Census, "Current Population Reports," series P-20, No. 331.

One feature characterizing many rural areas is the high proportion of elderly people, due largely to the outmigration of younger people and the relocation of older people to rural areas for retirement. Persons 65 and older comprise from 15–20 percent of the population of many rural counties and small towns, while overall the national proportion of those over 65 is about 11 percent.[3]

Older rural Americans are not evenly distributed across the country. Table 1 shows that older rural people are concentrated in the north-central and southern regions of the country. While this trend applies generally to all older people living in rural areas, it is particularly true of older people living on farms.[4]

[2] U.S. Department of Commerce, Bureau of the Census. Social and Economic Characteristics of the Older Population: 1978, Current Population Reports, Series P-23, No. 85 [Washington, D.C., 1978], p. 13.

[3] The White House Rural Development Background Paper, Social and Economic Trends in Rural America (Washington, D.C., October 1979), p. 14.

[4] Gerontological Society Conference Report, Rural Environments and the Aging, Lexington, Ky.: March 1975 (Washington, D.C., November 1975), p. 3.

Chapter 8

RURAL ISSUES

CHAPTER HIGHLIGHTS

This chapter represents the first time that the problems and issues confronting elderly persons living in rural areas have been addressed as a separate focus in the committee's annual report. The chapter is intended to provide background information which can serve as a foundation for an ongoing examination of the problems and concerns of the rural elderly. Many of the issues to be addressed have gone undocumented to date, and therefore have received little, if any, attention.

Our attempt to gain a clearer picture of the needs and problems of the rural aging has been frustrated by a lack of comparative data. Much of the data available was derived from 1970 census tract information and, therefore, does not adequately reflect changes in the rural elderly population over the past 10 years.

A further frustration in analyzing and comparing the problems of the rural elderly with those of their urban counterparts is the lack of a common understanding or definition of the term "rural." While no attempt is made in this chapter to reconcile variations in definition, the problem is raised as one which policymakers and the Congress need to address more fully.

Thirty-eight percent of Americans 65 and older (8.4 million persons) live in nonmetropolitan areas—in small towns, or farms or generally in rural settings.

In 1979, the greatest incidence of poverty among the aged was still in rural areas.[1]

Many of these rural elderly are isolated and immobile and face extreme difficulties in gaining access to jobs, health care, social services, shopping, recreation, and friends.

For minority elderly persons residing in rural America, the problems of poverty, isolation, poor health, inadequate housing and transportation are particularly keen.

The 1978 amendments to the Older Americans Act brought new focus to the service needs of the rural elderly.

During 1979, the White House announced a series of rural development initiatives addressing the problems of rural America.

The Senate Special Committee on Aging has begun an ongoing exchange with Federal agencies, national rural leaders and organizations to delineate further the problems of the rural elderly in order to develop public policy recommendations in this area.

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[1] The National Rural Center, The Rural Stake in Public Assistance. Information and Analyses to Guide Public Policy (Washington, D.C.: December 1978).

One such proposal, sponsored by Senator Lloyd Bentsen and cosponsored by Senator Charles H. Percy and other Special Committee on Aging members, would exempt from Federal income tax up to $201 in interest and dividend income for single persons and up to $400 for a joint tax return. This bill was passed by the Senate as an amendment to the Crude Oil Windfall Profits Tax Act of 1979 (H.R. 3919) on December 17, 1979. At the end of the 1st session of the 96th Congress, H.R. 3919 was pending consideration by a House/Senate conference committee.

IV. TELEVISION PROGRAMING FOR THE DEAF

It has been estimated that there are over 14 million deaf and hearing-impaired consumers who would benefit from captioned television programs. In the past, most-prime time television programing sponsored by the major networks has not been captioned; however, the Public Broadcasting Service has developed the technology to soon make available a variety of closed-captioned television programs. Furthermore, three major television networks, the American Broadcasting Co., the National Broadcasting Co., and Public Broadcasting Service have agreed to buy up to 20 hours of closed-captioned programing each week for prime-time television programing with closed captions.

In recognition of this technological achievement and the social response of these communications companies, in May 1979, Senator Percy and the members of the Special Committee on Aging sponsored a Senate resolution (S. Res. 167) commending their efforts.[12]

[12] Percy, Charles, resolution commending broadcasters for television programing for the deaf. Remarks in the Senate. Congressional Record, vol. 125, May 22, 1979: S6436-37.

affluent savers market rates of interest. Ironically, those who most need a substantial return on their savings, often have small amounts to invest. In addition, savings options which produce a higher yield (such as U.S. Treasury notes, money market certificates and mutual funds) may be unattractive to small savers because of a minimum deposit requirement, lack of liquidity and, in some cases, higher risk.

High interest rates, rapid inflation, and the growth of uninsured intermediaries have reduced the impact of regulation Q meeting its original mandate, and during 1979, considerable attention was focused on tax incentives for savings and the lifting of regulation Q.

Both the Senate and the House addressed the issue of phasing out regulation Q. In September, the House of Representatives passed the Consumer Checking Account Equity Act of 1979 (H.R. 4986), which authorizes certain financial institutions to offer interest bearing checking accounts nationwide. A broader financial reform bill (S. 1347) was introduced earlier in the Senate and reported in September as a substitute text for H.R. 4986 by the Senate Committee on Banking, Housing, and Urban Affairs. The Senate bill is known as the Depository Institutions Deregulation Act and provides for the following:

(1) Interest bearing checking accounts (also known as NOW accounts—negotiable order or withdrawal accounts) by banks, Federal savings and loan associations and Federal credit unions.

(2) Phasing out of regulation Q by 1989 by raising the interest rate ceiling .005 percent per year, but not to increase by more than 4 percent between 1982 and 1989.

(3) Federal savings and loan associations are authorized to hold 10 percent of their assets in consumer loans, commercial paper, corporate debt securities or bankers acceptances, and to offer personal trust services and make mortgage loans.[10]

H.R. 4986 was approved by the Senate in November 1979. A conference to resolve differences in the House and Senate versions of the bill is scheduled to be held on March 4, 1980.

