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FRAUDS AGAINST THE ELDERLY: BOSTON, MASS.

A BRIEFING

BY THE

SELECT COMMITTEE ON AGING

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FRAUDS AGAINST THE ELDERLY: BOSTON, MASS.

WEDNESDAY, MAY 20, 1981

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING
AND THE FEDERAL TRADE COMMISSION,
Boston and Springfield, Mass.

The participants met, pursuant to notice, at 9 a.m., in Gardner Auditorium, Commonwealth of Massachusetts Statehouse, Boston, Mass., Hon. Barney Frank (acting chairman of the committee) and Hon. Lois Pines, regional director, New England Office, Federal Trade Commission (acting cochairwoman) presiding.

Member present: Representative Barney Frank of Massachusetts.

Also present: Lois Pines, regional director, New England office, Federal Trade Commission.

Staff present: Val Halamandaris, senior counsel, Select Committee on Aging; Robert S. Weiner, former staff director, Select Committee on Aging.

OPENING STATEMENT OF REPRESENTATIVE BARNEY FRANK

Mr. FRANK. I am pleased to welcome you here this morning to this hearing of the Select Committee on Aging which is being held in conjuction with the Regional Office of the Federal Trade Commission. The subject of today's hearing is frauds against the elderly.

I would like to introduce Lois Pines, the regional director of the FTC who has been the moving force behind these hearings. In her tenure she has done excellent work to protect the interests of the elderly and consumers in general from all manner of abuse. We are pleased to have you join us in these hearings. The House Select Committee on Aging has conducted several hearings on this subject. The Committee learned that every year senior citizens are victimized for about $1 billion in phony arthritis cures largely sold through the mails, while we are spending only something $40 million a year in legitimate arthritis research. Driven by pain and despair many older Americans at the same time fall victim to con men who sell grape cures, goat's milk, olive oil, or snake oil juice as alleged cures for cancer. Senior citizens likewise spend millions on tonics to grow hair or restore a youthful appearance.

At recent hearings, the Committee learned about a number of devices which are being sold to the elderly. The "Acudot" for example, was taken off the market by the Food and Drug Administration. It is a small round band-aid with a tiny magnet in the center. The idea is that you put the magnet on the area and the

magnet draws the pain from the body. The Committee also learned about several varieties of health slippers. One was filled with what was described as uranium ore which allegedly let of healing radon gas. In fact the slippers were filled with gravel. Another variety comes with a long electric cord so that they can be plugged into the wall socket. Another device was nothing more than a metal box with a light bulb in it with some colored filters attached. One color of filter would allegedly cure cancer and another was supposed to cure arthritis. The catch is that the user had to be nude and facing north in order for it to work. The Committee also received examples of vibrators which were sold with extravagant healing claims and ordinary sun lamps to which were ascribed marvelous therapeutic value.

The Committee has also had extensive hearings on the subject of abuses in the sale of insurance to the elderly. The Committee found that some salesmen of some unscrupulous companies were selling 3, 4, and sometimes and many as 30 different health insruance policies to the aged in supplementatic of Medicare, while all the while knowing they contained a clause which says that in a case of duplication only one policy will pay. Some of these companies return as little as 20 cents on the premium dollar back to their insured in the form of claims while Blue Cross and reputable insurance companies are returning 90 cents or more of the premium dollar. The Committee has issued two reports on this subject and last year they were successful in bringing about the enactment of legislation which makes it a Federal crime for agents to indulge in assorted abuses such as deliberately overselling insurance which is not in the best interests of the insured or pretending to be an employee of Medicare or the Federal government.

One of the witnesses, Assistant United States Attorney Paul Troy, will testify about the abuses which they have discovered right here in the New England area. The Committee also looks forward to having testimony of Jim Montgomery, director of the Attorney General's Consumer Protection Division. The Committee is also greatly honored to have the Deputy Chief Postal Inspector of the United States Bill Murphy testifying before the Committee today.

Before we begin the testimony, I would like to call on Lois Pines for any opening statement she would care to make.

STATEMENT OF LOIS PINES, REGIONAL DIRECTOR, NEW ENGLAND OFFICE, FEDERAL TRADE COMMISSION

Mrs. PINES. Thank you. I am Lois Pines, and I am the regional director of the New England office of the Federal Trade Commission. Today's hearings on fraud against the elderly are not pleasant ones for us to hold. It is not pleasant to learn about ripoffs and swindles against the most vulnerable in our society, the elderly and the poor. It is not pleasant to learn of Massachusetts senior citizens who are sold land in Florida only to find it buried under water, nor is it fun to hear about a 93 year old woman who is sold maternity insurance. It is far from pleasant to hear about work at home schemes and phony home repairs perpetrated against the elderly by unscrupulous sales people who take the money and run. It is neither pleasant nor fun to learn of nursing home evictions which

take place when patients run out of money, of double billing by nursing homes, pension fraud, of over pricing of medical appliances such as eyeglasses, hearing aids, and dentures desperately needed by nine-tenths of all older people, but we believe that this is a hearing that desperately needs to be held.

The Federal Trade Commission and the House Select Committee on Aging are committed to taking necessary action to correct these kinds of abuses, to deal with abuses against the Nation's 24 million senior citizens by those just out to make a buck. Today's hearings in Boston and Springfield will be the opening session of a series of hearings in New England on this important subject, and we are already planning another hearing in Hartford.

I am grateful to Congressman Barney Frank for agreeing to join with me in kicking off these critical hearings and to the House Committee Chairman Claude Pepper for permitting key staff members of the Committee to join with us today.

The following remarks are only the views of a member of the Federal Trade Commission's staff and they are not intended to be construed as representative of official Federal Trade Commission policy of the views of any individual commissioner.

The Federal Trade Commission in general and my office in particular has had a strong interest in protecting the rights of the elderly over the past several years. Our office has become identified as a place where an aggrieved consumer can go for action, and I am pleased to tell you that we have been able to resolve complaints from thousands of individuals satisfactorily. Our staff has made an aggressive effort to stay in touch with senior citizens and consumer groups in order to learn what is happening and what we as an agency can do to address problems that are identified.

What we have learned after years of investigation is that senior citizens are extremely vulnerable. They constitute 11 percent of the population but a disproportionate percentage of those who are victimized by swindles of all kinds. For example, the U.S. Postal Service estimates that 60 percent of all medical quackery promoted through the mails has been targeted at senior citizens.

The Commission has been active in a number of areas of particular importance to the elderly. They include:

Hearing aids: The FTC staff has conducted an extensive investigation of sales practices in the hearing aid industry. Among the misrepresentations which were complained of by senior citizens were such claims as; aids can actually halt or retard the progression of hearing loss, and hearing aids can be prescribed like eyeglasses. To deter questionable sales techniques in the hearing aid industry, the Federal Trade Commission's staff has recommended that the Commission issue a trade regulation rule in the hearing aid area.

Business opportunity schemes: Senior citizens have recently been bombarded by sales pitches to withdraw their savings from low interest passbook accounts to invest their money in high return investments. In a time of double digit inflation, it is a pitch that is all too often persuasive. A variety of investments in gold, vending machines, or farmers cooperatives are proposed, and not surprisingly these schemes in many instances turn out to be frauds. The gold may not exist at all. The cooperative may be nothing but a

paper shell, and the vending machines which senior citizens are told are pure profit either do not exist, do not work, or are placed in places so out of the way that they generate no income.

Interstate land sales: The Federal Trade Commission is currently investigating a number of land sale cases where apparently worthless land has been sold to senior citizens often at exorbitant prices. Unfortunately these schemes seem to be all too common.

Funerals: Even in death senior citizens are frequently victimized. At a time when they are particularly vulnerable, senior citizens and their relatives must make detailed funeral arrangements. Frequently they are quoted one particular price only to receive a bill which is double or triple what they expect. These and other abuses are being addressed by the FTC as it completes its consideration of the funeral rule.

Insurance: The FTC has issued several reports related to various aspects of insurance plans sold primarily to the elderly. In particular we expect a staff report entitled "Private Health Insurance to Supplement Medicare" to be a great help to the various States throughout the country in identifying and addressing financial abuse in the sale of medigap insurance.

Home and automobile repair schemes: Our office has received innumberable complaints over the years by senior citizens who have been victimized by repairmen. Among the most common are claims that an automobile ran fine until it was repaired or that repairs were not professionally made. We recently received a complaint from a senior citizen who was told that his furnace needed extensive repairs only to learn that no repairs were needed and in fact he had been swindled. Then there are the senior citizens who purchase aluminum siding and find themselves several thousand dollars poorer when left with a house which has but one side completed.

Nursing homes: Nursing homes are supposed to provide care and protections, but all too often come to represent pain and degradation for our elderly citizens. Many senior citizens see nursing homes as not only synonymous with death but with the notion of protracted suffering before death. The FTC has been conducting an investigation to see what should and can be done to protect the rights of nursing home patients. In far too many instances, important protections available to those patients on medicaid or on medicare are not available to private patients.

Medical quackery: There is no more cruel racket in the world than the practices of those who peddle hope while picking the pockets of the elderly. Those who sell phony arthritis and cancer cures to those in desperate need should be prosecuted to the full extent of the law.

Work-at-home schemes: Our office receives complaints daily from senior citizens who have been attracted by ads that tell them that they can earn thousands of dollars in the comfort and privacy of their homes while stuffing envelopes or growing earthworms for market. The senior citizen usually ends up with tons of earthworms or stuffed envelopes for which there is no market. In the meantime, the senior citizen has paid hundreds of dollars for the privilege of being ripped off.

As we can see from the list, the elderly are all too often victims of fraud in this nation. Fraud is visited upon them in many different forms through many different schemes perpetrated by many different kinds of con men. What these con men have in common is a lack of respect for the elderly and an avaricious conscienceless compulsion to separate them from their hard earned dollars. As we have learned, con men sometimes pass around the names of elderly who can be easily victimized. These so-called goose or gofer lists are common. A gofer is one who will go for anything, and a goose is someone who is easily plucked.

It is all too easy to see that all of us have our work cut out for us. Senior citizens have made this Country what it is today. They deserve our help and our protection. We must find ways to work together to weed out the con men who are victimizing the aged at every turn. I pledge my very best efforts to make sure that this happens, and I sincerely hope that this hearing will lead to new enforcement initiatives by the Federal Trade Commission where appropriate and, where necessary, new reform legislation at both the state and the Federal levels.

Mr. FRANK. Thank you. The House Select Committee on Aging, which is chaired by Claude Pepper, and is really his creation to a very great extent, and which I am very happy to be able to serve on, has been concerned with this area for a long time. It is important that we go ahead with the kind of law enforcement activities that are necessary to protect the elderly. That is why I think by far the most important portion of this morning's activity will be the testimony from the federal and state law enforcement officials because it is essential that we provide the fullest protection of the law to the older people who have been victimized by an unscrupulous minority of people in the private sector. It is also important that we continually update the law. One of the things that we have learned is that your average swindler is a pretty good amateur lawyer, and the life cycle of effective antiswindle legislation is not infinite. You have a law on the books that prevents some of these things, and some of these people unfortunately have the ingenuity to devise ways to get around it. So it is important in this situation that we not sit back and rest on our laurels, but that we constantly try and keep the law updated to meet the kinds of people we are dealing with. Unfortunately dealing with some of these people is like dealing with children. You tell them not to set the living room furniture on fire, and the next thing you know you have got a fire in the bedroom. It is very difficult when you are dealing with criminal statutes to think out in advance everything people might do, and, because these are in many cases criminal statutes, the law is so much restricted in its application, you have to give people a fairly clear set of instructions.

So the reason that the Select Committee on Aging—which is, for the United States House of Representatives, the major place in which the public policy toward the elderly is really formulated—continues its interest in this is precisely that unfortunately the swindlers who are out there and the people who would prey on the vulnerable are constantly very active.

I just also want to add that I don't regard this as in any way an assault on the private sector or on the market. I think this is an

effort to make the market work better. No one is proposing that there is a substantial conspiracy to defraud the elderly out there that includes most private business people. In fact the minority of unscrupulous thieves whom we are talking about are in fact a hindrance to the private market, and one of the things we want to be able to do is to give the older people the confidence that they can go out and deal in the marketplace just like anyone else and not fear the victimization. One of the encouraging things I think that has happened in the last year or so and is just beginning to happen is that the private sector, the TV programers, the advertisers they have begun to rediscover older people, and it is beginning to dawn on people that not everybody goes into a permanently comatose state at the age of 36 and that there are in fact people among the elderly population who have interests, who have consumer needs, who do want to participate fully as adults in this world, and one of the things that we have got to do is to make the economy safe so that they can in fact be full fledged consumers.

I would add finally that unfortunately these hearings have taken on an even greater need because we have recently seen from the United States Senate and the President of the United States proposals that I would not have thought possible but which propose substantially to lower the real incomes of older people and retirees in this Country. Now, on their own, I think those are an outrage and require that we do everything we can to fight them off, but they underline the need for the kind of protection that these hearings offer to older people. Especially at a time when the already meager incomes that many older people are forced to live on are under assault, it is all the more important that we protect them from these kinds of robberies which are robberies and they are a form of crime that are every bit as disabling to the elderly people as any other kind of property theft. Because that is what we are talking about, the theft of private property by people who have no regard for the law, and it is the function of both the Executive Branches and the commissions and the Legislative Branch to try and provide those protections.

With that, we will now begin this hearing which is an official hearing of the House Select Committee on Aging, and we will begin with Mr. William Murphy who is the Assistant Chief Postal Inspector for Criminal Investigations in Washington. He is accompanied by Wayne B. Kidd who is the Manager of the Fraud Branch in Washington, D.C.

STATEMENT OF WILLIAM T. MURPHY, ASSISTANT CHIEF POSTAL INSPECTOR, CRIMINAL INVESTIGATIONS, WASHINGTON, D.C.

Mr. MURPHY. Thank you, Mr. Chairman. As the Assistant Chief Postal Inspector for Criminal Investigations, I do appreciate the opportunity to appear before this Committee this morning and to discuss our efforts to prevent crime and crimes against the elderly. The Postal Inspection Service is the investigative arm of the United States Postal Service. It has investigative jurisdiction over all violations of Federal criminal laws relating to the Postal Service and those involving mail fraud.

Senior citizens are heavy users of the mail. It is a convenient method of doing business for them. It provides a way by which they can obtain services or goods without leaving their homes. In addition, senior citizens, as a group, are very conscientious about paying their bills. Unfortunately these very factors make the elderly prime targets for the mail order swindler. Let me here insert a cautionary note that my remarks do not deal with the vast majority of mail order firms whose offerings are legitimate. Today I am focusing on the relative few who have distorted and used the Postal system for illegal gains.

The Inspection Service has designated combating crimes against the elderly as one of our highest priority items. While we feel successful criminal prosecution in these cases is in fact a deterrent, the fact remains that the victims of the crimes generally do not get their money back. The ideal solution is to prevent individuals from being victimized in the first place. Prevention is the best tool in our criminal investigative effort. The Postal Service believes a substantial reduction in crime can be accomplished through a combination of public awareness and a lessening of opportunity for the criminal.

To this end, the Postmaster General in September of 1979 initiated the Consumer Protection Program, a program of prevention through education and awareness. We have selected and trained a number of inspectors across the country as consumer protection specialists. Part of their job is to educate and inform consumers. They work with groups such as the American Association of Retired Persons. For instance, we will be providing information programs for all 6,000 chapters of that organization. We are also working in similar regional and local groups. As a part of that effort, the Postal Service has prepared pamphlets and other handouts, some of which I have here, which address specific problems and areas or schemes. In addition, we are developing other promotional materials. We are using the media in an effort to heighten public awareness. Inspection Service representatives have appeared on many interview programs to bring the problem to the attention of the public.

When we have evidence that frauds have been committed, we consider the possibility of criminal action under Title 18, United States Code, Section 1341, which in fact is the mail fraud statute. The mail fraud statute is one of this nation's oldest consumer protection laws. Essentially, whoever uses or causes the mails to be used in a scheme to defraud is guilty of mail fraud. Second, and perhaps even more important to the consumer, we consider action under Title 39 of the United States Code, Section 3005. This provision provides the Postal Service, upon a proper showing of evidence before an administrative law judge, to withhold and return to the sender mail addressed to anyone who solicits money through false representations. Under a companion statute, Title 39, Section 3007, the Postal Service can, through the agency of the United States Attorney's office, petition the District Court in the state where the promotion receives mail to issue a temporary restraining order that prevents the delivery of mail until the administrative law judge renders a decision on the false representation order. Oftentimes this is the only effective remedy available, particularly with

work at home and medical schemes, where victims are sometimes reluctant to publicly admit their gullibility in a criminal proceeding.

There are several types of fraudulent promotions which tend to focus on our senior citizens. They include work at home schemes, investment and job opportunity ventures, land and merchandise fraud and spurious medical promotions. The latter probably affects senior citizens more than any other segment of our society. Through cleverly conceived advertising, promoters tout all manner of miracle cures. Due to the rising costs of medical care and perhaps previous unsuccessful attempts to alleviate their suffering, the elderly are often tempted to try these purported cure-alls for a long list of problems, including arthritis, cancer, obesity, impotence and baldness.

All kinds of concocted potions and tablets have been touted as cures for arthritis. Over the years, these so-called cures have taken many forms. They have included powders containing wheat cereal, protein and small amounts of vitamins, mixtures of cod liver oil and orange juice, copper bracelets, and bracelets made of sea plants. Unfortunately for those who spend their money on these purported remedies, they do not work.

Other false claims have dealt with vision improvement, a major concern among our older citizens. One promoter used a half page newspaper advertisement to claim a cure for nearsightedness, astigmatism, and middle age sight problems. The cure was actually an eye exercise program. The exercise method directed users to ignore standard medical advice, telling them instead to do such visually destructive things as to gaze directly into the sun and to ignore their medication for such disorders as glaucoma. The program cost $9.95 plus a dollar for handling. Medical experts who reviewed the program said it could lead to blindness. Approximately 66,000 people responded to the ads with an estimated loss of $726,000.

Dr. John Gamel, an Assistant Professor of Ophthalmology at the University of Louisville, read the advertisement. I would like to quote to you some of the unsolicited comments Dr. Gamel sent us about the eye exercise program known as the Bates Method. This is quoting Dr. Gamel.

> Although I feel the lesson learned by investing $10.00 in a mail order fraud might very well be worth the minimal monetary cost, I think that blindness is a most unreasonable price for someone to pay for simple mindlessness or guillibility. I will unequivocally support your department with all my professional expertise and will stake my professional titles upon the dangerousness of Dr. Bates' method.

A New York based promotion enticed 36,000 people to respond to an advertisement which promoted a product that would enable a person to "make love with anyone you desire". The advertisement claims this product was the "miracle that can revitalize your sex life in just days even if you are 100 years old." For $10.00, a person received a bottle of vitamin/mineral capsules similar to those that might be purchased across the counter of any drugstore and a so-called advice manual which in fact resembled an advice to the lovelorn column. Robert Butler, M.D., Director at the National Institute on Aging, provided the expert opinion which refuted these

advertising claims. Approximately $360,000 was lost to this phony promotion before the concern was put out of business.

We are frequently asked to place a dollar value on medical fraud, but any effort to do so would be strictly a guess. However, let me assure you, the losses are substantial. One medical fraud promotion which we recently stopped resulted in returning to the senders over $400,000 worth of orders, representing only 30 days of business. A diet type fraud, stopped last summer, was receiving 5,000 pieces of mail a day with an average order of $22.45. That promotion was grossing $112,000 a day. During the last 12 months, we have initiated action against 232 medical fraud promotions, and we estimate that 20 percent of those cases originated in this region. We estimate too that about 60 percent of the victims are elderly individuals who unfortunately are grasping for the miracle cure or the vitality or appearance of youth.

Another prevalent fraud aimed at the elderly is the so-called work at home scheme. The most common offerings are for envelope stuffing or the making of a product, perhaps baby booties or aprons. It is usually alleged that there is a market for such products when in fact there is none, or that the promoter will buy the finished product when in fact he will not. I think you are all familiar with the kind of advertisements that I am talking about. "Earn $400 or more a month in your own home, no investment necessary, choose your own hours," and that kind of come-on.

In an effort to expose these operations, we have developed a brochure which describes the typical work at home scheme and cautions for the customer. It also asks the consumer to notify us of suspicious advertising and has a tear-off reply card for this purpose. Since we issued the brochure in June of 1980, we have been receiving over 150 reply cards a week identifying numerous promotions. In the last six months, we have put out of business, through false representation orders, consent, agreements, or criminal prosecution, approximately 2,000 of these phony work at home promotions.

A typical scheme involved the promoter who offered work at home employment making foundations for wreaths. These foundations were to form the backing for decorated Christmas or funeral wreaths. The operator, Harry Morrison, formed a company called W. C. Wreath and guaranteed to purchase these foundations for $1.50 apiece. Morrison also guaranteed the investors that they would be earning more than $1,200 a month. No wreaths were ever purchased by Morrison, and, before we were able to arrest and convict this man for fraud, 300 senior citizens invested $47,000 in the promotion. This wreath is one of 500 made by Mr. Frank J. Gruber, a 68 year old retired machine designer who wanted to continue his life as a productive citizen. Mr. Gruber personally went to Morrison with some of his earlier wreath foundations and was assured that they were quality and would be bought by the W. C. Wreath Company. That is all Mr. Gruber got, a lot of promises.

Another example involves four promoters from San Antonio, Texas. Through a nationwide, direct mail and newspaper advertising campaign that went beyond our borders and into Canada, they offered work at home employment stuffing envelopes. For a $15 application fee, respondents were guaranteed a weekly income of

more than $350. Actually, those who sent in the application fee were instructed to place a newspaper advertisement exactly like the one that enticed them to send $15 and then send any responses they received directly to the San Antonio promoters. These respondents were then given the same instructions. At the peak of the promotion, the operators were receiving up to 5,000 pieces of mail a day. When we stopped the scheme through a false representation order, we returned to the senders over 25,000 pieces of mail containing approximately $375,000 in additional orders. A letter of instruction and an innocuous booklet on business opportunities were all the people had received for their application fees.

Another growing problem area which affects the elderly is the broad spectrum of investment swindles. This involves a variety of schemes, including franchise/distributorships, investments in coins, gems, stocks, land sales, and a host of others. We feel that the increase in investment related schemes has had a direct relationship to the economic situation today. During times of inflation people are looking to invest their savings in a way that will keep up with inflation. Those on fixed or low incomes are seeking ways to supplement those incomes. We frequently find that the victims are elderly people who have been persuaded to invest their life savings. Some of these opportunities are legitimate, but this serves only to give the mail fraud operator a better climate in which to conduct a fraudulent promotion.

A sophisticated land investment swindle was carried out by L. T. P. Properties Incorporated in DeBary, Florida. Through direct mail solicitation, newspaper advertisements and personal contacts, 507 individuals, almost exclusively elderly, lost about six and a quarter million dollars in this promotion. The average age of the victim was 63 years old. L. T. P. used glossy photographs depicting a golf course, boating, horseback riding, and other unfulfilled promises to induce these individuals to invest. They were given guarantees of a 12 percent annual interest and alleged first mortgages on specific lots in the development. Little did they know that their mortgage was frequently subject to a prior mortgage, a mechanic's lien, a lease, or that the mortgaged lot was in fact on the bottom of a lake, on top of sewage plant, or a part of a golf course. The paved roads were little more than footpaths plowed out by a bulldozer. Ms. Lorraine Huber, a quadriplegic, formerly a resident of this region, was one of the victims of this scheme. She lost $21,000 of her deceased father's retirement money, retirement money he received after 42 years of service in the New York City Fire and Police Departments. That money was to insure the future of her 82 year old mother and herself. Now Ms. Huber is losing her home because of this swindle. Another victim, Dr. Martin Skowronski survived the concentration camp at Dachau. He lost $15,000 he received in reparation to these con artists. Although the promoter of this scheme started a seven year prison term this past September, this is of little solace to those who lost their investments.

Mr. FRANK. Mr. Murphy, excuse me. We want to maximize time for questioning. I wonder if we could submit part of the statement for the record.

Mr. MURPHY. I would be glad to if you would like to move right on.

Mr. FRANK. If you just could summarize, I am worried about the time and the other witnesses. I think that would be helpful if we could.

Mr. MURPHY. Sure thing. Going right from the illustrations, perhaps we could just sum up and say that our intent is to keep the mails as free as possible from mail order promotions that are in fact frauds. We have devoted significant resources to this program, and we would be more than happy to distribute as many brochures as you wish.

At this point, Mr. Chairman, perhaps it would be better just to go directly to the questions.

Mr. FRANK. Thank you. We appreciate it. The statement is an excellent one, and without objection it will be printed in the record that the Select Committee will have done.

[The remainder of Mr. Murphy's prepared statement follows:]

Another investment swindle was carried out by the Progressive Farmers Association (PFA); an investment corporation formed in the State of Missouri by Russell Phillips. Phillips allegedly organized the corporation to raise working capital for a new type of cooperative which would bring farmers and consumers together, eliminating the middleman, and would raise crop and livestock prices while cutting food prices. To raise capital, Phillips sold securities known as "Estate Builders" to individuals, the majority of whom were retired or semi-retired farmers. PFA salesman conned people into investing their savings with promises of doubling their money. These investments were to be used to establish farmer's cooperative markets. However, none of the promised markets were opened. Instead, the operators of PFA used the money to pay themselves exorbitant salaries and for investments in other personal enterprises. In May 1977, PFA filed bankruptcy, but not before they had convinced 6,000 people to invest $12 million in this venture.

One 72-year-old man invested over $70,000. Another elderly farmer, who invested approximately $50,000, committed suicide as a result of his lost investment. A federal grand jury indicted 22 individuals on 175 counts for Mail Fraud and Rico Statute violations. Twelve pleaded guilty and in August 1980, after a 10-month trial, Phillips and the remaining defendants were found guilty. Prior to sentencing, Russell Phillips, the mastermind of this operation, spoke for nearly an hour on his own behalf, in an attempt to explain to the court the business failures of the corporation and how he never intended to cheat anyone. After hearing Phillips' comments, the sentencing judge stated that it was now evident that Phillips could not be rehabilitated and sentenced him to 15 years in prison with five years probation and fined him $20,000. The other defendants received sentences ranging from five to ten years in prison.

In an investigation prosecuted with the Boston District Attorney's office, a Boston attorney was sentenced to one year in prison for swindling 100 of his elderly clients. Over a nine-year period, he convinced his victims to invest in a variety of promotions with promises of 15 to 20 percent annual interest and full return of their principal in one to three years. He gained the confidence of many of his victims as a result of his position as the president of a religious organization. In many cases he knew the financial status of the victims because he had prepared wills for them. As soon as they received an insurance settlement on the death of a spouse, he began talking them into investing money with him. Most of the money received was invested in his name or in the names of members of his family. To prevent his clients from knowing what actually happened to their money and enable him to continue his swindle, he would send them some interest payments. This lulled his victims into a false sense of security.

Distributorship/franchise schemes are oftentimes directed to those on retirement of fixed incomes. This type of employment is particularly attractive to the retired person who wants to continue as a productive citizen yet not be employed on a full-time basis. Massachusetts residents were among the 540 victims from 40 states who lost $3.6 million to a Cleveland, Ohio, promotion which offered jewelry franchises throughout the United States.

These investors responded to a nationwide newspaper advertising campaign which include the New York Times and promised exclusive territories, guaranteed gross monthly incomes of $3 '00, 35 percent profit by working only seven to ten hours per week, no selling required and the investment was secured by inventory plus a 100

percent repurchase agreement. The cost of this dream-come-true offer was $6,495. In most cases investors received less than $100 worth of cheap costume jewelry. No accounts were established with major department stores and no exclusive franchise territories were set up. Joseph Van Dyke, III, who operated this scheme under the name Rings 'N Things, diverted the investor's money to his personal needs including a salary of $10,000 per month. Van Dyke was convicted of mail fraud and sentenced to four years imprisonment.

As you can see, the variety of fraudulent schemes is seemingly endless. We feel very strongly about our obligations to keep mails as free from abuse as possible. Phony mail order promotions are a small percentage of the total mail order industry, but the substantial dollar losses and the cost in terms of human suffering caused by the dishonest promoters deserve our attention.

I will be pleased to answer any questions you may have.

Mr. FRANK. As I said, we did want very much to get to questions. Director Pines will begin the questioning.

Mrs. PINES. We are really outraged by the material that you have provided to us this morning, and we are very pleased that you did take the time to come up and participate in these very important hearings. Mr. Murphy, how do Postal officials work with law enforcement officials in prosecuting frauds that they find?

Mr. MURPHY. If you are speaking of the Federal prosecutions, in a very close relationships, of course. The Inspection Service, Postal officials, are the investigators. Once we have developed evidence of any violations, we present it to the United States Attorney's office who makes a determination on prosecution and carries through the trial procedures.

Mrs. PINES. Do you think that federal officials are doing enough?

Mr. MURPHY. I think they are doing all that they possibly can.

Mrs. PINES. What sorts of schemes prove the most difficult for the Postal Service to deal with?

Mr. MURPHY. It is hard to say what would be the most difficult to deal with. A sophisticated fraud naturally requires a great element of proof as far as the intent of the operators' part. A patent fraud, such as a phony product, that can be immediately identified as a phony, is a lot easier. I suspect that a more sophisticated investment type scheme might be harder to prosecute.

Mrs. PINES. You have developed brochures, but is this really enough? Shouldn't there be Federal action of a stronger type against these kinds of frauds? What would you recommend?

Mr. MURPHY. Well, we have some hopes in our activities in the field of title 39, 3005, in our administrative actions. What we are hoping for is the ability to expedite our procedures against these individuals. As it stands now, we would appreciate the ability to obtain the products in less time than it presently takes. As it is now, we purchase through the normal purchase procedure, which can be delayed for a period of time.

Mrs. PINES. How would you recommend that you might be able to do that, to expedite?

Mr. MURPHY. I think if we had legislation that possibly requested or demanded that the perpetrator sell that product to us upon demand, I think that would do it.

Mrs. PINES. So that you think that you would need legislation to accomplish this?

Mr. MURPHY. Well, I think in order to give it any enforcement ability, yes. We could go to an operator right now and say we would like to buy your product, but there is nothing that says he

has to sell it to us at this point. What we would like is legislation that would say you are required to sell it to the Inspection Service or the Postal Service or whatever when they make a demand for it.

Mrs. PINES. Have you submitted or are you working with any members of Congress with regard to proposing this kind of legislation?

Mr. MURPHY. We have had such legislation proposed last year. I guess it did not process in time. We are hopeful again this year through Claude Pepper's group to do something along those lines.

Mrs. PINES. Is there much success in getting consumers their money back, or is what you are doing basically shutting down the bad actors? Do consumers get redress?

Mr. MURPHY. In a criminal prosecution, redress of course is up to the judicial department, but, as I mentioned in our administrative actions, we are successful in cutting off the incoming funds of the fraud operator, and, once our case is presented to the administrative law judge, we can return incoming mail thus depriving the operator of his funds and providing in effect a refund to the victim.

Mrs. PINES. But what about people who purchased earlier before you have moved in, they really, they have had it?

Mr. MURPHY. Unless as part of a criminal proceeding we have some decree by the judge that the person will make restitution, but that is not always the case. Sometimes there is no money to make restitution from, no identifiable funds to make restitution from.

Mrs. PINES. So basically what you are saying is that there are substantial numbers of consumers who never receive restitution, who are never made whole, who are defrauded by various unscrupulous operators in the marketplace?

Mr. MURPHY. I would have to agree with that. Yes.

Mrs. PINES. One last question, Mr. Murphy, how are these brochures which appear to be very useful distributed throughout this Country?

Mr. MURPHY. We do it in a variety of ways. If you recall, I mentioned special inspectors who are designated consumer specialists. They, in our field divisions which number 18 throughout the Country, distribute these brochures. They are also available in any Post Office in the Country, or by request from the Postal Service.

Mrs. PINES. Are there any ways that you could recommend to speed up the process in addition to being able to secure legislation that you would automatically be able to purchase a product?

Mr. MURPHY. I am afraid I don't understand.

Mrs. PINES. Are there any other suggestions that you might have for legislation that would speed up the process of reviewing products and taking action as the Postal Department?

Mr. MURPHY. There are two other aspects that we would like to see considered as legislation. One additional one would be to obtain the test results from someone who advertises that they have in fact had tests conducted on their product. For example, the diet pill that is supposed to be examined and tested by a medical board, we would like to be able to go to the operator and say, give us the results of that test. We can't at this point. We have to wait for that material. We have to do our own examination on it.

It would be helpful if we could get tests, or perhaps you have seen ads with before and after photographs. We would like to see

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some evidence of that. In essence what we would like to be able to do is to be able to go to the operator and get back-up material. Additionally, if I might, there is one other point of legislation that we consider important a civil remedy for someone who attempts or in fact violates Section 3005 where we have a false representation order issued against that firm. As it stands, that person need only change the name of the product, the address he is dealing from, or his company name, and we have to start all over again. What we would like to see is a civil remedy attached to that statute, so that if someone does in fact make an attempt to circumvent a fraud order, that he can be penalized for doing that. That would be another aspect.

Mrs. PINES. Do you do much efficacy testing of the product?

Mr. MURPHY. Yes, constantly.

Mrs. PINES. Do you have adequate budget for that?

Mr. MURPHY. I believe, yes, we are budgeted adequately for it, notwithstanding that it would reduce the amount that we have to do, I think, if we had access to the alleged tests conducted by a promoter. But we do conduct tests constantly.

Mr. FRANK. Mr. Murphy, I would like to follow up on Mrs. Pines because I think this is an area where I would like to see legislative activity to help your activities. What about subpoena power, what is the status of your subpoena power in this area?

Mr. MURPHY. Well, we have no administrative subpoena power. I think that was essentially what I was referring to when I requested it.

Mr. FRANK. Your right to buy?

Mr. MURPHY. Not only to buy the product, but primarily to get the tests.

Mr. FRANK. So subpoena power would really subsume both of those?

Mr. MURPHY. Right, and, as past legislation proposals had read, our subpoena power would be limited to the tests, tests or things related to the test.

Mr. FRANK. You would subpoena the test results. You would buy the product?

Mr. MURPHY. Yes.

Mr. FRANK. It would be kind of hard to subpoena some of these, subpenaing nonexistent things.

Mr. MURPHY. What we would like as far as the purchase power is concerned is to be able to offer the individual the stated price and obtain the product, and, his failure to do that, I would like to see some kind of teeth put in that.

Mr. FRANK. What about the states' ability to enforce these matters? I know we are going to hear from the Attorney General's office here, and I would like to acknowledge, as a matter of fact, that the Secretary of Elder Affairs of the Commonwealth has sent a representative, my former colleague from the Ways and Means Committee, Eva Hester, who I am glad to see here. Obviously the state has got some responsibility which they are trying to discharge. What about leaving this to the states?

Mr. MURPHY. I think in certain aspects parts of it can be left to the states, but I think, when we deal with the Postal Service, the initial intent in the passage of the Mail Fraud Statute in 1872 was

to protect the individual from someone across the country who is dealing with the product, someone out of his own State, and I think we are the viable method of combating that.

Mr. FRANK. So you would say that in fact this, I would think, is one of many examples where in fact we need a strong national government. That given that we have a national economy, trying to do this purely on a state by state basis would not be effective?

Mr. MURPHY. I think the mails by themselves tends to that in the transmission of the materials. I don't see how we can avoid that.

Mr. FRANK. I appreciate that, and I don't mean to get you in a fight with anybody else, but it seems to me that there is clearly emanating from the Executive Branch in Washington today a wholly exaggerated emphasis on what can be done by states, and I think it is important to have reminders that there are issues, given that we are a national economy, that really cannot be wholly done by the states, and also that there is no conflict. Would I be correct in assuming that you and state authorities have been able to work cooperatively together?

Mr. MURPHY. I would have to comment positively on that as far as the cooperative attitude is concerned. I refrain from commenting on the other.

Mr. FRANK. I appreciate it, but I did want to get it in the record because I think too often these people trying to set up state versus federal jurisdictional questions assume that it has to be all one or the other. I think just in the selection of the witnesses today that we have, it shows that in fact there can be cooperation.

Mr. MURPHY. Absolutely.

Mr. FRANK. People can work together. It is also a case where what we are saying in this case is that we don't really have enough power on the part of the Postal Service to do the most effective job of protecting people from criminal activity which is what we are talking about?

Mr. MURPHY. I would agree with that, although, when you say criminal activity, the legislation that we are primarily talking about deals with our administrative statute.

Mr. FRANK. I agree. You are talking about the civil side as well. In effect, I just would like to say that what, it seems to me, comes through the testimony, and again I don't ask you to respond to this, but we are talking about an area where we may be under regulating. I know regulating is supposed to be a bad word these days, and there are areas where we regulate too much, but I take it that what we are talking about here is an area where a sector of the population which includes some vulnerable members, and I don't want to set up the notion that every elderly person is, none of us are suggesting, that every elderly person is some mark for every two bit sharpie that comes along, but we are talking about a sector of the population where people are somewhat isolated, they are somewhat cut-off in some ways, and they are suffering, in many cases, physical ailments, they are being preyed upon by some people in the private sector, and what we are talking about is the need for more regulation, sensible regulation, we hope, carefully planned, but more regulation to protect them. I am glad to have that testimony.

Those I believe are my questions, and I guess we can move on to the next panel of witnesses whom Director Pines will be introducing. Thank you very much.

Mrs. PINES. We appreciate your comments.

We would like to recognize Paul Troy, the Assistant United States Attorney in Boston, and he will be accompanied by John Burns who is a U.S. Postal Inspector, as well as a Mrs. McKeon who is a 78-year-old resident of Massachusetts. Mr. Troy, we are pleased that you could join us today at these joint hearings of the Federal Trade Commission and the U.S. House Select Committee on Aging.

STATEMENT OF PAUL E. TROY, ASSISTANT U.S. ATTORNEY, DISTRICT OF MASSACHUSETTS, BOSTON, MASS.

Mr. TROY. Thank you very much. I appreciate the opportunity of appearing before the panel today. I prepared some remarks which, because of the time restrictions, I won't stick to them, but I felt that they were important to point out to the Committee.

Mr. FRANK. I appreciate that, and without objection I will see that they are printed in the record of the Select Committee so that the remarks will be printed in toto and made a part of the record.

Mr. TROY. Thank you very much, Congressman.

I have been asked to speak today on insurance frauds concerning the elderly. The United States Attorney's office under Mr. Ed Harrington, has been actively prosecuting insurance fraud concerning the elderly. We have two major investigations underway right now. Evidence has been presented to the gand jury on each. Those investigations concern approximately six agents who are allegedly defrauding the elderly in the sale of insurance. Another agent has pleaded guilty on May 6 in Federal Court in Springfield, and he will be sentenced the beginning of June. We expect to seek an indictment against another agent within two months.

As you have heard from the previous speaker, the U.S. Postal Inspectors investigate mail fraud. With me today is Postal Inspector John Burns from Boston who has been working almost full time investigating insurance frauds against the elderly, and I can't say enough about him and the support which the Postal Inspection Service has thrown into this problem which has very recently come to our attention. Within the last few years, it became known that some unscrupulous insurance agents are out trying to bilk elderly people.

Also with me is Miss McKeon. You added a year to her age which she reminded me. She is actually 77 years old. We haven't identified her further for two reasons. The first reason is that her privacy should be protected. The second reason is that we have encountered a problem where, when the victims' names have become known, other unscrupulous agents have followed around our investigation trying to sell them insurance because they feel that they may be more susceptible than others, and, of course, we are out there trying to get back the money and cancel the policies for the victims, and, of course, the victim might then be willing to buy some more insurance.

I prosecuted last year three cases involving five agents from a West Springfield insurance agency. The investigation first came

about when one of the agents, the Insurance Commission in Massachusetts, the special investigations unit under Marty Kelley who could not be with us today, he began getting all these complaints from people that they had been sold too much insurance. Usually it would come about when the family would be talking to the parent or relative and find out that their relative is spending a lot of money on insurance. Mr. Kelley contacted the Postal Inspection Service, specifically John Burns, and the investigation started.

