BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 10—PRICE, UTAH

APRIL 20, 1974

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
37-767 WASHINGTON : 1974

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 75 cents

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

SATURDAY, APRIL 20, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Price, Utah.

The subcommittee met, pursuant to notice, at the College of Eastern Utah, Hon. Frank E. Moss, presiding.

Present: Senator Moss.

Also present: Val Halamandaris, associate counsel; Margaret Fayé, minority professional staff member; and Kay Thomas, clerk.

STATEMENT OF DEAN McDONALD, PRESIDENT, COLLEGE OF EASTERN UTAH

President McDONALD. We are delighted to have you here at this college this morning. I am sure that aging is a thing in which all of us are interested, at least we are all getting older each day, and I am sure of considerable significance to us.

Senator Moss, we are delighted to have you with us today, with your staff.

I wanted to publicly extend our appreciation to you and your staff for the fine help you have extended to the college in the past, and the enthusiasm that your offices have given in helping us acquire some of the programs we currently have going.

A recent grant of $60,000 through the Mine Education and Safety Administration, which was made possible by the efforts of many people, and certainly your office was very helpful, Senator.

I am sure that you know that you are in a good Democratic country down here, and we hope that that will persuade you to come back regularly.

The occasion of discussing the problems of aging is something that ought to give each and every one of us cause to stop and reflect, and to give some cognizance to the factors of time, and as we grow older, I am sure that time is something that we will all look to, and become a little envious of, as we see the days and years slipping by.

One thought in this connection which impressed me, which I would like to leave with you, an anonymous author once said, "I expect to pass through this world but once. Any good therefore that I can do, or any kindness that I can give to my fellow creature, let me do it now. Let me not defer or neglect it, for I shall not pass this way again."

On this occasion we have here today, it will never be replicated in exactly the same fashion, so, therefore, hopefully our discussions today

will be fruitful and productive and beneficial to all of us, so at this time it gives me a great deal of pleasure to introduce to you our Senator, whom you all know well, and I shall not extend the introduction except to tell you, Senator, how delighted we are to have you here.

I would like to turn the time over to you now, sir. [Applause.]

OPENING STATEMENT BY SENATOR FRANK E. MOSS, PRESIDING

Senator Moss. Thank you very much, President McDonald. I was going to address these people as ladies and gentlemen; but, with your encouragement, I will say Democrats.

I am pleased to be back here at the college, and to be able to participate in this hearing. I wanted to especially commend President McDonald and Dr. Selman for their efforts in putting together a meeting of this sort so that people could learn some of the answers to problems that they have, and these problems center around the process of aging.

As the President said so accurately, we all take an interest in that, because there is no way to stop the clock or the calendar, and we are all getting a little older, but beyond that facetious remark, the fact is that all of us are involved.

In any way you look you see people who have problems incident to aging; therefore, our country, in the interest of the welfare of people generally, must concern itself with the problems and find ways to extend to our elderly or senior citizens the opportunities which we so diligently seek for younger people in our society. That is the reason this committee is holding public hearings today, and that is why it has concerned itself over a number of years in trying to analyze and define the problems and then to suggest solutions.

The hearing this morning is to be an official public hearing conducted by the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging. A full printed transcript of the hearing will be made available to all members of the committee, and of course, all Members of the U.S. Senate. It will be available to those who have an interest in the subject matter discussed, and at a later date any of you who wish to have a copy can secure one very readily by dropping a note to me, or to Val Halamandaris, your native neighbor here. Val has been with me for 12 years; is the associate counsel to the Committee on Aging on which I have served for 11 years and with whom I have worked very closely.

Val has done a great job. I suppose one of the reasons we came to Price is that this is where he was born. We decided this would be a good place in Utah to start on what we hope will be a series of meetings of this sort to learn the facts, and to extend information and assistance to those in need.

Our hearing is a part of the general seminar that was organized by the college, and by Dean McDonald, and I want to again commend the college for having the vision and the initiative and the desire to render service to the community that caused it to organize the seminar and allow us to take part in it.

The hearing this morning will be a departure somewhat from the general formula we follow in Senate hearings. I say this because it was the desire of the committee staff and the college to allow questions and participation from the audience. Ordinarily in a hearing we have

certain selected witnesses who sit and talk to the presiding officer, or the members of the committee who are sitting, listening, and questions are asked by the members of the committee back to the one person testifying, and that is really the extent of it.

This morning we hope to have real audience participation. We will have experts available here on various subjects, and we encourage you, any one of you, who has a question or a problem, to ask that question of a person who can give the answer, and we may have more than one of our experts answer the question. Following the presentation of the experts, some of you may wish to make statements, some of you will, I hope, be ready with questions.

Income and Health Needs of the Elderly

As you know, we wish to focus on the income and the health needs of the elderly at today's hearing. I would like to begin my remarks which are a little longer than they ought to be, and I apologize for that, but I would like to begin by reading of what happens when good men and women, regardless of their age and background, are pushed up against the wall of injustice.

This is a quote from a newspaper which I consider a classic:

> Topeka, Kans., police were called today to help restore order at a Methodist Home for the Aged, scene of a week-long revolt. Three militant octogenarians were arrested after a scuffle in the north parlor. They were identified as leaders of an activist group that seized control of the parlor 3 days ago and locked Mrs. Norma Sunderland, matron, in the closet.
>
> George Whitlock, 84-year-old spokesman for the "activists," told reporters the demonstration was staged to enforce demands that the old folks be given more role in management.
>
> "We have a bunch of young whippersnappers running things around here," he said, waving his cane indignantly. "We don't trust anybody under 65," he added, proudly displaying his "Senility Power" button pinned on his shawl.
>
> Two officers suffered minor injuries during the disturbance. One was hit by a runaway wheelchair and the other was jabbed by a knitting needle.
>
> The revolt began last week when a small group of hard-nosed superannuates held a "dodder-in" at which some burned their Social Security cards. Although peaceable in early phases, the protest movement took a violent turn when someone hit Emery Dains, home administrator, with a bottle of Geritol. Mr. Dains blamed the trouble on a misunderstanding caused by difficulties in communicating with the militants.
>
> "Some turn off their hearing aids when administrative personnel seek to explain policies, etc.," he explained.
>
> Mr. Whitlock reacted, "What is the sense of living a long time if some kid who's only 45 or 50 years old can tell you what you have to do?"

This account is amusing, because it is well written, but it is painfully relevant. It is also perhaps a warning what could happen in America should the 20 million members of the geriatric set—the Nation's most shamefully neglected minority—use some of the techniques which get results for other groups who feel bypassed or abused these days.

"It's hell to be old in this country."

Someone said that not long ago. It's the simple truth—for most of our elderly.

The pressures of living in the age of materialism and the pursuit of the good life have produced a youth cult in America. Our preoccupation with staying young knows virtually no boundary. We spend millions on elixirs and remedies all the way from pep pills to hair transplants and face liftings. Hang the expense. Drink Pepsi, drive

a Ford, smoke Silva Thins, or do anything else anybody insists will keep you looking young.

Why this obsession with youth? Some blame the movies. Others blame advertising for the kind of images sold to the public. The real reason goes deeper. Most of us are afraid of getting old. This is true because we have made old age in this country a wasteland. It's T. S. Eliot's rats walking on glass. It's the nowhere, in between this life and the great beyond. It's being robbed of your eyesight, your mobility, and even your human dignity.

And yet every year more and more of us make it to our 65th birthday and beyond.

The rate of growth in the ranks of our elderly has been nothing short of phenomenal. In 1900 there were about 3 million people over age 65 in America. By 1970 there were over 20 million, almost a 700-percent increase in just 70 years.

Moreover, it appears that we may be on the verge of a major breakthrough in identifying the aging process which will enable more millions of older Americans to live longer and longer.

Search To Unlock the Secrecy of Growing Old

How familiar are you with developments in the search to unlock the secrecy of why man grows old? I must say the older I get the more interested I become.

The most popular present theory is that there is a master "blueprint" in each of our bodies called DNA which determines the shape of each of our future cells. The theory goes that as the blueprint is used millions of times it becomes ragged and the cells that are produced are slightly distorted. Research efforts are directed at eliminating this distortion.

Another theory involves what are called free radicals which someone has compared to a "convention delegate away from home without his wife." Free radicals attach themselves to other molecules, just about any other molecule around, and bring about the eventual breakdown of this molecule. Scientists have found some chemicals which prevent the attachment of free radicals.

In Illinois, Dr. Paul Gordon has developed a drug called isosine which is being tested at the Drexel Nursing Home in Chicago and in other cities under the direction of the Food and Drug Administration. In earlier studies the drug was given to old, decrepit rats, and they quickly began to function like young rats. They became once again interested in rats of the opposite sex; they were able to learn new tricks and remember all their old ones.

Still other experiments with small animals such as rats and rabbits have been successful in expanding the life-span two to three times normal length. One of these experiments features lowering the body temperature of the animals by 2 degrees. Another cuts back on food. When animals were fed only every third day, their bodies produced greater amounts of adrenalin and longevity was increased.

I don't want to leave you with the impression that these experiments offer any final answer to aging. We are getting closer to these answers, but we still have a long way to go. We've been looking for ages. Remember the many things man has done in the past to try to stay young and the many times that man has thought he has found the answer?

For example, the ancients practiced "geronomics," which is the practice of inhaling the breath of young women. Dr. Elié Mentchigoff of the Pasteur Institute told us in 1877 that the answer was to eat "lactobacillus" or to have your large intestine removed. Most people elected to eat yogurt rather than have their intestine removed, but it obviously was not the final answer to aging.

New developments in science and technology will from time to time, undoubtedly, add more years to life. This is good, but these developments will also serve to increase dramatically the problems confronting our older population. Let me speak briefly and more specifically of these problems.

The Health Needs of Older Americans

First, let us consider the health needs of older Americans. Medicare today only covers 40 percent of these health needs. Eyeglasses, prescription drugs and dental care are among the services excluded. Likewise, Medicare, for all intents and purposes, excludes coverage for long term or nursing home care. Only 70,000 individuals out of the 1 million that are in U.S. nursing homes on any given day have their care paid for by Medicare. In all, the average older American pays today out of pocket $292 a year for Medicare care or more than the total cost of his health care bill in 1965 when Medicare was enacted.

To try to give him a better deal, I have cosponsored legislation to bring under Medicare coverage some of the items not now covered. I have also introduced my own bill, S. 1825, to broaden the scope of Medicare to provide in-home nursing services for individuals who can be treated at home and to provide the full range of nursing home benefits for those who need such care. In short, the bill would cover anyone whose needs were more than board and room or short of hospitalization. This bill, or Senator Edward Kennedy's proposal which is similar, stands a good chance of being enacted next year.

Income Needs of Senior Citizens

Second, let us look at income needs of senior citizens. In 1972, those of us who are members of the Senate Special Committee on Aging became disenchanted with President Nixon's reluctance to raise Social Security benefits despite the galloping inflation which was, and is, continuing to rip into the fixed incomes of our retired citizens. We helped push through a 20 percent increase in Social Security benefits against stiff opposition from the administration which paradoxically later claimed the credit for the increase.

This increase had the effect of boosting millions of older Americans—many of whom were never poor before they became old—up over the established poverty line. But there are still some 4 million of our elders with incomes below this minimum subsistence level. We must work to end this inequity.

It is for this reason that I have cosponsored legislation to raise beyond the recently established $2,400 level the amount of money that can be earned by an older person before forfeiting part of his Social Security benefits. The ceiling level should be $5,000 or perhaps even removed completely because it discourages people from working who are willing and able to work.

Not long ago the Congress authorized a two-step, 11-percent increase

in Social Security benefits. The first portion of this increase was effective the first of this month and the remaining 4 percent will be visible in your July checks. At the same time Congress passed similar increases in veterans' pensions, Civil Service and railroad retirement benefits. While far from adequate these measures only serve to keep the elderly even with increases in the cost of living occasioned by the present runaway inflation.

Rapidly Rising Property Taxes

Third, there is the problem of property taxes and the elderly. Rapidly rising property taxes are almost confiscatory in some States. For example, the Committee on Aging has documented instances where individuals were paying as much as 50 percent of their annual income in property taxes. An individual might have an annual income of $1,000 and pay $500 in taxes. Some 29 States have already enacted legislation to exempt the elderly from such taxes in proportion to their incomes. I have introduced my own bill, S. 1958, which is pending before the Senate Finance Committee.

Fourth, there is also a problem of housing. Housing is the largest single expense for the elderly. More than a third of the budget of our over-65 individual goes to pay for housing. Some 30 percent of our 20 million older Americans live in substandard housing—that is, without electricity or plumbing or other necessities. How to solve this problem is a topic very much under debate in Washington.

The Nixon administration has decided to limit sharply Federal housing subsidies to the elderly. The details of this move are not clear. Nevertheless, the approach is to remove Government from the housing field as much as possible. This, I believe, would be a grave mistake. I favor a loan program myself—the type of program we had until the Nixon administration took over in 1969.

Under this program, church groups and nonprofit sponsors could borrow funds at 3 percent interest directly from the Government if the funds were used to provide housing for the elderly. This so-called section 202 program was the most successful housing program we ever had, providing thousands of units specifically designed for the elderly. It operated 10 years without a failure or foreclosure. It is a mystery to me why the Nixon administration decided to phase it out. I believe that they should reconsider.

For my own part, I have introduced a bill, S. 1997, which is designed to get private enterprise involved in designing and providing housing for our elderly at low rents. Essentially my bill sets up a design contest. It employs the total-living environment concept. The three best designs submitted would be funded and become prototypes for further construction. I call the bill "Campuses for the Elderly."

Under the provisions of this bill, all types of housing from board and room right through nursing home care would be provided in one general area adjacent to a senior citizens center which would also provide outreach services to the community. One successful model exists in Syracuse, N.Y., where such housing for the elderly is built adjacent to the university campus. Senior citizens have the benefit of the university facilities and may even find part-time employment or attend classes.

Students have greater exposure to the older members of society

which promotes understanding. This would be a very helpful and progressive type of development to promote.

Transportation for Older Americans

Fifth—and one of the greatest problems—is transportation for older Americans. As some of you might know, there are several bills pending before the Congress to authorize reduced rate transportation on mass transit for senior citizens. Some 60 cities now feature such reduced fares on their buses and subways. I have cosponsored such legislation. In addition I have for years been the sponsor of legislation to provide reduced fares for senior citizens on the airlines. The bill was passed by the Senate last year but lost in conference with the House. This year the Senate again passed the bill. Hopefully, the House of Representatives will act favorably on this proposal some time this year.

Nursing Home Problems

Sixth, there is the special problem of nursing homes. Earlier I pointed out that Medicare does not cover nursing home benefits to any significant degree. I told of the increasing numbers of elderly and suggested the concomitant increase in disability. It is a fact that the older you are, the more chance there is you will have some sort of disability. Individuals in nursing homes average 82 years of age, and have three or more major disabilities. Obviously, more and more individuals will need nursing home care. It is, therefore, incumbent upon us not only to enact legislation to help pay for nursing home care but also to insure that the best quality of care is provided by these facilities.

Many nursing homes are providing fine care. We seldom hear about them. We always hear about those that are doing a poor job—the ones that neglect patients or engage in penury or profiteering. During the past 11 years my Subcommittee on Long-Term Care has held hundreds of hours of hearings and labored to improve the quality of care provided in this industry.

We will soon release an exhaustive study of nursing home problems which it has taken us 5 years to compile. The report will conclude that we need to find ways to get the medical profession more interested in the care of the aged; that we need to provide training for nursing home personnel; that we need to enforce standards of care and to pay the nursing home operator a fair rate of return.

I have already introduced many of the report's recommendations in the form of bills which are pending before the Congress. It is my hope that when enacted these bills will result in a substantial upgrading of the quality of care of nursing homes. We have already come far in this regard, but we still have a long way to go.

In summary, let me remind you that the major problems which confront the aged are, after all, the same problems which confront all people—problems of health, of housing, of income, and of transportation. The thing which makes them more brutal for the elderly is that they come in a distorted and amplified form at a time of life when people have the least strength and ability to deal with them.

In the years we have been trying to help the elderly find solutions to these problems, there has been an increasing awareness among the remainder of our population of the plight of our older Americans. We

have seen some progress made toward solving the most overwhelming of the elderly's dilemmas. We can therefore end this talk on an optimistic note.