The Senate bill provides for a "ratcheting up" plan to eliminate the regulation gradually over a period of several years, after a 2-year period in which current regulation Q authority would be extended. This would not, of course, give immediate relief to small savers.

In addition, several bills have been introduced or are in draft stages which would provide for an accelerated phaseout of regulation Q, increased flexibility for savings institutions, and the removal of some restrictions to enable them to offer savers a better rate of interest without jeopardizing the viability of the lending institution.

It appears that the phased elimination of regulation Q will take place in the near future. However, the timeframe and methods of phaseout will depend on the final provisions of pending legislation.

In a related issue, more than 75 bills have been proposed by Members of Congress to provide tax incentives for savings, including exclusion of a portion of interest income from personal income taxes, rollover plans for tax deferral on certain investments, dividend reinvestment, and the modification of individual retirement accounts (IRA's).[11]

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[10] U.S. Congress. Senate Committee on Banking, Housing, and Urban Affairs report to accompany H.R. 4986 (Washington, D.C. S. Report No. 96-368).

[11] U.S. Congress. Joint Committee on Taxation. Description of Bills to Provide Tax Incentives for Savings. Prepared for the Committee on Ways and Means (Washington, D.C.—January 28, 1980).

2. HOUSE ACTION ON FTC REAUTHORIZATION

The House FTC reauthorization bill, H.R. 2313, passed by the full House on November 27, would authorize $75 million for fiscal year 1980 and $80 million in 1981. The bill also contains a provision that would prohibit the FTC from adopting its proposed "funeral rule" that establishes consumer protections for people arranging funerals. One of the major provisions of the proposed "funeral rule," which has been tentatively approved by the FTC, requires funeral directors to disclose itemized price information. In addition, the rule prohibits funeral directors from: (1) Misrepresenting legal and cemetery requirements and the preservation or protective value of embalming, caskets, and vaults; (2) engaging in certain unfair practices, such as requiring caskets for cremation and embalming without express permission; and (3) using boycotts, threats, disparagement, and similar tactics to hinder competition.

H.R. 2313, now before the Senate, also contains a provision that would allow one house of Congress to veto a proposed FTC rule, with the other house granted 30 days to disapprove the veto.

III. SMALL SAVERS

The lower income status and economic problems of elderly persons are well documented in this report and elsewhere. Particularly in the second half of this decade, inflation has made it very difficult for many retired people to maintain an acceptable standard of living. Many retired persons attempt to supplement social security and private pensions with income from their own assets, mostly interest on savings accounts. As discussed in one of the preliminary chapters, Economic Performance and Elderly Economic Status, 10 percent of all income received by persons 65 and over in 1978 was obtained from interest on savings. The United States Savings and Loan League estimates that over 47 percent of all savers who have accounts with savings and loan institutions are age 55 and over. Furthermore, these older savers have larger amounts in their savings accounts than younger savers in any age classification. In 1975, those over 65 years of age had the largest savings accounts with an average annual account balance of $6,500.[9]

Despite high inflation and rapidly increasing interest rates on loans, interest on passbook savings has not been allowed to rise with the market rate, primarily because of a series of Government restrictions. These interest rate controls on time and savings deposits, commonly known as regulation Q, were promulgated in 1966 to regulate interest rates paid by financial institutions in order to make savings and loan institutions competitive with commercial banks and improve the flow of funds for the home mortgage market.

The low ceiling on interest rates for passbook savings accounts poses a particular problem for older persons who use their savings to supplement other sources of retirement income. As a result, regulation Q has been opposed by a number of organizations representing the elderly as an unfair practice restricting a financial institution from paying more than 5½ percent interest to a small saver, while offering more

[9] United States Savings and Loan League. Consumer Financial Services Survey (Washington, D.C. 1975.)

(4) Studies into various aspects of insurance (including medicare supplemental insurance, which as discussed in this chapter, is health insurance sold to supplement gaps in medicare coverage).

Recently, the FTC has been criticized by those who believe that it has overstepped its authority in undertaking certain studies or rulemaking proceedings. Much of this criticism relates to regulations issued under authority of the Magnuson-Moss Warranty/Federal Trade Commission Improvement Act, which was passed in early 1975 and gave the FTC authority to issue industry-wide trade regulation rules.

One approach to curbing what is viewed by some as the overly broad or ambiguous legislative mandate of the FTC is passage of a provision authorizing a congressional veto of proposed FTC regulations. Debate over this issue contributed to rejection of FTC reauthorization legislation during the 95th Congress (1977 and 1978).

In the 95th Congress, the House of Representatives passed an FTC reauthorization bill that created a mechanism for possible congressional review and disapproval of proposed FTC rules. The Senate did not act on a similar provision and conferees twice returned a conference report to the House which did not contain a legislative veto. On both occasions, it was rejected.

Despite the rejection of reauthorizing legislation, the FTC has been funded through continuing resolutions. In fiscal year 1978, FTC appropriations were $62.1 million and appropriations for fiscal year 1979 were $65.3 million.

B. 1979 Congressional Action

During the 1st session of the 96th Congress, the full House and the Senate Committee on Commerce favorably reported two separate FTC reauthorization bills, which are discussed in detail below. Consideration of the issue by the full Senate, where both bills are pending, should take place in early 1980, since FTC appropriations, which are contained in a continuing resolution (Public Law 96–123), expire on March 15, 1980.

1. SENATE ACTION ON FTC REAUTHORIZATION

The Senate reauthorization bill, S. 1991, was unanimously reported by the Senate Committee on Commerce, Science, and Transportation (S. Rept. 96–500) on November 20, 1979. The bill authorizes $70 million for the FTC in fiscal year 1980 and $75 million in 1981.

As amended by the committee, the bill contains a provision stating that the FTC's general investigatory and report-making powers do not apply to the business of insurance. Hence, if the bill is passed by Congress and becomes law, the FTC will be unable to complete its analysis of different State regulatory approaches to the sale of medicare supplemental insurance to older Americans, as well as being prohibited from studying other aspects of the insurance industry.

