The original documents are located in Box 1, folder "Aging (1)" of the Spencer C. Johnson Files at the Gerald R. Ford Presidential Library.

THE FITNESS CHALLENGE

. . . . in the Later Years

an exercise program for older Americans

Prepared by

The President's Council on
Physical Fitness and Sports
and the Administration on Aging

Published by the
Administration on Aging

An eminent physician, commenting on the phenomenon of aging, has said: "Most of us don't wear out, we rust out."

Disuse is the mortal enemy of the human body. We know today that how a person lives, not how long he lives, is responsible for many of the physical problems normally associated with advanced age.

This book has been prepared to help the elderly take advantage of the added years of life which medical science is making possible. It outlines methods for maintaining youthful health and energy, and it suggests ways of enhancing the enjoyment of leisure.

Advanced age need not mean inactivity or infirmity. For those who are physically and mentally active, it can be a time when long experience of life enriches each passing day.

The Active Life

PHYSICAL FITNESS

PHYSICAL FITNESS is a quality of life. It is the condition that helps a person to look and feel well, to carry out his daily duties and responsibilities successfully, and yet have enough physical reserves to enjoy his social, civic, cultural, and recreational interests. In addition, it enables him to meet unusual or emergency demands.

There are two "mainstreams" of physical fitness: **organic fitness** or basic health, and **dynamic fitness.**

Organic fitness. The foundation of fitness is good organic health—a body free of disease or infirmity and well nourished. This may mean an adjustment by the individual to certain physical conditions that cannot be reversed by medical or dental care—wearing properly fitted eyeglasses and dentures or using a hearing aid when prescribed.

Dynamic fitness. A person may be free of disease but not fully fit. There is the additional dimension of dynamic fitness which involves the resources to move vigorously, to do, to live energetically. This dynamic quality has several components: efficiency of heart and lungs, muscular strength and endurance, balance, flexibility, coordination and agility.

THE YEARS in later life—particularly those of the post-retirement period—should be happy years. But the full promise of this stage of life comes only to those who are healthy, alert, and active. The later years can be truly rewarding if you have the energy and zest to use them well. The purpose of this book is to help older Americans maintain—or regain—a lively way of life.

The way to *keep* lively is to *be* lively; the way to stay active is to move. Energy begets energy, and the only way to develop the capacity to expend more and more energy is to keep increasingly active.

It is nice to come into retirement with a bankroll of physical resources, just as it is comforting to have sufficient financial reserves. Some folks hit their 60's with plenty of bounce, having kept fit and active throughout their adult years. And this is an immense wealth to the older person.

Fortunately, even if you have let too many years slip by when good intentions of keeping fit were sacrificed to other demands of life, you still can pick up at *some level of physical performance* and work yourself up several notches. One of the objectives of this book is to bring you from your present level of fitness up to the point you would like to attain. The move upward will depend on the amount of movement you are willing and able to undertake.

The Importance of Exercise

Why strive in these later years for more "bounce to the ounce"?

Most medical authorities support the belief—and most active people experience the fact—that exercise helps a person look, feel, and work better.

Various organs and systems of the body, particularly the digestive process, are stimulated through activity and as a result work more effectively.

Posture can be improved through proper exercise by increasing the tone of supporting muscles. This not only improves appearance but can decrease the frequency of lower-back pain and disability.

Physically-active individuals are less likely to experience a heart attack or other forms of cardiovascular disease than sedentary people. And apparently an active person who does suffer a coronary attack will probably have a less severe form and will be more apt to survive the experience.

Physical activity is as important as diet in maintaining proper weight. And being overweight is more than a matter of individual discomfort. It is related to several chronic diseases, shortened life expectancy, and emotional problems. Medical authorities now recommend that weight reduction be accomplished by a reasonable increase in daily physical activity, supplemented, if necessary, by proper dietary controls.

Exercise can't prevent the stresses of life, but it can help you cope with them. For many individuals, frequent involvement in some sort of physical activity helps to reduce mental fatigue, tension, strain, or boredom produced by our highly technical and sedentary way of life.

There is an advantage also in keeping fit and maintaining your physical capabilities to meet conditions caused by illness or accident. The person who has good control of his body and physical reserves is much better equipped to cope with such problems and to follow a rehabilitative program if he should have to do so.

The physically active and able person usually has a positive feeling about himself. He also possesses a degree of physical courage that propels him into interesting and stimulating experiences; moves with grace and ease; and generally presents a trim, attractive, and self-confident bearing.

Perhaps the greatest benefit of maintaining physical fitness is the degree of independence it affords. This is a quality to be most prized in the later years. There is a great psychological and financial advantage in having the ability to plan and do things without depending upon relatives, friends, or hired help. To drive your own car, to succeed with do-it-yourself projects rather than trying to find and pay someone else for the service, to go and come as you please, to be an aid rather than a liability in emergencies—these are forms of personal freedom well worth working for.

How Exercise Promotes Dynamic Fitness

Efficiency and Endurance of the Heart and Lungs

The proper working of the heart, lungs, and blood vessels is probably the most important aspect of fitness in the adult years. Vital to good fitness are a strong and responsive heart that can pump the blood needed to nourish billions of body cells, good lungs where gases of cell metabolism are exchanged for life-giving oxygen, and elastic blood vessels free of obstructions.

Activities involving leg muscles help maintain good circulation by the "squeezing" action of the muscles on the veins. This benefit cannot be achieved by any other means. More and more evidence from scientific research points to the importance of regular physical activity in maintaining good circulation and respiration.

Muscular Strength and Endurance

Muscles grow in size and strength only if they are used. They grow soft and flabby and lose their strength and elasticity if they are not used.

While strength does decrease with advancing years, the rate of decline can be lessened by keeping the muscles toned through regular exercise. Strength and endurance can be promoted by increasing the number of times an exercise is performed, by adding more weight or friction, and by increasing the speed of movement.

Balance

The balance mechanism of the body is commonly neglected and yet is extremely important in the fitness of older people. The balance mechanism is maintained through use and degenerates when not used.

Many older people tend to lose their sense of balance much more quickly than nature intended. The need to use bi-focal or tri-focal glasses increases the hazards for many. A well-maintained sense of balance can help make up for the problems caused by quick changes in vision from one optical focus to another.

Flexibility

The ability to move the joints through their normal range of motion is important, but here again the aging process and disuse cause the tissues surrounding the joints to increase in thickness and lose their elasticity. Moving the joints in a proper exercise program can delay this process. Exercise of the joints also helps slow down the onset or the development of arthritis, one of the most common and painful diseases associated with old age. Proper exercise that stretches the muscles can help keep them supple and prevent them from becoming short and tight.

Traditional "concern" for older people has perhaps done them a disservice. The idea has been to put the pushbuttons in easy reach, to keep the shelves low, to avoid necessity for bending and stretching. Instead, older people should be encouraged to bend, move, and stretch in order to keep joints flexible, muscles springy, and the heart feeling young.

Coordination and Agility

A well-coordinated individual should be able to direct parts of the body in skillful movement, to coordinate different actions with each other and with the eyes, to move and change directions quickly and safely.

Highly refined skills may not be essential in the later years. But for enjoyment of recreation and to keep in condition to move freely and safely, you should exercise regularly in order to maintain reasonably good levels of coordination and agility.

Principles of Exercise and Fitness Programming

Physical fitness can be improved by gradually increasing the amount of work performed, but it is necessary to progress in easy stages. The enthusiast who tackles a keep-fit program too fast and too strenuously soon gives up in discomfort, if not in injury.

While some activity has to be sustained to obtain major benefits, the "cumulative effect" of exercises and activities carried on during a period of time counts. For example, every movement uses calories, so the way to "burn up" calories is to move. And even though certain actions—such as a short walk—may not use many calories at the time, a number of short walks in the course of a day can use up a fair-sized total. Similarly, the benefits of movement to the organs, the joints, the muscles add up little by little.

Therefore, try to step up activity throughout your day, in addition to following specifically planned periods of exercise.

At all ages, but increasingly in later years, it is important to prepare your body for vigorous activity by "warming up." Any individual, and especially an older person, should definitely avoid suddenly undertaking a strenuous activity. A warm-up period should be performed by starting lightly with a continuous rhythmical activity such as walking and gradually increasing the intensity until your pulse rate, breathing, and body temperature are elevated. It is also desirable to do some easy stretching, pulling, and rotating exercises during the warm-up period.

Periods of vigorous activity should be alternated with periods of lesser stress. "Put the pressure on" for a while and then release it. By gradually increasing the stressful interval and reducing the less vigorous interval, you improve your physical condition. This principle of "interval training" can be applied to many forms of exercise and is particularly adaptable to walking, jogging, and swimming.

The proper way to advance in strength and physical condition is to put increasing workloads on your system. This is called the "overload principle." Challenge yourself little by little toward improved performance by increasing the amount of exercise performed or the speed at which you perform it. For example, if you repeat an exercise five times, a certain amount of work has been done and value derived. The next step is to perform the exercise six times, and then gradually increase the count until you can do it, say, ten times with ease.

Unless the overload principle is employed, only minimal gains will be achieved. This is why it is important to follow a graduated, progressive schedule. This principle applies to the circulatory system as well as to the voluntary muscles. To increase the efficiency of the heart and lungs, the performance of continuous rhythmic exercise for a period long enough to stress the circulatory system is recommended—brisk walking, jogging, bicycling, swimming, rope skipping, or the like. Action should be increased until it can be sustained hard and long enough to keep the pulse rate above 130 for several minutes and to increase the body temperature gradually to the point of perspiration. Programs that promise "fitness" in a minute a day are more than inadequate in their effect on circulation. So, too, are the traditionally recommended activities for the elderly, such as puttering in the garden or taking a leisurely stroll.

Exercise is, of course, only one facet of the active and physically-fit life. Medical and dental care, proper diet, sufficient rest, and other good health practices are all important and part of the "balanced life."

However, since this pamphlet is principally concerned with physical activity, it begins with exercise. Other health matters are discussed briefly in its later pages.

Now—to work!

Your Exercise Program--Red, White or Blue?

IN THIS "reasonable" exercise program planned for you, there are three series of exercises, graded according to their difficulty or the amount of stress involved. They are identified as the *Red,* the *White,* and the *Blue* programs, with Red the easiest, White next, and Blue the most difficult and sustained. They let you start where you should, and they provide for an easy progression as you improve your physical condition.

Each of these three exercise programs is designed to give you a balanced workout, utilizing all major muscle groups. Performing your program regularly will lead to improvement in the various components of physical fitness, especially in functioning of the heart and lungs.

As you grow proficient at the exercises in your program, you should increase the number of repetitions of certain exercises, and increase the duration and speed of walking and jogging.

As you become able to increase the number of repetitions and handle more complicated and demanding exercises. you can move up to the next level with new confidence and a growing feeling of well being.

Which Series?

How do you know where to start? Are you a Red, a White, or a Blue?

First, you should ask your physician for advice. Discuss your plans with your own doctor (or public health clinic physician) and follow his recommendations. Take this booklet along to show him. Ask him to review the program recommended here and to advise you accordingly. Also give yourself the following simple tests to determine your present condition and your exercise tolerance. In other words, find out just what kind of shape you are in.

The tests will help you select your appropriate exercise level and pace. Keep in mind that there are wide variations in physical performance. Your own individual physical condition must dictate your personal exercise program.

Pre-exercise Tests

Check yourself in easy stages. First, try the walk test below.

Walk Test

The idea behind this walk test is to determine how many minutes, up to 10, you can walk briskly, without undue difficulty or discomfort, on a level surface. Test yourself outdoors preferably, but walking around the room indoors will do if necessary.

If you can finish 3 minutes, but no more, you should begin your daily exercise program with the RED level.

If you can go beyond 3 minutes, but not quite to 10 minutes, you can *warm up* at the RED level for a week or two, and then move up to the WHITE level.

If you can breeze through the whole 10 minutes, you are ready for bigger things. Rest awhile, or wait until the next day, and then take "Walk-Jog Test #1".

One note of caution. **If at any time during the Walk Test you experience any trembling, nausea, extreme breathlessness, pounding in the head or pain in the chest, STOP immediately. These are signs that you have reached your present level of exercise tolerance. Start your keep-fit program at the corresponding level described in relation to this test. If these symptoms *persist* beyond a point of temporary discomfort, check with your physician.**

Walk-Jog Test #1

This test consists of alternately walking 50 steps and jogging 50 steps for a total of 6 minutes. Read instructions under Exercise #2 on page 10 and the section on Jogging (page 24) before undertaking this test.

Walk at the rate of 120 steps per minute; that is, your left foot strikes the ground once each second. *Jog* at the rate of 144 steps per minute; your left foot hits the ground 18 times every 15 seconds. Time your walking and jogging intervals for 15 seconds occasionally to check your pace.

If you stop this test before the 6 minutes are up, plan your schedule of exercises at the WHITE level.

If you complete the 6-minute walk-jog test without difficulty, you can probably undertake the BLUE level. It might be well to *warm up* for a week or two on the WHITE program first, however.

If you can perform this test without difficulty and feel you are capable of a more rigorous trial, rest a day, and then take "Walk-Jog Test #2".

Walk-Jog Test #2

This test consists of alternately walking 100 steps and jogging 100 steps for a total of 10 minutes. Follow the directions and use the same rates of speed—walking and jogging—as described for Walk-Jog Test #1.

If you complete this 10-minute test without difficulty, you can obviously handle the BLUE program in this book, and might want to consider going beyond it to more advanced exercises contained in another publication of the President's Council on Physical Fitness. See note on *Adult Physical Fitness—A Program for Men and Women* on page 8.

If you do not complete the 10-minute walk-jog, better stay with the BLUE level for awhile, after warming up a few days on the WHITE program.

Keep an Exercise Schedule

Now that you've tested yourself and determined where to begin, schedule a definite period for your basic exercises every day and stick with it.

This means setting aside 30 minutes to an hour a day for a planned program of physical activity. You should consider your exercises just as important as eating a proper diet or keeping clean.

General Directions—All Levels

The exercises in this program are not graded separately for men and women but are tailored to individuals. A couple can do the exercises together. More than likely, however, a man who has been active can start at a higher level or progress faster than most of the women who undertake the program.

Begin *very easily* and increase the tempo and number of repetitions *very gradually*. This will keep stiffness and soreness to a minimum. If you do get a little stiff during the first few days, don't let it slow you down; the stiffness will soon be overcome and it is an indication that you *needed* the activity.

Follow the directions for your exercise exactly. If, for example, you are at the RED level and a particular exercise should be performed only twice as a starter, stop after two repetitions—even though you may feel you can do many more. A warm-up is built into each exercise series. Therefore, the exercises should be performed in the order presented to give best results (see page 9).

Keep a record of the exercises you perform, and how many times you repeat them. The little extra time required to keep a record of your activities and to set more and more challenging goals for yourself is well spent. A fitness program should be carefully designed and carefully followed. The best way to keep track of each day's performance is to write it down. The exercise schedules outlined in this booklet will be more beneficial to you if you keep good records.

One way of adding to the fun of your exercise program is to play music while you are exercising. You can select lively tunes and find music that fits the tempo of the various movements. This is particularly interesting when walking or jogging indoors. Some people also enjoy exercising while watching TV.

You can exercise with family and friends. Many groups get together in each other's homes or at a local center or club.

Wear comfortable clothing. Avoid tight-fitting, restrictive clothes, although, if you feel more comfortable wearing foundation garments, do so. Shorts or slacks, T-shirts or short-sleeved blouses are usually desirable. Wear well-fitting shoes with non-slip soles and low (or no) heels.

Specific Instructions for Individual Programs—Red—White—Blue

Red Program

- Try to complete the entire sequence without undue rest periods between exercises, but, of course, rest awhile if you feel overtaxed. One indication of improvement in condition is the ability to go through the workout in less and less time (up to a point), which means doing the exercises at a faster cadence and resting shorter periods between exercises. However, never let the effort to increase speed cause jerky movements or otherwise interfere with correct performance of the exercise.

- For the first week at least, perform only the smallest number of repetitions or shortest duration of time shown for each exercise under its illustration (pages 10-18). If you find even this amount to be strenuous,

or if you feel fatigued at the end of the week, do not increase the repetitions or duration but continue at the same pace for another week.

● After the first week—or as you are ready—in each exercise where a range of repetitions is shown, increase the minimum by *one*. Do this number, but no more, the second week. (If you need to stay at the lowest count, as explained above, don't increase the count at all.) In the following weeks, gradually increase the number of repetitions as you feel you can. Most people should take 3 to 4 weeks to reach the highest counts in the RED program.

● After you reach the point where you can do the higher number of repetitions shown for each exercise, continue on the RED level until you can complete the whole series without resting between exercises.

● When you can do this for 3 days in a row, move on to the White level.

White Program

○ When you are ready to undertake the WHITE level, proceed in a fashion similar to your Red Program. That is, start at the lowest frequency of repetitions and gradually work up.

○ Most people should remain at the WHITE level for 3 to 5 weeks before moving to the Blue.

○ After you pass your "prove out" test by performing all of the WHITE exercises at the highest frequency shown without resting in between for three consecutive workouts, move on to the Blue level.

Blue Program

● Follow the same directions as for the Red and White programs. Start slowly; step up activity gradually.

● When you reach the upper limits of the BLUE exercises and can go through the workout without stopping on 3 straight days, you are ready to tackle bigger things. At this point you can (1) continue with the exercises in this book, gradually increasing the number and speed of repetitions, the distances walked and jogged, and also engage in more sports and recreational activities; or (2) obtain a copy of *Adult Physical Fitness—A Program for Men and Women,* which includes more difficult exercises, and advance to its level one without going through its orientation level. You can find out how to order it on page 28.

● If you decide to "graduate" to the advanced publication, remember to keep working faithfully at your BLUE Program until the new book arrives.

Important Note

Most, but *NOT ALL*, of the exercises illustrated on the next pages are included in all three Exercise Programs—the Red, White, and Blue; but the same order *IS NOT* followed in the three programs.

Do only those exercises included in your program level, as indicated by color blocks.

Perform your exercises in the order indicated for your program.

Order of Exercises

■

RED Program Sequence

Walk 2 minutes
Bend and Stretch
Rotate Head
Body Bender
Wall Press
Arm Circles
Wing Stretcher
Walk 2-5 minutes
Lying Leg Bend
Angel Stretch
Walk-a-Straight-Line
Half-Knee Bend
Wall Push-Away
Side Leg Raise
Head and Shoulder Curl
Alternate Walk (50 steps) Jog (10)
1-3 minutes
Walk 1-3 minutes

* Illustrations of each exercise and figures for number of repetitions or length of time to perform it, appear on pages 10-18. Where two figures are given, start at the lower figure; gradually increase the repetitions or duration over a period of days or weeks until you can perform the higher number.

□

WHITE Program Sequence

Exercises * to be performed in the following order.

Walk 3 minutes
Bend and Stretch
Rotate Head
Body Bender
Wall Press
Arm Circles
Half-Knee Bend
Wing Stretcher
Wall Push-Away
Walk 5 minutes
Lying Leg Bend
Angel Stretch
Walk-the-Beam
(2-inch by 6-inch beam)
Knee Push Up
Side Leg Raise
Head and Shoulder Curl
(arms crossed on chest)
Diver's Stance
Alternate Walk (50 steps) Jog (25)
3-6 minutes
Walk 1-3 minutes

■

BLUE Program Sequence

Alternate Walk (50 steps) Jog (50)
3 minutes
Bend and Stretch
Rotate Head
Body Bender
Wall Press
Arm Circles
Half-Knee Bend
Wing Stretcher
Alternate Walk (50 steps) Jog (50)
3 minutes
Leg Raise and Bend
Angel Stretch
Walk-the-Beam
(2-inch by 4-inch beam)
Hop
Knee Push Up
Side Leg Raise
Head and Shoulder Curl
(hands clasped behind neck)
Stork Stand
Alternate Walk (50 steps) Jog (50)
5 minutes, gradually increasing to walk 100 steps—jog 100
Walk 3 minutes

Exercises

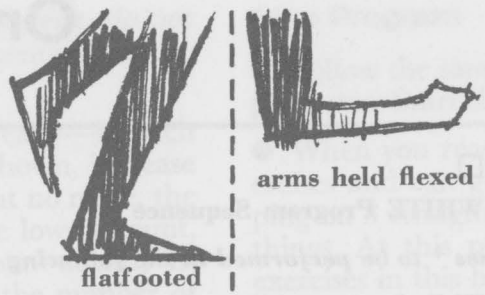
1. Walk

■ *2 minutes*
☐ *3 minutes*

Starting position: **Stand erect, balanced on balls of feet.**

Action: **Simply begin walking briskly on a level space, preferably outdoors, but walking around the room will do if necessary.**

VALUE: A good warm-up exercise, loosening muscles, and preparing you for your full exercise schedule.



2. Alternate Walk-Jog

■ *Blue only at this time*
Alternately walk 50 steps and jog 50—for about 3 minutes.

Starting position: **As for walking, arms held flexed, forearms generally parallel to the ground.**

Action: **Jogging is a form of slow running. Begin walking for 50 steps, then shift to a slow run with easy strides, landing lightly each time on the heel of the foot and transfer weight to the whole foot in flatfooted style. (Heel-toe running in contrast to the sprint in which the runner stays on balls of his feet.) Arms should move loosely and freely from the shoulders in opposition to legs. Breathing should be deep but not labored to point of gasping.**

VALUE: Good warm-up for more advanced exercises. Good for legs and circulation.

3. Bend and Stretch

■ *Repeat 2 to 10 times*
☐ *Repeat 10 times*
■ *Repeat 10 times*

Starting position: **Stand erect, feet shoulder-width apart.**

Action: Count 1. **Bend trunk forward and down, flexing knees. Stretch gently in attempt to touch fingers to toes or floor. Count 2. Return to starting position.**

NOTE: Do slowly, stretch and relax at intervals rather than in rhythm.

VALUE: Helps loosen and stretch most muscles of body; helps relaxation; aids in "warm up" for more vigorous exercise.

4. Rotate Head

■ *Repeat 2 to 10 times each way*
□ *Repeat 10 times each way*
■ *Repeat 10 times each way*

Starting Position: **Stand erect, feet shoulder-width apart; hands on hips.**

Action: **Count 1. Slowly rotate the head in a full circle from left to right. Count 2. Slowly rotate head in the opposite direction.**

NOTE: Use slow, smooth motion; close eyes to help avoid losing balance or getting dizzy.

VALUE: Helps loosen and relax muscles of the neck, and firm up throat and chin line.

5. Body Bender

■ *Repeat 2 to 5 times*
□ *Repeat 5 to 10 times*
■ *Repeat 10 times*

Starting position: **Stand with feet shoulder-width apart, hands extended overhead, finger-tips touching.**

Action: **Count 1. Bend trunk slowly sideward to left as far as possible, keeping hands together and arms straight (Don't bend elbows). Count 2. Return to starting position. Counts 3 and 4. Repeat to the right.**

VALUE: Stretches arm, trunk, and leg muscles.

6. Wall Press

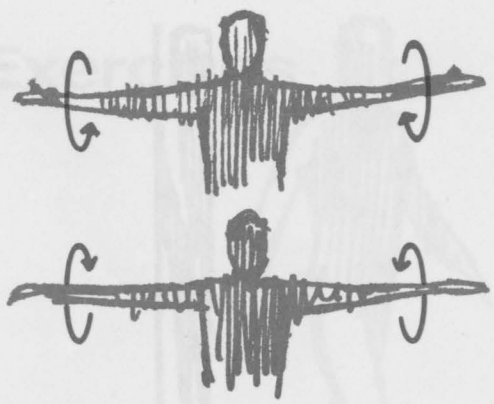
■ *Repeat 2 to 5 times*
□ *Repeat 5 times*
■ *Repeat 5 times*

Starting position: **Stand erect, head not bent forward or backward, back against wall, heels about 3 inches away from wall.**

Action: **Count 1. Pull in the abdominal muscles and press the small of the back tight against the wall. Hold for six seconds. Count 2. Relax and return to starting position.**

NOTE: Keep entire back in contact with wall on Count 1 and do not tilt the head backward.

VALUE: Promotes good body alignment and posture. Strengthens abdominal muscles.



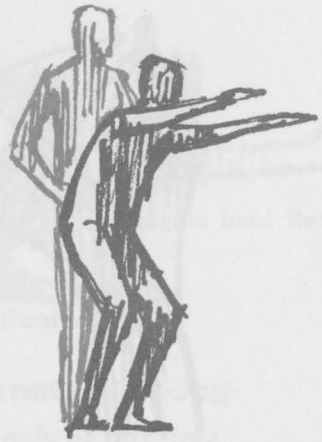
7. Arm Circles

■ *Repeat 5 each way*
□ *Repeat 5 to 10 each way*
■ *Repeat 10 to 15 each way*

Starting position: **Stand erect, arms extended sideward at shoulder height, palms up.**

Action: **Describe small circles backward with hands. Keep head erect. Reverse, turn palms down and do circles forward.**

VALUE: Helps keep shoulder joint flexible; strengthens muscles of shoulders.



8. Half Knee Bend

Red skip this exercise at this time.
□ *Repeat 5 to 10 times*
■ *Repeat 10 to 15 times*

Starting position: **Stand erect, hands on hips.**

Action: **Count 1. Bend knees halfway while extending arms forward, palms down. Keep heels on floor. Count 2. Return to starting position.**

VALUE: Firms up leg muscles and stretches muscles in front of legs. Helps improve balance.

9. Wing Stretcher

■ *Repeat 2 to 5 times*
□ *Repeat 5 to 10 times*
■ *Repeat 10 to 20 times*

Starting position: **Stand erect, bend arms in front of chest, extended finger tips touching and elbows at shoulder height. Counts 1,2,3. Pull elbows back as far as possible, keeping arms at shoulder height and returning to starting position each time. Count 4. Swing arms outward and sideward, shoulder height, palms up and return to starting position.**

NOTE: This is a bouncy, rhythmic action, counting "one-and-two-and-three-and-four."

VALUE: Strengthens muscles of upper back and shoulders; stretches chest muscles. Helps promote good posture and prevent "dowager hump."

NOTE: At this point in sequence

■ *Red now return to WALK (Exercise #1) and walk 2 to 5 minutes*

■ *Blue return to Alternate WALK-JOG (Exercise #2) and walk 50 steps, jog 50 for 3 minutes*

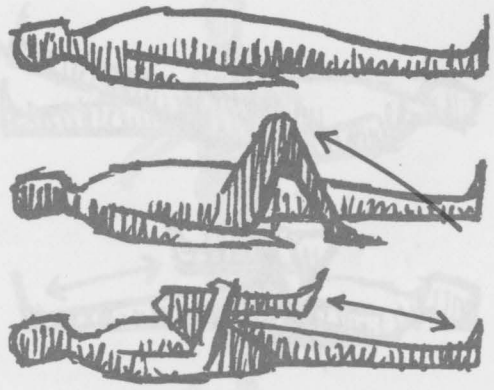
10. Wall Push-Away

☐ *White only at this time*
Repeat exercise 10 times
Then WALK for 5 minutes

Starting position: **Stand erect, feet about six inches apart, facing a wall and arms straight in front, palms on wall, bearing weight slightly. Count 1. Bend elbows and lower body slowly toward wall, meanwhile turning head to the side, until cheek almost touches the wall. Count 2. Push against wall with the arms and return to the starting position.**

NOTE: Keep heels on floor throughout the exercise.

VALUE: Increases strength of arm, shoulder, and upper-back muscles. Stretches muscles in chest and back of legs.



11. Lying Leg Bend

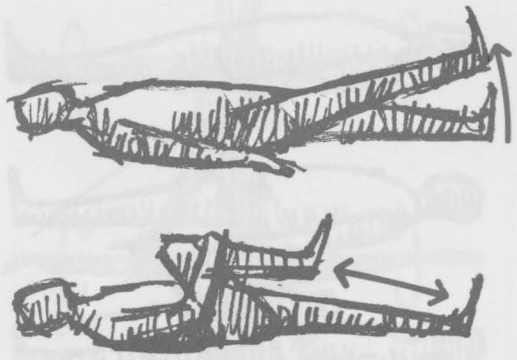
■ *Repeat 2 to 5 times, each leg*
☐ *Repeat 5 to 10 times, each leg*
Blue skip this exercise

Starting position: **Lie on back, legs extended, feet together, arms at sides.**

Action: **Count 1. Bend left knee and move left foot toward buttocks, keeping foot in light contact with floor. Count 2. Move knee toward chest as far as possible, using abdominal, hip, and leg muscles; *then* clasp knee with both hands and pull slowly toward chest. Count 3. Return to position at end of count 1. Count 4. Return to starting position.**

NOTE: After completing desired number of repetitions with left leg, repeat the exercise using right leg.

VALUE: Improves flexibility of knee and hip joints; and strengthens abdominal and hip muscles.



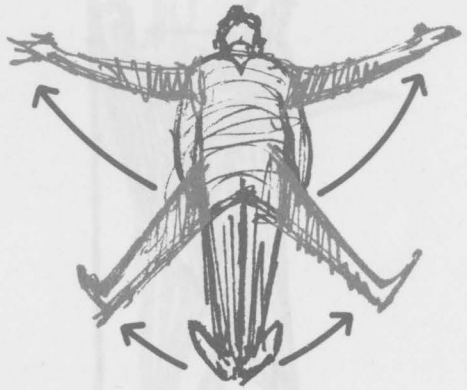
12. Leg Raise and Bend

■ *Repeat 2 to 5 times* *Blue only*
After completing desired number with left leg, do exercise with right leg.

Starting position: **Lie on back, legs extended, feet together, arms at sides.**

Action: **Count 1. Raise extended left leg about 12 inches off the floor. Count 2. Bend knee and move knee toward chest as far as possible, using abdominal, hip, and leg muscles; *then* clasp knee with both hands and pull slowly toward chest. Count 3. Return to position at end of count 1. Count 4. Return to starting position.**

VALUE: Improves flexibility of knee and hip joints; strengthens abdominal muscles.



13. Angel Stretch

■ *Repeat 2 to 5 times*
□ *Repeat 5 times*
■ *Repeat 5 times*

Starting Position: **Lie on back, legs straight, feet together; arms extended at sides.**

Action: **Count 1. Move arms and legs outward along the floor to a "spread-eagle" position. Slide—do not raise—arms and legs. Count 2. Return to starting position.**

NOTE: Throughout the exercise try to compress the lower back against the floor by tightening the abdominal muscles. Do not "arch" the lower back.

VALUE: Stretches muscles of arms, legs, trunk, aids posture; improves strength of abdominal muscles.

14. Walk a Straight Line

■ *Red only—walk for 10 feet*
White and Blue skip this, do Walk-the-Beam (#15) instead.

Starting Position: **Stand erect with left foot along a straight line. Arms held away from body to aid balance.**

Action: **Count 1. Walk the length of the straight line by putting the right foot in front of the left foot with right heel touching left toe, and then placing the feet alternately one in front of the other, heel-to-toe. Count 2. Return to the starting point by walking backward along the line, alternately placing one foot behind the other, toe-to-heel.**

VALUE: Improves balance; helps posture.

15. Walk the Beam

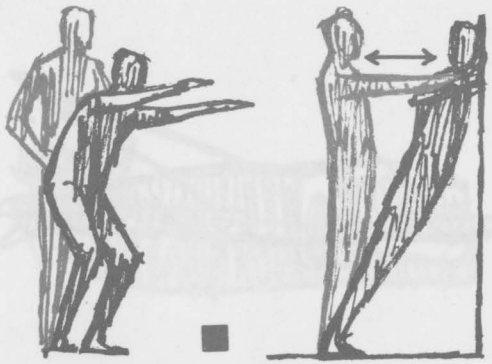
☐ *Walk 10 feet on 2″ x 6″ board*
■ *Walk 10 feet on 2″ x 4″ board*

Starting position: **Stand erect with left foot on board, long axis of foot in line with board.**

Action: **Count 1. Walk the length of the board by putting the right foot in front of the left foot with right heel touching left toe, and then placing the feet alternately one in front of the other, heel-to-toe. Count 2. Return to the starting point by walking backward along the length of the board, alternately placing one foot behind the other, toe-to-heel.**

NOTE: The board is placed flat on the floor, not on the 2″ edge.

VALUE: Improves balance; helps posture.



NOTE: At this point in sequence Red perform Half-Knee Bend (#8) repeating it 2 to 5 times; Wall Push-Away (#10) repeating 2 to 10 times; then skip #15, 16, & 17, moving to #18 next.

16. Hop

■ *Hop 5 times on each foot*
Blue only

Starting position: **Stand erect, weight on right foot, left leg bent slightly at the knee, and left foot held a few inches off the floor; arms held sidewards slightly away from the body to aid balance.**

Action: **Count 1. Hop on right foot, moving few inches forward each hop.**

NOTE: Perform the desired number of hops on right leg, then change to left leg and hop.

VALUE: Improves balance, strengthens extensor muscles of leg and foot; increases circulation.

17. Knee Push Up

☐ *Repeat 1 to 3 times*
■ *Repeat 3 to 6 times*

Starting position: **Lie on floor, face down, legs together, knees bent with feet raised off floor, hands on floor under shoulders, palms down.**

Action: **Count 1. Push upper body off floor until arms are fully extended and body is in straight line from head to knees. Count 2. Return to starting position.**

VALUE: Strengthens muscles of arms, shoulders, and trunk.

18. Side Leg Raise

■ *Repeat 2 to 5 times each leg*
☐ *Repeat 5 to 10 times*
■ *Repeat 10 times*

***Starting position*: Right side of body on floor, head resting on right arm. Count 1. Lift left leg sidewards about 30″ off floor. Count 2. Return to starting position.**

NOTE: Do the desired number of repetitions with the left leg and then turn over, lie on left side and exercise the right leg.

VALUE: Helps improve flexibility of the hip joint and strengthens lateral muscles of trunk and hip.

19. Head and Shoulder Curl

■ *Repeat 2 to 5 times; hold each for 4 seconds*

***Starting position*: Lie on back, legs straight, feet together, arms extended along the front of the legs with palms resting lightly on the thighs.**

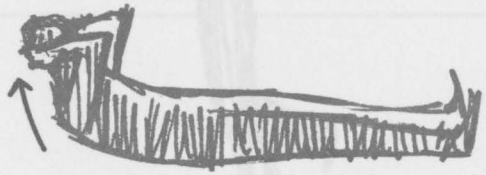
Action: **Count 1. Tighten abdominal muscles and lift head and shoulders so that shoulders are about 10 inches off the floor. Meanwhile slide arms along the legs, keeping them extended. Then hold the position for 4 seconds. Count 2. Return slowly to starting position, keeping abdominal muscles tight until shoulders and head rest on floor. Relax.**

NOTE: Red skip Exercises #20, 21.

19. Head and Shoulder Curl

☐ *Repeat 5 times; hold each for 6 seconds*

Same as Red except on starting position arms are crossed over chest (kept in that position throughout).



19. Head and Shoulder Curl

■ *Repeat 5 times; hold each for 10 seconds*

Same as Red, except on starting position, hands are clasped behind the neck (held that way throughout).

NOTE: The head should lead in a "curling" motion, chin tucked to chest, back rounded, not arched.

VALUE: Excellent for improving abdominal strength and stretching back muscles.

20. Diver's Stance

☐ *White only— hold position for 10 seconds*

Starting position: **Stand erect, feet slightly apart, arms at sides.**

Action: **Rise on toes and bring arms upward and forward so that they extend parallel with the floor, palms down. When this position is attained, close eyes and hold balance for 10 seconds.**

NOTE: Head should be straight and body should be held firmly throughout.

VALUE: Improves balance; strengthens extensor muscles of feet and legs; helps maintain good posture.

21. Stork Stand

■ *Blue only—*
hold position 10 seconds on each leg.

Starting position: **Stand erect, feet slightly apart, hands on hips, head straight.**

Action: **Transfer weight to the left foot and bend right knee, bringing the sole of the right foot to the inner side of the left knee. When this position is reached, close eyes and hold for 10 seconds.**

NOTE: After holding on left leg, change to the right leg and repeat.

VALUE: Improves balance.

22. Alternate Walk-Jog

(Repeats—Exercise #2)

■ *walk 50 steps, jog 10*
1 to 3 minutes.
□ *walk 50 steps, jog 25*
3 to 6 minutes.
■ *begin walk 50 steps, jog 50*
gradually increasing to
walk 100 steps, jog 100
continue for 5 minutes.

VALUE: Provides an "interval" of exercise for circulatory system, and for strengthening leg muscles.

23. Walk

(Repeats—Exercise #1)

■ *walk 1 to 3 minutes*
□ *walk 1 to 3 minutes*
■ *walk 3 minutes*

VALUE: Tapering off, as heart rate, breathing, body heat, and other functions return to normal.

END OF DAILY WORKOUT

Alternatives to Your Daily Exercise Schedule

IF YOU can enroll in a keep-fit program at the Y, at a school, or the local recreation center, you can skip your home-exercise routine on those meeting days.

IF YOU are able to take part in a sport appropriate for your physical condition, by all means do so. Swimming is an excellent activity if you really swim. Take advantage of any opportunities you may have to swim regularly. Hiking, hunting, bicycling, tennis, or similar sports may sometimes be available to you.

On days when you can participate in such sports, you can substitute the sport for your home-exercise routine, or better still, add it to your day's activity. But make sure, if you substitute it, that the exercise involved in the sport is the equivalent of your regular workout. Incidentally, by doing your home exercises, you can keep in shape for an occasional opportunity to participate in a sport, and also help avoid soreness, stiffness, injury, or overfatigue.

Other active forms of recreation should be worked into your daily life whenever possible. Such activities as gardening, fishing, archery, horseshoes, ping-pong, shuffleboard, a family outing, an evening of social or square dancing are not only fun, but will also help you keep vigorous. Age need not be a barrier to participation. These activities should be added to—not substituted for—your daily exercise.

Stepped-up Daily Activities

To the Daily Exercise Schedule and your supplementary recreation add a little more action. Gradually, day by day, find ways to move *more* rather than *less*. Walk to the neighborhood store instead of driving (or being driven). Walk down a flight of stairs instead of taking the elevator; when you're back in shape, walk *up* the stairs.

In today's sedentary world, particularly the older person's world, you need to look for opportunities to move your body. Many well-meaning friends and relatives try to spare older people from any exertion. It is satisfying to be able to say: "Thank you, but I'd rather do it myself. I *can,* you know."