Hopefully, the day is not too far distant when those in the last third of life can enjoy their remaining years to the fullest without worry and concern. This should be the legacy of years of contribution to the building of a nation. With your help perhaps we can make this vision a reality, if not for ourselves, then for our children and grandchildren. [Applause.]

I do appreciate your attention to that overly lengthy introduction to the subject matter, but I wanted to place it before you, because this is the area in which we have been working for many, many years, and again I give Val Halamandaris credit for compiling this nursing home report which will be released shortly. It has been a monumental effort. I will now call the first panel of witnesses: Sterling Peterson, Assistant Regional Commissioner of Social Security, from the Denver Regional Office, who will give you a few words about Social Security, and then we will hear from Jack Walsh of the Bureau of Supplemental Security Income who will speak on the new Supplemental Security Income program.

After their presentations, the members of the audience may address questions to them. Accompanying them to help answer the questions are E. Donald Davis, associate regional representative, Bureau of Disability Insurance; Don Donaldson, district manager, Social Security Office, Provo, Utah; and Walter D. Mackey, operations supervisor, Social Security Office, Provo, Utah.

We will first hear from Sterling Peterson.

STATEMENT OF STERLING K. PETERSON, ASSISTANT REGIONAL COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, DENVER REGIONAL OFFICE; ACCOMPANIED BY JOHN F. WALSH, JR., SENIOR PLANNING OFFICER, BUREAU OF SUPPLEMENTAL SECURITY INCOME; E. DONALD DAVIS, ASSOCIATE REGIONAL REPRESENTATIVE, BUREAU OF DISABILITY INSURANCE; DON DONALDSON, DISTRICT MANAGER, SOCIAL SECURITY OFFICE, PROVO, UTAH; AND WALTER D. MACKEY, OPERATIONS SUPERVISOR, SOCIAL SECURITY OFFICE, PROVO, UTAH

Mr. PETERSON. Thank you very much, Senator Moss. I have a bad habit, ladies and gentlemen, of digressing from my notes. I trust I will not digress too much, Senator.

I was most pleased, and I am digressing already, I was most impressed to hear your account of problems that elderly people are facing. I say this with the greatest of sincerity, Senator, despite having some prejudice, as a Richfield, Utah, native, who has been trying to get back there for the last 23 years, and I hope to make it some time. That Senator Moss, and I have heard many discussions, many reports on problems of the aging, but I think the Senator identified in a very clear and very succinct way the same problems I would identify as the most critical areas that elderly people are faced with today.

I commend you, sir.

President McDonald, we very much appreciate this opportunity to be in these lovely surroundings, and exchange information with you and the people from the four-county area. We are grateful for the help Dr. Selman gave us in preparing for this seminar.

I think of all of us and all of you as fellow pioneers. I use the word pioneers because I believe everyone here is anticipating, as evidenced by the Senator's comments, a new era for the elderly, a new era that we have waited for a long time, in which we hope to see the reintegration of older people into the mainstream of our society.

Moreover, I think we are all dedicated, we in the Social Security Administration, to developing and implementing programs that will help make the later years of life truly golden and significant and important, programs that will provide the opportunity for the large numbers of older persons who are eager and able to give creatively, an opportunity that is too frequently lacking, in my judgment.

Although Social Security occupies only a small part of this hearing, of this conference, we have some of our region's most expert technicians with us today. The Senator identified them. They are all sitting to my right. Thank you, gentlemen, for joining us.

I will hasten to add that we do not intend to overburden you with Social Security nor monopolize this conference.

SOCIAL SECURITY—A HOUSEHOLD WORD

Social Security to me is sort of a household word. Many people know in a general way what Social Security is all about. We would be very willing and happy, as the Senator indicated, to answer your questions, your general questions. Although Social Security cannot

guarantee the coming of this golden era for all of the older people, the benefits of Social Security can contribute to a goal recently expressed by the American Medical Association, and I quote, "That of making the aging experience a cause for national celebration, rather than the national disgrace that it is today."

I would like, therefore, to give you a brief overview of the Social Security program as it operates now with particular emphasis on its operation in Utah, and more specifically on the Social Security impact in Grand, Emery, Carbon, and San Juan Counties, the area in which most of you are concerned.

When the average person thinks of Social Security, he thinks of retirement insurance, but the program has grown through the years to meet or attempt to meet many replacement income needs with increased benefits and increased contributions to keep pace with spiraling living costs.

I am reminded when we talk about living costs and inflation, of a story I heard at a luncheon the other day in Denver.

It is about a dog, a boy, and a banker. The banker was on his way to the office, and he customarily and traditionally walked about the same way from his home to the office. As he was going down the street on a nice, bright, warm day, rather early in the morning, he noticed a young boy on the sidewalk with a sign, "Dog for sale."

The banker stopped. "How much would you charge for the dog, son?"

"$20,000."

The banker said, "That is incredible. That is rather expensive. Do you hope to find a customer that will pay $20,000 for your dog?"

"Oh, yes, I do not think I will have a bit of difficulty."

"Will you accept cash, or will you go on the installment basis?"

"Oh, I would prefer to have the money right away."

The banker said, "I am sorry, I cannot buy your dog."

That evening, as he was walking home on the same route, he noticed the same boy, and the dog was gone. The sign was gone. He stopped, and he said, "Well, apparently, young man, you sold the dog. I am amazed. Did you get full payment?"

"Oh, yes, I traded the dog in for two $10,000 cats."

In 1940, when only employed workers in commerce and industry were covered under Social Security, the employer and the employee each paid 1 percent on a $3,000 annual salary base.

The maximum benefit in 1940 for a worker retiring at age 65 was $40 per month. Through the years, the coverage has expanded, and today almost every category of employed and self-employed persons is included within the Social Security benefit program, but there are other changes.

This year, 1974, the annual wage base salary is $12,000. The maximum benefit for a retired worker at age 65 is $286.80, about a 700-percent increase over 1940.

On the other hand, the contribution of both the worker and his employer has risen almost 600 percent since 1940.

Last year some 109,000 persons in Utah received a total of $198 million in Social Security benefits. In Carbon, Emery, Grand, and San Juan Counties, approximately 6,000 persons received about $685,000 a month in Social Security benefits. Considering the total population

of the 4 counties, an estimated 42,000, about 1 out of every 8 persons in 1973 was receiving some type of Social Security benefit in the 4-county area.

While these benefits have increased periodically, most recently with the April check, I know that today's payment will not meet all of the economic needs of the average Social Security recipient, but it does go a long way in meeting the basic needs. Social Security, as I am sure many of you are acutely aware, was conceived from the beginning in 1937 as only a partial replacement for earnings when a worker retired or died or became disabled. It was never designed to meet all of the beneficiary's economic needs.

Disability Benefits

Disability benefits became payable in 1957. In Utah today, there are over 10,000 disability beneficiaries drawing more than $1 million in benefits each month. Added to this figure are the more than 1,000 black lung beneficiaries in Utah who are also receiving benefits, since a black lung law was passed in 1969.

Utah is one of the two Western States with a high incidence of black lung, and a large portion of these black lung cases are in this area, where mining is such an important part of the economy.

In 1966, the Medicare program started providing workers and their dependents with financial help in paying hospital bills as well as doctor fees and other medical expenses. Last year, Social Security paid out over $28 million for the medical expenses of Utah residents covered by Medicare.

Now, let us very briefly discuss H.R. 1. This law was passed in 1972, and amended twice in the last session of Congress. This brought more drastic changes to the Social Security Administration programs. Among other things, it provided that a widow whose benefits started at age 65 would receive an amount equal to 100 percent of the benefits that her deceased husband would have received had he been living, in contrast to the 82½ percent she received prior to the enactment of H.R. 1.

Another important amendment now allows a working beneficiary, as alluded to by the Senator, to earn $2,400 a year and still get all of his monthly Social Security retirement benefits. The amount a beneficiary can earn in the future and still get his benefits will be raised automatically.

The bill also made other changes in the Social Security cash benefits as well as some 57 changes in the Medicare program, but the most striking and most revolutionary part of the new law is the abrogation of the Federal-State programs of aid to the aged, the blind, and the disabled, thus creating the Supplemental Security Income program.

Jack Walsh, to my right, will give you more detailed information about this Supplemental Security Income program, generally termed in our jargon, SSI, and now a part of our official Social Security program.

I will tell you that in Utah, as of January 1974, the date of our most recent figures, 8,903 aged, blind, and disabled persons received $771,553.18, exclusive of any Social Security benefits they may have received.

Of this total, about 725 Supplemental Security Income recipients were from this four-county area.

Before Jack Walsh goes into greater detail about the Supplemental Security Income program, I would like to remind you of something many of you have probably heard or read by Dr. Victor Kassell, a very eminent geriatrician, and a personal friend of mine, who believes "Wisdom, unlike knowledge, is only acquired through living."

I would like to express the hope that this hearing, this conference will help America to utilize the tremendous capabilities, talents, and wisdom of the aged.

Thank you, sir.

Senator Moss. Thank you very much. [Applause.]

Thank you, Mr. Peterson. It was excellent. You gave us an overview of Government operations of the Social Security system.

I am sure that there will be some questions that will come up later, but we will go now to Mr. Walsh, who will talk about the Supplemental Security Income benefits that were alluded to. Mr. Walsh?

STATEMENT OF JOHN F. WALSH, JR., SENIOR PLANNING OFFICER, BUREAU OF SUPPLEMENTAL SECURITY INCOME

Mr. WALSH. Thank you, Senator, President McDonald, ladies and gentlemen. I will try to give a very short background of how Supplemental Security Income came about, and then outline its major provisions.

In October 1972, after many months' consideration of the issue of a Federal income maintenance program, Congress passed and President Nixon signed into law Public Law 92–603. This public law established what has become known as the Supplemental Security Income program (SSI). This program was designed to establish a guaranteed Federal income floor for the aged, blind, and disabled, those previously referred to as the adult categories of assistance.

I don't want to go further into the technical aspects of the program at this point, as these will be covered later. However, in July 1973, Congress passed and the President signed Public Law 93–66 which, as we shall see, had a substantial impact on the implementation of the SSI program.

Public Law 93–233 was signed in December 1973 with additional implications for the implementation of the SSI program. This is the first time in Social Security history that two major pieces of modifying legislation were enacted prior to the implementation of the basic program.

I would like to spend a few minutes discussing the goals of the program. By its design it is to provide a uniform Federal floor of income for the aged, blind, and disabled in this country, and to consolidate under one administration a program which was being administered by 1,152 separate jurisdictions previously. One of the congressional mandates associated with this program required that it be administered with the greatest possible regard for the personal dignity of the individual.

Over the years, I think the Social Security Administration had demonstrated its ability to deal with people in the manner envisioned by Congress. The Social Security Administration could also fulfill

another objective. That objective was the effective and efficient administration of the program. As I am sure you are well aware, the Social Security Administration already had in place a nationwide network of offices serving the public and an equally comprehensive communications and computer system needed to make the program work.

By using this administration, there was no need to set up an additional Federal agency. These, I think, were the main reasons the Social Security was called on to administer the program.

SSI Eligibility Program

Now that you have an idea of how the program came into being and what the objectives are, I want to outline eligibility to the SSI program. As I said before, the adult categories of welfare were the ones affected. The SSI legislation repealed the Federal laws establishing the State-administered programs of income maintenance for these categories and established the SSI program effective January 1, 1974. The definitions of aged and definitions of blindness were not changed from the State plans. The definition of disability adopted by Congress is the same one used in the disability insurance program already in existence under Social Security.

One of the major jobs was to convert the preexisting State roles, that is, to make sure that people who were being paid under the former State plans in December 1973, would get paid in January 1974, by the Social Security Administration.

We called these people "grandfathered in." The reason is there are certain rights conferred upon this group of people that are not conferred on people who apply in the future. They are guaranteed entitlement, for example, as long as they continue to meet either the new Federal SSI criteria, or the former State criteria, whichever is more lenient.

Those July amendments that I spoke of earlier extended this protection to another category of recipients under the State plans, which they called an essential person. Generally speaking, an essential person is not eligible in his own right, and need not be aged, disabled, or blind, but this individual's continued presence in the household of an aged, blind, or disabled individual must be essential to that individual or to the couple.

Now, this is one of these rights conferred to only the people under State plans in December 1973. Now that we have talked of whom in general is potentially eligible for the income maintenance program, we need to find out just how much income we are talking about.

The benefit has been $140 a month for an eligible individual, $210 for an eligible couple, and $70 for the essential person since January 1974.

I might add that under the original law, those amounts were lower. They were $130 for an individual and $190 for a couple, but Congress saw that even before the law went into effect, that this was not adequate.

In addition, these amounts are scheduled to be increased, effective July of this year, to $146 for an eligible individual, $219 for an eligible couple, and $73 for the essential person.

I think this brings up a very valid question of how these amounts

were arrived at. I understand Congress reviewed a number of possibilities for arriving at these amounts of the Federal income floor. It could have identified and paid the highest amount available from any State or county plan in the United States.

On the other hand, it could have identified and paid the lowest amount paid by any county or State, and there is quite some variance.

Obviously, neither of these alternatives were feasible. The impact of a $250 payment, for example, in a State whose prior standard to an individual was only $70 would be substantial, and not necessarily positive.

This could indeed be an incentive to stop working at a level below $250, and to go on to this new program, SSI.

The impact of using the lowest amount paid by a State or county is even more staggering in terms of the human element. The remaining alternate is somewhere in the middle ground, and Congress therefore arrived at, in essence, an average of the various State payments as the standard of payment under the SSI program.

Those July amendments introduced an additional wrinkle to this program. The original law had made possible, and in fact, encouraged States to supplement the basic SSI payment essentially from State moneys. Some States had already decided to offer this optional supplement to, as we call it, the SSI payments. However, it became obvious that some States might not provide a supplement. This would have disadvantaged thousands of recipients, whose payments under SSI would be less than they had received before under the State plan.

Mandatory State Supplement Under SSI

Congress acted very quickly to solve this problem, and made it mandatory that a State supplement the Federal payment so that no one received less under SSI than they had from the State before, and I think I should add here, this is one of those special grandfather provisions that applied to the people who were receiving assistance in December 1973, and not to people who applied for payments under the SSI program later.

There are two major elements used in determining an individual's eligibility. These are his income and his resources. Under this program though, not all income is used to reduce the amount of payment. Income is divided into two types, earned and unearned, with a different treatment for each type.

Unearned income has a very simple definition; it is any income which is not earned, but here are some examples. This would be Social Security retirement benefits, Social Security disability benefits, veterans' benefits, civil service annuities, private retirement, or interest from a savings account.

Earned income, on the other hand, is defined as income received in the form of gross wages or net earnings from self-employment. An incentive to work is built into the treatment of this earned income, and the formula for this contains a disregard for the first $65 per month of earned income, plus a disregard of one-half of the remaining income.

Another little twist, if the individual has no unearned income or

unearned income less than the $20 we would normally disregard, we are able to disregard additional amounts of earned income. This means an individual with only earned income could earn up to $363 a month and still receive an SSI payment.

In addition to considering earnings, we consider resources, those things individuals own.

A person is allowed to keep certain resources under the SSI program. An individual may retain up to $1,500 of countable resources, while a couple may keep up to $2,250 of countable resources.

The real key to this eligibility provision is the word "countable." For example, a house whose assessed market value is $35,000 or less is not counted. A car whose value does not exceed $1,200 is also excluded. A person may exclude life insurance whose value is $1,500 or less. Household goods and personal properties which do not exceed $1,500 in total value are not counted. What this says, I think, is that an individual may retain his resources within the specific $1,500 or $2,250 limit, and be qualified for SSI without being forced to drastically alter his lifestyle.

I thought perhaps we should take a look at the State of Utah's former requirements for the treatment of income and resources.

To begin with, in December 1973, Utah would pay $121 for an aged or disabled individual, $131 for the blind.

The State plan did not provide for a standard disregard for unearned income for any of those three categories, therefore, most unearned income was used to reduce the grant on a dollar-for-dollar basis.

Earned income was treated differently for the aged and the disabled than for the blind. The first $20 of earned income for the aged and disabled was regarded, plus half of the remainder, but only up to a total of $50.

The blind earned income was treated almost in the same way as the Supplemental Security Income except that the first $85 was disregarded, plus one-half of the remainder.