After a while it became apparent that the only way we could track down the amount of the frauds was to subpoena the actual insurance company records because you couldn't depend upon the elderly victims. They didn't know often what they had purchased, what types of policies and how much. So by subpoenaeing the actual records from the insurance company of all business done by any of the agents from this particular agency, then we could set down and try to get a pattern, people from the same addresses and the same names having purchased the same types of policies over and over.

Finally, one of the agents when confronted with all the material, the number of people he had sold, the duplicate policies he had sold, he agreed to cooperate with the investigation in return for his pleading guilty to a three count offense which had a maximum of 15 years and our telling the judge of his cooperation. The next thing that happened was he appeared in the grand jury, and we sought an indictment against a second agent. The second agent was indicted, and, before the trial, he agreed to cooperate. Basically the same basis, 15 year maximum, tell the judge, he cooperated.

Finally we sought an indictment against the final three agents. Now, these weren't the dregs of our society. These were, if you would, high class agents. The head of the agency was the head of the Agawam Liquor Board. They were respected people in the community. The indictment listed 34 particular people whom they defrauded. The investigation centered on 100 elderly victims. They did go to trial, and, at the beginning of the third week of trial, they pleaded guilty.

Miss McKeon was a victim of just about every type of crooked technique which is commonly used today. She, like most of the victims, already had Medicare A and B, and Blue Cross supplement which in Massachusetts is called Medex. She also had a policy from the Association of Retired Poeple. That is before they started. She was hit mainly by two of the agents.

Miss McKeon thought that she only had two policies. What they would do is they would come and tell her that she would need riders or they have increased the insurance, they have increased the cost, and every time they would come they would want another check.

Insurance companies have internal checks so that, if one person is sold too much insurance, then the insurance company computers will pick it up. So they used a technique of selling in the name of beneficiaries. What this means is, if you list as your beneficiary on a policy, for instance, your nephew John, then the agent would write up the policies in the name of the nephew John, and, of course, the victim didn't know that she was buying policies.

Now, that is one of the things that makes insurance fraud against the elderly very difficult to prove. Usually you will find that the insurance agent always makes up a policy, and the reason for this is because the commission on at least a life insurance policy is as much as 80 percent the first year. So these agents never just stole the money. They would always take the money, buy a policy for somebody. When the investigators would go and interview the insurance agents, they would say, "She bought the policy for her nephew or for her niece, and here is the policy right here." Then you would be going back to the elderly victim and say, "Hey, listen, are you sure you didn't buy this policy? They have it right here. I have a copy of it." And the victim would very often say, "Well, I don't think I did," depending on how mentally alert the elderly victims were.

Another problem in prosecuting is that the elderly victims were very forgetful. For instance, one night the investigators went to visit two elderly sisters. One was 89. The other was past 92. We were going to video-tape their deposition the next day. They agreed to come. The investigator went over the checks with them. We had all their testimony ready to go. The next day myself and Inspector Burns went to pick up the ladies, and they didn't know why we were there, and they weren't going anywhere with us, and they weren't really sure who we were. That type of problem was not uncommon in the investigation, besides the fact that when people are in their late eighties and nineties they can get too sick to go to court. In our case, at least one of the main victims died before the trial, and it makes it difficult, and I think that the agents often know this.

Besides selling Miss McKeon policies in the name of her relatives, she only wanted health insurance and they sold her several life insurance policies. Of course they never left brochures or pamphlets or receipts, so she couldn't track where her money was going. At one point Miss McKeon was very sick, and so they asked that she give them her bank book and an authorization, they would go to her account and withdraw money for new policies. When Miss McKeon finally checked how much she was paying for insurance, it was over $6,200 a year in premiums.

We tried to arrange to have some other of the victims come to the hearing, but, because of their ill health or their greatly advanced age—Miss McKeon is very young compared to most of the victims—we arranged to have a composite of three of the victims made up. If I can backtrack a little bit, because of the age of many of the victims, we couldn't bring them into court. We were concerned about their health. So we rented hotel rooms in Worcester and Connecticut and Springfield just before the trial, and we set up video-tape equipment, and we brought the victim to the hotel where it could be a more relaxed environment and video-taped about five victims a day for a total of 15 victims. Then it was, as I say, more relaxed. We could serve them coffee and doughnuts, and there wasn't the pressure from a courtroom environment. We still had the tapes which were subsequently played for the trial, so we put together clips from three of the tapes, and we can play them on that machine there if the committtee wishes.

As sort of background, no names of the three witnesses are on the tapes on purpose. I should point out that each already had Blue Cross supplement as well as Medicare A and B at least, if not other policies, prior to buying any policies from the Marquis agent. The first woman is 86 years old. You will see that she bought a large amount of insurance. She was a professional teacher. Most of the questioning concerns policies which had been purchased in the names of her relatives which she didn't know about, and she was asked, "Did you buy this policy? Did you buy this one?" And she kept saying, "No, I didn't."

The second woman is 83 years old. She was sold by several Marquis agents. They would take turns hitting their victims. She purchased $26,000 worth of insurance in a short time, and she was also sold in the names of many beneficiaries. She had no idea. We found policies issued on her brothers and sisters and everyone else that you can imagine. She had no idea they existed until we subpoenaed the insurance company records at the grand jury.

The last woman, we took this clip because she was a victim of high pressure. She had had a stroke. She is in her 80's. I am not sure of her exact age. She is telling about how she was forced to buy a policy by the agent. Now in there, she talks about the lapsed policies that she went into a room and she come back and the agent had written lapsed across several of her policies. In fact, as you can imagine, they weren't lapsed. He just wrote lapsed so she would buy more policies.

[The prepared statement of Mr. Troy follows:]

PREPARED STATEMENT OF ASSISTANT U.S. ATTORNEY PAUL E. TROY, DISTRICT OF MASSACHUSETTS

I appreciate the opportunity of appearing before this Committee to testify concerning my experiences in the prosecution of unethical insurance agents who defraud elderly persons in the sale of health and life insurance. The United States Attorney's Office for the District of Massachusetts, under U.S. Attorney Edward F. Harrington, is actively prosecuting unscrupulous insurance agents who sell senior citizens unneeded and often worthless health and life insurance. Two major investigations are presently underway involving several insurance agencies from across the state. Evidence has already been presented to Federal Grand Juries on these investigations. As a result of the third investigation, an indictment against another insurance agent will be sought within two months. Another insurance agent pleaded guilty to defrauding the elderly in Federal Court on May 6, 1981, and he will be sentenced next month.

The investigation of the cases I prosecuted began in 1978 when the Massachusetts Division of Insurance received several complaints from elderly persons who believed that they had been defrauded by insurance agents of the Charles T. Marquis Insurance Agency of West Springfield, Massachusetts. Martin Kelley, Director of the Special Investigations Unit, Division of Insurance, Commonwealth of Massachusetts, uncovered what he believed to be a pattern of elderly persons being sold duplicate and excessive insurance by agents of the Marquis Agency. The U.S. Postal Inspection Service, which has targeted defrauding of elderly persons as a prime area of investigation under its Consumer Protection Program and which has committed an extensive amount of resources and personnel to investigate this problem, instituted a criminal investigation into the selling practices of the Marquis agents. Postal Inspector John Burns was the inspector in charge of this investigation. The Massachusetts Division of Insurance instituted successful civil proceedings to revoke the licenses of several of the Marquis agents, and assisted the U.S. Postal Inspection Service in this, as well as the other criminal investigations now in progress. In addition, the Massachusetts Division of Insurance has been conducting administrative proceedings against insurance agents who have been using questionable sales techniques with elderly customers. These proceedings have resulted in several agents voluntarily surrendering their licenses. The Connecticut Division of Insur-

ance also provided assistance concerning the Connecticut victims in the Marquis Agency case.

As a further example of the cooperation exhibited by the various government agencies in the Marquis case, after the Marquis agents, were convicted, Assistant Attorney General Robert J. Gaines of the Public Protection Division of the Massachusetts Attorney General's Office aggressively sought reimbursement for the elderly victims of the Marquis case from the 11 insurance companies represented by the Marquis agency. The insurance companies have agreed to reimburse all the elderly victims. The victims will be repaid in an amount which may be as high as $200,000. In addition, the Connecticut Division of Insurance has obtained over $80,000 from these insurance companies for Connecticut senior citizen victims.

Each of the Marquis agents was indicted under the federal mail fraud statute (Title 18 U.S.C. § 1341). The Postal Inspection Service is charged with enforcing this statute which makes it a federal offense to use or cause the use of the mails for the purpose of furthering a scheme to defraud. In the insurance industry, the use of the mails is a daily occurrence since applications, policies, benefit checks, renewal notices and premium payments are routinely sent through the mails.

After the investigation started, one of the Marquis agents admitted that for some time he had been defrauding many of his elderly customers. He agreed to plead guilty to criminal charges and cooperate with Postal Inspector Burns in his investigation if his cooperation were made known to the sentencing judge. I next conducted an extensive Grand Jury investigation, after which a second Marquis agent was indicted. Prior to the trial, he also agreed to plead guilty and cooperate in the investigation. I finally sought Grand Jury indictments against the owner of the agency, Charles T. Marquis, who was a prominent figure in the Springfield area and a member of the Agawam Liquor Board, as well as two more of his agents. A 37-count indictment was returned by the Grand Jury. These three agents interrupted their trial which was in its 11th day to plead guilty before Federal Judge Frank H. Freedman. The five agents received sentences ranging from a short incarceration and a public service requirement for one agent with medical problems to four years imprisonment for Charles T. Marquis, as well as heavy fines.

During the trial, a large number of elderly victims testified. Although seldom permitted in a criminal trial because of the age and physical condition of some of the victims, the testimony of 12 of the elderly witnesses was video-taped at locations near their homes prior to trial. The video-tapes were then played for the jury on a large screen color T.V. during the trial. The oldest witness to appear personally at the trial was 95. The ages of the witnesses varied from a 64-year-old woman with multiple sclerosis to several women in their 90's. Although the Postal Inspectors' investigation concerned allegations that as many as 100 persons were defrauded, 38 elderly women were specifically named as victims in the indictment. The amount of the fraud is estimated at several hundred thousand dollars, although it cannot accurately be determined.

Most of the victims were elderly women who lived alone. They were generally well educated with varied occupations before they retired, including teachers, nurses, and a college professor. Several testified that they trusted their agents to care for their insurance needs and gave them money whenever their agent told them it was needed. Several women testified that they had no idea how much money they were paying for insurance until the investigation started and they totalled up their expenditures from their check registers. Some of the women then realized that they were paying $6,000 to $9,000 per year for insurance premiums. One woman paid over $40,000 since 1971 for insurance premiums and never put in a claim. If a small refund was received from a company, the agents would often use the refund to pay their own office expenses. If it was a large refund, the agents would sometimes write up a fictitious insurance application and forge the name of the insured to use up the refund rather than return the refund to their client. Health histories on applications were often falsified by the agents so that the insurance company would not reject an application, resulting in claims being denied when the company learned of the falsified health history. When this happened to one 88-year-old woman, the agent never told her why her insurance company would not pay a $400 claim. Instead, he brought her a check for $5.20 and told her that's all she'll get "because they had to pay the politicians with it."

Some of the terms and techiques used by the Marquis agents and which are apparently common to unethical insurance salesmen when selling to the eldering are the following:

"*Soft Touch*" or "*Mark*".—These are expressions used to describe an elderly person who can easily be sold insurance. Once an unscrupulous insurance salesman determines that his client is a "soft touch" or a "mark", the client will undoubtedly begin to receive frequent visits from the insurance salesman or his compatriots

(they will split the commission). During these visits, the sales man will often remind his victim of the high cost of medical care and how a serious illness could wipe a person out and cause him or her to be a burden to their children.

"*Twisting*" or "*Churning*".—The commission an insurance salesman receives on the first year premium is large. With some companies, it can amount to well over 80 percent of the first year life insurance premium. The commission on the second and subsequent years drops drastically. An unethical salesman therefore has incentive to urge his customer to drop one policy when the year is completed and buy another policy in its place. The unethical salesman's interest in "twisting" the client from one company to another or one policy to another is only to gain the high first-year commission. He is not concerned with whether his customer is actually getting a better policy. Side effects which result from "twisting" are that the customer is now a year older and must pay a higher premium, the new policy may require waiting periods before the coverage comes into effect, and "pre-existing conditions" may not be covered for a period of months or even years, depending upon the terms of the policy.

"*New Face Approach*".—Sometimes an elderly person will come to realize that her insurance salesman is constantly coming to her home looking for money for "riders", "increased hospital costs", "new age bracket costs", "consolidation of existing coverages", "decreases in Medicare reimbursements" or some similar explanation for the repeated visits. If the insurance salesman gets the impression that his elderly client is balking at his constant requests for money, he may enlist another unethical salesman with whom is is associated to go to the home and take over the client as his own. They may even take turns going to the home of the client. Sometimes the salesmen have entirely different sales techniques, as, one salesman may pressure the client to buy, while another may be very polite and non-aggressive. Before going to the home the old insurance salesman will completely brief his compatriot on the best ways to sell the client. Both salesmen will then split the commission.

"*Overloading*" or "*Loading*" or "*Stacking.*"—These terms refer to the practice of selling "soft touches" or "marks" whatever policy the salesman has available whether needed or not. The sales are made with no consideration given to whether the coverage duplicates other coverage or whether the policy has a coordination of benefits clause. If the elderly person only wants accident and health insurance the only policy left to sell him or her is life insurance, the elderly person would be sold the life insurance policy. The insurance salesman would merely neglect to deliver the policy so the customer would not realize that life insurance had been purchased or else deliver the policy if the salesman felt the elderly person would not know the difference.

"*Nursing Home Policies.*"—Unethical insurance salesmen sometimes prey on an elderly person's fear of a lengthy and expensive nursing home confinement. Almost no nursing home policies cover custodial care type nursing home confinements (where the person enters a nursing home to recover from an illness or when the person is unable to care for himself because of his poor physical or mental condition) because the cost would be prohibitive. Medicare, as well as the usual "gap filler" and "nursing home" policies pay benefits only under very specific circumstances, including only while the patient is receiving "skilled nursing care" in a qualified "skilled nursing facility." Policies that do pay for custodial care nursing home confinements pay only a negligible amount, such as $2 to $4 per day.

"*Lump Sum Payments.*"—Almost every insurance policy can be paid semi-annually, or quarterly, and some can be paid monthly. Unethical insurance salesmen often tell the elderly person that the premium has to be paid in a lump sum annual payment. This insures that the salesman gets his commission as soon as the policy goes into effect rather than getting it periodically as the insured makes the installment payments. The agent may even arrange for a bank loan for the victim to enable the victim to pay the entire payment in a lump sum. Paying the interest on the loan is the customer's problem.

"*Character Reference Questionnaire.*"—In order to get leads for new customers, some unethical insurance salesmen tell their customers that before the policy can be issued, the customer has to give the names of three character references who can be contacted to make sure that the insured is of good moral character. The salesman would go to the homes of the "character references" under the guise of checking up on his customer, and then attempt to sell the "character references" insurance of their own.

"*Name X.*"—Many insurance companies have internal computer controls that will notify the company if one person has what the company considers to be too much insurance. If an agent attempts to place more insurance on a person who has the maximum amount allowed by the company, the company will send the application

and the person's check back to the agency and notify the agency to refund the money to the customer because in the company's opinion, the customer is overinsured. To avoid having to give back premiums to the insured, if an unethical insurance salesman believes the company may reject the application because the person has reached a maximum allowable coverage in the company, the insurance salesman utilizes a derivative of the person's name. To the computer, it will appear to be another person buying insurance. For example, John Robert Doe becomes J. R. Doe or J. Robert Doe.

"*Control the House.*"—In order to keep the customer in the dark as to the types and quantities of insurance which they have purchased, unethical insurance salesmen resort to many tactics. They push the customer to buy the insurance on that particular day rather than waiting to think about it. They have the elderly customer sign blank or partially completed applications, leave no literature or brochures or receipts which describe the policy purchased, don't fully explain what the insured is buying, and don't deliver the policy.

Why are elderly persons particularly susceptible to being defrauded by insurance agents? During the investigation of the Marquis Agency insurance salesmen, it became clear to Inspector Burns and I that many elderly persons are justifiably concerned about prolonged illnesses. They fear not only being wiped out themselves, but they also fear being a burden on their families or having to receive some type of welfare assistance. How good the elderly person's memory is or how gullible she or he appears will determine what sales techniques the unethical insurance salesman will use. If his costomer appears knowledgeable and mentally alert, he will probably be treated like any other customer. However, if the unethical insurance salesman determines that his customer's memory is poor or his customer is very trusting, then the customer is ripe for being defrauded.The unethical insurance salesman has other allies when he deals with elderly customers. Some elderly persons are confined to their homes and welcome a visitor, such as an insurance salesman. Some elderly persons become more trusting and less suspicious as they advance in age. When interviewed, many of the elderly victims told the postal inspectors that they simply could not believe their insurance salesman would have cheated them and were reluctant to testify against them. Many elderly persons, in addition, do not discuss their business dealings or finances with their children or families and the children or families are often afraid to ask. The daughter of one elderly person told a postal inspector that, "Mom always told me not to worry about her because she had plenty of insurance. I never suspected that she had bought all of these worthless policies." Another ally of the unethical insurance salesman is that no one likes to admit that they were defrauded. Many elderly persons expressed embarrassment and fear that their children, families, or friends would find out that they were "taken", so the chances are good that if they realize they have been defrauded, they will simply let the policies lapse rather than report what happened.

Some suggestions we have made to elderly persons who are afraid of being defrauded by an unethical insurance agent are:

1. Know what coverage you already have. Most people over 65 who paid into Social Security are eligible for Medicare. There are two parts to the Medicare program which is administered by the Department of Health, Education, and Welfare. "Part A" is basically concerned with hospital and skilled nursing facility expenses. It is free to all eligible persons although you must enroll to be covered. "Part B" is basically concerned with physician's expenses. Although Medicare "Part B" is subsidized by the federal government, a person who is covered by "Part B" must pay a small monthly premium. You must also enroll in Medicare "Part B" to be covered. If you are not sure whether you are enrolled in Medicare, or have questions concerning its coverages, you should visit or call your nearest Social Security Office.

When a person is covered by Medicare "Part A" and "Part B", although the hospital, doctor and skilled nursing home coverage is extensive, there are "gaps" in the coverage which the patient must pay himself. These "gaps" include some deductibles (the patient pays the deductible), some "co-insurance" provisions (Medicare pays a certain percentage; the patient pays the rest), and limits on the number of covered days in a hospital or skilled nursing facility. To fill these "gaps", many insurance companies sell "gap-filler" policies. These policies generally pay the patient's deductibles, co-insurance amounts, and extend the number of in-patient days covered, as well as cover various additional medical services. An example of this type of Medicare supplement policy is "Medex", sold by Blue Cross-Blue Shield.

If an elderly person is already covered by a Medicare supplement policy, he should be wary of an insurance salesman who tries to sell him an additional "gap filler" policy since it will more than likely duplicate the same benefits as the first "gap filler"policy.

2. Be wary of an insurance salesman who tries to rush you into buying insurance coverage or if he tells you this is the last day you can get the coverage. Be especially wary if he offers to drive you to the bank so you can transfer money from your savings to your checking account. He should be willing to give you as many days or weeks as you need to carefully consider your purchase.

3. An insurance salesman should give you brochures or some type of literature which fully explains the policy you are considering purchasing. He should also fully explain the policy orally, including its provisions concerning waiting periods, pre-existing conditions, and whether it has a "guarantee renewable" clause so the company will have to renew your insurance each year even if you have submitted a large number of claims.

4. Always make your check out to the insurance agency or company and never to the agent himself. Never pay in cash.

5. Never sign an application for insurance which is not completely filled out. If you are asked to sign any other papers, make sure you fully read and understand them or do not sign them.

6. Be wary if the insurance salesman tells you that the premium must be paid in a lump sum before the policy can be issued. Be especially wary if he offers to arrange a bank loan for you so you can pay the premium.

7. It is common for an unethical insurance salesman, in order to gain a customer's confidence, to introduce himself as a representative of a senior citizens group or a federally associated or founded insurance program. Insist upon written documentation which you can check on.

8. Be wary of an insurance salesman who advises you to drop one coverage or let a policy lapse in favor of other coverage or advises you to "consolidate" your present policies into new coverage. He could be trying to "twist" your coverage so he can receive the high first year commission on your new policy.

9. Be wary if your insurance salesman makes frequent trips to your home to sell you insurance, or if more than one agent comes to your home to sell you insurance. (The "New Face" approach.)

10. Be wary of a salesman who tells you a policy is approved" by the government since the government does not give such endorsements.

11. Beware of high pressure or scare tactics in the sales talk or literature given by the insurance salesman, such as highlighting cases of extreme expenses or an exaggerated likelihood of illness.

12. Make sure your insurance salesman accurately records your health history. If he is unethical, he may leave an illness off on your application if he fears the company may refuse to issue the policy. If he leaves off a health problem you had and you later have a claim, the insurance company can refuse to pay you.

13. Keep a record of every policy you purchase. Make sure you actually get the policy, that it is the one you had purchased, and that its coverage and restrictions agree with what the salesman had told you. Often a xerox copy of the application you signed is stapled inside the policy by the insurance company. Look at the application carefully. Has anything been changed, added, or deleted? It is difficult for the unethical insurance salesman to "control the house" when you keep accurate records of all your dealings with him.

14. If you have been purchasing insurance, go through your check register or cancelled checks to be sure you can account for the money you spent for insurance.

15. When checking over the insurance you have purchased, don't just look at the policies because an unethical insurance salesman may not have delivered all the policies so his client would not realize how many policies were purchased. Once again, your check register or cancelled checks should indicate how much you have actually spent on insurance.

16. Always get the name, address, and telephone number of the insurance salesman, his agency, and the company he represents in case a problem arises.

Since the investigation and trial of the Marquis case, numerous people have called and come in to the U.S. Attorney's and Postal Inspectors' Offices because they suspected that they themselves had been cheated when they purchased insurance. Our advice to them is to contact the nearest U.S. Postal Inspector's Office (their number is in the telephone book). A postal inspector will investigate and report the matter to the U.S. Attorney's Office for prosecution if it appears warranted. If the elderly person contacts us with questions concerning his coverage or the adequacy of his insurance, we advise him to talk to someone who knows and understands his needs. This may be a family member, an accountant, an attorney, or a friend with a knowledge of insurance. Some "Senior Citizens" or "Golden Age" type clubs have members with a background in insurance who will go over a fellow member's insurance coverage and make suggestions.

Although the vast majority of insurance salesmen are highly ethical and concerned for the well being of their clients, it is our hope that the hearings held by this Congressional Committee, besides determining what legislation is needed to curb abuses in this area, will alert our elderly citizens that there are also unethical salesmen who may try to defraud them and that they should be on their guard if and when they purchase insurance.

Mrs. PINES. I think that we would very much like to hear from Miss McKeon before we see the video-tapes. So as soon as we hear from Miss McKeon, we would go on to the video-tapes if that is all right.

Mr. TROY. Sure. Do you want to tell them what it was like, Miss McKeon?

STATEMENT OF MISS McKEON, MASSACHUSETTS

Miss MCKEON. Well, it was after I came out of the hospital after a heart operation that one of the agents visited me a lot, and, as far as I knew, I was only taking out two policies which might be for, say, hospitalization or going to a nursing home in any event that anything happened to the heart. I had a full by-pass at Mass. General.

He would come, and, due to the fact that I was having trouble with where the artery was removed from the leg, I couldn't go to the bank. So I would write a letter and say pay to him the sum that he would ask, and, invariably, it was anywhere from five, six, seven, eight hundred dollars, and then he would go up, sometimes he had an agent with him, and the bank there accepted both their signatures. Then they would come back to me, and I would endorse the check over to him. He said it most cases it was due to the fact that I was entering another age bracket because at that time I was around 70, just 70, 71, and I had taken a lot of the policies out in '68 right after I retired from work.

I never received most of the policies. I would get the premium notices which were due every three months or so. In fact, I am still getting some of them from two companies, and all I want was health. When I worked, I traveled, so I would have accident insurance also, and every time, as I say, he would come, he would call at night and ask if I was going to be home the next day. I live alone. I would say yes, "Do you want money?" And he would say, "Well, we will talk about that when I get there." Then when he would get there, due to the fact that there was a change in Medicare or Medex or some darn thing, I would have to increase five or six hundred dollars.

Then he also would ask me, under no circumstances at any time to have anything to do with any of the other agents, one in particular. If he called me, I was to hang up on him. If he came to the door, I wasn't to talk to him. I wasn't to let him in. Which I stuck with just that one that came to me, and over the years it has gone on, and, as far as I am concerned or know of, I am only in two companies now, the Continental Casualty and the Beneficial Standard, and they wrote and said one was ready to expire about three or four months ago, and I wrote and said, according to my records, no, with my checks and all. They wrote me a letter and said that I was paid up until March or April of 1982, but I am still getting premium notices.

Mr. TROY. Why don't you tell them what happened when the investigation started and they were concerned about your testifying?

Miss MCKEON. One night I was in a restaurant having my dinner, and one of the agents, not the regular one, came, and he wanted to speak to me. I told him would he wait until after dinner, and I told him to have some coffee or wait for me, and then we went upstairs to the apartment. He wanted to know if he could get a letter from me telling about how he had treated me and all. He said there was a rumor around that they might be investigated and lose their jobs, and, of course, he wanted me to feel that I didn't want to be responsible for either of the two men to lose their jobs. So I listened to all his talk and all that. I said no, I would not give him a letter, I wouldn't sign anything at all, but I assured him that, if anybody came to me, that I would personally take care of myself first because I had paid out an awful lot of money and I didn't have any policies.

In fact, when Mr. Kelley sent me a letter and listed all the companies I was with, there was at least, in my estimation, almost 25, and I am getting premiums all the time. The pièce de résistance was when they sent me one that was made out to my nephew in his name and his wife's name and that they were to pay the premium. So I sent them back, and I said they don't have any insurance with you. I am the one that has the insurance, and I am the one that makes the payments. So then they corrected the premiums, sent them back to me, and I sent them a check.

Mrs. PINES. Miss McKeon, what you have described is really, truly sad. How did they find their way into your confidence? How was it that he was able to get you to trust him?

Miss MCKEON. He did part of it through my sister who was a retired school teacher, and she had insurance with them, and thank God she was well. She didn't have any sickness or anything, and she didn't have to use any of them until she had her heart attack and died.

Mrs. PINES. Had she purchased a substantial number of policies from them as well so that she was over insured, inappropriately insured?

Miss MCKEON. Well, probably at least two that I know of.

Mrs. PINES. But not 25?

Miss MCKEON. No.

Mrs. PINES. And they got her to introduce them to you?

Miss MCKEON. Yes. I used to visit her. I worked in Boston, and I used to go, one weekend she would come and visit me and another weekend I would go back and visit her and stay with her, and she would say so and so was coming. At that time I was doing auditing work, and I was traveling. She said, "You are in planes. You are in buses and trains. Take out coverage."

Mr. TROY. One thing we found was that an agent chooses his victim. In other words, if he has someone that is very nervous about health and health problems and feels they are susceptible, then he would more than likely overload them if he was unscrupulous. Whereas, he may have another client who is very on top of things, and he would treat them as an ordinary client without trying to defraud them.

In Miss McKeon's case, she had been very sick and was quite concerned.

Miss McKEON. He even called me. He called me at the Mass. General Hospital and apologized that he didn't come to see me.

Mrs. PINES. You were sold life insurance, but you had no idea you were purchasing life insurance?

Miss McKEON. No.

Mrs. PINES. How many of the policies were life versus health or accident insurance?

Mr. TROY. About 25 percent of the policies were life insurance. We did have another 93 year old victim who was sold a maternity policy.

Mrs. PINES. But you didn't bring her with you today?

Mr. TROY. No, we did not. She is quite advanced in age, and she lives a distance from Boston, so we could not.

Among these agents, it was very common to sell life insurance to the victim who only wanted health insurance. Some of the policies, unfortunately, are written in such a way that a life insurance policy looks like a health insurance policy. Some of the health insurance policies have annuity clauses. There are clauses in certain policies that when you look at them it is obvious to perhaps you or I that it is a life insurance policy or it is a health insurance policy, but, for someone trying to talk an elderly victim into buying it, there are clauses, for instance in a life insurance policy, that relate to health, so they can say, if the victim does catch on, they can say, "Oh, no, it really is health," and usually it was just accepted.

Miss McKEON. But the catch there too is, if you send in bills after you are out of the hospital, they don't pay them. You have to be in the hospital. Since 1968 I go every two and every three months to have the heart checked, and I still can't collect from Continental Casualty.

Mrs. PINES. Did you read the policies? Did you physically see the policies? Did they give you policies?

Miss McKEON. Just two, those two.

Mr. TROY. Just gave her two.

Mrs. PINES. Just two out of 25.

Mr. TROY. I don't know how many they had on her. They didn't deliver them.

Miss McKEON. Later on as it near got time for the trial, there was a lot came because at that time I think Mr. Kelley came around with one of his employees, and they asked for all the policies. When I took out all the ones I had, they were staggered at it, as I was too, and they listed them and took them from me, and, in the last couple of years, I haven't had a policy. If I died tomorrow, I haven't got—they even have my house insurance policy.

Mrs. PINES. The area of being able to understand what you have purchased has been an area that I have been very concerned with. As a state legislator, I fought for five years here in Massachusetts to try to secure passage of a law that would require that all insurance policies be written in easy to understand language, and I am quite pleased that we, in the Commonwealth of Massachusetts, were successful in securing passage of that so that perhaps in the

future individuals who receive a policy will be able to see what it is that they have purchased because they will be able to read them.

Miss McKEON. You don't get them for months. I didn't.

Mrs. PINES. But when you did receive them, you continued to pay the premiums.

Miss McKEON. Naturally. When they send them through the mail, they are due. They give you a date that is due. I am still paying.

Mrs. PINES. But you are only paying for two instead of the 25 now?

Miss McKEON. I think there is one I wouldn't be surprised but what it has elapsed. The Continental Casualty sent two agents to the house a couple of years ago, and they checked through, and they said there were two policies I shouldn't pay if I get notices. Like say one ended in three and one ended in four.

Mr. HALAMANDARIS. Miss McKeon, do you know other people who purchased so much insurance?

Miss McKEON. I know one of the women in the building with me had it. Yes, and she had an accident.

Mr. HALAMANDARIS. Do you think this is a common problem?

Miss McKEON. I would say with that company it was. And the thing that I didn't like was when one agent would come to me and tell me not to have anything to do with another agent. I thought that was the strangest thing. I mean, after all, you work with people, you can at least speak to them. I wasn't even to speak to him on the phone.

Mr. HALAMANDARIS. What is the name of the company?

Miss McKEON. Marquis, and I think it is in western Massachusetts.

Mr. TROY. West Springfield, Charles Marquis Insurance Agency. They are out of business now because five of the seven agents went to jail.

Miss McKEON. In West Springfield.

Mr. HALAMANDARIS. However, they dealt with different companies?

Miss McKEON. Yes.

Mr. HALAMANDARIS. Lots of different insurance companies?

Mr. TROY. They represented 11 different insurance companies.

Miss McKEON. Texas, Florida, a lot of them in Los Angeles and some in the Middle States.

Mr. TROY. I should say too, what Miss McKeon just said that she doesn't have her policies, we have taken them away from her. The reason is that the Attorney General's office from Massachusetts has instituted suit and has reached agreement with the 11 insurance companies, and they have agreed to repay all of the money that Marquis agents defrauded the elderly out of. We were just saying to Miss McKeon before the hearing that she should be getting a check around August. The company is going to pay as much as $200,000 restitution to the Massachusetts victims and some $80 to $90,000 to the Connecticut victims. The companies were not involved in the criminal aspect at all, but they are repaying because their agents are the ones that defrauded the elderly, so they said, well, we will pay up and we will stand behind it.

Mrs. PINES. How much was paid a year by Miss McKeon in premiums?

Mr. TROY. Six thousand two hundred something?

Miss MCKEON. At least that much.

Mrs. PINES. And it went on how many years?

Miss MCKEON. Six to eight years.

Mr. TROY. She paid more at the end.

Mrs. PINES. So you paid $6,000 a year for 6 to 8 years for all of these premiums?

Miss MCKEON. When I turned my checks in to the CPA who did my taxes, he wanted to know what was wrong. He said, "I can't deduct this from your income tax." He said, "The State and the Federal won't permit it." I had a stack of checks about that big. Every 3 months, and some of th n were $300. One was $400.

Mr. TROY. The amount of money increased. It wasn't $6,000 a year. It started small, and I think that was the last year it was $6,200 when the investigation finally broke and to help her figure out how much was she actually paying.

Mrs. PINES. Mr. Troy, what is a tracing box and what are they used for?

Mr. TROY. A tracing box basically is used to forge a signature of an insured. There were two different kinds that were used that were described at our trial. The main one was just a box with a glass surface and a very strong light in the bottom, and a piece of paper, perhaps an old policy with the insured's signature on it, was put on the bottom and the new policy on top, and they would just trace over the signature. This way they could write out policies in the name of the beneficiary or a relative or a fictitious person. As I said, they always made up a policy, but at times no company would accept another policy, so they would have to make up a fictitious policy, and that is what a tracing box would be used for.

Miss MCKEON. My signatures weren't—on a false application weren't even similar to mine.

Mr. TROY. That was used when they couldn't get the elderly or for some reason didn't get an elderly victim to sign a blank application, which was very common.

Mr. BURNS. Many times they would go into the homes and collect a predetermined amount, for example $1,000, and then for the purpose of writing policies, to use this portion of money, they would have to use the tracing box on subsequent policies that would have been created.

Mr. TROY. In other words, they wouldn't have a policy in mind. They would just give a figure, $999 or $1,000, and then they would have to go back and figure out what can they buy with the thousand dollars, a cancer policy, and they would get it as close as they could. There was testimony at the trial, if there were $40 or $50 left, they would use it for their office expenses. They had no problem with a small amount, but at least they wanted to be able to produce a policy for every check.

Mr. HALAMANDARIS. Mr. Troy, you have been using the mail fraud statute to prosecute and effective next July, July 1, 1982, the Congress has enacted a new specific criminal statute making it a federal crime for an agent to pretend to work for medicare or for an agent to deliberately oversell insurance as well as for an agent

to practice twisting or to cause a person to drop an existing policy to buy a new one. This allows the agent to claim a first year commission of 60 percent instead of the five year commission on renewals. Do you think that this statute is going to solve what was Miss McKeon's problem?

Mr. TROY. I haven't read the statute, but it sounds like it is just what we need. The problem you will always have is what the agents use as their defense, what we were told throughout the trial would be their defense, is that how much insurance is too much or we made a good faith decision to twist, for instance, because it was just a better policy. Because a twist, what they call them, is that the waiting periods start over again and you are a brand new customer and you perhaps have an eight month period before you have any insurance in force, and there is always the problem of having to show a pattern. You can't just show one victim because the agent can say I did it because of this and this and this and it was my good faith impression or feeling that this was a better policy. But the statute sounds like it would be very helpful to put the insurance agents, the unscrupulous ones, on notice. I think in conjunction with the mail fraud statute it could be a very big help.

Mr. HALAMANDARIS. Do you think that the federal government has another role to play in trying to prevent the kind of abuses that Miss McKeon has been subjected to?

Mr. TROY. Well, I may be out of my field, but I think that the federal government ought to be doing more as far as the actual policies go. Some of the policies that are sold are an absolute disgrace. When an insurance policy is being sold that pays $1.33 a day for a nursing home, there is something wrong. It can only be in there for an agent to be able to say this provides you nursing home coverage. There are some that are being sold that provide from $1.33 to $3.33 a day for custodial care nursing.

On the other hand, I am greatly concerned about the federal government approving any policies because, as we all know, the vast majority of insurance agents are completely concerned for their customer and would never do anything to cheat their customer, but we are talking about the extreme minority, and this is one more selling technique, this policy is approved by the government, and that was a standard technique used in our case where the agent would go in and say, this has been approved by AARP, Association of Retired People, or it has been approved—sometimes they are just lies—it has been approved by the U.S. government, and in my prepared remarks there, I specifically said that the government doesn't approve a policy. So it is sort of a middle ground. If the government does require that insurance policies pass minimum standards, there is the danger that this will be used as you should buy this one too because this one has been approved by the government and the other one hasn't.

Mrs. PINES. The policies that you have spoken of in which $1.33 or a similar small amount would be covered for nursing home care, can they be sold in Massachusetts?

Mr. TROY. Yes.

Mrs. PINES. The Commissioner of Insurance has approved the sale of policies that would include that degree or that limited

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amount of coverage? Is there any limitation in terms of what is or isn't approved by the Commissioner of Insurance?

Mr. TROY. I am not completely familiar with the way policies get approved. I know that they are really working trying to get rid of the bad policies. I do know that some policies are approved if no action is taken disapproving them under the legislation in the Commonwealth, but I know the Division of Insurance is working on this problem right now. As I said, the special investigations unit is really cracking on the field of insurance for the elderly, fraud in the field of insurance for the elderly, at this time. So I think, and we all hope to see improvement in this area, that some of the policies will be weeded out.

Mrs. PINES. I think that we would like to see your tape at this time.

Mr. TROY. The first woman is, as I said, 86 years old. She was sold a large amount of insurance in the names of her relatives and friends, and she is a former teacher.

[Video-tape played.]

Mrs. PINES. Mr. Troy, could you move on to the second tape?

Mr. TROY. This woman bought $26,000 worth.

[Video-tape played.]

Mr. HALAMANDARIS. Can we stop the tape? Let us just summarize here very quickly and then go on. You brought us three people on tape, am I correct?

Mr. TROY. Right.

Mr. HALAMANDARIS. The first woman had $40,000 in premiums?

Mr. TROY. That is right.

Mr. HALAMANDARIS. The second woman was taken for $26,000 more or less?

Mr. TROY. That is correct.

Mr. HALAMANDARIS. The third woman was taken for how much?

Mr. TROY. She had twenty five policies, and she paid $8,000.

Mr. HALAMANDARIS. Eight thousand dollars for 25 policies?

Mr. TROY. And she is the woman that had the stroke and was pressured, and that is why we chose that particular tape.

Mr. HALAMANDARIS. In the tapes that we have seen, some of the things that were pointed out, one of the agents obviously made a number of visits and in some cases they asked that the checks be made out to them as individuals rather than to the company. I see Miss McKeon nodding that that happened. "Make the check out to me" is a common abuse.

Secondly, we also heard about the agent coming around to pick up the cancelled checks so that nobody could nail him for defrauding old people. You are nodding your head in agreement that that happened. Then I guess we heard commonly that people were told that the purchase of these policies is a means around estate taxes. That is a common abuse. Then we heard of out and out forgery when one of the ladies on the tape admitted that she didn't sign that policy and that wasn't her signature.

Are there any other kinds of generic abuses that come to mind?

Miss MCKEON. The medical reports as shown on the applications never were right. I had just gotten out of the hospital with a full by-pass. He said I didn't have any high blood pressure, I didn't have this, I didn't have that, I hadn't seen a doctor recently.

Mr. HALAMANDARIS. All right, that is an abuse for the agent not to record your medical history correctly which could allow the company later on not to make payments.

Miss MCKEON. But he knew I had just gotten out of the hospital. I couldn't go out to pay him money.

Mr. TROY. That was very common to misstate the medical history because if they put it down correctly oftentimes the insurance company would refuse the policy, but also what was common, the insured would then have some sort of an ailment and the insurance company then would refuse to pay it.

Mr. HALAMANDARIS. I would like to say from our point of view this has been extraordinarily helpful. I want to commend you personally for the investigation that you conducted, Mr. Troy, and I know you had assistance from the Postal Service to help make the case.

Mr. TROY. Tremendous assistance.