It is good to always have some active project underway—putting in a new flower bed, cutting wood, building a fence, painting a room, mowing the lawn, and a thousand other jobs and interests that keep you busy and youthful.

Keeping Score

TWO OF YOUR most important pieces of fitness equipment are the pencil and paper with which you keep a continuous record of your status and progress. In addition to a record of your special daily exercises, you should also keep account of other activity undertaken during the day. Remember that the effects of exercise in some respects are cumulative, so the day's total counts even though it may have been gained a little at a time.

On the score card opposite, you will note that various activities are given a point value. *Make a chart like this for yourself to use each week.*

Each day you should enter in the appropriate space the number of points you have earned through all the activities you have engaged in during that day. Activities have been grouped in several categories and you should try to gain credits in each category.

Your total number of points should gradually increase as you attain higher degrees of physical condition. For example, a total of 10 points per day or 70 per week would be satisfactory for someone on the RED level. The top of the BLUE level would give you 20 points per day or 125 per week. Once there, you can push on with an advanced schedule of activities (call it BLUE +) to earn 25 points per day or 150 per week. This level will keep you fairly vigorous.

These point values are approximations based upon the clinical experience of exercise specialists. Sufficient research data are not yet available to pinpoint more specific and final figures. So set your own goals according to the way you feel. But don't *underestimate* your vitality—and keep increasing the total points achieved each day until you become one of the "lively ones." Then stay that way.

GOALS

Add your points daily, but classify yourself according to your weekly total. As you will notice, most weekly goals allow you some time off for good (active) behavior.

Physical Activity Level	Points Per Day	Points Per Week
RED	10	70
WHITE	15	100
BLUE	20	125
BLUE +	25	150

Daily Physical Activity Score Card

IN ORDER to receive credit for the variety of activities you may participate in each day, the following classification and scoring system is provided. Determine your daily physical activity score by adding up the time you spend performing various activities during the day according to categories listed below.

After adding up the approximate time spent on activities in each category, give yourself the appropriate number of points acquired in each category and total them. Do not exceed the maximum allowable points for categories 2 and 3.

	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total for week
1. Your Basic Daily Exercise Program **For performing any of the following activities, give yourself the points listed.** ■ **RED exercise program = 5 points** □ **WHITE exercise program = 10** ■ **BLUE exercise program = 12** ■ **BLUE + exercise program, or other programs such as Adult Physical Fitness, jogging and calisthenics, swimming, or YMCA keep-fit programs, lasting 30 minutes or more = 15–19**								

2. Light Activities	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total for week
Give yourself 1 point for each hour spent in the following type activities. Maximum allowable points per day = 3								
—Personal care—dressing, washing, shaving								
—Sitting and actively rocking, typing, writing, playing cards, peeling potatoes, polishing shoes, sewing, playing musical instrument								
—Standing or slowly moving around room or yard								
—Shooting pool, shuffle board								
3. Light-Moderate Activities								
Give yourself 2 points for each 30 minutes spent in the following type activities. Maximum allowable points per day = 8								
—Domestic work—sweeping floors, ironing, washing clothes, making beds								
—Light gardening, mowing lawn (power mower), washing automobile								
—Light industrial work—auto repair, store clerk (not lifting), building with wood, painting, shoe repairing								
—Walking on level at slow pace (2-3 mph) or down stairs								
—Bicycling on level at easy pace (5½ mph)								
—Canoeing slowly (2½-3 mph)								
—Pitching horseshoes, playing golf with cart, archery, bowling								

	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total for week
4. Moderate Activities **Give yourself 4 points for each 30 minutes spent in the following type activities. Maximum allowable points per day = 12** **—Gardening—pulling weeds, digging, mowing lawn (not motorized)** **—Mopping-scrubbing floor** **—Walking on level briskly (3½-4 mph)** **—Walking up and down small hills, in sand** **—Playing ping pong, golf without cart, badminton, volleyball, or tennis (doubles)** **—Canoeing briskly (4 mph) or rowing for pleasure** **—Dancing—Fox trot, waltz, square**								
5. Heavy activities **Give yourself 8 points for each 30 minutes spent in the following type activities. No maximum.** **—Walking upstairs, up hills, or climbing** **—Bicycling briskly or up and down hills** **—Playing tennis (singles)** **—Water skiing** **—Cross country snow skiing** **—Chopping wood, digging holes, shoveling snow**								

Special Notes on Exercise

Jogging

The fast-growing number of people who are jogging nowadays is good testimony to its value as a fitness-producing activity.

Jogging lends itself very well to the interval method of gradually increasing the stress of the activity. The main idea is to alternate walking and jogging bouts and to gradually increase the proportion of jogging to walking. In addition, the total distance covered can be gradually increased as well as the speed with which the distance is traversed. However, the speed element is not emphasized beyond the point of getting a good workout within a reasonable time.

The walk-jog intervals outlined in the RED, WHITE, and BLUE exercise schedules provide for easy progression. If you can handle the BLUE level fairly easily and wish to go forward with jogging, by all means do so. First work up both the walking and the jogging intervals simultaneously until you are ultimately walking 100 yards and jogging 100 yards (about the length of a city block). Then hold the walking interval constant at 100 yards, but gradually increase the jogging interval to 200 yards—or more as you feel ready. Also, gradually increase the total distance covered. There are many people around the country in their 60's and 70's who are jogging 2 to 5 miles daily. But don't set your goals this high unless you have gradually raised the distances jogged without experiencing severe reactions or extreme fatigue lasting for several days. Remember too to "taper off" by walking the last interval and moving around until your breathing and pulse rate return to near normal.

It is important to wear the correct shoes and clothing while jogging. Clean, thick, well-fitting socks are a "must," and the shoes should also fit well and have soft, nonslip soles, with no heels. If gym shoes are worn, they should have a built-in arch support. Shoes made especially for jogging, having short rippled soles, are now being sold. Other clothing should fit so as not to restrict movement and should be sufficiently warm to protect the jogger on cool days. In cold weather, a cap and ear protectors, as well as gloves, are often desirable. It is generally not advisable for older people to jog in midday during summer.

Jogging is great for the circulatory system and the legs but does not provide a complete and balanced workout. Therefore, calisthenics or other conditioning exercises should be added to the jogging session each day. The exercises described in this booklet will serve this purpose very well.

Swimming and Water Exercises

Swimming is such a good activity it deserves special mention. It involves all the major muscles groups, can be adjusted from very mild to strenuous responses, and can be easily graded for progressive conditioning by gradually increasing the distances.

You can work out your own system of interval training. For example, swim across the pool, get out and walk around to the other side and repeat this procedure until your swimming trips across total a good distance. The next progression might be to swim the length of the pool and walk back, and so on. The workout can be varied by using different strokes to swim the intervals.

The buoyancy of the water makes it easier to do some exercises. Therefore, if your physical condition is such that you cannot do even some of the RED exercises on land, find the ones that you *can* do in the water and get your workout that way. On the other hand, the water also causes resistance for certain other exercises. Use this medium as a way of increasing the workload.

Exercise Problems Due to Foot Conditions or Leg Pains

Problems with the feet, the legs, and the knee and hip joints are fairly common. Any problem of the lower extremities, be it bunions, arthritic knees, or varicose veins, may interfere with proper performance of some of the exercises outlined in this booklet, particularly walking and jogging.

If you have such a problem, first make sure that you have done all that you can do to obtain needed medical care.

Next, don't let your ailment sidetrack you in your determination to get fit. The following activities can be substituted for walking and jogging, and can provide healthful exercises.

- Swimming and water exercises.
- "Bicycling" movement, while lying on the floor, hips and legs in the air, supported by the arms and elbows. Do not try this if you think you will have difficulty supporting your weight.
- Riding a bicycle (choose a safe area).
- Pedalling a stationary bike.
- Playing golf. (Here's one time a golf cart is justified.)
- Exercising on wall pulley-weights or rowing machine.
- Passing a medicine ball with a partner while standing or seated—or bouncing the ball off a wall in continuous rhythmic movement.

Special Notes on Health

A PROGRAM of physical fitness must, of course, include much more than exercise. It should begin with basic health considerations. Here are a few reminders:

Medical and Dental Supervision and Care

The importance of having continuing supervision by a physician and dentist cannot be overemphasized. Periodic checkups, at least annually, are the best form of preventive-maintenance.

If you do not now have a personal physician, check on available health services with your local public health officer or the public health nurse who visits your neighborhood. If you cannot find a local public health person, ask at the closest hospital to you, or call the local medical society. Remember, it is not only important to find the physician and dentist, but it is even more necessary to follow their advice once it is given.

Remember also, your medical "advisor" should know your exercise plans before you start your program—be it RED, WHITE, or BLUE. And let him really advise you—follow his recommendations.

Diet and Nutrition

A good basic diet is necessary at all ages and does not change radically when one approaches age 60. Authorities recommend that the older person makes sure he gets the adequate nourishment provided by the basic four food groups. These groups and recommended *daily* servings are:

Bread and cereals (4 or more servings)

Fruits and vegetables (4 or more servings)

Meat, poultry, fish, eggs (2 or more servings)

Dairy products (2 or more cups of milk or its equivalent)

Overweight is a problem with many older persons and, therefore, the total number of calories consumed should be carefully adjusted according to individual needs. Because many persons become less and less active as they increase in years and tend to continue eating the same amounts, it becomes difficult for them to *avoid* getting heavy.

This is often the case even when they attempt to reduce their diet. Sometimes the energy expenditure is so low that they would have to go hungry most of the time to keep from growing fat. But to do this would be risking the loss of an adequate amount of certain vitamins and minerals necessary to maintain good health. This is another reason for increasing your physical activity.

Some older people find that they become uncomfortable after eating a large meal. There is evidence to support the suggestion that it may be better to spread food intake over five or six small meals a day rather than the traditional three hearty meals. The *total* amount of food, however, should be considered in terms of the individual's daily need for calories and nutrients.

The matter of vitamin supplements or special adjustments in the diet for health conditions is for your physician to decide.

Sleep and Rest

There is some indication that as you grow older, you require more sleep or rest. The day's program should include rest periods. A nap in the afternoon is probably a good idea. Several rest periods or "cat naps" are particularly desirable for the person who usually sleeps less than 8 hours during the night.

Cigarette Smoking

The relationship of cigarette smoking to lung cancer, emphysema (a serious condition of the lung affecting breathing), bronchitis, and heart disease has been well established. The data show that the chances of developing these chronic diseases are related to the number of years a person has been smoking as well as the amount or number of cigarettes smoked. The evidence also indicates that it is possible to overcome some of the harmful effects. That is, the sooner a smoker stops and the longer he stays stopped, the better his chances of improved health.

Detrimental effects of smoking cigars and pipes are not as pronounced as in cigarette smoking—but the risk is greater than for non-smokers. Also, the incidence of cancer of the lip and oral cavity is greater among those who use cigars and pipes.

The data call out loudly, "If you smoke, stop; if you don't smoke, don't ever start." By increasing the amount of daily exercise, you can help prevent an increase in weight that some people experience when they stop smoking.

Studies show that children are more apt to start smoking if their parents smoke—and probably if their grandparents do, too.

So, That's the Challenge

THE EXERCISES are here—their reasons and promises—goals and scores to keep. Now the rest is up to you. It won't be easy to get going, especially if you haven't been active for a long time. There is no easy way to fitness.

But once you get started you'll begin to feel the benefits, and before long you will be looking forward to each day's activities. The self-discipline you must employ pays off in two ways—the act of overcoming the tendency toward a sedentary, self-pampering existence gives a psychological boost; and your activity opens the way to a more zestful and worthwhile life.

Good Luck. Good Health.

Want to Read More?

Adult Physical Fitness—A Program for Men and Women, a President's Council on Physical Fitness publication, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, 35 cents.

Exercise and Fitness, available from the Department of Health Education, Division of Socio-Economic Activities, American Medical Association, Chicago, Ill., 10 cents.

Physical Fitness, available from the Department of Health Education, Division of Socio-Economic Activities, American Medical Association, Chicago, Ill., 15 cents.

Food for Fitness, a U.S. Department of Agriculture publication, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, 25 cents.

For Information on programs of the Administration on Aging write to: Director, Public Information, AoA, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201

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94th Congress
1st Session

COMMITTEE PRINT

THE PROPOSED FISCAL 1976 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS

A STAFF REPORT

PREPARED FOR THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

FEBRUARY 1975

Printed for the use of the Special Committee on Aging

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THE PROPOSED FISCAL 1976 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS

A STAFF REPORT

President Ford submitted the Administration's proposed budget for fiscal 1976 to the Congress on February 3, 1975.

The new budget recommends $349.4 billion in Federal spending and a $51.9 billion deficit, a peacetime record.

To summarize the impact of the fiscal 1976 unified budget on older Americans [1]—in terms of trust fund items and discretionary spending—the Committee staff has prepared the following analysis.

AoA Funding Slash

A $42.4 million cutback in funding (compared with the fiscal 1975 appropriation levels) is proposed for the Administration's fiscal 1976 budget for programs under the Older Americans Act. The new budget, which calls for $202.6 million in funding for AoA programs, represents a 17-percent reduction compared with the fiscal 1975 appropriation of $245 million. It would also constitute the largest dollar and percentage reduction in the entire history of the Older Americans Act.

The fiscal 1976 budget proposed for AoA programs is identical to the Administration's fiscal 1975 request. It recommends $96 million for Title III Community Programs on Aging, $7 million for Title IV Research, and $99.6 million for the Title VII Nutrition Program. For Title III, the Administration proposes $76 million for Area Planning and Social Services, $15 million for Administration and $5 million for Model Projects. This level of funding would maintain the current amount of assistance to States and would support at least 412 Area Agencies on Aging. It would also fund approximately 40 Model Projects grants, nearly the same as for fiscal 1975. For fiscal 1976 the nutrition program is projected to provide 200,000 meals, five days per week, in 665 areas. During the first quarter of fiscal 1975 the average daily participation for Title VII was about 212,000. Nearly 705,000 elderly persons participated in the program during this period.

Again, no earmarked funding is requested for training, a special transportation study mandated in the 1973 amendments, multidisciplinary centers of gerontology, and multipurpose senior centers. The Congress, however, appropriated $8 million for Title IV Training in fiscal 1975.

[1] As well as rescissions proposed for fiscal year 1975 appropriations. See p. 12 for discussion.

Additionally, $10.2 million is projected for salaries and expenses for 128 persons at AoA and 179 aging specialists in the HEW regional offices. This sum would also fund the National Information and Resource Clearing House and the staff of the Federal Council on the Aging. Approximately $500,000 is projected for the Federal Council on the Aging.

PROPOSED FUNDING FOR PROGRAMS UNDER OLDER AMERICANS ACT

[In millions of dollars]

	Budget request, fiscal 1976	Fiscal 1975 appropriation	Proposed rescission for fiscal 1975 [1]
Title III: State and community programs on aging	$96.0	$105	$96.0
Title IV:			
Training	0	8	0
Research	7.0	7	7.0
Special transportation study	0	0	0
Multidisciplinary centers of gerontology	0	0	0
Title V:			
Multipurpose senior centers	0	0	0
Annual interest grants	0	0	0
Personnel staffing grants	0	0	0
Title VII: Nutrition program	99.6	125	99.6
Total	202.6	245	202.6

[1] See p. 12 for additional discussion of rescission.

Social Security Benefits

The new budget projects that 29.1 million persons will receive almost $62.9 billion in Old Age and Survivors Insurance benefits for fiscal 1976, compared with an estimated $54.7 billion in payments for 28.3 million beneficiaries for 1975. Disability outlays are projected to increase from $7.6 billion in 1975 to $9.1 billion in 1976. And, the number of disability beneficiaries is estimated to rise from 4 million in 1975 to 4.4 million in 1976. Benefit payments are expected to increase because of the enactment of the two-step, 11-percent Social Security raise (which became fully effective for checks delivered in fiscal 1975) and the automatic cost-of-living adjustment in July 1975.

The Administration has also called for the enactment of several legislative proposals to reduce Social Security outlays: Among the major recommendations (which are incorporated into the budget allocations):

1. Prohibit entitlement to retroactive benefits if future monthly payments would be permanently reduced as a result. Under present law, a person who has just become entitled to Social Security benefits may receive up to 12 months retroactive payments. However, future benefits are actuarially reduced if the individual receives payments for any month before age 65. (Projected outlay reductions: $45 million in 1975 and $443 million in 1976.)

2. Eliminate the monthly test of the Social Security earnings ceiling except for the first year that an individual receives a cash benefit. Under present law, a beneficiary under age 72 who earns more than $2,520 in 1975 has $1 in benefits withheld for each $2 of earnings above this amount. But regardless of an individual's annual earnings, he or she may still receive full benefits for any month in which his or her earnings do not exceed the monthly exempt amount: $210. (Projected outlay reductions: $15 million in 1975 and $205 million in 1976.)

3. *Place a 5-percent ceiling on the cost-of-living increase scheduled for July 1975. (Projected outlay reduction: $2.5 billion in 1976.) Present projections place the cost-of-living raise at 8.7 percent. Senators Frank Church, Edward Kennedy, Walter Mondale, and Harrison Williams have sponsored legislation (S. Con. Res. 2),[2] which is cosponsored by 50 other Senators (making a total of 54 sponsors), to express opposition to any proposed reduction in the cost-of-living increase.*

Medicare Outlays Projected at $15.5 Billion

Medicare outlays in fiscal 1976 for hospital and medical services for the aged and disabled are projected at $15.5 billion ($11.4 billion for Hospital Insurance and $4.1 billion for Supplementary Medical Insurance), approximately $2 billion above the fiscal 1975 estimate. The budget attributed the projected rise in benefit payments to "increases in the size of the covered population and increases in the cost of medical services." Approximately 24 million persons (22 million aged and 2 million disabled beneficiaries) will be enrolled in the Part A Hospital Insurance program for fiscal 1976, and 23.8 million for Part B Supplementary Medical Insurance. Nearly 5.6 million beneficiaries are expected to receive reimbursed services under Part A and 13.3 million under Part B.

The Administration is also recommending legislation to reduce Medicare outlays, including:

1. Modify Medicare's cost-sharing structure to provide: (a) A coinsurance charge under Part A equal to 10 percent of all charges above the deductible amount on all covered services (now the elderly pay a $92 deductible and nothing thereafter for covered hospital services until the 61st day of hospitalization); (b) an increase in the Part B deductible (effective in calendar year 1976) from $60 to $70, and rising thereafter in proportion to the percentage increase in Social Security benefits; (c) a 10-percent coinsurance charge on hospital-based physician services and home health services, and (d) a ceiling of $750 per benefit period for a patient's payments under Part A and a $750 limitation per calendar year for Part B. These amounts would rise proportionately as Social Security benefits increase. (Outlay reductions: $225 million in 1975 and $1.279 billion in 1976.)

2. Place limits on the rates of yearly increases in provider (e.g., doctors and hospitals) costs recognized as reasonable under Medicare. (Outlay reduction: $100 million in 1976.)

[2] For additional information, see statements by Senators Church and Kennedy, pp. S. 574–5, Congressional Record, January 21, 1975; statement by Senator Williams, p. S. 829, Congressional Record, January 23, 1975; and statement by Senator Mondale, p. S. 933, Congressional Record, January 27, 1975.

PROJECTED MEDICARE BENEFIT PAYMENTS FOR FISCAL 1976

[In millions of dollars]

	Part A—	Part B—
	Inpatient hospital services	Physicians' services
Aged	$9,938	$2,900
Disabled	1,060	408
	Skilled nursing facility services	Outpatient services
Aged	260	358
Disabled	11	322
	Home health services	Home health services
Aged	107	44
Disabled	4	6
		Other medical and health services
Aged		78
Disabled		29
	Total benefit payments	Total benefit payments
Aged	10,305	3,380
Disabled	1,075	765
Total	11,380	4,145

Projected Increases for Supplemental Security Income

The Supplemental Security Income (SSI) program's projected expenditures for fiscal year 1976 total approximately $5.5 billion. This includes $4.63 billion [3] for benefit payments, $275 million for Federal contributions toward State supplementation, $55 million for vocational rehabilitation, and $499 million for administration. These figures represent substantial increases when compared with $4.86 billion expenditure level for fiscal year 1975: $4.08 billion [4] for benefit payments, $255 million for Federal contributions toward State supplementation, $49 million for vocational rehabilitation, and $473 million for administration. The number of recipients is expected to reach 4.47 million in fiscal year 1975 (2.53 million aged and 1.94 million blind and disabled). The Social Security Administration will also make a supplemental request for $121 million for fiscal year 1975 for 11,500 new staffing positions for the agency, with approximately 7,000 positions earmarked for SSI.

[3] Based on President's proposal to put a 5-percent ceiling on benefit programs such as SSI. If SSI is exempted from the ceiling, benefit payments will increase by $85 million, estimated on an 8.7-percent cost-of-living rise.

[4] Includes a proposed supplemental appropriation of $83.1 million.

SSI BENEFIT PAYMENTS AND BENEFICIARIES

	1974	1975	1976
Payments (in billions)	$1.83	[1] $4.08	[2] $4.63
Beneficiaries (in millions)	3.60	4.47	5.07

[1] Includes a proposed supplemental appropriation of $83,100,000.

[2] Based on President's proposal to put a 5-percent ceiling on benefit programs such as SSI. If SSI is exempted from the ceiling, benefit payments will increase by $85,000,000, estimated on an 8.7-percent cost-of-living rise.

HUD Emphasizes Section 8

Section 202.—One major disappointment of the President's new budget is the lack of any request for increased funding for the popular Section 202 program. The Housing and Community Development Act of 1974 authorized a borrowing level of $800 million. To date, the Administration has yet to request that any of this amount be approved. In spite of this reluctance, Congress last November approved a borrowing level of $100 million for fiscal year 1975, plus the unobligated balance of the monies accumulated in the old 202 "revolving fund" as of December 31, 1974 (representing another $115 million).

The new authority combined with the unobligated balance in the old fund, provides $215 million. The Department of Housing and Urban Development (HUD) estimates that the following amounts will be reserved:

	Estimated reservations
Fiscal year:	
1975	$34,000,000
1976	175,000,000
Transition period	40,000,000
Total	249,000,000

The excess over $215 million is an estimate of the amounts that will be received by HUD before the end of fiscal year 1976 from loan repayments under the original 202 program. The transition period is from July 1, 1976, to September 30, 1976, when the budget will go on a new fiscal year.

Section 8 (housing assistance payments program).—The fiscal 1976 budget states that the new Section 8 program "will be used as the primary vehicle for providing housing assistance to lower income families in 1975 and 1976." Authority is available for HUD to process 400,000 units in both fiscal years, 1975 and 1976. However, because the program will not be available for all of fiscal year 1975, it is estimated that only 200,000 units will actually be processed. The budget requests an additional $662.3 million in contract authority, which, when added to contract authority expected to be available in 1976, will support 400,000 units.

Conventional public housing.—As required in the 1974 Act, HUD will continue to provide a limited amount of housing assistance under the conventional public housing program. The estimate is for 38,000 units in fiscal year 1975 and 6,000 units (Indian housing) for 1976.

There is no request for additional authority for this program, as HUD wishes to use the Section 8 program instead.

Operating subsidies for public housing will be budgeted at $450 million in 1975 and $525 million in 1976. Additional assistance for existing public housing projects will be provided under the modernization program with contract authority of $40 million for 1975 and $20 million for 1976.

Section 236 multifamily housing and rent supplement.—Very few, if any, new units will be approved under these programs; no new request is made. The budget will reflect obligations for commitments made prior to January 5, 1973 (the start of the housing freeze), and amendments to existing projects. Projects under these programs will be approved on a limited basis but only where bona fide commitments cannot be met under the lower income housing assistance program (Section 8).

Direct cash assistance.—The direct cash assistance experimental program will continue during fiscal year 1976, but no additional funds are requested.

Nonprofit sponsor assistance.—Assistance to nonprofit sponsors of low- and moderate-income housing was authorized by section 106 of the Housing Act of 1968. Activity under this program was discontinued in 1973, and no request is made to revive it.

Community development block grant program.—Title I of the Housing and Community Development Act of 1974 authorizes HUD to make grants to units of general local government and States for the funding of local community development programs (replacing such programs as urban renewal and model cities).

In 1976, it is estimated that assistance will be provided to 2,500 communities, including about 600 metropolitan cities and urban counties. Outlays are projected at $225 million for 1975 and $1.3 billion for 1976. The program began operation on January 1, 1975.

Proposed ACTION Budget for Aging Is Down $1.8 Million

ACTION's aging programs would be reduced by approximately $1.8 million under the Administration's budget recommendations for fiscal year 1976. The Retired Senior Volunteer Program (RSVP), Foster Grandparents, Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE), and Senior Companions have a total budget request of $45.47 million. The proposed fiscal year 1976 budget recommends an increase of approximately $1.5 million for RSVP, from $15.98 million to $17.50 million. This would enable RSVP to increase its volunteers from 140,000 in fiscal year 1975 to 185,000 for fiscal year 1976. Funding for Foster Grandparents would be reduced by $2.4 million, from $28.29 million to $25.93 million. This would cause a reduction in participation, from 12,200 for 1975 to 11,900 for 1976. The number of children served by the Foster Grandparents would decrease, from 24,400 served per day in fiscal year 1975 to 23,800 children in fiscal year 1976. The SCORE/ACE budget for fiscal year 1976 is identical to the 1975 appropriations level: $400,000. However, it is estimated that the number of volunteers would increase from 5,221 to 6,000 for SCORE and from 2,532 to 3,000 for ACE.

Funding for Senior Companions would be cut back by almost $900,000, from an appropriation of $2.56 million in fiscal year 1975 to $1.64 million in fiscal year 1976. The number of volunteers would, though, remain constant at 1,000 for 1976. And, 2,000 persons again are projected to be served.

ACTION'S AGING PROGRAMS

[In millions of dollars]

	Authorization, fiscal 1976	Budget request, fiscal 1976	Appropriations, fiscal 1975
RSVP	$20.0	$17.5	$15.98
Foster Grandparents and Senior Companions	40.0	[1] 27.57	[2] 30.84
SCORE/ACE	([3])	.4	.4
Total		45.47	47.22

[1] This includes a breakdown of $25,930,000 for Foster Grandparents and $1,640,000 for Senior Companions.
[2] This includes a breakdown of $28,280,000 for Foster Grandparents and $2,560,000 for Senior Companions.
[3] Amount as necessary.

Administration Proposes Increase in Cost of Food Stamps

The Administration proposes an increase in the cost of food stamps (effective March 1, 1975), raising the average price of stamps from approximately 23 percent of one's net income to 30 percent in nearly all cases.

This increase, if implemented, would force many low-income recipients, especially the elderly,[5] to quit the program because the purchase requirement would exceed the bonus value in stamps. With a 30-percent purchase requirement, the Administration is requesting $3.7 billion for fiscal year 1975 and $3.85 billion for fiscal year 1976. Otherwise, the Administration would request $3.9 billion for fiscal year 1975 and $4.5 billion for fiscal year 1976. It is estimated that there would be approximately 15.8 million participants in the program for each year. Approximately 14 percent of the participants are 60 years of age and over, and about 10 percent are in the 65-plus age category.

However, the House of Representatives (on February 4) and the Senate (on February 5) overwhelmingly passed legislation (H.R. 1589) to prohibit an increase in charges for food stamps for 1975. President Ford announced on February 13 that he would allow H.R. 1589 to become law without his signature.

Nursing Home Expenditures

Expenditures for nursing home care would increase only slightly in fiscal year 1976 under the President's budget. Expenditures in 1974 reached $7.5 billion, of which $4 billion represented public funds.

Medicare's contribution in 1974 was only $204 million. It is expected to increase to $232 million this year and is projected at $239 million in the new budget. Medicaid's contribution will remain more substantial. In 1974 Medicaid contributed some $3.7 billion, approximately $2 billion in Federal funds and about $1.7 billion in State and local funds.

[5] For additional discussion, see *The Impact of the Ford Administration's Proposal to Raise Food Stamp Prices*, published by the Community Nutrition Institute, December 1974. Special attention is paid to older food stamp recipients.

The Federal share of Medicaid funds is projected to increase from $2 billion to $2.4 billion in the 1976 budget. Expenditures for nursing home care comprise 35 percent of total Medicaid expenditures, compared to 26 percent paid to hospitals.

Home Health Expenditures

Expenditures for home health care would increase very modestly under the President's new budget. Nearly $64 million was spent in fiscal 1974 under Medicare's Part A (Hospital Insurance) program, increasing to $94 million for the current fiscal year. Reimbursements are expected to reach $98 million in fiscal year 1976. Under Part B (Supplementary Medical Insurance) of Medicare, home health services were funded at $36 million in 1974, increasing to $43 million this year. Reimbursements are estimated at $50 million for fiscal 1976. In short, the projected figure for Medicare home health services for 1976 is $148 million or less than 1 percent of Medicare's estimated $15.5 billion outlays in that year.

National Institute on Aging

For fiscal 1976 the Administration is recommending $16.19 million for the new National Institute on Aging. The budgeted amount for fiscal 1975 stands at approximately $15.74 million, $14.95 million in transferred funds from the National Institute of Child Health and Human Development and an additional amount to cover prorated management costs. However, the Administration's proposed rescission for fiscal 1975 would reduce the NIA budget to $14.1 million.[6] The fiscal 1976 request is expected to support 157 grants and projects, up slightly from the projected level of 147 for fiscal 1975.

Aging Research at NIMH

The Administration has requested a $306 million funding level for the National Institute of Mental Health for fiscal 1976, nearly $100 million below the fiscal 1975 appropriation ($405.35 million). The Administration has also proposed a rescission which would reduce funding for 1975 to $363.44 million.[7] Only about 0.4 percent of the NIMH funding request for fiscal 1976 would be specifically targeted for aging research ($1.32 million). This figure, however, is $362,000 more than the projected amount allocated for fiscal 1975.

ADEA Request at Nearly $2.2 Million

A $2,168,000 funding level is sought by the Administration for fiscal 1976 to enforce the Age Discrimination in Employment Act. This amount would support 81 positions, the same number projected for fiscal 1975. The authorization for the Age Discrimination in Employment Act was increased from $3 million to $5 million under amendments (Public Law 93–259) to the law approved in 1974.

[6] See p. 12 for information about rescission.
[7] See p. 12 for additional discussion of rescissions.

Funding Request for CETA Unchanged

Proposed funding for the Comprehensive Employment and Training Act in fiscal 1976 is identical with the fiscal 1975 appropriation: $1.58 billion for the Title I State and local manpower revenue sharing, $400 million for Title II public service jobs (in areas with at least 6.5-percent unemployment for three consecutive months), and $414.4 million for Titles III and IV national programs. The number of participants is projected at almost 2 million for Title I and 156,000 for Title II in 1976.

Congress has also appropriated $1 billion for the Emergency Jobs and Unemployment Assistance Act: $875 million for public service jobs (distributed under a nationwide formula) and $125 million for labor intensive public works. The Administration, however, has asked that the $125 million for labor intensive public works be rescinded and transferred to public service jobs. Present estimates call for $350 million of the $1 billion appropriation to be expended for fiscal 1975 and $650 million for fiscal 1976.

Legal Services Request at $71.5 Million

A $71.5 million funding level is requested in the fiscal 1976 budget for legal services. The program is now operated under a continuing resolution. The Administration, however, plans to request a supplemental appropriation of $71.5 million for this fiscal year. This appropriation is projected to continue 734 legal services offices into fiscal 1976. Under the fiscal 1976 budget there would be about 2,000 attorneys, nearly 200 below the fiscal 1971 level.

A $100 million spending level is authorized for legal services under the Legal Services Corporation Act. The Community Services Administration (formerly the Office of Economic Opportunity) will be responsible for administering the legal services program until the Legal Services Corporation officially comes into existence, soon after a Board of Directors is confirmed.

Major earmarked activities for the elderly now include:

1. $366,100 (through June 30, 1975) for the National Senior Citizens Law Center (Los Angeles, California, and Washington, D.C.) which provides legal research and other assistance for legal services attorneys representing older Americans.
2. $175,000 (through June 30, 1975) for California Rural Legal Assistance (San Francisco, California) to provide legal research and community education for legal services lawyers and to serve as a contact point with State agencies in California concerning problems of elderly clients.
3. $87,000 (through November 30, 1975) for the Council of Elders (Roxbury, Massachusetts) lay advocates demonstration program.

4. $160,000 (through June 30, 1975) for the Presbyterian Senior Citizens Center in New York City to represent aged clients.

Administration Calls for Termination of SOS

For the third consecutive year, the Administration has requested no funds for the Senior Opportunities and Services program. SOS, however, has been continued through Congressional appropriations and continuing resolutions. SOS is now operating under a continuing resolution through February 28. For fiscal 1975, $7.5 million has been allocated for SOS. This amount of funding is sufficient to continue SOS operations through March 31, 1975. The fiscal 1976 Budget Appendix states "Administratively phase-out costs are expected to be minimal and no additional funds have been provided."

More than 1 million elderly persons are now served under 300 SOS programs (200 receiving earmarked funding and 100 community action agencies funded out of local initiative efforts).

The Administration gave this rationale for discontinuing SOS:

> This program was designed, according to the Act, "to identify and meet the needs of older, poor persons above the age of 60." This authority duplicates similar programs, especially the Administration on Aging, a much larger program within HEW.

Social Services—Title XX

Federal costs for Title XX social services under the Social Security Act are projected at $1.95 billion in fiscal year 1976, compared with $1.9 billion in fiscal year 1975. This amount will decrease by $488 million if the Administration's proposal to decrease the Federal matching share of 75 percent to 65 percent for fiscal year 1976 and 50 percent for fiscal year 1977 is adopted. However, both estimates are still below the $2.5 billion ceiling placed on social services expenditures. Outlays for the aged, blind and disabled (adult) categories for fiscal year 1976 are expected to be about one-third of the total or approximately $608 million (compared with $556 million for fiscal year 1975). Nearly 2.7 million aged, blind and disabled persons are expected to receive services under Title XX.

Veterans' Pension and Compensation Payments

More than 2.7 million veterans (1.563 million) and survivors (1.155 million) are expected to receive non-service-connected disability pensions in fiscal 1976, including nearly 1 million veterans and survivors from World War I and prior conflicts. The average payment per case is projected at $1,580 a year for veterans and $942 for survivors. Compensation payments for service-connected disabilities or death will be made to nearly 4.5 million veterans (3.744 million) and survivors (873,000) in 1976. This projection is identical with the fiscal 1975 estimate. The average annual payment per case is estimated at $1,693 for veterans and $2,385 for survivors.

Rural Highway Public Transportation Demonstration Program

For fiscal 1976 the Administration's budget requests $20.35 million for the Rural Highway Public Transportation Demonstration program. A $9.65 million funding level is provided for fiscal 1975.

No Funding Requested for Senior Community Service Employment Program

For the third consecutive year, the Administration has failed to seek appropriations for the Title IX Older American Community Service Employment Act. During the past two years, the Congress has approved $10 million for fiscal 1974 and $12 million for fiscal 1975. Title IX now provides 2,970 jobs in a wide range of community service activities for low-income persons 55 and above with poor employment prospects. Senator Edward Kennedy, the author of the Older American Community Service Employment Act, plans to introduce legislation to continue the program for at least three years.

Mainstream.—Older worker national contractor programs will be funded through June 30, 1975. Under the Administration's proposal, national contractors would then apply for funding with State and local governments under the Comprehensive Employment and Training Act.

Railroad Retirement Annuities

Payments for retirement, disability, spouse, and survivor benefits are projected at $3.3 billion in fiscal 1976, approximately $300 million above the fiscal 1975 estimate ($3 billion). More than 1 million persons are expected to receive benefits. And 130,000 individuals will receive supplemental annuities.

$4 Million Requested for Community Education

The Administration's budget request of $4 million for community education is $13 million below the $17 million authorization level for fiscal year 1976 ($12 million for program grants and $5 million for training). A decision concerning the distribution of the $4 million has not yet been made. The Commissioner on Education will make this decision with the advice of the Community Education Advisory Council.

No Funding for Special Educational Programs

The fiscal 1976 budget makes no request for three educational programs for the elderly under Title VIII of the Older Americans Comprehensive Services Amendments: (1) An Older Reader Services program (including training of librarians to work with the aged and providing in-home visits by librarians); (2) assistance for utilizing the resources of higher education for developing programs concerning transportation and housing problems of the elderly in rural and isolated areas; and (3) special programs for persons with limited English-speaking ability.

Rescissions for Fiscal Year 1975 Expenditures

All budget proposals discussed thus far would apply to expenditures for fiscal year 1976, that is, the year beginning July 1, 1975.

But the Administration, in another action taken on January 30, has proposed cutbacks in funding for appropriations already made by the Congress for expenditures for fiscal year 1975.

This would be done through a "rescission" process now authorized, should the Congress concur.

Among the major rescissions for aging programs:

1. A $9 million cutback for the Title III State and community programs under the Older Americans Act, from the Congressional appropriation of $105 million to the Administration's budget request of $96 million.

2. Elimination of funding for Title IV Training. The Congress had approved $8 million in the Labor-HEW Appropriations Act for fiscal 1975.

3. A $25.4 million reduction in funding for the nutrition program for the elderly, from $125 million to $99.6 million.

4. Impoundment of the entire Congressional appropriation for the Older American Community Service Employment Act.

5. A reduction in the budgeted amount for the National Institute on Aging, from $15.74 million to $14.1 million.

Under the new Budget and Impoundment Control Act, Congress must give its approval to all executive actions which seek to withhold funds. If a President proposes a rescission of spending authority in order to terminate programs or cut funding, both the House and Senate must pass a rescission bill within 45 days of the President's proposal. Otherwise, the funds must be spent by the Administration. If the President fails to spend the money under these circumstances, the General Accounting Office is authorized to bring suit on an expedited basis in Federal District Court to release the funds.

○

Your Medicare Handbook

Important:
If you are under 65 and you have Medicare protection under the special chronic kidney disease provision of the law, you will receive additional material which describes how Medicare pays for kidney dialysis and kidney transplant services. For all other covered services you receive, use this Medicare handbook for the information you need.

DHEW Publication No. (SSA) 75-10050

Contents

How to use Your Medicare Handbook

This is *Your Medicare Handbook*. It tells you what Medicare is and how it works. Keep the handbook where you can find it. Then, when you need medical care, you can use the handbook to find out whether the services you need are covered by Medicare and how much Medicare can pay.