The State plan limited resources to only $750 for an individual and $1,500 for a couple. They, too, excluded one automobile, household goods, and the house occupied by the recipient. However, for the aged, a lien was required on all real property.

The Federal provisions do not call for a lien on anyone's property, nor do they call for a relative responsibility; that is, that a relative would have to contribute to the support of the individual before payment could be made.

How To Apply for SSI Payments

Sometimes that is not feasible, but these provisions are not in the Federal law. Now that you are familiar with the criteria, I am sure that you might ask, how would one apply for SSI, and that is a lot simpler than explaining how you are eligible for it.

You just go to your local Social Security office. I want to note, though, that in Wyoming, Montana, and South Dakota, an application for SSI is also an application for Medicaid. However, in the other three States in this region, Utah, Colorado, and North Dakota, another application is required to become entitled to Medicaid.

The States continue to have the responsibility for food stamps and for social services. Basically, what this law did is to make the Federal Government and Social Security responsible only for income maintenance.

Now, I hope I have provided you with a good overview of the SSI program, past and present. It has come a long way since October 1972, but we all recognize it has a lot of changing and growing to do before it can become the program that Congress envisioned.

With a little patience and a lot of work, and a little help from our friends, we will arrive there very soon.

Thank you. [Applause.]

Senator Moss. Thank you, Mr. Walsh, for explaining the Supplemental Security Income program. It sounds complex, and I am sure there will be questions coming up on it.

We will now start the question and answer period of these gentlemen seated at the table; Mr. Peterson, Mr. Walsh, Mr. Davis, Mr. Donaldson, and Mr. Mackey. If you would, when you have a question to ask, would you please stand up and give your name, and then state your question loud enough so that we can all hear.

This is not a large room, and I believe we can be heard. The person to whom the question is addressed will then attempt to give an answer, and as I said, it may be supplemented by other members of the panel. We will try to move along and not get stalemated on one or more questions. We will try to get the answer to a question and move on so we can cover as much as possible.

We may call a halt to the questioning, because we want to move on and get into the forenoon at least, or before we have our luncheon break, have one other of our speakers, so whoever has a question may volunteer it now.

Give your name and ask your question.

Mrs. Burr. My name is Eliza Burr, and I was born in the frontier town of Moab, June 13, 1897. A year ago, last June, it will be a year this June, I wanted to get married. I found a man that could help me. He was 14 years younger than I, but we could not get married because if I did, I get $155, and $100 would be taken away.

He gets $200, and he has a home, and I have a home, so we could not get married, because I could not live on that $55.

I am still eligible, I still have my mental faculties, I could work, but I am 77, and I cannot get a job, so I do all volunteer work, all of this without any pay. Why?

Now, I think that is wrong. I got the third Social Security number in Grand County. I worked for the county 7 years as a cook at the hospital, and they did not hold out Social Security, so when I first got mine at age 65, I got $40 a month, after my husband died 40 years ago, I got part of his, and now I get $155.70 a month, and my taxes are almost that much.

This year my children brought me into a new mobile home. I had to pay a tax, pay a tax of $650 on that mobile home.

Benefits Cut for Remarrying

Senator Moss. What you would like to know is why if you married a person who also had Social Security, plus yours, why yours must be reduced, and I will pass that along.

Mr. PETERSON. Mr. Mackey will handle that question.

Mr. MACKEY. Congress originally, in Social Security, decreed if a person were to marry, benefits would have been stopped entirely.

A few years ago, the law was changed so that if a person were over 60, a widow who remarried, would retain 50 percent of what her husband's benefit would have been, were he living at that time.

This is the law at present. It is 50 percent of the husband's benefit if they remarry after age 60.

Senator Moss. I believe, though, she said she would be cut from $155 or would have been cut from $155 to $55. That would be two-thirds.

Mr. MACKEY. She was probably receiving 82½ percent benefit of the husband's amount, and this seems like a little drastic in the dollar amount of the cut. I do not think it would have been that great.

Senator Moss. Well, one of the problems, and it occurred to me, it might have been in part because she was getting some of her husband's benefits, and it was presumed when she had a second husband, she did not need the husband's benefits simply to retain her own, is that part of the rationale?

Mr. MACKEY. This is part of the rationale of why the cuts in benefits of a widow remarrying.

Senator Moss. Does this pose a problem of inducing people who wish to marry, and they both have benefits, of just neglecting to go through the ceremony and living together?

Mr. MACKEY. We have heard it does.

Senator Moss. I did not recommend that. I just asked the question.

Mr. PETERSON. I will take Mr. Mackey off the hook, and say, yes, there is that potential, and as a matter of fact, it has occurred.

Senator Moss. It was said by Mr. Peterson that there have been problems of that sort; I have heard them before.

I might say, of course, the gentleman can give you the answer on what the law or the regulations provide, but they are not free to override what the law provides, and they personally have no inclination to enforce anything that seems inequitable, but at least we can get what the factual situation is.

Now, my situation would be that in the event you felt the present law is inequitable and wanted to tell me about it, then the law itself might be changed. But the answer to you is that under the law, you must forget some of your income benefits if you remarry on the basis that some of them were designed really to maintain a widow, and you would no longer be a widow if you remarried.

BLACK LUNG BENEFITS

Mr. PERO. My name is Pete Pero. I am 61 years old. I have been working in a coal mine since 1913. My problem is black lung. Now, I applied for black lung in April of 1972. I have been turned down four times.

Seven years ago, I developed an awful breathing problem. Now, my problem is not exactly my lungs, but I still have a breathing problem. In January of this year, I had a heart attack, which affected my breathing more. Now, my problem is this, that we who have worked in the mines, I have been working in the mines now for over 40 years.

We who have been working in the mines all of these years have to go through so much redtape. I have been turned down four times on my black lung. I cannot name you the people, but right here in Carbon County, there are so many people that have never been in the mines in their lives, there is a barber in this town who is 53 years old who has never been in the mine, and I can name you sheepherders, I can name you pimps, I can name you gamblers, and widows in this town whose husbands have been dead over 35 years, they wrote one letter and received black lung benefits, and there are several men here that I can see today that are here, who have been plagued by black lung for the past 3 or 4 years, and they cannot get any response whatsoever, because we are always denied. I would like to know why.

Senator Moss. Thank you. We will ask Mr. Davis to respond to that. Your problem, to me, seems to be with your physician or whoever it is that keeps turning you down, but we will ask Mr. Davis.

Mr. DAVIS. Pete, I do not know the specifics, of course, of your application. In your case, without knowing the individual facts, it would be impossible to address myself to your particular circumstances.

If you have pursued it, and you apparently have filed a reconsideration type of action——

Mr. PERO. Yes.

Mr. DAVIS [continuing]. And I would hope and assume you would have several medical tests introduced as evidence, and then it perhaps becomes, again, the problem of a medical judgment, a decision, that it does not appear that you meet the requirements. Now, I know that you said you do, and you feel so.

Mr. PERO. I understand that.

Mr. DAVIS. Have you pursued it to the hearing stage?

Mr. PERO. I pursued it to the fullest.

Mr. DAVIS. You had a hearing?

Mr. PERO. I got an appointment for a hearing before the judge, but the point that gets me, sir, is this, that men that have never been in the mine before that I know personally, sheepherders, there is just any number of them, that wrote one letter to the Social Security, only one, and have received their black lung, and they have received a nice check besides, what I mean, they have received a backpayment. I tell you, there are three barbers right here in town, two of them have never worked over 3 months in the mines.

Senator Moss. Perhaps I could intervene there. If you have any question of the irregularities of claims or payments, and you furnish the names and the incidents, I will see that they are examined, and find out whether they are bona fide, or there are any irregularities. Now, in your case, you have reached the hearing stage. Are you going to have a hearing?

Mr. PERO. I suppose, yes, sir.

HEARING ENTITLEMENT

Senator Moss. You are entitled to a hearing, and if at that hearing you can present your evidence about the length of time working, and the disability that is connected with working in the mine, then it should be in your favor.

Mr. PERO. I have the medical report here.

Senator Moss. If you have a doctor that has made that finding——

Mr. PERO. It has been in already twice. I cannot work any more. I have not received a dime of any kind since January.

Senator Moss. I think we are all sympathetic with you, but what you have to do now is go through that hearing and present the evidence you have, the medical evidence, to show that you indeed are afflicted by black lung from your work in the mine, and then you are entitled to the benefit.

Mr. PERO. I understand, Senator, but my point is this hearing, how is it that these people have never worked in the mine can get something so fast?

Senator Moss. I am asking you if you would furnish us names of the persons.

Mr. PERO. If I gave you the names, if I had those names, I would name them. I will try to get them.

Senator Moss. If you do, send them directly to me, or you can send them to Mr. Peterson, and I will see that they are investigated, because we are anxious that nobody takes advantage of the system.

Mr. PERO. That is exactly what we should have right here in this county, is one of the biggest investigations of this black lung deal they have here in Carbon County, that is, even the dogs talk about how dirty it is, that these people do not deserve what they are getting, and the coal miners, the ones sitting there right now, one has been in the mines longer than I have, and he is worse off than I am, he has been trying for 5 years, and he cannot get it, and the man who has never been in the mine is getting it.

I think there should be an investigation of these men that are not eligible, that the man who has worked in the mines hardly no time at all are getting it, and us who have worked in the mines all of our lives, have got to go through so much red tape.

Senator Moss. I assure you we are anxious for an investigation, because there should not be any abuse of the system. It is hard enough to operate without people abusing it. We do not want it abused. Just from what you have said orally, I will see that everything I can do to make sure there is an investigation and verification of the payments.

Yes, sir, this gentleman here.

SOCIAL SECURITY OFFICE NEEDED

Mr. CARL PETERSON. I am Carl Peterson, chairman of the Council of Aging of Carbon County. One of the big things that we lack here as far as the Social Security is, we do not have an office. You gentlemen who come up here, I imagine some of you have been up here at times on Thursday, have seen these long lines of elderly people, especially, sitting out in the hall of the courthouse, those chairs, I imagine, get awful hard. They are about like these here.

Mr. DONALDSON. They are hard inside also.

Mr. CARL PETERSON. For the tremendous amount of work the Social Security is handling here, I am aiming my question at Mr. Sterling Peterson and Mr. Donaldson, and I did get a partial answer from you, Mr. Donaldson, why is it that we cannot have a full-time Social Security here so that these problems which this gentleman has brought up can be taken up, because I cannot see how the gentleman who came

here from Provo can take care of the tremendous amount of work, especially with the black lung, I cannot see how you can do it, and you can do just this to what is here.

That is the first part of my question. The second part, I am going to make it two parts, and I will sit down, is the information and referral. Why is it that even though we are charged as being an area agency here, to get information and referral from the Social Security, so that we can help, and I am talking now as the area agency, and the Council on Aging, and as the aging agency of Carbon County, so that we can help and follow up the things that are brought up to the Social Security.

We have never had one referral in our office down there. I have been there for about, it is around 8 months now that I have been chairman, and there has never been one referral given to us from the Social Security.

We had one here talk to us, that gave us a very nice talk, told us what they would like to do.

Why is it, Mr. Peterson, we cannot have an office for Social Security, a man who is competent, who is a competent Social Security man in Carbon County?

Now, there are two questions there.

Mr. STERLING. PETERSON. I would be happy to respond to the first, and Mr. Donaldson, the second question, and I would like the record, sir, to show we are in full agreement for the need of an office in this area. Mr. Donaldson, our manager in Provo, recommended to us some weeks ago, Senator, that there be an office, a branch out of the Provo office, in the Price area; this recommendation was approved in my office. It is now awaiting approval of Commissioner Bruce Cardwell, and we fully anticipate that it will be approved, and that there will be expanded services, Mr. Peterson, that is by having people on almost a permanent basis in the Price area.

Mr. CARL PETERSON. How long will that take?

Senator MOSS. I will add my recommendation to that and see if we can hurry it along.

Ms. JENSEN. What about East Carbon. How about putting one there?

Mr. DONALDSON. When we get this office open in Price, which we call a resident station, we will have better service in both East Carbon and Emery County, as well as in Price.

I was over in East Carbon and talked to the mayor and to other people, and they requested local service, and I think we may be able to get something on the road right away without waiting for the new office to open in Price.

Mr. STERLING PETERSON. Does that answer the first part of your question, Mr. Peterson?

SOCIAL SECURITY OFFICE—REFERRALS

Mr. DONALDSON. On the second part as to the referrals, the Social Security Administration has always tried to direct people to other agencies, whether they are Government or private, that can take care of the needs that we cannot provide.

Most of our referrals in the past have been with other agencies like the department of public welfare.

Someone comes in and applies for Social Security and for some reason cannot qualify. In this type of case, we have made a referral to the welfare agency. We have students who think we handle scholarships and loans for college, which we do not. We at least try to refer them to the people who can help them.

In Utah County our referral system is better than in the outlying areas. The reason it has not been better in this area—you already answered your own question—is that we do not have a permanent force here.

Nevertheless, we try to work very closely with the senior citizens, the unions, everyone that we can, and we will try to do a better job on this.

As far as referring specifically to the Council on Aging it would help us if you would let us know what kind of service you could provide.

Frankly, at this point, we would have to know a little more about your operation. We will be happy to get together with you on this.

Mrs. MALALY. I am Ethel Malaly. I work with Mr. Peterson. In Carbon City, I am asking for other people, why there is a discrimination of black lung only for miners. Can that be explained to me?

Senator Moss. We will attempt to explain it. I will pass this on to Mr. Davis. Mr. Davis, the question is why black lung only for miners. She wants to know.

Mr. STERLING PETERSON. Why a special benefit being paid for black lung?

Senator Moss. Yes. Maybe I should take a shot at it first since these gentlemen execute the law, and I have a part in the law writing.

There was a period of time, a long period of time, when there was a real medical problem that existed in mining areas, and back in Appalachia, and other parts of the country, because it was a coal mining area, where adequate medical care was not available for people who were suffering from black lung from long work in the mines. This problem became acute enough, and there was enough evidence brought forth to the Congress and enough requests, that the Congress finally enacted the law, saying that people who by reason of working in the mines had acquired what is called black lung, that had a disease which would be entitled to special benefits, because it is, in effect, an incurable disease. People with this disease were considered to be disabled.

I think I sense in your question a feeling that perhaps some other people who suffered disabilities were left out, and, therefore, it was somewhat discriminatory, and I suppose you could argue that whenever there is a special problem.

You might even argue it about the blind or people who are crippled in some way.

These gentlemen have to take the law as it is written, and it comes down to them, and they try to administer it fairly. You gentlemen can go on from there, and if you can add to it for me, please do.

Mr. DAVIS. I think the Senator covered it pretty well.

Mrs. MALALY. The point I have is that railroad men who have to work around this coal dust, as it is going into the feeder, they get this dust in their lungs, and they have the same proposition, but they are railroad men, and they do not get any benefits, and then we have men that have to weld these coal cars, they get the same effect from the coal

dust, and so on, and so forth, some of these men really have a lung problem. What about those men?

Mr. DONALDSON. I think the reason it was confined to the coal industry is that mining was recognized as a dangerous occupation, where we had a lot of lung disease, and if we are to include railroad workers, it would require new legislation.

Mr. STERLING PETERSON. Railroad employees are covered under the Railroad Retirement Survivors program, and they have somewhat different standards, and the requirements and qualifications for those insured and entitled under the railroad plan are different than those under the Social Security plan.

Senator Moss. That is true. It is a different system of compensation. The gentleman back here?

Mr. GALANIS. My name is George Galanis, and I am legally blind. However, I can see to get around, so I do receive Social Security disability.

I was receiving $148.10, whatever it was, so now I am getting $159 a month. How much am I allowed to make before the Social Security, I am not allowed to get it anymore?

Now, under retirement, you are supposed to make $2,400 a year, but what about disability?

Senator Moss. Mr. Donaldson, could you answer the gentleman's question?

EARNINGS TEST FOR RETIREMENT DISABILITY

Mr. DONALDSON. Yes, there is a difference in the earnings' test for retirement and disability. The $2,400 earnings test does not apply to disabled beneficiaries.

Going back to the point that Mr. Peterson made earlier, the Social Security law was passed to partially replace the income a person loses when he retires, becomes disabled, or dies.

It is obvious that when you retire, you lose earnings, and eligibility is based on this fact, plus other requirements, such as being 62 or older.