Mr. HALAMANDARIS. The Postal Service is one of the best government agencies that we have found. I have been very, very sold on the Inspection Service and what they do. Our committee has been as well in Washington, and I would like to commend you, and I think we will turn the chair back over to the chairlady here, and perhaps in the interest of time we may want to go on to our next witness. Thank you very much.

Mrs. PINES. But we really appreciate your taking the time in bringing this very important information to this hearing. Thank you very much, Miss McKeon. We certainly hope that you will receive your check in August and that you will gain restitution. You have certainly been through a great deal, and we certainly hope that the Select Committee on Aging will be able to take appropriate action in this area.

Miss MCKEON. I am scared of agents now when they come to the door.

Mr. HALAMANDARIS Mr. Troy, may I ask for a copy of the tape? Do you have an extra of that you could send or perhaps a transcript that we could have entered in the record?

Mr. TROY. Sure. Can I send it along because this is our only copy right now.

Mr. HALAMANDARIS. Yes, please. Thank you.

[Material not received at time of publication.]

Mrs. PINES. We are very pleased that Assistant Attorney General John Montgomery, Chief of the Consumer Protection Division of the Commonwealth of Massachusetts, is with us this morning as well.

STATEMENT OF JOHN T. MONTGOMERY, ASSISTANT ATTORNEY GENERAL AND CHIEF OF THE CONSUMER PROTECTION DIVISION, COMMONWEALTH OF MASSACHUSETTS

Mr. MONTGOMERY. I want to thank you for inviting me to make a statement to you today. As you well know from the work that both the Federal Trade Commission and the Select Committee have done, the elderly are without doubt the single most vulnerable group to abuse in the marketplace in our society, and, with their limited and fixed incomes, they can least afford to be victimized by unscrupulous and insensitive businesses.

Unfortunately in the course of our law enforcement work, we find that the elderly are easy marks for those that choose to take advantage of them, and we congratulate both the Committee and the FTC for spearheading what we think is a belated government attention at both the federal and the state level to consumer problems of the elderly.

Attorney General Bellotti is charged in Massachusetts with the responsibility of enforcing the state consumer protection act which prohibits unfair and deceptive acts or practices. We have become all too familiar over the years with the variety of settings in which elderly consumers are victimized by unlawful practices, and we have seen the often devastating impact that these practices can have on elderly purchasers of goods and services.

I would like to provide the Committee today with characteristic examples of elderly consumer problems which we have discovered in the course of our enforcement efforts, concentrating on home improvement problems, work at home frauds, medical quackery and nursing home problems. We have compiled representative samples of pleadings and affidavits from a number of cases which hopefully will demonstrate to you the typical consumer problems that we think have occurred in Massachusetts.

[See appendix 1, p. 75 for material submitted by Mr. Montgomery.]

Mr. MONTGOMERY. First, with respect to home improvement, as the Committee knows, senior citizens who own their homes are frequently targets for unscrupulous home improvement contractors who overcharge for poor work or who do not perform the work at all, and the Consumer Protection Division in Massachusetts has filed law suits against numerous such contractors. For purposes of my statement today, I want to draw your attention to one case concluded last fall which serves, I think, as an unfortunate but poignant example. The case involves a Lowell, Massachusetts, roofing contractor who performed his services poorly for most of the consumers that he worked for and seriously overcharged a number of elderly consumers. He routinely failed to provide consumers with cost estimates prior to commencing work. He failed to provide notice of cancellation rights provided by both state and federal law. He performed his work in an extremely shoddy manner and, through apparent intimidation, imposed grossly unconscionable charges on a number of elderly citizens of Massachusetts.

At the time he performed the roofing services which are the subject of the affidavits that I am going to provide to you, he was the subject of an outstanding Superior Court injunction obtained by our office in 1977. In one instance, even under the threat of contempt on the violation of that Superior Court injunction, he worked on the home of a 75 year old Dorchester woman who lives alone with her epileptic son and mentally ill daughter. The contractor was engaged to repair a leaking skylight. He and his crew represented to her that other work was also needed on her roof and her chimney and was engaged to perform that work. After originally providing an estimate of $2,500, the contractor then informed the consumer at completion of the work that the bill was actually $2,900. He demanded immediate payment and offered kindly to

drive the consumer to the bank. At which time, she was told that the bill was actually $3,350.

Now in testimony in the course of subsequent contempt proceedings against the contractor for this and other violations of the injunction, an expert for the Attorney General stated that the fair market value of the work that was performed, and work performed, he said, in a shoddy manner, was actually $400, a difference of $2,950.

On another occasion, the same roofing contractor replaced portions of a slate roof of a 72 year old Waltham man with an angina condition without providing any cost estimate prior to commencing the work. The contractor informed the consumer at the completion of the job that the charge would be $18,000. Now, when the consumer out of a naiveté or fear informed him that he had only $16,000, the contractor, after consulation with his co-workers, reluctantly agreed to accept $16,500. The Attorney General's expert concluded, and I have provided his affidavit also, that the value of the work performed was $700.

Now, while the contractor was sentenced to a brief jail term for contempt of court and we continue our efforts to obtain restitution for the consumers who have been victimized by the contractor, it is unlikely in my view that the economic or the emotional damage caused by these unlawful business practices will be effectively repaired. Our experience suggests that elderly consumers because of age and physical infirmities will remain targets of unscrupulous home improvement contractors, and we concluded that it really is the responsibility of government to make concerted efforts to educate the elderly as to their legal rights and also provide improved and strong law enforcement efforts to combat this kind of pervasive crime against the elderly.

I would like to turn now to work at home schemes. I know that the Select Committee is certainly interested and has some experience with respect to that particular problem for the elderly, and I have described in my written statement the type of problems that occur in the course of work at home schemes which are particularly attractive to the elderly and to shut-ins. I won't go into any detail and will leave those remarks to my prepared statement. However, I would just like to say that the number of work at home schemes and other business opportunities that are advertised in newspapers and magazines is staggering. The Consumer Protection Division has developed a monitoring program for major local newspapers in Massachusetts, and I believe also that the Boston Regional Office of the Federal Trade Commission does monitor local newspapers in New England. Any advertisement which makes a claim for high earnings potential for this type of business receives a formal letter of inquiry from our office requiring verifying data, and a copy of this letter is also sent to the advertising editor of the newspaper that was the source of the ad. Now this investigative inquiry which is often sent only to a Post Office box is often sufficient to stop future advertisements and cuts off the problem right there. We believe—we not only believe, but we have observed a marked decrease since the monitoring program in the frequency of these ads in major daily newspapers in Massachusetts.

However, the primary source of this kind of advertising is in national, interstate publications, and we have neither the resources nor the jurisdiction to monitor national publications which contain the largest number of these ads. Now, since the work at home problem is national in scope, our experience indicates that only effective action by the federal government will be effective in eradicating this type of economic fraud against the elderly. I think the biggest problem is that the amount of money and sometimes, as a result, the amount of harm which results from any particular work at home scheme is often not high enough to generate interest of federal law enforcement authorities and sometimes even interest of state law enforcement authorities. I think an analysis has to be made of the aggregate impact of this kind of scheme on a vulnerable segment of society, that is the elderly, and a renewed effort and really a different approach, both federal and state, to work at home schemes has to be devised.

I would like to turn now to hearing aids, and I am going to mention hearing aids only briefly, and it presents a little different problem for us because I think we do have effective laws in Massachusetts to combat hearing aid fraud, but we are currently impeded by an uncharacteristic, I think, federal instrusion into our ability to enforce state law.

The elderly, as you know, are especially vulnerable to unfair practices in the sale of hearing aids. As might be expected, the elderly are, of course, the largest market for that product. In the course of numerous investigations and law suits by our office against hearing aid dealers, we have encountered many elderly consumers who have expended substantial amounts of money for hearing aids they do not need or from which they can derive no benefit. Now, one of the primary reasons for these problems is that potential hearing aid users are often not professionally evaluated prior to making a decision to purchase a hearing aid.

In response to this problem, the Massachusetts Legislature enacted a statute which requires a mandatory medical clearance examination and hearing tests prior to the purchase of a hearing aid. This statute permits a waiver of these requirements only for religious reasons. Now we have a serious enforcement problem which has developed, and which is different, as I think I indicated before, from that we have faced in most areas of elderly abuse because, unfortunately, under the authority of the medical device amendments of 1976, the Food and Drug Administration has issued a regulation which preempts the Massachusetts hearing aid statute by permitting a waiver of the hearing tests for any reason whatsoever. Now, we have found in the course of some investigations that 75 to 80 percent of the consumers who purchase hearing aids sign a waiver of the medical evaluation. We have applied for an exemption from preemption from the FDA along with approximately 20 other states, and last fall our applications were well denied. Now Massachusetts has challenged the preemptive affect of the FDA regulations in a suit that we filed a couple of months ago in federal district court, and, for your interest, I have provided a copy of the complaint in our materials.

On the subject of health quackery, I yesterday received a copy of the publication that the Select Committee on Aging put out last

fall, and I suspect perhaps you are far more familiar with the wide variety of health quackery devices that there are in the marketplace, and you are aware that health quackery—once an interesting sideshow in the medical marketplace—is now a multibillion dollar business. Untold numbers of consumers respond to the blandishments of quacks, and many have dissipated their savings, but, of course, even more importantly or more seriously, the victims of these schemes often allow their disease or disability to grow worse in reliance on quack remedies, and the number of people who have died in reliance on quack treatment I think is probably unknown.

One example of health quackery for which I can provide detailed documentation is the case of Interchurch Team Ministries which operated what was called the Still Waters Inn in Scituate, Massachusetts. Now until enjoined from engaging in the unlawful practice of medicine by the Massachusetts courts, Interchurch Team Ministries operated a business devoted to the treatment of physical ailments through nutritional remedies based upon the so-called theory of ionization developed by a man called Dr. Cary Reams who has been convicted of practicing medicine without a license in Georgia, Florida, Alabama and Virginia and, if I am not mistaken, was indicted for murder in California in connection with one of his schemes.

Now a number of the patients, and I use that term advisely, of Interchurch Team Ministries were elderly persons. In the course of our investigation of Interchurch prior to litigation, two investigators from our office were examined and diagnosed at the company offices. Each was diagnosed solely on the basis of urine and saliva tests. One investigator was told that he was in a major heart attack zone and could have a heart attack at any time. He was advised to purchase distilled water and to drink four ounces every hour. The other investigator was diagnosed as being in a zone for a minor heart attack and was having minerally deficient cells in a number of areas including the bladder and the kidneys. Each was encouraged at a cost of $250 a week to participate in a supervised program at the inn to fast, rest and change eating habits which are responsible for their present problems.

The former Chairman of the Harvard University Department of Nutrition, whose affidavit I have provided to you, testified or concluded in an affidavit that none of the tests performed on either our investigators or any of the consumers or elderly persons who went to Still Water could possibly be used to diagnose the supposed conditions. In addition, none of the treatment recommendations had any medical or nutritional value whatsoever and could not possibly prevent or treat the conditions attributed to our investigators. He concluded finally, and I quote, that

> The activities of Interchurch Team Ministries could be quite dangerous if, because of a diagnosis or treatment, one of the patients failed to consult a medical doctor about a serious ailment and that ailment was then left untreated or treated improperly.

We are currently devoting a lot of time to investigating a similar operation in Massachusetts, and we continue to fear that there are other operations that we don't know about. They are generally well financed and at least on the surface apparently very reputable.

I would like to turn now to the subject of nursing homes. We have spent a great deal of time in Massachusetts and certainly in the Attorney General's office addressing the problems of nursing home residents. We have enforced the consumer protection act in a number of cases where the elderly as purchasers of nursing services were being treated unfairly, and, in 1976, we promulgated nursing home regulations which, for the first time in the country, declared that nursing home patients were purchasers of goods and services and defined in detail certain rights for nursing home residents.

Elderly persons who reside in nursing homes are of course particularly dependent and vulnerable, and unfortunately we have seen on occasions that nursing homes utterly fail to provide proper service to elderly consumers. In the affidavit of a nurse employed by the Department of Public Health and submitted to the superior court in the course of one of our law suits, she describes one of the most serious situations which we have encountered, and I will beg your indulgence as I quote from that affidavit.

> I observed that the skilled nursing unit was odorous of urine. Patients had fecal and urine stained clothing and bodies. Several patients were lying in wet, urine soaked beds. Many patients had disheveled hair, dirty fingernails, dirty feet and lacked under garments. I observed patients with bed sores which resulted from a lack of proper skin care, lack of cleanliness, lack of proper positioning and changes of position, and inadequate supportive or preventive equipment. In addition to the poor patient care that I observed, I also noted poor housekeeping services. One patient's room had feces on the floor, while other patient rooms had pools of urine and/or food from previous meals littered on the floor.

This affidavit describes conditions in a nursing home which shockingly is in one of the wealthiest communities in Massachusetts and which contained a substantial number of private paying patients as opposed to Medicaid patients. Unfortunately, it is not an isolated example of neglect or abuse of the elderly. In the last five years, we have filed more than 12 patient abuse or neglect cases against Massachusetts nursing homes. The federal government through the Department of Health and Human Services is intimately involved in the day to day operation of nursing homes and has devised standards of certification for nursing homes as Medicare and Medicaid providers, and we often enforce these standards.

We urge this Committee to carefully consider as part of its focus on consumer abuse the affidavits and pleadings concerning nursing home abuse which are attached or submitted in connection with my remarks.

I have not included anything in my remarks on insurance. We have previously worked with the Select Committee on cancer insurance and Medigap insurance and have used the reports that have been issued by you as well as reports issued by the Federal Trade Commission, and we have also submitted copies of our complaints filed in superior court here in Massachusetts against Union Fidelity Life Insurance Company and American Income Life Insurance Company for the unfair and deceptive sale of their cancer insurance. I would merely like to say, having listened to the comments of Mr. Troy, that we believe that the problems in insurance, particularly insurance sales to the elderly, are perhaps more pervasive than in any other area. I believe that that is the case because we

have so long not devoted sufficient attention to the insurance industry or to the nature of the sales and marketing practices used by that industry.

In conclusion, we encourage your efforts to investigate and develop programs to combat consumer problems, and we stand ready to provide you with any additional information or instances of consumer abuse of the elderly. Thank you.

[The prepared statement of Mr. Montgomery follows:]

PREPARED STATEMENT OF ASSISTANT ATTORNEY GENERAL JOHN T. MONTGOMERY

My name is John T. Montgomery. I am an assistant attorney general and chief of the Consumer Protection Division in the Office of Attorney General Francis X. Bellotti.

The elderly are, without doubt, the single group most vulnerable to abuse in the marketplace. With limited, fixed incomes the elderly can least afford to be victimized by unscrupulous and insensitive businesses. Unfortunately, we find that the elderly are easy marks for those who choose to take advantage of them.

Attorney General Bellotti is charged with responsibility for enforcement of the state Consumer Protection Act, General Laws Chapter 93A, which prohibits unfair and deceptive acts or practices. We have become all too familiar over the years with the variety of settings in which elderly consumers are victimized by unlawful practices. And we have seen the often devastating impact that these practices can have on elderly purchasers of goods and services. I would like to provide the committee today with characteristic examples of elderly consumer problems which we have discovered in the course of our enforcement efforts, concentrating on home improvement, work-at-home fraud, hearing aids, medical quackery, and nursing home problems. We have also compiled representative samples of pleadings, and affidavits from a number of cases which demonstrate typical consumer problems of the elderly.

HOME IMPROVEMENT

Senior citizens who own their own homes are frequently targets for unscrupulous home improvement contractors who overcharge for poor work or who do not perform the work at all. The Consumer Protection Division has filed suit against numerous such contractors. A case concluded last fall serves as an unfortunate but poignant example.

The case involved a Lowell, Mass., roofing contractor who performed his services poorly for most consumers and seriously overcharged a number of elderly consumers. He routinely failed to provide consumers with cost estimates prior to commencing work, failed to provide notice of cancellation rights provided by state and federal law, performed his work in an extremely shoddy manner, and through apparent intimidation, imposed grossly unconscionable prices on consumers at the completion of the work. At the time he performed roofing services for the consumers whose affidavits have been provided to the Committee, the contractor was the subject of an outstanding Superior Court injunction obtained by the Attorney General in 1977.

In one instance, the contractor worked on the home of a 75-year-old Dorchester woman who lives with her epileptic son and mentally ill daughter. The contractor was engaged to repair a leaking skylight. The contractor and his crew represented to the elderly woman that work was also needed on portions of the roof and chimney. After originally providing an estimate of $2,500 for the work, the contractor informed the consumer at the completion of the work that the actual bill was $2,900. The contractor demanded immediate payment and drove the consumer to the bank at which time she was told that the bill was actually $3,350. In testimony in the course of subsequent contempt proceedings against the contractor for this and other violations of the injunction, an expert for the Attorney General stated that the fair market value for the work performed was $400, a difference of $2,950.

On another occasion the same roofing contractor replaced portions of a slate roof for a 72 year old Waltham man with an angina condition. Without providing any cost estimate prior to commencing the work, the contractor informed the consumer at the completion of the work that the charge would be $18,000. When the consumer informed him that he had only $16,000, the contractor, after consultation with his co-workers, "reluctantly" agreed to accept $16,500. The Attorney General's expert concluded that the total value of the work performed was $700.

While the contractor was sentenced to a brief jail term for contempt of court, and the Attorney General's Office continues its efforts to obtain restitution for the many consumers who have been victimized by this contractor, it is unlikely that the economic and emotional damage caused by his unlawful business practices will be effectively repaired.

Our experience suggests that elderly consumers, because of age and physical infirmities, will remain targets of unscrupulous home repair contractors. We conclude, therefore, that government should make efforts to educate the elderly as to their legal rights vis-a-vis home repair contractors and also provide a strong law enforcement effort to combat pervasive economic crime against the elderly.

WORK-AT-HOME SCHEMES

Work-at-home schemes are often attractive to elderly persons on fixed incomes as a means to earn extra money. This type of scheme generally involves the sale of a work at home service for which the promoter knows there is no demand. For example, a consumer may be sold a mail order business plan through which he or she can sell various products, with the promoter supplying mailing lists, envelopes, and product flyers. The scheme may involve the sale of an alleged money making system for addressing envelopes, labels, catalogues, etc., a work at home service the promoter well knows is in no demand in this age of automated mail preparation systems.

This type of scheme is commonly advertised in the business opportunities section of the classified ads, and often involves out of state companies located in glamour areas such as California. A typical ad may begin as follows: "Earn $5,000 part time; 10 to 15 hours per week. Invest only $1,950." Promoters will generally simulate accepted investment recruitment methods used by honest businesspeople until the money changes hands. Thereafter, the pretense of a continuing business relationship tends to evaporate in a series of excuses and outright refusals to acknowledge oral agreements and understandings. The success of these schemes generally depends on similar false assurances such as: huge profit potential through no more than part time efforts; full backing by a responsible company which, in truth may be a one of two man fly-by-night operation utilizing a telephone answering and mail receiving service; exclusive territorial rights which may later turn out to overlap with other purchasers; products of demonstrated public acceptance later found to be unknown to the buying public; and alleged assistance in obtaining sales locations and accounts.

The number of work-at-home and other business opportunities advertised in newspapers and magazines is staggering. The Consumer Protection Division has developed a monitoring program for major local newspapers in Massachusetts. Any advertisement which makes a claim for high earning potential for this type of business receives a formal letter of inquiry from the Attorney General requiring verifying data. A copy of the letter is also sent to the advertising newspaper. The investigative inquiry, often sent to a post office box, is often sufficient to stop future advertisements. This monitoring program has resulted in a marked decrease in the frequency of these ads in major daily newspapers in Massachusetts. However, we have neither the resources, nor the jurisdiction to monitor national publications which contain the largest number of these advertisements. Since the work-at-home problem is national in scope, our experience indicates that only action by the federal government will be effective in eradicating this type of economic fraud against the elderly. Without federal action, a state like Massachusetts can only force the fraud out of its state, and into another state.

HEARING AIDS

The elderly are especially vulnerable to unfair practices in sale of hearing aids. As might be expected, senior citizens provide the largest market for hearings aids. In the course of numerous investigations and law suits against hearing aid dealers by our office, we have encountered many elderly consumers who have expended substantial amounts of money for hearing aids they do not need or from which they cannot benefit. One of the primary reasons for these problems is that potential hearing aid users are often not professionally evaluated prior to the purchase of a hearing aid.

In response to this problem, Massachusetts enacted a statute, G.L. Chapter 93 Section 71 et seq., which requires a medical clearance examination and a hearing test prior to the purchase to the hearing aid. This statute permits a waiver of these requirements only for religious reasons. Unfortunately, under the authority of the Medical Device Amendments of 1976, the Food and Drug Administration has issued

a regulation which preempts the Massachusetts hearing aid statute by permitting a waiver of a hearing test for any reason whatsoever. We have found as many as 75 to 80 percent of the consumers who purchase hearing aids sign a waiver of the medical evalution. In October 1980 the FDA denied the Commonwealth's application for exemption from preemption submitted by the Attorney General. We have recently challenged the preemptive effect of the FDA regulation in a suit filed in Federal District Court in Massachusetts in February 1981.

HEALTH QUACKERY

Health quackery, once an interesting side show in the medical marketplace, has now become a multi-million dollar business. Untold numbers of consumer respond to the blandishments of mail-order quacks, and many have dissipated their savings in the hope of finding the cure. More seriously the victims of these schemes have often allowed their disease or disability to grow worse. The number of people who have died because they relied on quack treatment until it was too late for conventional therapy is unknown.

An example of health quackery for which I can provide detailed documentation is the case of Interchurch Team Ministries, Inc., which operated the Still Waters Inn in Scituate, Mass. Until enjoined from engaging in the practice of medicine by the Massachusetts Superior Court, Interchurch Team Ministries operated a business devoted to the treatment of physical ailments through nutritional remedies based upon the so-called theory of ionization developed by Dr. Carey Reams, who has been convicted of practicing medicine without a license in Georgia, Florida, Alabama, and Virginia. A number of the "patients" of Interchurch Team Ministries were elderly persons.

In the course of an investigation of Interchurch prior to litigation, two investigators from the Consumer Protection Division were examined and diagnosed at the company offices. Each was diagnosed solely on the basis of urine and saliva tests. One investigator was told that he was in a "major heart attack zone and could have a heart attack at any time." He was advised to purchase distilled water and to drink four ounces every hour. The other investigator was diagnosed as being "in the zone for a minor heart attack" and as having minerally deficient cells in a number of areas including the bladder and the kidneys. Each was encouraged at a cost of $250 a week to participate in a supervised program at the Still Waters Inn to "fast, rest, and change eating habits which are responsible for present problems."

The former chairman of the Harvard University Department of Nutrition, testifying in the course of litigation against Interchurch Team Ministries, concluded that none of the tests performed could possibly be used to diagnose the supposed conditions of the investigators. In addition, "none of the treatment recommendations have any medical or nutritional value whatsoever and cannot possibly prevent or treat the conditions attributed to the Attorney General's investigators." He concluded, finally, that "the activities [of Interchurch Team Ministries] could be quite dangerous if, because of a diagnosis or treatment, one of the patients failed to consult a medical doctor about a serious ailment, and that ailment was then left untreated or was treated improperly."

We are currently investigating an operation similar to Interchurch Team Ministries.

NURSING HOMES

The needs and problems of nursing home residents are of special concern to the Massachusetts Attorney General's Office. We have enforced the Consumer Protection Act in Massachusetts in cases where the elderly, as purchasers of nursing services, were being treated unfairly. In 1976, Attorney General Bellotti promulgated nursing home regulations which, for the first time in the nation, declared that nursing home patients were purchasers of goods and services and defined in detail certain rights for nursing home patients.

Elderly persons who reside in nursing homes are particularly dependent and vulnerable. Unfortunately, we have seen on occasions that nursing homes utterly failed to provide proper service to elderly consumers. The affidavit of a nurse employed by the Department of Public Health describes one of the most serious situations we have encountered:

"I observed that the . . . skilled nursing unit was odorous of urine. Patients had fecal and urine stained clothing and bodies. Several patients were lying in wet, urine-soaked beds. Many patients had disheveled hair, dirty fingernails, dirty feet and lacked undergarments. I observed patients with bedsores (decubiti) which result from lack of proper skin care, lack of cleanliness, lack of proper positioning and

changes of position and inadequate supportive or preventive equipment. In addition to the poor patient care that I observed, I also noted poor housekeeping services. One patient's room had feces on the floor while other patient rooms had pools of urine and/or food from previous meals littering the floor."

This affidavit describes conditions in a nursing home in one of the wealthiest Massachusetts communities. Unfortunately, it is not an isolated example of neglect or abuse of the elderly. In the last five years, this department has filed more than twelve patient abuse or neglect cases. The federal government, through the Department of Health and Human Services, is intimately involved in the day to day operation of nursing homes. Standards for certification of nursing homes as Medicare and Medicaid providers are devised by the federal government, and often enforced by our office. We urge the committee to carefully consider the affidavits and pleadings concerning nursing home patient abuse which are attached to these remarks. Nursing homes are a major area where the elderly infirm and often helpless, look to the federal government not only for the Medicare or Medicaid funds to pay for their care, but also for regulations and enforcement action to protect the nursing home patient from abuse, mistreatment or neglect.

In conclusion, we encourage your efforts to investigate and develop programs to combat consumer problems of the elderly. Attorney General Bellotti's Office stands ready to provide the committee with whatever further information it requires regarding the consumers frauds highlighted in my remarks today.

Mrs. PINES. Thank you very much. When you think of the subject of frauds against the elderly, what kinds of abuses are most common and most serious from your point of view?

Mr. MONTGOMERY. I think first, in terms of the priorities we set in our office, that nursing home problems are perhaps the number one priority because they threaten the life and safety of elderly consumers. Next to that I think that we often look to certainly other medical problems, and then we are concerned most about consumer problems, such as home improvement problems, more insurance problems which involve basic necessities of either security, psychological security for future medical payments as well as keeping a roof over your head, and, where substantical amounts of money are being expended on services such as that, we think that the problems in those areas are the most serious.

Mrs. PINES. How serious are the jurisdictional problems with regard to the interstate aspects of some of these abuses?

Mr. MONTGOMERY. That varies, of course, from area to area. In terms of work at home frauds, the jurisdictional problems are insurmountable with respect to a large number of the kinds of problems that we see. We, I think, are literally powerless to do anything about the national advertising that comes in the variety of publications that elderly consumers receive.

With respect to home improvement fraud, I don't think that the jurisdictional problems are serious at all. On occasion there are jurisdictional problems, particularly in a small state like Massachusetts where we have a New Hampshire or a Rhode Island company, but those problems are not insurmountable.

If I could just add, I think that our biggest problem in some of these areas is, of course, limited resources which we all suffer from.

Mrs. PINES. Would you have any recommendation with regard to how we might better deal with some of these problems? If the various attorneys general on a state by state basis can't take action because of the jurisdictional problems, what would you recommend?

Mr. MONTGOMERY. First of all, I think that we need a different approach for different problems. As a matter of fact to start again with the nursing home area, I think that there needs to be a broad

re-examination of the relationship between nursing homes and their patients, and I think it is an area which is appropriate for some type of sweeping federal omnibus legislation creating federal rights of action enforceable by private individuals as well as by state and local or federal and state law enforcement agencies, similar to the Civil Rights Act, housing discrimination, age discrimination. I think there needs to be a nursing home rights bill. In areas such as home improvement——

Mrs. PINES. Excuse me. Before you go on, is there anything that you think the various states can do on an individual basis in this area? Would you recommend the same kind of legislation to be adopted by each of the states in New England? Would that be of assistance to you as a law enforcement agency on a state basis?

Mr. MONTGOMERY. Well, it certainly would be of some assistance. Massachusetts, however, I think probably has not entirely adequate but at least minimally adequate laws. We have the consumer protection act. We do have, as of last year, what is called the patient abuse statute in Massachusetts, and we probably have an adequate legislative statutory basis to protect nursing home patients. We are, however, inhibited by a lack of resources. In addition to that, I think that private persons are inhibited by a lack of incentives and in some instances a lack of jurisdictional standing to protect themselves. In some instances, or actually I would say, in most instances, the government is really the only protector in Masschusetts. So in Massachusetts, I would agree that we are in need of some private enforcement capabilities for nursing home residents and their families.

Mrs. PINES. Do you think that HHS would deter action because of the jurisdictional overlap? Would we have a problem in terms of promulgating standards or passing legislation in Massachusetts because of the imposition of federal regulations?

Mr. MONTGOMERY. In my view, no, as long as the federal regulations were not designed to preempt state enforcement. I think what we need in this area is the kind of—because the problems are so pervasive, is the kind of dual enforcement that we have with the FTC and state attorneys general on the more common unfair and deceptive trade practices. I think that kind of cooperation is certainly possible. In fact it is probably likely if it is designed to work in that way.

Mr. HALAMANDARIS. Can you tell me a little bit about the state Medicaid fraud unit? Am I correct that it is part of your office?

Mr. MONTGOMERY. It is part of our office. I am not sure that I am really capable of commenting too much on their work.

Mr. HALAMANDARIS. I was just interested in some sort of a reaction, whether you think that was a good idea initially for the Congress to fund the 90 percent funding?

Mr. MONTGOMERY. I certainly can't comment on how well Medicaid fraud units across the Country have worked. I know that our office thinks that ours has been very effective. They worked very hard. I think that it is the kind of approach, whether on a 90 percent basis or some other percentage basis that can work in a number of areas that are, in the judgment of some, local problems, and I think that kind of approach, I was going to suggest if you asked, that that is the kind of approach that might work in other

areas of consumer fraud like home improvement problems which really do seem to be primarily local.

Mr. HALAMANDARIS. You are anticipating my question because, as you know, in Washington there is a mood now to turn everything over to the state. We have the block grant proposals. I suggest that if we do that, if we turn tremendous lump sums of money over to the state, it is going to make the problem of fraud and abuse much worse than it is. One of the things that I have been toying with is legislation which would broaden the scope of the jurisdiction of the Medicaid fraud units to encompass all kinds of fraud and to set aside a set percentage of whatever block grants we are talking about. Assuming that the state of Massachusetts gets a block grant of a hundred million dollars, then I think the Congress should mandate that one percent of that amount be set aside for purposes of ferreting out fraud and abuse. In other words, I think there should be a direct index based on the amount of the block grant. Do you think that is a sensible approach?

Mr. MONTGOMERY. I certainly think it is sensible for the Congress which I think, at least certainly in areas like this, has a perspective on these problems which is perhaps more comprehensive than we sometimes have at the state level to mandate the allocations of these funds for certain types of enforcement efforts.

Mr. HALAMANDARIS. I have one last question, and that is, has there been any disposition of the suits that were brought by the Attorney General's office against various insurance companies to recoup the funds, either in your cancer investigation?

Mr. MONTGOMERY. In the cancer cases, the litigation is ongoing. I don't expect that we will reach any resolution in those cases for some time. They are extremely active. Some portions of the Union Fidelity case are now up on appeal for some procedural reasons, and we are engaged actively in discovery, and I am really hopeful that we might be able to try that case perhaps by the end of the year or maybe early next year.

Mr. HALAMANDARIS. Thank you.

Mrs. PINES. I want to express my personal thanks to you, John. It has been a particularly useful and I think effective relationship that the FTC and the Massachusetts Attorney General's office has had over the past two and a half years, and I am particularly grateful on a personal basis to you for your efforts as the Chief of the Consumer Protection Division in working with us.

Mr. MONTGOMERY. Thank you. I agree, and I hope it can continue in the coming years.

Mrs. PINES. Thank you. We have with us Eva Hester who is the Legislative Liaison for the Massachusetts Department of Elder Affairs. Eva, do you want to make a statement at this time?

Miss HESTER. Madam Chairman, I think it would be better if we submit a statement. The department has been working in these areas that you have been talking about all morning, and we are very much interested and very happy to have you here doing this important work. We would like to tell you what we are doing. We are involved in many of these areas, particularly in the nursing home areas, the health areas, as well as fraud. Practically everything you have talked about has been, and is, a concern of our department. So, with your permission, we will submit a statement

of what we are doing, and certainly hope that we will have the cooperation of the federal government in the area.

Mrs. Pines. We will be delighted to receive your written testimony which will become part of the record of today's hearing. Thank you very much for joining us.

[The prepared statement follows:]

PREPARED STATEMENT OF THOMAS H. D. MAHONEY, PH. D., SECRETARY, MASSACHUSETTS DEPARTMENT OF ELDER AFFAIRS

It gives me pleasure to submit to the Select Committee on Aging of the House and the Regional Office of the Federal Trade Commission this statement of activities of the Massachusetts Department of Elder Affairs regarding our continuing concern and responsibility in protecting the rights of the elder citizens of the Commonwealth against fraud.

As Secretary of the Department, I have given priority to traveling throughout the Commonwealth to make personal visits in our network of agencies serving elders, including the Councils on Aging, Senior Centers, Home Care Corporations, Nursing Homes, Congregate and Elderly Housing Units and Nutrition Sites, this have given me the opportunity to meet individual elders under a wide variety of circumstances and to hear directly from them concerning their problems. More specifically in the subject areas of your hearing today, namely nursing homes, hearing aids, housing repairs, health insurance and fraud via the mails; the Department has been directly active in all with the exception of only limited involvement to date on the mails. We have established an Elder Rights Review Committee, headed by the legal counsel of the Department, which has focused primarily on the rights of the elderly in regards to medical, social and other scientific research. The Committee is charged with safeguarding the rights of individuals and yet encouraging the continuation of essential research. The investigations of this committee have included public announcements and advertising for the purposes of recruitment of elder participants in research projects, including such recruitment through the mails.

In 1977 the Department played a leading role in the participation of the development, promotion and implementation of legislation resulting in Chapter 353 of the Laws of 1978 on the sale of hearing aids. The Law defines hearing test evaluation and qualified professionals; requirement of medical clearance for sale of hearing aids and restriction of medical professionals from selling hearing aids.

In the area of housing repairs our focus has been on weatherization and insulation through the Energy program. Here we have worked in conjunction with the Department of Energy and the Executive Office of Communities and Development on the issues of quality home energy audits and weatherization services for conservation.

Another example of quality assurance is the technical assistance liaison established by the Berkshire County Area Agency with the Center for Ecological Technology, a non-profit educational research organization serving many of the cities and towns of that county. Requests for information concerning contract services for home improvement for energy conservation were referred to this technical resource.

In the area of Health Insurance, the Department has been working closely with the Insurance Commission over the last few years to inform and educate elders and to develop more effective brochures and easy-to-read literature regarding insurance frauds and high pressure tactics to sell unnecessary or duplicative insurance coverage.

In 1979 the Commissioner of Insurance promulgated Regulation Number 211 C.M.R. 47 under the principle authority of Chapter 175, Section 108 and 110E to protect the public against the duplication and or a purchase of specific disease insurance policies. This regulation standardized non-group Medicare supplement policies in the Commonwealth. The 47 regulation does not apply to Health Maintenance Organizations (HMO's) insurance plans for the elderly.

In 1980 the Commissioner of Insurance promulgated Regulation Number C.M.R. 32 under the principle authority of Chapter 176D, Section 11. The purpose of this regulation is threefold:

1. Require insurers to deliver to buyers of Life Insurance information which will improve the buyer's ability to select the most appropriate plan of Life Insurance for his needs.

2. Improve the buyer's understanding of basic features of the policy which has been purchased or is under consideration (a summary of policy).

3. To improve the ability of the buyer to evaluate the relative cost of similar plans of Life Insurance.

In the June issue of the Department's Newsletter which is sent to some 4500 elders throughout the Commonwealth, I highlighted the need to regulate the Medigap insurance programs.

Staff of the Department have also participated in a number of Community Education programs, which have examined the full scope of problems, services and needs in this area.

The Department has a special unit within the Office of Advocacy to investigate and resolve complaints arising in nursing homes. This is the Long Term Care Ombudsman project headed by the State Ombudsman. This special unit, a component of the Older American Advocacy Assistance Program, recently investigated and is attempting to resolve a complaint which was received from seven elderly nursing home patients, alleging that their personal needs allowances (amounting to approximately $25,000) were unaccounted for. However, through the efforts of the Department, the owner/administrator after a series of meetings and letters eventually admitted to using the patients' funds for operating expenses and although promised to make restitution, the owner failed to do so. Thus, this case has been brought to the attention of the office of the Attorney General and the Sanctions Unit of the Department of Public Welfare.

Miss HESTER. I would like to introduce Margaret Clemons who is the Assistant Secretary of the Department Advocacy and who is probably the most well informed person in the network on the various issues.

Mrs. PINES. Thank you very much. We are delighted that you could join us.

Donald Becker who is at the present time an attorney, a private attorney here in the Commonwealth of Massachusetts, was the former staff counsellor for the Massachusetts Division of Insurance. We are pleased that he is going to be joining us this morning.

STATEMENT OF DONALD L. BECKER, ESQ., FORMER STAFF COUNSEL, MASSACHUSETTS DIVISION OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS

Mr. BECKER. I appreciate the opportunity to speak before you this morning as a private attorney and as a former member of the legal staff of the Massachusetts Division of Insurance concerned about abuses and fraud in the sale of insurance to elderly persons. I will be brief as I understand that you have to leave for Springfield shortly.

Starting in June of 1977, the division started receiving information concerning high pressure sales to elderly people by a number of insurance agents and brokers in the Springfield area. The Division's Special Investigation Unit under the direction of Martin Kelley thereupon undertook an examination of the books and records of these agents and brokers to ascertain the nature and extent of their apparently illegal activities.

As a result of this investigation, the Division commenced an action in February of 1978 for the revocation or suspension of licenses and for the imposition of fines. Seventeen days of hearings were held between July 17 and November 15, 1979. The voluminous evidence which is set forth in the brief which I have just given you and which I am offering as an exhibit in this hearing showed that the respondents were engaged over a number of years in a pervasive pattern of violations of the insurance laws and regulations of Massachusetts, violations which impacted severely to the detriment of elderly people purchasing health insurance protection in the

Commonwealth. These violations were the subject of the criminal prosecutions to which Paul Troy has already testified and also were the subject of a settlement recently entered into by the Attorney General's office for restitution of premiums to the elderly victims.

When the respondents realized in July of 1977 that the Division was looking into their activities, they commenced a concerted effort to obscure their activities and to obstruct the Division's investigation. This effort included their refusal to provide the Division's examiners information pertaining to their insurance business and the destruction of records. Nevertheless, the Division was able to obtain a great deal of information from various sources, primarily policy holders and insurance companies. This information revealed a multi-faceted, complex and conscious scheme by the respondents to circumvent the regulatory authority of the Division and the insurance laws and regulations of the Commonwealth.

The violations involved included misrepresentations regarding the nature and cost of policy coverages and included within the representations were twisting elderly people from adequate coverages they already carried for years into new coverages which cost more for less protection, misrepresentations regarding the effective dates of coverages, misrepresentations regarding insureds' needs for coverages, and that included loading and the sales of worthless coverages. One elderly victim in a period of just under two years paid an amount that we calculated at $18,897.55 for insurance coverage to the agents and brokers working for Marquis. Miss McKeon who testified earlier this morning spent, in a period of just under three years, an amount of $13,637.

Premium overcharges were involved as well in the misrepresentations. In addition, there were forgeries of applicants' signatures on applications which we have heard testimony about earlier, failing to forward claims information to companies, failing to cancel unwanted policies, falsification and omission of information on applications, failing to deliver policies to insureds, taking policies and premium payment records from insureds, confusing insureds about their coverages and premiums and using extreme pressure.

The respondents' scheme constituted actually a conspiracy to engage in the acts alleged in the Division's complaint. They were all related contractually through various general and subagency agreements with insurance companies, and several of them are related by blood or marriage.

On April 13, 1981, the hearing officer issued his decision which I have also offered as an exhibit revoking the licenses of seven of the respondents and imposing fines totaling $73,000. The respondents' standard of conduct was to use any method, whether legal or illegal, that they thought necessary to maximize their insurance sales. Their victims were and continue to be a large number of vulnerable elderly people whose trust the respondents abused for their own illegal purposes.