Medicare will help pay for many of your health care expenses, but not all of them. You should know in advance what expenses Medicare does not cover. On pages 42 and 43 there is a list of the services and supplies Medicare cannot pay for and some that Medicare can pay for only under certain conditions.

Page 48 tells you how to submit your medical insurance claims, and beginning on page 52 there is an address list showing where to send your claims.

Page 39 tells you what to do if you think there has been a mistake in a Medicare decision or the amount of payment.

As you read the handbook, you will see stars (*) by some words. A star means there is a footnote at the bottom of the page that will give you additional information.

There is also an index at the back of the book. If you want to know about a particular subject, look it up in the index to find out what page it's on.

This is the 1975 edition of the handbook. If you have an earlier copy of the handbook, please throw it away. As changes occur in the Medicare program, we will keep you informed.

Whenever you can't find information you need in this handbook, call a social security office. Look up Social Security Administration in your telephone book to get the number of a social security office near you.

What is Medicare

Medicare is a health insurance program for people 65 and older and some people under 65 who are disabled. It is a Federal Government program run by the Social Security Administration. Medicare has two parts. One part is called hospital insurance. The other part is called medical insurance.

Medicare's hospital insurance (sometimes called Part A) can help pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility and for care in your home by a home health agency.

Medicare's medical insurance (sometimes called Part B) can help pay for medically necessary doctors' services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Medical insurance also can help pay for necessary home health services when hospital insurance cannot pay for them.

You are responsible for part of the cost of some services covered under Medicare. The amounts or the share of the costs for which you are responsible are described in this handbook. As general health care costs rise, these amounts may increase. We will keep you informed of any changes in the amounts you have to pay under Medicare. If you cannot pay these amounts or for other health care expenses, you may be able to get help from the Medicaid program in your State.

Medicare payments are handled by private insurance organizations under contract with the Government. Organizations handling claims from hospitals, skilled nursing facilities, and home health agencies are called **intermediaries.** Organizations handling claims from doctors and other suppliers of services covered under the medical insurance part of Medicare are called **carriers.**

Your Medicare card

Be sure you keep the Medicare health insurance card we sent you in the mail. The card shows the Medicare protection you have (hospital insurance, medical insurance, or both) and the date your protection started. If you don't have both parts of Medicare, see page 44 to find out how you can get the part you don't have.

The card also shows your health insurance claim number. The claim number has 9 digits and a letter. In some cases, there will be another number after the letter. Be sure to put your full claim number on all Medicare claims and correspondence. If a husband and wife both have Medicare, they get separate cards and different claim numbers. Each must use the exact claim number shown on his or her card.

Important things to remember

- Always show your Medicare card when you receive services that Medicare can help pay for.
- Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare.
- Carry your card with you whenever you are away from home. If you ever lose it, ask the people in the social security office right away to get you a new one.
- Do not use your Medicare card before the effective date shown on your card.
- Permanent Medicare cards made of metal or plastic, which are sold by some manufacturers, are not a substitute for your officially issued Medicare card.

Who can provide services or supplies under Medicare

To help make sure that health care furnished to Medicare beneficiaries is of acceptable quality, persons or organizations providing services must meet all licensing requirements of State or local health authorities. Persons and organizations shown below also must meet additional Medicare requirements before payments can be made for their services:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Independent diagnostic laboratories and organizations providing X-ray services
- Ambulance firms
- Chiropractors
- Independent physical therapists (those who furnish services in your home or in their offices)
- Facilities providing kidney dialysis or transplant services

All hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program also must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Except for certain situations described later in this handbook, Medicare cannot pay for care you get from a non-participating hospital, skilled nursing facility, or home health agency.

You should always make sure that the persons or organizations providing services are approved for Medicare payments. If you are not sure, ask them.

Two important rules

Under the law, Medicare does not cover care that is not "reasonable and necessary" for the treatment of an illness or injury. Medicare also does not cover care that is "custodial." These two rules are explained on this page and the next page.

Care that is not reasonable and necessary

If a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay would not be considered reasonable and necessary. So Medicare could not cover your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments would end at the time further inpatient care is no longer reasonable and necessary.

To help Medicare decide whether inpatient care is reasonable and necessary, each hospital and skilled nursing facility has a Utilization Review Committee, which is made up of at least two doctors. And in some parts of the country there are Professional Standards Review Organizations, which are made up of local doctors who review the care prescribed by their fellow doctors.

If a doctor (or other practitioner) comes to treat you or you visit him for treatment more often than is the usual medical practice in your area, Medicare would not cover the "extra" visits unless there are medical complications. Medicare cannot cover more services than are reasonable and necessary for your treatment. Any decision of this kind is always based on professional medical advice.

Some health care services and supplies are not generally accepted by the health community as being reasonable or necessary for diagnosis and treatment. This includes acupuncture, histamine therapy, and various kinds of medical equipment, for example. Medicare cannot cover services and supplies unless they are generally recognized as safe and effective by the health community.

Care that is custodial

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

Your Medicare hospital insurance

Medicare's hospital insurance helps pay for three kinds of care. The three kinds of care are (1) inpatient hospital care; and, when medically necessary after a hospital stay, (2) inpatient care in a skilled nursing facility, and (3) home health care.

There is a limit on how many days of hospital or skilled nursing facility care and how many home health visits Medicare can help pay for in each benefit period.* However, your hospital insurance protection is renewed every time you start a new benefit period.

Medicare hospital insurance will pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency. There are covered services and non-covered services under each kind of care. Covered services are services and supplies that hospital insurance can pay for.

***Benefit period**

A benefit period is a way of measuring your use of services under Medicare's hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. When you have been out of a hospital (or other facility primarily providing skilled nursing or rehabilitation services) for 60 days in a row, a new benefit period starts the next time you go into a hospital. There is no limit to the number of benefit periods you can have.

The next two chapters tell you more about inpatient hospital care and inpatient care in a skilled nursing facility. Home health care is explained in the chapter beginning on page 34. There is a list of covered and non-covered services in each of these chapters.

You do not have to send us any bills for care you receive from a participating hospital, skilled nursing facility, or home health agency. Medicare will pay its share of the costs directly to the place where you received the care.

Whenever a hospital, skilled nursing facility, or home health agency sends Medicare a hospital insurance claim for payment, you will get a notice that explains the decision made on the claim and shows what Medicare paid. If you have any questions about the decision or the payment, get in touch with the intermediary that sent you the notice or call a social security office.

If you receive covered services from a non-participating hospital (see page 15) or from a Canadian or Mexican hospital (see page 16), the hospital can tell you about Medicare payment arrangements.

When you are a hospital inpatient

Medicare's hospital insurance can help pay for inpatient hospital care if **all** of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of an illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital does not disapprove your stay.

If your stay in a hospital is covered by Medicare, you are responsible for the first $92 in each benefit period. This is called the hospital insurance deductible. Medicare will pay for all other covered services for up to 60 days if your medical condition requires that you stay in the hospital that long.

From the 61st through the 90th day, hospital insurance pays for all covered services, *except for $23 a day*. Hospital insurance pays the rest of the cost for covered services during this time. (If you ever need more than 90 days of inpatient hospital care in a benefit period, see page 14 to find out how hospital reserve days can help with your expenses.)

Hospital insurance does **not** cover your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare's medical insurance. Page 25 tells how medical insurance helps with doctor bills.

The tables on the following page show some of the services that are covered and services that are not covered when you are in the hospital.

Major services covered when you are a hospital inpatient
Medicare's hospital insurance can pay for these items.

1. A semiprivate room (2 to 4 beds in a room)
2. All your meals, including special diets
3. Regular nursing services
4. Intensive care unit costs
5. Drugs furnished by the hospital during your stay
6. Lab tests included in your hospital bill
7. X-rays and other radiology services, including radiation therapy, billed by the hospital
8. Medical supplies such as casts, surgical dressings, and splints
9. Use of appliances such as a wheelchair
10. Operating and recovery room costs
11. Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient
Medicare's hospital insurance **cannot** *pay for these items.*

1. Personal convenience items that you request such as a television, radio, or telephone in your room
2. Private duty nurses
3. Any extra charges for a private room, unless you need it for medical reasons
4. The first 3 pints of blood you receive in a benefit period (see page 38)

Hospital inpatient reserve days

We said earlier that Medicare will help pay for your care in a hospital for up to 90 days in each benefit period. But what happens if you have a long illness and have to stay in the hospital for more than 90 days? Medicare's hospital insurance includes an extra 60 hospital days you can use if this ever happens. These extra days are called reserve days.* You are responsible for no more than $46 a day for each reserve day you use. Hospital insurance pays the rest of the costs for covered services for each reserve day. **But once you use a reserve day you never get it back.** Reserve days are **not** renewable like your 90 hospital days in each benefit period.

***Reserve days**
Since you only have 60 reserve days in your lifetime, you can decide yourself when you want to use them. After you have been in the hospital 90 days, you can use all 60 reserve days at one time if you have to stay in the hospital that long. But you don't have to use your reserve days right away if you don't want to. Maybe you have private insurance that can help pay your hospital bill if an illness keeps you in the hospital for more than 90 days. If you don't want to use your reserve days, you must tell the hospital in writing ahead of time. Otherwise, the extra days you need to be in the hospital will be taken from your reserve days automatically.

Care in a non-participating hospital

Medicare's hospital insurance usually can help with your bills only if you are a patient in a participating hospital. However, hospital insurance can help pay for care in a qualified non-participating hospital if (1) you are admitted to the non-participating hospital for emergency treatment, and (2) the non-participating hospital is the closest one to get to that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.

If the hospital does not submit the Medicare claim, any social security office will assist you in getting the hospital insurance payment for the covered care you received.

Care in a psychiatric hospital

Hospital insurance can help pay for **no more than** 190 days of care in a participating psychiatric hospital in your lifetime.

In addition, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. The days you were an inpatient in the 150 days before your hospital insurance started must be subtracted from the days you could otherwise use in your first benefit period for inpatient psychiatric care. Any social security office can give you further information about this special rule.

Care in a foreign hospital

Medicare generally cannot pay for hospital or medical services outside the United States* except for care in qualified Canadian or Mexican hospitals in three specific situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services you need, (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs which requires that you be admitted to a Canadian hospital. (This provision does not apply if you are vacationing in Canada.)

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. Any social security office will help you get Medicare payment for the covered services you receive.

Care in a Christian Science sanatorium

Medicare's hospital insurance can help pay for inpatient hospital and skilled nursing facility services you receive in a Christian Science sanatorium if it is operated, or listed and certified by, the First Church of Christ, Scientist, in Boston. You can get more information at any social security office.

***United States**
Puerto Rico, the Virgin Islands, Guam, and American Samoa are considered part of the United States, along with the 50 States and the District of Columbia.

Inpatient care in a skilled nursing facility

Medicare's hospital insurance can help pay for inpatient care in a participating skilled nursing facility* after you have been in a hospital. Hospital insurance can cover this care if you no longer need all the services that only a hospital can provide, but your condition still requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

Hospital insurance can help pay for care in a skilled nursing facility if **all** of the following five conditions are met: (1) you have been in a hospital at least 3 days in a row before your transfer to the skilled nursing facility, (2) you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital, (3) you are admitted to the facility within a short time (generally within 14 days) after you leave the hospital, (4) a doctor certifies that you need, and you actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and (5) the facility's Utilization Review Committee does not disapprove your stay.

As we said, **all** five conditions must be met. But it's especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

*Skilled nursing facility

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services as well as other related health services. If you are not sure whether a facility participates in Medicare, ask someone at the facility.

By skilled nursing care, we mean care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled nursing care and skilled rehabilitation services you receive must be under the general direction of a doctor.

Hospital insurance cannot pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 9). Also, hospital insurance cannot pay for your stay if you only need skilled nursing or rehabilitation services on an occasional basis, such as once or twice a week.

When your stay in a skilled nursing facility is covered by Medicare, your hospital insurance can help pay for your care for up to 100 days in each benefit period, but **only** if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 14 days, you do not have to have a new 3-day stay in the hospital in order for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, your care can be covered.

In each benefit period, hospital insurance pays for all covered services for the first 20 days you are in a skilled nursing facility. After 20 days, hospital insurance pays for all covered services for the 21st through 100th day, *except for $11.50 a day*. Of course, if you receive any non-covered services, you are responsible for these costs.

Hospital insurance does **not** cover your doctor's services while you are in a skilled nursing facility. Medicare's medical insurance covers doctors' services. Page 25 tells you how medical insurance helps with doctor bills.

The tables below tell you some of the services that are covered and services that are not covered when you are in a skilled nursing facility.

Major services covered when you are in a skilled nursing facility

Medicare's hospital insurance can pay for these items.

1. A semiprivate room (2 to 4 beds in a room)
2. All your meals, including special diets
3. Regular nursing services
4. Rehabilitation services, such as physical, occupational, and speech therapy
5. Drugs furnished by the facility during your stay
6. Medical supplies such as splints and casts
7. Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility

Medicare's hospital insurance **cannot** *pay for these items.*

1. Personal convenience items you request such as a television, radio, or telephone in your room
2. Private duty nurses
3. Any extra charges for a private room, unless you need it for medical reasons
4. The first 3 pints of blood you receive in a benefit period (see page 38)

Your Medicare medical insurance

Medicare's medical insurance can help pay for (1) doctors' services, (2) outpatient hospital care, (3) outpatient physical therapy and speech pathology services, (4) home health care, and (5) many other health services and supplies which are not covered by Medicare's hospital insurance.

The following chapters will tell you more about these different kinds of care, the services that are covered by medical insurance and those not covered, and what part of your medical expenses Medicare can pay.

As a general rule, after you have $60 in **reasonable charges** (see page 21) for covered medical expenses in each calendar year, your medical insurance will pay 80 percent of the reasonable charges for any additional covered services you receive during the rest of the year.

Your first $60 in covered expenses in each calendar year is called the medical insurance deductible. You need to meet this $60 deductible only once in a calendar year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you might receive. There is also a special carryover rule* that will help you if your medical expenses do not reach the deductible amount until the last 3 months of the year.

***Carryover rule**
If you have covered medical expenses in the last 3 months of a year that can be counted toward your $60 deductible for that year, they can also be counted toward your $60 deductible for the next year. Any social security office can give you more information if you think the carryover rule might apply in your case.

Reasonable charges

Under the law, medical insurance payments are based on "reasonable charges" for covered services and supplies. Because of the way reasonable charges are determined, they may sometimes be less than the actual charges made by doctors and suppliers.*

The Medicare carrier for your area determines the reasonable charges for covered services and supplies on the basis of an annual review. New reasonable charges are put into effect on July 1 of each year, based on the actual charges made by physicians and suppliers in your area during the previous calendar year.

Here's how reasonable charges are determined.

First, the carrier determines the **customary** charge (generally the charge most frequently made) by each doctor and supplier for each separate service or supply furnished to patients in the previous calendar year.

Then, the carrier determines the **prevailing** charge for each covered service and supply. The prevailing charge is the amount which is high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service and supply.

Whenever a medical insurance claim is submitted, the carrier compares the charge shown on the claim with the customary and prevailing charges for that service or supply. The charge approved by the carrier will be either the customary charge, the prevailing charge, or the actual charge, **whichever is lowest.**

***Suppliers**
Suppliers are persons or organizations, other than doctors or health care facilities, that furnish equipment or services covered by medical insurance. For example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

If the actual charge by your doctor or supplier is higher than the reasonable charge, it may be because he recently raised his charge and it has not been in effect long enough to be included in Medicare's annual review. In other cases, of course, the actual amount billed may be more than the reasonable charge because the doctor or supplier has higher charges for the particular service or supply than most other doctors and suppliers in your area.

When a doctor or supplier accepts an assignment of the medical insurance payment (see page 24), he also agrees to accept the reasonable charge as his total charge to you for covered services. For this reason, you may want to find out in advance whether the doctor or supplier will accept assignment.

Reasonable charges for kidney dialysis and kidney transplant services are based on special fee arrangements between Medicare and doctors, hospitals, dialysis centers, and dialysis equipment suppliers who furnish services covered under the medical insurance part of Medicare.

How medical insurance payments are made

There are two ways payments are made under Medicare's medical insurance. The medical insurance payment can be made to the doctor or supplier. This payment method is called assignment. Or, the medical insurance payment can be made to you.

After you or the doctor or supplier sends in a medical insurance claim, Medicare will send you an *Explanation of Medicare Benefits Notice** to tell you the decision on the claim.

***Explanation of Medicare Benefits Notice**
Medicare will send this notice to you whenever a medical insurance claim is submitted, whether you send in the claim yourself or it is submitted by a doctor or supplier. The notice shows what expenses were covered, what charges were approved, how much was credited toward your $60 deductible, and the amount Medicare paid. If there is anything on the notice that you don't understand, you can get an explanation from the carrier that sent you the notice or from any social security office.

Assignment

The assignment method, in which the doctor or supplier receives the medical insurance payment, can be used **only** if you both agree to it. If the doctor or supplier is willing to use the assignment method, he also agrees that his total charge for the covered service will not exceed the reasonable charge set by the Medicare carrier. Medicare then pays your doctor or supplier 80 percent of the reasonable charge, after subtracting any part of the $60 deductible you have not met. The doctor or supplier can charge you **only** for any of the $60 deductible not yet met, the remaining 20 percent of the reasonable charge, and for any services that Medicare does not cover.

Payment to you

Medicare makes direct payment to you covering 80 percent of the reasonable charges, after subtracting any part of the $60 deductible you haven't met. Charges to you by the doctor or supplier are not limited to the reasonable charge set by the Medicare carrier.

See page 48 to find out how to send in a claim for medical insurance payment.

When a doctor treats you

Medical insurance can help pay for covered services you receive from your doctor in his office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Your medical insurance can also help pay for doctors' services you receive in connection with covered inpatient care in a Canadian or Mexican hospital. See page 16 to find out about care in Canadian and Mexican hospitals.

After you meet the $60 yearly medical insurance deductible, medical insurance pays 80 percent of the reasonable charges for covered services you receive from your doctor.

Payment can be made either to you or to your doctor. Page 24 describes the two payment methods.

Radiology and pathology services by doctors

While you are an inpatient in a hospital, medical insurance pays 100 percent of the reasonable charges for services by doctors in the fields of radiology and pathology, even if you haven't met your medical insurance deductible for the year. Because the full reasonable charges are paid, they do not count toward meeting your $60 deductible.

Outpatient treatment of mental illness

Doctors' services you receive for outpatient treatment of a mental illness are covered, but medical insurance can pay **no more than** $250 in any one year for these services.

Chiropractors' services

Medical insurance helps pay for only one kind of treatment furnished by a licensed and Medicare-certified chiropractor. The **only** treatment that can be covered is manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. Medical insurance does not pay for the X-ray or for any other diagnostic or therapeutic services furnished by a chiropractor.

Podiatrists' services

Medical insurance can help pay for any covered services of a licensed podiatrist, except for routine foot care. Routine foot care includes hygienic care; treatment for flat feet or other structural misalignments of the feet; and removal of corns, warts (including plantar warts), and calluses. However, medical insurance can help pay for routine foot care **if** you have a medical condition affecting the lower limbs (such as severe diabetes) which requires that such care be performed by a podiatrist or a doctor of medicine or osteopathy.

Dental care

Medical insurance can help pay for dental care **only** if it involves surgery of the jaw or related structures or setting fractures of the jaw or facial bones. Care in connection with the treatment, filling, removal or replacement of teeth; root canal therapy, surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting teeth are **not** covered.

The tables below show some of the doctors' services that are covered and some that are not covered by medical insurance.

Major doctors' services covered by medical insurance
Medicare's medical insurance can help pay for:

1. Medical and surgical services
2. Diagnostic tests and procedures that are part of your treatment
3. Other services which are ordinarily furnished in the doctor's office and included in his bill, such as:
   - ► X-rays you receive as part of your treatment
   - ► Services of your doctor's office nurse
   - ► Drugs and biologicals that cannot be self-administered
   - ► Medical supplies
   - ► Physical therapy and speech pathology services

Some doctors' services not covered by medical insurance
Medicare's medical insurance **cannot** *pay for these services.*

1. Routine physical examinations
2. Routine foot care
3. Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
4. Immunizations (unless required because of an injury or immediate risk of infection)
5. Cosmetic surgery unless it is needed because of accidental injury or to improve the functioning of a malformed part of the body

Outpatient hospital services

Medicare's medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury.

Medical insurance pays the hospital 80 percent of the reasonable charges for covered services you receive as an outpatient after subtracting any of the $60 deductible you have not met. The hospital will apply for the medical insurance payment and will charge you for any part of the deductible you have not met plus 20 percent of the remaining reasonable charges.

When you go to a hospital for outpatient services, be sure to show the people there your most recent *Explanation of Medicare Benefits Notice*. From this form, they can tell how much of the $60 deductible you have met and how much of the deductible, if any, they may charge you.

If the hospital cannot tell how much of the $60 deductible you have met and the charge for the services you received is less than $60, the hospital may ask you to pay the entire bill. If you pay the bill, any medical insurance payments that are due will be paid directly to you. Usually, the hospital will prepare the medical insurance claim for you. But if you ever need help with a claim, get in touch with any social security office.

Under certain conditions, medical insurance can also help pay for emergency outpatient care you receive from a non-participating hospital.

The tables below tell you some of the outpatient hospital services that are covered and the services that are not covered by medical insurance.

Major outpatient hospital services covered by medical insurance

Medicare's medical insurance helps pay for these items.

1. Services in an emergency room or outpatient clinic
2. Laboratory tests billed by the hospital
3. X-rays and other radiology services billed by the hospital
4. Medical supplies such as splints and casts
5. Drugs and biologicals which cannot be self-administered

Some outpatient hospital services not covered by medical insurance

Medicare's medical insurance **cannot** *pay for these items.*

1. Routine physical examinations and tests directly related to such examinations
2. Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
3. Immunizations (unless required because of an injury or immediate risk of infection)
4. Routine foot care

Outpatient physical therapy and speech pathology services

Medicare's medical insurance can help pay for medically necessary outpatient physical therapy or speech pathology services. There are three different ways you can receive these services under medical insurance.

You may receive physical therapy or speech pathology services as part of your treatment in a doctor's office. In this case, the doctor must include the charge for the services in his bill. Medical insurance will pay 80 percent of the reasonable charges after the $60 yearly deductible has been met. Either you or the doctor can submit the claim as described on page 48.

You may receive services directly from an independently practicing, Medicare-certified physical therapist in his office or in your home if such treatment is prescribed by a doctor. Your medical insurance will pay 80 percent of the reasonable charges after the $60 yearly deductible, but can pay **no more than** $80 in total benefits in any one year. Either you or the physical therapist can submit the claim as described on page 48.

You may receive physical therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare if these services are furnished under a plan your doctor sets up and periodically reviews. In this case, the organization providing services always submits the claim and may only charge you for any part of the $60 deductible you have not met, 20 percent of the remaining reasonable charges, and for any non-covered services.

Other services and supplies covered by medical insurance

Medicare's medical insurance also helps pay for other services and supplies described in this chapter. Medical insurance will pay 80 percent of the reasonable charges for these covered services and supplies after you have met the $60 yearly deductible. Usually when these services and supplies are furnished by a hospital, skilled nursing facility, or home health agency, it will make the claim for medical insurance payment. Otherwise, you or the supplier submits the claim. Page 48 tells you how medical insurance claims are submitted.

Independent laboratory services

Medical insurance can help pay for diagnostic tests provided by independent laboratories. The laboratory must be certified by Medicare for the services you receive. Not all laboratories are certified by Medicare and some laboratories are certified only for certain kinds of tests. Your doctor can usually tell you what laboratories are certified and whether the tests he is prescribing from a certified laboratory are covered by your medical insurance.

Ambulance transportation

Medical insurance can help pay for ambulance transportation **only** if (1) the ambulance, equipment, and personnel meet Medicare requirements and (2) transportation in any other vehicle could endanger the patient's health.

Under these conditions, medical insurance can help pay for ambulance transportation from your home to a hospital or skilled nursing facility, between hospitals and skilled nursing facilities, or from a hospital or skilled nursing facility to your home.

Medical insurance usually can help pay for ambulance transportation only in your local area. However, if there are no facilities in the local area equipped to provide the care you need, medical insurance will help pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment still will be based on the reasonable charge for transportation to this closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 16) can also be covered by medical insurance.

Prosthetic devices

Medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include, for example, heart pacemakers, corrective lenses needed after a cataract operation, and colostomy or ileostomy bags and certain related supplies. Medical insurance can also help pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Orthopedic shoes are covered only when they are part of leg braces. Dental plates or other dental devices are not covered.

Durable medical equipment

Medical insurance can help pay for durable medical equipment such as oxygen equipment, wheelchairs, home dialysis systems, and other medically necessary equipment that your doctor prescribes for use in your home. You can rent or buy this equipment. Whether you rent or buy, Medicare usually makes

payments monthly. If you rent, medical insurance will help pay the reasonable rental charges for as long as the equipment is medically necessary. If you buy, whether you pay the entire purchase price in a lump sum or pay in installments, medical insurance will make monthly payments until its share of the reasonable purchase price is paid or until the equipment is no longer medically necessary, whichever comes first.

Portable diagnostic X-ray services

Medical insurance helps pay the reasonable charges for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and if they are provided by a Medicare-certified supplier.

Medical supplies

Medical insurance can also help pay for surgical dressings, splints, casts, and similar medical supplies ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

Home health care under Medicare

Sometimes people are confined to their homes because of an illness or injury and need skilled health services only on a part-time basis. These services may be medically necessary, for example, after treatment in a hospital or skilled nursing facility. Or, part-time skilled care provided at home could help avoid an inpatient stay.

If you need part-time skilled health care in your home for the treatment of an illness or injury, either hospital insurance or medical insurance can help pay for covered health care services furnished by home health agencies* participating in Medicare.

Medicare does not cover home care services furnished primarily to assist people in meeting personal, family, and domestic needs. These services include general household services, preparing meals, shopping, or assisting in bathing, dressing, or other personal needs.

When care in your home is covered by Medicare, the services you receive are counted in visits. For example, if you receive one home health service twice in the same day, or two different home health services in the same day, two visits would be counted.

***Home health agencies**
A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home.

The tables below tell you the home health services Medicare covers and the services that are not covered.

Home health services covered by Medicare
Medicare can pay for:

1 Part-time skilled nursing care
2 Physical therapy
3 Speech therapy

If you need part-time skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- ► Occupational therapy
- ► Part-time services of home health aides
- ► Medical social services
- ► Medical supplies and equipment provided by the agency

Home health services not covered by Medicare
Medicare **cannot** *pay for these items.*

1 Full-time nursing care at home
2 Drugs and biologicals
3 Meals delivered to your home
4 Homemaker services

When hospital insurance pays for home health care

Medicare's hospital insurance can pay for home health visits if six conditions are met. **All** six conditions must be met. These conditions are: (1) you were in a qualifying hospital for at least 3 days in a row, (2) the home health care is for further treatment of a condition which was treated in a hospital or skilled nursing facility, (3) the care you need includes part-time skilled nursing care, physical therapy, or speech therapy, (4) you are confined to your home, (5) a doctor determines you need home health care and sets up a home health plan for you within 14 days after your discharge from a hospital or participating skilled nursing facility, and (6) the home health agency providing services is participating in Medicare.

Under these conditions, hospital insurance can pay the full cost of up to 100 home health visits after the start of one benefit period and before the start of another. Payment for these visits can be made for up to a year following your most recent discharge from a hospital or participating skilled nursing facility. You may be charged only for any non-covered services you receive.

The home health agency will submit the claim for payment. You don't have to send in any bills yourself.

When medical insurance pays for home health care

Medicare's medical insurance can help pay for up to 100 home health visits in a calendar year. You do not have to have a 3-day stay in the hospital for medical insurance to pay for home health care. But medical insurance can pay for the visits only if four conditions are met. **All** four conditions must be met. These conditions are: (1) you need part-time skilled nursing care or physical or speech therapy, (2) a doctor determines you need the services and sets up a plan for home health care, (3) you are confined to your home, and (4) the home health agency providing services is participating in Medicare. Medical insurance can also pay for home health visits if this care is still needed after you have used up the 100 visits covered under hospital insurance.

After you meet the $60 yearly deductible, medical insurance pays the full costs for covered home health services in each calendar year. You may be charged only for any non-covered services you receive.

The home health agency always submits the medical insurance claim for home health care. You don't have to send in any bills yourself.

Coverage of blood under Medicare

Both hospital insurance and medical insurance can help pay for blood, except for the first 3 pints (or equivalent units of packed red blood cells) you use under each part of your Medicare insurance. You will not have to pay for these 3 pints if you can arrange for blood replacement.*

If you need blood while you are an inpatient in a hospital or a skilled nursing facility, you are responsible for the first 3 pints of blood in each benefit period. After that, hospital insurance pays the full cost of any additional blood you need during that benefit period.

If you are receiving blood as an outpatient or as part of other services covered by your medical insurance, you are responsible for the first 3 pints of blood in each calendar year. After that, your medical insurance will pay 80 percent of the reasonable charges, after you have met the $60 annual deductible, for any additional blood you receive as an outpatient during the year.

***Blood**
If you are covered by a blood donor plan, it can replace the first 3 pints of blood for you. Or, you can arrange to have someone donate blood for you.

Your right of appeal

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you always have the right to ask for a review of the decision.

Under Medicare's hospital insurance, the health facility that provides the services submits the claim for payment. But, Medicare will send you a notice of the decision made on the claim. If you feel that the decision is not correct, you can ask for a review of the claim. Any social security office can help you request a review. If you are still not satisfied after the review and if the amount in question is $100 or more, you can ask for a formal hearing. Cases that involve $1,000 or more can eventually be appealed to a Federal court.

Under Medicare's medical insurance, whether you or the doctor or supplier submits the claim for payment, Medicare will send you a notice of the decision made on the claim. If you disagree with the decision, you can ask the Medicare carrier that handled the claim to review it. Then, if you still disagree with the decision and if the amount in question is $100 or more, you can request a hearing by the carrier.

The notice you receive from Medicare which tells you of the decision made on your claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right of appeal and how to request it, get in touch with any social security office.

Waiver of beneficiary liability

Under the law, Medicare cannot pay for custodial care or other services that are not reasonable and necessary (see page 8). For example, if you go into a hospital when the kind of services you need could be provided in a less expensive health facility, on an outpatient basis, or in your home, Medicare will not pay for the hospital services. Or, for example, if your doctor gives you services that are in excess of accepted standards of medical practice in your area for similar medical conditions, Medicare will not pay for the excess services.

But there is also a provision in the Medicare law that says you will not be held responsible for paying for such services if you could not reasonably be expected to know they were not covered by Medicare.

This provision of the law is called "waiver of beneficiary liability." Waiver only applies, however, when Medicare denies payment on a claim because it is decided that the services you received were custodial or that they were not reasonable or necessary for diagnosis or treatment. In addition, the waiver provision does not apply to medical insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method.

If you are a member of a prepayment plan

Prepayment plans make health services available to their members in a special way. Generally, each member pays regular premiums to the plan. The member can then receive health services the plan provides, whenever he needs them, without additional charges. In some plans, small charges are made for certain services, such as drugs or home visits.

Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish which are covered under the medical insurance part of Medicare. Some prepayment plans have contracts with Medicare as Health Maintenance Organizations and can receive direct payment for services covered by either hospital insurance or medical insurance.

If you are a member of a prepayment plan, ask the people in charge of the plan what arrangements have been made for Medicare payments. Find out, too, what you should do when you get health services that are not provided by the plan.

If you are interested in finding out whether there are any Health Maintenance Organizations or other types of prepayment plans in your area, contact any social security office.

What Medicare does not cover

This alphabetical list shows most of the major services and supplies that Medicare usually does not pay for. Items shown in blue can be covered by Medicare only under the conditions described here or on the pages indicated.

Acupuncture

Chiropractic services
(See page 26)

Christian Science practitioners' services

Cosmetic surgery
(See page 27)

Custodial care
(See page 9)

Dental care
(See page 26)

Drugs and medicines you buy yourself with or without a doctor's prescription

Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses

Foot care that is routine
(See page 26)

Foreign health care
(See page 16)

Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids

Homemaker services
(See page 34)

Immunizations unless required because of an injury or immediate risk of infection

Injections which can be self-administered, such as insulin

Meals delivered to your home

Naturopaths' services

Nursing care on a full-time basis in your home

Orthopedic shoes (unless part of a leg brace) and other supportive devices for the feet

Personal convenience items that you request such as a phone, radio, or television in your room at a hospital or skilled nursing facility

Physical examinations that are routine and tests directly related to such examinations

Private duty nurses

Private room (See table on page 13 or 19)

Services performed by immediate relatives or members of your household

Services which are not reasonable and necessary
(See page 8)

Services payable by workmen's compensation or another government program

Services for which neither the patient nor another party on his behalf has a legal obligation to pay

How to get the part of Medicare you do not have

Most people who have Medicare's hospital insurance do not pay monthly premiums for this protection. They have hospital insurance because of credits for work under social security.

If you have Medicare hospital insurance, but do not have the medical insurance part of Medicare, you can sign up for medical insurance in the first 3 months of any year. Generally, for each year you delay signing up after you were first eligible to enroll, your monthly medical insurance premium* increases by 10 percent. Your protection does not start until July 1 of the year you sign up.

***Medical insurance premium**
The basic monthly medical insurance premium is $6.70. This premium may go up if the costs of medical care rise. Under the law, however, the premium cannot be raised unless there has been a general increase in social security cash benefits since the last premium change. Also, the premium increase cannot be more than the percentage increase in cash benefits. Your medical insurance premium is never more than one-half the cost of your medical insurance protection.

If you are 65 or older and have Medicare medical insurance, but not the hospital insurance part, you can get hospital insurance by paying a monthly premium. You can sign up for hospital insurance in the first 3 months of any year. Generally, for each year you delay signing up after you become 65, the hospital insurance premium* goes up by 10 percent. Your protection does not begin until July 1 of the year you sign up.

Your social security office can answer any questions you may have on how to get the part of Medicare you do not have now.

***Hospital insurance premium**
The basic monthly hospital insurance premium is $36 through June 30, 1975. It will be increased to $40 a month for the 12-month period starting July 1, 1975. This premium represents the present cost of Medicare hospital insurance protection. This premium may go up if the costs of hospital care rise. Under the law, however, hospital insurance premiums cannot be changed more often than once a year.

Events that can end your Medicare protection

If you are 65 or older and you have Medicare hospital insurance because of work credits under social security, you will have this protection as long as you live. Your medical insurance protection, however, depends on the payment of monthly premiums, which are either deducted from social security checks or paid directly.

Medical insurance can stop only if you do not pay premiums or if you voluntarily cancel. Remember, though, that you may not be able to get private insurance that offers the same protection. Also, you can re-enroll only once, and your premium will be higher.

If you are buying hospital insurance protection, you cannot cancel your medical insurance without losing your hospital insurance, too. However, you can cancel your hospital insurance and still continue your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with any social security office.

If you are disabled

If you have Medicare because you are disabled, both your hospital and your medical insurance protection will end if your entitlement to disability benefits ends before you are 65. Your Medicare protection will continue for one calendar month after the month notice is sent to you that you are no longer entitled to disability payments.

As long as you are getting disability checks, you will have the protection of hospital insurance. If for any reason you ever want to cancel your medical insurance, get in touch with any social security office.

If you have Medicare because of chronic kidney disease

If you are under 65 and you have Medicare because of chronic kidney disease, your protection will continue until 12 months after a successful kidney transplant or 12 months after dialysis treatment ends. Your medical insurance protection could stop before that if you fail to pay premiums or you decide to cancel. Get in touch with any social security office if you ever want to end your medical insurance protection.

How to submit medical insurance claims

A *Request for Medicare Payment* form, also called Form 1490, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All social security offices, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is willing to use the assignment method of payment, he submits the claim. You complete and sign Part I of the form. He completes Part II and sends in the form.

If the doctor or supplier does not accept assignment, you submit the claim under the payment-to-you method. Complete and sign Part I of the form. Ask the person who provided the services either to complete Part II of the form **or** to give you an itemized bill to send in with the form. An itemized bill **must** show (1) the date you received the services, (2) the place where you received the services, (3) a description of the services, (4) the nature of your illness or injury (diagnosis), (5) the charge for each service, and (6) your name **and** your health insurance claim number, **including** the letter at the end of the number. If the bill doesn't include all of this information, your payment will be delayed.

If you are sending in itemized bills, you may submit a number of bills with a single *Request for Medicare Payment* form. It doesn't matter whether all the bills are from one doctor or supplier or from different people who gave you services.

Before any medical insurance payment can be made, your record must show that you have met the yearly deductible. So, as soon as your bills come to $60, send them to the carrier that handles your medical insurance claims with a *Request for Medicare Payment* form. Once you have met the $60

deductible, we suggest that you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly. Page 51 will tell you where to send your claim.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charges for each service, and the name of the person who provided each service.

Claims for a person who died

When someone who has Medicare dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, or home health agency that provided covered services.

For services covered under medical insurance which were furnished by doctors or suppliers, some special rules apply. If the doctor or supplier accepts an assignment, the medical insurance payment can be made directly to him. If the doctor or supplier will not accept an assignment, then any medical insurance payment due will be paid to whoever pays the bill and submits a medical insurance claim with proof of payment. The person who pays the bill will need to file two forms. One form, called *Request for Medicare Payment*, is explained on page 48. The other form is called *Statement Regarding Medicare Payment for Medical Services to Deceased Patient*. Copies of both forms can be obtained at any social security office.

If the patient paid the bill prior to his or her death, call any social security office for information about how to get the medical insurance payment.

Time limits for submitting claims

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

When you receive services	When your claim must be submitted
Between October 1, 1973, and September 30, 1974	By December 31, 1975
Between October 1, 1974, and September 30, 1975	By December 31, 1976
Between October 1, 1975, and September 30, 1976	By December 31, 1977
Between October 1, 1976, and September 30, 1977	By December 31, 1978

Where to send your medical insurance claims

The list beginning on the next page gives the names and addresses of the organizations selected by the Social Security Administration to handle medical insurance claims. These organizations are called carriers. In most cases, one carrier handles claims for an entire State. But some carriers handle claims for only part of a State. To find out where to send your medical insurance claim, look in the list for the State **where you received the services.** Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the **county** where you received services to find the carrier that will handle your claim. (See page 48 to find out how to submit medical insurance claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent on to the right place.