The same thing is true of disability. To qualify for the disability benefits, you must meet certain requirements. You have to be totally disabled or unable to enage in any substantial gainful activity. So if you can go out and still work at a high rate of earnings, the indications are you are not disabled.

In other words, you have to be disabled to qualify for the benefits in the first place. It is possible, however, to work in sheltered employment and have a small income after becoming disabled, and in some cases it would not affect your benefits.

Senator Moss. I think, Mr. Peterson, there is another part of the question. What are the outside limits a gentleman can earn without losing any of his Social Security disability payments?

Mr. DONALDSON. We cannot talk about an outside limit. We have to take each individual case and determine whether or not this individual is engaged in substantial gainful activity under the law, or whether he is not, so there is no dollar amount, like the $2,400 for people receiving retirement benefits.

Mr. GALANIS. I had a gift shop at the Carbon Hospital, which was set up by the Utah individually handicapped, for services for the blind under rehabilitation.

I was getting Social Security under that, but my profit was so little, you could not make ends meet, and my wife wrote over to there, and as we were realizing a little profit, last October 9, a hospital board meeting, without me knowing it, without consulting us, they said we were out.

In other words, they turned it over to the Pink ladies, so that leaves me without a job, so I did nothing except volunteer work, I was told I can come in to do volunteer work with the nursing home, which I do, so at age 59, nobody is going to hire me, or at 60, so I had to make my own job, so now what I do is take orders that the blind make in Salt Lake.

Sometimes you make it, sometimes you do not, but I will still keep on going. Thank you.

Senator Moss. Thank you for your questions. I am sure you will. I commend you for your desire to keep working and find ways to supplement your income, and I would hope that it did not interfere in any way with your benefits.

Mr. GALANIS. No, it did not.

Senator Moss. We could not get a definitive answer on that, because your individual case has to be examined. It indicates to me that the general desire of people to find a way to earn some additional income, that is wonderful, and that is the reason, I think, and I said in my opening remarks, I think we ought to lift these outside restrictions on earning income and having it affect the entitlement of the person by reason of his willingness and ability to go out and earn some money on his own. This gentleman back here.

BLACK LUNG BENEFITS

Mr. THAYS. My name is Leo Thays. I worked in the coal mines for 30 years. I got black lung, and I get $266.40 a month.

I was wondering, I have to go before a judge for Social Security.

Senator Moss. You do draw black lung, but you do not draw Social Security?

Mr. THAYS. Yes.

Senator Moss. How old are you?

Mr. THAYS. Fifty-six.

Senator Moss. I see. Of course, you are disabled. I see what you are talking about.

Could you give that gentleman an answer?

Mr. DONALDSON. Your question is why you do not qualify for the Social Security disability, when you already qualify for black lung?

Mr. THAYS. Yes, sir.

Mr. DONALDSON. Under the black lung law, if a person has worked for at least 15 years, and he has a lung condition that is so severe that he can no longer do the type of work he used to do in the mines, then he will probably qualify for black lung benefits.

But under the disability law, the requirement is different, the factor of entitlement is different here. To qualify for disability benefits you have to be totally disabled and not be able to really do any type of substantial work.

Mr. THAYS. I do not do any type of work.

Mr. DONALDSON. The point is that even though you cannot work as

a coal miner, you may not qualify for disability benefits whereas you did for black lung benefits.

Senator Moss. That is probably the reason you are going before the judge, to establish whether or not you do have an ability to do some other kind of work.

You might be a salesman or some job that does not require a great deal of physical exertion.

You look like a very healthy and able man. Maybe you might do well, but I do not make light of that. I understand you do have a problem, and you have to present that matter to a competent tribunal to judge whether or not you are disabled so you can do some kind of gainful employment. This young lady here.

Mrs. JENSEN. I am Elaine Jensen. I have a question. I would like to know if there is anything being done for widows who are being discriminated against. Now, we know that it is 60, I believe, that she can get Social Security.

What if a woman has to quit work to take care of a disabled husband? She has to give up her job of gainful employment, and he passes away. She has no dependent children at home, and she is alone. If he is a miner, she gets $75 for 22 months and hospitalization. Say she is 55, she will receive $75 a month and hospitalization until she is 57.

She has never worked, and they send her to college or some place to be qualified, she is qualified with no job, what is more frustrating to a person, and they do not want to go on welfare, is not there something, how long, what is the record of a man receiving Social Security, what is the average year?

This woman has helped all of his life, and now when she really needs it, if he should die, she has nothing.

Senator Moss. Does not the widow have an entitlement?

Mrs. JENSEN. Not until she is 60.

Mr. DONALDSON. If a widow has children under age 18, she can receive benefits at any age.

If a widow has a disabled child over age 18 and she gives personal care, she can get benefits before age 60. Also, a disabled widow at age 50, but otherwise, you are absolutely correct, a widow would have to wait until age 60.

Mrs. JENSEN. That is a black age for women.

GAP IN ENTITLEMENT

Senator Moss. You put your finger on a real problem. There apparently is a gap of entitlement there. The hypothetical case you presented would leave that woman for about 3 years without any income, and she may find difficulty.

Mrs. JENSEN. If the woman dies, he continues to get it, the same amount.

Senator Moss. Because of his entitlement, yes. He had qualified for it by reason of age or disability, whichever, and that is the reason he would go on getting it.

If she had not qualified for it, and there is a gap apparently in which she would not qualify between the age of 55 and 60, when she might find it extremely difficult to find any kind of job and get any income, that is true, and perhaps that needs a little examination, and maybe we can get it amended.

Yes, sir?

Mr. DUKE. My name is Harold S. Duke. I am a schoolteacher. I have been a schoolteacher all my life, most of it in Carbon County, and touching on the same thing that Elaine mentioned here, has been the question in my mind, now when I became 65, I applied for and got Social Security, and at the same time, my wife who is 2 years younger at 63, she applied, and we both received Social Security.

Now, my problem is this, should I die first, that income would suddenly drop from around $300, we will say, down to a mere, less than $100, and I would like to know some answers.

I do not know the answer to it. I would like to address it to Mr. Donaldson, because I think he is the man who knows more about my situation than anyone here.

Senator MOSS. Mr. Donaldson?

Mr. DONALDSON. In other words, you are asking, after you die, will your widow still get a benefit?

Mr. DUKE. Yes, just how much of an income could she get?

Mr. DONALDSON. The minimum that would be paid to an entitled widow at age 62 would be 82½ percent, and it could be as much as 100 percent of the benefit amount you received if she begins to get benefits at age 65.

Mr. DUKE. Thank you.

Senator MOSS. What you are saying, she would get at least 82½ percent?

Mr. DONALDSON. That is correct.

Senator MOSS. It might be as high as 100 percent of the benefit?

Mr. DONALDSON. Of his benefit, yes.

Senator MOSS. That Mr. Duke receives?

Mr. DONALDSON. Yes.

Senator MOSS. It looks like he is in pretty good condition. The young lady there.

Mrs. WARDE. I am wondering what happens to your money, it is taken out of your wages, like the man who dies, why could not she get the full amount?

Senator MOSS. Are you talking about the contributions that would have been made?

WIDOW'S SOCIAL SECURITY BENEFIT

Mrs. WARDE. Like the man and wife, if the man dies, she only gets 82½ percent, why could not she get the full amount like he is still living?

Senator MOSS. All right. We will ask Mr. Donaldson, why is it only 82½ percent in some cases?

You say sometimes it is 100 percent. When the man dies, and the widow is left, why is it not always 100 percent?

Mr. DONALDSON. I will have to throw this right to you, Senator Moss, because that is the way Congress passed the law.

Actually, we just reached the point under the 1972 Social Security amendments where we can pay 100 percent to widows who start benefits at age 65.

The amount of 82½ percent used to be the limit, so this represents a vast improvement, to go from 82½ percent to 100 percent.

Mrs. WARDE. This money actually belongs to them, because it has been held out of their wages.

Mr. DONALDSON. One thing that you have to remember is that once you become entitled to these benefits, you may live for another 20, 25 years, you will draw ordinarily much more in Social Security benefits than your husband would ever have paid into it.

Mr. PETERSON. I think this is another consideration.

Senator Moss. I understand that at the first part, but then I thought she modified it back.

Social Security is paid into a trust fund, as you know, and then the benefits come out on a certain formula, and it does not come the same to everybody. Everybody cannot just take his money out and go at any time. There would be no way to administer the act and so they have to have actuaries that determine what the average length of life will be, or the projected length, and so on, in order to make the system work.

Now, it is true that a person that dies within a year or two after he has first qualified for Social Security probably received very little of the money that he paid in.

On the other hand, some other fellow may live to be 95 years old, may draw for 30 years or something, and he is drawing much, much more than he ever put in, but the two balance off.

Now, on the payment of only 82½ percent, the only reason I can think that Congress did that, was the theory that it costs a little more than when there were two people eating, than when just one was left.

That may not be totally valid, because the amount we are talking about is relatively small, and I realize that nobody is living in luxury on what they draw from Social Security benefits.

Both Mr. Peterson and I stressed, that the Social Security program, when it was set up, it was thought to be a supplemental type of program, and not ever designed to really cover all of the needs of the people who are beneficiaries.

Now, we have been moving up, trying to get closer to supplying a livable income, but we never have achieved that. I do not think anybody believes that Social Security overpays anybody at any time with the cost of living as it is today, but, you know, we have to find answers, and that is part of the pressure on the other side. Yes, this lady.

Mrs. GALANIS. I am Mrytle Galanis, wife of George Galanis. I would like to speak on his behalf. When he lost the gift shop, the 31st of December of 1973, this left George with no job.

VOCATIONAL REHABILITATION PROGRAMS

I was working part time at the nursing home, with his disability, Social Security, and part-time work for me, that was not enough to feed us, to pay our rent, or for a car to get back and forth to work, so we started fishing around for a place for George to work.

We learned of the Green Thumb program. We thought perhaps he could get on that, so we filled out all of the necessary papers, and called on the various organizations in the community in regard to helping the unemployed, and the handicapped, and so forth.

It took quite a few months. Finally we heard from Green Thumb, he had been turned down. He made a few dollars too much in 1973. That was 1973, what is he going to do in 1974, that is when we need it, now, not last year.

Last year we were getting by, but this year, George is without a job, nothing coming in, so this is why George made his own job, February 1, he awakened in the morning, he said, "Guess what I am going to do?"

I said, "I have not any idea what you are going to do."

He said, "Today I am going out, and I am going to take orders for merchandise the blind make."

And that is what George has been doing ever since, because he was turned down on ever so many places around town about getting a job.

With George, what can you do, you cannot do that, you cannot do this. Nobody gave George a chance. I asked permission if George could be my volunteer over at the nursing home, and he comes most everyday, some days he has to make deliveries or take orders from the various people around town, so why should he be denied a job because he made a few dollars more than what was allotted last year, but that does not count for this year.

Mr. PETERSON. I would like our district office, with your approval, to review his Social Security status, Senator, and look at it to determine his earnings and his income, and what we can do about this situation. If you could check it, and get the necessary information, we will review the case. Then I would like to ask Dr. Walter, or there may be some other State people with the Division of the Blind and Vocational Rehabilitation programs here, about the question on employment and on rehabilitation.

Are you with those programs, Dr. Walter?

Dr. WALTER. I would have to look into it.

Senator Moss. Or Dr. White?

Dr. WHITE. I am familiar with them, but not that thoroughly.

Mr. PETERSON. I would like to ask for an investigation of the program for employment.

Senator Moss. Thank you for that suggestion, and I would say to all of you who are here, these gentlemen, when we finish the open hearing part, would be glad to talk to you on your individual situation, such as it has been presented here by Mrs. Galanis, to see if there is any way that your problem can be met, because you do have a very severe problem, and we would like to see it met without any hardship to you, if that is possible, and that is what these gentlemen will do who are here today, and you take advantage of this and go over to talk with them. The gentleman in the rear row.

Mr. SANCHEZ. I am Manuel Sanchez, and I have been turned down, and two doctors said I have got black lung, and I do not see why I cannot get it. I have the reports right here.

Senator Moss. Do you have a hearing scheduled to come up?

Mr. SANCHEZ. I have to put in a new claim.

Senator Moss. You have two doctors, you say, who have examined you, and it is their finding, positive, that you have it?

Mr. SANCHEZ. I have the letters here and the reports. Do you want to read them?

Senator Moss. No, I do not, because I do not have the authority to say yes or no in your individual case. I do not know whether there was any other reason. How long did you work in the mines?

Mr. SANCHEZ. Forty-five years.

Senator Moss. That seems to be long enough to me.

I cannot tell you specifically, but I again would advise that you should consult, on your specific case with the gentlemen here and see if they can give you advice as to how you can proceed.

Mr. PETERSON. We would be very happy to. You see Mr. Donaldson after the meeting.

Senator Moss. Yes, sir. We have now President McDonald.

RAISING MINIMUM EARNINGS AMOUNT

Mr. MCDONALD. Would you care to comment further on the legislation you referred to in your opening comments relative to raising the minimum amount that a person can earn, and still qualify for the Social Security, and, the second question, what is the progress, if any is being made, to increase the Social Security benefits to encourage or make early retirement more attractive, say age 62.

Senator Moss. Yes. What I said in my opening remarks, and I am very glad to comment on this, is that with the establishment of Social Security, for some reason, the Congress felt that they should prohibit outside earnings.

Of course, that was in a time of depression back in the 1930's and early 1940's, the beginning of the 1940's, and I think that influenced a lot, the psychology of saying you cannot have people who are drawing some income and also taking up jobs, when so many people are out of work, but as the years have gone by, and as we have watched Social Security expand and develop, and become better, we recognize that there was an inequitable thing here, and in a sense, it was somewhat self-defeating to prohibit people who are drawing benefits because of age and of qualification of seeking outside employment, and doing many things we needed done in our society. So bit by bit, we have been raising the amount, and the last raise was up to $2,400 a year, so now a person on Social Security may earn as much as $2,400 from outside income, without affecting his entitlement, but with that, I said that I believed we ought to disregard even that limitation.

I would hope that we could put it as high as $5,000 a year. or it would not bother me at all if we just eliminated that prohibition altogether.

I think people who have reached the age of entitlement ought to be encouraged to go right along and do what they are qualified to do. In fact, I think that is one of the great wastes of society, is to suddenly tell people, now you have to stop working, just stay home and rock on the porch and do whatever else.

Now, of course, some people are not physically well, they gradually find they cannot do the kind of work they did before.

Well, let them find alternative types of work, and the great quote that was about—we gain wisdom—Dr. Kassell's quote. "we gain wisdom by living," is the thing we are throwing away if we do not let those people contribute to the mainstream of society, to be effective, to do their thing in helping people around them, and so I am a great advocate that we remove that limitation, but at the present time, under the law, it is $2,400 a year that may be earned on the outside. What was your second question?

Mr. MCDONALD. The Social Security benefits.

Senator Moss. By lowering the age for qualification. This is rather

a controversial decision to be made, and it is being debated rather hotly, and, as you can see, it does cut both ways.

One, because what we have said before, it encourages maybe some people to move off into the more nonproductive area at a younger age, when actually they could continue, and, of course, it makes it somewhat more expensive to operate the system under that, and coupled with that, since there are disability qualifications, if a person is really disabled, he can qualify at that earlier age without going to the full 65 or 63.

I would say there ought to be perhaps a little relaxation on how a person qualifies, how much disability he has to qualify, but I am not too sure we ought to begin dropping the age.

We are all living a little longer, and hopefully, with the advances of medicine, we are in pretty good shape when we get up there at 63 or 65, and I am hoping that we can improve our general level of health to where that would still be the realistic time to make the qualification.

I do not know whether any of you gentlemen want to add anything to that or not.

Mr. PETERSON. I think I can speak for my colleagues, that we are in total agreement. It would ease our administrative problems also.

Senator MOSS. Thank you very much. I think we must now terminate this part of our panel, and I want to thank all of you gentlemen who have come and participated.

You have done an excellent job, and you have offered to talk with individuals, if they have a specific problem, and I ask you to try to work it through for them, to finding a solution to their problems. We have a marvelous system, but it does baffle me sometimes, when I try to answer some of the technical questions involved.

IMPROVED SOCIAL SECURITY SYSTEM

I think that the Social Security system is an area in which we have grown as a country and as a society.

There are improvements that need to be made, and other areas that perhaps we need to move into, but it has so changed the pattern of society, that it is hard to remember now back before there was a Social Security system, when there was always a county poorhouse and things of that sort, so at least we can be that optimistic.