I would strongly recommend to this hearing the need for further investigative and enforcement resources in order to address the problems that are involved with these abuses. Thank you.

[Materials submitted by Mr. Becker retained in committee files.]

Mrs. PINES. Thank you. We very much appreciate your coming here this morning. As I am sure you know, Mr. Becker, the Federal

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Trade Commission, absent a specific request from the Congress, is not permitted to investigate insurance issues. I am sure, however, that the House Select Committee on Aging will review this material very closely and consider making recommendations to the Congress for action.

Mr. BECKER. If you need further copies of the brief, by the way, which really is sort of a bible of all of the possible abuses that are involved with elderly insurance fraud, I would be happy to provide further copies.

Mrs. PINES. Thank you very much.

Mr. HALAMANDARIS. May I just say that I would like to commend you, Mr. Becker. You and I have corresponded previously. I think I told you in my letter that it was an excellent piece of work that you put together. I would agree with your statement that this brief is kind of a seminal report, a bible to be used by other prosecutors that are involved in similar cases. I commend you because of that effort, and others who follow you will now be able to use this for the same thing that you did. I commend you for appearing here today.

Mr. BECKER. Thank you.

Mrs. PINES. We are pleased to enter into the record a Legislative Research Council Report on Criminal and Fraudulent Victimization of the Elderly. It has been presented to this hearing by Thomas R. Asci, of the Legislative Research Bureau of 11 Beacon Street, Boston, and we will review it and certainly include it as a piece of the official record.

[See appendix 2, p. 129 for report.]

Mrs. PINES. We very much appreciate your joining us this morning. We anticipate that there will be additional hearings, and we would hope that you will feel free to communicate with Val Halamandaris, Deputy Staff Counsel for the House Select Committee on the Aging or with myself at the Boston office of the Federal Trade Commission.

Thank you.

[Whereupon, at 11:35 o'clock a.m., the hearing was adjourned, to reconvene that same afternoon at Springfield, Mass.]

AFTERNOON SESSION

SPRINGFIELD CITY HALL,
Springfield, Mass.

Mr. MARKEL. My name is Bob Markel, a Springfield City Councilor. I have been asked to introduce our principal guest today who is Lois Pines, the Regional Director of the New England office of the Federal Trade Commission. Miss Pines is going to be conducting a hearing this afternoon regarding fraud against the elderly which is certainly a topic that is of great interest for many. It is a topic which I think needs to be discussed particularly in this city where we have had a number of incidents and problems. It seems as though it is a problem which is growing as the onset of economic problems of this kind of activity seems to be a natural by-product.

Let me just say that I am very happy to have Mrs. Pines here in the Federal Trade Commission hearing and I hope you will join me in welcoming her.

OPENING STATEMENT OF LOIS PINES, REGIONAL DIRECTOR, NEW ENGLAND OFFICE, FEDERAL TRADE COMMISSION

Mrs. PINES. Thank you very much, Bob. I am pleased to have the opportunity to be here in Springfield. Unfortunately, the traffic was a little bit more than we anticipated, so we apologize for getting started late.

The remarks that I am going to make represent only the views of the Federal Trade Commission staff. They are not intended to be construed as representative of official Commission policy or the views of any individual commissioner of the Federal Trade Commission.

Today's hearings on frauds against the elderly are not pleasant ones for us to hold. It is not pleasant to learn of swindles of the most vulnerable segment of our society, our elderly. It is not pleasant to learn of Massachusetts senior citizens who are sold land in Florida only to find that it is under water nor is it fun to hear about a 93 year old woman who gets sold maternity insurance. It is far from pleasant to hear about work-at-home schemes and phony home repairs perpetrated against the elderly by unscrupulous sales people who take the money and run. It is not pleasant nor fun to learn of nursing home evictions when patients simply run out of money or of double billings by nursing homes, of over pricing of medical devices such as eyeglasses, hearing aids and dentures which are desperately needed by nine tenths of our elderly community, but this is a hearing that we think desperately needs to be held. The Federal Trade Commission and the House Select Committee on Aging are committed to taking necessary action to correct the kinds of swindles and rackets against the Nation's twenty four million elderly citizens by those who are just out to make a buck. The outrage that we all feel together today I hope will be a spur to a national outcry for action.

Todays hearings which were initiated in Boston and will be completed today in Springfield will be only the opening session of hearings in New England on this very important subject. We're already planning another session in Hartford.

I am particularly grateful to the staff of the House Select Committee on Aging for joining us and appreciative of Congressman Claude Pepper's efforts to help us conduct these hearings today. The Federal Trade Commission in general and my office in particular, namely the Boston or New England office of the FTC has had a strong interest in protecting the rights of the elderly over the past several years. Our office has become identified as the place where a consumer can go for action and I am pleased to say that we have been able to resolve thousands of complaints of elder citizens satisfactorily. Further, our staff has been making an aggressive effort to stay in touch with senior citizens as well as consumer groups throughout the New England area in order to learn what is happening and to try to identify what we as an agency can do to address the problems that have been identified and are being identified. What we have learned after years of investigating complaints and launching investigations is that senior citizens are frequent targets. They constitute 11 percent of our population, but comprise a disproportionate percentage of those who are victimized by swindles of all kinds.

The U.S. Postal Service estimates that 60 percent of all medical quackery perpetrated through the mails has been targeted at senior citizens.

The Commission has taken action in a number of these areas important to our Nation's elderly. Hearing aids, for example. The FTC has conducted an extensive investigation of sales practices in the hearing aid industry. Among the misrepresentations frequently complained of by senior citizens are claims that:

Aids can actually halt or retard the progression of hearing loss, and aids can be prescribed like eye glasses.

To deter questionable sales techniques in the hearing aid industry, the Federal Trade Commission staff has recommended that the Commission adopt a trade regulation rule in this area to better protect the elderly. In the area of business opportunity ripoffs, senior citizens have recently been bombarded by sales pitches to withdraw their savings from low interest passbook accounts to invest their money in high return investments. At a time of double digit inflation, it is a pitch that is all too often persuasive. A variety of investments in gold, vending machines or farmers cooperatives are proposed. Not surprisingly, these schemes in many instances turn out to be frauds. The gold may not exist at all. The cooperative may be nothing but a paper shell and the vending machines which the senior citizens are told are pure profit either don't exist, don't work or are placed in places so out of the way that they generally are of absolutely no worth.

INTERSTATE LAND FRAUD

The FTC is currently investigating a number of land fraud sale cases where apparently worthless land has been sold to senior citizens, often at an exorbitant price. Unfortunately, such schemes are all too common.

FUNERAL SERVICES

Even in death, senior citizens are frequently victimized. At a time when they are particularly vulnerable, senior citizens, upon the death of one of their relatives, must make detailed funeral arrangements. Frequently they are quoted one price only to receive a bill which is double or triple what they expect. These and other abuses are being addressed by the Federal Trade Commission as it completes its consideration on the Funeral Rule.

INSURANCE

The Federal Trade Commission has issued several reports related to various aspects of insurance plans sold primarily to the elderly. In particular, we expect that the staff report which is entitled "Private Health Insurance to Supplement Medicare," will be of great help to the states in this country in identifying and addressing financial abuses in the field of insurance.

HOME AND AUTOMOBILE REPAIR SCHEMES

Our office has received innumerable complaints over the years by senior citizens who have been victimized by repair people. A most common example is the claim that an automobile ran fine until it was repaired and the repairs were not professionally made. We recently received a complaint from a senior citizen who was told his furnace needed expensive repairs only to learn that no repairs were needed and in fact he had been swindled. Then there is the senior citizen who purchased aluminum siding for several thousand dollars. Unfortunately, despite payment in full the contractor disappeared after completing only one side of the house.

Nursing homes are supposed to provide care and protection, but all too often, they come to represent pain and degradation. Many senior citizens see nursing homes as not only synonymous with death but also with the notion of protracted suffering prior to death. The FTC has been conducting an investigation to see what can be done to protect the rights of nursing home patients. In far too many instances, many protections available to those patients on Medicaid or Medicare are not available to private patients.

MEDICAL QUACKERY

Well, there is no crueler racket in the world than the practice of those people who hold out hope while picking the pockets of the desperate. Those who are guilty of this should be prosecuted to the fullest extent of the law.

WORK-AT-HOME SCHEMES

Our office has received complaints daily from senior citizens who have been attracted by ads that tell them that they can earn thousands of dollars in the comfort and privacy of their own home by stuffing envelopes or growing earth worms for market. Unfortunately the senior citizen usually winds up with tons of earth worms or stuffed envelopes for which there is no market. In the mean-

time, the senior citizen have paid hundreds of dollars for the privilege of being ripped off.

Well, as we can see from the list that I have just articulated, the elderly are all too often victims of fraud. Fraud is visited upon them in many different forms through many different schemes perpetrated by many different kinds of con men. What these con men have in common is a lack of respect for the elderly and the aberrational consciousless compulsion to separate them from their hard earned dollars. As we have learned, con men sometimes pass the names of the elderly onto others because they can be easily victimized. These so called goose or go-for lists are common. The go-for is one that will go for anything and a goose is someone who is easily plucked.

It is easy to see that all of us have our work cut out for us. Senior citizens have made this country what it is today. They deserve our help and our protection and we must find ways to work together to weed out the con men who are victimizing the aged at every turn. I very much pledge my efforts to make sure that this happens. I sincerely hope that our hearing here in Springfield will lead to more initiatives and more enforcement by the Federal Trade Commission where that is appropriate and where necessary, new reform legislation on both the State and Federal levels.

Joining me today is Val Halamandaris, Senior Council of the Select Committee on Aging, and we're delighted to be here and look forward to hearing from you to help us target where we ought to be doing more to protect the elderly. Also with us today is Bob Weiner, former Staff Director of the Select Committee on Aging who is now a resident in the Springfield area; and Russ Nusome who has been exceedingly helpful to us in the setting up of this particular hearing.

Mr. Benjamin, would you begin?

Mr. Benjamin is an Elderly Unit Attorney with Western Massachusetts Legal Services and we are very appreciative of his presentation as well and the presentations of the rest of the people here.

STATEMENT OF PETER BENJAMIN, ELDERLY UNIT ATTORNEY, WESTERN MASSACHUSETTS LEGAL SERVICES

Mr. BENJAMIN. It is a pleasure to be here to have an opportunity to talk about a few of these problems. Obviously in my capacity serving elderly people in the legal area, I get just about every problem that you mentioned in your opening statement. We have the land sales, the home improvements, the car repairs, all of it; and obviously, I can't address all of those things.

I would like to highlight just a few of the particular problems that either we see a lot of or that are particularly serious and that need to be dealt with.

First of all, you mentioned in your opening remarks nursing homes and some of the many problems that exist there. I would like to talk for a minute about a case that I have just been dealing with in the past few weeks, and it does, to some extent, point up what you said about the fact that private paying patients in some ways are not in as good a position as people who receive Medicare and Medicaid.

There was a lady 87 years old paying about $1,500 a month in a nursing home and very comfortable, a good mursing home, was happy there. Her roommate left and the nursing home wanted the room for a couple and told the woman that she would be moved to another wing of the nursing home with different staff, different residents there with her, a whole new environment at the age of 87. When the woman's family resisted this move, the nursing home told her all right, if you are not going to cooperate, you can find another place to go and threatened, and we were'nt sure whether they were kidding, to send the woman to her daughter's house in an ambulance and let the daughter deal with it. Fortunately, we here in Massachusetts do have some very good regulations promulgated by the Attorney General on nursing homes and in particular, on transfer and discharge, and we were able to make clear to the nursing home that the consequences to them of taking the action that they proposed might be very serious, and they have not made any attempt to discharge or to transfer the woman, but it was a very, very close case and I only shudder to think how many like it never come to our attention and how many of them end up with elderly people dying as a result of things like that. That is one area that obviously needs to be dealt with.

Health insurance has, of course, been a focus of a great deal of attention in recent months and years, and again, Massachusetts has done some things that I think could be, in many ways, a model for other states or perhaps even for the Federal government. Whether they are likely to be getting involved in that, I don't know, but I don't know how many people I have seen who were overinsured, who were misinsured, people who were sold policies that they just don't need.

I have had people in their 80's living on supplemental security income on three hundred ninety five dollars a month covered by Medicare, covered my Medicaid, shelling out thirty and forty dollars a month for supplementary health insurance that won't get them anything that they don't already have.

Also, a great deal of duplicative coverage, people with two, three, four policies. I have had people come into my office with a stack eight inches high of all of their health insurance policies, spending enormous amounts of money, money that they need to pay their rent and to buy clothing and to eat, and they are spending all of this money on health insurance that they don't need. They may need one policy, but as we all know, insurance policies have coordination of benefits provisions, so that nobody is going to get paid four times for the same thing, but there is nothing that prevents them from paying the same premium four times.

The cancer policies, the dread disease policies, we have seen all of these kinds of things. Massachusetts now, as I said, has set some very strict limits on what can be sold as a medicare supplement for medigap policies and could well serve as a model for other parts of the country.

Perhaps the most frequent problem that I see occurs in the area of double billing or illegal billing. I don't think a week goes by that I don't have a client come into my office or call me on the telephone who is being billed by a provider or being dunned by a collection agency, sometime with phone calls at various hours of

the day and night or even being sued on a bill for which they are not legally obligated. These bills are almost always covered or would be covered or maybe are being covered by third party reimbursement sources.

Let me give you a couple of examples. Mr. S is a gentleman in his 60's who was hospitalized for open heart surgery after a very serious heart attack. He had Medicaid coverage which would reimburse the hospital for his care. Probably though inadvertence, through one can never be sure, the hospital didn't bill Medicaid. Instead, the client came into my office with a $27,000 bill. This is a man living on under $400 a month in income, and to be honest with you, I wish that I was a doctor rather than a lawyer because I always thought the man was going to have another heart attack in my office over this bill. That may have been inadvertent.

The case of Mrs. C, a lady well up in her 80's was clearly not inadvertence. This lady had cataract surgery and required cataract glasses. She went with her prescription and her Medicaid card to a local optician here in Springfield, and the Medicaid program here in Massachusetts will pay for some types of cataract glasses and won't pay for other cataract glasses. The lady made it very clear to the optician that she had Medicaid and expected the Medicaid program to pay for her eyeglasses. Without telling this lady what he was doing, the optician chose a type that Medicaid did not cover. Not only were the glasses not suited for Mrs. C, but she was billed several hundred dollars for these glasses because he couldn't bill Medicaid for glasses that were not covered under the program.

Finally, one other lady who was in a hospital for a few weeks and then went into a nursing home; again, only for a few weeks. It was not a long-term care situation, just a convalescent time. This lady also had Medicare and Medicaid which would cover all of her nursing home bills. She was ready to leave the hospital. Her doctor discharged her. The only problem was the nursing home said you can't go until you pay us this seven hundred dollars that you owe us. Mrs. C said, but I have Medicaid. They said well, we haven't gotten paid by them yet and as soon as we do, we'll give you back your seven hundred dollars. Clearly illegal under Federal law, under Federal regulation, but what was Mrs. C going to do? She could pay the bill or she could not get out of the nursing home.

Fortunately, all of these people we were able to resolve the problems, but I don't know how many of them don't come to me, and the people that I represent, the elderly people, are people who have gone through their life working very hard to pay their bills. They don't want to let things go unpaid if they owe them, and these kinds of unscrupulous operators will bill people and will dunn people and will sue people, and people in their 70's and 80's will go without food to pay bills that they never should have gotten, and I think if there is one area among all these many problems that could use some concentration, that is where I would like to see it. Thank you.

Mrs. PINES. We appreciate your comments, Mr. Benjamin. Speaking for myself personally, it is gratifying to know that there are people such as yourself in the legal services area here in the western part of the state who are fighting to protect our elderly, and I am certainly very concerned about the proposed cutbacks in

the funding of that, and I would hope that those people who are receiving services from you fully understand the benefits that they receive.

Mr. BENJAMIN. I hope so too, thank you.

Mrs. PINES. Next will be Mr. Paul Edwards, A National Vice Chairman of the Citizens Commission on Pension Policy as well as the Publicity Chairman for the Springfield Gray Panthers, and with him is Ed Johnston who is the founder of the Springfield Gray Panthers, and you can decide which order you would like to make your presentation.

STATEMENT OF PAUL EDWARDS, NATIONAL VICE CHAIRMAN, CITIZENS COMMISSION ON PENSION POLICY; AND PUBLICITY CHAIRMAN, SPRINGFIELD GRAY PANTHERS

Mr. EDWARDS. My name is Paul Edwards. Ed Johnston is generally a very good follow man and takes up where I leave off, so we will proceed that way.

First of all, my briefcase is missing with all my notes, so I will do the best I can by memory and if there are any specific points of specific data or references to specific persons or whatever, I can augment this at a later date in writing or by mail.

Mrs. PINES. You should feel free to submit testimony to us and it will be printed as part of the record.

Mr. EDWARDS. First of all, from the perspective of the retirement income scenario, just recently, our committee testified in front of Claude Pepper's group with regards to the citizen's viewpoint on the overall impact of the retirement income system. A lot of people are overlooking today the attempts by the Reaganites such as Mr. Stockman who is trying to divy up a few extra bills for defense funds. A lot of people are missing the fact that much of this was started already with the Carter administration. Many of the proposals that are coming forward right now came from the President's Commission on Pension Policy which came from President Carter's Commission.

I personally feel that the area of fraud has no greater magnitude for the elderly than retirement income. There are people who are either retiring now or who are about to retire, people who have contributed to the system with its private pensions or Social Security, what have you, and may find themselves without the type of funds they anticipated or had been promised. They had assumed that they would be taken care of in old age. Although less than half of all those now covered under the privates pension assistance will ever collect less than half, people still feel that they have something coming from retirement today. This is why the system is so full of holes. It ought to be better called the system that very few will actually collect from. There are warnings on pack of cigarettes telling them that it will be dangerous to their health if they partake in this, and yet there are no warnings when people go into the private sector of the retirement income system.

One of the most important things that I feel is outrageous is the fact that the people who are left behind have no recourse or no hope whatsoever until just very recently. Congressman Howard Wolpe from Michigan has just introduced legislation to provide these individuals, over a hundred thousand, with some kind of

relief, and that effort was started here in Springfield, Massachusetts.

Another matter which I think is very important has to do with the nursing home situation. The Gray Panthers in Springfield got very heavily involved with two nursing homes that were trying to evict, I believe it was, 180 individuals because their financial resources had diminished to a point where they were now on Medicaid.

One of the most gross examples is not from that situation but from another nursing home. Can you possibly believe this? A person who is 85 years old—she is 87 now—was literally shipped from her nursing home to a hospital and then reshipped out of state against her will, heavily sedated, literally kidnapped. This was brought to my attention. I in turn got the Department of Elder Affairs involved, Mr. Donovan who in turn had a representative, Reverend Alcott who represented the interested parties, and we had meetings here with other individuals from the community. Yet it took months, literally months, to get this woman back into the Springfield area. The only reason was that she did not have a place to go around here. They did not have available space. That was their reason, but I ask you why and how come an individual, because they reach a certain magic age such as 65 or whatever and are put in a nursing home, lose all their rights. I couldn't find one agency person around here who would give me an answer as to how somebody can lose their rights. Do you realize the trauma this person went through? She is not senile, was not senile. Difficult maybe, but not senile. She has very serious physical problems, but the fact remains is that she was shipped out of this state, and I was told by one of the operators of a nursing home in the area that this goes on quite often. People from Massachusetts have been shipped to Rhode Island, to New York. I am dumbfounded that this is happening and I believe it is continuing to happen, so if your committee can do one very positive thing, it is getting into this area.

When I was out at a conference in Maryland of the Gray Panthers, their nursing home group told me that this is going on across the country. In the Midwest, this has happened also. The isolation that is caused by a person being shipped across state lines, the problems of other family members getting to this party are enormous, let alone the individual trauma that that person experiences.

At this point, I want to turn this over to Ed if he wants to say anything further.

STATEMENT OF ED JOHNSTON, FOUNDER, SPRINGFIELD GRAY PANTHERS

Mr. JOHNSTON. In the nursing home field, we are very concerned about someone who is told that he has no rights but started a pension effort. They are the pension losers. The fact is that a congre[illegible]man had entered into the Congressional record that these people are left without any rights or any recourse, and I questioned then and I question now, how can any American, proven American, be without any rights and be without any recourse?

Where we are today is there is a bill in Congress right now to take care of pension losers. There has been a great deal of activity from the populace when they read articles in the National Council of Senior Citizens, a newspaper, and the AARP, and responses have come in, we're told, in droves, five thousand, from every state, I believe, but Utah. If such a response can come from two organizations' comments on what they published in their magazine, I am sure everybody would be surprised at what would happen if this could get national coverage in every paper in the country; and why not? Isn't it news? Thank you.

Mrs. PINES. Thank you very much. Next is Mr. Markham, a citizen of Northampton and a retired professor of History at NYU. Please feel free to improve on my introductions.

STATEMENT OF GEORGE F. MARKHAM, SECRETARY, NORTHAMPTON ELDERLY AMERICANS

Mr. MARKHAM. I am not going to try to question the accuracy, but what I am here for or the reason I am here is because I am one of the founders and secretary of an advocacy organization of the elderly in Northampton, the Northampton Elderly Americans, and while I was coming down here, aside from casting a vote for Lois Pines again, I have felt that while I don't question the sincerity of the Committees, these things have been going on for a long time and the introductory remarks of the Director indicate that there is no secret to what is happening in these various areas.

I would like to testify first in the form of reading a letter from one of the people that is one of the protectors, in a sense, of the elderly in Franklin and Hampshire Counties, Joan Weston who is the Director of the Consumer Protection Agency which works under the District Attorney's office and covers Franklin and Hampshire counties. I would like to read her letter first which is addressed to the House Committee on Aging and the New England Regional FTC Hearing:

> I submit for your consideration a copy of my testimony presented before a Hearing Officer of the Food and Drug Administration, Department of Health, Education and Welfare on October 16, 1979, in Boston supporting exemption for Massachusetts from the FDA Rules and Regulations governing the sale of hearing aid devices. Because the FDA found against exemption, all of my remarks on that earlier occasion are sadly still valid and describe the most frequent problem this office encounters on behalf of the elderly. I would like to point out that Massachusetts is not the only state seeking preemption from the permissive FDA rules: Florida, Kentucky, Maine, Minnesota, Rhode Island and Wisconsin have similarly requested preemption and been denied.
>
> Please don't think this is a trivial concern. Hearing aids are expensive, especially when sold by door to door hustlers or at so called hearing clinics. Our cases show that the cost from sales promoters average twice that of units purchased through dispensing clinics. And hearing aids are not covered by Medicare.
>
> If this group is really looking for ways to eliminate rapacious business practices directed particularly against the older population, you cannot start more directly than by strengthening the FDA regulations or persuading the FDA to grant exemptions to states enacting tougher legislation.

She appended to this testimony of October 16, 1979, testimony of March 16, 1977, before the Joint Health Committee of the Massachusetts Legislature and some other evidence.

[Material submitted by Mr. Markham follows:]

THE COMMONWEALTH OF MASSACHUSETTS,
OFFICE OF THE DISTRICT ATTORNEY,
Northampton, Mass., May 20, 1981.

To: Joint Hearings: House Committee on Aging, Northeastern Regional FTC, Springfield, Mass., May 20, 1981.
From: Joan Sammel Weston, Director, Consumer Protection Hampshire and Franklin Counties.

I submit for your consideration a copy of my testimony presented before a Hearing Officer of the Food and Drug Administration, Department of Health, Education & Welfare, on October 16, 1979, in Boston, supporting exemption for Massachusetts from FDA Rules & Regulations governing the sale of hearing aid devices. Because the FDA found against exemption, all of my remarks on that earlier occasion are sadly still valid and describe the most frequent problem this office encounters on behalf of the elderly. I would like to point out that Massachusetts is not the only state seeking preemption from the permissive FDA rules: Florida, Kentucky, Maine, Minnesota, Rhode Island, and Wisconsin have similarly requestion preemption and been denied.

Please don't think this a trivial concern: hearing aids are expensive, especially when sold by door-to-door hustlers or at so-called hearing clinics. Our cases show that the cost from sales promoters average twice that of units purchased through dispensing clinics. And hearing aids are not covered by Medicare.

If this group is really looking for ways to eliminate rapacious business practices directed particularly against the older population, you cannot start more directly than by strengthening the FDA regulations or persuading the FDA to grant exemption to states enacting tougher legislation.

Appended: Testimony of October 16, 1979; testimony of March 16, 1977 before Joint Health Committee, Massachusetts Legislature; sections 71, 72, & 73 Massachusetts General Laws; and clipping from Hampshire Gazette, February 25, 1981.

Respectfully submitted.

JOAN SAMMEL WESTON.

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE DISTRICT ATTORNEY,
Northampton, Mass., October 16, 1979.

Re Docket No. 77 P 0222—Hearing aids.

To: Department of Health, Education and Welfare, Food and Drug Administration.
From: Joan Sammel Weston, Director, Consumer Protection Agency Hampshire and Franklin Counties.

I am the director of the Consumer Protection Agency of Franklin and Hampshire Counties, a division of the District Attorney's office for the Northwestern District of Massachusetts. I am here to speak in support of the audiological-test requirement of § 72 of Massachusetts General Laws chapter 93. First I would like to characterize my district and the audiological facilities available to our residents.

Franklin County is a mainly rural area with about twenty small towns and one main town—Greenfield, which has full audiological services through Franklin County Public Hospital. No place in Franklin County is more than about twenty-five mile from Greenfield. Futhermore, at the eastern edge, people are also quite close to Worcester with its full services. Franklin County Public Hospital Audiological Clinic charges $16.00 for a basic audiogram, $21.75 if written report is to be sent to the consumer's physician. The Clinic fits and dispenses hearing aids. Evaluations are made with models from five to six manufacturers. The total cost for testing, fitting, and the aid itself is $325.00. While there is no specific price reduction for elderly or low-income consumers, the business office regularly arranges confortable payment schedules.

Hampshire County is somewhat smaller but more populous than Franklin, also with about twenty small towns central to which is the Amherst-Northampton nexus with two full audiological facilities: the nationally-distinguished Clark School for the Deaf in Northampton and the Communications Disorders Clinic of the University of Massachusetts in Amherst. No part of the county is more than twenty miles from one or the other of these. And again, residents in the eastern part are quite close to Worcester and in the south and west to either Pittsfield or Springfield, each of which has full service.

The Clark School Clinic is open to everyone; the waiting period for appointments is rarely longer than two weeks. The Clinic is closed during the month of August. The Clinic is a Medicaid-approved facility; for clients not Medicaid-eligible, standard

private rates apply. In addition, the Clinic has a sliding scale for lower-income patients. Complete initial evaluation at Clark costs $26.00. The Clark Clinic does not dispense aids but recommends the kind of aid indicated by the evaluation which the client can then order through a local dealer.

The University of Massachusetts Communications Disorders Clinic, located on the campus in Amherst, is open to everyone. Testing is by appointment, normally with a two-week during the academic year. During University recesses the Clinic schedule is somewhat limited. There is no charge. The Clinic does not dispense or prescribe aids but will recommend the suitable type—glasses, body, earmold, etc., and may lend instruments for trial.

So the hearing-test required by the Massachusetts statute will pose no geographical or economic hardship. Indeed, when we were drafting the bill we studied just this distribution and cost of services to be sure that the testing requirement would not work to the disadvantage of people with hearing difficulties.

Quite the contrary. In the five years that my agency has been in operation we have had numerous hearing-aid complaints, all from elderly consumers, all but one of which involved aids from the only exclusively hearing-aid company active in our area. I think it is significant that in every case involving this company the cost has exceeded the $325 inclusive price charged by Franklin County Public Hospital, frequently by about three times that amount. Our two most recent cases are typically illustrative, the first of the kind of misfitting which can result from untrained testing and the second of the kind of high-pressure sales to which a customer is subject when the salesperson and the tester are one.

First the case of an elderly man in Hampshire County who four years ago, on the basis of a door-to-door promotion—"someone told us you are hard to hearing"—bought a binaural set for about $900. In order to get service or batteries for this set he had to go all the way to their branch store in Greenfield or their main store in Springfield. Eventually the Greenfield store was closed and after a time another branch opened in Holyoke. In the spring of this year he went to Holyoke for service and was persuaded to buy a new, "better" set, this for about $800. The ear molds for this set were never comfortable, performance was intermittent, and the sound level went up and down. None of the service adjustments corrected any of these problems. When the consumer came to my office hoping for some kind of refund, he was advised to go to the Clark School Clinic for an evaluation (a copy of which I submit with these remarks). Briefly, the report shows that the aids provided insufficient gain but when the gain was increased it exceeded the consumer's tolerance. The intermittent performance was caused by crimps in the coupling tubing. A thorough clinical evaluation as required by the Massachusetts statute would have prevented these difficulties: it would have found his reduced discrimination on the left side and the tolerance difficulties in both ears, for each of which problems the particular set sold to him is inappropriate according to the report. And in the kind of follow-up routinely practiced by any audiologist or competent dealer, the crimped tubing would have been immediately obvious. (This consumer's woes are further complicated by the fact that since he bought the second set, the company has been sold so it may be impossible to secure any refund short of suing the former owner.)

The second of these two recent cases might also have been avoided had the consumer been tested by a licensed audiologist prior to ordering aids. The hearing-aid company of which I have been speaking has, over the years, arranged so-called hearing clinics in conjunction with bona fide blood-pressure clinics offered from time to time in the various towns in our counties. The post cards announcing these clinics give the clear impression that the hearing clinic is, like the blood-pressure tests, offered under the auspices of the town. (I am including such a card along with an affidavit from the consumer whose case I am recounting.) One such card was put into his post box (these cards are never cancelled or post-marked) announcing tests in Williamsburg even though he is a resident of Cummington. He and his wife were given blood-pressure tests nonetheless and then they took the hearing test offered in the next room. When this preliminary test indicated some hearing loss, the salesman arranged to perform more tests at the man's home. After that test, and I quote, "he asked me if I was going to see a doctor. I said that I had no plans to do so, and he gave me a card to sign. I did not notice what the card said. I just signed it and gave it back to him." He signed a contract for the purchase of two aids for $549 each, $1,099 total, which the salesman marked "paid in full." Again quoting from the affidavit: "I noticed this and told him that I couldn't come up with that much money all at once. He explained that he needed it to be paid in full before he left because some old people have died before paying. I said that maybe I could cash in one of my Agway stocks but that I didn't know how long that would take. He suggested that I call Agway to find out. I did, they informed me that if I sent it in to the Syracuse office right away that a check could be sent to me by the end of the

following week. I relayed this . . . and he instructed me to make a check out for the full amount and to date it July 28 . . . by which time I should get the money to cover it. He told me to circle the date on the check so that his office girls (sic) would notice it and not cash the check until then. He did not give me a copy of the contract nor was anything said about my having any time to cancel it."

Fortunately this consumer was able to stop payment on the check and cancel the contract and plans now to be tested at the Clark School before buying another hearing aid or aids. Our double purpose in drafting the statute as we did with the audiological test requirement was to assure the hard of hearing, particularly the elderly, the benefits of modern, skilled testing and evaluation techniques widely available to them and to protect them from the high-pressure, high-priced sales to which our numerous case studies showed them to be particularly susceptible. I cannot see how a manufacturer of marketable hearing aids, that is to say, aids which are technologically acceptable and not unconscionably high priced, has anything to fear from our statute. Nor can I see why the State must take any special notice or protect in any way the interest of manufacturers or dealers whose products cannot satisfy these two essentials.

Thank you.

JOAN SAMMEL WESTON.

COMMONWEALTH OF MASSACHUSETTS,
OFFICE OF THE DISTRICT ATTORNEY,
Northampton, Mass., March 16, 1977.

Re S-72H-2775: An Act Regulating the Sale of Hearing Aids.

To: Members of the Joint Health Care Committee.

From: Joan Weston, Director, Consumer Protection Agency.

Hearing aids and hearing-aid sales give rise to by far the greatest number of consumer problems among the elderly in our District, more than home improvement contracts or health-insurance promotions. And every hearing-aid case we have had has concerned an elderly consumer.

Our cases and the practices involved fall into familiar patterns. One is the so-called hearing clinic which is offered as a free community service under the implied aegis of the federal government or of the benevolent association whose hall is hired for the occasion. The promoters invariably represent themselves as being qualified in some way or other to administer hearing tests and judge the results. We consider any sale resulting from these clinics as tainted: the initial contact has been secured by deception. If we are asked for help in connection with such a sale we can always have it cancelled. The problem is all the cases we never hear about. The sales promotional hearing clinic would be virtually eliminated by the proposed legislation.

Another of the frequent practices is more insidious. What typically occurs is that the elderly customer is not satisfied with the instrument he or she had purchased either recently or a number of months ago. The salesman will respond to the call and offer to adjust the set in some way or another, sometimes sending it to the factory, sometimes adjusting it in the customer's home. After several such helpful episodes, the salesman will say that the consumer really needs a newly-developed model or, very frequently, a new *pair* of instruments at considerable additional expense, usually with very little allowance on the original set. For instance, in October 1974 our client bought a single aid for $389. From time to time he complained to the salesman who finally suggested another test. In December 1975 after testing, the salesman recommended binaural aids for $899 with a trade-in allowance of $80 on the original set. The proposed legislation would virtually eliminate this practice as well.

The worst aspect of course is improper fitting such as my very first but prototypical case: that of an elderly gentleman in Easthampton who was tested and sold a $450 aid in his home. The aid made him very uncomfortable and seemed to him to blur anything beyond single conversation. I arranged for him to be tested at the Speech and Hearing Clinic at the University of Massachusetts. The results showed the ear mold to be wretchedly ill-fitting and the aid fitted to the wrong ear! We have had a spate of cases where professional testing subsequent to a door-to-door sale showed no need for an aid. And the reverse of that, the hearing-impaired person who is led to expect vast improvement but where none can result from the kind of set sold.

Generally hearing aid cases are delightful for consumer protection staff: the violations are usually transparent and egregious. We have been able to settle every one which has come to us either by cancelling of contract, return of deposit, refund

of all or most of purchase price, replacement of unit at no charge, etc. But we get only a fraction of the actual violations, not to mention of the misfittings. We hear only from those elderly citizens who are fairly combative or whose problem is referred to us by a relative or social worker or home-care person. We cannot help the vastly greater number of elderly people whose poorly-fitted or useless aids are stuck away in closets or whose contracts never come under scrutiny. The great advantage of S-72/H-2775 is that it will protect the elderly community from improper sales pressures and at the same time assure them of the benefits of the many technologically excellent aids available to them.

REGULATION OF THE SALE OF HEARING AIDS [NEW]

§ 71. Definitions

As used in sections seventy-two to seventy-five, inclusive, the following words shall have the following meanings:

"Audiologist", a person who has at a minimum a master's degree in audiology and a minimum of three hundred hours of supervised practical training, and meets the requirements of the American Speech and Hearing Association certificate of clinical competence in audiology.

"Hearing aid", an electronic instrument or device worn on the human body for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments or accessories, but excluding batteries, cords and earmolds; provided, that equipment devices and attachments offered by a public utility company and used in conjunction with its services shall not be included within this definition.

"Hearing test evaluation", a written statement from a physician, audiologist or otolaryngologist, prepared in triplicate, based on testing conducted by such physician, audiologist, or otolaryngologist that includes the following information: the ear or ears to be fitted and the date of the hearing test.

"Person", an individual, partnership, association, organization or corporation.

"Physician", a person licensed in the commonwealth in accordance with the provisions of section two of chapter one hundred and twelve.

"Otolaryngologist", a physician licensed in the commonwealth who specializes in medical problems of the ear, nose and throat, and who is eligible for qualification by the American Board of Otolaryngology as an otolaryngologist.

"Sell" or "sale", a transfer of title to a hearing aid or transfer of the right to possession of a hearing aid by sales contract, lease, bailment, loan or any other means, excluding wholesale transactions of dealers and distributors.

"Medical clearance", a written statement, from a physician or otolaryngologist, prepared in triplicate, based on a medical examination by such physician or otolaryngologist, that concludes that the prospective purchaser has been examined, that the physician or otolaryngologist has determined that the prospective purchaser is a candidate for a hearing aid and that there are no medical conditions to contraindicate the use of a hearing aid. Such statement shall include the date of the medical clearance, and whether or not the person, at the time of the medical examination, owns or uses a hearing aid for the designated ear.

Added by St. 1977, c. 978, § 1. Amended by St. 1978, c. 353, § 1.

1977 Enactment. St. 1977, c. 978, § 1, was approved Jan. 11, 1978.

1978 Amendment. St. 1978, c. 353, § 1, approved July 8, 1978, inserted "the following" and deleted "regarding" following "information" in the definition of "Hearing test evaluation".

§ 72. Purchases and sales of hearing aids, prerequisites

No person shall enter into a contract for the sale of or sell a hearing aid unless within the preceding six months the prospective purchaser has first obtained a medical clearance and then a hearing test evaluation.

No person shall sell a hearing aid not conforming to the hearing test evaluation required by this section without written approval from the physician, audiologist or otolaryngologist involved.

No person except a person whose religious beliefs preclude consultation with a physician may waive the requirement of either a medical clearance or a hearing test evaluation.

This section shall not apply to the replacement of an identical hearing aid within three years of the date that the purchaser received the hearing aid.

Added by St. 1977, c. 978, § 1. Amended by St. 1978, c. 353, § 2.

1977 Enactment. St. 1977, c. 978, § 1, was approved Jan. 11, 1978.

Section 2, as amended by St. 1978, c. 353, §4, provided: "A person over eighteen years of age who, on the effective date of this act, owns or is using a hearing aid for a designated ear shall not be required to obtain a hearing test evaluation pursuant to section seventy-two of chapter ninety-three of the General Laws, added by section one of this act, provided that the hearing aid being purchased is for the same ear."

1978 Amendment. St. 1978, c. 353, §2, approved July 8, 1978, inserted "first" and "then" in the first sentence of the first paragraph.

§73. Conflict of interests; inducement to influence recommendation of purchase

No physician, otolaryngologist, or audiologist acting pursuant to section seventy-two shall sell hearing aids or have a direct or indirect membership, employment, co-ownership, or proprietary interest in or with a business which fits and sells hearing aids; provided, that this restriction shall not apply to a non-profit or charitable organization, clinic, hospital or health care facility.

No person directly or indirectly shall give or offer to give or permit or cause to be given money or anything of value to a physician, otolaryngologist or audiologist as an inducement to influence the recommendation of the purchase of a hearing aid.

Nothing in this section shall prevent a physician, otolaryngologist or audiologist as an inducement to influence the recommendation of the purchase of a hearing aid.

Nothing in this section shall prevent a physician, audiologist, or otolaryngologist from suggesting a specific make and model of a hearing aid.

Added by St. 1977, c. 978, §1. Amended by St. 1978, c. 353, §3.

1977 Enactment. St. 1977, c. 978, §1, was approved Jan. 11. 1978.

1978 Amendment. St. 1978, c. 353, §3, approved by July 8, 1978, inserted "acting pursuant to section seventy-two" in the first paragraph.

AG LAWSUIT FILED AGAINST FEDERAL REGULATIONS

BOSTON (AP).—A suit against the U.S. Food and Drug Administration, challenging its recent decision barring enforcement of a Massachusetts law that requires a medical evaluation prior to sale of a hearing aid, has been filed by Attorney General Francis X. Bellotti.

The 1977 law was intended to curb widespread abuse in the sale of hearing aids to the elderly, according to a statement from Bellotti's office Tuesday.

The state law says the medical evaluation may not be waived except for religious reasons, but the FDA regulations allow consumers to waive the evaluation for any reason.

Bellotti said consumers frequently "spend large sums of money for hearing aids they do not need. Many of them are elderly consumers on fixed incomes."

The complaint was filed in U.S. District Court in Boston.