Whenever you send in a claim, be sure to include the word Medicare in the carrier's address on the envelope. Also, be sure to put **your** return address on the envelope.

After you make a claim, the carrier will usually send you another *Request for Medicare Payment* form for your next claim. The form will usually show the carrier's name and address in the top left-hand corner. If you ever need to file a medical insurance claim and don't have a claim form, you can get one by phoning a social security office.

Note: If you are entitled to Medicare under the railroad retirement system, send your medical insurance claims to The Travelers Insurance Company office which is nearest to your home—no matter where you received services.

Alabama
Medicare
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205

Alaska
Medicare
Aetna Life & Casualty
Crown Plaza
1500 S.W. First Avenue
Portland, Oregon 97201

Arizona
Medicare
Aetna Life & Casualty
Medicare Claim Administration
3010 West Fairmount Avenue
Phoenix, Arizona 85017

Arkansas
Medicare
Arkansas Blue Cross and
Blue Shield
P.O. Box 1418
Little Rock, Arkansas 72203

California
Counties of: Los Angeles, Orange, San Diego, Ventura, San Bernadino, Imperial, San Luis Obispo, Riverside, Santa Barbara
Medicare
Occidental Life Insurance Co. of California
Box 54905
Terminal Annex
Los Angeles, California 90054

Rest of State:
Medicare
Blue Shield of California
P.O. Box 7968, Rincon Annex
San Francisco, California 94120

Colorado
Medicare
Colorado Medical Service, Inc.
700 Broadway
Denver, Colorado 80203

Connecticut
Medicare
Connecticut General Life Insurance Co.
200 Pratt Street
Meriden, Connecticut 06450

Delaware
Medicare
Blue Cross and Blue Shield of Delaware
201 West 14th Street
Wilmington, Delaware 19899

District of Columbia
Medicare
Medical Service of D.C.
550 – 12th St., S.W.
Washington, D.C. 20024

Florida
Counties of: Dade, Monroe
Medicare
Group Health, Inc.
P.O. Box 341370
Miami, Florida 33134

Rest of State:
Medicare
Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32203

Georgia
The Prudential Insurance Co. of America
Medicare Part B
P.O. Box 95466 Executive Park Station
Atlanta, Georgia 30347

Hawaii
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Idaho
Medicare
The Equitable Life Assurance Society
P.O. Box 8048
Boise, Idaho 83707

Illinois
Cook County
Medicare
Illinois Medical Service
233 N. Michigan Avenue
Chicago, Illinois 60601

Rest of State:
Medicare
CNA Insurance
Medicare Benefits Division
P.O. Box 910
Chicago, Illinois 60690

Indiana
Medicare Part B
120 West Market Street
Indianapolis, Indiana 46204

Iowa
Medicare
Iowa Medical Service
324 Liberty Building
Des Moines, Iowa 50309

Kansas
Counties of: Johnson, Wyandotte
Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
Kansas Physicians Service
1133 Topeka Boulevard
Topeka, Kansas 66601

Kentucky
Medicare
Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, Kentucky 40504

Louisiana
Medicare
Pan-American Life Insurance Co.
P.O. Box 60450
New Orleans, Louisiana 70160

Maine
Medicare
Union Mutual Life Insurance Co.
Box 4629
Portland, Maine 04112

Maryland
Counties of: Montgomery, Prince Georges
Medicare
Medical Service of D.C.
550 – 12th St., S.W.
Washington, D.C. 20024

Rest of State:
Maryland Blue Shield, Inc.
700 East Joppa Road
Towson, Maryland 21204

Massachusetts
Medicare
Blue Shield of Massachusetts, Inc.
P.O. Box 2194
Boston, Massachusetts 02110

Michigan
Medicare
Blue Shield of Michigan
P.O. Box 2201
Detroit, Michigan 48231

Minnesota
Counties of: Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona
Medicare
The Travelers Insurance Company
8120 Penn Avenue, South
Bloomington, Minnesota 55431

Rest of State:
Medicare
Blue Shield of Minnesota
P.O. Box 8899
Minneapolis, Minnesota 55408

Mississippi
Medicare
The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39205

Missouri
Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth
Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
General American Life
Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

Montana
Medicare
Montana Physicians' Service
P.O. Box 2510
Helena, Montana 59601

Nebraska
Medicare
Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

Nevada
Medicare
Aetna Life & Casualty
1535 Vassar Street
P.O. Box 3077
Reno, Nevada 89505

New Hampshire
Medicare
New Hampshire-Vermont
Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

New Jersey
Medicare
The Prudential Insurance Co.
of America
P.O. Box 3000
Linwood, New Jersey 08221

New Mexico
Medicare
The Equitable Life Assurance
Society
P.O. Box 3070, Station D
Albuquerque, New Mexico 87110

New York
Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare
Blue Cross-Blue Shield of
Greater New York
Two Park Avenue
New York, New York 10016

County of: Queens
Medicare
Group Health, Inc.
P.O. Box 233—Midtown Station
New York, New York 10018

Counties of: Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Medicare
Genesee Valley Medical Care, Inc.
41 Chestnut Street
Rochester, New York 14647

Counties of: Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming
Medicare
Blue Shield of Western
New York, Inc.
298 Main Street
Buffalo, New York 14202

Counties of: Albany, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Cortland, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Tioga, Tompkins, Warren, Washington
Medicare
Metropolitan Life Insurance Co.
276 Genesee Street
P.O. Box 393
Utica, New York 13503

North Carolina
The Prudential Insurance Co.
of America
Medicare B Division
P.O. Box 2126
High Point, North Carolina 27261

North Dakota
Medicare
Blue Shield of North Dakota
301 Eighth Street, South
Fargo, North Dakota 58102

Ohio
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Oklahoma
Medicare
Aetna Life & Casualty
1140 N.W. 63rd Street
Oklahoma City, Oklahoma 73116

Oregon
Medicare
Aetna Life & Casualty
Crown Plaza
1500 S.W. First Avenue
Portland, Oregon 97201

Pennsylvania
Medicare
Pennsylvania Blue Shield
Box 65 Blue Shield Bldg.
Camp Hill, Pennsylvania 17011

Rhode Island
Medicare
Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

South Carolina
Medicare
Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota
Medicare
South Dakota Medical Service, Inc.
711 North Lake Avenue
Sioux Falls, South Dakota 57102

Tennessee
Medicare
The Equitable Life
Assurance Society
P.O. Box 1465
Nashville, Tennessee 37202

Texas
Medicare
Group Medical and Surgical Service
P.O. Box 22147
Dallas, Texas 75222

Utah
Medicare
Blue Shield of Utah
P.O. Box 270
2455 Parley's Way
Salt Lake City, Utah 84110

Vermont
Medicare
New Hampshire-Vermont
Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

Virginia
Counties of: Arlington, Fairfax
Cities of: Alexandria, Falls
Church, Fairfax
Medicare
Medical Service of D.C.
550-12th St., S.W.
Washington, D.C. 20024

Rest of State:
Medicare
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23261

Washington
Medicare
Washington Physicians' Service
Mail to your local
Medical Service Bureau
If you do not know which bureau
handles your claim, call any
social security office
for the address

West Virginia
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Wisconsin
County of Milwaukee
Medicare
Surgical Care—Blue Shield
P.O. Box 2049
Milwaukee, Wisconsin 53201

Rest of State:
Medicare
Wisconsin Physicians Service
Box 1787
Madison, Wisconsin 53701

Wyoming
Medicare
The Equitable Life
Assurance Society
P.O. Box 628
Cheyenne, Wyoming 82001

Puerto Rico
Medicare
Seguros De Servicio De Salud De
Puerto Rico
P.O. Box 3628
104 Ponce de Leon Avenue
Hato Rey, Puerto Rico 00936

Virgin Islands
Medicare
Seguros De Servicio De Salud De
Puerto Rico
P.O. Box 3628
104 Ponce de Leon Avenue
Hato Rey, Puerto Rico 00936

American Samoa
Medicare
Hawaii Medical Service Assn.
P.O. Box 860
Honolulu, Hawaii 96808

Guam
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

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Department of
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Social Security Administration

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U.S. Department of
Health, Education, and Welfare
Social Security Administration
DHEW Publication No. (SSA) 75-10050
March 1975

Aging

MEDICARE PART B CLAIMS PROCESSING SYSTEM

April 10, 1975

INDEX

Receipt of Claims (Mailroom)

Medicare Part B claims (1490's, 1554's, etc.) are received in the mail-room and the envelopes are sliced. The claims and envelopes are then forwarded to the mail desk in the Medicare Part B and Complementary Claims Department.

Receipt of Claims (Department)

Claims are removed from the envelopes and sorted by type of claim form (1490, 1554, etc.). Those claims which are missing Health Insurance Claim Numbers are separated. All claims are stamped with the julian date of receipt. The sorted claims are put into four equal batches and forwarded to the Scanner in each Unit of the Claims Processing Sections. The Health Insurance Claim Number look-ups are checked against the "CAST" (alphabetic) microfilm file and then forwarded to the Scanners.

Scanning Function

Scanners review the claims and further sort them into the following categories: A) claims ready for CRT input, B) claims requiring assignment of procedure codes and/or creation of "splits" prior to CRT input, C) claims requiring development, utilization screening, or other review. Category "A" claims are forwarded to the control clerk, category "B" claims are forwarded to the fee assigners, and category "C" claims are forwarded to the appropriate review area.

Clerical Assigning of Control Number

The julian calendar date and a unique five digit number are assigned to each claim as the Control Number. The incorporation of the julian date in the control number enables the system to age all claims and reflect this data on management reports. The control numbers are computer-prepared on adhesive labels in team (unit) order. One label is affixed to each claim, the claims are batched, and then forwarded to the CRT operator.

Coding Function

Fee assigners review the claims, create splits if necessary, and complete the required coding. The claims are then forwarded to the control clerk.

Development and Utilization Review

Appropriate area reviews the claim immediately and determines if the claim can be adjudicated without delay or whether further development is necessary. Claims released back into the processing cycle are returned to the Scanner. Claims requiring further development are forwarded to the control clerk.

CRT Operation

Claims are controlled and entered into the system. Those claims needing further development are entered as "Control Only" claims. Input (the validity module) and Reasonable Charge (the pricing module) exceptions

are re-entered on the CRT's. Input validity errors are detected within the claim itself or between the claim and the Beneficiary Extract File. (NOTE: The Beneficiary History File is not available via the CRT's). In the reasonable charge module, the claim is priced by the doctor's/ supplier's customary charge or by the prevailing charge. After the claims are entered into the system, they are forwarded to the "Freeze Files," where they are filed in control number order. (NOTE: After CRT entry, the claim enters the "batch" system and is processed to completion.

Duplicate Check/Query Reply Exceptions

Claims which cannot be processed to completion are "kicked out 'of the system as exceptions. Exception report print-outs and "turnaround cards" are computer generated. The exception claims are manually corrected and re-entered into the system using the "turnaround cards."

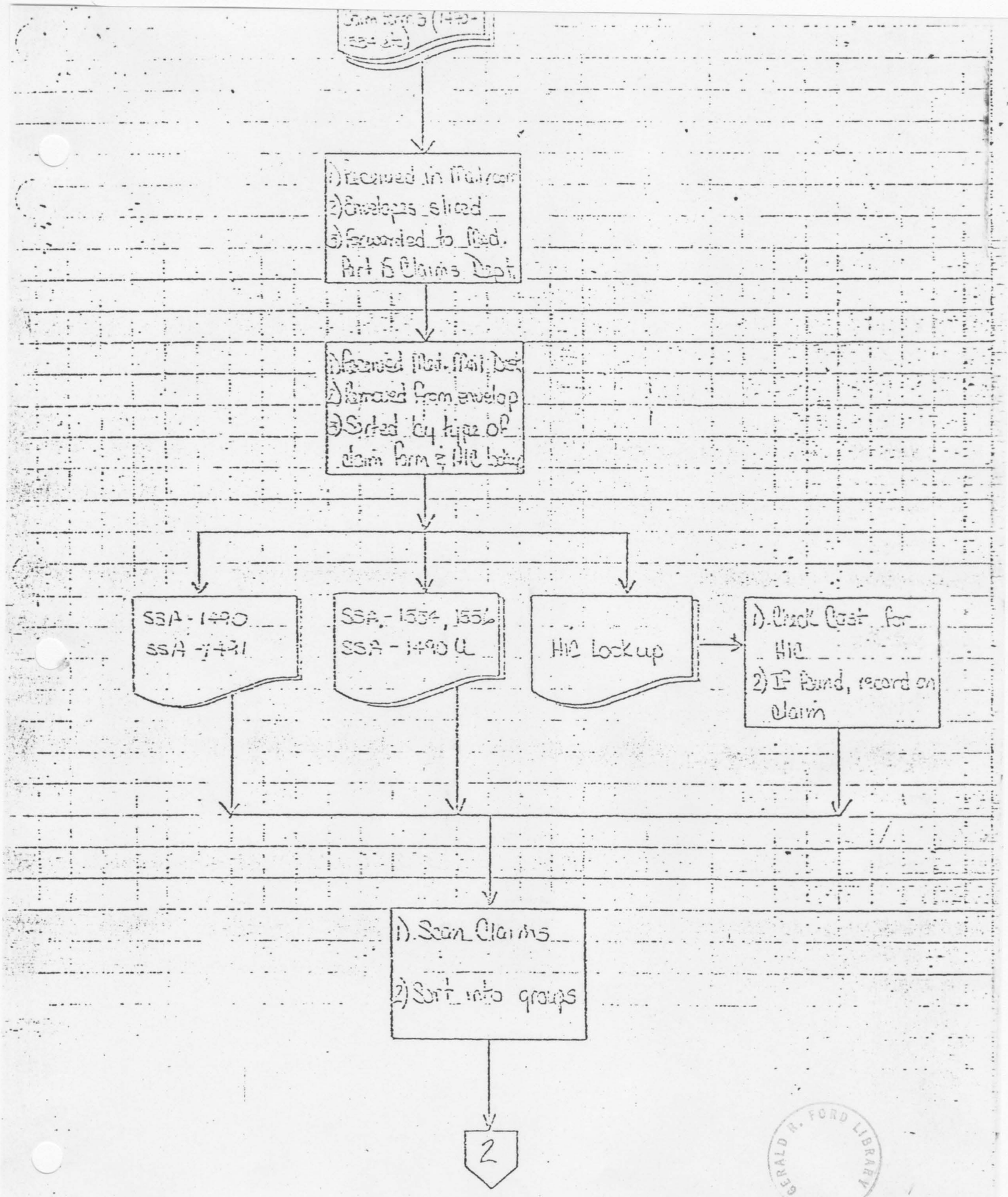
Completed Claims

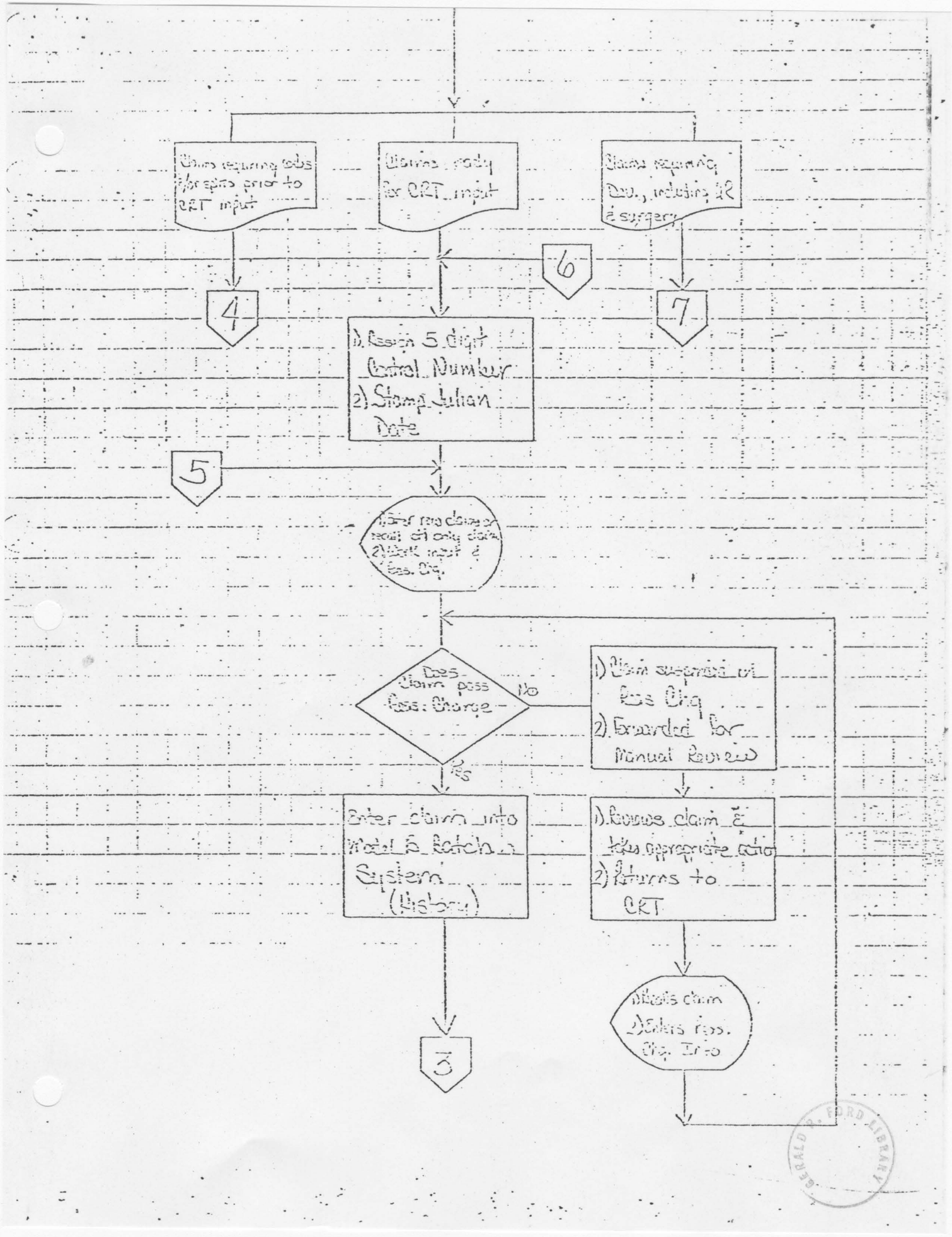
Claims which appear on the daily completed claims listing are purged from the "Freeze Files" and forwarded to the Review and Files Section for preparation for microfilming.

Microfilming

Claims are microfilmed by completed date and in control number order. Two reels of film are made simultaneously. The film is processed and reviewed in the Claims Service Department. The film and claims are then forwarded to the Medicare Part B Claims Department, where the film is

verified. The SSA 5% sample claims and claims for beneficiaries who have Medicaid coverage are forwarded to the Social Security Administration and the Medicaid Agencies respectively, and the remaining completed claims are prepared for shipment to the Federal Records Center.




Claims requiring edits for spec. prior to CRT input
Claims ready for CRT input
Claims requiring Dev., including PP & surgery
4
6
7
1) Assign 5 digit Control Number
2) Stamp Julian Date
5
1) Enter new claims record or only claim
2) Check input & Pass. Chg.
Does claim pass Pass. Charge
No
Yes
1) Claim suspended w/ Pass Chg
2) Forwarded for Manual Review
Enter claim into Medical Batch System (History)
1) Reviews claim & Pass appropriate code
2) Returns to CRT
3
Modifies claim
2) Enters Pass. Chg. Info
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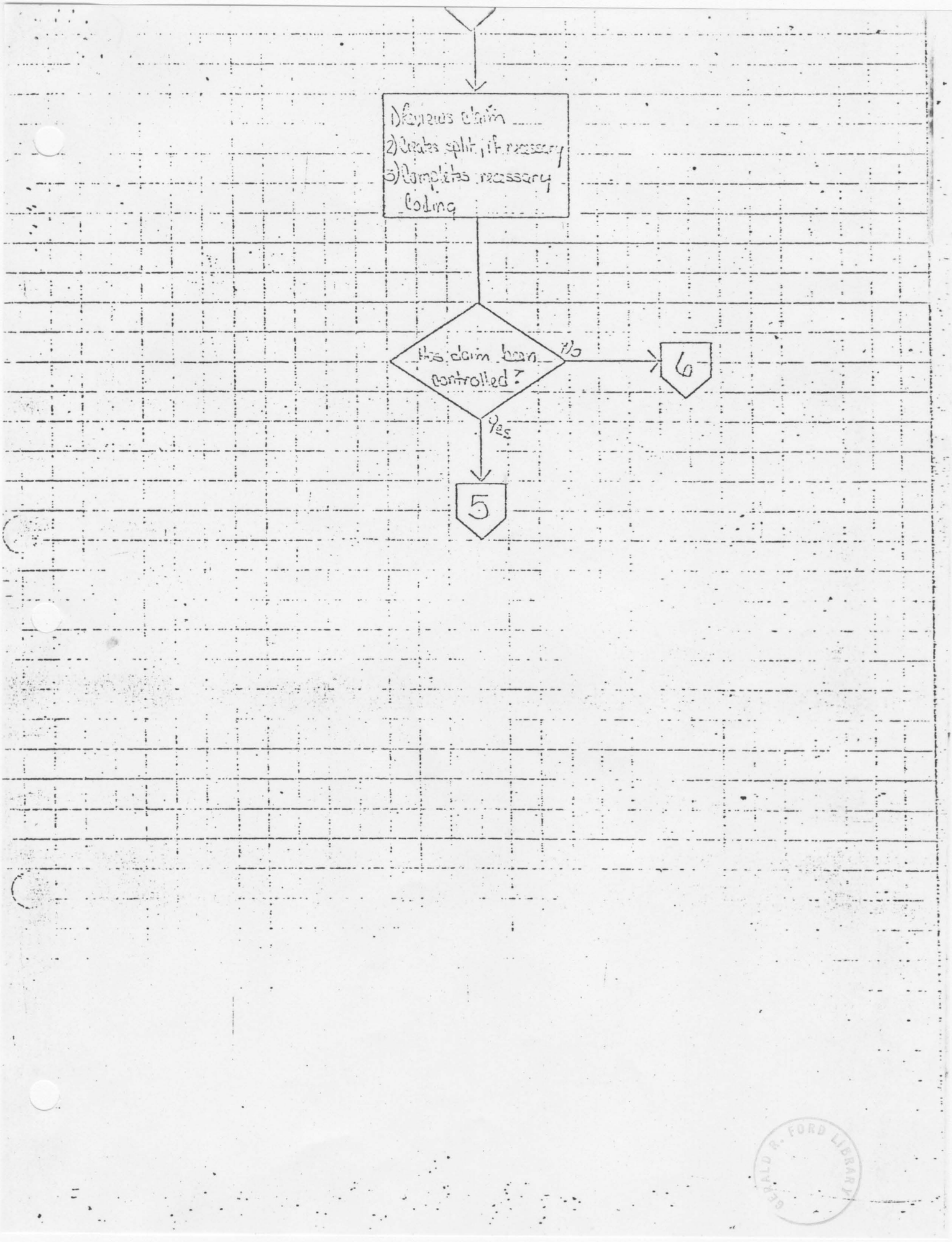
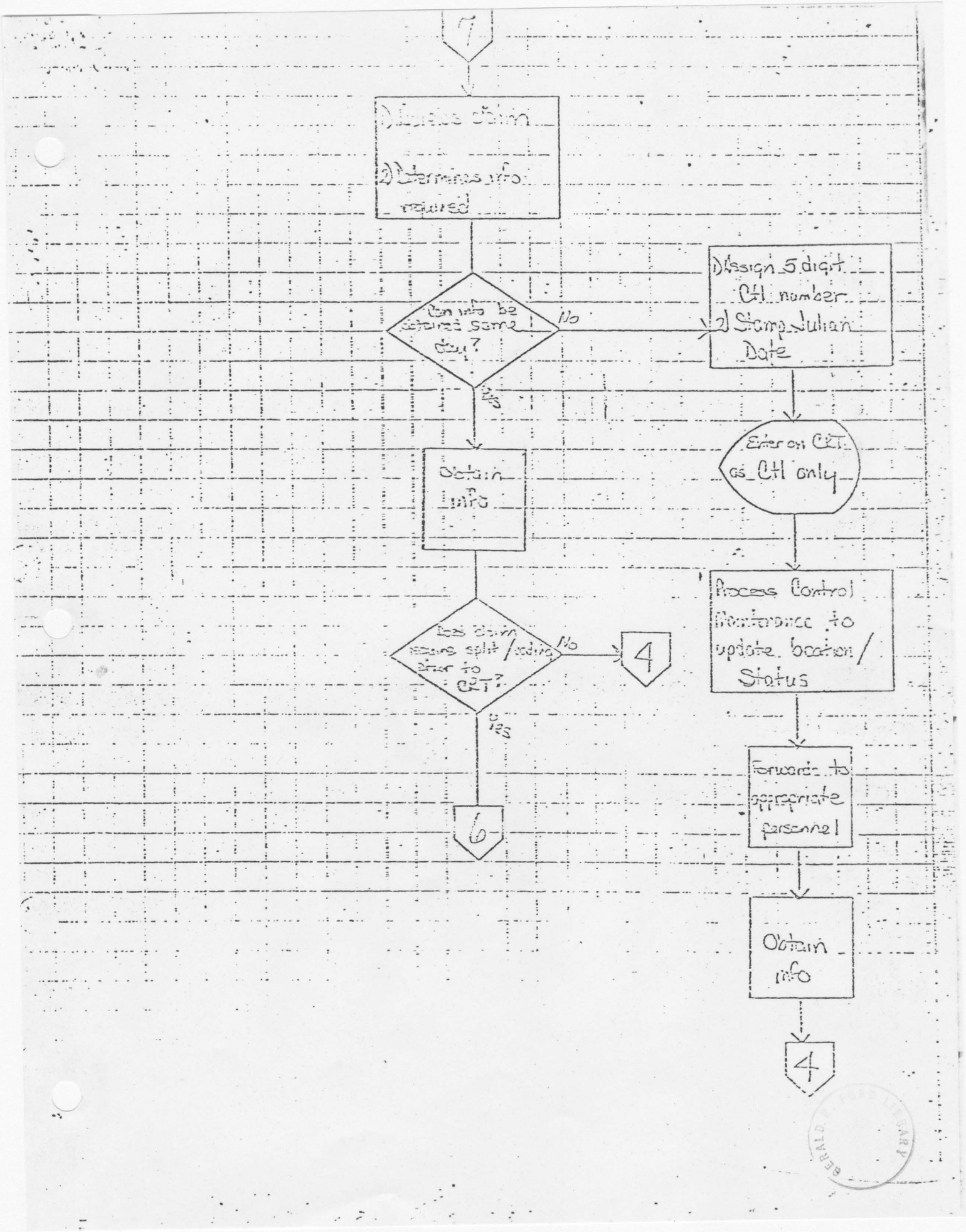



7
1) Locate claim
2) Determine info required
Can info be obtained same day?
No
Yes
1) Assign 5 digit Ctl number
2) Stamp Julian Date
Enter on CRT as Ctl only
Obtain info
Process Control Maintenance to update location/ Status
Does claim require split/adding letter to CRT?
No
4
Yes
6
Forward to appropriate personnel
Obtain info
4

MEDICAL SERVICE OF D.C.

UTILIZATION REVIEW DEPARTMENT

DATE DEC 1975 — PHYSICIAN PAYMENT REGISTER (YEAR TO DATE) — PAGE NO 64

DOCTOR NUMBER	NAME	TOTAL PAID	TOTAL PATIENTS	AVERAGE / PATIENT	TOTAL SERVICES	AVERAGE / SERVICE	TOTAL CLAIMS	AVERAGE / CLAIM	SPE-CIALTY
		194,738.40	8,943	133.59	19,340	61.78	16,461	72.58	01
		865,999.56	6,211	139.43	19,256	44.97	8,563	101.13	49
		855,306.61	4,192	204.03	11,952	71.56	10,165	84.14	16
		655,539.28	11,462	57.19	13,511	48.52	13,129	49.93	30
		454,253.42	160	2,839.08	1,297	350.23	653	695.64	11
		452,183.45	1,623	278.61	3,048	148.35	2,307	196.00	35
		439,452.99	3,370	130.40	10,364	42.40	5,189	84.69	99
		427,946.46	8,085	52.93	9,811	43.62	9,584	44.65	30
		424,176.95	3,129	135.56	6,786	62.51	4,922	86.18	20
		421,989.38	2,728	154.69	6,270	67.30	3,481	121.23	13
		419,177.02	538	779.14	1,821	230.19	1,138	368.35	26
		392,804.00	3,454	113.72	6,828	57.53	6,238	62.97	16
		354,734.71	4,899	72.41	7,798	45.49	7,575	46.83	20
		343,653.52	3,925	87.56	4,259	80.69	4,258	80.71	05
		338,426.63	1,540	219.76	7,182	47.12	4,637	72.98	34
		324,884.50	3,130	103.80	11,975	27.13	7,188	45.20	11
		314,489.28	3,772	83.37	4,101	76.69	4,030	78.04	49
		305,899.39	3,613	84.67	4,042	75.68	3,937	77.70	05
		304,657.53	4,778	62.76	10,640	28.10	8,354	36.47	01
		302,965.56	8,461	35.81	13,562	22.34	12,146	24.94	22
		298,993.90	87	3,436.71	901	331.85	373	801.59	49
		285,085.24	4,706	60.58	10,966	26.00	7,268	39.22	08
		278,108.15	8,763	31.74	12,077	23.03	10,986	25.31	22
		276,768.36	1,769	156.45	6,105	45.33	3,006	92.07	11
		271,822.72	1,688	161.03	7,173	37.90	3,546	76.66	11
		262,493.96	12,615	20.81	14,573	18.01	14,599	17.98	01
		261,035.30	1,225	213.09	1,619	161.23	1,523	171.40	16
		254,840.71	1,755	145.21	3,105	82.07	2,200	115.84	11
		247,599.08	2,230	111.03	6,319	39.18	3,496	70.82	34
		246,813.57	4,880	50.58	5,378	45.89	5,369	45.97	30
		245,600.35	2,068	118.76	3,916	62.72	3,220	76.27	16
		237,897.30	421	565.08	1,041	228.53	549	433.33	33
		223,354.52	1,116	200.14	6,028	37.05	2,967	75.28	11
		217,109.55	2,888	75.18	4,719	46.01	4,049	53.62	44
		216,556.70	2,414	89.71	4,039	53.62	3,100	69.86	20
		215,906.51	1,079	200.10	3,046	70.88	2,184	98.86	16
		215,475.04	673	320.17	4,084	52.76	2,189	98.44	11
		215,468.65	1,454	148.19	4,347	49.57	3,358	64.17	11
		215,406.83	1,072	200.94	1,579	136.42	1,264	170.42	16
		209,708.17	1,129	185.75	2,162	97.00	1,531	136.97	16
		205,476.89	673	305.31	2,753	74.64	1,641	125.21	16
		202,987.58	10,245	19.81	11,791	17.22	11,797	17.21	01
		202,014.60	2,101	96.15	3,362	60.09	3,011	67.09	16
		201,023.09	11,838	16.98	13,094	15.35	13,163	15.27	01
		200,066.15	1,302	153.66	2,412	82.95	1,694	118.10	16
		198,805.10	980	202.86	2,695	73.77	1,778	111.81	20

** TC41Y ** DOCTOR UTILIZATION REVIEW 01/21/76

PHYSICIAN PAYMENT REGISTER (YEARLY REPORT)
BY SPECIALITY WITHIN COUNTY

COUNTY = 01

SPECIALITY = 07

DOCTOR NUMBER	DOCTOR NAME	TOTAL PAID	TOTAL PATIENTS	AVERAGE / PATIENT	TOTAL SERVICES	AVERAGE / SERVICE	TOTAL CLAIMS	AVERAGE / CLAIM
		196,575.95	1,698	115.77	3,110	63.21	2,390	82.25
		72,141.93	912	79.10	1,876	38.46	1,492	48.35
		72,044.33	976	73.82	2,670	26.98	2,311	31.17
		66,424.50	776	85.60	1,946	34.13	1,468	45.25
		51,361.40	396	129.70	873	58.83	662	77.59
		30,899.84	798	38.72	1,563	19.77	1,377	22.44
		27,053.02	478	56.60	921	29.37	744	36.36
		24,150.56	444	54.39	1,078	22.40	910	26.54
		24,056.50	364	66.09	638	37.71	536	44.88
		24,002.50	531	45.20	960	25.00	733	32.75
		23,334.08	397	58.78	720	32.41	497	46.95
		22,324.45	439	50.85	1,053	21.20	834	26.77
		13,974.46	228	61.29	481	29.05	353	39.59
		13,301.42	162	82.11	275	48.37	232	57.33
		8,464.00	242	34.98	418	20.25	401	21.11
		7,954.73	158	50.35	191	41.65	174	45.72
		6,611.60	179	36.94	307	21.54	248	26.66
		6,054.90	82	73.84	110	55.04	86	70.41
		5,909.59	130	45.46	169	34.97	162	36.48
		5,239.40	80	66.07	141	37.49	111	47.92
		3,119.25	115	27.12	190	16.42	166	18.79
		2,534.00	64	39.59	78	32.49	70	36.20
		1,953.00	49	39.86	84	23.25	53	36.85
		1,796.00	49	36.65	59	30.44	57	31.51
		75.00	01	75.00	01	75.00	01	75.00
		55.75	03	18.58	03	18.58	03	18.58
		0.00	02	0.00	00	0.00	02	0.00

SUB TOTALS FOR SPECIALITY ** 07 ** WITHIN THE COUNTY ** 01 ** ARE:

AMOUNT PAID	TOTAL PATIENTS	AVERAGE/PATIENT	TOTAL SERVICES	AVERAGE/SERVICE	TOTAL CLAIMS	AVERAGE/CLAIM
711,458.16	9,753	72.95	19,915	35.72	16,073	44.26

SPECIALTY AVERAGES

SPECIALTY	DESCRIPTION OF SERVICE	AVERAGE NUMBER OF SERVICES FOR POT1	POT2	POT3	AVERAGE SERVICES	AVERAGE % OF INCOME
01	ANESTHESIA	001	000	000	001	0.3
01	ASST. SURGEON	001	000	000	001	0.4
01	CONSULTATIONS	002	000	000	002	0.8
01	EEG	000	000	000	000	0.1
01	EKG	000	000	033	033	5.5
01	LABORATORY	000	006	212	219	32.8
01	MATERNITY	001	000	000	001	1.9
01	MEDICAL CARE	016	040	012	069	19.1
01	PHYSICAL THERAPY	000	000	000	000	0.0
01	PSYCHOTHERAPY	001	000	000	001	1.2
01	RADIOTHERAPY	000	000	004	004	1.2
01	SURGERY	005	072	058	136	29.2
01	X-RAY	000	001	043	043	7.3
01	OTHER	000	000	001	001	0.1
PEER GROUP AVERAGES		027	121	364	512	100.0
PEER GROUP AVERAGE # OF PATIENTS		296				
PEER GROUP AVERAGE # OF CLAIMS		412				

SPECIALTY	DESCRIPTION OF SERVICE	AVERAGE NUMBER OF SERVICES FOR POT1	POT2	POT3	AVERAGE SERVICES	AVERAGE % OF INCOME
02	ANESTHESIA	000	000	000	000	0.0
02	ASST. SURGEON	002	000	000	002	0.8
02	CONSULTATIONS	009	000	000	009	1.6
02	EKG	000	000	003	003	0.3
02	LABORATORY	000	001	035	036	3.7
02	MATERNITY	000	001	000	001	1.2
02	MEDICAL CARE	012	007	003	022	5.0
02	PHYSICAL THERAPY	000	000	000	000	0.0
02	PSYCHOTHERAPY	000	000	000	000	0.0
02	RADIOTHERAPY	000	000	001	001	0.1
02	SURGERY	057	039	061	157	87.1
02	X-RAY	000	000	003	003	0.3
02	OTHER	000	000	000	000	0.0
PEER GROUP AVERAGES		080	048	106	234	100.0
PEER GROUP AVERAGE # OF PATIENTS		163				
PEER GROUP AVERAGE # OF CLAIMS		199				

MEDICAL SERVICE UTILIZATION REVIEW

DATE 01/21/76 — PHYSICIAN PRACTICE ANALYSIS SUMMARY REPORT —

SPECIALTY WITHIN COUNTY AVERAGES

COUNTY	SPECIALTY	DESCRIPTION OF SERVICE	AVERAGE NUMBER OF SERVICES FOR POT1	POT2	POT3	AVERAGE SERVICES	AVERAGE % OF INCOME
01	01	ANESTHESIA	001	000	000	001	0.2
01	01	ASST. SURGEON	000	000	000	000	0.0
01	01	CONSULTATIONS	006	000	000	006	1.4
01	01	EEG	000	000	000	000	0.0
01	01	EKG	001	001	023	025	4.1
01	01	LABORATORY	001	001	205	207	21.2
01	01	MATERNITY	001	000	001	003	3.8
01	01	MEDICAL CARE	021	078	017	116	21.1
01	01	PHYSICAL THERAPY	000	000	000	000	0.0
01	01	PSYCHOTHERAPY	001	000	000	001	3.1
01	01	RADIOTHERAPY	000	000	004	004	0.8
01	01	SURGERY	016	091	044	152	38.0
01	01	X-RAY	000	000	045	046	6.0
01	01	OTHER	000	000	001	001	0.2
PEER GROUP AVERAGES			050	172	341	563	100.0
PEER GROUP AVERAGE # OF PATIENTS			332				
PEER GROUP AVERAGE # OF CLAIMS			480				