We have moved along, and we are doing better.

I thank you all, gentlemen, for coming.

We are going to run for a little longer, but I will not be able to stay in the afternoon. We are glad to have so many people here.

There will be a luncheon prepared for you at the school at 1 o'clock, and, therefore, we will proceed until that time.

We are going to hear now from Dr. Melvin White, and Dr. Bruce Walter, both of whom are here.

Dr. Melvin White is the director of the Rocky Mountain Gerontological Center at the University of Utah, and Dr. Bruce Walter is the director of the Medical Care Services, Utah State Department of Social Services, Division of Health.

The gentlemen, obviously, will be speaking on the health problems of the elderly, and will be available to answer questions as the panel has been before.

Probably, we can only cover one of these before the break, but I wish both Dr. White and Dr. Walter would come up here at the table, and on my list, I have Dr. White first, but if for any reason you want to turn that around, we can do it. All right.

Dr. Melvin White, director of the Rocky Mountain Gerontological Center at the University of Utah. You may make whatever opening remarks you have, Dr. White, and then we will see if there are questions that the people here would like to have you answer.

STATEMENT OF DR. MELVIN WHITE, DIRECTOR, ROCKY MOUNTAIN GERONTOLOGICAL CENTER AT THE UNIVERSITY OF UTAH

Dr. WHITE. Thank you, Senator Moss. I appreciate very much being here today.

It is interesting, the topic they asked me to speak on is how to stay mentally alert and prevent senility; I felt pretty comfortable on this topic until several months ago, when I was addressing a women's group in Salt Lake. I was speaking on the same subject, "how to avoid senility." There were about 50 women present. After I finished speaking, they thanked me, and as I was leaving, one of the ladies asked if I would wait for a few minutes as she had something she wanted me to hear. After I heard her comments, I again waved goodbye to the group—they were all watching me—and I turned the corner through an archway which I thought led to the outside, but went right into a closet. Leaving the closet, I then had a choice of two other doors, and made another mistake in choosing the wrong door of the two. The only thing I could say jokingly, was that if there were any volunteers to help lead me to my car, I would appreciate it. I think the women in attendance will always remember that talk, given by a senile old man on how to avoid senility. In a more serious vein, it is unfortunate that we have long accepted that certain conditions are inevitable in aging, and one of the conditions which we have accepted is that intellectually we have to decline as we grow older.

Let me share with you just one or two studies which perhaps may shed some light on this.

There is a study made by Paul B. Baltes and K. Warner Schaie, at Pennsylvania State, of 500 individuals, aged 21 through 70. They studied these people over a period of 7 years to see whether or not there was a decline in their intellectual functioning over that time. What they found, in essence, is that there is no decline on the basis of age.

In other words, those people, even over 70, showed no marked evidence of decline in their intellectual ability to function.

This type of study is supported by others. At Iowa State, at one time where they gave a group of students at the beginning of World War I the old Army Alpha test, and they tested the same people later in their sixty's and seventy's, and on the basis of this test, they found again on four out of eight subtests, there were no changes intellectually and on four subtests, the people actually improved.

Another longitudinal study conducted at Duke University, determined the same thing—that intellectually, we do not have to go downhill, we do not have to regress as we grow older, at least not to the extent we have previously believed.

Now, probably the reason for the differences in how we used to believe and what we believe now is based on the fact that most of our

earlier studies were of cross-sectional design, where you examined older people and younger people in the same period of time. The more recent studies have been longitudinal, where they have basically looked at the same people over a period of time.

In the earlier studies, they were comparing younger people who had different educational advantages, and a different time and era in our society, with older people, and that perhaps was the reason for the difference.

There is one exception involving intellectual decline. There appears to be some intellectual decline for older people approximately 5 years prior to death.

With that exception, there is no reason, as far as we can determine, why there has to be an appreciable intellectual regression.

Avoiding the Intellectual Decline

Now, let me address my remarks for a few moments on how to avoid this intellectual decline and how to stay mentally alert, although I do not want to imply that I know all of the answers to why we regress. I do not; however, let me share with you some of the ideas and some of the present thinking in this regard.

First of all, there is the statement by an author named Wacowan. He stated the following: "The best thing to save for your old age is yourself."

There is no question that the pattern of behavior we develop during our early years affects our later lives.

For instance, physically, and Dr. Walter will address himself to this subject, if we take care of ourselves physically when we are young, the chances are much better of having good physical health when we are old.

I often think of the cartoon that I saw of the doctor examining the older gentleman, and after the examination, he looked at him, and said, "John you are in great shape for a 69-year-old. Too bad you are only 50."

This is the type of thing that happens mentally. There is some evidence again to indicate that if we stay mentally active, we can avoid the mental regression, assuming that our health remains somewhat constant.

I hate to talk about rats, but Senator Moss did, so maybe I can get away with it. Some studies have been made with rats at the University of California in Berkeley, and they placed one group of rats in a setting which provided a mentally stimulating setting, and do not ask me what is mentally stimulating for a rat, because I do not really know. Another group of rats were provided a setting where there was no challenge at all; then they performed an autopsy on the brains of the rats, and found that the rats which were placed in the setting in which they were mentally stimulated, the brain appeared much healthier at the time of autopsy than the other group of rats. People may be the same. In terms of this, perhaps we have an individual responsibility to ask ourselves such questions, how long has it been since I have challenged myself mentally, or accepted a problem that goes just beyond my present ability to solve, yet you are willing to wrestle with it; or how long has it been since you have taken up a new activity which requires mental as well as physical effort to achieve that activity?

Socio-Economic Characteristics

A study was made by the Utah Division of Aging on the Socio-economic characteristics of older persons, which included about 25,500 people. In response to the question, "Which of the following activities did you engage in last week," 59.6 percent indicated they watched television, 12.1 percent indicated they worked on hobbies, 6.2 percent read books, and 4.7 percent read newspapers; that at least implied that perhaps many of us as we grow older are doing those things that perhaps require less amount of mental stimulation, unless you consider watching television stimulating.

There is also a tendency, as we grow older, to program for death rather than life. We tend to look at the number of years we have remaining by comparing the difference between our present age and the age at which our parents died.

For example, if we happen to be 65 years of age, and our parents died at the age of 72, we start thinking 72 minus 65, gives me 7 years to live, and because I only have 7 years to live, why should I start new things, because chances are I will never complete them.

Let me give you two short stories, one which is not true, one which is true, that illustrates this point.

The one which is not true is a story of two old, Spanish-American War veterans in a cemetery who are watching the burial of their comrade-in-arms, and they have just lowered the casket into the grave.

The one older gentleman poked his comrade in the side, he said, "By the way, John, how old are you?"

John said, "Well, I am 93."

His friend looked at him, and said, "Hardly worth going home, is it?"

Now, that is the programing for death.

Now, a true story, and it happened not far from here. In a meeting we were having, an older gentleman in his eighties asked to be excused, and when asked why he had to be excused, he said, "I have 100 fruit trees that I have to plant."

As I recall, he was 87 years of age, and statistically, he will never live to see those fruit trees bear fruit, but he was living as though he would live forever, and with that attitude, perhaps he may.

Preretirement Planning

Now, in terms of other approaches to this challenge of remaining mentally active and avoiding senility; first of all, I think preretirement planning is very important.

Now, unfortunately, most of the preretirement planning that is being done throughout many parts of the country is kind of a 1- or 2-day affair where people, prior to retirement, are brought together, and you talk about such things as physical and social planning.

I feel we have a real need to begin preparation for later life at an early stage—even to the age of high school students. One of my staff members now is conducting some classes with high school students at Cottonwood High School in Salt Lake City; they call it "lifetime planning," not "preretirement planning."

They are looking at some of the ways in which you can develop a

pattern of living that will carry you through all of your life, and will not cease simply when you reach the age of retirement.

Another thing that is significant in terms of preretirement is to tell ourselves, and believe that we are important because of "who we are," not because of "what we do."

One of the most common mental health problems of all older people is depression. One reason for depression is the fact that we build our self-concepts, our worth, our values, on what we do. We are a doctor, a carpenter, a dentist, and then when we retire, we come to the sudden realization that the status and the recognition remains with the position we held, and does not go with us.

Women quite often build their importance around their children, and when their children leave home, many women feel that their lives are worthless, which results in a high rate of depression.

Popeye said, "I am what I am, that is all that I am, I am Popeye the sailorman." I like that.

Somehow, we have to incorporate this concept throughout our lives. I am important because I am what I am.

If you want to look at it from a religious point of view, I am important because I am a child of God, and this will help avoid many of the problems we see as we retire and move into later life.

Another direction I think we should go is in terms of what I can call mental health through self-help.

We know that most older people, for one reason or another, will not use our mental health centers or our psychiatric health care facilities in this State and throughout the country.

There may be a number of reasons for the failure to seek psychiatric care. Perhaps many people in the field of mental health are not interested in older people; many people think that going to a psychiatrist means you are crazy, so you avoid psychiatric help as if it were the plague.

We know in terms of mental health problems people have that they usually do not start with one major crisis. There usually are a series of little crises that accumulate over a period of time. I would like to see a program developed by such groups such as the councils on aging, the American Association of Retired Persons/National Retired Teachers Association, nursing home groups, and other groups, whereby groups of older people could be educated to understand some of the common problems that eventually get us into trouble, such as economic problems, the lack of visitation by family, the lack of activity and primarily inactivity in institutions, where you sit around and worry about yourself. This happens at any age, but if we can train older people themselves to understand these problems and what can be done through intervention to basically alleviate the problems at that time, we will be better off helping older people resolve minor but particularly serious problems that could lead to institutionalization through early intervention procedures than to attempt to restore a person with serious mental illnesses.

We are currently working with the mental health people in this area in developing a program of this nature. We also want to reach out to those people who do not belong to formal organizations, but who tend to blend into the wallpaper, because as we well know, they are the older people who frequently have the most serious problems and who tend to be in institutions such as nursing homes and hospitals.

Several studies indicate that older people are not institutionalized on the basis of health needs alone. They are frequently the individuals who, in addition to health needs, are alone, alienated, and rejected by society, and often are placed in institutions for social reasons as well as for medical reasons.

The next point I would like to make, and Senator Moss has touched on this, so I will not dwell on it, but there are many social factors such as income, mandatory retirement, transportation, and so forth, that limit the opportunities of all of us as we grow older, to reach our full potential and express ourselves in terms of what we would like to do and can do.

Regarding retirement, I certainly support the idea of removing the limitation on earnings.

Flexible Retirement System Needed

I think that is very important, but I also feel that we need a flexible retirement system, and somehow I cannot believe that even though we can put a man on the Moon, we cannot find some ways to get around or over barriers that stop us from getting a job when we are over 65. It does not make sense. We may or may not have the technology to measure functioning ability, but I think we have the capability of developing it, so that a person can work as long as he is capable of doing his job. If you do retire, voluntarily or involuntarily, what do you retire to? Here again, we have to look at new roles for older people, roles that can be mutually beneficial to both the older person and the Nation.

I am personally convinced that one of the roles older people play is working with our youth. Let me briefly touch on this.

Certainly, programs such as Foster Grandparents, Retired Senior Volunteers, crossing guards, and others, have all demonstrated that older people can serve youth very effectively. They have also demonstrated that giving the older person the opportunity to serve is a major deterrent to development of psychiatric problems and senility.

For example, a middle aged woman told me when her mother was working on the Foster Grandparents program, that before mother went to work on that program, she was having all kinds of problems—she could not remember things, she was losing interest, she did not take interest in her personal appearance, and "we could not stand being with her, but since she has been working on that program, my mother is a new woman." This is the type of testimony you hear over and over again.

We had a workshop at Brighton, Utah, where we had young people and older people meeting together for 3 days to discuss reciprocal roles among generations, value differences, and communication problems. A very interesting thing happened on the third day. A young girl about 17 years old stood up and said:

> I am representing all my peer group here when I say what I am going to say. Before I came to this meeting, I was a delegate to the White House Conference on Youth. I found it difficult to communicate with my own age group at that conference. When I returned home, I had received a letter inviting me to this workshop, and I asked myself, "If I cannot communicate with my own age group, how can I ever communicate with a bunch of old fogies?" I and my peers have learned something here. We have learned that you people here understand us better than our own parents.

This was the testimony of a young lady.

I think we should do more to explore roles that older people can serve, because I think we have a wealth of talent which we are permitting to go to waste; at the same time, I think permitting older people to serve will prevent or deter the premature senility we keep talking about.

The last couple of quick points here, one is in terms of values.

We talk about social programs, and over the years, I have become convinced, if we are every going to become successful with many of our programs, we have to change our own values in terms of how we see older people.

Negative Attitudes Toward Aging

I was surprised the other day reading a doctoral study of the attitudes of second-year social work students toward the aging. Many students expressed negative attitudes, as was expected. What was unexpected was that those students who were members of a major church group had more negative attitudes than the group as a whole. The sample studied was relatively small and it would be extremely dangerous to generalize the finding; however, I think that there is an indication that perhaps something is wrong in terms of the way we set our values, and we need to take a look at ways of changing the values of our young people. By changing the values of our younger people, we change the attitudes of older people toward themselves. If we have a poor attitude toward ourselves we are heading toward senility, and we are heading toward mental illness and other problems. We have to convince ourselves that we are important, and the best way to do this is to have society also think we are important.

Carl Jung, a psychoanalyst, made the statement that "man cannot stand a meaningless life." With older people, we have created a situation where we are forcing them, in many instances, into a meaningless life, a life they do not choose, a life they do not want, a life that is superimposed on them.

Therefore, I think we have to develop a pattern of life that guarantees mental exercises; we must detect problems and alleviate these problems before people end up in mental hospitals, and this can best be accomplished through the use of older people, to identify older people who are members of organized groups. We must remove the social barriers to enable people to maximize their potentials, both mentally and physically. Finally, we must remove the myths we have that lead to the values that are so detrimental to older people through education and through actually giving older people a chance to demonstrate their abilities.

Thank you.

Senator Moss. Thank you very much, Dr. White, for an informative, and I might say, inspiring address. I find so much in your statement with which I agree and which seems to me so meaningful for all of us.

Your reference to the Foster Grandparents program that we have been struggling so hard to keep going, was interesting. I have seen the things that you have been talking about. People who are alone and feel they have little worth, but when they have the opportunity to serve, working with children as Foster Grandparents, it becomes a

marvelous world again. And then, too, this is a great thing for the children, of course, but even greater, it seemed to me, for those people who suddenly found that they were needed and wanted, and that they could communicate and could aid those who needed the services that could be rendered.

We must not put them aside unneeded and unwanted. Simply to take care of their physical needs is a travesty and one reason we have fallen into it is the thing Dr. White talked about, the failure to plan for a whole life, to plan what we are going to do.

A person gets all wrapped up in his business or profession or farming or whatever he does, and suddenly he comes to age 65, or whatever time he decides to retire, and there he is, cut off from what he was doing before and he has not anything to go on to, and he cannot go fishing forever.

It would be fine for a couple of weeks to go fishing, but not having anything to demand his attention and his input and his worth, and this is what I think Dr. White so knowledgeably and eloquently told you is the reason you see senility in elderly people. More often they just withdraw into themselves, they do not feel needed, and consequently, reality begins to escape them.

I certainly cannot improve on what Dr. White said, and I am very appreciative of your appearance here, and your very fine discussion, Dr. White.

I am a little concerned about the time aspect. I know some of you want to ask Dr. White some questions. The luncheon will be ready at 1. I might ask, Dr. Walter, would you like to go ahead now, and we will ask you to save your questions for Dr. White, and then you can ask questions of either gentleman this afternoon. Dr. Walter is the director of Medical Care Services of the Utah State Department of Social Services, Division of Health, and is going to talk about health problems of the elderly.

Dr. Walter?

STATEMENT OF DR. BRUCE WALTER, DIRECTOR OF MEDICAL CARE SERVICES, UTAH STATE DEPARTMENT OF SOCIAL SERVICES, DIVISION OF HEALTH

Dr. WALTER. Thank you, Senator Moss.

Dr. Selman, what I will probably do is give my presentation in two parts, the forepart at this time, and then after lunch, I will show the difference between Medicaid and Medicare, so that the members of the group will understand these two programs, especially when I have the backup of the Social Security Administration assist me.