While S. 1991 does not contain a provision authorizing a congressional veto of FTC trade regulations, it is likely that an amendment proposing such a veto will be offered when the bill is considered by the full Senate. Other possible amendments include one that would prohibit the FTC from taking any action against any legal, dental, medical or other State-regulated profession, and another that would terminate the FTC's rulemaking proceedings on the sale of mobile homes.

New York

A consumer guide book, with comparisons and ratings of medi-gap insurance policies sold in the State, was developed by the State Consumer Board and the State Office on Aging. In May, the State insurance superintendent argued that five insurance companies were making too much money selling hospital indemnity policies to the elderly and called for an immediate reduction of at least 20 percent on premiums paid by those age 60 and over. In October, joint hearings on medi-gap insurance abuses and proposed legislation for minimum policy standards were conducted by the New York Assembly Standing Committee on Aging and the Standing Committee on Insurance.

South Carolina

The department of insurance conducted hearings on proposed new medi-gap regulations in November.

Vermont

The Vermont Public Interest Research Group and the Vermont State Council of Senior Citizens filed a petition with the department of banking and insurance to request that measures be taken to aid elderly consumers who purchase medi-gap insurance. The petition asked that the department require insurance companies to give prospective customers a disclosure sheet and a booklet on medi-gap insurance prepared by the department.

New Jersey

In February, the State insurance department was investigating the sales of medi-gap insurance policies to the elderly by 10 companies. The investigations were spurred by 3,500 life and health insurance complaints received by the department in 1978.

II. FEDERAL TRADE COMMISSION REAUTHORIZATION

A. Background

The Federal Trade Commission (FTC), through 27 separate acts passed since its creation in 1914, has historically been charged with insuring that the marketplace is not distorted by anticompetitive practices that are unfair or deceptive. (For a summary of FTC statutory authority, see S. Rept. 96–184.) This authority has led to action by the FTC in a number of areas that are of significance to older consumers. A few of these actions include:

(1) The issuance of proposed regulations affording consumers certain protections when arranging for a funeral.

(2) The issuance of regulations removing State and local government bans on advertising by eye doctors and opticians.

(3) The issuance of a proposed rule to address the false or misleading advertising of the therapeutic effects of hearing aids, and affording the purchaser a 30-day right to cancel that gives the purchaser the right to return a hearing aid for a refund after trying it for 30 days.

tion have been participating in NAIC's effort to develop model State legislation and regulations governing the sale of medi-gap insurance (see above).

The HIAA has also notified the committee that it is urging its member companies to review marketing practices, including agent training, and encouraging State insurance departments to enforce existing law, and strengthen penalties where they are "not severe enough to match the abuse committed." [8]

5. EXAMPLES OF STATE ACTIVITY

A variety of State actions took place during 1979, including new investigations, consideration of legislation to control medi-gap abuses, and publication of numerous "buyer's guides" to help medicare beneficiaries shop for private health insurance. Following are a few examples of this activity:

California

The insurance commissioner announced in September that the insurance department would subpena the records of eight insurance companies to identify the names of 6,000 people who recently terminated their medicare supplement coverage. The department believed that almost 90 insurance agents had left one insurance company after it had "cleaned up" its medi-gap sales techniques to sell for other companies, and had "rolled over" their previously-sold medi-gap policies. (California had implemented legislation earlier to require minimum benefits, loss ratios, and information disclosure for medi-gap sales in the State.)

Massachusetts

An insurance agent pleaded guilty to three counts of defrauding at least 17 elderly persons by inducing them to sign up for insurance policies with little or no value and then using the U.S. mail to send them the policies. The agent had used a variety of methods including falsifying health histories, forging signatures, and overcharging. At the same time, the insurance department was issuing new regulations, proposed by the Massachusetts Association of Older Americans, to standardize medi-gap policies sold in the State and set minimum benefits and loss ratios.

Florida

The new department of insurance regulations, effective in July 1979, would revoke the license of or fine insurance agents, for: (1) Presenting themselves as representatives of any government agency or impartial agents of senior citizens groups; (2) misrepresenting policies or making incomplete comparisons to induce medicare beneficiaries to buy, amend, forfeit, duplicate, or replace a medi-gap policy; and (3) not delivering to both the policyholder and to the insurance company represented a certification form signed by the agent and the buyer disclosing basic policy information and certifying agent compliance with information disclosure requirements. The Florida House of Representatives Committee on Insurance is also considering legislation to require State regulation of out-of-State group insurers.

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[8] Letter to Senator Lawton Chiles from Robert F. Froehlke, president, Health Insurance Association of America, April 24, 1979.

of Insurance Commissioners (NAIC) is a voluntary association of all 50 State insurance commissioners and acts in an advisory capacity to States. One of its major activities has been the development of model insurance statutes and regulations which can then be considered by individual State legislatures and insurance departments.

In June 1979, NAIC adopted changes in its model regulation to implement its model law, called the "Individual Accident and Sickness Insurance Minimum Standards Act," to address more directly some of the medi-gap insurance abuses which had surfaced during the previous year. (Changes to the model statute had been adopted earlier. The NAIC created a special task force on medicare supplemental insurance in June 1978. An advisory group to the task force includes representation from HEW, the FTC, health insurance companies selling medi-gap insurance, the National Senior Citizens Law Center, and the Urban Institute. See "Developments in Aging: 1978," pt. 1, p. 99, for an account of the NAIC's work last year.)

The model regulations adopted by the NAIC suggested that health insurance policies should not be labeled "medicare supplement" or "medi-gap" unless they:

—Pay noncovered medicare part A charges from the 61st through the 90th day of hospitalization and during the period of lifetime reserve, and pay 90 percent of charges beyond the lifetime reserve to a maximum of 365 days.

—Pay 20 percent of medicare part B reasonable charges (as determined by medicare) up to a maximum out-of-pocket deductible of $200 and at least a maximum benefit in one calendar year of $5,000.