COUNTY	SPECIALTY	DESCRIPTION OF SERVICE	AVERAGE NUMBER OF SERVICES FOR POT1	POT2	POT3	AVERAGE SERVICES	AVERAGE % OF INCOME
01	02	ANESTHESIA	000	000	000	000	0.0
01	02	ASST. SURGEON	000	000	000	000	0.1
01	02	CONSULTATIONS	008	000	000	008	1.5
01	02	EKG	000	000	001	001	0.1
01	02	LABORATORY	000	002	028	029	3.2
01	02	MATERNITY	000	002	000	002	2.8
01	02	MEDICAL CARE	012	013	005	030	5.6
01	02	PHYSICAL THERAPY	000	000	001	001	0.0
01	02	PSYCHOTHERAPY	000	000	000	000	0.0
01	02	RADIOTHERAPY	000	000	000	000	0.0
01	02	SURGERY	060	037	066	164	86.5
01	02	X-RAY	000	000	002	002	0.2
01	02	OTHER	000	000	000	000	0.0
PEER GROUP AVERAGES			081	054	102	237	100.0
PEER GROUP AVERAGE # OF PATIENTS			167				
PEER GROUP AVERAGE # OF CLAIMS			202				

MEDICAL SERVICE UTILIZATION REVIEW

01/21/76 PHYSICIAN PRACTICE ANALYSIS SUMMARY REPORT

INDIVIDUAL PHYSICIAN REPORT

DOC NUM	CO	SP	DESCRIPTION OF SERVICE	TOTAL SERVICES FOR POT1	POT2	POT3	TOTAL SERVICES	TOTAL ALLOWED	TOTAL CHARGED	% OF INCOME	% OF DEV.	AMOUNT ABOVE	FLAG
	11	11	RADIOTHERAPY	000	000	001-	001-	016.50-	018-	21.3	19.5	015.11-	*
	11	11	X-RAY	000	000	001-	001-	016.50-	020-	21.3	11.8	009.15-	*
	01	11	LABORATORY	000	000	000	000	000.00	000	0.0	48.4-	000.00	
	01	11	MEDICAL CARE	000	000	001	001	002.40	175	100.0	78.4	001.88	*
	01	01	EKG	000	000	005	005	098.75	104	2.1	2.0-	000.00	
	01	01	LABORATORY	000	000	112	112	4,544.10	4,964	95.8	74.6	3,539.66	*
	01	01	RADIOTHERAPY	000	000	001	001	052.50	052	1.1	0.3	014.23	*
	01	01	SURGERY	000	000	002	002	032.00	050	0.7	37.3-	000.00	
	01	01	X-RAY	000	000	001	001	017.50	025	0.4	5.6-	000.00	
	13	07	LABORATORY	000	000	002	002	034.50	036	3.8	3.7-	000.00	
	13	07	SURGERY	000	000	045	045	868.00	977	96.2	4.7	042.42	*
	01	05	SURGERY	000	000	000	000	000.00	000	0.0	4.4-	000.00	
	23	18	MEDICAL CARE	000	000	001	001	042.00	042	0.8	6.1-	000.00	
	23	18	SURGERY	009	001	041	051	5,521.00	6,173	99.2	8.9	495.11	*
	13	30	MEDICAL CARE	000	000	000	000	000.00	000	0.0	0.2-	000.00	
	13	30	SURGERY	000	000	000	000	000.00	050	0.0	3.6-	000.00	
	01	11	LABORATORY	000	000	002	002	031.00	036	100.0	51.6	016.00	*
	13	02	ASST. SURGEON	001	000	000	001	030.19	225	0.1	0.1-	000.00	
	13	02	CONSULTATIONS	026	000	000	026	821.92	875	2.9	0.9	257.85	*
	13	02	LABORATORY	000	000	013	013	065.50	097	0.2	6.0-	000.00	
	13	02	MEDICAL CARE	006	003	005	014	442.82	615	1.5	3.0-	000.00	
	13	02	SURGERY	072	025	104	201	27,289.74	33,527	95.3	10.1	2,893.67	*
	01	01	LABORATORY	000	000	000	000	000.00	000	0.0	21.2-	000.00	
	01	01	MEDICAL CARE	000	000	002	002	091.86	455	70.7	49.6	064.41	*
	01	01	SURGERY	000	000	001	001	038.00	153	29.3	8.7-	000.00	
	01	01	X-RAY	000	000	000	000	000.00	001-	0.0	6.0-	000.00	
	11	60	SURGERY	002	000	000	002	396.00	600	90.8	1.4-	000.00	
	11	60	X-RAY	001	000	001	002	040.00	040	9.2	1.6	006.98	*
	01	24	ANESTHESIA	001	000	001	002	168.00	304	1.6	1.5	153.47	*
	01	24	ASST. SURGEON	000	000	001	001	150.00	150	1.5	1.4	143.24	*
	01	24	LABORATORY	000	000	000	000	000.00	001-	0.0	0.1-	000.00	
	01	24	SURGERY	012	005	042	059	9,913.42	11,231	96.9	1.9-	000.00	
	13	30	SURGERY	001-	000	001	000	122.00-	122-	100.0	96.4	117.61-	*
	24	20	CONSULTATIONS	020	000	000	020	707.00	795	1.9	1.3	490.41	*
	24	20	MEDICAL CARE	014	000	001	015	1,647.00	1,885	4.4	3.1-	000.00	
	24	20	SURGERY	085	039	208	332	34,940.40	39,850	92.6	29.5	11,128.46	*

MEDICAL SERVICE PAYMENTS TO PHYSICIANS

DOCTOR NUMBER	DOCTOR NAME	YEAR 1973	YEAR 1974	YEAR 1975
		5,448.55	8,277.80	8,619.90
		42,010.50	50,163.00	59,114.74
		10.00		0.00
		6,653.73	5,757.34	3,040.35
			13.00	15.00
		4,349.85	6,497.75	6,432.70
		2.84	38.58	0.00
		27,998.34	26,596.03	23,078.36
		4,539.00	29,940.21	76,385.91
		37,973.12	36,539.12	41,824.27
		16,375.80	16,248.43	20,211.65
		12,893.40	11,061.00	12,247.45
		1,646.50	1,629.65	1,220.79
		13,104.00	7,985.69	11,778.44
		657.50	2,251.00	0.00
		34,860.50	29,824.50	5,369.75
		261.00	413.00	305.50
		15.00		0.00
		2,989.80	3,183.97	2,923.75
		232.00		79.25
				4.00
		59,576.24	51,590.32	54,896.36

PROVIDER NUMBER	PROVIDER NAME	1974 AMOUNT	1973 AMOUNT	1972 AMOUNT
		5,527.80	3,234.32	3,484.40
		6,170.74	6,253.23	3,630.44
		67.60	.00	.00
		8,841.31	9,403.31	15,774.15
		24.00	.00	.00
		12,391.74	9,987.86	12,594.34
		.00	235.20	.00
		669.20	100.40	413.99
		5,297.15	3,822.42	9,258.30
		5,328.70	240.80	2,029.48
		44.40	.00	420.00
		7,553.10	3,115.96	574.66
		.00	.00	12.00
		32,590.35	17,636.37	34,895.21
		.00	.00	86.40
		4,544.28	3,250.32	3,053.40
		4,409.71	3,537.88	4,119.56
		409.00	825.40	378.40
		2,589.58	2,409.93	2,037.36
		135.20	16.00	331.20
		27.20	156.80	84.00
		637.08	360.00	.00
		.00	36.48	.00
		15,772.56	10,821.18	4,560.76
		2.40	59.60	400.40
		.00	.00	308.00
		5,179.92	2,152.80	906.44
		8,357.32	5,226.34	5,370.27
		21,203.32	11,106.24	4,330.36
		19,504.77	11,890.04	7,236.30
		1,882.17	3,792.65	6,472.06
		.00	.00	7.95
		90.96	316.48	695.20
		16.40	.00	18.00
		8.00	528.00	.00
		2,813.28	5,736.64	4,853.75
		.00	52.48	502.96
		.00	36.80	.00
		4,712.56	5,504.84	2,234.90
		968.00	.00	.00
		97.60	124.80	140.00
		224.00	97.60	265.60
		.00	1,001.48	3,819.00
		2,571.56	3,304.88	1,610.56
		.00	2,550.97	2,035.76
		40.00	188.00	9.60
		432.16	611.84	2,538.88
		690.20	.00	.00
		225.60	.00	.00
		.00	.00	641.97

SPECIAL MEDICARE B DOCTOR SELECT REPORT 01/24/76
SUPPLEMENTAL CONTROL SHEET
FOR PROVIDER

PROVIDER NUMBER_____

1976	PAID PROVIDER	PAID BENEFICIARY	ALLOWED	SUBMITTED	PERCENT OF TOTAL
TOS 1	$3,483.04	$.00	$5,082.30	$6,785.00	66.78
TOS 2	$94.32	$.00	$117.90	$220.00	2.17
TOS 3	$1,281.60	$.00	$1,770.00	$2,440.00	24.02
TOS 4	$.00	$.00	$.00	$.00	0.00
TOS 5	$386.72	$.00	$591.20	$715.00	7.04
TOS 6	$.00	$.00	$.00	$.00	0.00
TOS 7	$.00	$.00	$.00	$.00	0.00
TOS 8	$.00	$.00	$.00	$.00	0.00
TOS 9	$.00	$.00	$.00	$.00	0.00
TOS 0	$.00	$.00	$.00	$.00	0.00
TOTAL	$5,245.68	$.00	$7,561.40	$10,160.00	100.01
1975					
TOS 1	$69,592.78	$842.96	$94,308.45	$125,620.00	81.78
TOS 2	$1,068.16	$.00	$1,409.20	$2,135.00	1.39
TOS 3	$6,101.76	$47.20	$8,635.00	$13,295.00	8.65
TOS 4	$632.80	$.00	$899.20	$1,240.00	0.81
TOS 5	$5,847.08	$116.32	$8,410.00	$10,928.50	7.11
TOS 6	$.00	$.00	$.00	$.00	0.00
TOS 7	$.00	$.00	$.00	$.00	0.00
TOS 8	$.00	$.00	$.00	$.00	0.00
TOS 9	$24.00	$.00	$30.00	$393.00	0.26
TOS 0	$.00	$.00	$.00	$.00	0.00
TOTAL	$83,266.58	$1,006.48	$113,691.85	$153,611.50	100.00
1974					
TOS 1	$88,684.08	$305.08	$117,524.80	$155,754.88	88.70
TOS 2	$645.28	$18.80	$925.85	$1,355.00	0.77
TOS 3	$3,010.40	$200.00	$4,543.25	$7,195.00	4.10
TOS 4	$1,077.48	$.00	$1,505.70	$1,795.00	1.02
TOS 5	$5,017.44	$38.40	$7,411.50	$8,784.00	5.00
TOS 6	$.00	$.00	$.00	$.00	0.00
TOS 7	$.00	$.00	$.00	$465.00	0.26
TOS 8	$.00	$.00	$.00	$.00	0.00
TOS 9	$.00	$.00	$.00	$255.55	0.15
TOS 0	$.00	$.00	$.00	$.00	0.00
TOTAL	$98,434.68	$562.28	$131,911.10	$175,604.43	100.00

UR...INFORMATION RETRIEVAL SYSTEM

PROVIDER IDENTIFICATION REPORT

PROVIDERS WHOSE NUMBER OF PATIENTS RECEIVING A SPECIFIC PROCEDURE EXCEEDS HIS PEER GROUPS AVERAGE NUMBER OF PATIENTS RECEIVING THAT SAME PROCEDURE BY MORE THAN 2.0 STANDARD DEVIATIONS

PROVIDER NUMBER	TS/PROC CODE	NUMBER-OF-SER PROV	NUMBER-OF-SER PG-AVE	NUMBER-OF-PAT PROV	NUMBER-OF-PAT PG-AVE	SV/PAT-RATIO PROV	SV/PAT-RATIO PG	P/TP RATIO	%-CHANGE SER	%-CHANGE PAT	RECENT-4-QUARTERS $-CHARGED	RECENT-4-QUARTERS $-ALLOWED	AVE-CHG/PATIENT PROV	AVE-CHG/PATIENT PG	AVE-ALL/PATIENT PROV	AVE-ALL/PATIENT PG	LOB
	067056	23	11	05	02	4.6	5.1	0.06	109+	67+	520	249	104.00	104.61	49.80	71.09	04
	067078	09	06	06	02	1.5	3.6	0.07	29+	20+	470	349	78.33	120.88	58.17	56.00	04
	0E7900	02	01	02	01	1.0	1.0	0.00	100+	100+	509	441	254.50	96.00	220.50	86.44	04
	097	316	17	273	14	1.2	1.2	0.25	15-	19-	4,911	2,050	17.99	27.75	7.51	13.79	04
	097900	72	11	72	10	1.0	1.1	0.06	1-	1-	9,354	6,590	129.92	122.06	91.53	84.20	04
	099557	29	05	28	05	1.0	1.0	0.03	71+	75+	1,685	1,076	60.18	63.40	38.43	38.18	04
	099630	835	91	753	80	1.1	1.1	0.68	2+	1+	24,842	20,779	32.99	32.24	27.59	27.20	04
	060678	07	03	04	01	1.8	2.3	0.33	0+	0+	670	78	167.50	111.64	19.50	16.05	04
	088746	06	03	06	02	1.0	1.1	0.04	500+	500+	35	34	5.83	6.41	5.67	6.00	04
	020103	123	07	44	03	2.8	2.2	0.94	208+	69+	1,935	1,345	43.98	35.71	30.57	24.57	04
	088002	56	07	43	07	1.3	1.1	0.34	24+	34+	1,092	970	25.40	25.04	22.56	22.81	04
	020445	10	03	10	03	1.0	1.1	0.11	20-	20-	1,785	1,220	178.50	204.38	122.00	145.24	04
	023311	09	03	09	03	1.0	1.1	0.10	33-	22-	270	158	30.00	34.80	17.56	21.08	04
	088692	20	04	17	03	1.2	1.3	0.10	33+	42+	218	205	12.82	17.38	12.06	14.70	04
	088746	11	03	07	02	1.6	1.3	0.04	0+	0+	71	71	10.14	7.64	10.14	7.15	04
	088919	17	04	16	03	1.1	1.1	0.09	31+	33+	102	98	6.38	7.34	6.13	6.23	04
	020103	172	16	94	09	1.8	1.7	0.08	2-	6-	3,864	2,950	41.11	38.14	31.38	28.95	04
	020173	03	02	03	01	1.0	1.4	0.00	100-	100-	140	120	46.67	44.54	40.00	38.92	04
	020369	56	05	55	04	1.0	1.1	0.04	17+	17+	657	429	11.95	14.31	7.80	8.64	04
	020386	10	02	10	02	1.0	1.3	0.01	60-	60-	94	71	9.40	13.33	7.10	9.02	04
	020424	41	07	23	04	1.8	1.7	0.02	29-	26-	972	877	42.26	37.59	38.13	34.06	04
	057101	168	18	158	17	1.1	1.1	0.13	2-	6-	3,654	2,782	23.13	23.18	17.61	17.70	04

UR...INFORMATION RETRIEVAL SYSTEM

PROVIDER PRACTICE SUMMARY

PROVIDER NUMBER	TS/PROC CODE	*******QUARTERS 1-4******** CHARGED	ALLOWED	SV/PAT RATIO	P/TP RATIO	NUMBER SERVICES	PG AVE SERVICES	STD DEV SERVICES	FLAG	PROVIDER NUMBER	LOB	PEER GROUP
	020171	70	49	1.00	0.01	02	07	10.74			04	07 11
	020172	00	00	0.00	0.00	00	06	4.01				
	020174	190	171	1.00	0.02	03	02	0.93				
	020181	55	52	1.00	0.01	01	02	1.10				
	020193	00	00	0.00	0.00	00	05	4.63				
	020402	57	50	1.00	0.01	02	04	3.74				
	020403	00	00	0.00	0.00	00	02	1.13				
	020404	00	00	0.00	0.00	00	03	1.69				
	020410	115	57	1.00	0.01	02	06	6.04				
	020415	22	18	1.00	0.01	02	06	8.05				
	020416	180	112	1.10	0.06	11	09	8.35				
	020418	45	18	1.50	0.01	03	03	3.20				
	020419	55	48	1.00	0.02	04	04	4.03				
	020424	55	48	1.00	0.01	02	13	16.43				
	020429	20	08	1.00	0.01	01	05	8.67				
	022000	175	21	1.00	0.01	02	14	17.79				
	023311	20	16	1.00	0.01	01	01	0.00				
TYPE SERVICE TOTALS		1,552	1,015			64						
	057605	30	25	1.00	0.01	02	02	0.00			04	07 11
TYPE SERVICE TOTALS		30	25			02						
	060678	117	21	1.80	0.02	07	17	20.91			04	07 11
	060679	42	38	1.00	0.01	01	04	4.13				
	067042	105	35	7.00	0.01	07	07	0.00				
	067056	85	38	1.50	0.01	03	03	0.00				
	067078	105	35	7.00	0.01	07	04	3.00				
TYPE SERVICE TOTALS		454	167			25						
	087	50	49	1.00	0.02	03	08	7.05			04	07 11
	087000	32	05	1.00	0.01	01	02	1.14				
	087900	2,917	2,592	1.10	0.31	56	29	29.97				
	088000	05	06	1.00	0.01	01	01	0.00				
	088001	05	05	1.00	0.01	01	06	6.81				
	089002	12	10	1.00	0.01	01	02	1.79				
	088411	13	10	1.00	0.01	01	06	6.36				
	088628	13	17	1.00	0.02	03	04	2.08				
	088900	133	121	1.00	0.01	02	02	0.71				
	088903	520	403	1.20	0.12	24	56	43.19				
	088919	05	04	1.00	0.01	01	01	0.00				
	088920	20	16	1.00	0.01	01	01	0.00				
	088933	09	07	1.00	0.02	03	02	1.41				
	088950	300	241	1.10	0.08	15	09	5.82				

Applicant: _____ Part. #: 7049 Date: 3/11/76

Specialty: 70 Podiatry County: Montgomery

Soc. Sec.

Problem:

Statistical Data:

	Blue Shield	Medicare	CHAMPUS	Supplemental
Income 1972	--	$39,476.13	--	--
1973	$23,492.31	39,602.75	--	--
1974	12,107.12	3,977.44	$623.62	--
YTD 1975	14,052.10	338.40	590.00	$144.80
Jan. YTD 1976	$ 260.00	--	$ 15.00	--

BLUE SHIELD

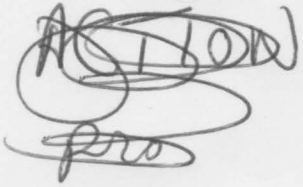
	Total Patients	Average/ Patients	Total Services	Average/ Services	Total Claims	Average/ Claims
December 1975	113	124.35	405	34.70	231	60.83
YTD 1976	10	26.00	13	20.00	10	26.00
Average for Physicians Speciality within County		121.51		39.82		62.85

Service	POT 1	POT 2	POT 3	TOTAL ALLOWED	% of INCOME	% OF DEVIATION	AMOUNT ABOVE
Surgery	4	0	265	$10,660.50	75.9	1.4-	--
X-ray	0	0	101	2,956.00	21.0	5.7	$800.97
Lab	0	0	38	630.50	4.5	1.9-	--
Radiotherapy	0	0	1	49.00	0.3	0.2	28.10

MEDICARE

	Medical Care	Surgery Service	Consult.	X-ray Service	Lab Service	Anesth.	Other
Submitted charges, 1974	$18,982.10	$18,122.10	0	$3,105.30	$686.00	0	$2,224.00
% of submitted charges, 1974	44.02%	42.03%	0	7.20%	1.59%	0	5.16%
Submitted charges, Dec. YTD 1975	$30,120.00	$19,688.50	0	$3,500.00	$626.00	0	$7,526.00
% of submitted charges	49.01%	32.03%	0	5.69%	1.02%	0	12.25%

File



Programs for the Aged

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

DATE: 5/30/75

TO: Art Quern

FROM: Don Derman DM

Per your conversation with Bill Fischer, attached is a description of the current status of the Foster Grandparents Program.

3312

OMB FORM 38
REV AUG 73

All progs would have - no termination of vol

only one of Action's OAA prog

RSV

May 30, 1975

ACTION - Foster Grandparent Program

	FY 1975	FY 1976
No. of Volunteers Funded	12,200	11,130
Budget Authority	$28,260,000	$25,903,000

Volunteers - low income persons 60 years of age and over - serve four homes a day, five days a week. They receive a stipend of $1,670 per year.

The 1976 budget request would continue all existing projects at a slightly lower level than FY 1975. No volunteers are planned to be terminated, however, approximately one-half of the volunteers who leave the program would not be replaced.

The proposed funding decrease was a choice made with the intent of restricting the total size of the ACTION budget without impairing projects for the Older Americans Programs.

It now appears, however, that sufficient funds will be available from 1975 grant monies to enable ACTION to make grants for this program at such a level that no reduction in volunteer strength will be required. A letter to the Appropriation Committees to this effect is being prepared by ACTION.

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: June 5, 1975 Time: 730pm

FOR ACTION: Art Quern
Max Friedersdorf
Ken Lazarus
Paul Theis

cc (for information): Jim Cavanaugh
Jack Marsh

FROM THE STAFF SECRETARY

DUE: Date: June 6 Time: 400pm

SUBJECT:

Annual Report-Federal Council on the Aging

ACTION REQUESTED:

____ For Necessary Action

____ Prepare Agenda and Brief

x ____ For Your Comments

x ____ For Your Recommendations

____ Draft Reply

____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

I support the OMB recommendations and draft.

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

MAY 15 1975

MEMORANDUM FOR MR. WARREN HENDRIKS

Subject: Annual Report of the Federal Council on the Aging

Attached in response to your request is a draft of Presidential comments and recommendations on the Annual Report of the Federal Council on the Aging (FCA) for transmittal to the Congress.

Background

The FCA is appointed by the President with the advice and consent of the Senate. The FCA considers its ideal role to consist of a "delicate blend of powers and leadership in planning, coordination, development, and advocacy." As such, it reviews Administration policy and Federal agency activity and works in concert with the Administration on Aging, serving as a spokesperson on behalf of older Americans.

In addition, the FCA is required by the enabling legislation to prepare and submit to the Congress three special studies:

(1) Effects of the formulae for allocation of Older Americans Act (OAA) funds with recommendations to the Congress. (This study was completed but recommendations were not included in any versions of the proposed modifications of the Older Americans Act).

(2) A study of the interrelationships of benefit programs for the elderly operated by Federal, state, and local government agencies.

(3) A study of the combined impact of all taxes on the elderly.

The latter two studies are not completed and the Administration has requested an extension of the required reporting dates in our legislative proposal for the extension of the OAA.

Comments

The report clearly does not support the Administration's fiscal policy (see page 7). It contains several inaccuracies--the enabling authority language is modified (see page 1); there is no separate line item in the President's FY 1976 Budget (see page 3).

We also draw your attention to the lack of supporting data and analysis which would enable the FCA to justify or rationalize their policy positions and recommendations as well as permit more responsive Presidential comments.

Recommendations

The OAA requires the President to transmit the annual report to the Congress together with his comments and recommendations. The transmittal letter should point out the mandated advocacy role nature of the FCA, avoid reference to errors in the report, and re-emphasize the need for FCA to complete the required studies in a timely fashion. We have drafted the required transmittal.

Paul H. O'Neill
Deputy Director

Attachment

THE WHITE HOUSE
Washington

TO THE CONGRESS OF THE UNITED STATES:

Secretary Weinberger has forwarded the Annual Report of the Federal Council on the Aging to me, and I hereby transmit this document to the Congress together with my comments and recommendations.

The Federal Council on the Aging was established by the 1973 amendments to the Older Americans Act of 1965 to advise and assist the President on matters relating to the special needs of older Americans, and for other purposes specified in the enabling legislation. Members of the Federal Council on the Aging were appointed June 5, 1974. The Federal Council on the Aging considers its role to consist of a "delicate blend of powers and leadership in planning, coordination, development, and advocacy."

As the annual report indicates, the Federal Council on the Aging has undertaken a number of advocacy activities pursuant to their legislated mandate. The report, as submitted to me for transmittal, does not include supporting

data or analysis which would provide the basis for a detailed review of the stated policy positions and recommendations.

The Administration, on behalf of the Federal Council on the Aging, has requested the Congress to authorize an extension until January 1, 1976, of the date for submission to the Congress of two legislatively mandated studies underway by the Federal Council on the Aging.

One study would review the interrelationships of all benefit programs operated by Federal, state, and local agencies to save the elderly. Such information could provide a useful perspective for the Executive Branch and the Congress to rationalize, improve, and more effectively target our Nation's limited resources on those most in need. A second study of combined impact of all taxes on the elderly could also provide insight into the relative values and limitations of public and private sector mechanisms to address human needs. I look forward to the availability of quality analysis and information which will assist in the economical delivery of services to our elderly citizens.

The Council specifically recommends "legislative action to develop high standards of safety and care in nursing homes." The Department of Health, Education, and Welfare has set high

standards of nursing home care and safety that must be met by nursing homes participating in the Medicare and Medicaid programs. The enforcement of these standards is one of my Administration's highest priorities. Federal funds pay 100 percent of the costs of inspection to monitor compliance with these standards. The Federal Government pays its share of the costs of meeting nursing home standards through health care financing programs, primarily Medicare and Medicaid. Financial assistance is also made available by the Department of Housing and Urban Development to assist nursing homes in meeting selected fire safety standards.

The Council also expressed its concern about the effect of restricting the rate of fiscal growth in several areas that assist the elderly. I am and will continue to be sensitive to the problem of inflation and the dilution of purchasing power that affects the elderly. To improve the status of all Americans (e.g., elderly, poor, rural, urban), it is necessary to dampen inflationary pressures while at the same time working to assure a growing and productive economy. My 1976 Budget was developed with this objective in mind.

This report provides a perspective and recommendations which are, of course, limited to the particular area of interest of the Federal Council on the Aging.

They do not reflect the Administration's policies which must be formed in the context of a comprehensive review of the total Federal role and capability to assist the aged in light of other competing priorities.

June 24, 1975

MEMORANDUM FOR: JACK VENEMAN

FROM: ART QUERN

SUBJECT: Federal Council on the Aging

I learned today that the Federal Council on the Aging which is a federally funded, semi-independent operation housed in HEW is conducting two Congressionally mandated studies with a target date of January 1, 1976, for a report to the President and the Congress. The studies are:

1. A study on the interrelationship of all benefit programs for the elderly.

   -- Apparently the Council is negotiating to have the Urban Institute prepare this study.

2. A study to determine the combined impact of all taxes on the elderly.

   -- The Council plans to use work underway in HUD (a broad property tax survey) and Treasury (a study across the board of how taxes affect the entire population).

I have expressed interest in working with the Council and more particularly, in keeping in close touch with them as they proceed with these studies. Staff of the Council seemed to be quite ready to cooperate.

File

FEDERAL COUNCIL ON THE AGING
WASHINGTON, D.C. 20201

THE DEVELOPMENT OF NEW NATIONAL POLICY CONCERNING THE FRAIL ELDERLY

The Federal Council on the Aging has adopted, as a major priority, the development of national policy recommendations for that group among the aging population which can be characterized as the "frail elderly". This target group consists of persons, usually but not always over the age of 75, who require one or several supportive services in order to cope with daily life. They are expected to become a sizable percentage of this country's population well before the end of this century.

Concern is being expressed for this population in many quarters. They comprise the major age grouping in nursing homes. Dissatisfaction with the quality of care in a number of these institutions is responsible for the veritable avalanche of proposals for improving institutional care -- and possibly avoiding it with community-based alternatives.

The Federal Council on the Aging believes that there are no simple approaches to financing, planning and delivering a package of services to these frail older persons. The Council does not necessarily conceive of these as "health" services. Other major programmatic areas in the Federal government such as social services, income and housing are equally involved. The FCA has embarked on a process that will produce recommendations for action by the Federal executive and legislative branches.

This process has and will involve a broad range of interested parties. A seminar to which were invited national experts in the field was held on March 13, 1975. Individual dialogue by FCA members and staff has been initiated with gerontologists and other officials inside and outside government. Special studies may be commissioned if the FCA feels they are needed. Completed and ongoing related research efforts will be tapped for ideas. This very document will be distributed to solicit recommendations using the following outline which has been prepared by the Council's Task Force on the Frail Elderly as a systematic means of obtaining information:

1. POPULATION AT RISK

Can we achieve a public policy based on the hypothesis that there are so many people so much at risk that at some certain point the program of care gets "turned on"?

Are any one or several of the following the indicator of the population at risk?

age, debility, income, race, sex, marital status, living arrangement, milieu, geography.

June 11, 1975

Can a basic set of services be determined?

Can there be a place where people can develop whatever is needed and one's entitlement is access to that place that does whatever you need rather than to an individual service (Morris personal services concept)?

Is intensity and level of the service a criteria?

Is geography a factor in delivery and availability?

Should services be age-only or multi-generational or both?

Are any one or several of the following the appropriate service package:

social casework, counseling, coordination, advocacy, brokering, ombudsmanship and "benign oversight"

assessment: social, medical, etc.

reassessment

prescription, recommendation, plan

transportation

nutrition

maintenance: physical environment, personal support

3. SYSTEM OF SERVICES

What system should be developed to deliver the services?

How are roles of family and friends enhanced?

Should it be age oriented or multi-generational?

Should it be centralized or decentralized?

Should it be governmental - Federal, State, local?

Should it be regional or local jurisdiction

Should it be private - voluntary or proprietary?

Should it combine government and the private sectors?

Should it be categorical or generic?

Are one or several of the following elements of a system of services:

a. planning - coordination

b. assuring service

c. delivery

d. monitoring

Should the system be built on the existing health care system (Medicare - Medicaid) or the multi-generational social services (Title XX) or the aged-only services (Older Americans Act) or a new system?

How complex and broad can a system be and still work?

4. MANPOWER NEEDS

Are new types of personnel needed to operate services for the frail elderly? How defined?

What numbers of personnel will be required?

What kind of short- and long-range training will be needed?

5. SPONSORSHIP

Should the auspices or sponsorship of the system be any or several of the following:

a. public or private

b. proprietary or non-profit

c. health or social services system

d. national, state, sub-state, local

What should be the relationship between and among existing social and health planning agencies?

What should be the role of the individual citizen including the consumer, client, patient?

What are roles of family, relatives, friends?

6. BENEFIT - ENTITLEMENT

Should it be a categorically funded, generic program for a target group?

Should it be an entitlement tied to an individual?

Should it be an insurance program?

Should the individual participate in cost-sharing through a deductible, co-insurance or a means test?

7. FUNDING - REIMBURSEMENT

Should there be provision for capital funding and start-up costs?

Should the services be financed through any or several of the following measures:

general tax revenues

dedicated tax - trust fund - employer contribution

voluntary - mandatory

participation by consumer in premium payment

use of private insurance carrier

Federal - State - local match

voluntary funding

vendor - voucher

direct payment to consumer

8. PHILOSOPHICAL RATIONALE

What services should the frail elderly have because they are citizens and a population at risk? Are these services a right?

Can these basic assumptions be made: that these are services which cannot be cashed out and that an income floor is guaranteed?

How can freedom of choice and self-determination be assured while at the same time providing needed protection?

What should be the nature of filial responsibility?

What should be the nature of filial responsibility?

How can family involvement be enhanced?

How can universality and equal access be assured?

How can there be sensitivity to racial minority needs?

Are there special problems for frail older women?

How can the role and status of the frail elderly in society be maximized and enhanced regardless of their level of productivity?

Should need be the only criterion for service? Should age be the only criterion for service?

How is quality of services monitored?

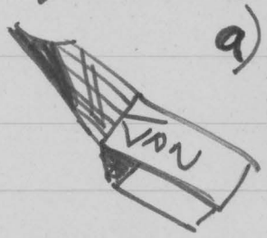
6/23

Cleo Tarani

1. Bertha Hitchins re appointment to Fed Council on Aging

2. Council priorities: (mandated

a) interrelationships of benefit programs for the elderly
-- Urban Institute
-- recommendations to Pres



b) determine combined impact of all taxes on elderly (state/local/Federal

1
HUD
-- property tax study

2
Treasury: request re
BLS: Consumer Expenditure Survey

relay McClung

c) Frail Elderly
what services
how finance
means tests

OFFICE OF THE VICE PRESIDENT

WASHINGTON

June 26, 1975

File

MEMORANDUM FOR ART QUERN

FROM: JACK VENEMAN

SUBJECT: Federal Council on the Aging

Regarding the Federal Council on Aging, enclosed is a copy of a letter I received from Bob Harris of the Urban Institute. When I was on their Board, I recommended that they take on a project to do an independent study of social security financing which I believe is underway.

In any event, they are doing a lot of work in the aging field, and I am sure that we can have access to virtually all of their material.

Maybe we should have lunch with Bill Gorham and Bob Harris one of these days.

Attachment

THE URBAN INSTITUTE 2100 M STREET, N.W. WASHINGTON, D.C. 2003

ROBERT HARRIS
Senior Vice President

June 20, 1975

Honorable John Veneman
Counselor to the Vice President
The White House
Washington, D.C.

Dear Jack:

I am responding to your request for information on work we are doing relating to the elderly, in Bill Gorham's absence. The Urban Institute is engaged in a number of projects that are relevant, but most are fairly new and thus have yet to reach any conclusions. I have selected work that is directly targeted on the aged, or which is problem-oriented but where the relevance to the elderly is clear and strong. What follows is not a comprehensive review--as most of our work has some implications for the elderly.

Income of the Aged. We have a number of studies underway which focus on earnings, wealth distribution, private pensions, social security, and longer run trends in factors affecting income distribution. Much of this work bears on income adequacy of the aged. These are long-term ongoing projects. The Social Security and private pension studies, which you encouraged us to develop last year, are fairly new. Some results will be available this year--but the bulk of the findings will come later.

Combined Benefits. We will be starting work soon on a study for the National Council on Aging to define and measure the combined benefits available to the elderly under multiple programs and to analyze the way in which these programs interact (e.g., what benefits are lost or reduced when Social Security benefits are increased). In addition, we will try to pinpoint important gaps in coverage. This study will review all federal programs and selectively survey a number of states' program packages. The contract calls for completion in about six months--so results will be available soon. (This study is in response to a congressional mandate to the Council.)

Income Maintenance. The above cited studies are part of our income maintenance group agenda. In addition, other work in the group is relevant although not focused on the aged per se. For example, we have programmed an SSI module for the TRIM model, which allows us to prepare estimates of utilization of that program by the aged, and to measure the impact of SSI on

income of the aged. A Food Stamp module can be similarly used. We expect over the next year to develop a Medicaid module for TRIM. As you know, the aged are heavy users of Medicaid, and thus we will be able to conduct analyses of the impact of the program on that group as well as others. A Medicare module will also be added to TRIM as part of the study in the National Council on Aging.

Comprehensive Needs of the Most Severely Handicapped. As you know, the most severely handicapped are now excluded from vocational rehabilitation programs--because favorable vocational outcomes are unlikely. In response to a congressional mandate to HEW for a review of the needs of that excluded group, the Urban Institute was commissioned last year to conduct a Comprehensive Needs Study (CNS) of "individuals most severely handicapped" (IMSH). That study is nearing completion, and will be of great interest to policy makers concerned with problems of the aged. From original surveys that we conducted, as well as from analyses of other data sources, we found that over 50% of the IMSH are over 50. These individuals are generally precluded from rehabilitation services because they are unlikely to be able to get jobs--yet clearly rehabilitation services could enhance their ability to function independently. There are many clear policy implications of the study that bear directly on needs of the aged.

A draft report has been submitted to HEW for review. A revised version will be ready in several weeks, and you will no doubt see it when it is submitted by HEW for clearance prior to submittal to Congress.

Transportation. Our work on para-transit, with which you are familiar, has implications for the aged, since such programs as dial-a-ride, shared taxis, etc., frequently are designed with a view towards the needs of the aged. We have recently completed a book reviewing experience with such transit systems and assessing future potential. We are working closely with the Urban Mass Transit Administration of DOT on the design and evaluation of demonstration projects. One such project is to provide discounted vouchers for payment for taxi services. The project is designed with three integral objectives:

- to improve the limited mobility of the elderly and other transportation disadvantaged groups through their use of the tickets;
- to implement a subsidy mechanism dependent upon the use of the transportation service being provided; and
- to provide an opportunity for taxi operators to maintain economic viability by offering more flexible taxicab services such as shared-riding.

Two cities currently have pending applications to UMTA to implement a demonstration of this type.

Making Policy Research More Relevant. We are developing a project which would attempt to make the results of our problem-oriented policy research more available to those specifically concerned with policy towards the elderly. As I have indicated above, much of our problem-oriented research generates information on the needs and problems of the aged. We plan to develop a new project focused on extracting those policy implications from our other ongoing work, as well as from the problem-oriented policy research of other organizations. I met with Commissioner Flemming two weeks ago to discuss this idea, and he has encouraged us to develop a proposal for AOA. We have since met twice with members of his staff to outline the scope of such a project, and we will submit a proposal in August. This would be a new one, and a most interesting approach.

If you are interested in papers that are available, or more detailed information on any of these projects, please let me know.

Warmest personal regards,

Sincerely yours,

Robert Harris

cc: W. Gorham
H. Guthrie

File AGING

FOR IMMEDIATE RELEASE July 24, 1975

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

I am transmitting herewith the Annual Report of the Federal Council on Aging, together with my comments and recommendations.

The Federal Council on the Aging was established by the 1973 amendments to the Older Americans Act of 1965 to advise and assist the President on matters relating to the special needs of older Americans, and for other purposes specified in the enabling legislation. Members of the Federal Council on the Aging were confirmed by the Senate on June 5, 1974.

As the annual report indicates, the Federal Council on the Aging has undertaken a number of advocacy activities pursuant to its legislated mandate. The report, as submitted to me by the Secretary of Health, Education, and Welfare for transmittal, does not include supporting data or analysis which would provide the basis for a detailed review of policy positions and recommendations.

Since the Council was only recently formed, the Administration, on behalf of the Federal Council on the Aging, has requested that the Congress authorize an extension until January 1, 1976, of the date for submission to the Congress of the two legislatively mandated studies.

One study calls for a review of the interrelationships of all benefit programs -- Federal, State, local -- serving the elderly. Such information could be useful to the Executive Branch and the Congress to identify duplicative and overlapping programs and to propose the necessary reforms so that our resources may be more effectively applied to help those most in need.

A second study, dealing with the combined impact of all taxes on the elderly, could also be helpful in determining the burdens and benefits of government actions as they affect the Nation's elderly.

I look forward to the study reports to help us provide an effective and economical delivery of services to our elderly citizens.