This particular portion of my remarks concerns a number of problems that I presently see in the recent governmental medical system, and I would like to bring out a number of these things which may elicit some questions from you after lunch.

First of all, I have a major concern in one particular area. This is called the Medicare deductible. The deductible now has reached, to my knowledge, the level of $84 before you can participate in the A part of Medicare.

This deductible, I believe, has probably reached the level of being

a deterrent for care, and probably now is blocking the care that some people should seek, and unfortunately, they may seek care somewhat too late. I am advocating, therefore, that the present deductible system be done away with, in new legislation. Since it is probably necessary to find a mild deterrent, a specific charge for hospitalization, for example, could be levied on each first, second, or third day, and then a level of amount of coinsurance or that 20 percent or 10 percent or some other figure could be levied continually thereafter.

This, of course, could be reduced to a lower figure. The deductible, especially on the amount that now exists at the present time, should be eliminated. This would also reduce the present administrative problem.

The second problem is in the area of catastrophic illness. We see problems where one member of the family develops a very major illness. The other member of the family who may be healthy, but sees the family finances depleted at a tremendous rate, or perhaps eventually depleted entirely, and they finally find themselves on welfare.

What I am advocating is a full investigation of the catastrophic area, and protection of the family finances, where the illness is bona fide, legitimate, major, and where the family finances in no way can finance the continued chronic care that is necessitated by major illness.

High Cost of Custodial Care

Next is a companion concern. This is the level of custodial care. Senator Moss also stated that Medicare does not take care of people in custodial categories.

In this particular situation, we run into the same type of problem that I mentioned previously. We have extremely high costs, even if the patient does not require a high level of nursing home care, the cost is prohibitive.

We also find that families have to contribute to the care of one of the family members or grandparents. We find after a period of time that a great deal of resentment is built up by the family, directed to the family member. They have to contribute to the continued care of one of the family members. We all know that in yesteryears, we all used to take care of our family members, especially if we lived on the farm, where it was quite easier.

However, that type of culture has dwindled and many of our people do not live in family farm situations anymore. It is very, very difficult for families to care for them and have to pay out of their wages, especially in our present day, to take care of people for time immemorial.

Another area that I would like to also mention is the area of physical examinations. The physical examination on a routine basis is now not a covered benefit under Medicare. This is the routine type of screening, the checkup, so to speak. This was eliminated in the original bill for a very good reason. This can be overdone and expensive, so what I am asking here is that there be provisions in the new law that physical examination programs under innovative programs can be funded or assisted so that this type of exam can be performed without major expense to the beneficiary.

In Prosser, Wash., the administrator of a hospital and the physi-

cians got together and developed a system. They found there was time during the hospital day that was quiet. There was time when the laboratory and the X-ray room was quiet, so they developed a screening system where the senior citizen paid $6 for the whole year.

For this $6, the senior citizen received a physical examination, a blood exam, a urine exam, a chest X-ray, a hearing examination, and a number of other evaluations.

There was an eye exam as well. These were performed throughout the year, at the hospital, performed by the physicians, and the trained personnel in the hospital, and at slack times when they were not overly busy. The examinations were performed by appointment, organized, and as you might guess, it has been successful.

It is my hope that these innovations could be supported, so that this type of innovative program could be developed many places.

Next is the area of homemaker services. Homemaker services, as you know, is not a benefit under Medicare or Medicaid. However, it is my general feeling that if properly controlled, and properly administered, that homemaker services could be of benefit of medical programs, therefore, by allowing many more people to remain in their homes and enjoy their surroundings when they are infirm. I believe that with this kind of administration, especially through the established home health agencies, that this type of program could be successful. I am hopeful under proper guidelines, that these kinds of programs could be supported in new legislation.

Improving Health Activities

I am also hopeful that home health activities can be improved, and rather than just skilled nursing type services, that they be extended to people who are perhaps not in need of skilled services entirely, but could have lesser needs, and could be supplied with these needs.

I am also hopeful that occupational health activities, which are presently a benefit of the program could be pushed.

Presently, much of our problem is in the area of occupational health which asserts rehabilitation and retraining, could be expanded.

At the present time, we have very few people trained in occupational health, which has been one of the major deterrents of why this benefit has not been widespread.

I know in Price there is an interest in securing funding under certain Federal programs. Funding is unavailable primarily because the expertise in writing the complex grants simply was not here, and I am hopeful that there can be a system developed so that Federal grants, grantmanship can be brought into the outlying areas, or if it cannot be brought in, that there be some simplification of grant-writing so that rural areas and outlying areas can benefit from grants as well as the major metropolitan areas.

We also have a number of problems which we relate to the Federal Government. Some of you probably do not know some of the problems that State administrators go through; however, some of you are experiencing difficulties in going through and getting and applying for benefits, which is somewhat similar.

Essentially, State administrators have much of the same type of difficulty, and I might say sometimes much greater than this.

We are hopeful there will be in the new legislation some stipulations on timely response by Federal administrators so that there can be decisions made, more timely than we are now getting them in the medical field, in the construction field, and in the environmental impact studies field. The latter has been a major problem area.

We are also concerned that now we are going into a period where undoubtedly we will experience greater Federal programs. I hope there will be stipulations in the law that personnel who are in major decisionmaking areas have specific qualifications, education, and experience related to the programs they administer. In many of our areas, we find people making decisions and are in jobs that they neither have the experience nor the education to properly perform the duties.

When this happens, there are delays, difficulties, unhappiness, and defensiveness on the part of these Federal employees. I hope that if it takes more money to employ qualified people for these administrative positions, especially in national health insurance, that perhaps that certain Federal requirements on salaries may be waived for certain positions.

Denial-of-Service Area

I am also concerned about another area, and this is called the denial-of-service area. In many of our programs, we have denial of service. Some of these are administrative, and many we have heard today are part of the design of the law.

This is realistic because there has to be some constraint on finances. However, sometimes there are denials where perhaps they are not in the design of the law.

One of these areas is inhalation therapy, one of which is of some importance in this particular region, because it is useful for people who have lung disease.

This particular benefit was restricted about a year or two after the Medicare program began, primarily because of overuse, and probably some misuse.

It is my belief, however, that this benefit could be returned with proper controls so that people such as the people in this region could receive these benefits.

Now, these are just some of the points I wish to make. I believe they are pertinent perhaps to your particular area.

This concludes the first of my discussion, and if there are any questions, I would be glad to answer them.

Thank you.

Senator Moss. Thank you very much, Dr. Walter, for that presentation, and as Dr. Walter announced, he does have additional information to present after the luncheon which will include some slides and pictures. This undoubtedly will be very informative, and help clear up some of the questions on Medicare and Medicaid which are confusing to many people.

Now, I think this is about as good a time as any to take a luncheon break. I noticed we have some additional visitors that have come in, one very distinguished visitor, Mr. Holbrook. I am glad you came, and Betty is with you also. Mr. Holbrook is an attorney in Salt Lake City.

We are glad you came to listen; today we have been having a very interesting hearing, and should you achieve your goal, this is one of the problems that will be with you in the Senate.

I think the morning has been very productive, and I am grateful to all of you who participated on the panel, and to Dr. Walter and Dr. White, who are sitting here now, and have functioned essentially as a panel. Both are well versed in the problems that surround aging people, as far as health is concerned, and it has certainly been informative to me.

I want to say that I think it is of the greatest importance to have gatherings of this sort.

I want to compliment all of you who have come today. You have been here before, no doubt, for the other meetings, the seminar, and you have given us careful attention; you have asked very good questions, and I hope over the luncheon break you will think of other questions that will shed more light on the problems that plague you and your neighbors. Perhaps together we can try to do better in our society: dealing with the aging process and with those who become older. We have only begun, the job is incomplete. Dr. Selman, perhaps you could announce details of where we go for our luncheon.

Dr. SELMAN. Senator, may I ask my question before we go, because if I am doing housekeeping, I may not get back.

I want to ask Dr. White a question. As director of Community Services and Community Education on this campus, we are wondering now—in your presentation, you talked about mental health, spiritual as well as the physical, and we have Meals-on-Wheels, we have Medicare and Medicaid and all of that, but we cannot get a program going through the legislature wherever it is needed, and maybe Mr. Holbrook could answer it better than anyone, where we could allow the elderly to come into our classes, even though they may not have all of the chairs full, to come in without any charge for tuition, because it is set that we have to charge so much.

Now, maybe someone can tell us how we can work on that. This is one of the things that came up yesterday in our session.

Senator Moss. Thank you very much. We will recess, and it looks as though we ought to be able to get back here about 1:30. We will start as soon as you are back.

[Whereupon, the subcommittee was in recess at 12:50 p.m.]

AFTER RECESS

Dr. SELMAN. Senator Moss has asked to be excused. He is opening a thrift store in Helper for the Community ACTION people, and has other obligations, and so Val Halamandaris will be presiding over the rest of the hearing.

Mr. HALAMANDARIS [presiding]. Thank you very much. I want to say that it is a real pleasure for me to be back home here at the College of Eastern Utah, to see so many old friends and to make new ones. When I was in school here I ran for office. I had developed such a large head from being president of the high school that my friends decided that it was time that I be put in my place. They did that very successfully, by electing the other fellow. Thereafter, I went to Washington, D.C., and I found that was an even more humbling experience.

I would like to say I am very grateful for the opportunity to see so many of you here, and I would like to introduce Peg Fayé, who is at the table, representing the minority staff.

To give you a bit of background, the Senate Committee on Aging has Democratic and Republican members. The Democrats are in the majority at the present time, so we have more people, that means Peg and the people with her have to work a lot harder than we do.

She is representing Senators such as Edward Brooke, Charles Percy, and Hiram Fong from Hawaii, the ranking member of our committee. If in the next election, the Republicans should gain control of the Senate, Senator Fong would be the chairman of the Committee on Aging, and most likely I would be grossly overworked or looking for work, one or the other. But at the present time, the committee in its daily dealings is nonpartisan. We work together very well, united in our attempt to help older Americans. If I may, I would like to turn the presentation back to Dr. Bruce Walter, and I hope I can prevail on Dr. Melvin White to come back to the table, with Mr. Peterson and his people. Ultimately I would like to have all of you sitting back here so you could help receive any questions after Dr. Walter is through with his presentation.

Thank you.

Dr. WALTER. I wish to make the presentation this afternoon informal, as informal as possible. If there is anything that you would like to ask in the way of a question during the presentation, please do so.

I am going to present a short course in Medicare and Medicaid, and some related information on various health care programs. This will be an overview of the programs.

We will be very happy to answer questions. We have Mr. Peterson here who can give you almost any information concerning Social Security programs.

I would like you to examine the initial slide carefully for one reason. This is the key in the medical programs as far as facilities are concerned in the care of people in hospitals and nursing homes, and so forth.

EXHIBIT I—LEVELS OF CARE

1. Hospital care:
   - A. Intensive.
   - B. Acute.
   - C. Advanced.
2. Skilled nursing care:
   - A. Hospital S.N.F. (E.C.F.)
   - B. Freestanding S.N.F. (E.C.F.)
3. Intermediate—High.
4. Intermediate—Low. (Personal care in Utah.)
5. Residential health care:
   - A. Supervised.
   - B. Managed.
   - C. Guided.
   - D. Day, night, clinic (<24 hrs. care).

It is important for cost and quality of medical care. It is a key that Senator Moss has to be concerned with every time he writes legislation. The use of these facilities are associated with dollars, and also the use of them are tied to the quality of medical care, because they each give a different kind of care.

The whole point and whole purpose of a medical program, when it comes to institutions, is placing the patient in the right kind of facility so the patients may receive the care they need.

It is that simple. However, regulating this is not too simple. I would like to just go through this and give you the information because it will have some bearing on your questions.

First of all, these are the five levels of care which the Association of State and Territorial Health Offices has endorsed. They have printed 7,000 copies of this concept and its explanation.

Essentially, at the top you see hospital care. As far as hospital care is concerned, we have intensive care. Some hospitals intensive care may run somewhere between $100 and $200 a day, so hospital care then, in an intensive care unit is a consideration that everyone has to think about, because it is very costly.

It is also very essential for those that belong there. Acute care is the standard hospitalization, and advanced care is a new concept where an effort is being made to reduce the amount of nursing needed while still in the hospital. It saves about 20 percent on the hospital bill.

The next is skilled nursing care. This is also known as in the past as ECF care. We still have the ECF name present, but all are called skilled nursing care at present. The slang term in Government is SNF.

This particular type of care can be delivered in a hospital, in a section, or it may be in a free-standing nursing home.

In many of the hospitals of the State, some 25 of them have skilled nursing services in these hospitals. This is by grace of a project which Senator Moss has helped bring to us.

The next is the intermediate care, that is a level of nursing home care also, and intermediate low or personal care in Utah is another.

There are three nursing home levels of care, two, three, and four on the chart.

The welfare program is an example. It gives you an idea of costs, the board and room costs only pays $16.59 for number two, about $10.50 for number three, and around $8.50 for item number four.

That is board and room only. All other services are extra.

Levels of Care

Now, we get down to the fifth level of care in an area that we are developing in this State, and it exists elsewhere as well, which is a particular living area for those people who need a little supervision, or a little help, but really do not need nursing care. We have three levels of this type of care, we call supervised, managed, and guided. They are less expensive homes, and they will probably run somewhere in the general area of $5 a day.

The next one has to do with day care, we have geriatric day care, day care for mental patients, day care for children, and there also is care for people at night who do various activities in the day time, but spend time in an institution at night.

So this gives you sort of a general idea of the entire system that we have for delivery care to people who need institutional type services. There it is, the whole thing. The "machine" that runs this is called the utilization review program. They indirectly regulate the levels of care of where the patient should be. Some of you may well have been

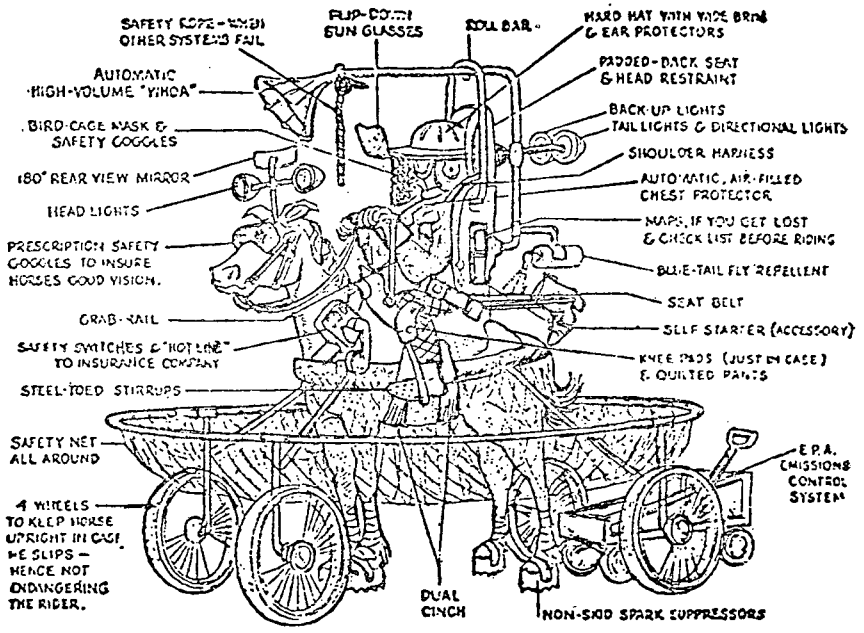
involved with utilization review, if you have been in the hospital. This is when your doctor said, "the committee says you have to go home."

That is utilization review, and that is what protects this system. There is the whole story of levels of care on one slide.

I am going to describe Medicare and Medicaid to give you an idea of what they are. Some of you may have some problems as to what these particular programs are, who they benefit, who could use them, and just how they were developed.

This slide will give you an idea of some of the regulations that came out on the occupational safety and health agency, and believe it or not, the person who is on this horse underneath all of this is supposed to be a cowboy. These are the restrictions they placed on the cowboy to make it safe for him to do his job, and, as you can see, there is a net all the way around him.

EXHIBIT II



The Environmental Protection Agency has provided him with a cart to go along behind to catch the droppings. There is of course a seatbelt, headlights, a horn when the horse cannot hear, and of course there are hearing aids for the horse and all kinds of other things to make absolutely sure he does not have an accident. I can see him catching a calf.

I would like to give you an idea of these programs.