—Provide that these cost-sharing amounts automatically rise with rises in medicare cost-sharing (premiums may also rise).

—Contain no exclusions more restrictive than medicare imposes for any type of care.

—Do not contain preexisting condition clauses longer than 6 months.

—Provide the buyer with a right to return the policy within 10 days (for agent-sold policies) or 30 days (for policies sold by mail).

The model regulation did not include a minimum loss ratio, but the NAIC suggested that 60 percent was reasonable for medi-gap policies.

The model regulation did suggest that information disclosure be implemented by States by requiring agents to deliver a buyer's guide for medicare supplemental and hospital indemnity policies to the purchaser at the time of application (to be made available on request from mail-order companies), and requiring all policies sold to medicare beneficiaries to contain an outline of coverage.

These standards were also used by House and Senate committees in the development of legislation for a voluntary certification program (see above). During 1980 the NAIC task force will consider additional model regulations for limited benefit insurance policies, including dread disease or cancer policies, and agent and company marketing practices.

4. HIAA: ENCOURAGING COMPANY SCRUTINY

The Health Insurance Association of America (HIAA) represents approximately 320 insurance companies which sell most of the health and accident insurance in the Nation. Representatives of the associa-

C. Activity in Other Areas

After evidence of the severe problems being experienced in the sale of medi-gap insurance was brought to light in the 1978 hearings of the Senate and House Committees on Aging, and while legislation was being considered in Congress, action was also being taken by the administration, the health insurance industry, the National Association of Insurance Commissioners, and a number of States.

1. FTC: STUDY OF NEW STATE REGULATIONS

Following up on Senate hearings and requests by members of the Senate Committee on Aging, the Federal Trade Commission's Bureau of Consumer Protection took preliminary steps during 1979 to undertake a national impact evaluation of the relative effectiveness of varying State approaches to regulation of medi-gap insurance sales. The implementation of new medi-gap rules in Wisconsin, California, and New Mexico would be evaluated to determine their impact on making changes in the insurance information available to older Americans, on the price of medi-gap insurance policies, on benefits offered by insurance companies, on the range of medi-gap policies offered, and on consumer satisfaction.

The design of a full-scale evaluation was completed during the year and consumer and industry surveys were begun. Further action, however, may be precluded by amendments which were pending before the Senate at the end of the year which would bar any FTC activity in the "business of insurance," including such a study of medi-gap problems. (See below for a discussion of provisions in FTC reauthorization bills which could affect the agency's actions in a number of areas of concern to older Americans.)

2. HEW: IMPROVED INFORMATION

In March 1979, HEW Secretary Joseph Califano, notified the Committee on Aging that the Department would initiate a public information campaign to help medicare beneficiaries be "better shoppers" for medicare supplementary insurance. Steps would include revisions in the medicare handbook, mailings to beneficiaries, and revisions in medicare forms.[7]

By the end of the year, a "Guide to Health Insurance for People With Medicare" had been distributed by HEW. Notices of the guide's availability through local social security district offices and area agencies on aging were sent to all social security beneficiaries. The guide was developed jointly by HEW, the National Association of Insurance Commissioners, consumer groups, representatives of the Federal Trade Commission, and some health insurance companies selling medi-gap insurance.

The Department plans to reissue an updated version, reflecting changes in medicare benefits, in 1980.

3. NAIC: MODEL LAW AND REGULATIONS

Regulation of all insurance matters is in the hands of an insurance department or commission in each State. The National Association

[7] Letter, HEW Secretary Joseph Califano, to Senator Lawton Chiles, March 5, 1979.

Additional Senate floor action on H.R. 3236 is expected early in 1980 before the bill will be finally passed.

2. HOUSE ACTION

A medi-gap amendment was approved by the House Ways and Means Committee during consideration of numerous medicare and medicaid amendments. The full committee adopted an amendment offered by Representative James M. Shannon to establish a voluntary certification program for medi-gap insurance policies as part of H.R. 4000 (section 22) favorably reported to the House floor on November 5, 1979. The Ways and Means Committee amendment is substantially similar to the provision approved by the Senate (see above), but does not provide criminal penalties for duplication of existing insurance coverage, or for sale of medi-gap insurance policies by mail without the prior approval of a State's insurance commissioner.

The Ways and Means Committee in H. Rept. 96–589 noted that:

> Hearings conducted by both Houses of Congress have disclosed the existence of significant abuses and problems in the sale of private supplementary health insurance to aged medicare beneficiaries. Among the many problems identified were the dissemination of misinformation about the extent of coverage provided, unethical sales practices, restrictive policy clauses, and complex and confusing policy language. As a result of these disclosures, the committee believes that a consensus has emerged about the critical need to: (1) Eliminate the flagrant abuses resulting from unethical sales practices; (2) develop more effective ways for assuring informed choices by beneficiaries among the range of available private policies; and (3) apply more effective approaches to assuring the development and implementation of acceptable minimum standards for these policies.

On December 19, however, the House Interstate and Foreign Commerce Subcommittee on Health and the Environment modified the Ways and Means Committee action, adopting a substitute amendment which would:

—Impose criminal liability for insurance companies "knowingly" allowing their agents to employ deceptive sales practices when selling medi-gap insurance.

—Require a study of dissemination of information to older Americans, criteria used to evaluate medi-gap policies, the extent to which policies actually cover medicare's gaps, the extent and efficacy of existing State regulation, and abuses in the sale of medi-gap insurance by mail.

The full Interstate and Foreign Commerce Committee must still act on medi-gap legislation, and differences between the Ways and Means and Interstate and Foreign Commerce Committees' versions must be resolved before medi-gap legislation will be voted on by the full House. Any differences between House and Senate passed versions must then be resolved, and accepted by both Houses, before becoming law. Further action is expected early during 1980.