The Council specifically recommends "legislative action to develop high standards of safety and care in nursing homes." The Department of Health, Education, and Welfare has set high standards of nursing home care and safety that must be met by nursing homes participating in the Medicare and Medicaid programs. The enforcement of these standards is one of my Administration's highest priorities. Federal funds pay 100 percent of the costs of inspection to monitor compliance with these standards. The Federal Government pays its share of the costs of meeting nursing home standards

more

through health care financing programs, primarily Medicare and Medicaid. Financial assistance is also made available by the Department of Housing and Urban Development to assist nursing homes in meeting selected fire safety standards.

The Council also expressed its concern about the level of funding for programs to assist the elderly. I sympathize with this concern, but I am determined to reduce the burden of inflation on our older citizens, and that effort demands that government spending be limited. Inflation is one of the cruelest and most pervasive problems facing older Americans, so many of whom live on fixed incomes. A reduction of inflation, therefore, is in the best interests of all Americans and would be of particular benefit to the aging.

The perspective and recommendations of this report are limited to a particular area of interest and advocacy.

The report does not reflect the Administration's policies, which must reflect a broader range of responsibilities and priorities.

GERALD R. FORD

THE WHITE HOUSE,
July 24, 1975

# # # #

Art-FYI

THE WHITE HOUSE

WASHINGTON

September 11, 1975

PRESENTATION CEREMONY TO FOSTER GRANDPARENTS
Friday, September 12, 1975
10:30 a.m. (10 minutes)
The Rose Garden

From: Jim Cannon

I. PURPOSE

To present 10 year service awards to the 20 Foster Grandparents from throughout the United States who have been with the ACTION Foster Grandparents Program since it began. The Foster Grandparents are in Washington to join ACTION's celebration of the program's decade of service.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background:

The Foster Grandparent Program is an ACTION Agency program which offers older men and women the opportunity to provide companionship and guidance for emotionally, physically and mentally handicapped children.

Some 13,627 low income persons are serving as Foster Grandparents in 157 projects throughout the United States. Volunteers receive needed financial assistance, transportation allowance, hot meals while in service, accident insurance, and annual physical examinations.

As a key member of the child-care team of the institution where assigned, the Foster Grandparent is responsible for supplying individual attention to two children. The "grandparent" devotes two hours each day to each child. During a five-day week, tasks may vary from feeding and dressing the small child, playing games and reading stories,

to helping with speech and physical therapy. The Foster Grandparent is active in residential facilities and hospitals for retarded, disturbed and handicapped children and in correctional institutions and homes for neglected, dependent children. Under some circumstances, non-institutionalized children may receive daily visits from Foster Grandparents in their own homes.

B. Participants:

List attached at Tab A.

C. Press Plan:

Open Press Coverage

III. TALKING POINTS

To be provided by Paul Theis.

PARTICIPANTS

Michael Balzano, Jr., Director, ACTION

John L. Ganley, Deputy Director, ACTION

Ronald E. Gerevas, Associate Director for Domestic Operations, ACTION (Mr. Gerevas was appointed in June by your nomination)

Victor E. Hruska, Director of Older American Volunteer Program, ACTION (Mr. Hruska is the brother of Senator Roman Hruska)

Recipients of the Service Awards

Jeffalonie Allison
Pauline Culmer
Dewey DeHart
Cornelia Ford
Ruth Fox
Opal Greaby
Marie Hartos
Nellie Harvey
Dolores Herrera
Mary Ann Hickok
Norvelle Maddox
Lenice McEwen
Regina Novotny
Theresa Papoza
Lois Perry
Freda Peterson
Daisy Pope
Daisy Bell Spear
Edna Wallace
Zela Watts

THE WHITE HOUSE

WASHINGTON

October 14, 1975

Dear Mr. Renner:

In further discussion of your interest in proposing a new approach to assisting the poor and the aged, I must report that a written statement of your proposal is a necessary prerequisite to any further explorations.

A written plan will provide the basis for the analysis which is needed to make any discussion of these very broad issues productive.

With best wishes,

Sincerely,

Arthur F. Quern
Associate Director
Domestic Council

Mr. Fred T. Renner
211 Lindenwood Road
Staten Island, New York 10308

File

September 12, 1975

Arthur F. Quern
Associate Director
Domestic Council

Dear Mr. Quern:

In response to your letter of September 2.

My plan entails the creation of a walk oriented city to provide all essential services for the elderly who no longer are able to afford the high cost of living in urban areas.

The change in their status will be on a voluntary basis and would provide financial releif to all communities and demonstrate the ability of the Federal Government to assist the economy, and, at the same time, conserve energy.

The years of thought that have been spent on my plan cannot be detailed in a letter and I would welcome the opportunity to go to Washington and talk to a group of President Ford's advisors regarding my ideas.

Sincerely,

Fred T. Renner

Fred T. Renner
211 Lindenwood Road
Staten Island, N.Y. 10308

Fred T. Renner
211 Lindenwood Road
Staten Island, New York 10308

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Mr. Arthur F. Quern
Associate Director
Domestic Council
The White House

Wash. D.C.

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The National Council on the Aging, Inc.

25 Years of Service to the Elderly

1828 L STREET, N.W.
WASHINGTON, D.C. 20036
202/223-6250

November 17, 1975

Dear Colleague:

The National Council on the Aging is pleased to send you the 1975 Public Policy Statements from the NCOA Board of Directors which were issued at our 25th Annual Meeting held in Washington, D.C. in late September. As you may know, NCOA is a private nonprofit organization whose membership consists of individuals and organizations who serve the nation's older citizens. For 25 years, we have provided leadership in the field of aging to public and private agencies at the national, state and local levels.

NCOA believes that the voluntary sector has a vital role to play in the development and implementation of a public policy responsive to the needs and capacities of the nation's older citizens. As firsthand observers of the elderly's needs, those working in the field are able to evaluate the effectiveness of programs and services designed to serve the older population. NCOA is convinced that it can and must serve as a conduit of such information to policymakers at all levels of government.

Because the development of policy statements is an ongoing process, we are interested in your comment on them. In the coming months, NCOA will use the enclosed papers as a basis for additional policy statements. We hope you will keep these and forthcoming statements as a cumulative record of NCOA's position on issues affecting the lives of older Americans.

NCOA's 25 years of service have demonstrated the significance and validity of the private sector's involvement in the creation of an effective public policy in aging. Following the lead of the elderly themselves, and working with organizations and individuals concerned about the wellbeing of older persons, NCOA will continue to encourage a social policy responsive to the aged. We look forward to facing that challenge in cooperation with you in the years ahead.

Sincerely,

Albert J. Abrams

Albert J. Abrams
President

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September, 1975

OLDER AMERICANS AND THE ARTS

For 25 years the National Council on the Aging has sought to facilitate the full utilization by the aged of services and programs that could make their lives more meaningful and personally gratifying.

NCOA continues to seek new alliances that can improve the quality of life for older people particularly as that quality relates to the loneliness, isolation and lack of new social roles that exist in the world of the aged. Leaders and policy-makers in the burgeoning field of cultural services must be increasingly made aware of how the arts network, both public and private, can serve and be served by older Americans. Agencies and practitioners in the field of aging must become active advocates for older persons in the field of the arts.

NCOA believes that while the aged's involvement in cultural services and programs may not be a matter of life and death for older persons, it can be a matter of happiness or unhappiness, usefulness or uselessness. The overall goal in

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this area is to ensure that older persons have an equal opportunity, with other population groups, to participate in and have access to cultural programs and services.

In addition, NCOA recognizes the need to preserve the folklore and forgotten arts of America, including the ethnic heritages of our diverse population, for the enjoyment of all citizens. It is the older adult who has the knowledge and skills not only to produce such crafts and artwork, but also the capability to teach others the techniques of these accomplishments.

With these goals in mind, NCOA makes the following recommendations:

1. The arts constituency should be broadened to include the elderly.
2. The quality of arts programs now available to older people should be upgraded.
3. New employment opportunities for artists young and old in the field of aging should be provided.
4. Art forms which otherwise might be lost forever must be preserved.
5. Support for the arts should be broadened through better use of the energy and ability of older persons whether as volunteers or as paid professionals.
6. Arts resources at local, state and national levels in both the public and private sectors that are currently overlooked or underused in the field of aging should be mobilized.
7. Local initiatives to preserve the folklore and forgotten arts of America can be encouraged by developing co-ops and/or channels to the retail market where they can reach the consumer. Any public effort to develop such channels should ensure that the proceeds of sales benefit the older artisan.
8. Older artisans should be given opportunities to share their knowledge

with others and be provided opportunities to improve their skills. Both Federal and state governments need to be sensitive to these needs and provide avenues by which this unique talent can be shared and enhanced.

To date, cultural services for, with and by the aged is a concept without priority status in either the arts or aging fields. We recognize that promoting a new concept which is not considered as important as survival support services is difficult at best and is more so in two fields that are currently underfunded. The arts are primarily concerned with survival of cultural institutions and the individual artist. Likewise, practitioners in aging emphasize survival and support of aging service agencies and the aged themselves. Nevertheless, NCOA remains convinced that there is something positive for both the arts and the aging fields in the marriage we have proposed.

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September, 1975

CRIME AGAINST THE ELDERLY

The elderly, especially the urban elderly, are the most vulnerable victims of the recent dramatic increase in crime in America. Millions of the aged are virtual prisoners in their own homes, self-confined victims who fear even going out in the streets. The quality of life for thousands and thousands of elderly people is degraded not only by the existence of robberies, assaults, fraud and rape, but also by the threat of such crimes. In a recent NCOA study conducted by pollster Louis Harris, those over 65 rate crime or the fear of crime as their most serious personal problem.

Unfortunately, there is no reliable index of the volume of such offenses against the elderly. Numerous studies showing the high numbers of unreported and underreported crimes also indicate that the elderly are more likely to be silent victims. In addition, reported crime records only note the age of the criminal, not that of the victim.

NCOA believes that a number of steps must be taken

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immediately, at both the national and local levels, to make America safe for its nearly 21 million older citizens.

1. A national Senior Citizens Crime Index should be developed to monitor the growth and delineate the development of offenses against older people.

2. The Law Enforcement Assistance Administration (LEAA) of the Justice Department should undertake studies to determine how localities may best cope with the problem of crime against older people and to use its resources to fund programs which protect the elderly.

3. Local police authorities should be encouraged to set up strike forces to prevent attacks on the elderly and to pinpoint the locations and modus operandi of the attacks.

4. Local police should undertake regular visits and liaison to facilities used by the elderly such as senior centers, housing projects, etc.

5. Self-help programs which train the elderly themselves in crime-prevention procedures should be developed.

6. Senior center leaders should be trained to train their members in crime prevention.

7. Community watch programs, involving community groups of all ages (teen patrols, radio-dispatch cab drivers, police hookups, high school student escorts, etc.) should be established to be alert to threatening or suspicious activities.

8. Patrol of streets (perhaps by retired policemen or police cadets) and areas older people use that have high incidences of criminal activities should be encouraged, and escort services to and from transportation services to housing projects, shopping malls, senior centers, clubs, clinics, etc., should be set up.

9. The police should train and assign the elderly stay-at-homes or home-bound to observe streets or sections of their neighborhoods, and to report suspicious behavior to police.

10. Regular police security checks of buildings and sites housing the elderly should be made (just as the fire department makes regular fire prevention inspections).

11. Housing for the elderly should have installed (on government subsidy or as tax-deductible expense) burglar-proof photoelectric beams on windows and doors, one-way glass, TV monitors in elevators and corridors, and central alarm buzzer systems linked to police dispatchers or patrol units.

12. Since crime against the elderly is reduced in specific housing as compared to intergenerational housing, more housing especially for the elderly should be encouraged and built.

13. Government checks should be mailed to banks for individual deposit; banks should provide free checking accounts for the elderly.

14. An offense against an older person should be made a Federal crime if committed in Federally funded facilities such as housing projects, centers, etc.

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September 1975

EMPLOYMENT

The nation is experiencing its highest unemployment rates since the Depression. Millions, regardless of occupation or age, are suffering. Middle-aged and older workers, with heavy family and financial responsibilities, tend to suffer special hardships when the economy takes a downward turn. Men and women over 40 constitute almost half of the present labor force and more than a fourth of all unemployed. As Bureau of Labor Statistics figures indicate, they undergo longer terms of unemployment than younger age groups. They tend to drop out of the labor force through discouragement in a futile job search. Advocates of a broader definition of unemployment believe that present figures--which categorize discouraged workers as not-in-the labor force--understate by a considerable extent the true unemployment rate. Middle-aged and older workers are often victims of age discrimination on the part of both employers and employment-manpower service agencies.

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25 Years of Service to the Elderly

One goal of a national employment policy should be to assure continued participation for all age groups since it is a major factor in a full and satisfying life style. It should also be noted that periods of unemployment have serious repercussions in terms of unemployment insurance, welfare costs and social security benefits.

The basic premise of employment and manpower programs from the inception of the Wagner-Peyser Act of the 1930's to the categorical manpower development and training programs of the 1960's to the present Comprehensive Employment and Training Act (CETA) approach, has been that all Americans in need of assistance related to employment may fully participate in available programs. The desired outcome is free access for all individuals to the job market regardless of age and other possible limiting factors over which the individual worker has no control.

The Comprehensive Employment and Training Act (CETA)

There is no question that middle-aged and older workers are not receiving an equitable share of manpower services through the CETA and the United States Employment Service networks. These groups of workers lack priority in these systems - only 4 to 8 percent of the CETA participants are men and women over 45 and analysis of Employment Service data reveals that middle-aged and older workers are less likely to receive services than those under age 40.

NCOA's concern, therefore, with the current regulations pertaining to CETA is that they in no way guarantee improved status for middle-aged and older persons in need of employment assistance. CETA regulations must be established which assure that funds allocated to prime sponsors are equitably distributed to all participating age groups.

NCOA recommends that the Department of Labor include the following general guidelines and specific changes in revised regulations pertaining to Title I and II of the Comprehensive Employment and Training Act.

Prime sponsors and their agents in order to assure fair and equitable participation of middle-aged and older men and women of all racial and ethnic backgrounds in CETA programs must include within any state plan an analysis of the universe of need of individuals they intend to serve by age and sex categories. The following groupings are suggested: Under 22; 22-39; 40-54; 55-64; 65+.

An appropriate reporting system should be standardized whereby Prime Sponsors and any Subcontractor can report comparative services to age groups on a quarterly basis.

Prime Sponsors should see to it that middle-aged and older individuals, familiar with the manpower and employment needs of workers over 40, are included in fair proportions of all state and local manpower planning committees.

Any Prime Sponsor with responsibilities for implementing a Title II Public Employment Program must develop an Affirmative Action Plan to accommodate individuals within the protected group of the Age Discrimination in Employment Act. All state and local government and/or public employers are now covered and bound by federal age discrimination in employment legislation.

Middle-aged and older workers, by reason of their long neglect on the part of the Department of Labor, should be regarded as a new minority. Each Prime Sponsor, therefore, should be bound to submit within his state plan special training and technical assistance provisions to agents, or subcontractors on how to:

-- Assess the needs of middle-aged and older workers within a community.

-- Develop outreach capabilities to bring these older workers into CETA training and employment programs.

-- Develop special training methodologies and skill conversion techniques for middle-aged and older men and women.

-- Develop job placement strategies, in cooperation with other employment related agencies (e.g., the State Employment Security Agency) for those older individuals.

Appropriate Prime Sponsors should be informed and directed by the Manpower Administration that it is their responsibility to support all Senior Aide programs currently being funded by the Department of Labor through national contractors. <u>These are programs of demonstrated effectiveness</u>.

A separate title should be established under CETA that will address the manpower needs of the middle-aged and older worker, just as the Job Corps has been established for youth. It is important to note that although older workers were specifically mentioned along with Indians and youth in Title III, no money has ever been appropriated for this group.

Age Discrimination in Employment (ADEA)

The Age Discrimination in Employment Act (ADEA) has recently fostered significant legislative, administrative and judicial activity. The law's major objective is to eliminate discrimination against individuals between 40 and 65 years of age in matters of hiring, job retention, compensation or other terms, conditions and privileges of employment. ADEA promotes a policy of employment according to ability rather than age. Despite recent legislative improvement in the Age Discrimination in Employment Act, systematic implementation and enforcement is needed. In addition, because any worker, regardless of age, should be evaluated according to functional ability, NCOA recommends that the present upper age limitation for application of ADEA be removed.

To ensure uniform national standards protecting all citizens against discrimination in employment, NCOA further recommends the establishment of one national regulatory body with the authority and resources to enforce effectively one federal statute which prohibits employment discrimination on the basis of race, color, religion, sex, national origin, age and handicapped status.*

Mandatory Retirement

A recent survey conducted by Louis Harris and Associates for NCOA

* Basic recommendation from the Federal Civil Rights Enforcement Effort 1974, U.S. Commission on Civil Rights, July 1975.

found that a large majority of Americans feel that "nobody should be forced to retire because of age," and a smaller majority agree that "most older people can continue to perform as well on the job as they did when they were younger." Yet in mid-1974 there were over four million unemployed or retired persons age 65 and over who wanted to work but were not employed, compared to some 2.5 million who were working full-or part-time.

NCOA strongly urges that flexible rather than fixed retirement ages be adopted by employers and unions, allowing those who wish to retire early or at the "normal" retirement age of 65 to do so and allowing others to work as long as they are able, perhaps as determined by a physical examination or an objective scale such as that employed in the Industrial Health Counseling Service for the last four years in Portland, Maine. The fact that not all employers require mandatory retirement is evidence that flexible retirement is administratively feasible.

United States Employment Service

To increase services to middle-aged and older workers, NCOA recommends that the Manpower Administration mandate that the Older Worker Specialist be a full-time position at the state and local office level and institute a system for financial incentives to local offices that do an outstanding job of placing older workers. In addition, we recommend that the Manpower Administration set up on a pilot basis an employment service based on the 40-plus methodology to test techniques and procedures for adequate service to middle-aged and older workers.

Senior Community Service Project (SCSP)

The Senior Community Service Project has clearly demonstrated that older workers can adequately carry out diverse work assignments, involve people in

meaningful relationships, motivate them to initiate action on their own behalf, mobilize community resources and generally serve as a bridge between the consumer of services and the agency providing the services. It has also demonstrated that the program participants measure up in all ways to standards for younger workers - and often exceeded these standards. SCSP is a manpower model for the older disadvantaged worker. It has successfully carried out its primary mission of providing meaningful public service employment for older workers.

NCOA believes that the funds available for this program and similar ones are totally inadequate and that steps should be taken by the national Manpower Administration, local prime sponsors and national contractors to establish these projects at the local level on a permanent basis.

Functional Capacity

NCOA believes that middle-aged and older persons should be assured of opportunities for continuing employment. The extension of employment opportunities for this group and the removal of barriers to their employment remain primary goals. There is a need for the expanded use of techniques which have been developed for relating the functional abilities of workers to the functional requirements of jobs. In general, functional capacity and not chronological age must become the primary employment standard.

Pre-retirement Planning

Planning ahead for retirement can significantly reduce the mistakes and frustrations that accompany a trial-and-error approach after retirement. Problems may still arise, but the individual will be better prepared to cope with them. The three critical elements are opportunity and incentive to plan, and concrete, relevant data on which to base the planning.

NCOA recommends that the Federal government recognize the need for planning and assume a partnership with educational institutions and private industry by funding research and training programs, sponsoring demonstration projects and providing incentives for employers to pay the tuition for appropriate courses as well as setting an example as a model employer.

Second Careers

A change in mid-life from one job pursuit to a different field is no longer considered unusual in our rapidly changing society. For some workers, because of technological displacement or involuntary early retirement, the need for a second career is a necessity. To fill the need, career oriented educational and training programs should be developed which are aimed not at the beginning worker but at those who must transfer from one career track to another.

Women and Minorities

Unemployment and poverty among middle-aged and older single women and members of minority groups are particularly severe problems. NCOA urges that special attention be paid to the employment problems of these groups in Employment Service job development and in training programs.

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September, 1975

ENERGY AND THE ELDERLY

A limited supply of electricity, natural gas, fuel and motor oil at inflated prices is potentially damaging to older people themselves, as well as to the institutions and programs which serve them. As the price of energy continues to rise, increasing numbers of older people living on fixed incomes will be forced to decide between heat or food. Cost-of-living increases in Social Security and Supplemental Security Income benefits are quickly eroded by inflation in this area alone. Already inadequate public and private transportation becomes either too expensive or non-existent. The loss of volunteer drivers due to the lack, or high cost, of gasoline can cripple many programs geared to serve older Americans, including homemaker-home health aide projects, escort services, meal deliveries and senior centers. Reduced heat in the home aggravates arthritis and many other chronic conditions that affect the elderly. The benefits of programs, including those authorized under the Older Americans Act, are reduced because

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25 Years of Service to the Elderly

appropriations do not include increased costs for lighting, heating, cooking and transportation.

To avoid and/or alleviate these present or potential problems, NCOA recommends the following:

1. The development and implementation of a national energy policy should assure that all citizens are equitably treated and particularly that the elderly and other vulnerable groups are not adversely affected.

2. The use of any gasoline allocation formula should include extra supplies to agencies who operate elderly transportation services and unrestricted access for volunteer agency drivers.

3. Any fuel allocation and/or rationing, if developed, should take into consideration the special needs of the elderly.

4. Government program regulations which restrict reimbursement of drivers should be changed periodically to reflect the higher price of gasoline.

5. The appropriations for service programs dependent on energy resources should be increased to account for inflation's impact on the cost of energy.

6. The Federal government should institute a program of low-cost loans for housing insulation.

7. Comprehensive consumer information on energy conservation and rights should be developed for the elderly and effectively distributed to them.

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September, 1975

THE PRESIDENT'S RESPONSE TO
THE ANNUAL REPORT OF
THE FEDERAL COUNCIL ON THE AGING

The National Council on the Aging urges the President to reconsider his rejection of the major recommendations made by the Federal Council on the Aging in its first annual report.

The Federal Council on the Aging was established by the 1973 Amendments to the Older Americans Act to advise and assist the President on the special needs of the elderly. Members of the Council were confirmed by the Senate on June 5, 1974, and, on March 31, 1975, as required by law, they submitted their first annual report to the President. On July 2, President Ford transmitted that report with his comments to the Congress.

NCOA believes that, because the FCOA is composed of leading experts from the field of aging, the recommendations and advice in that report deserve more consideration than the President's negative comments gave them. It is especially unfortunate that the first official dialogue between the

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President and the FCOA should be so negative. We hope that this is not the beginning of a pattern of animosity which would destroy a potentially valuable relationship for all concerned - particularly for the nation's 21 million older people.

The President criticized the report for being "limited to a particular area of interest and advocacy." NCOA believes this criticism is inappropriate and unjustified. The Congress established the FCOA to perform a limited and particular function which it also considered essential; that is, the Council was to provide advice, assistance and advocacy on the special needs of older Americans. The FCOA's first report definitely fulfills this mandate.

NCOA has consistently supported the major policy recommendations contained in the FCOA report: The development of high standards of safety and care in nursing homes and the rejection of Administration proposals to cut back Federal programs essential to the welfare of the elderly.

We congratulate the FCOA on its initial efforts and look forward to the findings and recommendations of its ongoing studies. NCOA remains hopeful that, in the future, the President will be more receptive to the recommendations of the Federal Council on the Aging.

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September, 1975

HEALTH OF THE ELDERLY

Good health is a basic ingredient of a satisfactory life for all people. For older Americans this goal is more difficult to attain and maintain than for the remainder of the population. Growing older is almost always accompanied by an increasing need for health care services (people aged 65 and over, while approximately 10 percent of the population, account for 30 percent of health care costs).

While recognizing that good health should be a public policy goal for all Americans, the National Council on the Aging is particularly concerned that there be a public commitment to assuring that the necessary steps are taken so that older Americans can live healthfully and can choose and purchase appropriate health care services.

NCOA believes that the final responsibility for comprehensive health services, both physical and mental, for older Americans lies in the public sector at the Federal level. The objective of such health services should be the provision of

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expanded and specialized health programs and facilities and rehabilitative and preventive care, including mental health services, for older persons. The provision of these facilities and services must be complemented by the establishment and enforcement of national standards to guarantee quality physical and mental health care and decent living conditions. Therefore, NCOA supports the early establishment of a national health security program which incorporates the following principles:

1. Comprehensive physical, mental, environmental and social health care benefits for all Americans;
2. The integration of Medicare into a national health security program for Americans throughout the life span;
3. The elimination of all co-insurance, deductibles and premiums;
4. Administration and fiscal management of the new health security program by a public agency without an intermediary between the providers and the public agency;
5. Financing of the health program through general revenues and payroll taxes.
6. Consumer participation of the aged in the development and implementation of this program including involvement in quality controls (in such areas as accessibility, acceptability and accountability) and in cost controls.
7. Coverage for the full range of long-term care services, including home-based, community-based and institutional-based services, with appropriate quality and cost controls specifically designed for the aged.
8. Monies allocated to research and output measurement to include appropriate attempts to develop criteria for evaluation of health care delivery to the aged related to functional capacity, ranging from minimal self-care

to full independence; and

9. The exclusion of means tests from any aspect of the program.

Pending the establishment of a national health security program and recognizing that health care costs are now increasing 50 percent faster than the economy as a whole; that per capita health care costs in 1973 were 3 1/2 times greater for people aged 65 and over than for younger age groups; that Medicare, which covered 49 percent of the total costs for medical expenses in 1969 covered only 38.1 percent of these expenses in 1974; and that skyrocketing costs of health programs do not reflect advances in health services for older people, NCOA recommends:

10. The present Medicare and Medicaid programs should be improved and expanded immediately to meet more adequately the health needs of older persons in relation to such matters as length of stay in acute hospitals; extended care and nursing home facilities; psychiatric hospitals; coverage for home care; diagnostic and preventive services; and out-of-hospital drugs and medicines; the elimination of the premium paid for Medicare Part B and the co-insurance features related to hospital care.

11. Greater coverage should be provided for dental care, eye and hearing care and aids as well as for other prosthetic devices which contribute to social and health functioning, and which facilitate mobility.

12. A nation-wide program of comprehensive long-term care for older persons suffering from chronic disease and disabilities must be developed. Such a program should include specialized health programs and facilities for rehabilitation and resocialization as well as alternatives to institutional care, such as health maintenance organizations, neighborhood clinics, day or night hospital care, and home care services.

13. Present standards of care should be better enforced and, when promulgated, vigorous state implementation of national standards for nursing homes and personal care homes should be encouraged. This should assure not only the safety and appropriate levels of health care for older persons, but also the inclusion of social care perspectives which help to preserve the human rights and dignity of the older residents.

14. The encouragement of specialties in geriatric medicine and other health professions should be a matter of national policy, with funds made available for recruiting and training these specialists required to staff a comprehensive health service for older persons.

15. A national policy and program on the physical fitness of older Americans should be developed and coordinated.

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HOUSING FOR THE ELDERLY

With the moratorium on subsidized housing, instituted in the last several years, the need for suitable housing for older persons has reached critical proportions. Waiting lists for existing low and moderate income housing for the elderly are extensive and growing. Hundreds of thousands of America's older people are forced to live in environments which are substandard, too expensive, too difficult to maintain, too inefficient for their age and capacities.

Older people everywhere find it difficult to understand why a demonstrated need for a program which has been singularly successful - financially and socially - should be suspended and unfulfilled.

Because of time, because of special needs with age, older Americans require a special priority today. They have the right to make independent choices of their living arrangements regardless of their current income situation. These choices can include single family homes, independent apartments,

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congregate facilities and rehabilitative centers. In all instances, such housing should have easy access to senior center activities, health services, therapy programs, nutrition programs, cultural activities - all designed and implemented to maintain independent living even when disability occurs.

NCOA has the following specific recommendations:

1. To achieve independent choice of living arrangements, all the programs of low and moderate income housing authorized by the Congress should be used fully and immediately. Of vital importance in this regard is the full implementation of the Section 202 Program. Congress has authorized and appropriated substantial funds for a new beginning of this very successful program of housing for the elderly. The Administration should accept this action and institute an effective program of direct financing both in the construction period and for the permanent loan for qualified nonprofit applicants.

2. Such loans should have available to them a special set-aside of Section 8 subsidy to ensure that low incomes will not bar older people from suitable housing. This is a priority, major action required today.

3. There should also be enactment and execution of full appropriations under the Section 8 Program and Section 236. These programs individually, and especially in combination, could generate the volume of specially-designed housing older Americans need and require.

4. In addition, a substantial program of special grants to senior citizens who own their own homes should be underway on a sizeable basis. This will permit older persons of modest incomes to improve and rehabilitate their own homes and to go on living independently in neighborhoods of their own choice.

5. In any housing program, more than sheer shelter is required. Urgently

needed senior centers, adequate nutrition programs, physical and occupational therapy, health programs, cultural enrichment programs, etc., should be financed by grants, rather than out of the rents of residents.

6. Administration of the subsidy programs must be realistic if the program is to be effective. This means reassessing fair market rents, construction costs, methods of financing and speed of administrative processing.

7. New construction should be emphasized. Too many older persons live in homes which are too old and too inefficient for them. They require having arrangements suitable to their age and physical conditions at rentals and prices they can afford.

8. A major national focus must be directed at rural America with particular emphasis given to the housing needs of older adults. An effort to broaden the programs of, and the appropriations for, the Farmers Home Administration specifically to meet the housing needs of rural America would be an important step in this regard.

9. There is a great need for a new investment in research on the physical and social aspects of housing for the elderly. New generations of older Americans with different values and different abilities will soon constitute our retirement populations. We need to evaluate the past, conduct research on the frontiers of our knowledge and develop criteria for the near future.

10. There should be legislative enactment creating the Office of Assistant Secretary of the Department of Housing and Urban Development for Housing for the Elderly. The field is so large and so important that overall policy and planning should be centered by law in an Assistant Secretary with trained staff to ensure effective knowledge, coordination and administration.

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THE DEVELOPMENT OF SOCIAL UTILITIES FOR LONG-TERM CARE

The growth of the nursing home industry in recent years has been phenomenal; and, for the most part, caused by the introduction of Federal funds through Medicare and especially the Medicaid program. In fact, public funds now account for approximately $2 out of every $3 in nursing home revenues. In 1973, Medicare contributed $200 million and Medicaid $2.1 billion to the industry. In addition, there are almost 50 other Federal programs which assist nursing homes. These public funds support an industry in which 77 percent of the nursing homes are operated for profit, 15 percent are philanthropic, and only 8 percent are government owned.

Despite this rapid growth and public support, a recent study by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging concludes that there is no coherent policy on the long-term care of older Americans. As a result, in too many cases, public funds are used to perpetuate deficient care for thousands of older people, thus causing them

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to live in unconscionable conditions. That Senate report concludes that the majority of nursing homes in the country do not meet minimum standards of acceptibility.

It is critical that the Federal government redirect public funds to encourage the development of quality long-term care institutions. Therefore, NCOA believes that there should be a systematic diversion of Federal funds now being spent on proprietary nursing homes (estimated between $3.5 and $7.5 billion) into public or private nonprofit social utilities for long-term care. By social utilities we mean facilities or services not exclusively oriented to the care of in-patients, but also planned to provide services beyond their walls. In other words, those facilities would become an integral component of the service delivery network to the elderly throughout the community.

The possible services are many and diverse - day care, congregate dining, disease detection, intellectual and social programs, group and individual counseling and psychotherapy, outreach care, social services and health education. Thus, while offering a quiet sanctuary for those who require it, these facilities for long-term care could also become lively places with ties to the larger community. Instead of the dread of inhumane treatment or the fear of being left in a home only to die, an older person entering such a facility would expect and receive the kind of care which offers rehabilitation and a renewed sense of hope and self-esteem

The elderly need and deserve long-term care facilities geared to meeting the full range of their medical and social needs, places where they can go and be assured of quality treatment. In the best tradition of American society, public support for the social utilities described here would reinforce competition in the nursing home industry and encourage proprietary homes to develop similar constructive programs.

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THE MEDIA AND THE ELDERLY

Because the Media reflect society's perception of older persons and also make these perceptions self-fulfilling, the National Council on the Aging believes that the Media must make a major nationwide effort to develop greater public understanding of the diverse character and characteristics of older persons. NCOA, through the National Media Resource Center on the Aging, has developed recommendations for a new focus within the Media on a more positive and accurate portrayal of older men and women.

1. The Media should enable more older persons to play a fuller role in the community by exposing and reducing ageism and discrimination by increasing public understanding of the older population's value.
2. The general public should be educated to a better understanding of the processes and potentials of aging. Everyone ages and therefore has a stake in assuring that society provides the elderly with opportunities

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and options making it possible for them to live a full and contributing life.

3. The Media should stimulate consciousness-raising among the elderly themselves to enhance their own sense of worth and power.

4. The social issues and programs which affect the elderly should be dealt with more fully so that lack of information or misinformation does not prevent them from participating in activities and assistance programs which are available.

5. Staff should be developed with special knowledge in the area of aging, perhaps to monitor neighborhoods with a high concentration of elderly residents and report accurately on developments within them.

6. More cultural programs which are for, by and with the elderly should be initiated by the broadcast media.

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NUTRITION FOR THE ELDERLY

Proper nutrition is a prerequisite of good health, but it is often hard for older people to maintain an adequate diet. Poor nutrition is frequently found among older adults because they live alone; they are often frail; and many more are poverty stricken. Inflation has increased food costs alone by 20 percent in the last year. Thus, the elderly poor are forced to "pay more to eat less." To ensure an appropriate public commitment to providing adequate nutrition benefits for older Americans, NCOA believes:

1. Title VII of the Older Americans Act should be fully funded to provide the necessary support for the Nutrition Program for the Elderly which, despite its success, now reaches only a minority of those who need such support.
2. The food stamp program should have an expanded outreach as well as an improved administration in order to be of greatest value to older persons.
3. Information about the influence of nutrition on the

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aging process should be incorporated into all health education programs. Such programs should be given in the public schools, be an integral part of the health education functions of the proposed national health security program, and be a significant part of senior center programs and of other services through which large numbers of older persons can be reached.

4. Standards for nutritional quality for food services for older people should be established at the Federal level and be included in the licensing and inspection procedures in every state and community.

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RESEARCH ON AGING

During the past decade there has been a substantial degree of Federal government support for research and development of social, behavioral and biomedical research on aging. This has come through as many as 30 government agencies and departments, each of which has found that it needs to support research on problems of aging and evaluation of its programs for the elderly.

There is naturally some question whether this variety of research projects and programs is well planned and coordinated so as to cover essential problems without overlapping in some places or causing serious gaps in other areas.

The situation is now ripe for a major effort to get more coherence and better planning into the Federal government's support of research on aging.

The new National Institute on Aging is almost ready to function and its National Advisory Committee has been at work for several months. Also, the Department of Health, Educatio

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and Welfare has a Federal Council on Aging consisting of non-governmental personnel which advises on programs in HEW. We urge these two groups to get together, and perhaps to jointly create a Task Force on Research and Development in Social Gerontology, with the mission of producing a Five Year Plan for government support of research and development in this area.

Some of the most needed research can be foreseen. NCOA recommends:

1. Studies of methods of providing long-term care of elderly persons in feeble physical condition should be undertaken. This involves studies of standards and methods of financing nursing homes; as well as studies of facilities that can serve home-bound or physically impaired people through home-maker services and home-delivered meals - thus avoiding the cost and difficulty of moving into a nursing home.

2. Research should be started on ways of protecting the incomes of elderly people from erosion by monetary inflation.

3. Senior centers should be carefully studied. These agencies are increasing in numbers, and probably are the most useful single service facility for the elderly. A variety of model programs should be studied, evaluated and then those that work well should be spread over the land.

4. Television and radio programs, as well as the printed media, should be monitored and evaluated for their values to elderly viewers. Possibly some experimental programs should be created and tried out.

5. Research should be done on the adequacy of existing retirement roles and programs for development of new retirement roles.

6. Factors that affect policies governing retirement age should be studied.

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RETIREMENT INCOME

In the last few years, there has been a sharp reduction in poverty for persons 65 and older, from one out of four older Americans in 1969 to one in six by 1973. Nevertheless, the elderly are still the most economically disadvantaged age group since the proportion of aged living in poverty (16.3 percent) is higher than for any other age group. The majority of aged persons in poverty are women living alone.

Many more older Americans, although not considered to be in poverty, do not have incomes sufficient to meet a modest standard of living. Almost half of all aged couples have incomes below the Bureau of Labor Statistics intermediate budget for a retired couple ($6,041 in 1974) which was recommended as a standard by the 1971 White House Conference on Aging.

Thus, the nation has still not achieved the long-sought goal of an adequate retirement income for all even though income maintenance for the aged has been improved in three major areas: Social Security benefits have been substantially raised;

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the old age assistance welfare program has been federalized by enactment of the Supplemental Security Income program administered by the Social Security Administration; and, private pensions have been made more secure by the pension reform law.

At the same time that these improvements have been made, however, inflation has offset their impact on retirement income. Social Security increases have lagged behind price increases, particularly in the areas where the elderly have their greatest expenditures--housing, food, medical care and transportation. In the SSI program, recipients in at least 21 states will not even receive the benefits of a recent eight percent cost-of-living increase which they are entitled to along with other Social Security and SSI recipients.

Reduced Social Security taxes because of the recession and a long-term change in the population mix, have generated questions about the financing of the Social Security program. The National Council on the Aging has addressed itself to the financing aspects as well as to the adequacy of benefits in a statement adopted earlier this year. The goal with regard to financing is to bring income and outgo of the Social Security trust funds into balance within the next few years and maintain them in balance over the long-range future. There is no need to achieve a close balance in the present recessionary period or to maintain such a balance in the future over every year or short period of years.

The suggested measures to achieve this goal are:

1. The amount of earnings subject to Social Security taxes and counted in determining Social Security benefits should be increased substantially, as of 1977, from the present $14,100, and from then on adjusted, on an automatic basis, to increases in average wage levels. An increase to $24,000 in 1977 could be expected to bring the Social Security system as

a whole (cash benefits and Medicare) into financial balance for the next several decades without an increase in the tax rates.

2. Beginning in about 1985 and increasing over the following three or four decades until covering about one-third of costs, a contribution from general tax revenues should supplement employer and employee tax contributions to the Social Security cash-benefits program. The general revenue contribution should begin within the next decade and be phased in gradually.