Mr. MARKHAM. So that a year and a half goes by and we're still where we were then, and I don't think it is necessary that this be a futile exercise today. I guess I am enough of a cynic to think that it is going to require a good deal more than the House Committee and the regional office of the FTC to really make a change. One of the reasons that I feel it is difficult to make the change is that while the Director was reading her initial statement at the hearing, if you just took the word elderly out, it fit because we are a ripoff society and it is only that the elderly are a more vulnerable section that they merit special consideration today here by your body.

Our organization has had some problems over the years with the nursing home question. For instance, the problem of nursing homes simply rejecting people who are on Medicaid instead of on a more profitable arrangement. We have had a problem with one of the large nursing homes in Northampton that they are accepting people from New York state because the rates are higher there, and the Cooley Dickenson Hospital has complained publicly about this. Cooley Dickenson Hospital cannot get people transferred to that nursing home out of the hospital, so that the financial cost of medical care is increased by such practices. There is a tendency by

many nursing homes to reject people who they consider heavy care patients, people that are going to be some kind of a problem in taking care of.

There is also a problem that we have encountered in a somewhat more modest fashion that was spoken of by the Gray Panther representative, the denial of ordinary citizenship rights. This same nursing home, one of our largest modern ones in Northampton, refused to allow circulation of petitions to the mayor among the patients. Now while it is a simple denial of citizenship, it is also a serious attack on their mental and physical health as well.

I think that if there are a few areas that I would suggest as reform where changing might be made, one would be action on the proposal of Jean Weston that the idea that the Federal government preempts this area and cannot allow stricter State standards to prevail. That is an obvious step there. I think furthermore that Federal sanctions on nursing homes could be increased and tightened up because the Federal government is a major financier of the homes through Medicaid and Medicare. As far as our experience in Northampton goes, regardless of the kinds of legislation that are passed, the kinds of regulations that are brought forward, the presence of area legal service, in our case, the Western Massachusetts Legal Service, is the best guarantee that some progress will be made there. We have problems with people being admitted or being rejected from nursing homes, but the only way that this can be kept track of, really, is through the skill of the Legal Services office, and they have been very effective, but as we know, it is one of the things that is labeled for the guillotine.

Finally, I would say that because of the extensiveness of this problem in all the areas affecting health, that if there is going to be a real change, that all of these leaches that are living off of the health of the American people should be eliminated and a clear cut system of national health service such as the Dellums Bill, which is perhaps the more extreme form but at least is going as far as Canada for the national health program, be adopted. Until that is done, there will be a constant problem of ripping off of people in the health program area and particularly for the elderly.

Mrs. PINES. I would like to ask whether you think the Massachusetts nursing homes regulations are adequate?

Mr. MARKHAM. Well, if the regulations were lived up to, there would be an improvement and the only way they are lived up to is by enforcement.

Mrs. PINES. So that there is inadequate enforcement, in your opinion, in that area?

Mr. MARKHAM. I think so. A weakness in it is the lack of an adequate operation, and the Legal Services can do that, but I think State provision for that would make a difference.

Mrs. PINES. Who would you recommend to provide that function?

Mr. MARKHAM. Well, I think coming out of the DA's office would be the most effective solution simply because that somehow when word comes down from the DA, that wields a great deal of pressure on people.

Mrs. PINES. Has the District Attorney in your area been active in this arena?

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Mr. MARKHAM. Well, Jean Weston has been active in a variety of problems affecting the elderly. By and large, the whole problem with nursing homes, however, has been handled through the Legal Services office. They have done—you can't call it an ombudsman because an ombudsman would probably be active continually in a given area and not necessarily just enforcing the law.

Mrs. PINES. Mr. Benjamin, how would you respond to that? What would you think might be done to better enforce the regs that we have or for that matter, what would you recommend might be altered about the regulations to provide additional support at the State level?

Mr. BENJAMIN. I think that the regulations by and large are pretty good and that the question is largely one of enforcement. I think what we need in Massachusetts is a statutory ombudsman system that is more than a friendly visitor program, a system that is oriented toward advocacy for the rights of nursing home residents.

Mrs. PINES. Do you think that Federal legislation is needed and if so, what would you recommend?

Mr. BENJAMIN. I don't think that Federal legislation is necessarily needed. I think it could be done that way. There could be incentives through the Medicare or Medicaid programs which are the principal financiers of the nursing home industry to states which provide that sort of advocacy system, I think principally through the Medicaid program, especially because that is where the money is flowing to the state to encourage states to set up active and vigorous mechanisms for enforcing resident rights. Coupled with that, obviously, with the advocacy program, you need enforcement. I think it could be done locally at the DA level. The Attorney General's office in Massachusetts has done some very good work, but they don't have adequate staff to deal with more than the most extreme cases. We need—we simply need more people and more attention devoted to the problem.

Mrs. PINES. This is obviously a very critical area, and nursing home problems constitute one of the major areas in terms of abuse of the elderly, and I think that it is obvious to all of us that the answers are not simple and it was our hope in scheduling these hearings that we could help identify additional means of dealing with some of the problems so that people could have self-enforcement rights as opposed to always having to have a third party or enforcement agency intervene on their behalf. The Federal Trade Commission has worked over the years in tying to identify mechanisms which would allow people to self-enforce those rights that they do have. Perhaps that is not a reasonable remedy in this particular area, but it is obvious we have a problem that needs to be dealt with.

Mr. MARKHAM. If I may, for one moment, while self-enforcement is an excellent thing, with residents of nursing homes, you are really dealing with people who are in the most difficult position possible to enforce their own rights. People, because of their age, because of their frequent physical frailty, are extraordinarily vulnerable and they often fear for their own lives. They are unwilling to speak out for their own rights and you must have an active advocacy organization that is prepared to speak out for them.

Regarding the problem of unemployment compensation, the State power could carry them out. That would be helpful and the Federal government could have saved some power in that field. I think mainly it is a state problem.

Mr. EDWARDS. I hate to look a little frustrated, but I have eight young, healthy men under eighteen ready to go for tryouts for the state swimming team in Massachusetts. We have to leave at 3:30. We have to go to Boston very shortly, but I can't resist commenting very quickly on my friends' comments here who recognize the serious problems that are involved with the nursing homes. I have taken a much stronger viewpoint that there is definitely some Federal intervention and override, if you will, with regards to legislation such as the case I mentioned. I can't see any of the states individually preempting the kind of scenario of rushing across the state lines with a woman in an ambulance heavily sedated against her will and her child and her son-in-law going to visit her and lo and behold, there is an empty bed there. That is the only reason why they found out. It really is an incredible scenario being played out again and again. I definitely think Federal legislation is necessary in this area.

The Gray Panthers in Springfield got the House of Representatives Committee to establish hearings here in Springfield of two nursing homes who were attempting to evict 180 people, and I will tell you something, that lobby represented over 50 percent of the people that were here. The nursing home lobby is big business. Don't let anybody kid you. It is big business, big bucks involved. Within hours after the press release was made with regard to the Gray Panthers going to take whatever action necessary we had within our means, I got a telephone call from all the local directors of all those homes involved and his point was come on, Paul, let's talk. Now I have a private unlisted phone. It didn't stop him. A couple hours later, my phone was ringing. I am saying there is a very strong lobby, and for John Q in a nuring home particularly to fight this on his own, no way.

Mrs. PINES. Thank you very much.

Mr. EDWARDS. There was one other thing too before I forget. In Maryland for the last conference we had, there were a number of individual ladies particularly who made reference to—and I can't think of the name—the prosthesis where a person who has cancer, for example, of the breast and needed some from of prosthesis build up material and so forth, this was not covered and so therefore, this is some kind of legislation that would be under your jurisdiction.

Mrs. PINES. Well, on the State level, I know that we worked on this in the Commonwealth of Massachusetts; and certainly, it is very important.

Our second panel today would include Representative Francis LaPointe who is now the Director of Human Resources for the Western Massachusetts Department of Social Services, Joseph Roche, Chairman of the Springfield City Health Council and the Chief Health Planner of the Western Massachusetts Health Planning Council, Marge Vallone who is the Director of the Springfield City Council on Aging and Robert Gallant who is the Director of the Highland Valley Elder Services.

I am delighted to welcome you on behalf of the House Select Committee on Aging and the FTC. I have had the distinct pleasure of serving with Representative LaPointe and it gives me great pleasure to be in Springfield welcoming him. I think that we're very fortunate to have Representative LaPointe as the Director of Human Resources for the Department of Social Services and we would love to hear from you.

STATEMENT OF FRANCIS LaPOINTE, DIRECTOR OF HUMAN RESOURCES, WESTERN MASSACHUSETTS DEPARTMENT OF SOCIAL SERVICES

Mr. LAPOINTE. Thank you very much. You did have an opportunity to appear before my committee many times and served on Beacon Hill. It is a pleasure to reciprocate that process. Let me give you a sense of what I hope to do with this testimony; first, give you, the Commission, a sense of the Department of Social Services as it reflects on this, where they see the elderly as to how they are vulnerable and some examples of the kinds of misuse of the marketplace that we have found in terms of the elderly.

The Department of Social Services is designed to carry out the function of retaining family structures in the traditional family mode. As we all know, that structure has been changing over the past half century considerably. At one time, we found a very large family unit ranging from newborn all the way to the elderly in one home and that provided assistance and help to the elderly which no longer exists. Now we're finding the elderly alone and who very much rely even upon Federal and State governmental programs, sometimes for subsistence but many times just for that companionship and warmth function which does not exist because the elderly are very often alone in a home, away from families and away from friends or alone in apartments away from friends.

Elderly housing has been a very important factor in alleviating some of that because then they are able to work together, but they are very much alone in many cases.

We also find instances of elderly abuse. We're not hearing as much about elderly abuse, I think, as exists today. It is similar to what we didn't hear about child abuse ten years ago. It is just beginning to come to the surface. We do find instances of elderly abuse. What happens is that basically the elderly who are abused are afraid to report partially because of taboos which exist relative to families; secondly, because many times, the person who is doing the abusing is the person that the elderly person relies on for support and subsistence.

Then there is the other kind of fear and abuse which goes on and that is that an elderly person living alone is afraid of being robbed, so all those kinds of abuse occur and then on top of that, the thrust of this hearing occurs and we find what I call the merchants of greed are all in the market place and they prey like vultures on the elderly as a source of easy money and profit.

Let me give you four or five examples of those kind of things we have come across. An elderly woman living alone owning her own house in her 60's competent to live alone and take care of herself. Her husband is dead. The children have moved away significantly far enough from the neighborhood that they are not there all the

time to help her. Her roof needs to be replaced. They called in a contractor. The contractor says $5,000 to replace the roof. We're talking about an average ranch home. I think the dimensions might be 35 by 30, something of that sort, a small house, $5,000 to replace that roof. The woman knows no better and spends five thousand dollars to replace the roof.

In the case that I dealt with, the woman got to pay about $2,500 and then spoke with me because she couldn't pay the rest and we were able to arrange something with the company by indicating we thought that the profit was excessive and they agreed not to charge quite as much, but if she hadn't come to someone, she would have paid the $5,000 one way or another or they might have attached her home.

Another similar kind of situation, two elderly people in a home, both living, don't want to paint the house any more. It is a job to climb the ladder, so they decided, let's get aluminum siding. They had aluminum siding put on the house, making no specific agreement. They trusted the person that was going to put the aluminum siding on. The bill is $10,000. They didn't pay $10,000 for the home when they bought it and they don't have $10,000 to make the payment. They are under threat of attachment to their home. Again, a case which we were able to work out but which was the kind of thing we found.

An instance which occurred in my own family, an elderly woman bought a sewing machine and made an agreement with the salesperson that she would pay half down and in thirty days, pay interest free the balance. One week later, she received a booklet of payments from a loan company. The loan had been sold to a loan company. I don't think they would have done that unless this person was an elderly person. In that case, a few calls straightened it out very quickly. She paid it off the next week to get them off her back, but that loan was actually sold and that wouldn't happen if that person wasn't elderly.

I think the worst one I came across was two elderly people both well into their 70's had an agreement with one of their children to hold the mortgage on a property. That child or that adult child who held the property then secured a loan on the property with the mortgage held by the parents. Subsequent to that, the child did not pay the payments on the loan. The loan became in default. The parents then sold the property, making a settlement and moved off into elderly housing. They had approximately $4,000 in the bank after all the occurrences of that sale. The bank continually sued that elderly couple. They went to court four times trying to receive the amount of payment from that loan. First, they didn't have the full amount of that loan. Secondly, they were not responsible for it. Their lawyer told them they were not responsible for it. The bank continually brought them to court. Finally, they made an agreement. I objected to it, but they told me, look, we want to get this off our back, we can not continue to do this, we're tired of it and every time we go, we have to pay the lawyer anyhow. They had $4,000 in the bank. The bank settled for $3,000 of the $4,000 to get it off their back. It was a loan they had no responsibility for. If they had not been elderly, I don't think that would have happened. Those cases exist.

The second category which I would like to address next very briefly is the institutional abuse that has been mentioned here. One of the things that has not been mentioned, however, is the institutions which care for the elderly which are designed basically to make money, and the way to make money is to hire cheaper non-trained, non-qualified and non-experienced personnel. A case came to us just this week because it affected some elderly folks where a non-trained, very young woman was placed into a nursing home—not placed but went to a nursing home to work and was requested to perform a semi-medical function which she had no training for whatsoever. She had a source of recourse to that and that situation was also straightened out, but I think we need to know that institutional abuse comes from the fact that these nursing homes are there to make money and perhaps what you need to look into is the possibility of greater control of staffing and training for those individuals in those nursing homes. These are issues which have come before us which we're concerned about. I think these hearings are a very important first step toward making corrections in these kinds of abuses. It may be a long road, but this is a good step and I wish you well on your journey. Thank you.

[The prepared statement of Mr. LaPointe follows:]

PREPARED STATEMENT OF FRANCIS LAPOINTE, DIRECTOR OF HUMAN RESOURCES, WESTERN MASSACHUSETTS DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services in Massachusetts is mandated to carry out functions which will retain family structures in the traditional family mode.

That structure has changed over the past half century from a rural cohesive family ranging from newborn to elderly living together in one large home to a considerably splintered family which is many cases leaves the elderly members of a family alone in an apartment or home away from their children and for some, away from all relatives, friends and acquaintances who might offer support and guidance.

We find elderly alone and reliant upon government programs not necessarily for sustenance (though some must have that category of assistance), but for the necessary companionship and warmth critical for a functional and worthwhile life. This lonely existance is sad enough, but beyond that there are some elderly who are physically abused as are children abused in this society.

Little is known or heard of elderly abuse as compared to spousal or child abuse; elderly abuse is presently at the point where child abuse was 10 years ago. It is occurring, but few are willing to report these violent acts because of fear of further acts of violence and because elderly who are abused generally are reliant upon the individual who is inflicting the punishment for support and sustenance.

Fear and abuse constantly haunt the lonely elderly person whether from persons who are responsible for them or intruders into their homes who frighten and rob them.

Beyond all of this, elderly who in some cases have little enough to eat are sold devices and services which range from contraceptive devices to unneeded insurance policies.

The merchants of greed prey like vultures upon the elderly as a source of easy money and profit. In the early seventies, the book, "The Dark Side of the Marketplace", by a U.S. Senator, told of elderly persons who were swindled out of the home through loans as small as $500.

Cancer insurance policies are sold as if the policy will prevent cancer. So-called cover all health policies are sold when little or no coverage is actually afforded. Patterns are defined by the merchants of greed in that in wealthy suburbs such as Longmeadow, they will sell burglar alarms to frightened elderly citizens and in areas of lesser income, they sell insurance policies which cost less using the old adage that you get what you can from the marketplace.

Institutional abuse must also be considered when one studies the problems of the elderly in this society. Institutions are designed to make money, therefore it is cheaper to hire non-trained, non-qualified personnel to carry our functions rather than train and or hire those with background and skills to service elderly institutions. In institutions, dignity is an important issue and it raises varied emotional

issues of life value and reason for existence in the minds of the elderly who reside in institutions which are controlled in some cases by greed rather than need.

Present budget decisions could keep elderly away from Home Care meals, lunch programs, etc. which bring them in contact with the outside world. That contact is a safety margin both for emotional and physical needs, but also for information and security from the greed merchants. When alone and isolated, the elderly are more vulnerable to the quick talker who will sell them products and services they do not need. The range in products is endless, but Health Insurance, land, funeral arrangements, hearing aids and protection devices are the main ones along with services which are on the list to sell to the lonely, frightened elderly person.

This Nation is not filled with vulnerable frightened elderly, many care for themselves and enjoy happy and full lives. This does not mean however that we should ignore those who need society's help. The challenge before us is to create an atmosphere in which our elderly citizens can flourish, be creative and lead lives of respect . . . . it can be done.

Perhaps it will require an entirely new attitude on the part of Americans, one which requires a turn away from self need to the needs of others. One which requires those with much to share their bounty with those with little. As President John Kennedy said, "A Nation which cannot provide for the few who are poor, cannot survive for the many."

But that goal may be elusive today and may never fully come, but today we can help the elderly with full funding of governmental programs to help them and by keeping them informed as to the pitfalls in which they can fall prey to in the marketplace.

Some I believe your agency can institute and some each of us can carry out easily:

1. Hug your Grandmother Day, the card may be nice, but the warmth of a youthful arm is better. Visit with the elderly, take them out with you.

2. Television has afternoon specials for kids as they return from school. Why not an early afternoon special for the elderly, one entertaining with information as the kids' specials are.

3. The FTC could purchase TV time for commercials warning against the abuses in the marketplace which the elderly should be cautious of.

4. Many elderly follow soaps, those soaps stars would be excellent spokespersons for the TV commercials dealing with protection of the elderly in the marketplace.

5. Appearances at the various elderly meetings each week by spokespersons both official and non-official warning of these problems could help.

6. Local clubs and organizations; Elks, Knights of Columbus, Lions etc. could help in the distribution of information.

7. The elderly read newspapers from cover to cover, that is another place for information and ads to warn of the dangers.

8. Doctors and hospitals are another source for the dissemination of this material.

9. Elderly Housing Associations will be happy to distribute literature, the housing authorities will probably be equally as enthusiastic.

I have suggested a limited number of directions and ideas which can be taken by people and agencies to begin to resolve this problem, few need great sums of money. The warmth must come from people, the information from governmental agencies perhaps in concert with reputable companies who will gain by supporting the development and distribution of this information.

Many say these are dark times for programs which help people, generally the elderly have been immune from that criticism in the past, but beyond that the budget crunch which we face both in this state and in the Nation can be the challenge to innovation which will make these proposals less costly and more effective for the elderly in our Nation.

These hearings are a first and vital step. I wish you well in your task, it is difficult but most worthy. I am sure you will succeed.

Mr. HALAMANDARIS. That was a good statement. I subscribe to everything you had to say and I think you put it succinctly and well. I would like to follow you with Mr. Gallant.

STATEMENT OF ROBERT GALLANT, DIRECTOR, HIGHLAND VALLEY ELDER SERVICES

Mr. GALLANT. As Director of Highland Valley Elder Services, Incorporated in Northampton, Massachusetts, I have participated these last four years in a system for which the Federal government

is responsible, a system of area agencies on aging which has blanketed the country since the Older Americans Act of 1965. Since my agency is designated by the State of Massachusetts as a home care corporation, I have also participated in one of the best systems of care in the country in a state where the commitment to quality community living for people over sixty is matched by one of the highest per capita investments in the country to continuing independence for elders in prevention of institutionalization.

The systems that have emerged these last years have had their mandate from the medical level, support at the State level and control at the local level by consumers themselves. They represent some of the best thinking of policy makers in our country and have the potential for some of the best results any of us could imagine for the quality of our lives, for the long life of our fathers, mother's, sisters, brothers, grandfathers, grandmothers, children and ourselves. Still in their infancy, these systems are making it possible for people to congregate in community dining experiences like meal sites, receive help from crews of chore workers, homemakers, companions, legal service workers and case managers. They assist the process of long living by increasing the options people can turn to. The nursing home is no longer the only alternative. Individuals and families can make and maintain their investments in quality long living with the assistance of these systems. Think of it. What more important systems could we think of? These systems certainly have to take a place of pride alongside the systems whose equally bright minds have devised moon landings, space shuttles and MBX missles. No one could rationally argue that systems designed for quality long living should not earn and maintain not only the commitment of a nation like ours but our investment in them as a first priorty. Yet these days, they are being replaced by safety nets.

I submit to you that the Presidential and Congressional budgets we're seeing voted in our Federal and State congresses are the greatest example of fraudulence against all of us who might expect a relationship of trusting partnership with our government as we live our lives. In the present climate, I as a manager am threatened with being an example of fraudulence and waste as people look for scapegoats to satisfy claims that our helping systems are shoddy. Elders who sit on governing boards controlling these systems have to sit on boards watching regulations, policies and funding disappear. Elder consumers and families who look to these systems are threatened with program cuts and broken promises. A hearing investigating fraudulence is a good place to bring this message. While we have eradicated deceitful practices and protect all of us against fraudulence, these practices may only be the tip of the iceberg. Are we that much of a throw away culture? We should not only chase after fraudulence but we should maintain investments in our values and commitment to quality long living and to the citizens who support these commitments. Thank you.

Mr. HALAMANDARIS. That too was an eloquent statement. We appreciate that. Once again, I would say wholeheartedly I subscribe to your comments. I too wish we could do something about it and we may be able to sometime tomorrow. There is a major hearing of our Committee which involves the proposals of cutbacks

of Social Security. I think there is some coalescence in the House of Representatives at least to stand up and fight against those cuts which will have an important effect not only on those who are present that receive Social Security but future generations as well.

Mr. Roche.

STATEMENT OF JOSEPH ROCHE, CHAIRMAN, SPRINGFIELD CITY HEALTH COUNCIL; AND CHIEF HEALTH PLANNER, WESTERN MASSACHUSETTS HEALTH PLANNING COUNCIL

Mr. ROCHE. I am Joe Roche and I come here today both as a professional health planner and the past Chief Planner of the Western Massachusetts Health Services Agency. Also, in my capacity, I have acted as Chairman of the Springfield Public Health Council which is a statutory body that oversees the Department of Public Health in the City of Springfield.

The purpose of my testimony today is really to talk about some systemic problems in the insurance area for the elderly which make them vulnerable to fraud. In essence, I plan to talk about the three conditions for fraud in the insurance market because I am of the opinion that if we had a more reliable, sound health insurance program for our elderly, they in fact would not be vulnerable to the types of fraud that takes place in the market place. And on that note, what I would like to do is spend a few moments talking about the Medicare program which, in my estimation in many cases, amounts to about a ten thousand dollar fraud, fraudulent in the sense that people enter that program or system thinking that they are going to be fully covered by them and finding out in the course of a year that frequently, they can run up a medical bill of about ten thousand dollars in addition to what is covered.

What I would like to do is take you through that scenario for a few moments. To begin with, in order to even begin to receive hospital benefits, there has to be a one hundred sixty dollar deductible that the Medicare recipient has to pay. That is the beginning of the ten thousand dollar figure. From there, there is a forty dollar co-payment after the first sixty days, so I came up with a figure of about twelve hundred dollars from that. Then there is a thing that is called reserve days. Well, the interesting thing about reserve days is after you use up your ninety days on Medicare, you're entitled to an additional sixty reserve days at double the price of the co-payment which you were paying during the first sixty days which comes to a pretty wopping forty three hundred dollars for an initial total of about fifty five hundred dollars that somehow, somewhere that person has got to pay out of pocket. Now perhaps that comes through some type of coverage in some other third party care of insurance, but frequently, it does not.

Let's take the case of someone that has a very chronic illness or is injured seriously and had some type of Medicare. Maybe they were in a serious accident. Perhaps there was someone that had a bad case of diabetes or some other type of serious chronic disease or illness. They use up all their days in the hospital. They use up all their reserve days. They now are in a nursing home. Nursing home coverage the first twenty days are paid for by Medicare. Thereafter, the Medicare recipient is expected to pay—and these are 1979 figures by the way—twenty dollars a day for the twenty

first to the hundredth day for about another sixteen hundred dollars, so here we have a case of someone who has been institutionalized for two hundred twenty days and it is conceivable they have got about a seventy two hundred dollar medical bill. Well, that Medicare does not entirely cover all the medicine, all the care that was given by the physician or other health care professionals. What I was talking about was Medicare A and Medicare B which is the Medicare part of it and has a program related to pay which is considered eighty percent of the reasonable charges. Frequently, physicians can have additional billing and some physicians do that. They are not on Medicare assignment, so it is conceivable in that same period of time, I would submit very easily, that someone could run up another medical bill of about three thousand dollars that they would be expected somehow to meet.

Now let me just go for a moment and give you some idea what Medicare does not cover. We're talking now about ten thousand dollars that they are in the hole already on the basis of services that can be covered. Let's just speak for the moment about services that cannot be covered by Medicare. Acupuncture, chiropractic services outside of manipulation of spine to correct subluxation, cosmetic surgery, dental care in connection with treatment, filling, removal, replacement of teeth, root canal therapy, surgery for impacted teeth and other surgical procedures involving the teeth or structures directly supporting the teeth, drugs or medicines to buy with or without a doctor's prescription, eye glasses and eye examinations, routine foot care, structural misalignments, removal of warts, calluses, corns, hearing aids and ear examinations, homemaker services, immunization unless required because of an injury or immedicate risk of infection.

By the way, the situation I have spoken of, Springfield right now in its budget, because of Proposition two and a half, does not have the funds for these services and we're trying to fight to get those monies back in.

Injections, meals served in the home, nursing care on a full-time basis in the home, custodial care in a nursing home are also not covered. That is, the person has to have some type of rehabilitative care in order for it to cover it.

Orthopedic shoes, routine physical examinations and related tests, services performed by immediate relatives or members of your household are also not covered, so I submit to you that when you have a system that has so many gaping holes in it, that virtually is no type of a safety for many people that are very vulnerable to fraud. If someone comes along with a slick sounding insurance proposal and tells them that these services will be met, the preconditions have been set and I submit that the direction that the committee should be going is not just trying to pursue all the perpetrators of fraudulence—and there are many of them—I suggest the real cure is to do something about patching up the system by curing——

Mr. HALAMANDARIS. May I interject? Congressman Pepper will be introducing a bill which will relate to some of these services presently not covered such as eye examinations or eye glasses and dental care and hearing aids and out of hospital prescriptions. That will be a funded 30 percent by a premium for senior citizens which

is equal to the part B premium and the remaining 70 percent of the program that will be raised by an excise tax. So we hear you and we're already moving in the right direction and we have issued a report which says exactly as you have said.

Mr. ROCHE. Along that level, in conclusion, what I was going to say is that I think that is one of the directions that the Committee needs to take; and frankly, I won't spend my time here urging you about my views on the National Health Service System. It is an absolute disgrace that we have elderly people, many of whom have paid into our taxation system for years and have given a great many things for this country that find themselves in the situation they do in terms of medical care insurance.

I think that some of the other ideas that perhaps you could explore in terms of protection against fraud—and I heard one of the ideas mentioned here earlier—is the whole idea of having an elderly ombudsmanship program. I know there was one experienced with the Massachusetts program, but I believe that is in a pretty weakened state today. I think there should be some thought given to coming up with experimental models of elderly care.

For example, in the city of Springfield, Mercy Hospital did have a health plan organization for the elderly which was a prepaid program. They get many of the services or products that they talk about that are not covered. In addition to that, I would suggest that the government would be well to invest some money in prime time television programs to talk about some of those more shoddy health insurance schemes that are going on.

Mrs. PINES. Thank you. Ms. Vallone, please?

STATEMENT OF MARGE VALLONE, DIRECTOR, SPRINGFIELD CITY COUNCIL ON AGING

Ms. VALLONE. One of the concerns that I have is the cuts in legal services. Poor people and elderly people come to us for free legal service. I know our office is an advocacy office and most of the people that need this type of service come into our office first or they call us and say, where can we go with this problem, where can we go with that. Now we are not lawyers, and I would say that a great deal of our clients need lawyers, legal services. If this is cut out, I see a great deal of fraud that we never even dreamed would happen, so we would hope that your committees will keep legal services in for all Americans who cannot afford them and I don't believe that pro bono services would ever answer the need in any community and I don't see it in this country. Most important is to keep legal services where people can get them.

Mrs. PINES. I would hope that you would communicate with your elected people in Congress with regard to that because your Congress people have the authority to vote on whether or not the funds are allocated to any particular program. Certainly the Federal Trade Commission doesn't have any auhority in the Congress with regard to allocation of dollars.

Ms. VALLONE. Well, I feel that in your position in Washington, that it would be proper—I am sure you have done it—to make them aware that if legal services are cut, that your job will be a hundred times as difficult as it already is today.

On the hearing aids, that has been a great, great problem in this area. It has been for a number of years. The fact that people are able to sign a waiver for medical exams has created problems. They don't actually understand what that means, and when hearing aid dealers go into the home, they sign a bunch of papers. Before you know it, they have signed a legal waiver.

I had a call this week from a visiting nurse who said there was an eighty four year old client of hers that had purchased a hearing aid or started to until the visiting nurse got there and she was telling her about it. The man had came in, given her a test and took forty dollars from her. The visiting nurse went over the information with her and she hadn't realized she signed a waiver and he never expressed that. The visiting nurse called him. They refused to give the money back and said that she absolutely understood when he gave her the information on the waiver.

I had a gentleman, after I had talked about hearing aids, at a very big meeting come up to me after and said Mrs. Vallone, I have the best hearing aid dealer around. He told me he was ninety years old and for the past seven years, that his hearing aid dealer had come twice a year, examined his ears and given him the very latest in hearing aids twice a year to find out that each time, the hearing aid cost eight or nine hundred dollars and he gave him a two hundred dollar trade-in value.

So people don't know about the hearing aids and that waiver should really be looked at. I can see for religious purposes, but people don't understand it and it is not explained to them.

On the nursing homes, people are in fear. They are on Medicaid. They don't feel that they are really wanted in the home and to think that the elderly who do have their wits about them along with people who have mental problems who are now filling our nursing homes across the country will never speak for themselves, I don't think this will ever happen. They are in fear and I would concur that there should be staff training for nursing home personnel on how to deal with elderly people.

Mrs. PINES. Thank you very much. I would like to address a question to Mr. Roche. I understand that there are proposals that are being discussed in Washington that would allow the states to opt out on Medigap. Would you like to comment to that?

Mr. ROCHE. Yes, I think that even though it is not a perfect program, to allow that to happen I think really would exacerbate the situation that we talked about here today; that if anything, we need a more comprehensive system, perhaps something along the lines of Option C. In the interim, I think it would be a real mistake. I know we're here talking about fraud, but I think we have set up a series of preconditions that make people extremely vulnerable to that. If you are looking ahead and you know that you might, over a course of a year, face anywhere from ten to fifteen thousand dollars in additional medical bills, you're ripe for somebody coming in and fast selling you some sort of insurance policy.

Ms. VALLONE. I wanted to touch on the health insurance also. Even a member of my own family had purchased health insurance unbeknown to me from out of state. They were hospitalized. They could never collect one dime and they didn't have another policy. They could not even collect on the original policy that they purchased, but through the five years that they were a member of that corporation, their checks were cashed each month, but their claim was never answered.

Mrs. PINES. We appreciate your taking the time to come. We very much hope that your comments will help the House Committee on Aging to determine what should be important in the future with regard to legislation, and the Federal Trade Commission will carefully consider the testimony you have provided and hopefully, we will be able to identify some objectives that will help us in dealing with some of the problems addressed here. We are particularly grateful for your concern, commitment, and interest in joining us this afternoon.

[Whereupon, at 4 p.m., the hearing was adjourned.]

APPENDIX 1

Submitted for the record by John T. Montgomery, Assistant Attorney General, and Chief of the Consumer Protection Division, Commonwealth of Massachusetts.

Commonwealth of Massachusetts

MIDDLESEX, SS. TEMPORARY INJUNCTION No. 77-1955

To Cherles R. Stott also known as Charles R. Scott, of Chelmsford, in the County of Middlesex; George Michael Ward of Lowell, in said County of Middlesex doing business as Town and Country Roofing, Waltham Roofing Service, Beacon Hill Roofing and Skylight Service, defendants and your,

Agents, Attorneys and Counsellors, and each and every of them,

GREETING:

WHEREAS, it has been represented unto us in our Superior Court, by Commonwealth of Massachusetts, a sovereign state represented by the Attorney General

plaintiff , thatitxxx , said plaintiff , has filed a complaint in our said Court against you, the said defendants

wherein said plaintiff , among other things, pray for a Writ of Injunction against you, the said defendant , GEORGE M. WARD

to restrain you and the persons before named from doing certain acts and things in said complaint set forth, and hereinafter particularly specified and mentioned. We, therefore, in consideration of the premises, do strictly enjoin and command you, the said defendant , GEORGE M. WARD

_____ and all and every the persons before named, to desist and refrain from selling, transferring, conveying or encumbering any valuable property, real or personal, you now own, jointly or individually, except for fair consideration and further from entering any contract for a price in excess of $1500.00, or collecting, receiving, or accepting any payment in excess of $1500.00 in connection with any future roofing, masonry, paving, home improvement or related services for personal, family or household purposes, until you shall have given the Attorney General seventy-two (72) hours' notice in writing of your intention to enter into such contract or to collect, receive, or accept such payment. Such notice in writing shall be given to Assistant Attorney General Susan H. Frey or her designee and shall state the name and address of the customer with whom you intend to do such business and further from collecting, receiving, or accepting any payment in excess of $1500.00 in connection with any future roofing, masonry, paving, home improvements or related services for personal, family or household purposes, until you shall have provided the Attorney General with a copy of the contract used by you in connection with such services. Such contract shall, in addition to conforming to all requirements of law and to all prior orders or judgments directed to you, contain an itemized statement of separate prices for labor and materials for each separate aspect of the work covered thereby and further from commencing to render or rendering any roofing, masonry, paving, home improvement, or related services to any consumer for personal, family or household purposes, until three (3) days after such consumer has executed and received a copy of a written contract, except where a bona fide emergency necessitates rendering of services during three (3) day period; and further from charging any consumer, for roofing, masonry, paving, home improvement or related services for personal, family or household

purposes, a price which exceeds the fair value of services rendered; and further from charging any consumer, for roofing, masonry, paving, home improvement or related services for personal, family or household purposes, when such services were not necessary and when you falsely represented them to be necessary; and further from representing, impliedly or expressly, to any customer the amount of time or labor required to perform services, when, in fact, you know or have reason to know that such amount of time or labor is not necessary and further from representing, impliedly or expressly, to any customer the cost of required materials, when, in fact, you know or had reason to know that the cost of materials

until the further order of our said Court, or some Justic thereof.

Witness, James P. Lynch, Jr. Esq. Esquire, at Cambridge, this sixteenth day of November, in the year of our Lord one thousand nine hundred and seventy-nine.

Edward J. Sullivan
Clerk.

_____ and all and every the persons before named, to desist and refrain from selling, transferring, conveying or encumbering any valuable property, real or personal, you now own, jointly or individually, except for fair consideration and further from entering any contract for a price in excess of $1500.00, or collecting, receiving, or accepting any payment in excess of $1500.00 in connection with any future roofing, masonry, paving, home improvement or related services for personal, family or household purposes, until you shall have given the Attorney General seventy-two (72) hours' notice in writing of your intention to enter into such contract or to collect, receive, or accept such payment. Such notice in writing shall be given to Assistant Attorney General Susan H. Frey or her designee and shall state the name and address of the customer with whom you intend to do such business and further from collecting, receiving, or accepting any payment in excess of $1500.00 in connection with any future roofing, masonry, paving, home improvements or related services for personal, family or household purposes, until you shall have provided the Attorney General with a copy of the contract used by you in connection with such services. Such contract shall, in addition to conforming to all requirements of law and to all prior orders or judgments directed to you, contain an itemized statement of separate prices for labor and materials for each separate aspect of the work covered thereby and further from commencing to render or rendering any roofing, masonry, paving, home improvement, or related services to any consumer for personal, family or household purposes, until three (3) days after such consumer has executed and received a copy of a written contract, except where a bona fide emergency necessitates rendering of services during three (3) day period; and further from charging any consumer, for roofing, masonry, paving, home improvement or related services for personal, family or household

purposes, a price which exceeds the fair value of services rendered; and further from charging any consumer, for roofing, masonry, paving, home improvement or related services for personal, family or household purposes, when such services were not necessary and when you falsely represented them to be necessary; and further from representing, impliedly or expressly, to any customer the amount of time or labor required to perform services, when, in fact, you know or have reason to know that such amount of time or labor is not necessary and further from representing, impliedly or expressly, to any customer the cost of required materials, when, in fact, you know or had reason to know that the cost of materials

until the further order of our said Court, or some Justic thereof.

Witness James P. Lynch, Jr. Esq. Esquire, at Cambridge, this sixteenth day of November, in the year of our Lord one thousand nine hundred and seventy-nine.

Edward J. Sullivan
Clerk.

Affidavit of Wilbur Cooney

I, Wilbur Cooney, hereby depose and state as follows:

1. Since 1950, I have resided at 16 Faneuil Street, Waltham, Massachusetts. My wife and daughter reside with me. My wife and I own the house at that address and rent out an upstairs apartment. I am 72 years old and have angina.

2. In or about December, 1973, my wife and I had interior redecorating done in the upstairs apartment, and around February, 1979, we had redecorating done downstairs.

3. In or about the first week of September, 1979, I noticed that there was some slate missing from the roof of the house, and I observed that I could see daylight through cracks in the attic ceiling.

4. On Monday and Tuesday, September 10 and 11, 1979, I called three roofers who were unable to do the job. One came to look at it, but said it was too high. I then looked in the West Suburban Bell Telephone Yellow Pages and observed the advertisement of Waltham Roofing Service, a copy of which is attached and marked Exhibit "A".

5. Around 11:00 a.m. on Tuesday, September 11, 1979, I called the number listed for Waltham Roofing Service. A woman answered and I left a brief message.

6. Around 1:30 or 2:00 p.m., I received a telephone call from a man from Waltham Roofing Service. I described my problem and told him I was worried about possibly-approaching hurricanes. He said he would come over that day.

7. Around 3:00 p.m., I was out in the driveway when two men arrived in a truck, which had no company name written on it.

I met the two men in the driveway. They introduced themselves as brothers from the roofing company and said their last name was Ward. The next day, I learned that one was named "George" and the other "Jerry".

I got two ladders from them and Jerry went up on the roof. He lifted up the slate shingles near the capping, and said "Those are bad." George said, "It's going to be an expensive job." He said it would take two men with a rope, one holding the other. He said the hourly rate per man would be $25.00.

I mentioned that I could also see light around the two vent pipes in the roof and they said that the vents needed doing.

George said that they would need copper plating to re-cap the roof.

I obtained a measure from the cellar, and they measured the dimensions of the house on the ground.

Then, George said, "We need $800.00 to purchase the copper". I said "I haven't got money like that around". Both George and Jerry then looked in their wallets and said they would take care of it. They left in the truck. No written contract was prepared. They did not say anything about my right to cancel.

8. Around 9:20 a.m., on Wednesday, September 12, 1979, four men from the roofing company arrived. George and Jerry were not with them. Three men went up on the roof and one stayed on the ground. One man with a mustache and light hair told me that the chimney also needed doing. I told him to go ahead, if it had to be done. The men took a half-hour lunch break and worked until about 3:20 p.m. George and Jerry came by at closing time.

9. Around 9:05 a.m., on Thursday, September 13, 1979, three men from the company arrived and began work again. George and Jerry were not with them, but popped in and out during the day. George seemed to be the boss. The men took lunch from 12:00 noon to 12:40 p.m., and finished work at 3:30 p.m. I gave them some tarpaper to cover the cap of the roof temporarily, as a storm was expected. They also took my broom and bucket, which they never returned.

10. On Friday, September 14, 1979, it rained and no one from the company came.

11. On Monday, September 17, 1979, six men from the company arrived around 10:00 a.m., and began work. George and Jerry came by later. They had finished work on the chimney and they started putting copper capping on the roof. During the day, I loaned them my torch for soldering. They stopped work around 4:00 p.m.