Health insurance companies and State insurance departments presented testimony to the House Interstate and Foreign Commerce Subcommittee on Health in opposition to any Federal legislation.

facilitate the sale of approved policies. The bill would also authorize criminal penalties for providing false or misleading information for the purpose of obtaining policy certification, for anyone who misrepresented an association with the medicare program for the purpose of selling medi-gap insurance, for anyone knowingly selling duplicative insurance policies, and for advertising and selling medi-gap policies by mail in any State without prior approval of that State's insurance department.

Senators Max Baucus and John Culver introduced S. 1295, a companion bill to H.R. 2602, in the Senate on June 7, 1979.

1. SENATE ACTION

The Senate Finance Committee approved a medi-gap amendment offered in committee by Senators Baucus and Dole on November 7, 1979. Committee members urged that the amendment be acted upon by the full Senate as soon as possible, and it was reported to the floor and adopted by the full Senate as an amendment to H.R. 3236 on December 5, 1979.[5]

The amendment adopted by the Senate would:

—Require the Secretary of HEW to establish a voluntary program for certification of medi-gap policies (effective July 1, 1981) which met minimum standards relating to policy benefits, premium charges, and information disclosure. Policies approved by and sold in States which had similar or stronger standards would be deemed certified.

—Criminal penalties would be provided for furnishing false information for purposes of certification, and for any insurance seller who misrepresented an association with the Federal medicare program for the purpose of selling insurance, or who knowingly duplicated existing coverage. Penalties would also be provided for mail order insurers who sold medi-gap policies in a State without that State's prior approval. A State could elect to have Federal certification of mail-order medi-gap policies take the place of prior State approval.

—The Secretary of HEW would be required to provide information to all medicare beneficiaries on the types of medi-gap policies available for purchase, explaining their relationship to the medicare program.

—The Secretary of HEW would be directed to conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medi-gap policies, with a report to Congress no later than July 1, 1981, with additional recommendations.

The Senate action was strongly endorsed by national organizations of older Americans, HEW, and the White House.[6] HEW Secretary Patricia Harris said "by acting to establish these programs, the Congress sends a strong message to those who prey upon the elderly and infirmed."

[5] Section 508 of H.R. 3236, Social Security Disability Amendments of 1979. Remarks in the Senate. Congressional Record, vol. 125, December 5, 1979: 17777.

[6] Letters to Senator Russell B. Long, Chairman, Senate Finance Committee, from Patricia Harris, Secretary, Department of Health, Education, and Welfare, December 10, 1979; from Stuart E. Eizenstat, Assistant to the President for Domestic Affairs and Policy, December 20, 1979; and from Esther Peterson, Special Assistant to the President for Consumer Affairs, December 19, 1979.

the information available to medicare beneficiaries to help them make informed purchases of needed supplemental health insurance.

Senator Lawton Chiles, citing testimony before the Senate Special Committee on Aging which had revealed "widespread misinformation, unchecked sales of policies with questionable benefits, and callous attitudes toward older Americans fearful of rising health costs," introduced S. 395 (the Medicare Supplemental Health Insurance Information Disclosure and Protection Act of 1979) with Senators Dole, Domenici, and others on February 8, 1979.[4]

The bill would require the Department of Health, Education, and Welfare to develop model minimum standards for medi-gap insurance policies and evaluate the feasibility of a program of voluntary certification of medi-gap policies meeting minimum standards; provide criminal penalties for anyone who misrepresented in any way an association with medicare for the purpose of soliciting medi-gap insurance business; require HEW to provide medicare beneficiaries with comprehensive information on the range of medi-gap insurance available; and require the Federal Trade Commission to evaluate further unfair and deceptive practices in medi-gap advertising, soliciting, and marketing and assess the impact of various State approaches to medi-gap insurance regulation. Senator Chiles called the legislation the "minimum necessary steps to acknowledge and fulfill our Federal responsibility to prevent (medi-gap) abuses."

Senator Robert Dole, commenting on the legislation, said:

> All the solutions will certainly not fall solely within the appropriate jurisdiction of the Federal Government, nor the insurance industry, nor of the State insurance commissioners. The responsibility for solving the problems with supplemental health insurance must be shared by us all.

In the House, Representative William Brodhead introduced H.R. 165 (the Senior Citizens Health Insurance Standards Act of 1979) on January 15, 1979. H.R. 165 would mandate Federal minimum standards which companies selling medi-gap insurance to the elderly would have to meet, including a minimum 75 percent loss ratio, limits on preexisting condition restrictions, full information disclosure, simplified policy language, and a prohibition on the sale of policies which duplicated medicare coverage. Each State would have to meet the Federal minimum standards. If the Secretary of HEW found that State enforcement of standards was insufficient, HEW would be empowered to enforce them.

The bill also directed the Secretary of HEW to make a comprehensive study of medi-gap insurance and methods of sale to assure that good quality health insurance was available to the elderly at a reasonable price.

On March 5, 1979, Representatives Claude Pepper and James Scheuer introduced H.R. 2602 (the Senior Citizens Health Insurance Reform Act of 1979) in the House. The bill proposed that HEW certify medi-gap policies meeting certain minimum standards, similar to those in H.R. 165. The program would be voluntary, with recertification every year, the State insurance departments would be encouraged to

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[4] Chiles, Lawton, Medicare Supplemental Health Insurance Information Disclosure Protection Act of 1979. Remarks in the Senate. Congressional Record, vol. 125, Feb. 8, 1979.

Together, Blue Cross and the commercial companies selling group insurance account for about 60 percent of all the policies sold in the United States. The staff found few problems with either of the above. Both return nearly 90 percent of the premium dollar to their insured.

The remaining 40 percent of policies sold by commercial companies on an individual basis have caused the greatest amount of concern. While there are some reputable companies in this group, the fact remains that typically they return 50 percent or less of the premium dollar to the insured. And then there are the really unscrupulous companies who superimpose an "anything goes" sales mentality on top of what is a product of questionable economic benefit.

Figures published by the committee on 28 commercial companies selling individual medi-gap policies showed a range of 22 percent to 86 percent loss ratios for those policies. The figures also suggested that many companies have lower loss ratios for their medi-gap policies than their other health insurance business.