In order to achieve more adequate Social Security benefits (and supplemental work income) the National Council on the Aging recommends:

3. An increase in the amount of earnings covered (see above no. 1) which would lead to higher future benefits and therefore greater economic security for workers in the middle and upper income brackets.

4. Gearing benefits to total wages in covered employment instead of to changes in the cost-of-living. Thus, as standards of living and levels of living increased for the working population, the retired would have a share in the increases.

5. Abolishing the premiums paid by beneficiaries for Part B Medicare.

6. Increasing the amount a Social Security beneficiary may earn in a year without reduction in benefits from $2,520 to $3,000.

The objective of the Supplemental Security Income program for the elderly is to provide an adequate standard of living for those who do not have income, or enough income, from Social Security, pensions or savings. It provides a federal "income floor" for those without other adequate income resources. Experience with the program has shown, however, that although there are some 2.3 million aged persons receiving benefits, there are still many aged persons not receiving benefits to which they are entitled, and that implementation of the

program is reducing already limited benefits.

To achieve the goal of bringing all eligible aged persons into the program and to provide a more adequate income from SSI benefits, NCOA recommends that the Social Security Administration take the following, necessary administrative steps:

7. Field visits to those potential beneficiaries who are homebound and unable to come to local SSA offices.

8. Development and implementation of a permanent outreach and information program to inform potential recipients of their rightful benefits.

9. States should be mandated to pass along all cost-of-living increases in the federal portion of the SSI payment by requiring states to at least maintain supplementation payments at June, 1975 levels.

10. SSI recipients should be guaranteed that SSI benefits will not be reduced when Social Security benefits rise.

11. All applications for SSI benefits should be processed with the utmost promptness, preferably within thirty days. The present $100 advance should be increased to cover the full amount of the standard monthly payment for two months, and the present provision for advance payments on the basis if presumptive disability should be broadened to include presumptive blindness.

12. Legislation should be enacted authorizing the Secretary of HEW to provide a permanent mechanism for on-going emergency assistance, as often as needed, effective within twenty-four hours of a recipient's application for such aid.

13. The use of an Ombudsman at the state or regional level to respond to claims that individuals have been denied benefits to which they are entitled should be studied and seriously considered for use in the program.

The Employee Retirement Income Security Act of 1974 provided some new protections and guarantees for the some 30 million employees covered by private pension plans.

Enforcement of the new pension reform law has just begun and it is too early to assess its impact. Studies will be needed (and some are provided in the law) to determine its impact in such areas as the employment opportunities of middle-aged and older workers, the improvement of survivor provisions and the expansion of private plan coverage. The provision establishing individual retirement accounts for those not covered by other pension plans is already quite popular, but there is little information if the additional requirements provided by the law have had any effect on establishment of additional group plans. It is important that additional plans be established to extend coverage for less than half of the work force in private industry is now covered by retirement plans.

NCOA recommends two goals with regard to private pensions:

14. Existing pension plans should continue to be liberalized with regard to such features as early vesting, portability between employers and the provision of survivor benefits.

15. The establishment of new pension plans should be encouraged so that coverage would be extended to a larger proportion of the workforce.

Specific legislative and other recommendations await further study and experience under the new pension reform law.

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EXTENSION OF THE GENERAL REVENUE SHARING PROGRAM
(STATE AND LOCAL FISCAL ASSISTANCE ACT OF 1972)

Since the inception of the General Revenue Sharing Program in 1972, the National Council on the Aging has provided technical assistance to public and private local, state and national agencies serving the elderly and poor on how they should go about obtaining their "fair share" of the allocated funds. We were pleased that social services to the poor and aged was one of the priority areas in which local governments were required to spend their funds. Yet a recent study by the General Accounting Office revealed that less than half of one percent of the total monies authorized for expenditure by the local governments surveyed were directed specifically to programs to benefit the aged. To compound the problem, cutbacks in and even complete elimination of categorical programs benefiting the poor and aged have been justified on the existence of general and special revenue sharing funds to take their place.

It is clear that, without additional safeguards in the

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legislation being drafted to extend the program, the needs of the poor, particularly the elderly poor, will not be a significant objective of revenue sharing programs. Therefore, NCOA urges the Congress and the President to support in any legislation extending the State and Local Fiscal Assistance Act of 1972 the following provisions:

1. A restriction on the use of general revenue sharing funds by both state and local governments to the eight priority areas in the current legislation.

2. A requirement that states and local governments spend no less of these funds on social services for the poor and aged than the percentage of aged and poor in that particular political jurisdiction as determined by Bureau of the Census data.

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THE RURAL ELDERLY

Until very recently there has been a large migration of the American people from rural to urban areas. Thus, people residing in rural areas faced a dramatic reduction in income, a lack of essential services and, of course, a reduced population. Rural America became less visible in terms of priority in Federal and state programs. What was once the backbone of the country became a skeleton, standing alone and forgotten. Interestingly, the same could be said of the older adult throughout America. For an older adult living in rural America, the problems of poverty, isolation, poor health, inadequate housing, and lack of visibility were compounded.

However, recent migration trends seem to be changing. The population is now leaving urban areas for rural ones, although services are not so quick to follow. The National Council on the Aging calls for a national effort through the voluntary public and private sectors to utilize the capabilities of rural older adults to restore them to productiveness and to expand

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and develop services to enable rural older adults to enjoy a life of dignity, health, and safety. To this end, we make the following recommendations:

In non-metropolitan society, pensions or annuities are almost non-esistent. Therefore, older adults rely on social security benefits or income maintenance programs for their only source of income. To relieve the burden of these often inadequate income levels for older adults in rural areas:

1. An accelerated effort to develop rural manpower programs should be made to enable older adults to remain self-sufficient.

2. An income maintenance program tailored and directed to meet the needs of the rural older adult should be established. Such programs should take into account the traditional multi-generational family model which is still common in rural America since this structure often prevents older family memebers from receiving full income benefits although they must contribute to the family's income in order to avoid impoverishing them.

3. An effort by Federal, state and local governments must be made to protect the independence of rural older adults by reducing property taxes, especially those of persons on limited incomes.

Noting that in 1973 the U.S. Department of Health, Education and Welfare spent only $7 million out of $175 million on health services delivery in rural areas although statistics show that approximately 140 rural counties in the nation do not have a physician and very limited auxiliary health services, NCOA recommends the following:

4. The Federal government should collaborate with medical schools in planning for special stipends for medical students who make a commitment to serve in rural areas (as well as other delivery areas) following their training as well as field placements during their training.

5. More support should be given to developing other professionals such as doctor's assistants, nursing and medical aides to provide supportive medical servcies to older adults in rural areas.

6. Mobile health service units, mini-medical clinics, visiting nurses services and emergency transportation services should be developed to alleviate this serious problem.

7. More emphasis should be given to medical service development, linkage of auxiliary services and provisions to enable the utilization of these services.

Public transportation is virtually non-existent in most rural areas and medical and social facilities are too distant from residential areas to be reached by taxi or by walking. These conditions immobilize older adults and keep them from making social contacts and reaching professional services. NCOA recommends:

8. The National Mass Transportation Act of 1974 should be re-examined and new allocations made to offer more than token assistance to rural areas.

9. Efforts should be made toward ensuring the full development and utilization of volunteer transportation services, minibus services and school buses during "off hours" to fill this transportation gap.

10. State Public Commissions should remove those regulations which might restrict the implementation of transportation programs, and state Agencies on Aging should be prepared to follow up such action with

recommendations of transportation programs which would benefit the elderly.

Sixty percent of the substandard housing reported in the nation's counties is in rural areas; one-fourth of those dwellings are occupied by the older adult. NCOA recommends the following:

11. A major national housing focus must be directed at rural America with particular emphasis given to the housing needs of older adults. An effort to broaden the programs of, and the appropriations for, the Farmers Home Administration specifically to meet the housing needs of rural America would be an important step in this regard.

12. Legislation should be enacted to make available funds for low-interest rate loans for major home repairs. The development of community services to provide minor home repairs could enable many older adults to maintain their independence by remaining in their own homes. Many others, by using their skills in carpentry, masonry and plumbing could earn extra income.

13. Planners and administrators should make greater efforts to provide social services, which are so often denied the rural elderly because of their limited mobility, with public housing projects for the elderly.

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SENIOR CENTERS

Findings from the National Institute of Senior Centers' Multipurpose Senior Center Research Project affirm the role of the Senior Center as a community focal point for older person services and activities. Nutrition, health and social services plus educational, recreational and community service opportunities are made accessible and available for older persons through Multipurpose Senior Centers in thousands of communities throughout the country. There are, however, great gaps in the development of Multipurpose Senior Centers. In rural areas, for instance, where services are particularly sparse and accessibility a major problem, there are great numbers of older persons who could benefit from Center services; yet, these are the communities which do not have sufficient local resources for such programs. NCOA thinks the following steps are necessary:

1. The Congress should appropriate funds to provide Title V of the Older Americans Act with the means to do

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the task it was authorized to accomplish. At the minimum, each planning and service area should have a Multipurpose Senior Center from which service delivery could be coordinated - in a sense the action arm of the Area Agency on Aging.

2. A Part C for Title V of OAA, which would provide assistance to existing programs which qualify or have the potential to become Multipurpose Senior Centers by authorizing grants to sustain all or part of the costs of staff, should be developed. The current focus of Title V is too limited. It reflects a major restriction on service delivery throughout the Older Americans Act - no support for ongoing programs. Emphasis is on new projects, with nothing to maintain services and activities which have been proven to be life-sustaining to millions of America's aged.

3. Community Development funds should be authorized for nonprofit Senior Centers in addition to those which are publicly sponsored. We also urge the Department of Housing and Urban Development to encourage support of Senior Centers in the Community Development program. The extension and ultimate funding of Title V remains the primary route of Federal support for Senior Centers. Reports from around the country indicate that centers are not receiving monies under the Housing and Community Development Act of 1974. Although Centers were specifically designated by the Congress as eligible recipients of such funds, little support has emerged.

4. The Administration on Aging should encourage Area Agencies on Aging to develop service contracts with Senior Centers whenever possible, thus recognizing and extending the comprehensive service delivery system which Multipurpose Senior Centers represent.

5. The Administration on Aging should provide support for the development of standards for Senior Centers. This would be an important step forward

in the provision of services for older people because it would assure more consistency in quality and a means to maintain programs meaningful to the community and to older persons. The Senior Center field as a whole should assist in the development of these standards and be involved subsequently in their adoption as a means of promoting the best for those who deserve the best - the older people of America.

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September, 1975

SOCIAL SERVICES AND THE ELDERLY

A social service system exists to help individuals and families to make optimal use of the resources which exist to sustain and enhance social functioning in our very complex society and its physical environment. Social services are needed by all people at some time in their lives to maintain or to attain their roles as socially or economically productive members of society, and to effectively cope with their environment.

The elderly particularly, because of their vulnerability and the impact of their problems on family and society, as well as their relatively little knowledge about the social interventions which are needed, represent a primary target for social services. The provision of social services in their preventive, supportive and restorative functions can provide for the individual and collective needs of older persons.

Social services can include a wide variety of individual and group or community services, such as nutrition, health,

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educational or recreation and involve not only delivery systems but policy formation, training, education, and research. Transportation as well is an important ingredient of services and a link to resources in the community.

Where responsibility rests for providing needed social services for the aged has not been clearly defined. Neither has accountability been clarified nor the mechanisms for this developed. Perhaps most importantly, the resources which are provided are insufficient.

Social services have developed in three separate systems, one private profitmaking, and the others private-voluntary and public. None of these systems functions adequately for the aged and the separation of the three systems has been dysfunctional to meet all needs of the total elderly person. The identification of this group as a special category to receive government resources has weakened not only the principle of right to service but the integration of all services, private (profit-making and voluntary) and public, into one cooperative system which functions effectively.

The National Council on the Aging is aware of the wide disparity which exists at present between the needs of the elderly and the social services which are provided to meet the greatly varied needs and wishes of this diverse population. No national policy now exists regarding meeting the needs of all Americans; this should be a primary goal. There should be a public commitment to the elderly so that necessary steps may be taken to ensure that the gap be closed between service needs and services for Older Americans.

The new Social Service Amendments of 1975 (Title XX) basically represent special revenue sharing as applied to public service programs. Unfortunately, Title XX does not provide for the provision of essential services and omits the specific language permitting group eligibility or standards for adult care; it does not define strongly what constitutes an eligible service. What is most

important, moreover, is that no attempt has been made to coordinate this social service program with other programs - private and public - which provide services to the elderly.

NCOA has continually worked for improvements to insure that the current delivery and future expansion of critical social services to older Americans be facilitated. Delivery and expansion of services, however, is not enough. NCOA is concerned with regulation and means to insure the quality of the services.

The assumption is that there will be little change this year in provision of social services, and the present pattern will continue until review and planning can affect new modes of implementation. Since Title XX provides for public review and comment, mechanisms for utilization of these to maximize allocations for the elderly are essential. In this way changes may take place in direct response to service needs of the elderly.

The National Council on the Aging makes the following policy recommendations accordingly:

1. Title XX should make explicit that services be designated for the elderly specifically, so that low-income elderly are not in competition with other groups for services;

2. Group eligibility in the provision of services to adults should be allowed under Title XX.

3. Standards which ensure quality adult care must be established under Title XX. Funding to ensure enforcement of these standards through inspection and education must also be forthcoming.

4. Attempts should be made to coordinate the Title XX programs with other service programs - private or public - which serve older people.

5. Provision of services under any law is useless unless knowledge and access to the services is made readily available to the group which needs

them. Thus, a system which will provide information and make referral for the elderly to link them to services should be developed.

6. Transportation is a means to bring services and older people together. Mass transportation and/or diverse mobility systems which are responsive to the unique needs of older people should be developed.

7. Levels of appropriation for services should meet the massive needs of the elderly. Insufficient funding represents tokenism and results in inadequate services and blocks access to services.

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September, 1975

THE SPIRITUAL WELL-BEING OF THE ELDERLY

Spiritual well-being is the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness.

The spiritual is not one dimension among many in life; rather it permeates and gives meaning to all life. We call attention to this fact of life: To ignore or to attempt to separate the need to fulfill the spiritual well-being of man from attempts to satisfy his physical, material and social needs is to fail to understand both the meaning of God and the meaning of man.

We recognize that human wholeness is never fully attained. Throughout life it is a possibility in process of becoming; thus, it is no less important to the older man and woman than it is to the adolescent. In the Judeo-Christian tradition, life derives its significance through its relationship with God. While we acknowledge and respect the rights of others to have other frames of reference, we reaffirm our belief that

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it is this relationship with God that awakens and nourishes the process of growth through wholeness in itself, crowns moments of life with meaning and extols the spiritual fulfillment and unity of a person.[1]

Spiritual wholeness is the right of all people. So that older persons can achieve and maintain a state of spiritual well-being and fulfillment, the National Council on the Aging recommends the following:

1. The spiritual leadership of the nation should address itself to a greater commitment of psychic and financial resources toward serving the elderly. While meeting the needs of the elderly and working for programs that contribute to the well-being of the elderly, religious bodies should attempt to ensure that older persons share in the planning and implementation of all programs related to them, and that these programs are directed not only to the independent aged in the community, but also to the elderly living in public or private institutions.

2. The religious community should take it upon itself to become the prime impetus toward developing special understanding and competency in satisfying the spiritual needs of the aging among its members and among those who deliver services to the aging in private and public agencies.

3. Religious bodies should take the initiative in developing a greater sensitivity toward, and appreciation of, the cultural and ethnic diversity of our nation in order to better serve the elderly. They should work closely with the diverse minority communities to ensure that cultural or language barriers to communication are broken down without destroying the common ethnic or racial identities which bind those communities and which give greater meaning and identity to so many older people.

[1]The introduction was adapted from a statement on Spiritual Well-Being developed by the National Interfaith Coalition on Aging at its Fourth Annual Meeting, April 29-30, 1975, in Washington, D.C.

4. Religious organizations should be aware of agencies and services other than their own which can provide a complete ministry to older persons. Other organizations designed for the benefit of older persons should develop, as part of their services, channels to persons and agencies who can help in spiritual problems.

5. Religious bodies have traditionally and properly developed their own philosophies. In this context, they should work together with the elderly and coordinate their efforts with other groups to develop and declare an affirmation of rights for the elderly as well as to become actively concerned with spiritual, personal and social needs. Such efforts would work to ensure the basic values of all while guaranteeing the basic right of freedom of religion.

6. Religious bodies and the government should affirm the right to, and reverance for, life. In that framework, we believe an individual has the right to choose to die a natural and dignified death. When there is no reasonable expectation of recovery from physical or mental disability, an individual should be allowed to die and not be kept alive by artificial or heroic means. Medication should be mercifully administered during times of terminal suffering, even if it hastens the moment of death. Such a decision by an individual does not ask that life be directly taken, but that dying be not unreasonably prolonged. This decision should be made by an individual for himself or herself. To ensure that such a request for a natural death is understood and not abused by others, individuals are urged to compose living wills. These wills would communicate the conscious desire to be allowed to die even though the individual be unconscious or otherwise incapacitated near the moment of death.

7. Institutions caring for the aged should provide the opportunity for

chaplaincy services. In all cases, however, the aged resident should be the sole arbiter of the religious denomination and degree of any assistance provided.

8. The government should cooperate with religious bodies and private agencies to help meet the needs of the elderly, but, in doing so, should observe the principle of separation of church and state.

We hope that these recommendations will stimulate a rededication of national efforts toward enriching the lives of older people. In particular, we seek a society and spiritual atmosphere in which the elderly can grow to accept the past, to be aware and alive in the present, and to live in hope of fulfillment.

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September, 1975

TRAINING AND EDUCATION

Training

With what is bound to be a major expansion of services and programs for the elderly during the next few years, there is a growing need for continuing education of people in the field. NCOA believes the following steps are necessary:

1. Continuing education and supplementary training programs for people who wish to serve as staff members of area agencies, as staff members of senior centers, and as staff of long-term care institutions should be supported.

2. The present flow of young people through doctoral programs in gerontology and related disciplines should be maintained. The provision of a limited number of fellowships for doctoral candidates in the spring of 1975 is commendable and should be continued.

3. Training grants for university programs in the social and biological aspects of aging should be maintained with

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funds that will guarantee the supply of research and university teaching personnel at a somewhat increased level.

4. The continuing needs for training persons at the doctoral and the semi-professional levels should be coordinated with the aid of the National Institute on Aging and the Federal Council on Aging. The time has come to set up an ongoing program for at least five years, with funding authorized by the Congress. Appropriations for training have been $8 million in the most recent years, and support should be continued at this level, or increased over the next five years.

Education

Programs of general cultural and socio-civic education provided for people in their 50s, 60s, and 70s are now beginning to catch the attention and interest of mature people much more than they have in the past. This is partly due to the ingenuity and effort of educators, working especially in community colleges and in extension divisions of the state universities. It is also partly due to the increasing level of formal education of elderly people. Within ten years, the majority of people aged 65 will be high school graduates. And those who have the most formal education are the ones who want more continuing education.

To encourage and meet this growing interest, NCOA recommends:

1. Educational programs should be effectively free of tuition charges for all people over age 60, which means that colleges and public schools should have access to Federal or state funds to support such programs.

2. Legislation has paved the way for support of continuing education programs, but very little money has yet been appropriated and made available. Federal funds should be appropriated specifically for these programs.

3. Curricula regarding the aging process should be developed and introduced at all educational levels.

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September, 1975

TRANSPORTATION AND THE ELDERLY

Transportation provides a link to needed services for the elderly, who are more reliant on transportation than any other segment of the population. Yet the elderly are least likely to be served by the present transportation system. Most transportation money goes to networks serving the private automobile, and the elderly are generally non-drivers. Where transportation is available - and almost none is available in rural areas - the elderly either can't afford it or design, routing or scheduling make use of facilities difficult. Thus, barriers are created to service and employment for the elderly, particularly the elderly poor. NCOA, therefore, recommends:

1. The Federal government must take the leadership in increasing the mobility of older people through subsidies and promotion of free or low-cost coordinated, accessible transportation systems with special attention to their unique needs. Ultimately, the responsibility in this

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area must rest with state, regional and local transit authorities.

2. The provision of transportation is an essential part of any social service, welfare or health program serving older people. Any of these which receives subsidy from local, state or Federal government should include transportation as the vital linkage between the older person and the service.

3. Funds should be provided by all levels of government to test out new alternative ways to provide low-cost transportation to meet the needs of older persons in both urban and rural areas.

4. Older people themselves should be actively involved in the planning, policy making and development of transportation programs designed to serve them.

THE NATIONAL COUNCIL ON THE AGING
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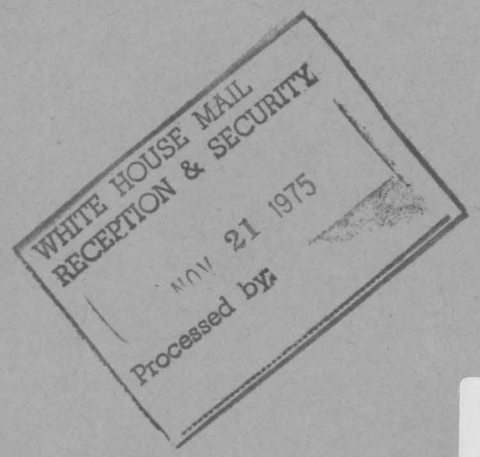
NON PROFIT
ORGANIZATION



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HON GERALD R. FORD
PRESIDENT OF THE UNITED STATES
OF AMERICA
WHITE HOUSE
WASHINGTON, DC 20501

HEARINGS ON THE PRESIDENT'S MEDICARE PROPOSALS - February 9, 1976
Before the House Ways and Means Health Subcommittee

Members Present: Dan Rostenkowski (D-Ill.), Chairman
Representatives Corman (D-Calif.), Burleson (D-Tex.),
Keys (D-Kans.), Martin (R-N.C.)

Witness List attached.

The witnesses, mostly Health Security Act proponents, opposed the Administration's Medicare catastrophic proposal, calling it arbitrary, deceptive, a gimick and an attempt to shift a greater burden of health care costs on to the recipients of Medicare and to State and local assistance programs. They were totally convinced this is not a catastrophic measure in any sense except that it actually would create the catastrophes for the program; i.e. many would be forced into catastrophic costs through the new co-insurance system and out-of-pocket requirements. Some came armed with figures, charts and examples to bear out this claim.

The central theme running through most of these statements (besides the philosophical rhetoric) was:

--The numbers of beneficiaries would be small--only 25,000 who would be hospitalized for 70 - 75 days. (One witness asked how many of the 25,000 are the elderly; what about ESRD patients for instance).

--The 4% cap on physicians' fees only limits the amount reimbursable under Medicare; a greater portion ofthe patient's bill would be passed along to the patient. (In that connection, several witnesses and Rep. Corman indicated a fixed fee is in order.) Further, the witnesses claimed this would lead to a decline in the assignment rate.

--The 7% cap on hospital fees would be passed along to non-Medicare patients.

--Medicare recipients would be inclined to seek care only after they become critically ill.

--Secretary Mathews' statement that "more would have to pay more" was quoted by one and all, but at times (such as during Senator Pepper's statement) was translated to mean "more poor would have to pay more." Representative Martin was quick to emphasize that not all the elderly are poor (Mr. Turk of the NASW put the poverty level for this group at 50%)

--Several witnesses voiced general but vague criticism with respect to the block grant proposal. Nelson Cruikshank, who seemed to have a better grasp of the concept of Share than the other witnesses (and perhaps some Members of the Committee) was concerned that the Medicare proposal would force more individuals onto Medicaid rolls and weaken that program's ability to meet the load.

--With respect to the Administration's rationale that the proposal would prevent overutilization, Mr. Cruikshank said it is the doctor, not the patient, who determines the use of hospital care. The overutilization of services was mentioned in connection with criticism of the Administration's home health policies by Rep. Keys and several witnesses within the framework of alternatives to institutionalization.

--Several spokesmen offered their own Medicare improvement proposals: i.e., the AFL-CIO, the NRTA-AARP (the Medicare Reform Act of 1975--Ribicoff/Matsunaga), and Senator Pepper's Home Health Improvement package.

The testimony of the National Association of Patients on Hemodialysis was not covered; however, in their prepared statement they opposed the amendments on the basis that they would cause the first experiment in catastrophic illness coverage to fall short of its goal because it would be too costly to those on fixed incomes, to the Federal government by shifting reimbursement from States and private carriers, to the renal program because it would block cost saving incentives; and it would give very little direct aid to those suffering from catastrophic illness.

The few questions asked of the witnesses by Committee Members were very basic ones.

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LIST OF WITNESSES TO APPEAR BEFORE
THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
ON
THE PRESIDENT'S MEDICARE PROPOSALS

MAIN COMMITTEE HEARING ROOM - LONGWORTH HOUSE OFFICE BUILDING

10:00 A.M.

MONDAY, FEBRUARY 9, 1976

1. Claude Pepper, M. C. (Florida)

2. American Federation of Labor
Congress of Industrial Organizations:

   Bert Seidman, Director, Social Security Department
   Larry Smedley, Assistant Director, Social Security Department
   Robert McGlotten, Legislative Representative

3. National Council of Senior Citizens:

   Nelson H. Cruikshank, President

4. United Mine Workers Health & Retirement Funds:

   Jerry N. Clark, Director of Research

5. National Council on Aging:

   Jack Ossofsky, Executive Director

6. American Association of Retired Persons
National Retired Teachers Association:

   Laurence F. Lane, Legislative Representative
   Peter Hughes, Associate Counsel

7. National Association of Social Workers:

   Oscar Turk, ACSW, Member, Health Action (New York Chapter)
   (Coordinator of Discharge Planning, Bird S. Coler Hospital, New York City)

8. Women's Lobby:

   Carol Burris, President

9. National Association of Patients of Hemodialysis and Transplantation:

   Phyllis Messer, Executive Director

THIS HEARING WILL CONTINUE AT 9:00 A.M., TUESDAY, FEBRUARY 10,
IN THE MAIN COMMITTEE HEARING ROOM.

NA. Council of Sr. Citizens

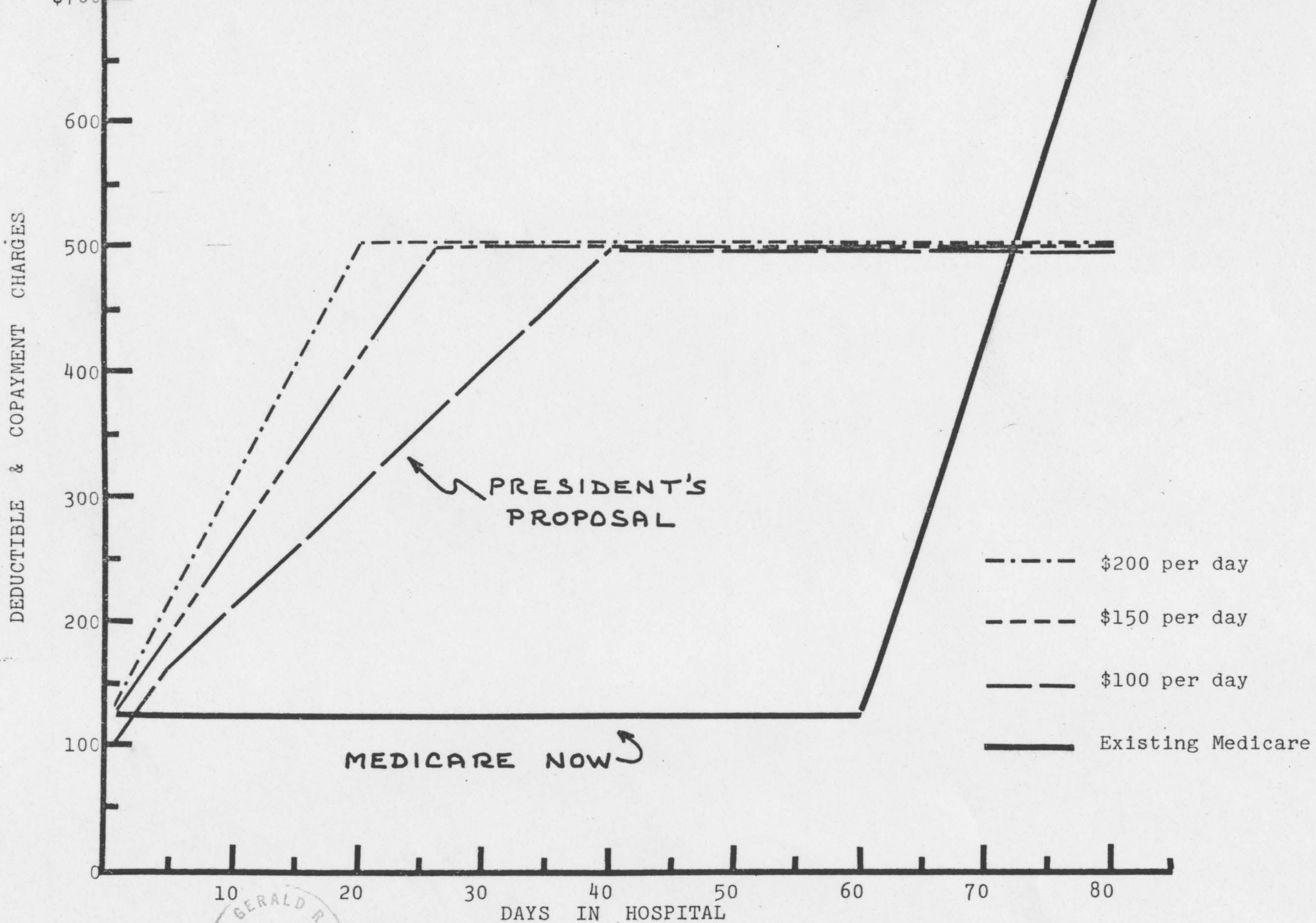
Table I Comparison of the out-of-pocket costs for covered hospital services under the existing Medicare program with the President's proposal, by number of days in hospital

Days in hospital	Deductible & Coinsurance under present Medicare program	Deductible & Coinsurance under Administration's proposal--based on average daily hospital charges of:		
		$100	$150	$200
1	$124*	$100	$127	$132
5	124	162	187	212
10	124	212	262	312
15	124	262	337	412
20	124	312	412	500
25	124	362	487	500
30	124	412	500	500
35	124	462	500	500
40	124	500	500	500
45	124	500	500	500
50	124	500	500	500
55	124	500	500	500
60	124	500	500	500
65	279	500	500	500
70	434	500	500	500
75	589	500	500	500
80	744	500	500	500
85	899	500	500	500
90	1054	500	500	500

*Deductible (now $104) estimated to be $124 in 1977 when President's proposal would go into effect

Chart I

Increases in Hospital Costs for Medicare Patients
Under the President's Proposal*
(Based on three average hospital charges per day)
*Effective in 1977 when Medicare deductible would be $124

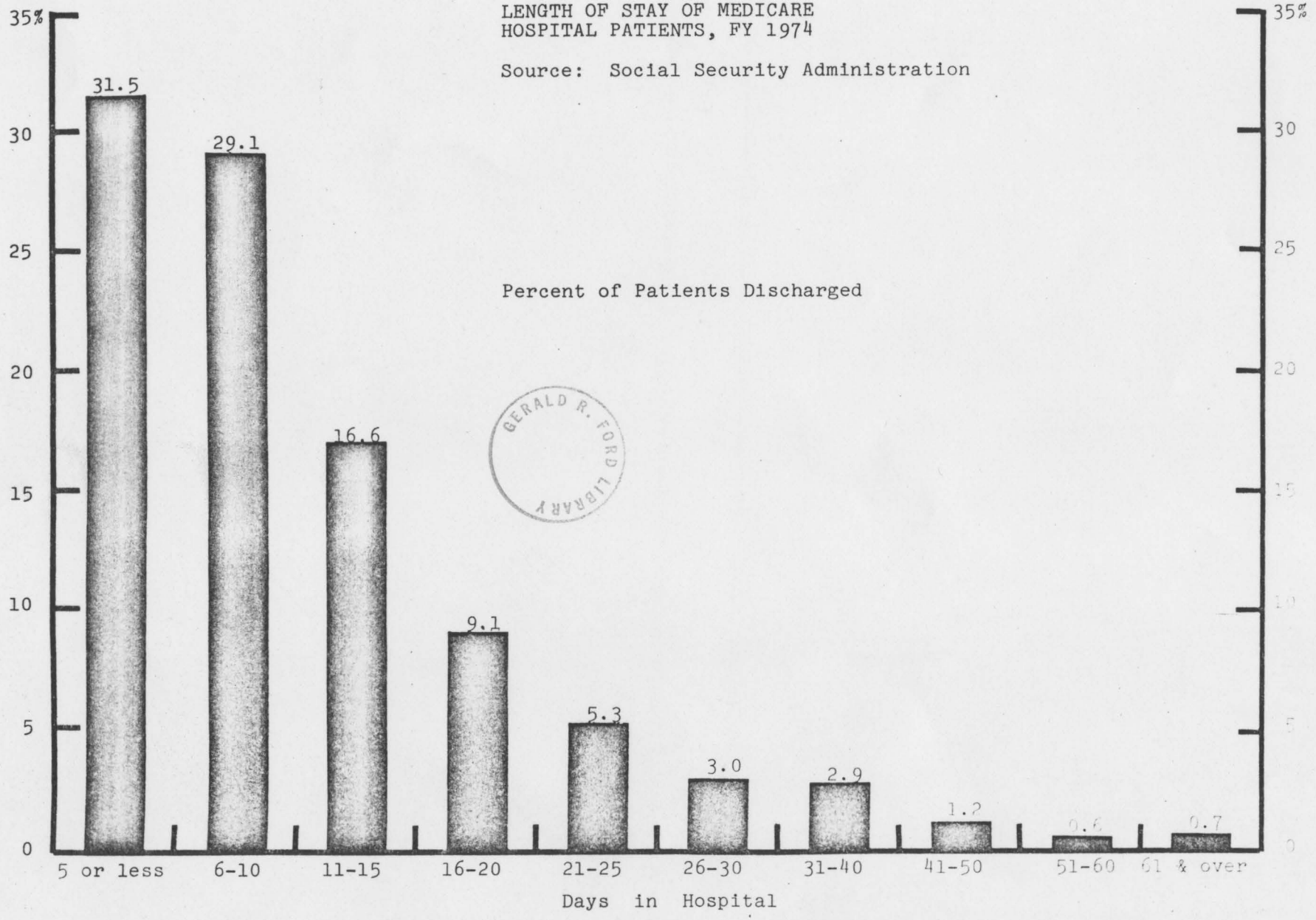


Na. Council of Senior Citizens

Chart II

LENGTH OF STAY OF MEDICARE
HOSPITAL PATIENTS, FY 1974

Source: Social Security Administration



United Mine Workers

Assumptions:

For the analysis of the cost impact on the Funds of these Medicare changes, the following assumptions are made:

1. The number of Medicare - covered beneficiaries included in the Fund population is assumed to be:

   Over 65 - 95,000

   Under 65 - 11,000

   Total 106,000

2. Hospital admission rate per 1000 Medicare covered beneficiaries is based on the FY 1975 level of 479 per 1000 beneficiaries.
3. Average length-of-stay is the same as US Medicare experience, or 11.7 days per admission.
4. Average hospital per-diem charge to Medicare is equal to $104 for calendar 1976; a 7% increase is projected for the next two years, to $111 in calendar 1977; and to $119 in calendar 1978.

TABLE I

ESTIMATED CHANGES IN FUNDS HOSPITALIZATION COSTS UNDER MEDICARE, ADMINISTRATION PROPOSALS (Assumes 7% cost limitation)

A. FISCAL YEAR 7/1/76 - 6/30/77

		Present	Administration Proposal
1.	Number of admissions	50,774	50,774
2.	First day deductible	$5,465,306	5,465,306
3.	10% Coinsurance	-	4,435,288
4.	Less catastrophic coverage	-	177,455
5.	Net coinsurance cost		4,257,833
6.	Total Funds cost	$5,465,306	9,723,139
7.	INCREASE		78%

B. FISCAL YEAR 7/1/77 - 6/30/78

		Present	Administration Proposal
1.	Number of admissions	50,774	50,774
2.	First day deductible	$5,847,895	5,847,895
3.	10% Coinsurance	-	6,257,248
4.	Less catastrophic coverage	-	250,257
5.	Net coinsurance cost	-	6,006,991
6.	Total Funds Cost	$5,847,895	11,854,886
7.	INCREASE		103%

TABLE II

INCREASE IN DEDUCTIBLE COSTS
UNDER ADMINISTRATION PROPOSAL

YEAR ENDING 6/30/77

1.	No. of beneficiaries	106,000
2.	Cost at $46.20 average deductible	$4,897,200
3.	Cost at $33.16 average deductible	3,514,960
4.	Difference	1,382,240

YEAR ENDING 6/30/78

1.	No. of beneficiaries	106,000
2.	Cost at $48.60 average deductible	$5,151,600
3.	Cost at $33.16 average deductible	3,514,960
4.	Difference	1,636,640

TABLE III

SAVINGS FROM PART B CATASTROPHIC
COVERAGE

YEAR ENDING 6/30/77

1.	Estimated Part B costs	$31,527,518
2.	4% catastrophic	1,261,100
3.	20% presently paid (savings)	252,220

YEAR ENDING 6/30/78

1.	Estimated Part B costs	$34,680,822
2.	4% catastrophic	1,387,232
3.	20% presently paid (savings)	277,446

TABLE IV

INCREASED CO-INSURANCE FOR PHYSICIANS
IN-HOSPITAL SERVICES AND HOME HEALTH

	Physicians In-Hospital	Home Health
YEAR ENDING 6/30/77		
1. Total Costs	$ 10,908,408	$ 252,395
2. Minus share of deductible	712,727	861
3. Net	10,195,681	251,534
4. 30% co-insurance	3,058,704	75,460
5. 20% co-insurance	2,039,136	50,307
6. Difference	1,019,568	25,153
7. Total Difference	$ 1,044,721	
YEAR ENDING 6/30/78		
1. Total Costs	$ 11,999,169	$ 277,633
2. Minus share of deductible	712,727	861
3. Net	11,286,442	276,772
4. 30% co-insurance	3,385,933	83,032
5. 20% co-insurance	2,257,288	55,354
6. Difference	1,128,645	27,678
7. Total Difference	$ 1,156,323	

TABLE V

NET COST IMPACT OF INCREASED
DEDUCTIBLE AND COINSURANCE AND
CATASTROPHIC COVERAGE, PART B
MEDICARE

YEAR ENDING	6/30/77	6/30/78
Increase from deductible	$1,382,224	$1,636,640
Increased coinsurance	1,044,721	1,156,323
Savings from catastrophic	252,220	277,446
Net increase	$2,174,725	$2,515,517

TABLE VI

EXPECTED MEDICARE REIMBURSEMENTS
FOR PART B

FY	Total Cost	Medicare Reimbursement expected at current rates	Medicare Reimbursement expected changes	Difference
1975	$24,000,000	$17,300,000	-	-
1976	30,290,000	22,190,000	-	-
1977	33,319,000	24,322,870	$23,077,600	$1,245,270
1978	36,650,900	26,755,157	24,000,704	2,754,453
				$3,999,723

TABLE VII

SUMMARY OF INCREASED COSTS
TO FUNDS OF ADMINISTRATION
MEDICARE PROPOSALS
FY 1977 & 1978

	FY 1977	FY 1978
1. Due to Part A direct increases	4,257,833	6,006,991
2. Due to Part B direct increases	2,174,725	2,515,517
3. Due to Part A indirect costs	5,000,000*	10,000,000*
4. Due to Part B indirect costs	1,245,270	2,754,453
Total Cost	$12,677,828	$21,276,961

Grand Total $ 33,954,789

# # # # #

HEARINGS ON THE PRESIDENT'S MEDICARE PROPOSALS - February 10
Before the House Ways and Means Health Subcommittee

Members present: Dan Rostenkowski (D-Ill.), Chairman
Representatives Corman, Cotter, Keys
Duncan, Crane

Witness List attached.