12. On Tuesday, September 18, 1979, about six men arrived and began work around 8:30 a.m. They worked until about 3:00 p.m., with time out for lunch. At the end of the day, George told me that they would come back and finish the next day. He said he would take some men off another job. George then asked whether I wanted new copper to be put above the bay. I said that it was just redone in 1974. George said it would only last a little longer. I said he should go ahead and do it.

13. On Wednesday, September 19, 1979, a number of men arrived around 9:00 a.m. I observed about three on the roof and two on the ground. In addition, George, Jerry, and a man named Paul worked inside the attic. I believe it was on this day

that George told me that his father was also a roofer and had taught him all he knew. He said his father was very exacting and you had to do everything right for him. Also, he said that his father had come by our house one night and told George to give me a break. I asked George where he lived and he said Chelmsford.

At one point, I also told George about my angina and he later told me that his father had had open-heart surgery.

14. At about 10:00 a.m. on Wednesday, I was working in the garden when George came over to me and stated that they would be finished that day. He then said the price would be $18,000. I said, "No. That's going to wipe me out. I only have $16,000 plus a little in another bank". George said he would go and talk to Jerry, and see what they could do.

I had seen George getting a little huffy and I knew he could flare up.

George came back to me and said they could accept $16,500. He said, "We'll give you today free". He said they wanted payment immediately.

I went into the kitchen and told my wife what they wanted, and we got ready to go straight to the bank.

George then said that he wanted cash, but I said, No, that we did everything by check. George then wrote out on a piece of paper the name of "Paul Fryns", to whom the checks should be made payable. He asked for two checks, one for $10,000 and the other for $6,500.

15. My wife and I then went to the Waltham Federal Savings on Main Street and drew out a bank check for $12,158.93. We then went to the Waltham Savings Bank and drew out a check for $4,341.07. We took these two checks to the Guaranty First on Main Street in Waltham and deposited them in our checking account.

When we returned to the house, I asked George for an itemized bill in exchange for the checks. He went out to the truck and came back with a statement, a copy of which is attached and marked Exhibit "B". The signature "Paul Fryns" was already affixed at the bottom. I signed in two other places, and George wrote "Paid in full" and the date, "9/19/79" across the statement. We then gave George two checks drawn on our checking account payable to "Paul Fryns" in the amounts of $10,000 and $6,500, respectively. The men finished work and left at about 3:30 p.m.

16. That afternoon, around 4:00 p.m., George called me and said, "How's the roof? I said, it was okay. He said not to tell anyone, not even his wife. I thought he didn't want anyone to know he had given me the $2,000 discount.

17. That evening, Wednesday, September 19, 1979, my wife, daughter and I tried to figure how the price had gotten so high. At some point, I had given George 82 pieces of slate, which he said he used. George also had told me that he bought 60 slates or more second hand at $1.62 a piece. George had also told me that they paid $72.00 a piece for copper sheets and had used 13 sheets. We tried to multiply our estimated number of man hours by the rate of $25.00 per hour, but we couldn't get it up to $16,500. My wife said George had given her a verbal estimate of $1,000 a day, and we couldn't reach $16,500 on that basis. We felt we had made a mistake, but perhaps we should accept it.

18. On Thursday morning, September 20, 1979, Mr. Russo, the banker at Guaranty Trust called and spoke to my wife. He told her that there were two men in the bank who wanted to cash two big checks of ours. My wife asked him to send them over to talk with us.

19. Shortly, Jerry and George arrived. George appeared very upset and told us the bank was holding up their money. My wife suggested that we might rather take out a loan. George said his father could help us with the paperwork, if that was what we wanted to do. My wife said we would prefer to use our own lawyer. George got red in the face and referred to "all this hassle". My wife got angry at George. She asked him who Paul Fryns was. George said he was the treasurer of the company. I asked George to sign the itemized statement, Exhibit "B", again. In our presence, he signed the name "Paul Fryns" right under the words "Paid in full". During this conversation, George went outside several times. They smoked a lot of cigarettes. At some point, George said, "Geez. The banker said he can't cash the checks until next Tuesday. All our men won't be able to work. This is payday". At one point, George also told a story about one time when his father punched a bank teller who was giving him a hard time. My wife finally agreed to call the Waltham Federal Savings and tell them that Mr. Russo at the Guaranty Trust had held up the check. She spoke to a Mr. Aucoin and asked him to call Mr. Russo. At that time, Jerry was standing at her elbow. She then called Mr. Russo and asked him to cash the checks.

20. George and Jerry then left. The Guaranty Trust has informed us that the checks were cashed, and we have received the cancelled checks.

21. In late September and early October, there were three rain storms. During the first, I observed no leakage in the roof. The second storm caused leakage at one spot

in the attic which I circled with chalk. During the third storm, on the night of October 5-6, 1979, a slate blew off the north side.

22. On Saturday, October 6, 1979, my daughter, Elaine, called the Waltham Roofing Service number and left a message with the answering service. We received no response.

23. On Tuesday, October 9, 1979, at 8:05 a.m., my wife called the answering service and left a messge to call. At 9:45 a.m., my wife called again and asked the woman who answered whether there was an office. She said there was no direct office phone. At 1:30 p.m., my wife called again. The woman who answered said she had given the message one-half hour before. My wife told her about the leak and the slate. At 3:30 p.m., my daughter called the number shown on the statement, Exhibit "B", for the residence of one "Gerald Greenhalge". He answered. She told him about the slate and the leak. He said he would come over first thing in the morning, but no one came.

24. On October 11, 1979, we complained to the mayor's office about this company, who in turn contacted the attorney general's office on our behalf.

25. On October 16, 1979, George Ward called me in the evening and said he would come over the next day. He wanted to know why I had called the Better Business Bureau and Suan Frey in the Attorney General's Office. My daughter then took the call.

26. On October 17, 1979, Jerry and two other men came and fixed the missing slate. My daughter asked them for an itemized bill which they said they had already sent in the mail.

Signed under pains and penalties of perjury this 19th day of October, 1979.

WILBUR W. COONEY.

WALTHAM, MASS.,
Middlesex, ss:

October 19, 1979.

Then personally appeared before me the above-named Wilbur Cooney and swore to the truth of the foregoing statement.

PETER J. VITALE,
Notary Public.

My Commission expires, October 19, 1984.

[Supporting documents are retained in committee files.]

AFFIDAVIT OF CATHARINE LANG

I, Catharine Lang, being duly sworn, hereby depose and state as follows:

1. I reside at 12 Lombard Street, Dorchester, Massachusetts, and have lived there for 10 years. I own the single-family house at that address. My husband died three years ago, and I am responsible for my epileptic daughter and mentally-disturbed son, who live with me. I am 75 years old.

2. On Wednesday, September 26, 1979, in the late morning, I looked in the Boston Bell Telephone Yellow Pages for a repair person to fix a leaking skylight in my roof. I found an ad for Beacon Hill Roofing and Skylight Service and called the number listed. (A copy of the ad is attached hereto and marked "A".) A man answered. I told him what was wrong and he said he'd take a run right over.

3. Around 3:00 p.m., no one had arrived, so I called again. A man answered and said that they would be over in a little while. He also told me that I'd have to give them a "yes" or "no" answer instead of keeping them waiting as so many others were doing, which caused them to delay their jobs, I said that I would. He asked me whether I had to talk it over with my husband and I explained that he was deceased.

4. A little later, two men arrived at my door. They said they were the roofers and that they were brothers. I later learned that one was called "George". They examined the skylight and said they would fix it up real good. They said they'd replace the glass with plexiglass and do inside all around it where the plaster had loosened on the wall.

George told me they had been in business from the grandfather down and that their father, who had a pacemaker, was still climbing roofs.

5. George went out to the car and started writing down figures. I heard him say, "She's not going to like this". Then I heard $1,300 to put up the staging. I told him it was too much. He seemed to get upset and said his staging was made of pipes and took five (5) men to put it up. He didn't want to take a chance on his men getting

hurt and he said my insurance could never take care of that. Then he said it would cost another $350 for the skylight.

6. George then discovered the back chimney which he said was missing so much mortar that another storm would blow the bricks down. I suggested shortening the chimney, which was quite tall, by about one foot. George said the job on that chimney would cost $700. He also observed that there were two holes on the corners of the house big enough for squirrels to get in. He would install metal plates on the corners for an additional $200.

7. George's brother gave me a written proposal on a printed form for a total price of $2,550. I did not read the proposal very carefully. Neither man said anything about a right to cancel the contract. There was no detachable cancellation form on the proposal. The brother signed the name "Paul Fryns" and I added my signature to the proposal. George said the skylight would take two (2) full days. He also said he paid his men $20/hour. (Later, he said it was $26./hour.)

8. On Thursday, September 27, 1979, around 10:00 a.m., a crew of five (5) men, including George and his brother, arrived. The three others included Paul Fryns (who George said was the treasurer), George's son-in-law, and another young boy. They came in two trucks, neither of which bore a company name. George took me around to the front chimney, which he said had holes in it large enough for sparks to fly out and burn the roof down. I thought it looked the same as it did about six (6) years ago when we had it completely rebuilt. He told me it would be $350 for the chimney and $50 for a new cap. I said to do it, if it had to be done. They did not write up an amended proposal to include this work.

They worked until about 5:00 p.m., with an hour out for lunch. George then came to me and said they were all finished. He said the total was $2,950.00 and he wanted payment the next day, Friday, which he said was payday. He offered to take me to the bank.

9. The following day, Friday, September 28, 1979, George, his brother, and Paul Fryns arrived at my house around 10:00 a.m. I had wanted to wait a few days to hear from the Better Business Bureau, where I had inquired about the company. However, the three of them drove me into Boston to the bank. George told me the total was now $3,350. He had added on an additional $400. I don't know what that was for. I thought the price was terribly high. We first went to the Warren Institution for Savings on Summer Street in Boston. Paul Fryns went into the bank with me. He said he had to be able to cash the check there, and it should be made payable to him. The teller said the bank would not cash the check for Paul Fryns, so I withdrew cash in the amount of $800. Paul Fryns gave me a receipt on the back of a deposit slip, which they later took back. We then went to the Charlestown Savings Bank. Paul Fryns again went in with me. The teller, a black girl named Melody, knew I was nervous and asked me if I would rather have a bank check. I said it had to be cash. I withdrew $2,500, which took my balance down to $49.00 and paid Paul Fryns in cash. He gave me a receipt on the back of a deposit slip, which they later took back. I also cashed a fifty dollar ($50.00) check in the bank and gave the cash to Paul Fryns.

10. They then drove me home. George gave me a handwritten receipt for $3,350.00, a copy of which is attached hereto as Exhibit "B". In my presence, George signed the receipt with the name "Paul Fryns". I asked what George's name was and he said "George White". He said he live in Lowell. George also said his wife would prepare a claim for me on my insurance for $550.00 on the skylight. She was supposed to call on Tuesday, but never called.

When they left, they took with them the proposal and the two little receipts I had gotten from Paul Fryns in the bank.

Signed under pains and penalties of perjury this 22nd day of October, 1979.

CATHARINE J. LANG.

DORCHESTER, MASS.,
Suffolk, ss:

October 22, 1979.

Then personally appeared before me the above-named Catharine Lang and swore to the truth of the foregoing statement.

PETER J. VITALE,
Notary Public.

My Commission expires, October 19, 1984.

[Supporting documents retained in committee files.]

AFFIDAVIT OF STANLEY G. MARTINI

I, Stanley G. Martini, being duly sworn, hereby depose and state as follows:

1. I am the owner of Martini Roofing Company, 411 Broadway, Somerville, Massachusetts 02145. The company has been in business since 1936, originally under my father's proprietorship and later mine. I began work as a roofer in 1949, and worked for several years with my father and brother. After the hurricane of 1954, I began doing appraisals of roof damage for insurance companies. At present, I am the manager of the company and I do appraisals for numerous eastern Massachusetts insurance companies, including Maryland Mutual, Hartford Insurance, Travelers, Shelby Mutual, Patriot's General and Middlesex Mutual. I also employ a crew of six men for tar and gravel work and another crew of six men for shingle and gutter work. My customary wage for non-union employees at present is $6,00–$9.00 per hour. Most of our roofing work is for homeowners, although we do an occasional industrial job. At the request of the Attorney General, I have inspected several roofing jobs performed by Waltham Roofing Service, and Beacon Hill Roofing and Skylight Service.

2. Catharine Lang, 10 Lombard Steet, Dorchester, MA.

On October 18, 1979, I inspected a roofing job at the residence of Katharine Lang, 10 Lombard Street, Dorchester, MA. Mrs. Lang informed me that the items covered by her recent contract with Beacon Hill Roofing and Skylight Service included: scaffolding, the skylight, the back chimney, the front chimney, and two copper corners. I took six (6) photographs covering those items, which are attached hereto as "Exhibit A".

Skylight (Photos 5 and 6)

The recent work on this skylight consisted of inserting a new plexiglass pane with putty and applying copper flashing around three sides of the old frame. This job could readily be done by climbing up to the skylight with a roof ladder and passing the skylight through the inside of the house. No scaffolding would be necessary. The copper flashing was done with very poor workmanship, since the corners were not properly turned and a gap was left at the corner. Less than one 3' x 8' sheet of copper was used.

The cost for materials on this job would be less than $50.00. I am currently paying $35.00 for a 3' x 8' sheet of copper.

The price for this job on the skylight should not have exceeded $100.00.

Copper Corners (Photos 2 and 3)

A small piece of remnant copper was nailed over each of these holes. I would customarily throw in these items for no extra charge.

The price for the two corners should not have exceeded $100.00 even if someone went out specifically for that job alone.

Back Chimney (Photo 5)

The only new work I observed was roof cement applied around the base of the chimney. I observed no new pointing or flashing.

Even assuming the chimney was shortened and roof cement applied, the price should not have exceeded $250.00.

Front Chimney (Photo 6)

I could observe no new work on this chimney. In my opinion, it is highly unlikely that this chimney would need repairing, if it was done five or six years ago, as stated by Mrs. Lang.

Staging

I saw no nail holes in this roof. Nails would be necessary in order to set up staging. Staging was not necessary for any of the recent work I observed.

The total price for all of the work I observed at Mrs. Lang's premises should not have exceeded $400.00.

3. Wilbur Cooney, 6 Faneuil Street, Waltham, Mass.

On October 17, 1979, at the request of the Attorney General's Office, I inspected a recently performed roofing job at the residence of Wilbur Cooney, 6 Faneuil Street, Waltham, MA. Mr. Cooney's residence is generally well-maintained and has good workmanship throughout. The work which I inspected consisted of: new copper sheeting over the "stubby shed dormer", flashing or sealing one chimney and two vent pipes, and a new copper ridge cap. I took ten (10) photographs of these items which are attached hereto as "Exhibit B".

Stubby Shed Dormer (Photos 1, 2, and 3).

This shed dormer was probably originally done in slate, and later redone with rolled roofing. The new work I observed consisted of covering the rolled roof with 3½ sheets of copper. These were nailed down with exposed nails and cemented with roof cement at the seams. The procedure was very poor workmanship. The exposed nails will draw in the sun, and the large sheets will buckle. The proper procedure, if copper is used, would be to install smaller strips of copper with a standing seam system. I would have recovered this area with slate, which would be easier than a standing seam copper system. My price for re-slating an area of that size (78 sq. ft.) would be $450.00.

Chimney and two vent pipes (Photos 4, 5, and 6)

I have never seen so much roof cement on a chimney. The front section of the cement is hanging and separating from itself. In general, ¼" of roof cement is sufficient. This was very poor workmanship. I could not detect any new flashing under the cement. My price to reflash this chimney with lead would have been $325.00.

Again, the two vents were loaded with unnecessary roof cement, extending unnecessarily onto several slates. My price to reflash these two vents would have been $180.00

Copper ridge cap (Photos 8 and 9)

This 45-foot ridge was re-capped with strips of copper 8 feet long by 9 inches wide. This required less than 2 full 3' x 8' sheets of copper. They should have used strips 12 inches wide. Because the strips were too narrow, the difference was made up with roof cement all along the borders.

The cap was soldered in some areas, which was unnecessary. A metal break should have been used to bend the copper. The entire recapping was done with very poor workmanship.

Had I done this re-capping, we would have used an aluminium ridge cap with screw nails, which would be cheaper than copper. However, if I had done it in copper, my price would be *$225.00.*

Slates

I observed no newly repaired or replaced slates, except the three slates shown in Photograph #1, which were replaced with poor technique. This slate roof is in good condition and does not need reslating.

All of the recent work I observed at Mr. Cooney's premises could have been done easily by three (3) competent roofers in one (1) day.

The total price for work, had I done it properly, would have been $1,180.00.

The total price for all the recent work I observed at Mr. Cooney's premises should not have exceeded $700.00.

4. Valentine Kamishlian, 3 Porter Street, Watertown, Mass.

My attached report and photographs, "Exhibit C", detail the poor workmanship I observed on this job in July, 1979. My price was $1,900.00 to correct the defective work based on July, 1979, gutter prices.

5. Louis Salza, 103 Lincoln Street, Lexington, Mass.

My attached report and photographs, "Exhibit D", detail the poor workmanship I observed on this job in July, 1979. My price was $2,250.00 to correct the defective work at that time.

6. Arcangelo Cascieri, 500 Concord Avenue, Lexington, Mass.

My attached report and photographs, "Exhibit E", detail the poor workmanship I observed on this job in July, 1979. My price was $3,550.00 to correct the defective work at that time.

7. Frances O'Leary, 565 Mt. Auburn Street, Cambridge, Mass.

My attached report and photographs, "Exhibit F", detail the poor workmanship and excessive price I observed on this job in July, 1979. The total price should not have exceeded $1,200.00. My price to correct the defective work was $575.00 at that time.

AFFIDAVIT

1. My name is Louis Salza and I reside at 103 Lexington Street, Lexington, Massachusets. I have owned the single family house at that address since it was built about 27 years ago. I retired from my work about three years ago because of health problems.

2. After the blizzard of 1978, I became concerned about the age of the roof on my house, although it had not yet begun to leak or cause any problem. In or about October, 1978, I called Waltham Roofing Service, a company listed in the Yellow Pages of my phone book, and left a message with the answering service.

3. A little later, three men came to my house, and one introduced himself as George Ward of Waltham Roofing Service. I already had a ladder up. I went up on the roof with George Ward, and he told me the roof had "vapor locks." I told him that I wanted a new roof. Ward said he could do the job. I told him I wanted a written contract and Ward said the price would be $3600, with one-third (⅓) up front as a downpayment.

4. On or about Friday, October 27, 1978, some of Ward's men arrived in the morning and started to go up on the roof. I told them to wait until Ward came. Very shortly, Ward arrived with a contract form. I dictated the contract specifications, while Ward wrote them. Ward then signed the contract in front of me and my wife, and I signed it. See Exhibit "A" hereto. On the same day, I went to the bank and withdrew $1200 by bank check payable to George Ward and delivered the check to him as a downpayment.

5. Three or four roofers worked on the roof on Friday, October 27, Monday, October 30, Tuesday, October 31 and Wednesday, November 1, 1978. Ward, himself, worked some of the time. I saw them strip the shingles and I saw some tar paper and insulation in the yard. I also saw them puting insulation back on the truck. One day I went with one of the men to get gravel at Waltham Cement Company. I also got them a permit to dump the stripped material.

6. On Wednesday, November 1, 1978, Ward informed me they were finished. I obtained a $2100 bank check payable to George Ward at the bank, but I told Ward I would not give it to him until they cleaned up the mess in my driveway and yard.

7. On Thursday, November 2, no one came from the roofing company. The next day, Friday, Novembr 3, a man came and asked for the check. I gave him the check for $2100 but I held up the balance of $300 in cash because the cleanup had not been done.

8. On Saturday, November 14, 1978, some men came and removed the heater and other equipment and I paid them the $300.

9. About three or four days later, I myself, raked up the debris they had left.

10. About one month later, on a Sunday, a severe rainstorm occurred. My roof started leaking almost immediately, the leaks coming both from the roof itself and through the walls. The total interior damage from this leakage was later estimated at one thousand four hundred dollars ($1400). When the leaks became more pronounced during the storm, I called Ward at home. I had obtained his home telephone number from one of his workmen. A woman (whom I assumed to be his wife) answered the phone. When I told her of my leakage problems, she said that George was not at home, but that she would pass my message on to him. I called several more times during the day, but I did not hear from Ward during the rest of the day.

11. On or about the following Monday, at 7 A.M., I called Ward at home. He appeared both startled and annoyed that I had reached him at that hour. I told him about the previous day's leakage and damage, and he said, "I'll send a guy down" and hung up abruptly. It did not rain that day, but no man came to my house during the entire day.

12. About 1 or 2 days later, two younger men came to my house, with roofing tar but without any tools or utensils, in order to perform a quick patching job on the areas of my roof where the leakage was most severe. Both men wore gloves, and since they had no tools they were forced to apply the roofing tar with their hands. They spent about ½ hour applying spot patches to my roof.

13. On or about the following day it started to rain again, and my roof soon began to leak. During this time, I received a phone call from George Ward. I found out later that my brother-in-law, Arcangelo Cascierei, had contacted Ward that very same day because his roof, which Ward had also fixed, was leaking. He had called Ward, which probably was the reason why Ward called me. Ward asked me if my roof was still leaking and I told him that I wanted him to come over and see exactly what was wrong with the roof. He said nothing, and then hung up. He never came over to investigate the leakage or repair the roof.

14. I called Ward at least 6–8 times afterwards, over a one or two week period, both at this home and at the number which was listed on the contract for Waltham Roofing. Whenever I called his house, either his wife or one of their children could answer, and would promise to pass my message along to George. Finally, I became frustrated with trying to reach him at home, so I tried calling at work, but my messages were not acknowledged. I have since heard nothing from either George Ward or any of the agents of Waltham Roofing Service.

15. I then filed a complaint with the Attorney General's Consumer Protection Division.

16. The leakage in my roof was so severe that I was compelled to hire another roofer in November, 1979 to redo the entire roof. I paid a total of $3800 for the job. See contract attached as Exhibit "B".

Signed under pains and penalties of perjury this day of ————, 1980 at Lexington, Mass.

LOUIS SALZA.

[Supporting documents retained in committee files.]

AFFIDAVIT OF BARBARA ROOT HOLBROOK

I, Barbara Root Holbrook, being duly sworn, hereby depose and state as follows:

1. I reside at 21 Charles River Square, Boston, Massachusetts. I live alone in the three-story, single-family row house at that address, which I own. I am 68 years old.

2. In June, 1978, I had George Ward of Beacon Hill Roofing and Skylight Service examine my roof. Ward came over, examined the roof. He stated that the tar and gravel roof needed redoing. I inquired about installing roof insulation, and Ward said his company could do that, also. I hired Beacon Hill Roofing and Skylight Service to perform these repairs at a total price of $5,200.00, which I paid in full. A copy of the contract, dated June 29, 1978, which George Ward furnished to me, is attached hereto and marked "A." The work took about one (1) or two (2) weeks, and was guaranteed for five (5) years.

3. In late May, 1979, the skylight in my guest bathroom leaked, causing damage to the ceiling. I called Beacon Hill Roofing and Skylight Service at the number on the contract, Exhibit "A." George Ward came around to my house. In conversation, we agreed that he would repair the flashing on the small skylight, repair the interior of the big skylight, and install a new copper gutter in the rear. He indicated that scaffolding would be necessary for the gutter repair. He said the scaffolding would cost $1,800.00 to rent. I asked for a written estimate on the total job. Ward said he would give it to me later. We also discussed whether my insurance would cover any of the work. Ward stated he would prepare a written statement of existing damage for insurance purposes, and he thought I might be able to get some reimbursement from my insurer.

4. In about the second week of June, 1979, Ward and his men began work. I believe he had approximately 5 or 6 men working each working day, until July 3, 1979. I trusted Ward and gave him the key to my house. I gave Ward and Greenhalge, his brother-in-law, coffee on several occasions.

5. After the work began, Ward showed me a rotten beam in the area of the roof behind the gutter, which had been removed. He said it was impossible to secure the gutter to this rotted wood. He suggested taking up the whole back part of the roof, which is 14' by 14', and installing a new tar and gravel surface. I agreed to this. Ward also showed me some loose bricks on the rear wall and said they must be repointed. He said we should repoint the rest of the rear brick wall to avoid future trouble, and I agreed.

6. On June 13, 1979, Ward requested a payment of $2,000.00 as a partial payment, which I paid by check. Exhibit "B." Ward asked that I make the check payable to "Arthur Lynch." Each week, Ward asked for money to pay his workmen. I frequently renewed my request for a written estimate or contract and he always promised to give it to me later. George's brother-in-law, Gerald Greenhalge, usually came with Ward when they were requesting payment. As the work was under way and the scaffolding was up, I continued to make payment. After the first check, I paid checks as follows: June 17, 1979, $2,000.00 payable to George Ward; June 22, 1979, $2,000.00 payable to Arthur Lynch; June 29, 1979, $3,000.00 payable to Alice Ward and $7,000.00 payable to Gerald Greenhalge; July 3, 1979, $5,000.00 payable to Gerald Greenhalge and $10,000.00 payable to Alice Ward. See, copies of checks, Exhibit "B." The total paid, as of July 3, 1979, was $31,000.00.

7. On July 3, 1979, the last day of work, George Ward presented me with a typewritten contract form, Exhibit "C," hereto. He did not sign the "contract." He requested payment of a twenty percent (20 percent) "contractor's fee," bringing the total to $35,400.00. I withheld payment of $4,400.00, saying that the price was too much, and I referred Ward to my trust officer, John Lowell, at Welch and Forbes, 73 Tremont Street, Boston, MA, with regard to this amount.

8. Also, on July 3, 1979, my house was broken into and $12,000.00 worth of silver and $300.00 of miscellaneous property was stolen. Ward discovered the robbery, as I

was not home. The police were called by Ward and/or a neighbor. Before I even got home, the roofers cleaned up part of the mess.

9. On July 5, I went out of town on vacation, and I returned July 24, 1979. Shortly after my return, I called John Lowell to discuss the balance of $4,400.00 due to Beacon Hill Roofing and Skylight Service. I had not yet receivdd the written report of damage which Ward had agreed to furnish me for insurance purposes. We decided not to pay the $4,400.00 until such a report was received. We discussed if there was any way I could avoid paying the check. I signed a check for $4,400.00, dated August 3, 1979, and left it with John Lowell. He was to disburse the funds if he felt that the report of Mr. Hills, a real estate and insurance appraiser for Welch and Forbes, required it. Mr. Hills did inspect the roof.

10. Therefore, in the first week of August, I understand that John Lowell received a telephone call from Ward's agent, Gerald Greenhalge, seeking payment of the $4,400.00 balance.

11. On or about August 8, 1979, the check dated August 3, 1979, in the amount of $4,400.00, drawn on my account at the Boston Safe Deposit and Trust Company was mailed with a cover letter from John Lowell to Mr. Greenhalge at 6 Beacon Street, Boston, Massachusetts, Exhibit "D" hereto.

12. During the weekend of August 12, 1979, while I was out of town, there was a severe rainstorm in Boston. Upon my return I discovered extensive water damage due to leakage in my bedroom, the second floor study, second floor bathroom, and dining room. The backdoor of the house was so soaked that would not open for 2½ weeks.

13. I made several calls to the number on the Beacon Hill Roofing and Skylight Service contract (227-5125) and each time there was no answer. I also called the home number (453-8049) on the contract and found it was no longer in service. I called information for Geroge Ward's number and was told that his number was unlisted. I then remembered that a Joseph Cooper had done some painting for me after the robbery, and had been recommended by Ward. I found Cooper's business card, call his home, and spoke to his wife, who said she would give George Ward the message. I did not hear from Ward at this time.

14. After the severe storm, I also called John Lowell and requested him to stop payment on the check for $4,400.00 because of the new leakage. I understand that he forthwith called the Boston Safe Deposit and Trust Company and placed a stop payment order on the check. However, we later learned that the stop payment order was not effective.

15. Before learning that the check was cashed, I understand that John Lowell wrote a letter, dated August 23, 1979, Exhibit "E" hereto, to George Ward explaining our action in stopping payment and the recurrence of leakage. We did not hear from Ward in response to this letter.

16. After the severe leak, I had Mr. Bogue, a roofer from Canton, do a patch job in the area of the new rear gutter. He provided me with a statement of his observations on the Beacon Hill Roofing and Skylight Service jobs, Exhibit "F" hereto. By apparent coincidence, on the same day that Mr. Bogue made his inspection, I received a phone call from George Ward, who said he was working right around the corner and that they would come over and fix my roof. I got quite angry and told him that I was having someone else fix it and that he owed me a lot of money.

17. On October 3, 1979, I had Mr. Bogue return to examine the roof with Mr. Ruocco, an appraiser from the City of Boston Housing Improvement Program. Mr. Ruocco provided me with an estimate for $2,580.00 to redo the entire tar and gravel roof. Exhibit "G", hereto.

18. Also, in October, I obtained an independent estimate from Hayden, Inc., for repair of the interior damage at a total price of $1,142.00. Exhibit "H", hereto.

19. I have not heard from Ward again, and he has never furnished me with a written guarantee as promised in his contract, Exhibit "D".

Signed under the pains and penalties of perjury this 7th day of November, 1979.

BARBARA ROOT HOLBROOK.

BOSTON, MASS.,
Suffolk, ss:

November 7, 1979.

Then personally appeared before me the above-named Barbara Root Holbrook and swore to the truth of the foregoing statement.

SUSAN H. FREY,
Notary Public.

My Commission expires November 26, 1982.

[Supporting documents retained in committee files.]

AFFIDAVIT OF STANLEY G. MARTINI

I, Stanley G. Martini, being duly sworn, hereby depose and state as follows:

1. I am the owner of Martini Roofing Company, 411 Broadway, Somerville, Massachusetts 02145. The company has been in business since 1936, originally under my father's proprietorship and later mine. I began work as a roofer in 1949, and worked for several years with my father and brother. After the hurricane of 1954, I began doing appraisals of roof damage for insurance companies. At present, I am the manager of the company and I do appraisals for numerous eastern Massachusetts insurance companies, including Maryland Mutual. Hartford Insurance, Travelers, Shelby Mutual, Patriot's General and Middlesex Mutual. I also employ a crew of six men for tar and gravel work and another crew of six men for shingle and gutter work. My customary wage for non-union employees at present is $6.00-$9.00 per hour. Most of our roofing work is for homeowners, although we do an occasionally industrial job. At the request of the Attorney General, I have inspected several roofing jobs performed by Waltham Roofing Service and Beacon Hill Roofing and Skylight Service.

2. On November 2, 1979, I inspected a roofing job at the residence of Barbara Root Holbrook, 21 Charles River Square, Boston, MA. With me was Joseph Bologna of 409 Broadway, Somerville, MA, a mason who has worked for me in the past. Mr. Bologna has six (6) years' experience as a mason and does very good masonry work, in my opinion. Mrs. Holbrook showed us a copy of her July, 1979, contract with Beacon Hill Roofing and Skylight Service, which covered the following items: Skylights; the rear gutter, tar and gravel the rear section of the roof (14' x 14'); repointing rear brick wall. I inspected these items. My report and nine (9) photographs are attached hereto as Exhibit "A".

Skylights

The recent work I observed on the exterior of the small skylight consisted of calking with roof cement. (Photo 7) A high price for this work would be $120.00.

The interior of the large skylight (over the stairwell) had been scrolled recently.

Rear gutter. (Photos 4 and 5)

I observed a recently installed new rear gutter, 19 feet long with a right angle bend. This gutter is well made and might have been prefabricated in a sheet metal shop. The gutter has a metal flange along its length, which attaches it to the roof.

I observed a temporary tar paper patch (Photo 5) over the metal flange of the gutter. I was not able to see how the flange had been flashed to the roof, but it appears that the patch was necessary because of leakage along the flange. My price to install this 19 foot gutter, including resetting the copper ledge, would be $380.00.

Tar and gravel rear roof area. (14' x 14') (Photos 8 x 9)

I observed that the rear 14' x 14' roof had been recently re-done with a tar and gravel system. Photos 8 and 9 show two spots of raw tar paper which were not properly covered with asphalt and stones. These areas can deteriorate, if not covered. This was poor workmanship. My price to install a tar and gravel roof in an area this size would be $500.00

Brick wall at rear and in alcove. (Photos 1, 2, 3)

All three faces of this rear wall had been recently re-pointed over 90 percent of the surface areas. My mason, Mr. Bologna, stated that the workmanship was adequate, but not high quality. He quoted a maximum price of $6,000.00 for a job this size, including installation of staging.

Signed under the pains and penalties of perjury this 7 day of November, 1979.

STANLEY G. MARTINI.

SOMERVILLE, MASS.,
Middlesex, ss:

November 1979.

Then personally appeared before me the above-named Stanley G. Martini and swore to the truth of the foregoing statement.

PETER J. VITALE,
Notary Public.

My Commission expires October 19, 1984.

CONTINUED

1 OF 2

MARTINI ROOFING COMPANY

APPRAISERS FOR EASTERN MASSACHUSETTS INSURANCE COMPANIES

TELEPHONE (617) 628-5881 • 411 BROADWAY • SOMERVILLE, MASSACHUSETTS 02145

Assistant Attorney General, Susan F. Frey
Consumer Protection Division
Public Relation Bureau
One Ashburton Place
Boston, Massachusetts 02108

DATE REQUEST RECEIVED_____
ADJUSTER_____
OUR FILE NO. AG-8
~~INSURED~~ Barbara Holbrook
ADDRESS 21 Charles River Park Square
Boston, Massachusetts
COMPANY Beacon Hill Roofing & Skylight Serv
AMOUNT_____

DESCRIPTION OF DAMAGE:

Upon inspection of above property, please be advised of the following:

Photo 1: General view of building.

Photo 2: General view of rear of the building.

Photo 3: The red divisional line indicates that the left side of the building owned by the claimant.

Photo 4: 19 ft. of copper gutter was installed by Beacon Fill Roofing & Skylight Service

Photo 5: Temporary repairs had been made with tar paper by a second roofer to prevent further interior damage.

REMARKS:

CONDITION OF ROOF: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

MARTINI ROOFING COMPANY

Stanley G Martini
STANLEY G. MARTINI, MANAGER

MARTINI ROOFING COMPANY

APPRAISERS FOR EASTERN MASSACHUSETTS INSURANCE COMPANIES

TELEPHONE (617) 628-5881 • 411 BROADWAY • SOMERVILLE, MASSACHUSETTS 02145

DATE REQUEST RECEIVED_____
ADJUSTER_____
OUR FILE NO. AG-8
~~INSURED~~ Barbara Holbrook
ADDRESS 21 Charles River Park Square
Boston, Massachusetts
COMPANY Beacon Hill Roofing & Skylight Ser
AMOUNT_____

DESCRIPTION OF DAMAGE:

Photo 6: Roofing debris that was not removed by the second roofer after installing temporary repairs.

Photo 7: The ~~second~~ roofer applied roof cement to the glass pane of the skylight to prevent water from seeping into the interior.

Photos 8 & 9: 224 sq. ft. of asphalt & gravel that had been installed by Beacon Hill Roofing & Skylight Service. Spotted areas that was not properly coated with asphalt to allow gravel to adhere.

Photo 9: The asphalt & gravel roof was installed directly over the old flashing, therefore allowing water to seep under the plies of felt paper. The tar paper should have been installed to the back of the flashing to prevent any leakage.

ESTIMATES:

GUTTER:	$ 380.00
ASPHALT GRAVEL ROOF:	500.00
SKYLIGHT:	120.00
MASONRY:	5,000.00 ✓ 6

REMARKS:

CONDITION OF ROOF: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

MARTINI ROOFING COMPANY

Stanley G Martini
STANLEY G. MARTINI, MANAGER

United States District Court

District of Massachusetts

CIVIL ACTION No. ——

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

MARK NOVITCH, IN HIS CAPACITY AS ACTING COMMISSIONER OF THE FOOD AND DRUG ADMINISTRATION, DEFENDANT

COMPLAINT

PRELIMINARY STATEMENT

1. This action arises under the Federal Food, Drug and Cosmetic Act. 21 U.S.C. §§ 301 et seq. The Commonwealth of Massachusetts seek judicial review of the denial by the Commissioner of the Food and Drug Administration of the Commonwealth's application for exemption from federal preemption for portions of Massachusetts General Laws c.93 §§ 71 et seq., an Act designed to protect Massachusetts consumers from abuses in the sale of hearing aid devices. The Commonwealth seeks a declaration that the Commission's actions are invalid under the standards enumerated in the Administrative Procedure Act, 5 U.S.C. § 706.

JURISDICTION

2. Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331(a) and 1337. The Court is empowered to grant declaratory and related relief pursuant to 28 U.S.C. §§ 2201 and 2202 and Fed.R.Civ.P. 57, and to grant declaratory and injunctive relief pursuant to 5 U.S.C. § 703. Venue lies in this Court pursuant to 28 U.S.C. § 1391(e)(4).

PARTIES

3. The Commonwealth of Massachusetts is a sovereign state of the United States, represented by the Attorney General thereof.

4. Defendant Mark Novitch is the Acting Commissioner of the Food and Drug Administration, and as such is responsible for the effective enforcement of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 301 et seq. and all regulations promulgated under said Act.

FACTS

5. The Food, Drug and Cosmetic Act ("the Act"), 21 U.S.C. § 301 et seq., as amended, vests general rulemaking authority for its effective enforcement in the Secretary of Health and Human Services ("the Secretary"), 21 U.S.C. § 371(a), who has delegated his rulemaking authority under the Act to the Commissioner of the Food and Drug Administration ("the FDA"), 21 C.F.R. § 5.1(a)(1).

6. The Act was amended by the Medical Device Amendments of 1976 ("the Amendments"). 21 U.S.C. §§ 360 et seq. The effective date of the Amendments was May 28, 1976. The Amendments were passed to ensure the safety and effectiveness of medical devices in widespread use throughout the United States. In furtherance of this objective, the Amendments vest regulatory power in the FDA.

7. Pursuant to the Act and the Amendments, the FDA published final regulations for hearing aid devices in the Federal Register on February 15, 1977, v. 42 at 9294–96 (amending 21 C.F.R. Part 801, adding §§ 801.420, 801.421). These regulations prescribe, inter alia, conditions for sale of a hearing aid device.

8. The regulations require, as a condition for sale of a hearing aid device, a written statement signed by a licensed physician stating that the patient's hearing loss has been medically evaluated, 21 C.F.R. § 801.421(a)(1). This requirement, however, can be waived For any reason by any prospective hearing aid user 18 years of age or older. 21 C.F.R. § 801.421(a)(2).

9. In December, 1977, the Commonwealth of Massachusetts, after extensive legislative hearings, enacted hearing aid legislation entitled "Regulating the Sale of Hearing Aids," G.L. c.93 §§ 71 et seq., as added by Chapter 978 of the Acts of 1977. The effective date of the Act was April 11, 1978. The Massachusets Act, like the FDA regulation, prescribes certain requirements for the sale of hearing aid devices.

10. Section 521(a) of the 1976 Amendments, 21 U.S.C. § 360k(a), provides that no state or political subdivision thereof may establish or continue in effect any requirement concerning the safety or effectiveness of a medical device which is "different from, or in addition to" a requirement applicable to the device under the Act.

11. Section 521(b), 21 U.S.C. § 360k(b), provides that the Secretary, upon application by a state or political subdivision thereof, may, by regulation promulgated after notice and an opportunity for an oral hearing, exempt from preemption under Section 521(a) any state or local requirement which is more stringent than a requirement under the Act or is required by compelling local conditions and does not cause the device to be in violation of any requirement applicable under the Act.

12. On May 2, 1978, the FDA published a final rule prescribing procedures for applying for exemption from preemption under § 521, 21 C.F.R. § 808. Section 808.25(g)(2) of the rule provides that the Commissioner may grant an application for exemption if the state or local requirements are more stringent than the federal requirements or are rdquired by compelling local conditions. Section 808.25(g)(3) further provides that the Commissioner may not grant an application for exemption if he determines that the exemption would not be in the best interest of public health, taking into account the potential burden on interstate commerce.