The staff report concluded, in part:

—For many older Americans who will do anything rather than go on welfare, the purchase of health insurance supplementary to medicare seems to be the only answer. It is wisdom that leads them to purchase one such policy, but it is fear which motivates them to buy 2, 3, 4, or sometimes as many as 30 different policies in a desperate attempt to insulate themselves against the cost of catastrophic illness. The simple fact is that policies sold to supplement medicare are very limited in scope.

—Virtually every major health insurance company polled agreed that medicare supplement policies presented a significant problem and that much of the current concern about sales abuses was justified.

—Older Americans are being defrauded of $1 billion a year.

—Commercial insurers generally do not have acceptable loss ratios for medicare supplementary policies. Loss ratio experience with group medicare supplemental policies, however, is higher and more acceptable. The principal problems in the field are caused by those companies which specialize in the sale of individual policies to older Americans.

—Limited economic value on some policies is only half the problem. The other half relates to abuses in the sale of these policies.

—"Lively scandals" in the sale of medi-gap insurance have erupted in 23 States.

—States are not doing an adequate job of regulation. Only six States have promulgated specific regulations addressing these abuses in the sale of medi-gap insurance. Even though most States feel they have adequate authority to correct such abusive practices, many State insurance departments do not have the resources to adequately enforce the law.

B. Legislation Considered by Congress

Early in 1979 a number of bills were introduced to provide safeguards against high-pressure sales of medi-gap insurance and improve

Committee hearings. The staff study was based on congressional hearings, a Select Committee on Aging investigation, and an analysis of 20 investigations and/or studies which had been undertaken during previous years by other congressional committees, State insurance commissioners, consumer organizations, and newspapers.[3]

The staff report related interviews with former insurance agents specializing in the sale of medi-gap insurance to the elderly and detailed long lists of common high pressure and unethical sales techniques practiced by agents. Responses to a questionnaire by State insurance departments, the staff report noted, confirmed that the practices were widespread. Insurance commissioners cited "twisting" and "stacking" (forms of overselling many policies) as the most common abuses.

Committee investigators, most of them senior citizens, received 50 visits from insurance salesmen in 10 States. The staff report said that in all but 8 of the 50 visits made, salesmen attempted to oversell additional insurance policies or engaged in other unethical practices.

Committee on Aging investigators also attempted to evaluate the experience of State insurance commissioners with complaints from older Americans on health insurance policies:

> Although complaint experience received from the 50 States was sketchy it appears that most complaints received by State insurance departments relate to companies refusing to pay on the grounds of preexisting conditions. Second, seniors complain that refunds of the premium were not paid. The third most numerous complaint disputes the amount which the company paid on a claim. Then there is the category of delay in the settlement of claims followed by charges that agents made misrepresentations during sale. Other complaints relate to the fact that premiums were paid but no policy was issued, or that the company either failed to renew or canceled existing policies allegedly without justification.

The report noted that most State insurance departments act on such complaints by writing to the company and that they generally are successful in getting the company to make a refund. However:

> There is no effort to put complaints together and to examine if the perpetrated abuses are a result of a company policy rather than the isolated acts of individuals. It is most unusual for States to fine or discipline insurance companies. Only 11 States have done so for health insurance related abuses in the past 3 years. It is also quite unusual for an agent to have his license revoked for abuses even if the abuses have been protracted.

House Committee on Aging staff attempted to compare medi-gap policy loss ratios, as one measure of the economic value of insurance policies. (Loss ratio refers to the ratio between the dollar amount of premiums paid to an insurance company on a policy form and the dollar amount paid out in benefits. A 50 percent loss ratio means that 50 cents is paid out for every $1.00 received in premiums.) On the basis of information collected from insurance companies selling medi-gap policies, the staff report concluded:

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[3] U.S. Congress. House of Representatives. Select Committee on Aging. "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal." Staff study, November 28, 1978. Released on June 13, 1979.

didn't have to know about the insurance policy's benefits. The company would take care of any questions and complaints. The agents were to be evasive if any questions were asked about benefits and were directed to use medicare and its gaps as their main sales tool.

In additional testimony, two anonymous Florida insurance agents described high pressure sales to "pigeons" (unsuspecting elderly persons who were judged susceptible to sales). They detailed practices such as: Agents pretending to be representatives of the Federal Government, "loading" (selling as many policies as the person will buy), "rolling," and "twisting" (convincing a policyholder to cancel policies already held in order to buy new policies from that agent), and falsifying medical information forms—a common practice among many agents who sell medi-gap insurance. One agent told the subcommittee that he believed three-quarters of all agents selling medi-gap insurance engaged in unethical selling practices in order to obtain higher commissions.

The subcommittee also heard testimony from the Department of Health, Education, and Welfare, members of the health insurance industry, State insurance regulators, and national organizations representing older Americans.

Leonard D. Schaeffer, Administrator of the Health Care Financing Administration, characterized medi-gap problems as "beneficiary confusion, in part caused by a host of misleading or exploitative marketing practices; high premium cost relative to benefits; and fragmented policies with limited, and sometimes even illusory, benefits."

Schaeffer outlined HCFA's cooperative efforts with the National Association of Insurance Commissioners to prepare a shopper's guide for medi-gap policies, and with the Federal Trade Commission (FTC) in a study of the impact of different State regulatory activities regarding medi-gap insurance sales. (See discussion of these activities, following.)

Schaeffer outlined the following administration proposals:

(1) That all health insurers be required to provide full information disclosure to potential purchasers of medi-gap insurance policies.

(2) That Congress authorize the Department to establish a voluntary certification program for medi-gap policies meeting minimum standards.

(3) That Congress impose Federal penalties of up to $25,000 and/or 5 years imprisonment for agent misrepresentation of a connection with the Federal medicare program for the purpose of selling medi-gap insurance.