The witnesses unanimously opposed the Administration's proposals and urged the Committee to reject them. The Administration was criticized by several of those testifying because of the "secrecy" surrounding these proposals and the vagueness of the information offered. They expressed an interest in analyzing them when they are put in legislative language.

The primary concern of today's witnesses was the 4% and 7% limitation on physicians' fees and hospital reimbursement (especially the latter). They stated the President had decided to subject the health industry to limitations not imposed on other sectors of the economy. Further, they

--warned of a further decline in assignment rate (estimated at 50% for 1975)

--predicted a wide variety of responses to the "intolerable" ceiling, including a reduction in quality of and accessibility to services.

--compared the rise in overall cost-of-living with the (comparatively low) allowable physician fees during the same period of time

--deplored the shift of costs to non-Medicare hospital patients

--justified increases in health care costs due to economy-wide inflation, citing increases in salaries, malpractice insurance, drugs, utilities, etc.

--stated that these controls duplicate existing authority (Section 223 of P.L. 92-603) and referred to cost controls already in place (UR, PSRO)

As did yesterday's witnesses, those testifying today opposed the $500-$250-coinsurance combination and said it was catastrophic only to the beneficiaries. They objected to increased out-of-pocket costs and said those who could least afford the added expense (i.e. the hospitalized) would have to pay. The witnesses performed basically the same Now-and-Proposed exercises and comparisons with the Proposed coming under sharp criticism. The AMA, though in basic agreement with the need for cost-sharing (they cited their NHI proposal, H.R. 6222 as an example) objected to the financing of the Medicare catastrophic and suggested costs be spread over the entire Medicare population. Concern was expressed that, since most Medicare patients cannot absorb more increases, the Medicaid rolls will swell, the States wont be able to meet the burden, and the result will be a reduction in health care services.

Dr. Charles Phillips, President of the American Protestant Hospital Association, spoke out against FAHCA. He said the past history of the States in providing services to the poor and medically needy is not too promising for the success of this program, and that the hospitals of this country are in no position to absorb any gap between what the States decide to pay for care and the cost of providing that care. He provided also specific examples of the impact of the 7% limit, which are attached.

Committee interests:

Rostenkowski -	acceptable approaches to control hospital costs; effect on patients of the 7% lid; whether coinsurance is an effective method of controlling utilization
Corman	Possibility of required assignment; reasonable fees
Keys	Home health; cut back in services; the cancer study*
Duncan	Financing
Cotter	Whether physician services in a hospital are affected by the 4% or 7% limit
Crane	H.R. 11030 (his bill to require consultation between the Executive Branch and Congress prior to issuing proposals

* The National Cancer Foundation cited a hospital survey which indicated the average hospital stay among cancer patients is 15 days; and 17 days for cancer patients over 65.

L(H):td:2/10/76

LIST OF WITNESSES TO APPEAR BEFORE
THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
ON
THE PRESIDENT'S MEDICARE PROPOSALS

MAIN COMMITTEE HEARING ROOM - LONGWORTH HOUSE OFFICE BUILDING

9:00 A.M.

TUESDAY, FEBRUARY 10, 1976

1. American Hospital Association:
   John Alexander McMahon, President
   Dr. Leo J. Gehrig, Senior Vice President

2. American Medical Association:
   Dr. Raymond Holden, Chairman, Board of Trustees
   Harry Peterson, Legal Counsel, AMA Legislative Council

3. Association of American Medical Colleges:
   Dr. David D. Thompson, Chairman-Elect, Council on
   Teaching Hospitals (Director, New York Hospital)

4. American Protestant Hospital Association:
   Charles D. Phillips, President
   Kenneth Williamson, Consultant on Washington Affairs

5. National Cancer Foundation:
   Eric L. Hirschhorn, Member, Board of Directors

6. Council of Community Hospitals:
   John F. Horty, President

7. Friends Committee on National Legislation:
   Dr. Malcom Lee Peterson (Johns-Hopkins, Dean of Health Services)

8. Hospital Financing Study Group:
   John M. Vickers, Chairman (Vice President, E.F. Hutton & Co.)

9. National Union of Hospital and Health Care Employees,
   District 1199:
   Judith Berek, Legislative Representative

10. Welborn Baptist Memorial Hospital, Evansville, Ind.:
    Donald I. Gent, Executive Director

11. Monongahela Valley (W. Va.) Assn. of Health Centers:
    Jim Burnell, Controller

12. Daniel J. Foley, Senator, Commonwealth of Massachusetts

THIS HEARING WILL CONTINUE AT 9:00 A.M., WEDNESDAY, FEBRUARY 11,
IN THE MAIN COMMITTEE HEARING ROOM.

Further, to force health care facilities to curtail needed services in order to keep within the limits of proposed unreasonable percentages of increases is arbitrary and unjust. Such a proposal may be consistent with the administration's objectives of reducing the influence of big government and the Federal budget, but it is not a rational manner to achieve such an objective nor to assure the best of health care for the nation's aging population.

In concluding my statement, I felt that I might be of more help to the committee by citing some additional specific examples of the impact the proposed limit of a 7% increase in reimbursement would have on some of our institutional members. I requested several institutions across the country to provide data which projects with specificity the effect of the 7% ceiling on their operation.

1. Presbyterian Hospital, Charlotte, North Carolina, experienced a 12.75% increase in the costs of care for Medicare patients during the last fiscal year. Had they been limited to the proposed 7% increase, and had they maintained their level of services, all non-Medicare patients would have been required to pay an additional amount of $2.00 per day to offset the loss.

2. Walther Memorial Hospital, Chicago, located in the district represented by the Chairman, experienced in the fiscal year just past an increase in per diem costs of 14.69%. Non-Medicare-Medicaid patients, under the proposed cap, would have been forced to absorb an additional $5.70 per diem, not including increases in malpracticce.

3. Hendrick Memorial Hospital, Abilene, Texas, experienced an increase in per diem costs during FY1975 of 15.22%. The proposed cap of 7% would result in a loss on Medicare patients of $277,040 and force an increase in per diem charges to non-Medicare patients in excess of $4.00 per day. This institution reports an increase of some 20% in costs of paper goods this year and an increase of more than 7% in labor costs.

4. The data from Bethesda Hospital in Cincinnati, Ohio, reflects data just as astounding. Increased costs at Bethesda forced that institution's per diem costs up from $98 in 1974 to $117 in 1975. The 7% limit would have limited reimbursement to a maximum of only $106 per diem, a loss of $704,000 on Medicare patients which would have to be recovered from non Medicare payors. The Vice-President of Finance for Bethesda reported that an institution which undertakes any type of expansion program, should the administration proposal be enacted, would be engulfed in an absolute disaster.

Finally, I want to state once again the total opposition of the American Protestant Hospital Association to the imposition of any arbitrary ceiling on reimbursements to hospitals and other facilities which does not relate rationally and operationally with other ever-present forces which affect the costs of providing health care services. On its face the proposal before you is arbitrary, inequitable, and untenable for the providers of services. It is counter-productive as a service on behalf of most recipients of Medicare.

When specific bills are written, we stand ready to offer any assistance possible as you consider them.

PRESS CONFERENCE NO. 26

of the

PRESIDENT OF THE UNITED STATES

4:00 P.M. EST
February 13, 1976
Friday

In the Grand Ballroom
At the Sheraton Orlando
Jetport Inn
Orlando, Florida

QUESTION: Mr. President, a two-part question, sir.

Since you took office, you have lashed out somewhat, of course, at Congress for its slowness in investment of a research and energy conservation plan. We now understand from ERDA that it will be possibly more than six months before the site for the solar research center is chosen and that politics has entered into the picture so much in that site selection that all the States in the Union may soon join in that competition.

The question is, sir, is the pot -- meaning the Ford Administration -- calling the kettle black?

QUESTION: Mr. President, would it possibly be in the best interest of the country's taxpayers to develop the center here in Florida, in Brevard County, with the expertise of the Kennedy Space Center is nearby, and particularly as Broward County maintained a 17 percent or more unemployment rate?

THE PRESIDENT: Certainly, Broward County and the whole area have many, many assets that certainly will be important at the time they submit their application under the criteria established by ERDA. But it would be ill-advised and probably completely wrong for me to make any commitment on behalf of ERDA because that is a technical decision. I am sure that the application will be a good one. I am certain this area will get excellent consideration, but it would be, I think, wrong for me to make a decision other than to say I know you had lots of sunshine.

QUESTION: Mr. President, you have given the first of some special messages to Congress on the problems of the elderly. What kind of help do you propose to help Florida's many senior citizens?

THE PRESIDENT: In the first place, I fully agree with whatever the increases in Social Security benefits will be under the cost of living escalator clause. That will take place later this year. I fully concur with that.

Number two, I happen to believe it is vitally important for us to make certain that the Social Security Trust Fund is fully funded. At the present time, it is running in a deficit of about $4 billion per year. Sometime in 1980, if we don't do something, the funds will be depleted. I have recommended one proposal to make sure--to make positive--that those who are retired and those who are to be retired will have a continuous flow of the benefits under Social Security.

Number three, I have recommended that we incorporate in the law a new program to take care of roughly the 3 million individuals, most of whom are among our older citizens, who are suffering from what we call catastrophic illnesses. At the present time, there is no program to take care of those who have expanded and serious illnesses. I have proposed a catastrophic health care plan that will take care of about 3 million people under Medicare. I think it is a good proposal and I hope the Congress will respond to it.

In addition, I have recommended good funding, I think, for what we call the Older Americans Act. It has a wide variety of services that are incorporated and I hope the Congress does as I have recommended in the funding of those programs.

MORE

QUESTION: On the health care plan you mentioned, Dr. Hobert Jackson, Vice President of the National Council on Aging, said in Gainesville that your health care program has some good concepts, but, in effect, it would help only one in every 300 people affected.

THE PRESIDENT: As I understand it, it would help, very specifically, 3 million out of roughly 24 million. Now the good part of it is that these 3 million are the ones who are most adversely affected by the cost of two, three and five years of extended care in mounting doctor bills. It seems to me that we ought to put special emphasis on taking care of those tragic cases where you have extended illnesses.

In the meantime, under Medicare, there still would be a health care program for those who participate. But we put a new tilt, trying to be helpful to the people affected with a catastrophic illness.

QUESTION: Mr. President, not too many years ago another American President put a challenge fourth to this country and put a man on the moon, technology met that challenge, as you know that task was met. The Project Independence was recently launched to make this country self-sufficient. This is failing and failing miserably. Why is it failing, Mr. President? Why can't this country be energy self-sufficient and would you put a timetable on that?

THE PRESIDENT: In January of 1975 in my State of the Union Message I laid out a ten year program. I have a number of specific items that, if Congress would respond, we could become energy independent in ten years, by 1985. Unfortunately, the Congress dilly-dallied, day after day after day, and finally in December they passed a partial answer to the request that I had made in January. The bill which I signed is a base from which we can operate. It provides for some conservation. It provides over a 40-month period, for increased production, domestically, and it has some conservation features.

On the other hand, it has done nothing to deregulate natural gas. Tragically, we had a setback a week or so ago in the House of Representatives, but we hope we can retrieve that. That would be something that I recommended Congress should do. In addition, I have recommended for the Energy Research and Development Program $2 billion, 900 million. It is about a 30-some percent increase in research and development funds for energy, including solar, geothermal, fossil fuels, nuclear energy. And if Congress appropriates the money, it will move us ahead in those fields as well as several other exotic fields. In the case of solar energy, the increase in research and development funds was over 40 percent. So we are trying to move ahead in conservation, in increased omestic production, the greater utilization of coal in research and development for the long term. Although the Congress did not respond as well as I would have liked last year, I think we will make more headway in 1976.

Medicine

FOR IMMEDIATE RELEASE FEBRUARY 14, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY
(St. Petersburg, Florida)

THE WHITE HOUSE

REMARKS OF THE PRESIDENT
AT
WILLIAMS PARK

11:00 A.M. EST

I pledge to you this morning that I will continue to uphold that commitment. In recent years, there has been dramatic progress in our efforts to meet the continuing needs of America's older generation. But, I want to do better, and with your help and with the help of the Congress, I will, and I am sure we will.

As President, I intend to do everything in my power to help our Nation demonstrate its deep concern for the dignity and the well being of our older generations. For those who need our help we have already a number of Federal programs providing assistance in a variety of ways.

The Social Security program, the largest of its kind in this world, will pay almost $83 billion to more than 32 million Americans in fiscal year 1977. That is more than a $10 billion increase over the current year.

Here in Florida the Social Security Trust Fund will pay an estimated $4 billion 400 million to participants in the next fiscal year. In my budget for fiscal year 1977, I am recommending that the full cost of living increase in Social Security benefits be paid during the coming year.

Now, let me assure you of one thing very emphatically. My Administration fully intends to preserve the integrity and the solvency of the Social Security system for your benefit and that of all working Americans, men and women, now as well as in the future.

I think that is good news, but now let's have some bad news.

This year it is projected that the Social Security Trust Fund will run a deficit of about $3 billion. Next year, unless my reforms are adopted, we will run a deficit of $3.5 billion. If this trend continues, there will be no Social Security for old or young.

As long as I am President, we are going to keep Social Security protection and every other retirement program strong, sound and certain, and we will do it.

Yesterday, the Department of Labor announced that wholesale prices were unchanged in January. In fact, wholesale prices have shown no appreciable change since October of last year.

This is more good news in our fight against inflation, and we are going to keep the pressure on.

MORE

In addition to the Social Security program, we are continuing our strong commitment to benefit programs for more than three million railroad, military and Federal Government employees. Of course, that means we will do the same job for the veterans who live here and live elsewhere in 49 other States.

After many, many years of sacrifice and hard work, you have contributed to America. You have earned the respect, and you have earned more than the prospect of poverty in your retirement years.

In my budget, the Supplemental Security Income program, or SSI, will pay almost $6 billion in Federal benefits to more than five million disabled and disadvantaged older Americans in 1977, 170,000 of them right here in Florida.

Let's be frank. There have been some problems with this program, as you probably know, because the SSI replaced a great number of Federal assisted State programs and inevitably there was some confusion in the process.

We have already begun to take extensive steps to correct these problems, and we will make sure that if any American qualifies for these benefits, he or she will get them, period.

Those who don't qualify won't be taking money that you should have. In the field of health care, the Federal Medicare program in 1976 will provide more than $17 billion for the health care of 24 million older and disabled Americans, about 1 million 400 thousand right here in the great State of Florida.

But, there are flaws in this program, which actually help raise the cost of your medical care and which fail to protect you adequately against the economic burdens of prolonged illness.

I have proposed major improvements in the Medicare program to make it serve you better. One of the most important improvements is the creation of a system of health insurance that would pay all but a very small fraction of the catastrophic cost of complex or extended care and treatment.

I don't have to tell you that medical treatment is very, very expensive today. Hospital costs have risen by more than 200 percent since 1965, to an average cost of $128 per day. If you have to stay in a hospital or a nursing home or under doctor's care for a very, very long time, it puts an incredible strain on your lifetime savings and on your peace of mind, and that strain is felt by your loved ones as well.

MORE

All of us know of cases in which someone in the family or a close friend or a member of your church has been stricken with an illness that lingers on and on and on. We know of the pain and of the heartache associated with a prolonged illness.

We know that being sick and bedridden for a long, long time is bad enough without having a person's income and life savings dwindle away as the medical bills keep piling up.

This must not continue, and it won't, with my program.

Let me put it this way. There is no reason that older Americans should have to go broke just to get well or stay well in the United States of America. Under my proposal the individuals' contribution would go up slightly, but consider what the increase would provide.

Nobody eligible for Medicare would have to pay more than $500 a year for hospital or nursing home care, and this does not mean that you pay the first $500 of your total cost. You would pay only 10 percent of the total cost, or $500, whichever is less, and the maximum annual cost to you for covered doctor's services would be $250, or 20 percent, whichever is less.

Medicare would pay the rest, whether it costs $1,000 or $10,000 or $50,000. It is a good program, and we are going to make it.

If the Congress passes my program, the ruinous economic burden of catastrophic illness is one thing you will never have to worry about again. Another of my programs would consolidate 16 Federal health programs, including Medicare, into a single $10 billion block grant program to the States.

If we can consolidate these programs, we can make them more humane and more effective. We can improve the services that they provide to you and millions like you, and we can get those services to more people who really, really need them.

Programs of this kind, despite some abuses, do a tremendous amount of good. For some of our neighbors, they provide the means for life itself. They provide the food, the services, the health care, without which some people would not be able to enjoy this beautiful sunshine today in St. Petersburg and in Florida.

MORE

It is all too easy to say that the Federal Government is too big, that this program and that program ought to be cut out of the Federal budget, tossed back to the States to cope with, if their taxpayers will permit it.

It is not that simple, and you know it and I know it.

I am concerned, as you are, about the growth of the Federal budget. I have been fighting to hold down the Federal budget in a responsible way for 27 years, 25-plus years in the Congress, a few months as Vice President, and approximately 18 months as your President.

You all know how hard I have been trying for the last 18 months to get control of the inflation which has done so much economic damage to all Americans. During 1974, when I became President, inflation was ranging at an annual rate of more than 12 percent, eating away at everybody's buying power but absolutely devouring the livelihood of people on fixed incomes.

I knew that something had to be done to bring that situation under control. I knew that deficit spending by the Federal Government was a major contributor to inflation and that slowing the growth of Federal spending was essential to solving the problem.

I have used my Constitutional power, that of veto, 46 times since becoming President, trying to hold down the level of Federal spending, trying to break the back of inflation. To hold down the cost of living, we must hold down the cost of Government. It is just that simple.

We made some very encouraging progress with these vetoes, saving the taxpayers about $10 billion. The inflation rate that was 12 percent has been cut nearly in half.

That is not good enough. That is progress, real progress, that helps especially people on fixed incomes more than anybody else in our society.

Just yesterday the Department of Labor announced the wholesale prices stayed level in January. In fact, wholesale prices have shown no appreciable change since October.

MORE

I want to drive that point home. This is more good news in our fight against inflation, and we are going to keep the pressure on, and we are going to be successful.

You probably heard that we had some other good economic news just about a week ago. Employment in January took its sharpest drop in 16 years. Ninety-six percent of all jobs lost during the depression have been recovered.

America is getting back to work, and we are going to make better and better and better progress in reducing unemployment. But, there is so much more that we have to do. I want all Americans, young or old, black or white, rich or poor, to live in dignity and security and in peace.

If we can continue making the progress America has made in the past, we will see that wonderful goal achieved. Too often people forget just how far and how fast we have come as a Nation. We have our problems, and we are not afraid to admit them.

Honesty in this situation is essential, but I think it is time people stop running down America.

I think it is time we remember how richly blessed this Nation is. You, or many of you, in this audience have seen much of America's phenomenal progress with your own eyes. In the space of your lifetime, man has taken himself from the horse and buggy and explored the far reaches of space.

Diseases which were once crippling and killing millions of Americans have now been conquered. America's population has more than doubled since 1910. Life expectancy, which in 1910 was only 50 years, is today more than 71 years.

The Gross National Product, the index of our total production, is now seven times greater than it was in 1910. To put it another way, the strength and growth of the American economy provides the average American living today with three and one-half times more in goods and services than Americans enjoyed in 1910.

No other generation of Americans has achieved such growth, and all of us thank you from the bottom of our hearts.

In 1910, some 156,000 young people graduated from America's high schools. Last year's college graduates totaled 944,000. That is another indication of the progress we are making in this great country.

MORE

In 1910 there was no regularly scheduled radio broadcasting in the United States. Nobody had ever heard of television -- maybe a few very outstanding scientists. Today, we are living in an age of instant and global communications. These examples -- and there are many, many, many more -- serve to remind us of how much has changed, of how much progress there has been in health, wealth, education, communication, law, and in every other aspect of life in our great country.

The fact is that you, your generation, has been the greatest pioneer of progress and change in the entire history of the human race.

But, some things thankfully have not changed at all. We are still a people in America with love of freedom, and after 200 years that love is undiminished. We are still a Nation dedicated to progress and peace in the world, We are still a Nation of compassion. We are still, as Lincoln called us a century ago, "The last, best hope of earth."

The United States is a great country, the greatest in the world. You helped to make it that way, and this Nation will never, never, never forget your contribution, past, present or future.

We will never forget the lesson which President Eisenhower taught us from the wisdom of his years. "America is not good because it is great" -- the President said -- "America is great because it is good."

Thank you very, very much.

END (AT 11:20 A.M. EST)

file
Jerry

THE WHITE HOUSE
WASHINGTON

DATE 2/23

TO: Spence

FROM: SARAH MASSENGALE

F. Y. I

which have jumped from $5.6 million in 1971 to $82.7 million last year.

One of the main uses of ESOPs by private companies has also been to forestall a sale to outsiders by providing a market for closely held shares. Thus, Hallmark Cards Inc. converted its profit-sharing plan to an ESOP last year partly to assure its 10,000 employees, who already enjoy pension and life insurance benefits, that the company will not go the merger route after its founder, Joyce Hall, and his wife die. Says Bill Johnson, director of corporate communications: "We wanted to share ownership with our employees and demonstrate that Hallmark will be staying in Kansas City."

A growing use of ESOPs has been to facilitate the divestiture of subsidiaries by large companies. This week, for example, the trustees of Omega-Alpha Inc, which is currently being reorganized under bankruptcy proceedings, announced that they were selling the company's Okonite Co. subsidiary to an Okonite ESOP for $38 million.

'Make it grow faster.' To Louis Kelso, the man most responsible for the mushrooming interest in employee stock ownership plans, the ESOPs that have been springing up are only the vanguard of what he hopes will become a major movement. He has long argued that the basic cause of the nation's economic ills lies in the maldistribution of wealth, which results in a chronic gap between production and consumption and the need for ever greater government intervention to redistribute income and manage demand. He believes that using ESOPs to finance new investment would restructure both wealth and income patterns in a fairly painless way. "The point," he says "is to make the pie grow faster and distribute the new growth more equitably."

To some observers, all of this is "pie in the sky," but Kelso's analysis has a certain pragmatic logic that many find appealing. Unlike traditional economic theory, which tends to stress labor as a major factor of production, Kelso holds that capital goods are the main producers of wealth and growth in a modern economy. Because capital ownership is already highly skewed, the common methods of financing new investment (mainly through retained earnings and debt) increases the concentration of wealth. The result is increasing efforts by labor to boost its share of national income, a quickening of inflation through the wage-price spiral, and the intervention of the government to alternately brake and accelerate the economy. "The system today aggravates the trends toward concentration and socialism," says Kelso. "The answer is a democratic capitalism."

Kelso's game plan goes beyond making ESOPs the principal source of investment financing. He would also do away with the double taxation of dividends, phase out the corporate income tax, and encourage companies to distribute most of their earnings to shareholders—thus providing a significant second income to wage earners. He would also establish special stock ownership plans for consumers and government workers, set up insurance funds to insure employee accounts, and empower banks to borrow low-interest ESOP funds directly from the Federal Reserve.

Until now, most economists have dismissed Kelso's ideas out of hand—partly because such a radical restructuring of the economy seems totally unrealistic and partly because he turns many economic concepts upside down. "Kelso really doesn't understand how the economy works," says one academic economist, "and he has compounded his problems by launching a hysterical attack on the profession."

Nonetheless, a few economists have become intrigued with Kelso's theories. James L. Green of the University of Alabama terms them "the only viable alternative to wage and price controls and state planning." Abel Beltran-del-Rio of Wharton EFA, Inc., the econometric research organization, acknowledges that Kelso's program is "theoretically weak and inflated in its claims," but he feels that it "contains nuggets of gold surrounded by mud."

Kelso says ESOPs can increase productivity and raise capital for growth

In light of the growing interest in ESOPs, several economists have begun to look more closely into Kelso's ideas.

Wharton EFA itself, is planning an econometric study testing the potential impact of Kelso's proposals and other capital diffusion schemes on the U. S. economy. And Carter Bacon of the Congressional Reference Service of the Library of Congress, is at work on a background report. "There's no question that ESOP financing can help some companies," he says, "and it seems likely that investment and savings would be higher in an economy that functions that way. But implementing such a change would raise serious questions of equity and would risk unsound patterns of capital allocation."

For the moment at any rate, such questions are not fazing Kelso and his followers on Capitol Hill. Among other bills they are pushing is the so-called Accelerated Capital Formation Act, which would remove the limit on employer contributions to an ESOP and make dividends paid on ESOP-held stock tax deductible to employers. If that passes, there may be no stopping the ESOP bandwagon. ■

Getting rid of 65-and-out

Senior citizens flex their political muscle on the grounds of discrimination

"Mandatory retirement at age 65," says Dr. Arthur S. Flemming, former Secretary of Health, Education & Welfare, "is just a lazy man's device to avoid making a difficult personnel decision."

Flemming, 70, heads HEW's Administration on Aging, one of the fastest-growing social agencies in the federal government. Along with other organizations representing older Americans, it is pressing for abolition of the 65-and-out rule—the actuarial bedrock of corporate pension plans, health insurance, and personal careers—as No. 1 on a long list of legislative goals. Last week the House subcommittee on aging held hearings on a bill that would achieve this end by including over-65ers in the law forbidding job discrimination against the aged, a category that now spans those 45 to 65. The bill would also open up pension plans that require retirement at 65.

Although 47 congressmen joined Representative Paul Findley (R-Ill.) in sponsoring the bill, no one expects it to meet instant success. Aside from its complicating effect on benefits programs, open-ended retirement inspires mixed feelings in industry, with some companies easing employees toward early retirement while others laud the work of employees over 65. At the same time, inflation has motivated many older workers to keep working to escape the hardships of life on a shrunken pension, swelling the ranks of those who work as a matter of lifestyle.

In the groove. "Time doesn't change our habits of self-discipline or teamwork," says Hoyt Catlin, 85, who runs Fertl Inc., a $600,000-a-year plant nursery in South Norwalk, Conn. "We've had less absenteeism and turnover than any firm of our size that I know," says Catlin, whose workers average 68 years of age.

"I think there are some things we can learn from Fertl," says C. Richard Blundell, vice-president of personnel at General Foods Corp., which acquired the nursery in 1972. General Foods has

not changed its own mandatory retirement policy, says Blundell, but "obviously, we have some thoughts about it, very much so." The big question, he believes, is whether older people would function as well in a large work environment as in the intimate 20-person Fertl.

Similar considerations apparently trouble other employers. Richard Dugdale, research director of the Mountain States Employers Council in Denver, reports a trend toward relaxation of mandatory retirement in the companies he surveys—but mainly in companies that employ fewer than 500 workers. Half of this group now has open-ended retirement, says Dugdale, compared with only 14% among companies that employ more than 500 workers. "Smaller firms are better equipped to set the retirement age on individual performance," he says.

In practice, the decision generally is mutual, says a spokeswoman for Paddock Corp., a Chicago-area newspaper publisher whose 400 employees have no mandatory retirement age. "Around the time we begin to feel that a worker is not performing up to par, it generally dawns on him that he is getting tired and is ready to leave," she says.

Matter of choice. This issue of personal choice explains the mass support among older Americans' groups for abolishing mandatory retirement. With links to labor, the National Council of Senior Citizens might be expected to favor enabling workers to retire earlier rather than later, and so it does. But President Nelson Cruikshank, a former AFL-CIO official, emphasizes that the worker who wants to keep working past 65 should have that option.

In fact, some theorists of the movement equate mandatory retirement with racial and sex discrimination. The law forbids an employer to reject a minority or female applicant as unqualified for a job unless he proves the applicant unqualified. They say it should also forbid him from rejecting—retiring—an elderly worker unless he proves him unqualified.

Such theories have more than a theoretical importance because the people who hold them wield increasing power through organizations ranging from the militant Gray Panthers to the sedate American Assn. of Retired Persons (AARP). First mobilized during the battle for medicare, which began in 1961, the elderly have become a political force. By Flemming's estimate, more than 11 million Americans over 65 belong to national organizations, compared with 250,000 in 1961.

So far the elderly have been most effective on the local level. In Washington state they forced enactment of a law that opened up the books of nursing homes. In Chicago they helped defeat a proposed utility rate increase and persuaded some 1,000 Chicago merchants to give them discounts of 10% to 25% under a program called PRIDE (Persons Retired in Dignity & Esteem). In addition, National Tea Co. offers discounts on food and drugs. In Houston, where retirees were successful in pressuring the city into reducing their bus fares, leader Henry A. Sherman warns, "Now come the gas, telephone, and electric companies."

Full-time occupation. "Retirement has become the occupation of being retired," says demographer Richard M. Scammon, coauthor of *The Real Majority*. With time on their hands, the elderly can write letters, make phone calls, organize caravans to Washington or City Hall, and stage demonstrations. President Ford reluctantly released $375 million for loans to build housing for the elderly after the Senior Citizens threw a picket line around the headquarters of the Housing & Urban Affairs Dept. last June.

Whether the elderly remember this episode with gratitude or resentment could affect Ford's election. In 1974, citizens above 65 cast 17% of the vote while making up only 14.8% of the electorate.

The two major organizations that represent them are the AARP (directed by John Martin, former commissioner of aging) and the Senior Citizens, which claim 9-million and 3.5-million members respectively. Both organizations accept recruits as young as 55 on the ground that retirement concerns begin at that age.

The Big Two of the elderly split on some issues. They back different versions of national health insurance, and the Senior Citizens regularly criticizes the AARP for its continuing ties to Philadelphia's Colonial Penn Life Insurance Co., which seems to have exclusive rights to promote its insurance in AARP publications. But both form a united front for such goals of the elderly as more health services, property tax abatement, a cost-of-living index for pensions, special transportation services, special housing, and liberalization of Social Security—especially increases in the amount that retirees can earn without losing money from their Social Security checks.

Pressure pays off. Increasing political pressure from these and other groups has yielded a steady stream of gains in the form of amendments to the 1965 Older Americans Act, among them the 1972 nutrition program that serves 240,000 daily free meals at an annual cost of $100 million and the recently authorized network of area agencies on aging.

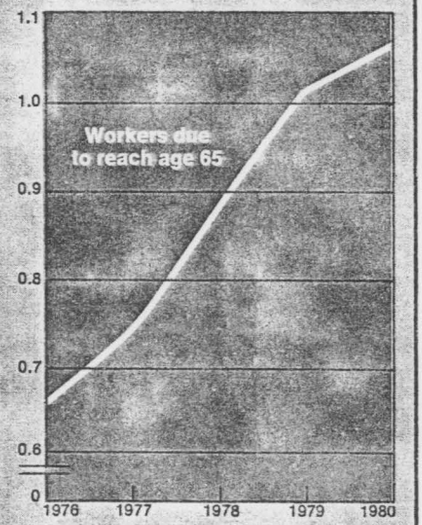
Financed by federal grants passed through the states to local communities, 500 of these agencies are already assessing local needs and mobilizing facilities to meet them. They also serve as "advocates for the aging . . . unique in terms of federal, state, and community relationships," says Flemming. He notes that they have recruited many of the 52,000 volunteers for the free meal program, mainly youngsters.

"There's a real affinity between the young and the old," Flemming remarks. "They have a common enemy—the middle-aged." ■

Flemming: 'The young and old . . . have a common enemy—the middle-aged'

Arthur Flemming's worry: Too many retirees

Flemming of HEW's Administration on Aging.



Data: Bureau of Labor Statistics

Chart: Mario De Vincentis—BW

THE WHITE HOUSE

WASHINGTON

February 25, 1976

MEMORANDUM FOR: JIM CANNON

FROM: SPENCE JOHNSON

Medicare

SUBJECT: Catastrophic Health Insurance

This is in response to your memo to Art Quern concerning questions raised by Bill Kovach regarding the Medicare catastrophic proposal.

About 98% of aged persons have Medicare coverage, and there is absolutely no reason for that percent to change as a result of the President's proposal.

Medicare does not have the concept of a participating physician. An enrollee can essentially go to any licensed physician and be reimbursed for necessary medical services.

Physicians may, however, elect whether or not to accept assignment. Accepting assignment means that the physician bills the Medicare program, which in turn pays the physician for any benefits due the patient. The physician in turn bills the beneficiary for any applicable coinsurance or deductible. This election is on a claim-by-claim basis, and most physicians accept assignment on some claims but not others.

A physician who accepts assignment agrees to the reasonable charge determination of Medicare and may not bill the patient for amounts above that level. When a physician does not accept assignments, he bills the full amount directly to the patient, who in turn collects from Medicare. Physicians do not face any charge limitation when they bill the patient directly.

As a result, as Medicare reduces the level that it will recognize relative to the amounts that physicians customarily charge, the assignment rate will drop and the patient will have to pick up a higher proportion of the bill. Currently, roughly 50% of claims are assigned. The fee increase

limitation of 4% proposed by the President is expected to cause the assignment rate to drop significantly. In addition, the $250 cap would apply only to covered charges. Physician billings over the Medicare-recognized level are not considered covered and thus would not be credited towards the $250 limit.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

NOTE TO SPENCER JOHNSON, DOMESTIC COUNCIL STAFF

Subject: Your Query on Cannon Memo re. Medicare

There are currently 24.9 million persons enrolled in Part A and 24.6 million enrolled in Part B. Roughly 98% of aged persons have Medicare coverage, and there is absolutely no reason for that percent to change as a result of the President's proposal.

Medicare does not have the concept of a participating physician. An enrollee can essentially go to any licensed physician and be reimbursed for necessary medical services. Physicians may, however, elect whether or not to accept assignment. This election is on a claim-by-claim basis, and most physicians accept assignment on some claims but not others. Accepting assignment means that the physician bills the Medicare program, which in turn pays the physician for any benefits due the patient. The physician in turn bills the beneficiary for any applicable coinsurance or deductible. A physician who accepts assignment agrees to the reasonable charge determination of Medicare and may not bill the patient for amounts above that level. When a physician does not accept assignments, he bills the full amount directly to the patient, who in turn collects from Medicare. Physicians do not face any charge limitation when they bill the patient directly. As a result, as Medicare reduces the level that it will recognize relative to the amounts that physicians customarily charge, the assignment rate will drop and the patient will have to pick up a higher proportion of the bill. Currently, roughly 50% of claims are assigned. The fee increase limitation of 4% proposed by the President is expected to cause the assignment rate to drop significantly. In addition, the $250 cap would apply only to <u>covered</u> charges. Physician billings over the Medicare-recognized level are not considered covered and thus would not be credited towards the $250 limit.

Pete

Peter D. Fox, Director
Office of Health Analysis

Spence
Would you send
~~draft~~ a
note to
Jim on
this
A

THE WHITE HOUSE

WASHINGTON

January 26, 1976

MEMORANDUM FOR: ART QUERN

FROM: JIM CANNON

SUBJECT: Catastrophic Health Insurance

Bill Kovach, No. 2 man in the Washington Bureau of the New York Times, told me Saturday that a part of the attached paragraph does, in effect, have the President promising something he cannot deliver.

Specifically, he says the section that states, "Nobody, after reaching age 65, will have to pay more . . . than $250 for one year's doctor bills," is not true, for this reason:

Only 40% of doctors now participate in the Medicare programs, and with the fee limitations we are proposing, that percentage will become lower.

Is this correct?

What percentage of people over 65 now take part in these programs? Under the President's program, is this percentage likely to become lower?

Federal petroleum reserves, stimulate effective conservation, including revitalization of our railroads, and the expansion of our urban transportation systems, develop more and cleaner energy from our vast coal resources; expedite clean and safe nuclear power production, create a new national Energy Independence Authority to stimulate vital energy investment and accelerate development of technology to capture energy from the sun and the earth, for this and future generations.

Also, I ask, for the sake of future generations, that we preserve the family farm and family-owned small business. Both strengthen America and give stability to our economy. I will propose estate tax changes so that family businesses and family farms can be handed down from generation to generation without having to be sold to pay taxes.

I propose tax changes to encourage people to invest in America's future and their own, through a plan that gives moderate income families income tax benefits if they make long-term investments in common stock in American companies.

The Federal Government must, and will, respond to clearcut national needs for this and future generations, Hospital and medical services in America are among the best in the world, but the cost of a serious and extended illness can quickly wipe out a family's life savings.

Increasing health costs are of deep concern to all, and a powerful force pushing up the cost of living. The burden of catastrophic illness can be borne by very few in our society. We must eliminate this fear from every family.

I propose catastrophic health insurance for everybody covered by Medicare. To finance this added protection, fees for short-term care will go up somewhat, but nobody, after reaching age 65, will have to pay more than $500 a year for covered hospital or nursing home care, nor more than $250 for one year's doctor bills. We cannot realistically afford Federally dictated national health insurance proving full coverage for all 215 million Americans. The experience of other countries raises questions about the quality as well as the cost of such plans.

MORE

99% part.

except assignment

↳ 48% of all claims assigned

(except contr. & treas. claims)