13. Section 72 of the Massachusetts Act prescribes requirements which are "different from, or in addition to" the FDA requirements described in paragraph 8. Specifically, the Massachusetts Act requires a hearing test evaluation in addition to a medical clearance evaluation. The hearing test evaluation can be conducted only by certain professionally-trained individuals. Neither the medical clearance evaluation nor the hearing test evaluation can be waived unless the religious beliefs of the prospective purchaser preclude consultation with a physician. Moreover, under the Massachusetts Act, no hearing aid dispenser may enter into a contract for sale of a hearing aid device unless the evaluation requirements are met. Under the FDA regulation, by contrast, the medical evaluation or waiver thereof may take place after the contract of sale but before delivery of the hearing aid.

14. Because of the discrepancies between the FDA requirements described in paragraph 8 and the Massachusetts requirements described in paragraph 13, the Commonwealth of Massachusetts filed an application for exemption from preemption with the FDA on July 3, 1978, pursuant to 21 C.F.R. Part 808.

15. The FDA published a proposed rule responding to the Commonwealth's application in the Federal Register on April 13, 1979, v. 44 at 22119–21. The FDA proposed to deny the application because of the differences between the Massachusetts and federal requirements described in paqagraph 13. In support of its proposal, the agency noted that, in issuing its hearing aid regulations, the agency had concluded that the requirement of an audiological or hearing test evaluation would create an additional barrier to receipt of a hearing aid in areas where audiological services are scarce and could increase the cost of obtaining a hearing aid. The agency also expressed its belief that an informed adult who has religious objections to medical examination should be permitted to waive such examination.

16. On October 16, 1979, a public hearing was held on the proposed rule concerning exemption from preemption. Francis X. Bellotti, Attorney General of the Commonwealth of Massachusetts testified along with numerous consumer and industry representatives. Attorney General Bellotti noted that the hearing test evaluation would not pose an additional barrier to receipt of a hearing aid in Massachusetts because there is no scarcity of audiological services in Massachusetts. In addition, he noted that investigations conducted by the Attorney General had shown that the stricter medical waiver requirement was necessary to protect Massachusetts consumers.

17. On October 10, 1980, the FDA published a final rule denying, for the most part, the Commonwealth's application for exemption from preemption with respect to the FDA requirements described in paragraph 8. Federal Register, v. 45 at 67325–26 (adding 21 C.F.R. § 808.71). The FDA granted exemption from preemption for G.L. c.93 § 72 only for the provision of the statute requiring both a medical examination and a hearing test evaluation before a hearing aid can be sold to a child under the age of 18.

18. The requirements of the Massachusetts Act described in paragraph 13 are more stringent than the requirements applicable to hearing aid devices under the federal Act, and provide significantly greater protection to Massachusetts consumers than the parallel FDA regulations.

19. The requirements of the Massachusetts Act described in paragraph 13 are required by compelling local conditions. Chapter 978 of the Acts of 1977 was enacted in response to widespread abuses in the sale of hearing aid devices in Massachusetts, and was intended to protect the citizens of the Commonwealth from such abuses.

20. There is no evidence that the provisions of G.L. c.93 §§ 71 et seq. summarized in paragraph 13 conflict with or impede the enforcement or effectiveness of the federal regulatory scheme.

21. An actual controversy exists between the Commonwealth of Massachusetts and the FDA concerning the Commissioner's denial of the Commonwealth's application for exemption from preemption.

22. The Commonwealth has exhausted its administrative remedies.

CAUSES OF ACTION

23. Where there was no evidence that the Massachusetts statutory requirements conflict with or impede the enforcement or effectiveness of the federal scheme, and where the Massachusetts hearing aid requirements are more stringent than the FDA requirements and are required by compelling local conditions, the Commissioner's denial of the Commonwealth's application for exemption from preemption was arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law.

24. Where the Massachusetts statutory requirements which are the subject of the Commonwealth's application for exemption from preemption in fact further the objectives of Congress in enacting the Medical Device Amendments of 1976, the Commissioner's failure to harmonize the Massachusetts and FDA hearing aid requirements is not in accord with Congressional intent, and as such the Commissioner's action was arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law.

25. Where the federal Act, section 521(b), 21 U.S.C. § 360k(b), and the FDA regulation, 21 C.F.R. § 808.25(g)(2), provide that the Commissioner may grant an exemption from preemption if the state or local requirements are more stringent than the FDA requirements or are required by compelling local conditions, the Commissioner failed to make specific findings whether the portions of G.L. c.93 §§ 71 et seq. subject to the application for exemption from preemption met the statutory criteria. This failure to make such findings was arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law.

26. In denying the Commonwealth's application for exemption from preemption, the Commissioner applied standards which were inconsistent with congressional intent, and as such the Commissioner's action was arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law.

27. In denying the Commonwealth's application for exemption from preemption, the Commissioner misapplied the standards set forth in the federal Act, section 521(b), 21 U.S.C. § 360k(b), and the FDA regulation, 21 C.F.R. § 808.25(g). As such, the Commissioner's action was arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law.

RELIEF

Wherefore, Plaintiff urges this Court to:

(a) Declare that the Commissioner's denial of the Commonwealth's application for exemption from preemption was arbitrary, capricious, and abuse of discretion, or otherwise not in accordance with law.

(b) Set aside the FDA's final rule denying the Commonwealth's application for exemption from preemption.

(c) Grant any other relief this Court deems appropriate.

Respectfully submitted,

FRANCIS X. BELLOTTI,
Attorney General, Commonwealth of Massachusetts.

Commonwealth of Massachusetts

SUPERIOR COURT CIVIL ACTION NO. ——

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

vs.

INTERCHURCH TEAM MINISTRIES, INC.; ALBERT R. FREEMAN, INDIVIDUALLY AND AS HE IS PRESIDENT OF INTERCHURCH TEAM MINISTRIES, INC.; DOROTHY FREEMAN, INDIVIDUALLY AND AS SHE IS TREASURER OF INTERCHURCH TEAM MINISTRIES, INC., DEFENDANTS

COMPLAINT

I. STATEMENT OF THE CASE

1. This is an action brought by the Attorney General of Massachusetts to restrain the defendants from engaging in unfair and deceptive practices in the conduct of their business, Interchurch Team Ministries, Inc. (hereinafter ICTM). The Attorney General believes that the defendants are engaged in the practice of medicine without having been registered and licensed as required by G.L. c. 112 § 6. The Attorney General also seeks restitution on behalf of consumers who have been injured by the acts and practices of the defendant.

II. JURISDICTION

2. Jurisdiction is conferred upon this court by G.L. c. 93A, § 4.

III. PARTIES

3. The plaintiff is the Commonwealth of Massachusetts, a sovereign state of the United States, represented by the Attorney General, who brings this action in the public interest.

4. Interchurch Team Ministries, Inc. is a Massachusetts corporation located at 411 Bedford Street, East Bridgewater, Massachusetts. See attached Articles of Incorporation, marked as Exhibit A.

5. Albert R. Freeman is sued individually and in his capacity as President of ICTM and resides at 411 Bedford Street, East Bridgewater, Massachusetts.

6. Dorothy Freeman is sued individually and in her capacity as Treasurer of ICTM and resides at 411 Bedford Street, East Bridgewater, Massachusetts.

IV. FACTS

7. At all times relevant hereto, ICTM has been incorporated as a charitable corporation pursuant to G.L. c. 180.

8. ICTM was formed, by Albert R. Freeman, Dorothy Freeman and others, on October 30, 1968 for the following purposes:

"To hold and conduct religious services and promote religion together with other religious organizations; to publish and distribute printed religious matter and other religious material. In conjunction with these purposes to hold, sell, buy, mortgage, lease and do all things necessary in regard to real and personal property needed in accomplishing the aforementioned purposes. Also to do all other things that are allowed under Massachusetts law for charitable corporations." See Exhibit A.

9. In the course of their corporate activities the defendants and their agents engage in the practice of medicine through the diagnosis and treatment of consumers for a fee. Specifically, the defendants and their agents:

(a) request from and take samples of consumers' urine and saliva, and examine their eyes without the use of instruments. See Affidavits of Richard Paul, Mary A. Pasciucco, Geraldine Cash, and George Dick, attached as Exhibits C, D, E, and F respectively;

(b) purport to analyze the urine and saliva samples in conjunction with optical examination for each consumer. The result of this analysis by the defendants is a series of 'numbers' which supposedly characterize levels of sugar, acidity (pH), salt, urea, and albumin (a blood protein);

(c) on initial visits to ICTM the defendants and their agents state that the consumers' 'numbers' will be analyzed by Dr. Black (see Exhibit D) or by Dr. Reams (see Exhibit E and F) and that the results of this analysis will be mailed to the consumers;

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(d) on the basis of the analyses described in subparagraphs (b) and (c), the defendants and their agents diagnose in consumers various ailments which include, but are not limited to, cancer, emphysema, danger of heart attack, tension, tiredness, low blood sugar, and various malfunctions of the lungs, liver, kidneys, bladder, and large intestine. See Exhibits C, D, E, and F;

(e) to treat the ailments described in subparagraph (d) the defendants and their agents prescribe a complex diet, including the drinking of large amounts of distilled water, the eating and drinking of certain fruits, vegetables and their juices, and avoidance of certain meats and other foods. The ICTM also prescribes that its "patients" take certain vitamines, minerals, herbs and other over-the-counter preparations on a regular, sustained basis, sometimes for the life of the patient. ICTM represents that many of these prescribed preparations can be bought from the defendant, and that some are sold only by defendant. The defendants also prescribe "colonics" (enemas) and sitz baths to its patients. (see Exhibits C, D, E and F).

(f) the defendants require a payment of between $10.00 and $30.00 for services rendered during each visit.

10. Interchurch Team Ministries, Inc. is one of a number of similar operations in various states which follow the Theory of Ionization developed by Dr. Carey Reams. ICTM has a formal relationship with Dr. Carey Reams.

11. Neither Albert R. Freeman nor Dorothy Freeman are medical doctors licensed or registered to practice medicine in Massachusetts. See Exhibit B. Upon information and belief, none of the agents of the defendants engaged in the practice of medicine is licensed or registered to practice medicine in Massachusetts pursuant to G.L. c. 112 § 6.

12. Dr. Carey Reams is not licensed or registered to practice medicine in Massachusetts. See Exhibit B.

13. Dr. Carey Reams has been convicted of practicing medicine without a license in Georgia, Florida, Alabama and Virginia. The Florida conviction was reversed on other grounds and Dr. Reams entered into a mandatory injunction with the State. Copies of the court record indicating these convictions are attached as Exhibits G, H, I and J.

14. Urine and saliva tests and eye examinations cannot detect any of the bodily states, diseases or ailments described in paragraphs 9(b) and 9(d). Such ailments or diseases cannot be prevented or treated by following any of the recommendations or prescribed treatments described in paragraph 9(e). In short, the defendants' and their agents' purported diagnoses and treatments have no foundation in medicine or in science. See Affidavit of Frederick J. Stare, M.D. attached as Exhibit K.

15. The diagnostic and treatment procedures described in paragraph 9 are performed, in part, at the offices of ITCM located at 411 Bedford Street, East Bridgewater, Massachusetts, and at a retreat run by the defendants and their agents called "Stillwater Inn," located in Scituate, Massachusetts. See Exhibits C and E. Upon information and belief, the Attorney General alleges the Inn is now closed, perhaps temporarily.

16. The ICTM diagnostic procedures and prescribed treatments are not in and of themselves known to be physically harmful. However, the ICTM treatments would be dangerous if used to treat a disease or ailment in lieu of conventional medical treatment. See Exhibit K.

17. The Commonwealth has sent and the defendant has received a five day notice of the intent of the Attorney General to file suit as required by G.L. c. 93A, § 4.

V. IRREPARABLE HARM

18. The Attorney General believes that the defendants and their agents have engaged in unlawful practices to the injury of numerous consumers, and that such practices will continue unless the defendants and their agents are enjoined by this court.

VI. CAUSE OF ACTION

19. The defendants and their agents and employees have violated G.L. c. § 2 and Regulations XV(C) promulgated thereunder by practicing medicine without a license. Such practice is unlawful under G.L. c. 112, § 6, a statute meant for the protection of the public's health, safety, or welfare, and intended to provide the consumers of this Commonwealth protection, and therefore such practice is a violation of Regulation XV(C). The defendants and their agents have practiced medicine by diagnosing medical conditions and ailments and prescribing specific treatments, represented to cure or alleviate such ailments.

20. The defendants and their agents, have violated G.L. c. 93A, § 2, and Regulations IV(A) and XV(B) promulgated thereunder, by:

(a) falsely representing that urine, saliva, and eye tests can be used to diagnose certain diseases, in order to induce consumers to the purchase of these tests and services from defendants;

(b) disseminating false and misleading medical diagnoses which are scientifically groundless in order to induce consumers to seek further tests and treatment from defendants;

(c) disseminating false and misleading medical recommendations which are scientifically groundless in order to induce the sale of services such as urine and saliva tests, consultations, and rest cures, and the purchase of products such as vitamins and minerals;

(d) misrepresenting that certain diets, treatments, and/or products are effective in treatment or cure of illness or disease and thereby inducing consumers to forego legitimate medical treatment and substitute useless ICTM treatments, resulting in physical and economic harm to consumers.

VII. RELIEF

Wherefore, the Commonwealth requests that this Honorable Court:

1. Issue an Order of Notice.

2. Issue a temporary restraining order restraining the defendants, their agents, employees, and servants from:

(a) administering urine, saliva, eye, or any other medical test or examination to any consumer;

(b) diagnosing medical conditions, illnesses, or diseases to any consumer;

(c) representing to any consumer that any diet, treatment, or product will cure or alleviate any medical condition, illness, or disease;

(d) representing to any consumer that the defendants or its agents, employees, or servants have any special knowledge or skill in the diagnosis or treatment of medical conditions;

(e) recommending to any consumer to forego diagnosis or treatment by a medical doctor for any illness, ailment, or disease;

(f) failing to immediately notify every person who has currently or is currently being diagnosed or tested by ICTM that ICTM has been preliminarily enjoined by this court from the acts and practices in (a) through (e) above.

3. Issue a Preliminary Injunction in accordance with Prayer 2.

4. After a hearing on the merits, issue a permanent injunction in accordance with Prayer 1, and award restitution to consumers injured by defendants.

5. Award the Commonwealth its costs and reasonable attorney's fees incurred in prosecuting this action.

6. Order such other and further relief as the Court deems just and equitable.

FRANCIS X. BELLOTTI,
Attorney General, Commonwealth of Massachusetts.

COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, ss. SUPERIOR COURT
CIVIL ACTION

(SEAL) NO. CA78-6984

COMMONWEALTH OF MASSACHUSETTS, Plaintiff(s)

vs.

INTERCHURCH TEAM MINISTRIES, INC., Defendant(s)
ET ALS.
(ALBERT R. FREEMAN, individually and as PRESIDENT OF INTERCHURCH TEAM MINISTRIES, INC., DOROTHY FREEMAN, individually and as TREASURER OF INTERCHURCH TEAM MINISTRIES, INC.)
SUMMONS AND RESTRAINING ORDER

To the above-named Defendant :

You are hereby summoned and required to serve upon Sally A. Kelly, Asst. Atty. Gen., plaintiff's attorney, whose address is One Ashburton Place, Boston 02108, an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint. You are also required to file your answer to the complaint in the office of the Clerk of this Court at PLYMOUTH either before service upon plaintiff's attorney or within a reasonable time thereafter.

Unless otherwise provided by Rule 13(a), your answer must state as a counterclaim any claim which you may have against the plaintiff which arises out of the transaction or occurrence that is the subject matter of the plaintiff's claim or you will thereafter be barred from making such claim in any other action.

WE ALSO NOTIFY YOU that application has been made in said action, as appears in the complaint for a preliminary injunction and that a hearing upon such application will be held at the Court House at said ~~PLYMOUTH-BROCKTON-BOSTON~~ in the ~~COUNTY OF SUFFOLK~~, in the first session without jury of our said Court on Tuesday the 9th day of May, A.D., 1978, at 9:30 o'clock A.M., at which you may appear and show cause why such application should not be granted.

In the meantime, until such hearing, WE COMMAND YOU, said defendants, INTERCHURCH TEAM MINISTRIES, INC., ALBERT R. FREEMAN, individually and as PRESIDENT OF INTERCHURCH TEAM MINISTRIES, INC., and DOROTHY FREEMAN, individually and as TREASURER OF INTERCHURCH TEAM MINISTRIES, INC., your agents, employees and servants be restrained from administering urine, saliva, eye, or any other medical test or examination to any consumer; (b) diagnosing medical conditions, illnesses or diseases to any consumer; (c) representing to any consumer that an diet, treatment or product will cure or alleviate any medical condition, illne or disease; (d) representing to any consumer that the defendants or its agents employees, or servants have any special knowledge or skill in the diagnosis or treatment of medical conditions; (e) recommending to any consumer to forego diagnosis or treatment by a medical doctor for any illness, ailment, or diseas (f) failing to immediately notify every person who has currently or is current being diagnosed or tested by ICTM that ICTM has been preliminarily enjoined by this court from acts and practices in (a) through (e) above.

Nancy D. Jones CLERK.

NOTES:

1. This summons is issued pursuant to Rule 4 of the Massachusetts Rules of Civil Procedure.
2. When more than one defendant is involved, the names of all defendants should appear in the caption. If a separate summons is used for each defendant, each should be addressed to the particular defendant.

Affidavit of Richard Paul

I am Richard Paul, Investigator, Public Protection Bureau, Department of the Attorney General.

During the course of my work I was assigned to investigate the establishment known as Interchurch Team Ministries (hereafter referred to as I.C.T.M.), 411 Bedford Street, East Bridgewater, MA.

On June 7, 1977 at approximately 2:00 p.m., I went to I.C.T.M. for the purpose of having a Urine/saliva test. When I arrived, a woman told me tests were given by appointment only. I made an appointment for June 8, 1977.

On June 8, 1977 at 1:05 p.m., I arrived at I.C.T.M. for my appointment and test. I then entered the house, apologized for being early and was told to wait in the living room.

At 1:40 p.m. I was called into another room which looked like an office and I was instructed by a woman to give a urine and saliva sample. She provided me with a bottle and a tray with 6-cup like indentations for my specimen. I used the bathroom for the samples. In the room next to the bathroom, I noticed a dark-haired female working in a room which looked like a laboratory.

I returned to the office with the samples and was given a lengthy questionnaire to fill out. The woman instructor hold me to encircle the "Y" if my answer was yes and to leave the "N" blank if my answer was no. The questions dealt with: Do you smoke? Do you have chest pains, headaches, leg aches (which ones)—a few questions had to be written, such as: What color are your teeth, color of gums, oily or dry skin and a few others?

While filling out this form the phone rang and was picked up by the woman instructor who was sitting in the office with me. After answering the phone, she yelled to the woman in the lab, "Phyllis, Chris Moore is on the phone, can you talk to her?"

Phyllis: "I'm busy, what's her problem?"

Woman Instructor: "She has blood in her urine."

Phyllis: "Tell her to juice a watermelon and drink 4 ounces every 3 hours."

Lois: "She's noticed the blood for over a week."

Phyllis: "Tell her to use the watermelon juice—it's delicious."

The woman told the caller to juice a watermelon and drink 4 ounces every 3 hours, she also said that she was busy with a client and hung up.

I asked the woman instructor if she was Phyllis or Dorothy—she replied that her name was Lois (she didn't give me her last name.) Lois left the office after I gave her the completed questionnaire and came back in a few moments with a slip of paper with numbers on it.

Lois told me that my urine salt count was 30.0c and that I was in a major heart attack zone and could have a heart attack at any time because the normal count was 6. She advised me to purchase distilled water and to drink 4 ounces every hour—I asked her to write this down so that I wouldn't forget and she did and gave me the slip. (Attached to this affidavit as Exhibit C1.) She also mentioned that I had a cholesterol build-up.

Lois asked me (looking at the questionnaire) if the pains in my legs were muscular or bone—I said muscular.

Lois asked me if my forgetfulness was remembered after the incident was mentioned to me—I said yes.

Lois asked me if I prepared my own food. I told her that my wife did and she then explained that I would receive the final results of the tests in 4 weeks and a diet would accompany them and I should instruct my wife on what the diet was for.

I asked Lois if I should stop salting my food. She said, "Throw the salt shaker away." I mentioned I had started jogging—she replied that I should not do anything which would apply pressure to my heart because I was on the borderline of a major heart attack.

Lois then asked me to smile and she wrote something on a pad of paper—she asked me to show her my gums—she said "Pink" and wrote something down.

Lois had me stand in front of her before the front window and without moving my head to look to the left—with her fingers she lowered the bottom lids of my eyes and wrote on a chart—she then had me look to the right and repeated the process.

Lois then gave me a 6 page newsletter that dealt with heart attacks (Attached to this affidavit as Exhibit C2.) and a booklet entitled, "Uro-Analytical Procedures Diet Booklet" that has my number formula written on the last page and dated. (Attached to this affidavit as Exhibit C3.)

Lois again explained that I would get a report in 4 weeks along with the diet. She told me to follow the diet and that they would notify me when to return to the clinic for another number test which would cost $10.00.

The consultation was concluded and I was taken into the reception room where I gave the secretary $30.00 and was given a receipt which stated that my payment was a tax deductible contribution to the ministry. (Attached to this affidavit as Exhibit C4.)

At no time did anyone at ICTM tell me that the establishment was a ministry—or in any way a religious organization or that the test or diet were related in any way to God or to religion. I left ICTM at approximately 2:25 p.m.

On or about June 30, 1977, I received through the mail a letter and a list of dietary suggestions from ICTM. This letter dated June 29, 1977, states that anyone having the numbers that were found on my card would have the following:

Tendency toward low blood sugar (fluctuates).
In zone for major heart attack.
Tip edge of Collagen disease.
System breaking down too rapidly.
Lot of inward tension and stress.
Demineralization.
Osteroarthritic changes.
Over-expansion of both lungs.
Congestion in bottom of both lungs.
Irritation in upper abdomen.
Delata cells in prostate.
Delata cells in colon.
Irritation in bladder.

The ICTM letter also states that Dr. Reans is not saying that I have cancer, but that a person with my numbers has minerally deficient cells in the above-mentioned areas. Also that these things are not discernible to the medical profession in their present state, but are figured by a unique method called The Biological Theory of Ionization which Dr. Reams alone is able to do. This letter was signed by Phyllis R. Greene (Attached to this affidavit as Exhibit C5.)

The other attachments to the ICTM letter, Exhibit C5, include dietary suggestions and a list of minerals, herbs and vitamins which ICTM claims are needed to supplement my diet. According to the dietary suggestions, I was instructed to drink four ounces of lemonade mixture on the hour, and four ounces of distilled water on the half hour. Also six ounces of prune juice diluted with distilled water in the morning and eight ounces of cranberry juice during the day. The minerals, herbs and vitamins I was instructed to take are as follows:

Cal II, 2 caps 3 times a day with meals.
Dolomite, 2 caps 3 times a day with meals.
Chaparral, 2 caps 3 times a day with meals.
Algavim, 2 caps 3 times a day with meals.
Min-Col, 1 cap 2 times a day with meals. for 30 days, then once a day for 49 years.
Royal Jelly, 1 teas. 2 times a day.
3 Vit., AD with D at 400 units 2 times a day between meals.
Lime water, ½ Tbs. in 4 oz. grape juice in the morning and at bedtime.

The ICTM letter states that a colonic treatment and a hot sitz bath are indicated. I was instructed that for the sitz bath, I should sit in a hot tub of water, waist high, for thirty minutes every day. The other comments that the ICTM letter made were that drinking distilled water on a regular schedule would take me out of the heart attack zone. They stated that there was nothing wrong with my heart—just stress of poor digestion. (Attached to this affidavit as Exhibit C6.)

On January 9, 1978, at 11:00 a.m. I called ICTM at 378-3946 for another appointment. I spoke with the secretary and she told me to come to ICTM for a re-examination at 1:00 p.m. January 13, 1978.

On Friday, January 13, 1978, at 1:05 p.m. I arrived at ICTM for my re-examination. Before I could put my hand on the door handle entrance to let myself into the building—the door opened and the woman who examined and interviewed me on my June 8, 1977 visit asked me to come in and to go straight into an office down the hall.

Once in the office I was handed a glass container and a saliva plate and was moved into the adjoining bathroom without being asked to remove my coat and was simply told, "We'll need another sample to recheck your numbers."

I assumed the woman want get a urine and saliva specimen and I obliged, while I was leaving the bathroom she told me to put them in "there"—a lab facility next to the bathroom. I laid the glass container filled with urine and the saliva tray with 6 specimens on the counter inside the lab.

Stepping into the office I said to the woman, "I can't remember your name." She replied, "Lois."

I remarked about the bad weather. She agreed it was bad and asked me to wait until my numbers came out.

I mentioned to Lois that I was instructed to bring my folder with me but I could not find it. She answered, "That's all right; we will check your new numbers and see how they compare with the originals."

After a pause, I said to Lois, "The last time I was here I overheard a woman tell an elderly couple about a new place you were going to have for testing." Lois replied "It's not for testing—it's a place for complete rest—it opened last summer—it's located in Scituate and is a very lovely place."

She stood up, walked over to a bookcase and handed me a loose leaf binder and said, "look through this and I'll be right back."

The binder contained glossy colored photographs of a place called Stillwaters Inn, 114 Branch Street, Scituate, MA. The photos were of the grounds and rooms inside the building. I handed Lois the binder and remarked that the Inn was beautiful and looked nice and peaceful.

I asked her how much it would cost to stay at the Inn. She said "$500.00 for 2 weeks." She continued and explained that the first three days were a fast period where you could drink only lemon juice and water and not eat at all. She said that it might be a little uncomfortable because it took that long to get the garbage out of your system. Then she said, you go on a prepared diet. She also said that basically the two weeks are for resting and to find yourself again.

Lois also told me that the evenings are filled with meetings and every one seems to enjoy it. Lois said, "We call it reams retreat." She also told me that they have had great success with people who have cancer.

I then mentioned it was too bad that when someone gets to be my age and has some money, but because he feels lousy, he can't really enjoy it.

Lois quickly said "You should, if you can, come to the retreat, it will do you a lot of good. It was closed for the Holidays, but it is open again." She handed me a card which reads "Still Waters Inn." She said that they can serve 37 people at a time. (The card is attached to this affidavit as Exhibit C7.)

I mentioned I had a headache, which was true, and Lois said, "I'll get you something."

She left the room and almost immediately returned with a teaspoonful of what she said was Honey. She said, "Take it and while I'm explaining the numbers it will make you feel better."

I swallowed the "Honey" and she asked how it tasted—I said "Good". Lois said, "It taste good because your low—otherwise it would have tasted too sweet."

Meantime, the woman from the Lab came in and handed Lois a piece of paper approximately 3" x 5" that had my name, date, and numbers on it. (Attached to this affidavit as Exhibit C8.)

Lois started to explain the numbers, she said that the numbers written in red were from the first visit she also said that on top of the paper there are also red numbers which characterize what the readings should be.

Lois told me I had a lot of acid and too much salt in my system and that there was heavy pressure on my chest.

She said the acid in my system could be from citrus fruits, heavy exercise, or jogging. She never asked me if I exercised or jogged.

At this time, Lois handed me a printed sheet with lists of minerals, herbs and vitamins which she told me to take to supplement my diet. (Attached to this affidavit as Exhibit C9.)

These supplements are as follows:

Cal II, 1 caps 3 times a day with meals.
Cal Lactate, 1 caps 3 times a day with meals.
Algavim, 2 caps 3 times a day with meals.
Min-Col, 2 caps 2 times a day with meals.

Lois said that she was prescribing some high calcium capsules to expedite the healing of my rib which I had previously mentioned was broken during an accident in September, 1977.

Lois also stated that I was to go on a Lime Water Diet to relieve me of the salt in my system. She told me to take 1 Tbs. of lime water in 4 oz. of grape juice at bedtime.

She told me to stay on distilled water and the diet and that I should return in 30 days if I found it necessary. She again told me that I should think about going to the retreat.

I asked Lois if someone could stay at the retreat one week only. She said that they prefer two weeks since the first week is primarily for fasting.

She then asked me about my headache and whether the Honey made me feel better.

I said, "I felt lighter", which was not true.

I said I get headaches because of Arthritis of the neck. She told me that ICTM sells a jelly which is very good for healing Arthritis. She also mentioned that ICTM sells vitamins.

Lois led me to the reception room so that I could pay for the visit.

I said to the woman in the reception area, "Are you Phyllis?"

She said, "No, I'm Carol."

Carol handed me a receipt after I gave her ten dollars in cash. Once again, the receipt stated that ICTM thanked me for my tax deductible contribution to the ministry. (Attached to this affidavit as Exhibit C10.)

I attest that the above is true to the best of my knowledge.

Signed under the pains and penalties of perjury on this 24th day of April 1978.

RICHARD PAUL.

MARJORIE COHEN,
Notary Public.

My commission expires May 28, 1982.

AFFIDAVIT OF MARY A. PASCIUCCO

I am Mary A. Pasciucco, Deputy Chief Investigator, Public Protection Bureau, Department of the Attorney General. During the course of my work I was assigned to investigate the establishment known as Inter-Church Team Ministries (hereafter referred to as ICTM), 411 Bedford Street, East Bridgewater, Ma.

On January 9, 1978 at 11:10 A.M., I called ICTM at 378-3946 for an appointment. On January 18, 1978 at 1:30 P.M., I arrived at ICTM for a test. I was accompanied by another staff membr, Joseph Mingolla.

Upon arrival at ICTM I was greeted by a female who simply said "Mary?" and then, "Come this way." when she greeted me she had a small glass jar and a white rectangular slab with six small holes in it. She escorted me into a lavatory, gave me the glass jar and told me to give her a urine specimen. She also told me to put some saliva into three of the six holes on the white slab. When I emerged from the lavatory she told me to give my specimen to another woman who was in the room next to the lavatory. She said to me, "this is the woman who will test your specimens." The latter woman asked me if I had just eaten and I said, "yes". She said, "Good". I said that I had just eaten and she said when and what. I said within the last 15 minutes, I had a hamburger and fries at McDonalds. She said it didn't matter.

I then went back to the waiting room and the first woman handed me a typed questionnaire. I filled out my personal history and proceeded to answer a total of 169 questions relating to my medical history. After I finished this, she examined my eyes. She asked me to stand up and face her—she was in front of a window. She made me look to the left and then to the right. During this time she lowered and raised my lower and upper eyelids. It appeared to me that she was diagramming the veins in my sclera.

She then handed me a booklet entitled "Uro-Analytical Procedures Diet Booklet (attached to this affidavit as Exhibit D1). She opened the back page and showed me my 'numbers' which she told me were the results of their tests on my urine and saliva.

She told me to read the first fiften pages of the booklet. She then explained to me what my numbers meant in relation to the 'norm' outlined on page two of the booklet.

First, she discussed my sugar. She told me my sugar number was 5.6 and that the norm is 1.5. She stated that this difference between my sugar number and the 'norm' could be the cause of my lethargy. (I had previously informed her that I had lost 15lbs. in the past six months and was feeling very lethargic). She then told me that I could go to a regular physician and get checked for sugar but he would tell me that my level was within normal limits. She stated that ICTM would not prescribe insulin, but that she did not think that my numbers were very healthy.

Next, she explained my salt level number which was 29.2c. She said that the "norm" is 6 to 7 c. She stated that if the number is 30, one could experience chest pain or a tightness in the chest. I asked if one could experience shortness of breath and she said that this could also occur.

After this she told me that I would receive a full analysis in a month after Dr. Black had a chance to look at my numbers. She informed me that a diet would accompany this and they would also tell me what minerals I had to take. She stated that ICTM sold the minerals right there and that ICTM preferred to have people

take these because they knew what the results should be. She informed me that I would have to stay on the ICTM diet for the rest of my life.

I asked her if there was anything I could take while I waited for Dr. Black's analysis. She said that she could not tell me what minerals to take now but that I should immediately start drinking four ounces of distilled water every hour.

She told me that I would have another appointment with ICTM after I received Dr. Black's analysis. I said "thank you" and she said "you can pay Carol". We went out of the waiting room and into the reception area. Carol who was in this room appeared to be the secretary. Joseph Mingolla and I asked her how much we owed her and she said $30.00. Joseph gave her $30.00 in cash and she asked us who she should make the receipt out to. I told her to make it out to me. I received a receipt from her dated January 18, 1978 (attached to this affidavit as Exhibit D2). It states that, "We thank you, Mary Glynn for your tax deductible contribution to the ministry." At no time did any of the people from ICTM mention that the establishment was a ministry or in any way related to religion.

On February 23, 1978 I received through the mail a letter and a list of dietary suggestions from ICTM. This letter dated February 18, 1978 stated that my recent test at East Bridgewater showed that anyone having the numbers that appeared on my card would have the following:

Notable adrenal stress.
Notable inward tension—tiredness.
Bruises too easily; heals too slowly.
Liver function depressed.
Sugar fluctuates.
In the zone for a minor heart attack.
Mineral and oxygen transport poor.
Stress on right kidney.
Stress on bladder.
Stress around ileocecal valve region.

It further stated that a person with my numbers has minerally deficient cells in the above-mentioned areas. Also, that these conditions are not necessarily discernible to the medical profession in their present state, but are figured by a unique method called The Biological Theory of Ionization.

The letter also stated that everyone who has a test would benefit greatly from at least two weeks at Still Waters Inn, Scituate, MA. The cost is $250 per week and the telephone number is 617-545-6224. At the Inn one would be "encouraged, under supervision, to fast, rest and change eating habits which are responsible for present problems." This letter was signed by Dorothy A. Freeman. (Attached to this affidavit as Exhibit D3.)

The other attachments to Exhibit D3 include dietary suggestions and a list of minerals and herbs which ICTM claim are needed to supplement my diet. According to the dietary suggestions, I was instructed to drink three ounces of lemonade mixture every hour and three ounces of distilled water on the half hour. Also three ounces of prune juice diluted with distilled water in the morning, four ounces of cranberry juice and four ounces of vegetable juice during the day.

The minerals and herbs I was instructed to take are:

Cal II—1 caps 3 times a day with meals.
Cal Lactate—1 caps. 3 times a day with meals.
Dolomite—2 caps. 3 times a day with meals.
Chaparral—2 caps. 3 times a day with meals.
Alqavim—2 caps. 3 times a day with meals.
Min-Col—2 caps. 2 times a day with meals for 30 days—then once a day for 77 years.
Fero Tonic—4 drops 2 times a day in 8 ounces of water every other day.
Vitamin C—500 units 2 times a day betwcen meals.
Vitamin E—500 units 2 times a day between meals.

I was also instructed that a colonic treatment was indicated. The other comments that ICTM made were that drinking distilled water on a regular schedule would take me out of a heart attack zone. They stated that the stress on my heart was from poor digestion. Also that if I experienced any headaches I should add a sweetener to my lemonade. (attached to this affidavit as Exhibit D4).

I also received a brochure form ICTM which advertises home water distillers. (attached to this affidavit as Exhibit D5).

I attest that the above is true to the best of my knowledge.

Signed under pains and penalties of perjury on this 20 day of April, 1978.

MARY A. PASCIUCCO.

MARJORIE COHEN,
Notary Public.
My commission expires May 28, 1982.

AFFIDAVIT OF FREDERICK J. STARE, M.D.

I am Frederick J. Stare, M.D., Professor of Nutrition at the Harvard University School of Public Health. I am a founder of the Harvard University Department of Nutrition and was its chairman for 35 years.

On April 5, 1978, I personally discussed with two investigators from the Office of the Attorney General, Richard Paul and Mary A. Pasciucco, their contact with the Interchurch Team Ministries (ICTM). I examined the materials given them by the ICTM. In 1977, the activities of the Ministries had been called to my attention by the Massachusetts Board of Registration and Discipline in Medicine.

It is my unequivocal professional opinion that the pseudo-health activities of ICTM and Dr. Carey Reams should be put out of business. Their advice to Ms. Pasciucco and Mr. Paul is pure quackery and charlatanism. It makes no medical sense whatsoever.

Both Mr. Paul and Ms. Pasciucco told me that the only examinations given them were tests of their urine and saliva, and an external examination of their eyes. These tests alone cannot be used to determine blood levels of sugar, acidity (Ph), salt, urea, or albumin (a blood protein). ICTM's type of external examination of the eyes is not useful in assessing body chemistry or in assessing internal ailments. The so-called numbers they were provided by ICTM made no medical sense to me.

These three tests alone cannot possibly be used to diagnose the conditions which the ICTM diagnosed for Ms. Pasciucco (see Exhibit K-1): adrenal stress, tension, tiredness, "bruises too easily", liver function, sugar level, danger of heart attack or malfunctions of the kidney, bladder, or ileocecal region in the large intestine. These three tests alone cannot possibly be used to diagnose the conditions which the ICTM diagnosed for Mr. Paul (see Exhibit K2): low blood sugar level, danger of heart attack, collagen disease, tension, stress, lung congestion, or abdominal or bladder "irritation". The terms "system breaking down too rapidly", "over-expansion of . . . lungs", and "delta cells" have to my knowledge no specific medical meaning.

Drinking large amounts of distilled water, as was prescribed for Ms. Pasciucco and Mr. Paul (see Exhibits K1 and K2) has no medical value, and certainly has no value in preventing or treating cancer, tiredness, tension, heart disease, or any of the conditions enumerated above. Drinking the juices of lemon or other fruits or vegetables is only medically beneficial for a narrow range of conditions caused by vitamin deficiency, such as scurvy. It has no value in treating the conditions attributed to Mr. Paul and Ms. Pasciucco. Juicing a fruit or vegetable in no way increases the quality or quantity of nutrients received. The taking of pills containing vitamins and minerals is only beneficial for a narrow range of conditions and has no value in treating the ailments attributed to Mr. Paul and Ms. Pasciucco.

None of the other recommendations in Exhibits K1, K2, and K3 have any medical or nutritional value whatsoever and cannot possibly prevent or treat the conditions attributed to Mr. Paul and Ms. Pasciucco.

A colonic (commonly called an enema) is only used in medical practice for extreme constipation. Neither a colonic or sitz has any value in treating the conditions attributed to Mr. Paul and Ms. Pasciucco.

The theory of ionization, as commonly known to the scientific community, is a simple chemical postulate that all compounds are composed of ions (charged particles). It has no special application or use in medicine.

To my knowledge, none of the recommendations given Mr. Paul and Ms. Pasciucco are themselves harmful. However, the ICTM's activities could be quite dangerous if, because of an ICTM diagnosis or treatment, one of its "patients" failed to consult a medical doctor about a serious ailment, and that ailment was then left untreated or was treated improperly by the ICTM.

In my opinion the conduct of ICTM members constitutes the practice of medicine insomuch as the members give purported diagnoses of medical conditions, and recommend specific treatments, even though such treatments only include use of over-the-counter vitamins and minerals and other simple preparations, and not prescription drugs.

Signed under the pains and penalties of perjury this 6 day of April 1978.

FREDERICK J. STARE, M.D.

Commonwealth of Massachusetts

SUPERIOR COURT CIVIL ACTION No. ——

FRANCIS X. BELLOTTI, AS HE IS ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS,

AND

COMMONWEALTH OF MASSACHUSETTS,

PLAINTIFF

v.

HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC.,

AND

JOSEPH F. HILL, JR., INDIVIDUALLY AND AS HE IS PRESIDENT OF HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC.,

DEFENDANTS

COMPLAINT

I. PURPOSES OF SUIT

1. This is an action brought in the public interest by the Attorney General of the Commonwealth of Massachusetts brought pursuant to G.L. c. 12 § 10 and G.L. c. 93A § 4 to restrain the defendants from injuring nursing home residents in violation of G.L. c. 93A and other state and federal laws and regulations and for the appointment of a receiver.