A representative of the National Association of Retired Teachers/American Association of Retired Persons told the subcommittee that the Associations supported Federal action and felt "immediate relief" was needed for the elderly. NRTA/AARP also proposed that HEW develop an active program of volunteer medicare assistance counsels throughout the country to help medicare beneficiaries understand and file for medicare—as well as to help medicare beneficiaries choose good private, supplemental health insurance policies.

2. STAFF REPORT OF THE HOUSE SELECT COMMITTEE ON AGING

The House Select Committee on Aging released an extensive staff study of medi-gap abuses at the Interstate and Foreign Commerce

I. MEDI-GAP INSURANCE

Abuses in the sale of private health insurance policies to supplement medi care were documented in hearings conducted by the Senate and House Committees on Aging during 1978. A number of disturbing questions were raised about: (1) The adequacy of "medi-gap" insurance benefits; (2) the lack of information, or misinformation, available to m edicare beneficiaries on the types of insurance available to them to supp lement medicare; (3) flagrant abuses by some insurance agents in the sale of policies with little or no value for high premiums to unsuspecting older Americans; and (4) the ability of health insurance companies, and State insurance departments, to control these abuses.[1]

During 1979, attention to medi-gap abuses continued and further documentation of these abuses was obtained, as is discussed below

A. Further Documentation of Abuse

1. HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE HEARINGS

Hearings before the House Interstate and Foreign Commerce Subcommittee on Health and the Environment provided additional evidence of wide-ranging medi-gap insurance abuses.[2]

The committee heard testimony from an attorney who successfully prosecuted a national insurance company, specializing in medi-gap insurance sales to older Americans in 26 States, of fraud and conspiracy.

The witness described training sessions in which company officials routinely:

—Told agents to frighten elderly purchasers into believing they would "lose everything they had" if they became ill without purchasing the company's policies. Agents were also told to stress the gaps in medicare protection during their presentations.

—Instructed agents to refuse to leave policies or policy outlines with prospective purchasers for review, even after a sale had been made, to prevent the purchaser from questioning false statements made.

—Described methods of presentation which would obscure severe policy restrictions and actual policy benefits and encourage the purchaser to asssume all costs would be covered. Agents were instructed to deliberately hide policy limitations.

When company sales trainees questioned what would happen if they were caught telling lies to the purchaser, they were told by company officials: "Don't worry, they (the elderly purchaser) won't read the policy anyway."

Former agents for the same company verified the purpose of company training sessions to the subcommittee. They also said they were directed to first determine an older person's assets, then decide how much insurance to try to sell them. When a potential buyer asked questions about the policy being sold, the agents were told they

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[1] U.S. Congress. Senate. Special Committee on Aging "Medi-gap Private Health Insurance Supplements to Medicare." Hearings held May 16 and June 29, 1978. Washington, D.C. See Developments in Aging 1978, Pt. 1, pp. 88-101, for a summary of hearing findings and additional actions during 1978.
U.S. Congress. House of Representatives. Hearings before the Select Committee on Aging. "Abuses in the Sale of Health Insurance to the Elderly." November 28, 1978.

[2] U.S. Congress. House of Representatives. Hearing before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 2602 and H.R. 165, Senior Citizens Health Insurance Reform Act. June 13, 1979 and October 16, 1979.

Chapter 7

CONSUMER ISSUES

CHAPTER HIGHLIGHTS

Attention to private health insurance policies to supplement medicare (medi-gap policies) continued during 1979 as bills to control abusive sales practices were introduced in the House and Senate early during the year with strong support from the administration and national organizations representing older Americans. Final action was not taken by the end of the year, however, even though the Senate approved an amendment to provide for a voluntary program of Federal certification of medi-gap insurance policies meeting specified minimum standards, as well as authorizing criminal penalties for certain sales practices.

Two House committees also considered medi-gap legislation during the year. The Interstate and Foreign Commerce Committee's Subcommittee on Health and Environment conducted 2 days of hearings, and had begun consideration of legislation by the end of the year. The Ways and Means Committee favorably reported a bill (similar to the Senate bill) to the House floor.

Action was also taken by the administration, State insurance regulators, and the health insurance industry.

Also of significance in the consumer field were two separate bills to reauthorize the Federal Trade Commission (FTC), which were favorably reported by the House and the Senate Committee on Commerce. Both measures (H.R. 2313 and S. 1991) contain provisions that would limit FTC authority. The House bill, for instance, would authorize a one house veto of FTC trade regulations, and would prohibit the FTC from adopting its proposed "funeral rule" that establishes consumer protections for people arranging funerals. Among significant provisions in the Senate bill is language stating that the FTC's general investigatory and report making powers do not apply to the business of insurance. Consideration of the FTC reauthorization issue by the full Senate, where both H.R. 2313 and S. 1991 are pending, should take place in early 1980, since FTC appropriations contained in a continuing resolution (Public Law 96–123) expire on March 15, 1980.

Largely in response to the high rate of inflation and a decline in the rate of saving, considerable attention was focused in 1979 on Federal interest rate controls on time and savings deposits—commonly known as regulation Q. During 1979, both the Senate and the House passed legislation phasing out regulation Q. Differences in the House and Senate measures (H.R. 4986 and S. 1347), which are explained in detail below, will be resolved in a conference committee meeting scheduled for March 4, 1980.

are abandoned or foreclosed and new construction is not keeping pace. The fact that almost half of the country's rental units are very old has significantly contributed to the increasing operating costs. In the last 5 years, operating costs have increased in rental units by 29 percent. Heating expenditures have increased by 69 percent. Elderly make up the largest percentage of the residents in the older housing stock.

A third factor contributing to the lack of rental units in metropolitan areas is "gentrification." According to sociologists, this term denotes the trend of persons, especially those young and white, moving back into the inner city thus displacing the poor and elderly. According to HUD, this "renovation" has occurred in 60 percent of the cities in the south, 53 percent of the cities in the northeast, 43 percent of the cities in the north-central States, and 25 percent of the cities in the west. While the renovation may physically improve the inner cities, local officials are finding it more and more difficult to find low- and moderate-income housing for those being displaced. With the vacancy rate for rental units dropping, housing officials are often forced to place the poor and elderly in more costly units, often far from their familiar neighborhoods.