Medicare, of course, is a program that most all of you are very familiar with. I want to make sure that you know that it is an insurance program. It is not an appropriation type program. It has limitations, and the moneys come from the Social Security trust fund.

Medicaid, however, is a different type of program. It is an assistance program for people who qualify for it by virtue of lack of income and lack of assets.

The money comes from taxes, and it comes from the Federal Government, the State government, and county government as well, under some circumstances.

I agree that in our particular State, the majority of the money comes from the Federal Government.

Medicaid is for certain needy and low income people. Essentially, it is a complete care program for everyone, whether they are 100 or whether they are 1 day old, in our State. You will see a little quip on the bottom where it says, "Some States also at State expense, service other needy people."

In our State, where some people who are not on welfare have a very major illness, Medicaid can help them. This is called medical assistance only. It will help people who have low incomes, but are not on welfare as long as they qualify under the provisions of the program.

It is still a low income program, however.

Medicare is actually a Federal program. It is the same all over the United States. The benefits come and the arrangements are the same.

Medicaid, however, is of great importance to you, because it is basically a State-run program. It does vary, and, for example, if you are eligible for Medicaid in the State of Utah, you may not have any eligibility in the State of Colorado, whereas with Medicare, you are. This is very important.

In Utah, our particular Medicaid program is very comprehensive. It takes care of almost everything. We are, I believe, one of two States that have very comprehensive and complete programs.

Again, Medicare is everywhere in the United States. Medicaid is almost everywhere. Medicaid was operational in only 48 States, and in certain territories. Alaska has the program, and we understand that Arizona, the last remaining State, has opted for the program. We will have Medicaid in 100 percent of the States.

EXHIBIT III

MEDICARE

Is A FEDERAL PROGRAM

BUREAU OF HEALTH INSURANCE

SOCIAL SECURITY ADMINISTRATION

MEDICARE Is THE SAME ALL OVER THE UNITED STATES

MEDICAID

Is A FEDERAL-STATE PARTNERSHIP

STATES DESIGN THEIR OWN MEDICAID PROGRAMS WITHIN FEDERAL GUIDELINES

MEDICAID VARIES FROM STATE TO STATE

EXHIBIT IV

MEDICARE

IS EVERYWHERE IN THE

UNITED STATES

MEDICAID

IS NOW IN 49 STATES, THE

DISTRICT OF COLUMBIA, GUAM,

PUERTO RICO, AND THE VIRGIN

ISLANDS

EXHIBIT V

MEDICARE HOSPITAL INSURANCE

PROVIDES BASIC PROTECTION AGAINST COSTS OF:

- INPATIENT HOSPITAL CARE
- POST-HOSPITAL EXTENDED CARE
- POST-HOSPITAL HOME HEALTH CARE

MEDICARE MEDICAL INSURANCE

PROVIDES SUPPLEMENTAL PROTECTION AGAINST COSTS OF PHYSICIANS' SERVICES, MEDICAL SERVICES AND SUPPLIES, HOME HEALTH CARE SERVICES, OUTPATIENT HOSPITAL SERVICES AND THERAPY, AND OTHER SERVICES.

EXHIBIT VI

MEDICAID

PAYS FOR AT LEAST THESE SERVICES:

- INPATIENT HOSPITAL CARE
- OUTPATIENT HOSPITAL SERVICES
- OTHER LABORATORY AND X-RAY SERVICES
- SKILLED NURSING HOME SERVICES
- PHYSICIANS' SERVICES
- SCREENING, DIAGNOSIS, AND TREATMENT OF CHILDREN
- HOME HEALTH CARE SERVICES

IN MANY STATES MEDICAID PAYS FOR SUCH ADDITIONAL SERVICES AS DENTAL CARE, PRESCRIBED DRUGS, EYE GLASSES, CLINIC SERVICES, INTERMEDIATE CARE FACILITY SERVICES, AND OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

Now, these are the basic ideas of the programs. Medicare provides these types of services. These exhibits will give you some general idea of what it provides. We will go into some of the specifics a little later, but this is generally the program. It has limitations, and a number of things that it does not pay for.

(See exhibits III–VI, pp. 1037–1040.)

It does not pay for intermediate care, which, if you will recall, was number three in that list of facilities.

Medicaid, however, does. This gives you the two types of Medicare levels of service in institutions.

Part A is something you are, I am sure, all familiar with, the hospital coverage and certain other services which relate to it.

Part B is essentially physicians' care and other services, primarily related to people who are on foot, ambulatory, move around, come into the office, and so forth. This is where you pay every month for this particular coverage.

Actually, the Federal Government also pays part of the premium as well. You do not pay the whole cost. You pay only part when you pay the monthly benefit, which I believe started at $4, and now it is $6.30. This is the program called medical insurance and it provides a whole host of activities for your care.

Medicaid, for those who are eligible, provides all kinds of services, a very sweeping amount of services for the people of Utah.

It also pays for things such as drugs on an out-patient basis, which of course Medicare does not, and these will give you an idea of what it does cover.

Now, in Medicare, it pays part but not all of the hospital, and if you remembered my comment before lunch about deductibles, this is one of the problems that we have in administering this particular program, primarily because people do not understand the deductible problem.

There is also another aspect called coinsurance, where you pay part on a daily basis. This is one of the things that people should understand, but generally do not.

Again, the deductible, that initial amount is now $84. It becomes a major problem for some Medicare recipients. This will give you an idea.

Now, the medical insurance part pays essentially 80 percent of the costs, you pay 20 percent. One of the ways that people who are on Medicare can help their situation is by buying supplemental insurance to pay the 20 percent or that other dollar out of the $5. Many do that.

Medicaid for those people who can't afford to pay for the deductibles, the amount of money you have to pay before you get the service, and what we call the coinsurance which is that extra percentage, Medicaid, for those eligible individuals, can pay so that it does not cost the people out of their pocket. They get their Medicare benefits and the extras that they would normally pay for can be paid for by Medicaid, allowing them to get the services.

[Voice From the Audience.] Medicaid pays the Medicare premium?

Dr. Walter. That is correct. Mr. Peterson reminded me of an important item, in this situation in the State of Utah, the Medicaid program for the eligible people pays the premium, plus the deductible, plus the 20 percent payment.

Again, the $6.30 for part B is paid by the beneficiary. The Federal Government is a partner in this particular situation by paying another $6.30.

I want to emphasize to you again the partnership arrangement of Medicaid so that you understand the arrangements of how things are paid. This, essentially, as you see, is a range where the Federal Government contributes from 50 percent of the dollars spent for Medicaid people to up to 83 percent. Utah is not considered one of the very poor States. I want to give you an idea of the general system that we have. Both Medicare and Medicaid came about through the Social Security Act, and they are called title XVIII for Medicare and title XIX for Medicaid. Those terms that you see and hear so many times, that is what they are, the same name for Medicare is title XVIII, the same name for Medicaid is title XIX.

Now, that concludes my little presentation to describe these programs, how they work, and what they are. [Applause.]

Mr. HALAMANDARIS. Thank you very much, Dr. Walter. Your prepared statement will be inserted into the record at this point.

[The prepared statement follows:]

PREPARED STATEMENT OF BRUCE A. WALTER, M.D., M.P.H., DEPUTY DIRECTOR OF HEALTH, UTAH STATE DIVISION OF HEALTH

Thank you for this opportunity to share with you some of my viewpoints on health care as I see them in my position in the State of Utah. As a medical administrator I have a number of problems which prevail in the delivery of medical services. Some of these concerns are primarily problems of older persons who are the major users of medical care and, in particular, of hospital services.

A number of the items I will discuss relate to administrative problems which, in some cases, reduce the effectiveness of the delivery of medical services or, by design, make these services more expensive.

I. MEDICARE DEDUCTIBLE

The first problem concerns the current Medicare deductible now required by the title XVIII program. It is my belief that the deductible has now reached a level which may well be restricting needed care. The present procedure also causes an expensive, disagreeable and administratively unworkable system. It is very difficult for a provider to find out how much of the deductible has been taken care of and utilized. This, in turn, causes disagreements, displeasure on the part of the patient, and an excess of administrative work to determine the present status for billing purposes.

I believe this dilemma could be resolved by developing a standard coinsurance program without the use of a deductible. If there is concern about the early expenses and the desire to reduce the unneeded utilization of hospital services, I would suggest that the coinsurance amount be higher on the first, second, or third day, and then dropped to a standard rate. This process would be clearly understood by both the patient and the hospital business office alike. The patient would pay a preset share of his/her initial hospital stay costs; thereafter, the standard, coinsurance rate would become effective. It would also be possible to charge the same daily coinsurance rate for all days, depending on the desirability of the program.

I am hopeful that coinsurance, or a standardized shared amount of money for hospital days, will be adopted and the deductible be eliminated.

II. CATASTROPHIC ILLNESS

It has been difficult to understand why the program is restrictive on the person who has a very major illness. It is generally understood that it is easier to find money early in the illness to provide deductibles and coinsurance, but it is extremely difficult after one has been ill for a long time; even the wealthy may need assistance after a very long illness. It is, therefore, my request that provisions be made for catastrophic illness, controlled by reviews, so that those recipients who have truly a major illness have their expenses covered so that they do not suffer more than others.

III. CUSTODIAL CARE COVERAGE

In America, it has been in the past the province of the family to take care of its own members. This, of course, posed only a relatively small hardship on the farm family of yesteryear; they could more easily take care of a loved one within the confines of the family unit which generally shared a reasonably cohesive life on the farm, producing much of their own food and creating fewer economic problems in caring for an aged or infirm member. In the present day, with the change of living patterns, custodial care becomes a major economic drain on the family. Even families with many working children find that long and continued care becomes incredibly burdensome and difficult, leading to concerns, guilt feelings and sometimes outright hate of the infirmed or aged family member.

The other concern is that if a spouse in infirm, very frequently all savings and

other moneys are exhausted before assistance is granted. This could leave the surviving member of the family, who may be able and interested in living, destitute for the remainder of his/her life.

I therefore ask that appropriate provisions be made, with proper medical and utilization review to cover these types of circumstances as in home care situations, nursing homes, and other facilities.

IV. Denial of Services to Title XVIII Recipients

We have experienced in the past somewhat arbitrary denials of supportive services for Medicare recipients. Sometimes this is done retrospectively but at other times it is done in a prospective situation. Just such a case involves inhalation therapy; admittedly, this service may be overdone under some circumstances, but it appears to me that under proper review and guidelines services of this type can be re-examined and permitted in a nonhospital setting.

V. Physical Examinations

It is my hope that physical examinations under Medicare be allowed with certain restrictions. We are presently examining the Prosser program, developed at the Prosser Memorial Hospital, Prosser, Wash. This program utilizes the standby time of personnel and other hospital services to perform physical examinations.

Ideally, flexibility can be built into the medical program allowing for the support of innovative programs such as this one to provide physical examinations. Supportive laboratory procedures, as well as other evaluations, could also be initiated. The main purpose of such programs is to provide alternative means of dealing with necessary, routine procedures. Since the costs are low, I urge flexibility for programs of this type.

VI. Home Health Services

I believe that, when properly administered, home health services can be of considerable benefit to the people. On a number of occasions we have had problems determining whether the services offered are custodial or whether they are more in the line of convalescent care. I hope that this rigid ruling can be relaxed so that needed services can be provided under appropriate guidelines and controls.

VII. Homemaker Services

Homemaker services are not presently a benefit under the Medicare program. It is our belief that, properly administered and with appropriate guideline, these services can be made a benefit which could be a major factor in assisting people to remain in their homes. Such a program may prove to be a financial benefit to other Federal programs by inhibiting institutional placement.

I urge a review of this program and inclusion of these types of services, under suitable guidelines, be added to the forthcoming Federal legislation.

VIII. Education in the Use of Health Services

As I have stated previously before this committee, I have a particular interest in educating recipients of our health programs in the proper use of benefits. Though there has been some improvement in the brochures describing benefits, it appears that more complete efforts should be made.

Subsequently, I hope that further explanations of the utilization review process be described in appropriate terms to help prevent the improper use of benefits.

IX. Administrative Problems

A. Appeals Panels

We presently have channels through our elected officials, such as you Senator Moss, to handle the problems of people in reasonably major situations, but we have found a number of areas on the local level where the appeal mechanism is cumbersome and nonresponsive to the needs of the people. It appears that we need an arrangement for either State or, in the case of large counties, county panels of appointed individuals to review adverse problems and complaints of coverage in Federal programs.

It is my hope that an appeal mechanism can be set up with representatives

of District Office, SSA, State personnel office, and consumers to act in behalf of individuals with grievances with the Federal system. This organization could handle the many small items which are vexing and in the opinion of the recipient an injustice, by adding some amount of expertise to the appeal.

B. TIMELY FEDERAL RESPONSES

We have found in many Federal programs in the health area a very serious delay in response. This is especially true where grants are involved, but is found in many other areas of a routine operational nature as well. It is our hope that certain administrative changes can be developed in the Federal system so that timely responses to requests can be forthcoming.

At the present time we have instituted in one of our State agencies a situation where, if the State response is not timely, the request by the individual is automatically answered in the affirmative. I am not advocating that the Federal Government adopt this particular system, but some exploration as to turnaround time of responses seems to be in order, especially in the health area where time may mean the difference between life and death.

C. QUALIFICATIONS OF FEDERAL DECISIONMAKERS

Since the health of the individual is a more critical concern than many other activities of government, it would appear that having qualified Federal employees placed in decisionmaking positions is of the utmost importance. We are continually faced with the placement of long-standing government employees in positions where they are neither experienced, trained nor otherwise qualified for the demands of the position. This leads to delay, insecurity on their part and, finally, adamant stands on issues which they do not understand.

I would urge that more stringent personnel requirements and job descriptions be exercised at the Federal level and that jobs not be filled unless qualified people are recruited. Congress should examine the pay scales of decisionmakers, especially those who may administer a new, more encompassing national health insurance program, and place restrictions within the law so that only qualified personnel occupy these decisionmaking positions. If it requires exemption from the national pay scale to recruit properly qualified personnel, I would hope this provision would be placed in the legislation.

D. ADMINISTRATIVE DIFFERENCES BETWEEN LARGE STATES AND SMALL STATES

We find in many of the Federal laws and regulations that no provision is made for flexibility in the administration of health services and health programs between large States and small States. Many of our smaller States find that certain innovative systems, which because of lower volume within the State have promise to become workable innovations that are more efficient than those required nationally. On the other hand, large States may find that these systems are unworkable because of their large volume of program participants.

We urge that flexibility in administrative methodology be written into the health care laws so that the programs may benefit from these different methodologies. We also urge, in a similar fashion, that flexibility be developed in regulations, as well as in laws, so that the administration of programs for small hospitals be somewhat different and more appropriate for their needs than an overall program designed for large hospitals.

A like problem exists in several types of programs for rural health delivery systems versus urban health delivery systems.

X. Hospital and Nursing Home Reimbursement

Since our hospitals and nursing homes need large numbers of personnel whose wages are increasing and utilize supplies which are becoming more expensive, with increasing Federal standards to meet, it has become increasingly necessary that hospitals and nursing homes be reimbursed by the Federal Government for the full cost of all bona fide expenses. The majority of hospitals and nursing homes must rely on reimbursements for patients to pay for these supplies, personnel and services. If these moneys are denied there is no other source than the private patient, donations or other small sources.

I urge a realistic reimbursement system, in light of the increased financial demands upon the present system.

XI. Technological Changes as Related to Hospital Costs

Perhaps the least understood reason for increased hospital costs is the ever-present need to respond to technological advances. Though we have some difficulty in this area, due to duplication, it is generally required that hospitals provide the new equipment, services or structural changes necessary to keep up with these technological advances that benefit their patients. Provision must be made in the realm of reimbursement so that these changes are adequately reimbursed and understood by Federal personnel.

XII. Hill-Burton Program

Certainly one of the most successful programs in recent history is the Hill-Burton program. This program, which has been at times criticized mostly by persons who are unfamiliar with its activities or who are not aware of the changes in planning over the years, has been eminently successful in improving the quality of services in the State of Utah. It has provided the needed financial support for improvement where, if the program had been lacking, services would not be available at all.

A number of new programs have come up in recent years which have fallen short of the mark of success achieved by the Hill-Burton program. This is all the more reason for our hope in the continued support for the program with its grants and loan guarantees.

This program has a qualified cadre existing in most states, which provides a basis for planning and the expertise needed for other grant organizations throughout the country.