All these factors—the higher cost of construction, conversion and abandonment of buildings, gentrification, higher operating costs—have led to a dangerously low vacancy in rental units. The General Accounting Office recommends that a joint effort by the Federal Government and the private industry is needed to correct this trend. During 1979, the Federal Government was able to support only approximately 250,000 new rental units to the 10.1 million low-income renters. Private industry turned to more lucrative ventures and left a void in construction of low- and moderate-income rental units. The GAO urged Congress, in working with the administration and private organizations, to:

> . . . develop alternative strategies to minimize the impact of the crisis which recognize, among other things, the preservation of existing stock as well as new construction of rental housing; and identify incentives necessary for private industry to enlarge its role in the rental market, and, to propose a national rental housing policy and plan of action to foster the availability and affordability of rental housing.[15]

[15] U.S. General Accounting Office. "Rental Housing: A National Problem That Needs Immediate Attention"; report to the Congress by the Comptroller General of the United States. (Washington, 1979) (B-171630, November 8, 1979).

nationwide for average dwellings. Larger dwellings (five or more rooms) dropped to 3.8 percent and dwellings with six or more rooms dropped to 2.8 percent.

Twenty-six million families live in rental facilities, according to HUD, and approximately 4 million of these families are headed by older persons. Of the 26 million households, 10.1 million are considered of low-income status ($10,000 or less) with the greater number of elderly renters in this category. These low-income families are especially hard hit by the declining vacancy rate as they are unable to afford the increasing costs of owning a home and are finding it more and more difficult to find low and moderately priced rental units. It is already estimated that the old "rule" of paying 25 percent of one's income for housing is a dream of the past.

Instead, HUD estimates that 20 percent of renters paid more than 25 percent of their income for housing. Furthermore, according to HUD's annual housing survey, based on 1976 data, 65 percent of the elderly renters paid more than 25 percent of their income for housing. It is anticipated that 1979 data will reveal a more dramatic percentage of income required to pay the rent for elderly renters.

What has caused this sharp decline in the vacancy rate of rental units? According to a study by the General Accounting Office (GAO), there are several major reasons.[13]

First, the new construction of low- and moderately-priced housing units is the lowest in 20 years. Increased costs of labor, building materials, financing, and land have made such construction unprofitable. The Joint Economic Committee of the Congress stated that "sophisticated investors view the multifamily structure, except under unique circumstances and unique locations, as a relatively riskful, noninflation proof investment."[14] Instead, most developers have turned to the more profitable construction of condominiums, commercial properties, and warehouses.

Second, increasing operating and maintenance costs have led owners to abandon, foreclose or convert buildings. According to HUD estimates in 1979, about 1.1 million rental units were removed from the Nation's inventory between 1973 and 1976. Again, the trend has increased substantially since 1976 and the rate of abandonment, foreclosure and conversion is even greater. For example, in 1977, 50,000 apartments units were converted to condominiums. In 1979, the number of converted units was 130,000.

Operating costs, especially utility expenses, have been significantly affected by the age of the housing stock in this country. According to HUD's 1977 annual housing survey, over 41 percent of the Nation's rental units were located in buildings built before 1939. Since older buildings are usually more costly to operate, many of these buildings

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[13] U.S. General Accounting Office. "Rental Housing: A National Problem That Needs Immediate Attention"; report to the Congress by the Comptroller General of the United States. (Washington, 1979) (B-171630, November 8, 1979).

[14] U.S. Congress. Senate and House. Joint Economic Committee. "Multifamily Housing Demand: 1975-2000," November 1978, Washington, U.S. Government Printing Office, 1978.

D. Farmers Home Administration and Administration on Aging Housing Projects

Under section 515 of the Housing Act, the Farmers Home Administration (FmHA) is authorized to provide loans for rental housing in rural areas. The elderly and handicapped are considered priority recipients under this program.

In 1979, FmHA established the congregate housing for the elderly program. This demonstration effort is a joint effort with the Administration on Aging (AoA) under which the FmHA provides $6 million for the construction of model congregate housing facilities for the elderly and AoA provides $500,000 to fund services in the FmHA facilities. The memorandum of understanding between FmHA and AoA stated the objectives of the congregate housing for the elderly program as follows:

> (1) To support a joint demonstration to establish in several selected communities model congregate housing facilities for the elderly with adequate supportive services. Some of the services provided the occupants will also be available for other elderly persons residing in the community.
>
> (2) To ensure the participation of local FmHA and AoA counterparts as well as the developers and community representatives in the planning, development, and implementation of the model congregate housing and related facilities.
>
> (3) To encourage the provision and expansion of outreach and information and referral services in the selected rural communities to inform older residents of this and other FmHA programs from which they may benefit.
>
> (4) To encourage the replication of this effort in other communities throughout the country.

After State FmHA offices and State units on aging screened applications and made comment, FmHA and AoA made 10 awards for the demonstration projects in rural areas of 10 States.[12] The congregate housing for the elderly program demonstration loans and grants, one time awards, were made to:

Project:	*Location*
Twilight Apartments	Port Gibson, Miss.
Mayville Partnership	Mayville, N.Y.
Oakwood Manor	Baldwin, Mich.
Accomack	Onancock, Va.
Sierra, Limited	Truth or Consequences, N. Mex.
Lamoni Colony Housing Authority	Lamoni, Iowa
Heritage Courts, Limited	Wagner, S. Dak.
Tavaglione	Beaumont, Calif.
Elkhorn Properties	Baker, Oreg.

III. DECREASING AVAILABILITY OF RENTAL HOUSING

During 1979, the vacancy rate for rental housing in the United States dropped to its lowest rate in recorded history. According to the Bureau of the Census, the rate in March 1979 dropped to 4.8 percent

[12] The tenth project awarded in New Hampshire was found to be in a flood plain and therefore the FmHA is in the process of receiving new applications in that area for the new award.