XIII. The Four Corners Regional Commission

Although this commission supports activities of all kinds, I wish to express my support and commendation for the program and its administration. I believe it has been of great benefit to the Four Corners Region and hope that it will continue to aid the people of this region in the same manner.

XIV. Residential Health Facilities

In Utah we are finding that there is a need for a primary level of supervision and support for the aged and infirm in our society. This, the fifth and lowest level of care, was developed by the Association of State and Territorial Health Officers. It can provide a service to those people who are still able to care for themselves but yet require some supervision, management services or assistance in arranging living functions. This level, if properly developed, can provide low cost but suitable housing for persons who are in need of this type of assistance. I am hopeful that monies can be made available to care for these persons or, where necessary, supplement their incomes for this level of assistance.

XV. Federal Funding for Certification of Health Facilities

The 100 percent funding for surveyors was inadvertently passed with a termination date of June 30, 1974. We strongly urge that this 100 percent Federal funding for certification activities be extended beyond the present termination date.

XVI. Flexibility in the Use of Health Facility Beds

Through the support of Senator Moss on this committee, we are presently engaged in a program which allows local control and usage of hospital beds for varying levels of care at the discretion of the medical staff and administration of the hospitals. This program was designed to bring local input into a Federal program and, in the process, benefit the local people by allowing the use of empty beds in their own communities, when appropriate, for levels of care other than acute hospital care. This reduces the transfer of patients away from their homes in areas which are either without nursing homes or have homes that are full.

It is believed that this program provides superior services for convalescent and rehabilitative types of patients, as well as for those who need more intensive physician supervision. There are also economic benefits by using standby empty beds which would otherwise not develop revenue. This particular program also provides for flexibility at the local level, thereby assuring the persons of beds for needed services.

Mr. HALAMANDARIS. I would like to have Dr. White come back up, and Mr. Sterling Peterson, and your colleagues.

At this point, we would be happy to entertain any questions you have about your particular health problems, experiences you might have had with Medicare, Medicaid; anything left unclear in your minds.

Mrs. WARDE. I am Mrs. Madge Warde, we live close to Grand Junction. A lot of our people are sent over there, and I am just wondering, in Colorado, they have a different Social Security, Medicare, and Medicaid. How much difference would it be than it is in Utah?

Dr. WALTER. We look after our own. In this situation, if you are a Utah citizen and eligible for Medicaid, we will pay Utah rates, benefits, and so forth; in Grand Junction, Cortez, or wherever you might go in Colorado, as long as you were an established recipient and have a card from the Medicaid program in Utah.

Mr. PETERSON. Another piece of that question, if I might respond, I think you inferred that Medicare was different in Colorado than in Utah.

Just to make it a clear distinction, as Dr. Walter did earlier, the Medicare program is the same in all States, all jurisdictions, counties, cities, hamlets, road-crossings, wherever.

The contributions are the same, the deductibles are the same, the coinsurance is the same, as well as the benefits, no matter what hospital you go into, whether it is an extended care facility, home health agency, doctor, clinic, Medicare is the same in all of the States.

Mrs. WARDE. Would that be the same in Hawaii?

Mr. PETERSON. Yes ma'am.

Mrs. WARDE. Thank you.

Mr. HALAMANDARIS. Mr. Galanis?

Mr. GALANIS. What do you have to do to sign up for Medicaid?

Dr. WALTER. You would have to go to an assistance payments office. It is a State office, and you would call or go to the assistance payments office, tell them that you are interested in Medicaid. They will talk to you, fill out a form, and find if you are eligible.

If you are, you will receive a card, and you may present that card for your health benefits.

ELIGIBILITY REQUIREMENTS

Mr. GALANIS. Because I am under Medicare, Social Security disability, but I was just wondering, what you had to do. Thank you, sir.

Dr. WALTER. Mr. Galanis, I wanted to mention the eligibility requirements. They are somewhat complex, and they have income limits as to property, and they have limits as to funds that are available and are equivalent for cash.

They do have limits, and I am dodging those limits because they are variable.

Mr. HALAMANDARIS. Mr. Peterson?

Mr. PETERSON. If any of the senior citizens of Carbon County will look in their last newsletter, they will find the letter from the assistance payments manager of our office down here, wherein he invites anyone to come into the assistance payments office to get this information,

which you are unable to get, because I tried to get it out of them, as to what the actual eligibilities were, and like you say, as far as I could find out, they were mighty complex, so I would recommend that any of you who have got these letters in Carbon County, just read this.

It is a nice letter from the Utah assistance payments management office, and if you do not have them, we have extras down at the senior citizens' center.

Mr. HALAMANDARIS. Any further questions?

Yes, sir?

Mr. BROCKBANK. My name is Orlon Brockbank, and I would like to know if this Medicaid, do you have to pay that out of your own pocket? Is there any way you can deduct it from your Social Security?

Mr. PETERSON. I am not sure I understand completely your question, and I am not ducking it. Could you explain it to me again, please, sir?

Mr. BROCKBANK. In this Medicare, there is a deductible in your Social Security.

Mr. PETERSON. May I interrupt you there? If you are drawing Social Security benefits, and you choose to want to have the medical part B premium paid from your Social Security check, then that part B premium is withheld from your regular Social Security payment.

Now, if you would proceed with your other part of your question.

Mr. BROCKBANK. With this Medicaid, would we have to pay that individually out of our own pocket?

Dr. WALTER. If you are eligible for Medicaid benefits, either under the regular welfare program, or for the medical assistance only. In medical assistance only, where you do not receive a welfare check, you would have an illness which is too expensive for your income, then you do not pay any premium to Medicaid.

Mr. PETERSON. Once again, do you have any brochures, or anything which will give a skeleton view of the more pertinent deductions, or eligibility requirements in the Medicaid program that we can have to distribute to our senior citizens from the various places, or in our case, put in our monthly newsletter which reaches around 2,000 senior citizens; if you have something of that nature, I think it would help us, even if it is not complete, just give us a kind of overview, which we would certainly appreciate having it to print.

Dr. WALTER. I would hope that you would contact your local assistance payments office. Because of the complexity, I would be worried about publishing the whole list, however, they may give you some rules of thumb, or guidelines. I believe that would be up to them to do it.

I do not know of any publication that exists that spells it out. That is changeable, and therefore, I would see what the assistance payments office would give you in the way of a letter that you might be able to publish.

INFORMATION ON MEDICARE PROGRAM

Mr. PETERSON. We do have a letter, but they did not find it was convenient to give in this letter any specific amounts or any specific information as to who would be actually eligible as far as moneys they would make or receive from properties or somewhere.

I do not think he wanted to put his neck out, so I am asking more of the heads to give us some of this information if it is possible, and I cannot see why it is not possible.

Dr. WALTER. I think the main reason he is not doing that is not because he is concerned about anyone criticizing him. I think it is because it is complex, and you may have a little more in some category, and a little less in some other. They may be able to work this out in the way of limitations, so it is not a hard and fast rule for each one of these categories.

I think what he was telling you was you might publish something people would misunderstand. I do not think it is because of criticism or anything of that nature. I think he is doing a service.

Mr. PETERSON. Say this person was making $2,500, is he one of those that can come to talk to them to chase down the eligibility?

This is what I was trying to get at, just an overview. There is no use in him being bothered with a lot of people who know that they are not eligible, and, personally, am I eligible? I do not know if Elaine here is eligible, she does not know. She said she is not 60 years yet, but I know I am eligible in that respect, because I am 73.

Mr. HALAMANDARIS. In fairness, I think I had better take Dr. Walter off the hook. This is not really his responsibility.

It is the responsibility of some other people who work in your State capital, and with your permission, Mr. Peterson, I will send them a letter to get you some rough ballpark figures.

My advice is that if there is any chance you are eligible, go down and present yourself. In the case of the State of Maryland, they allow you to have $2,500 worth of assets, and they exclude from that your house, if you own a house, regardless of the value, and they exclude any automobile, regardless of the value of that, and assets are defined to mean cash or securities, or the value of an insurance policy which is above $2,500.

As far as income, that does not matter in Maryland, because whatever income you have, they will take and apply it to the particular service you want. If you want nursing home care in the State of Maryland, and skilled nursing, what Dr. Walter called skilled nursing facility, SNF, the rate the State pays for nursing home care is something like $400 a month.

If you have a Social Security check that pays $200 a month, that check will be applied against this $400 bill, so roughly that means that your nursing home bill, $400 a month, will be paid for, half of your Social Security check, and half with the State's money. That is the way the system works.

If you had more income it wouldn't matter.

Again, there are great variables. Each State is different. The income matters in some States, the assets is what are important in other States; income meaning the dollars that you have coming in, assets meaning what you manage to acquire by way of property.

Standards vary, and the only way to be certain is to go to the office and ask: Am I eligible?

Dr. WHITE. You may want to invite people in to talk to some of your groups, and perhaps they can answer questions.

Mr. Peterson, if you would like to have similar kinds of infor-

mation on the Medicare program; if you do, we have readymade literature.

Mr. CARL PETERSON. I think we are fairly well off on the Medicare.

Mr. PETERSON. Of course, as Dr. White suggested, we would like to have somebody visit your group.

Mr. CARL PETERSON. I would say we have need for information, we are servicing 3,500 senior citizens and we have tried to get information. We did get a start, and if it will get us some of the salary information so we can give them some sign of a ball park figure, so that the poor guy down here is not deluged with a lot of people coming in here, I know I am not eligible, but I can go in there and find out, goodness, why should I, if I know that I am not eligible. This is what I am trying to find out.

Mr. HALAMANDARIS. OK. We will try to get the information for you, and I think we will be able to arrive at some rough ballpark figures, which is all you are asking for.

Dr. Walter warned you of that, and we will do the best we can, and again, my best advice, if you find somebody who says he is poor, send him in there, because he is probably eligible.

Now, do we have any more questions on any subject of aging?

Dr. SELMAN. I want to know what we can do to get free tuition for the elderly for the college.

Mr. HALAMANDARIS. The question is what can we do to get free tuition for the elderly.

Again, when you need something, and you do not have it, you have to look to your elected representative, so you point your finger at me, you do what Elaine Jensen did, grab me by the arm, she said: "Were you paying attention when I was talking? I did not come here just to shoot my mouth off. I was trying to get a message across. Here is the message again, a, b, and c."

You have to break it down fairly simple for those of us who are in Government. Once you have managed to get our attention, generally, you will get some results.

COMMUNITY SCHOOLS LEGISLATION

We are now working on a comprehensive bill, some legislation sponsored by Senator Frank Church, we call it our community schools bill, which will make available community facilities, the schools we use by day, and lie vacant by night, so they can be used by senior citizens, the schoolbuses we do not use by night, could be used, the ones we do not use in the summertime, again, could be used to some greater purpose. You were making some comment to this point, Dr. Selman, when we first came in the other day, it makes little sense when we have a valuable resource not to use it full time. For us to neglect the valuable resource and wisdom that all of you have obtained by the mere fact of living, to be 60 or 65, is ludicrous and a ridiculous situation, and I give you my promise, I will give you my efforts to move along Senator Church's community schools bill, and I have some belief that we will be successful in getting that enacted later this year.

Senator Church has been pushing for it very hard, and I see some signs of agreement within the Congress to enact the legislation, so I can offer you some hope there.

Dr. WHITE. There are a couple of things.

I was talking to President McDonald, and he indicated he would like to take steps in this direction, but there was a recent study, I would assume the information is available now by the Adult Education Association, on the number of places providing services to older people, and as you know, some private schools do provide reduced tuition to older people, but I think as far as the State is concerned, we might work together with the colleges and with some of the institutions that have some of the same interests, and maybe again go to the board of regents with a concerted kind of effort with all of us joining together, with this information, and to show what is being done, and can be done.

That is another suggestion that we might approach, away from the Federal aspect of it.

Mr. HALAMANDARIS. One last thing, we all tend to look at life from our own narrow tunnel of vision, so when you ask me about a problem in responding to legislation, I think of the Federal angle.

Just as important is the State angle, and Dr. White mentioned it. You have a State legislature, and the State legislature can promulgate legislation just the way the Federal Congress can, and Peg Fayé just pointed out to me that in her own State of Hawaii, that they have recently enacted just this kind of legislation, so if you were over there, and you were a senior citizen as most of you are, you could go to school free, just because Hawaii had enacted this into legislation.

If all of you get together and approach your elected representatives, your State senators, and those members of the House of Representatives of your State, it is possible you could get a similar bill passed through the Utah State Legislature.

Senior citizens are becoming more and more important. You saw some sign of that today.

My advice is: become increasingly politically active, and learn what is happening, and perhaps run for office yourself.

That very nice lady in Oregon, Mrs. McCall—mother of the Governor—was going to run for the governorship, but dropped out after she had dramatized the point that we are treating our senior citizens very shabbily. My advice to you, call the members of the State legislature and see what you can do with getting legislation introduced on the State level, and let Senator Moss and others worry about the Federal level.

Dr. WHITE. Maybe you tried this already, but another possible approach is to involve the community school people, because they do have the backing already of the State legislature, and they would just expand that concept and get some leverage that way.

Dr. SELMAN. Thank you.

Mr. LAPTHROP. My name is Fred Lapthrop, and I understand the way we work it, we are a nonpartisan militant group, and we go up there to the mass meetings with all of the people that we can get from our group, and almost take control.

Thank you.

Mr. HALAMANDARIS. That is strong language, but, you know, there is a group in Philadelphia, that call themselves the Gray Panthers. These senior citizens believe you need political action if we are ever going to get anything changed.

The days of going down to St. Petersburg and lying in the sun are all over. Just because you reach 65 does not mean you stop thinking, or you stop caring. It just means that the society has not realized your potential, and if all of you band together, you will be a sizable force, I think you should do just that.

Until the senior citizens of this country do that, I do not think things will change very much.

Mr. PETERSON. This might be of interest to some of the others.

In our newsletter, which sometimes takes as much as four or five pages, this next one will be a statement from the two aspiring Senators, and also a statement from the council advocating that all senior citizens go to the grassroots and go to their mass meetings.

It will give a detailed statement of where the mass meetings are for each political party, starting on the 20th, the 20th of next month. I believe this will give us quite a bit of clout as far as we are concerned.

We are not political as far as the council is concerned. I am, of course, a Democrat. We are not supposed to have any Republicans in Carbon County. We have one right here. My wife is chairman. I see another one over there.

Mr. HALAMANDARIS. It does not really matter. We do not concern ourselves about the party affiliation. You want to get people working for you that represent your interests.

I think this Watergate business proved one thing, that a lot of us when we get back in Washington, forget we are working for you. You are the ones that pay the taxes, April 15 was not so long ago, and those of you who put the check in the mail know you are paying a great deal, and in many instances, you feel that you are paying far too much for what you are getting.

You have to have some say in the choice that we are working for you, and we need your direction.

Are there other questions?

Dr. WHITE. This is still a comment on that question Dr. Selman raised. I feel we can get it through the State legislature, and it will have to be a coordinated effort of most of the councils on aging in the State.

If you want that, and nobody puts it in as a priority, and I would imagine the best way is to try to work this through the Division on Aging, and try to see if you can get a coordinated effort here, so you are all saying the same thing.

In this way, they will be more receptive. I know my experience with the State government that if only one area of the State wanted it, and the rest of the State is not too enthusiastic, it is hard to get it through, but if you all go in and say this is one of our priorities, you can get it through.

Mr. HALAMANDARIS. That is good advice. Well, then, are there any further comments from any of the gentlemen?

Well, I thank you very much, and this meeting is adjourned subject to the call of the Chair.

[Whereupon, the hearing adjourned at 2:45 p.m.]

APPENDIX

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by Senator Moss to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR MOSS: If there had been time for everyone to speak at the hearing on "Barriers to Health Care for Older Americans," in Price, Utah, April 20, 1974, I would have said:

The following reply was received:

LAVEE P. WATT, WELLINGTON, UTAH

I have taken many older people to see a doctor. It is absolutely pathetic at the time these people are required to wait for service. Can any of these agencies provide a doctor who could see only the elderly? They don't have the patience or stamina to sit so long and therefore neglect themselves. Since this field is so important why not have a doctor appointed and paid. Great amounts of money are being spent to correct, why not to prevent and give confidence to these people that they are being cared for.

I am interested in reducing the deductible. The amount is too great for old people. They are frustrated by the way this is figured and handled.

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