II. JURISDICTION

2. Jurisdiction is conferred on this court by G.L. c. 93A § 4.

III. PARTIES

3. Francis X. Bellotti is Attorney General of the Commonwealth of Massachusetts and is authorized by G.L. c. 12 § 10 to institute civil proceedings in the public interest whenever he believes that a law affecting the public welfare has been violated. The Attorney General is empowered by G.L. c. 93A, § 4 to bring an action for injunctive relief in the name of the Commonwealth against any person whenever the Attorney General has reason to believe that the person is engaged in any unfair or deceptive act or practice and that such proceedings are in the public interest.

4. The Commonwealth of Massachusetts is a sovereign state represented by the Attorney General.

5. The defendant Joseph F. Hill, Jr. is a natural person who resides at 44 Prentiss Lane, Belmont, Massachusetts in the County of Middlesex. Defendant Joseph F. Hill, Jr. is sued individually and in his capacity as president of the defendant Heritage Hill at Newton Retirement and Convalescent Home, Inc.

6. The defendant Heritage Hill at Newton Retirement and Convalescent Home, Inc. is a Massachusetts corporation licensed to do business in Massachusetts, with its principal place of business at 2101 Washington Street, Newton, Massachusetts.

IV. FACTS

7. At all relevant times hereto, and at least since 1975 the defendants have been engaged in the business of operating Heritage Hill Nursing Home at 2101 Washington Street in Newton, Massachusetts and thereby of providing and offering to provide nursing home services to consumers in Massachusetts.

8. Some, but not all, residents of Heritage Hill Nursing Home, have, at all relevant times, been recipients of financial assistance under the Massachusetts Medical Assistance Program, commonly called the Medicaid Program.

9. The Medicaid Program is a cooperative federal and state program established by G.L. c. 118E, pursuant to and in conformity with the provisions of Title XIX of

the Social Security Act, which provides medical care and services, including nursing home services, to certain residents of the Commonwealth.

10. Pursuant to G.L. c. 118E § 15, providers of health care services such as the defendants, may voluntarily participate in the Medical Assistance Program but are not required to do so.

11. Providers of nursing home services who choose to participate in the Medical Assistance Program are required to agree by contract to comply with all laws, rules, and regulations which govern the operation of the Massachusetts Medical Assistance Program. G.L. c. 118 § 18(4).

12. The defendants Heritage Hill have by contracts with the Massachusetts Department of Public Welfare agreed to provide nursing home services to recipients of Massachusetts Medical Assistance and to comply with all statutes, rules and regulations governing the Medical Assistance Program. Copies of these contracts are attached as Exhibit B.

13. The defendant Heritage Hill Nursing Home currently provides care to approximately 105 residents, of whom approximately 93, are recipients of Medicaid or other welfare assistance.

14. The defendants in the course of running Heritage Hill Nursing Home have on regualr basis and continue to:

(a) Fail to provide adequate nursing care of the nursing home patients in violation of 45 C.F.R. § 405.1124(c); and 42 C.F.R § 449.12(a)(1)(i), see Affidavit of Emily Winkeller, RN, Exhibit C to the Complaint; Affidavit of Commissioner of Public Health Jonathan E. Fielding, M.D., Exhibit D; Affidavit of Ruth M. Foster, Exhibit E; Affidavit of Kathleen Deveau, R.N., Exhibit F; Affidavit of Alfred Souza, R.N., Exhibit G; Affidavit of Margret Brunelli, R.N., Exhibit H;

(b) Fail to take proper precautions to prevent serious injury to patients in violation of L.T.C. Regulations 17.2.1 and 42 C.F.R. § 405.1124(c), see Exhibits C, D, E, F, G, and H;

(c) Fail to maintain proper sanitary conditions to protect the health of patients in violation of L.T.C. Regulations 1.7.7.5, 16.3, 16.4 and 16.5, 42 C.F.R. § 405.1120, and 42 C.F.R. § 449.12(a)(1)(vii), see Exhibits C, D, E, F, G, and H;

(d) Fail to maintain sufficient staff personnel, including nurses' aides and housekeeping personnel to meet the health and safety needs of patients in violation of L.T.C. Regulation 7.2.3.4. and 42 C.F.R. § 405.1120, see Exhibit I;

(e) Falsely hold itself out to consumers as a nursing home which will provide nursing home care which meets minimum state and federal health and safety requirements which in fact it does not in violation of G.L. c. 93A §2, see Exhibits B, E;

(f) fail to provide to consumers all the nursing home services included in the basic daily rate which the patients pay to the defendants or which is paid to the defendants by the Commonwealth of Massachusetts on behalf of the patients in violation of Attorney General Nursing Home Regulation 3.5, see Exhibits D, E, F, G, H and I;

(g) Charge patients and the Commonwealth of Massachusetts for services which are not actually provided to the patient in violation of Attorney General Nursing Home Regulation 3.6, see Exhibits A, B and G;

(h) Fail to change the clothes and linen of patients who are incontinent, with the result that helpless patients are left for hours in urine-soaked clothes and sheets in violation of L.T.C. Regulation 7.7.1.2 and 7.7.1.3 and 7.7.5.2, 42 CFR §405.1120, 42 CFR §405.1121(k)(7), 42 CFR §449.12(a)(6)(ii), see Exhibits C, D, and E;

(i) Fail to provide proper care to prevent and treat deculite (bed sores) in patients with the result that patients must endure needless preventable pain and suffering and with the further result that patients are in jeopardy of losing their lives, in violation of L.T.C. Regulation 7.7.1.2, 42 C.F.R. §405.1120, 42 C.F.R. §405.1121(k)(7), 42 C.F.R. §405.1121(k)(9), see Affidavit of Jonathan Fielding filed herewith, see Exhibits C, D, F, G and H;

(j) Fail to provide patients with baths, showers or bed baths often enough to render patients clean, comfortable and free of urine odors in violation of L.T.C. Regulation 7.7.5.1 and 42 C.F.R. §405.1120, 42 C.F.R. §405.1121(k)(7), 42 C.F.R. §405.1121(k)(9), 42 C.F.R. §405.1124(c), see Exhibits C, D and E;

(k) Fail to ambulate (walk) patients who are unable to walk unassisted as required by patient care plans ordered by the patient's physician in violation of L.T.C. Regulation 7.7.5.5 and 42 C.F.R. §405.1124(c), 42 C.F.R. §449.12(a)(9), see Exhibits C and E;

(l) Fail to maintain patient care plans which accurately reflect the patient's current condition and identify the patient's current needs in violation of 42 C.F.R. §405.1124(d), see Exhibit C;

(m) Fail to provide restorative nursing care to patients with the result that the medical condition of patients needlessly regresses in violation of 42 U.S.C. §405.1124(e) and L.T.C. Regulation 7.5.3, see Exhibits C, D, F, G and I;

(n) Fail to clean patients who are incontinent with the result that helpless patients are left sitting in their own urine and feces for days in violation of L.T.C. 7.7.5.1 and 42 C.F.R. §405.1124(c), 42 C.F.R. §405.1121(k)(7) and 42 C.F.R. §405.1121(k)(9), see Exhibits C, D and E;

(o) Fail to comply with orders of the patients' physician with the result that patients suffer pain in violation of 42 C.F.R. §405.1124(c), 42 C.F.R. §449.12(a)(9), L.T.C. Regulation 7.7.1 and 7.7.1.1, see Exhibit C;

(p) Fail to comply with the terms of its certification as a nursing home, see Exhibits B and J;

(q) Fail to comply with the terms of its provider agreement with the Department of Public Welfare, see Exhibit A.

(r) Fail to comply with state and federal laws and regulations passed to ensure patient care in violation of Attorney General's Regulations 15 (A), (B) and (C).

15. As a result of the acts in paragraph 15 the Department of Public Health inspected and evaluated the defendant nursing home and provided the defendants with a "Statement Deficiencies" for an inspection completed May 23, 1978, attached as Exhibit A to the affidavit of Emily Winkeller, Exhibit C hereto.

16. Because of the extreme seriousness of the defendants' violations of L.T.C. regulations, the Department of Public Health held a conference with defendant Hill on May 30, 1978. At this conference, each and every deficiency and violation of regulations was thoroughly reviewed and explained to defendant Hill by Department of Public Health officials.

17. On July 12, 1978, defendant submitted to the Department of Public Health a plan of correction to remedy the deficiencies cited by the Department of Public Health on May 30, 1978. See attachment A to Exhibit C.

18. The Department of Public Health revisited the defendant nursing home on July 27, July 31, and August 1, 1978 to ascertain whether the home had corrected the deficiencies and complied with its Plan of Correction. The defendant had not corrected the deficiencies and had not implemented their own Plan of Corrections. See Exhibits C and I.

19. As a result, the Department of Public Health issued a second deficiency statement. See attachment B to Exhibit C. During this inspection, Department of Public Health surveyors determined that six (6) patients were in jeopardy, i.e. serious medical trouble. See Exhibit C.

20. On August 14, 1978, as a result of the gross violations of law mentioned in paragraph 15 above, the Department of Public Health issued to the defendant nursing home a Notice of Cancellation of Medicaid Certification.

The defendant nursing home has appealed the decertification.

21. On October 5, 1978, the defendant home was again visited by the Department of Public Health surveyors who determined that serious violations of state and federal laws and regulations continued to exist. These violations, which related to staffing, patient care, and patient safety, seriously threatened the health and safety of the patients. See Exhibit I.

22. At this time, the best interests of the resident patients of Heritage Hill require that the home remain open and be operated in compliance with state and federal laws and regulations. If patients were moved at this time, there is a substantial likelihood that they would experience "transfer trauma," a phenomenon recognized as occurring in such situations. See Affidavit of Emily Winkeller (Exhibit C) and Affidavit of Commissioner Jonathan Fielding, M.D. (Exhibit D).

V. CAUSES OF ACTION

23. By the acts complained of in this complaint, the defendants, their agents, servants and employees, have violated

(a) G.L. c. 93A, § 2;

(b) Attorney General's Regulations, Reg. 15(A), 15(B), and 15(C);

(c) Attorney General's Nursing Home Regulations, Reg. 3.5 and 3.6;

(d) Long Term Care Regulations of the Department of Public Health, Regs. 1.7.7.5; 7.2.3.4; 7.5.3; 7.7.1; 7.7.1.1; 7.7.1.2; 7.7.1.3; 7.7.5.1; 7.7.5.2; 7.7.5.5; 16.3; 16.4; 16.5; and 17.2.1; and

(e) 42 C.F.R. §§405.1120, 405.1121(K)(7), 405.1121(K)(9), 405.1124(c), 405.1124(d), 405.1124(e), 449.12(a)(1)(i), 449.12(a)(1)(vii), 449.12(a)(6)(ii), 449.12(a)(9).

RELIEF

Wherefore, the Commonwealth requests that this Honorable Court:

1. Issue a temporary restraining order, ex parte, restraining the defendants, their agents and employees, from:

(a) Failing to provide adequate nursing care of the nursing home patients;

(b) Failing to take proper precautions to prevent serious injury to patients;

(c) Failing to maintain proper sanitary conditions to protect the health of patients;

(d) Failing to provide sufficient staff personnel, including nurses' aides and housekeeping personnel to meet the health and safety needs of patients;

(e) Failing to provide to consumers all the nursing home services included in the basic daily rate which the patients pay to the defendants or which is paid to the defendants by the Commonwealth of Massachusetts on behalf of the patients;

(f) Charging patients for services which are not actually provided to the patients;

(g) Failing to change the clothes and linen of patients who are bedfast and incontinent;

(h) Failing to provide proper care to prevent and treat decubite (bed sores) in patients;

(i) Failing to provide patients with baths, showers, or bed baths often enough to render patients clean, comfortable and free of urine odors;

(j) Failing to ambulate (walk) patients who are unable to walk unassisted as required by patient care plans ordered by the patient's physician;

(k) Failing to maintain patient care plans which accurately reflect the patients current condition and identify the patients current needs;

(l) Failing to provide restorative nursing care to patients;

(m) Failing to comply with orders of the patients' physician;

(n) Failing to comply with the terms of its certification by the Department of Public Health as a nursing home;

(o) Failing to comply with the terms of its provider agreement with the Department of Public Welfare;

(p) Failing to comply with state and federal laws and regulations passed to ensure patient care.

2. The Commonwealth also requests that this Court appoint a Temporary Receiver for the defendant nursing home and empower and direct the Temporary Receiver to do the following acts:

(a) To provide residents with any medical, nursing and dietary care which they require immediately in the following ways:

(i) Disburse out of the assets of the defendants sufficient money to hire staff, including but not limited to nurses, physicians, and aides to meet the immediate needs of the patients;

(ii) Disburse funds out of the assets of the defendants to correct immediately the unsanitary and unhealthy conditions in the facility, including but not limited to, cleaning floors, rooms and corridors;

(iii) Disburse funds out of the assets of the defendants to immediately purchase food for the residents in sufficient quantity and quality to meet the needs of the residents;

(iv) Disburse funds out of the assets of the defendants to purchase sheets, linen, towels and other items necessary to provide for the comfort, cleanliness and physical needs of the patients;

(v) Perform all the acts as may be necessary to the proper care of the patients at the facility;

(b) Authorize the receiver to immediately transfer any resident in the need of immediate hospitalization or medical care unavailable at the nursing home.

3. Issue a Short Order of Notice under Prayer 1, returnable in ten days, and after a hearing, issue a preliminary injunction on the relief prayed for in Prayer 1.

4. After a trial on the merits, enter the relief prayed for in Prayer 1.

5. Issue a short Order of Notice under Prayer 2, returnable in ten days.

6. Order such other and further relief as is just and equitable.

Respectfully submitted,

FRANCIS X. BELLOTTI,
Attorney General, Commonwealth of Massachusetts.

Commonwealth of Massachusetts

SUPERIOR COURT CIVIL ACTION NO. ——

FRANCIS X. BELLOTTI, AS HE IS ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS,

AND

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC.,

AND

JOSEPH F. HILL, JR., INDIVIDUALLY AND AS HE IS PRESIDENT OF HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC., DEFENDANTS

AFFIDAVIT OF ANN M. DAHLBERG, R.N.

I, Ann M. Dahlberg, being deposed, state the following:

1. I am a Registered Nurse licensed in the Commonwealth employed by the Massachusetts Department of Public Health in the Long Term Care Division. Since February, 1976 I have worked in the capacity of Health Facilities Surveyor. In 1961 I received my Bachelor of Science in Nursing Degree from Boston University. From 1961 to 1975 I worked as operating and recovery room supervisor at the Mt. Auburn Hospital in Cambridge.

2. In my present capacity as nurse surveyor, I was assigned to conduct a follow-up visit at the Heritage Hill at Newton Nursing and Convalescent Home to determine whether the facility had corrected deficiencies found during the follow-up visit conducted in May 1978.

3. During my follow-up visit which I conducted on July 27, 31 and August 1, 1978, I observed that the Level II or skilled nursing unit (called the Garden Unit) was odorous of urine. Patients had fecal and urine stained clothing and bodies. Several patients were lying in wet, urine-soaked beds. Many patients had disheveled hair, dirty fingernails, dirty feet and lacked undergarments. I observed patients with bedsores (decubiti) which result from lack of proper skin care, lack of cleanliness, lack of proper positioning and changes of position and inadequate supportive or preventive equipment. In addition to the poor patient care that I observed, I also noted poor housekeeping services. One patient's room had feces on the floor while other patient rooms had pools of urine and/or food from previous meals littering the floor. A deficiency statement summarizing my findings and regulatory violations is attached to the affidavit of my supervisor Emily Winkeller.

4. On August 31, 1978, I conducted an interim visit to the facility to learn whether the quality of patient care had improved. During this interim visit I again saw the skilled nursing patients who were located on the Garden Unit and found no improvement whatsoever in general patient care. At that time I became increasingly alarmed when I examined the staffing schedule and discovered that on certain shifts the skilled nursing unit had been left in the charge of an unlicensed graduate nurse. This is a violation of Departmental regulations. In one instance, a registered nurse worked 27 hours straight to provide licensed nurse coverage in the facility.

5. In addition to the shortage of nurses, there had been an insufficient number of nurses aides on duty at all times to meet basic patient needs. On Saturday, August 26, from 7 A.M. to 3 P.M. the facility had one licensed person and two ancillary personnel. Only one licensed nurse had been assigned to work the 3 to 11 shift on Saturday, August 26 to care for the thirty-two (32) patients in need of skilled nursing care. No nurses aides were assigned to assist her. The assistant administrators of the home filled in. On Sunday, August 20, on the 7–3 shift, the facility had had ony 2 5/8 aides to care for these 32 patients. State licensing regulations (7.2.3.4) require that a facility have sufficient ancillary nursing personnel to meet the needs of its patients. In my opinion, given the heavy nursing needs of these skilled care patients, a minimum of six adequately trained and supervised aides were necessary on the 7 to 3 shift. On the 3 to 11 shift, a minimum of five adequately trained and supervised aides was required.

6. When I returned to the facility on September 5, after Labor Day weekend, I learned that the skilled Level II (Garden) unit had been closed on September 1 and

that all 32 Level II patients had been disbursed to the intermediate care units within the facility. I was told by the Director of Nursing and the two assistant administrators that this was done because there was not adequate staff to keep the skilled nursing unit open. When suggested to them that they procure additional nursing personnel from the medical labor pools, I was told by Mr. Quilty, Mrs. Flash and Mrs. Hall that the facility owed the pools so much money that the pools would no longer supply the facility with personnel.

7. As a result of this transfer, the intermediate care unit (Cabot) had 62 patients, 22 of whom were skilled nursing patients who required concentrated nursing care and trained observation. The degree of dependence and the type of nursing care required by these patients can be illustrated by the following patient profile provided by Mrs. Flash, R.N., assistant administrator of the home, to myself and to my supervisor, Mrs. Winkeller. Four patients on the unit required full assistance with eating, 18 patients were incontinent of urine, 12 patients required assistance with basic activities such as bathing or dressing and 30 patients required total care inasmuch as they could neither bathe, dress, groom, toilet or ambulate themselves. In my opinion, a minimum of 10 aides on the 7-3 shift was necessary to adequately care for these patients. A review of the facility's schedules revealed the following staffing levels for the 7-3 shift:

For September 1, 2, and 3: one licensed person and 3 aides.
For September 4th: one licensed and 4 aides.
For September 5th: one licensed and 2 aides.

8. Staffing for these days on other shifts and on the other unit (Bradford) was similarly inadequate.

9. I was at the facility on September 5, 6 and 7 from 8:00 A.M. until at least 4:00 P.M. The facility was odorous, noisy, crowded and dirty. Patients were slumped in wheelchairs or poorly positioned and aligned in bed. Some patients were lying in urine and feces. Some decubitus dressings were wet with urine. Patients were poorly groomed and many lacked undergarments and shoes or socks. No between meal nourishments were observed being served. Some patients were served breakfast while lying in urine and feces. Unsupervised patients ate with their hands. In many instances breakfast was served cold to the majority of unit-bound patients. No diet restrictions which were ordered by physicians appeared to be followed. Cockroaches were plentiful in the kitchen. I also observed cockroaches and ants in the bathroom of room 222 of the Cabot wing used by 4 patients. The jar of Betadine Ointment used on patient dressings was left uncovered and flies were observed walking around the edge of the open jar. When I entered room 126, I experienced a wave of nausea because of the overwhelming odor of urine and feces emanating from the body and room of the patients. Flies were observed upon and about both patients.

10. On the 5th, 6th and 7th of September, the Bradford unit housed 53 patients. Of these, nine were Level II patients and 44 were Level III's. In my opinion at least eight adequate trained and supervised aides were required to care for the patients on this unit on the 7 to 3 shift. On the 5th of September, for this unit, only 3 aides were provided. On the sixth of September, only 1¾ aides were provided. On the 7th of September, they had only 2¾ aides. On the 8th of September on this shift, they had only 1¾ aides.

11. The Cabot unit, on which 10 trained and supervised aides were required on the 7 to 3 shift, the following number of aides were provided: on September 5, two were on duty; on September 6, 3 were on duty; on September 7, 3 were on duty; on September 8, 2 were on duty; on September 9, 2 were on duty.

12. On many shifts only one licensed person was on duty on the Cabot unit and on the Bradford unit. Licensed personnel are responsible for preparing, administering, monitoring, patients condition prior to and after administration of medications and charting medications. Licensed personnel also communicate the needs of patients to the aides, make out assignments for the aides and supervise them, do treatments, including dressings of wounds, assistance of physicians, observation of patients and notification of doctors in the event of change of patient condition.

13. Ancillary staffing levels were inadequate for all shifts on both units throughout September 5, 6, 7 and 8th. Several nurses aides worked a total of nine double shifts (i.e., 16 hours straight). The frequency and amount of such hours, coupled with ratio of patient to aide is endangering the health and safety of patients. The staff that was provided was not adequately trained or supervised. I observed a secretary distributing food trays and passing out coffee, tea and bread and butter. This same secretary was observed feeding a total care patient when the patient was improperly positioned for the ingestion and digestion of food. A young volunteer also distributed food trays and prepared food trays.

14. I was at the facility on Saturday, September 9 from 10 to 5 and on Sunday, September 10 from 9 to 1:40 and from 5:45 to 6:00. Staffing levels and condition in

the facility were just as poor as they had been during the week. The nursing staff, housekeeping staff and dietary staff were inadequate. The owner of the facility was not observed in the home on any day when I was there (from the 31st of August onward).

15. In my professional opinion, the health and safety of patients at the Heritage Hill at Newton Nursing and Convalescent Home is endangered because of (1) inadequate staffing, (2) poor patient care, (3) lack of proper fluids and diet, (4) poor sanitation, and (5) overcrowding of patients.

Signed under the pains and penalties of perjury this 13th day of September, 1978.

ANN M. DAHLBERG, R.N.

Suffolk, SS.:

Then appeared before me the above named Ann M. Dahlberg, R.N., who made oath that the above statement is true and is her free act and deed.

BARBARA S. LOATMAN,
Notary Public.

My commission expires May 11, 1984.

Commonwealth of Massachusetts

SUPERIOR COURT CIVIL ACTION NO. ——

FRANCIS X. BELLOTTI, AS HE IS ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS

AND

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC.,

AND

JOSEPH F. HILL, JR., INDIVIDUALLY AND AS HE IS PRESIDENT OF HERITAGE HILL AT NEWTON RETIREMENT AND CONVALESCENT HOME, INC., DEFENDANTS

AFFIDAVIT OF ALFRED SOUZA

My name is Alfred Souza, a registered nurse, nursing coordinator for Bay State Management Company, Inc., McGrath Highway, Quincy, Massachusetts, for over six (6) years.

The first patient to arrive from Heritage Hill Nursing Home was Mrs. Mary Lawless, 68 years old, at 7:45 P.M. by Chaulk of ambulance, on a stretcher. She was, in appearance, skin and bone and unkempt, dehydrated, malnourished and with a large cut with sutures above her left eye brow from an apparent fall. She could not verbally communicate, only scream. She appeared frightened and combative. Her finger nails were long and filthy and hair wasn't combed or washed for a a great length of time. She had a pungent odor. When offered liquids, patient was unable to stop drinking. She had several discolored marks, bruises and open cuts on various parts of her body. When patient was offered food, she was ravenous it was felt, that in my opinion the patient was obviously neglected.

The second patient was Mrs. Mary O'Leary, age 80 years old, who was unable to communicate verbally. She appeared thin and was dehydrated, and poor skin turgur. She had a fully catheter with extremely concentrated urine, due to lack of fluids. When patient was offered fluids she drank seven hundred 700 cc (7 glasses) of juice, without stopping. She had severe decubiti (bed sores) on both hips, tailbone, left heel, with severely reddened areas on both shoulders. Patient had severe contractures on both legs and spine. Patient needed personal hygiene, especially dental care.

The third patient was Mrs. Joyce Stevens, age 70 years old. She was a demanding patient that was verbally communicative. She had a small broken skin area on her back.

The fourth patient to arrive was Mrs. Ruth Foster, age 67 years old, who arrived claiming she was hungry and had no supper. She had decubiti (bed sores) on her tail

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bone and left elbow, which later that evening was discovered to be a staph infection, verified by a 11:00 P.M. to 7:00 P.M. nurse, Mrs. Barrett from Heritage Hill Nursing Home. No documentation was available on this, however. The bandage on the elbow was crusted and green in appearance, from not being changed recently. The patient asked what our policy was as far as toileting during the night, "Do we ask for a bed pan or do we go in the bed, as that was the policy at Heritage Hill Nursing Home". She stated that she did not have a shampoo for at least a month. She had not had hot cereal in one year at Heritage Hill Nursing Home. She also had a distinct body odor. She had a great appetite when offered food and juices. This patient states she is willing to go to court if necessary to describe the care she received at Heritage Hill Nursing Home.

The fifth patient was Mrs. Alice Howard, age 98 years old. She had a body odor, reddened areas on buttock and was dehydrated. She requested a bed pan every half hour throughout the night and day. She has a good appetite and can help herself to eat.

The last patient to arrive was Joseph Tretola, age 78 years old. He was obviously very frightened and apprehensive and can't communicate. His only communication with us is to strike out with his arms and legs. He appears to be frightened of people touching him. He was filthy, with a strong body odor. His mouth was dry, lips cracked and eye lids were stuck together (conjunctivitis?). He had a broken area on his right elbow and the ambulance driver stated that patient had been treated at a hospital for injury of same. In addition, patient had several small dime-sized eccymotic (black and blue) marks and broken areas on legs. He was very dehydrated. He had a three inch laceration on right hand. He had several reddened areas on buttock.

In my opinion the patients who arrived here from Heritage Hill Nursing Home appeared to be grossly neglected. The patients looked as if they had been in a concentration camp. I was upset that anyone in the nursing profession would let patients get in this condition.

Signed under the pains and penalties of perjury, this 13 day of September, 1978.

ALFRED SOUZA.

Commonwealth of Massachusetts

SUPERIOR COURT, DEPARTMENT OF THE TRIAL COURT, CIVIL ACTION NO. 47972

COMMONWEALTH OF MASSACHUSETTS,

PLAINTIFF

v.

SIX STATES MANAGEMENT CORPORATION D/B/A/ PARK HILL MANOR NURSING HOME,

AND

BERNARD BERKMAN, PRESIDENT OF SIX STATES MANAGEMENT CORPORATION,

AND

RAYMOND R. DUVAL, ADMINISTRATOR OF PARK HILL MANOR NURSING HOME,

DEFENDANTS

COMPLAINT

I. STATEMENT OF THE CASE

1. This is an action by the Attorney General brought on behalf of the Commonwealth of Massachusetts to restrain the defendants and their agents and employees from failing to report and investigate incidents of alleged abuse, mistreatment and neglect of nursing home patients and residents, in violation of G.L. c. 93A and other laws and regulations.

II. JURISDICTION

2. Jurisdiction is conferred on this Court by G.L. c. 12, § 10, G.L. c.93A, § 4, G.L. c. 111, § 72K, and G.L. c. 214, § 1.

III. PARTIES

3. The plaintiff is the Commonwealth of Massachusetts, a sovereign state, represented by the Attorney General who brings this action in the public interest.

4. The defendent, Six States Management Corporation, is a Massachusetts corporation licensed to do business in Massachusetts, and doing business as Park Hill Manor Nursing Home at 1 Gorham Street, Worcester, Massachusetts, in Worcester County.

5. The defendant, Bernard Berkman, is a natural person and is sued in his capacity as president of defendant Six States Management Corporation, with a mailing address c/o Bernard Berkman Associates, 842 Beacon Street, Boston, Massachusetts, 02215.

6. The defendant, Raymond R. Duval, is a natural person and is sued individually and in his capacity as the administrator of Park Hill Manor Nursing Home located at 1 Gorham Street, Worcester, Massachusetts.

IV. FACTS

7. At all times relevant hereto, the defendants have been engaged in the business of operating the Park Hill Manor Nursing Home (hereinafter "Park Hill Manor") in Worcester, Massachusetts, and thereby providing and offering to provide nursing home services to consumers in Massachusetts.

8. The defendant Six States Management Corporation is a provider of nursing home services. It has by contract with the Massachusetts Department of Public Welfare agreed to provide nursing home services to recipients of Massachusetts Medical Assistance and to comply with all statutes, rules and regulations governing the Medical Assistance Program.

9. Every nursing home in Massachusetts must be licensed by the Massachusetts Department of Public Health. G.L. c. 111, § 71. Pursuant to 105 C.M.R. 150.002(A), the licensee is responsible for compliance with all applicable laws and regulations. Additionally, nursing homes which participate in the Massachusetts Medical Assistance Program must be certified by the Department of Public Health as meeting minimum state and federal standards. In the absence of certification, the nursing home cannot receive federal payments through the Medical Assistance Program. Park Hill Manor is currently certified on a provisional basis until May 31, 1981.

10. Approximately 100 people currently reside at Park Hill Manor, a substantial number of whom are recipients of Medicaid or other forms of government assistance.

11. Pursuant to DPH regulations 105 C.M.R. 150.002(G), a nursing home administrator has a duty to report to DPH all incidents which seriously affect the health or safety of patients or residents.

12. DPH regulations also require that a nursing home maintain complete, accurate and current records of incidents at the nursing home, pursuant to 105 C.M.R. 150.013(C).

13. Nursing homes have a duty under DPH regulations to ensure that a staff member is accessible at all times to receive reports or complaints of injury and to ensure that prompt, appropriate action is taken regarding such complaints, pursuant to 105 C.M.R. 150.015(C).

14. On February 12, 1981, a visit was made to Park Hill Manor by two surveyors from the Department of Public Health (DPH), Division of Health Facility Regulation, to investigate a complaint made to DPH of at least five incidents of alleged patient abuse at the facility occurring in the period May, 1980 to February, 1981. The surveyors found indications of possible abuse, mistreatment or neglect, which were not fully reported or investigated as follows:

(a) Patient A—This patient was observed by the surveyors to have numerous skin tears and bruises on both arms and right hand. Based upon interviews with the patient and with an employee of the home, the surveyors attributed the patient's injuries to being tied to a grab bar and put in a Geri-chair and being showered by maintenance personnel, and snapping of towels towards patients' body for harassment purposes. No incident report was on file at the nursing home regarding these bruises nor was there any notation made in the nursing notes. No incident report was made to DPH of these occurrences by the administrator or any other person;

(b) Patient B—This patient fell through an open hole in the bathroom floor in May, 1980, where there was no barrier in place to keep patients out. The patient

was admitted to the hospital and died approximately 9 days later of a heart attack. This incident was only recently discovered by DPH since no incident report was filed with DPH as required by 105 C.M.R 150.002(G);

(c) Patient C—This patient was observed by the surveyors to have a large hematoma on right side of face which the patient stated was caused by an aide hitting her in the face. Only a brief internal incident report was in the patient's records;

(d) Patient D—This patient had massive bruises on the left side including the patient's breast and arm which the surveyors attribute to being roughly handled and abused by nursing home staff. The patient was admitted to the hospital because of the bruises sustained. While nursing home records indicate that the administrator was made aware of this incident, no incident report was filed with DPH;

(e) Patient E—This patient was observed by surveyors to have numerous bruises and skin tears covering both arms, from the hands up to the shoulder area, which they attributed to improper care and rough handling by nursing home staff. The patient was restrained to a chair although there were no written physician's orders for a restraint as required by 105 C.M.R. 150.015(C)(2).

15. The survey team conducted their investigation for two days (February 12–13, 1981) and submitted a written report of their findings, determinations and evaluations to the DPH survey administrator, David J. McGuire. (See Affidavits of Barbara Donovan and Monty Bidder, attached hereto as Exhibits "A" and "B").

16. At the conclusion of their investigation at the facility, on February 13, 1981, the survey team met with defendant Duval, the administrator, for approximately two hours to discuss all of their findings and evaluations relative to patient care, abuse, mistreatment or neglect and failure to report and investigate incidents of such. Defendant Duval generally denied all allegations.

17. Subsequent to the investigation of alleged incidents of patient abuse at Park Hill Manor by the survey team, the Department of Public Health invited defendant Berkman and his attorney to attend a meeting on March 3, 1981, to discuss the allegations. The defendant generally denied all the allegations.

18. Pursuant to G.L. c. 111, §72H(4), DPH forwarded to the Department of the Attorney General a summary of the survey teams' findings and as to the alleged incidents of patient abuse.

19. On March 6, 1981, the Attorney General sent a letter of his intent to bring suit pursuant to G.L. c. 93A, §4, and invited the defendants to meet with members of the Attorney General's staff to discuss the allegations of patient abuse, mistreatment or neglect and failure to report and investigate such, as outlined in paragraphs 15–18 above. Such discussions did in fact occur. Copies of the letters sent to each of the defendants are attached as Exhibits "C" and "D" hereto.

20. A follow up investigation by Department of Public Health surveyors on March 12, 1981, found no evidence of further possible abuse or mistreatment, since the February 12–13, 1981 visit to Park Hill Manor Nursing Home. However, the five specific incidents described in paragraph 14 above had still not been investigated fully.

21. After DPH surveyors visited the nursing home on February 12–13, 1981, the home instituted a new policy of "reporting" all incidents of patient injury to DPH. These reports are incomplete and inadquate in that they

(a) Do not list all relevant information, such as dates, patient age, time of incidents, etc.

(b) Contain conflicting information

(c) Lack medical findings and physician signatures when a physician sees the patient

(d) Do not contain evidence of more than cursory investigations by the administrator into the incident

(e) Do not document what action will be taken to assure that future incidents of the same nature will not reoccur.

(See Affidavits of Barbara Donovan and Monty Bidder, Exhibits "A" and "B").

V. CAUSES OF ACTION

22. The defendants, in the course of operating Park Hill Manor, have engaged and continue to engage in numerous illegal practices in violation of G.L. c. 93A, §2, regulations promulgated thereunder, and other state statutes and regulations, which include but are not necessarily limited to the following:

(a) Failing to record and report all incidents seriously affecting the health or safety of patients or residents to DPH in violation of 105 C.M.R. 150.002(G);

(b) Failing to maintain incident reports of all incidents involving patients or residents and personnel while on duty, and all accidents and other mishaps in

violation of 105 C.M.R. 150.002(G), 105 C.M.R. 150.013(C) and (D) and 105 C.M.R. 150.015(C);

(c) Neglecting to provide services necessary to maintain the health and safety of patients or residents by failing to report incidents of patient abuse, mistreatment or neglect to the Department of Public Health when there was reasonable cause to believe that it existed at the facility, in violation of G.L. c. 111, §72K;

(d) Failing and neglecting to investigate and/or take other appropriate action to deal with complaints of patient abuse, mistreatment or neglect, in violation of G.L. c. 111, §72K and 940 C.M.R. 3:16(1) and (3); and 105 C.M.R. 150.015(C).

(e) Falsely holding themselves out to consumers as operating a nursing home which will provide the minimum standards of nursing home care which are required by state law, and which will protect patients from abuse, mistreatment or neglect when, in fact, this is not the case, in violation of G.L. c.93A, § 2;

(g) Failing and neglecting to provide adequate safety precautions when dangerous conditions were known to exist at the nursing home, to wit, failing to place a barrier to keep patients out of the bathroom with the result that one patient fell through an open hole in the floor, in violation of 105 C.M.R. 150.007(A), 105 C.M.R. 150.007(G), 105 C.M.R. 150.015(A).

VII. RELIEF

Wherefore, the Commonwealth requests that this Court:

1. Issue an Order of Notice, to show cause why a preliminary injunction should not be issued.

2. After return of the Order of Notice, and a hearing, issue a preliminary injunction restraining the defendants, their agents, and employees from:

a. Neglecting any of the patients or residents of the nursing home by failing to report incidents of suspected abuse and by failing to take reasonable measures to prevent such incidents;

b. failing to keep adequate records of complaints by patients of abuse, mistreatment or neglect by nursing home staff including but not limited to:

(1) The name of the complainant patient;

(2) The date and time the complaint was made;

(3) To whom the complaint was made;

(4) The names of any individuals implicated by the patients in the complaint; and

(5) An accurate account of the nature of the patient complaint.

c. failing to investigate all incidents which the defendants, their agents and employees suspect, know, or have reasonable cause to suspect or know involve abuse, neglect, or misteatment of patients, including as part of any such investigation the following:

(1) interviewing the patient involved, the patient's roommates, staff on duty at relevant times, and any individual specifically implicated in an incident by the patient or any witness;

(2) Reviewing medical records of the patient by the owner or administrator;

(3) Interviewing any medical personnel, inside or outside the facility, who treated the patient;

(4) Documentation as to what action(s), if any, will be taken to remedy the incident and to avoid similar incidents in the future;

(5) Maintaining full records of investigations, including reports of interviews, nurses notes, medical records, and other data obtained or reviewed in the course of investigations.

(6) Reporting in writing to the owner or administrator the results of an investigation, in the event that the defendant owner or administrator does not personally conduct the investigation described above.

(7) Any other measures necessary to investigate fully such incident.

d. failing to investigate adequately the five incidents of alleged abuse described in this complaint and currently known by the owner and administrator, including as part of any such investigation the following:

(1) Interviewing the patient involved, the patient's roommates, staff on duty at relevant times, and any individual specifically implicated in an incident by the patient or any witness;

(2) Review of medical records of the patient by the owner or administrator;

(3) Interviewing any medical personnel, inside or outside the facility, who treated the patient;

(4) Documentation as to what action(s), if any, will be taken to remedy the incident and to avoid similar incidents in the future;

(5) Maintaining full records of investigations, including reports of interviews, nurses notes, medical records, and other data obtained or reviewed in the course of investigations;

(6) Providing a written report of the results of the above five investigations together with the conclusions reached as to the existence of abuse, mistreatment or neglect to the Commonwealth, through the Department of the Attorney General.

e. failing to report all incidents which the owner or administator suspects, knows, or has reasonable cause to suspect or know involve abuse, neglect, or mistreatment to the Department of Public Health within 48 hours.

f. falsely holding the facility out to consumers as a nursing home which will provide the minimum standards of nursing home required by state and federal law, and which will protect patients from abuse, mistreatment and neglect, when in fact, it does not;

g. failing to comply with laws and regulations and with all further orders of the court which are necessary to protect the health and safety of the patients and residents of Park Hill Manor.

3. After a trial on the merits, permanently enjoin the defendants from illegal conduct, as set forth in paragraph 22 of this Complaint, and impose a civil penalty of not more than $2,500.00 per each incident of neglect through failure to report and investigate, as provided by G.L. c.iii, § 72K; and

4. Grant such other and further relief as this Court deems just and appropriate.

FRANCIS X. BELLOTTI,
Attorney General, Commonwealth of Massachusetts.

AFFIDAVIT OF BARBARA DONOVAN, R.N.

I, Barbara J. Donovan, hereby depose and say that:

1. I am a registered nurse, employed by the Massachusetts Department of Public Health ("DPH") since 1976. My present position is Assistant Survey Administrator of the Division of Long Term Care. In this position, I have had extensive experience investigating and evaluating nursing home services.

2. On February 10, 1981, the Department received a telephone complaint followed on February 11, 1981 with a written complaint pertaining to Park Hill Manor Nursing Home, a 101 bed Intermediate Care facility located at One Gorham Street, Worcester, Mass. The complaint alleged that patients at Park Hill Manor had been physically abused and mistreated.

3. On February 12 and 13, 1981, Monty Bidder, R.N., a surveyor from the Department, and I conducted an investigation of the complaint at Park Hill Manor. During my visit, I observed and spoke with patients at Park Hill Manor regarding the complaint allegations, including those patients specifically mentioned in the complaint. In this affidavit, I refer to each patient by letter designation to protect their privacy.

4. *Patient D* was a 96-year-old markedly alert, oriented woman, who had lived at home with the assistance of Elder Care Services until last fall, when she fell and fractured her wrist. On October 2, 1980, this patient was admitted to Park Hill Manor Nursing Home.

On February 12, 1981, the first day of my visit, I learned that Patient D had been transferred from Park Hill Manor to the Worcester Memorial Hospital in Worcester, Mass. My review of the patient's record showed that nurses' notes written on the 3 p.m.–11 p.m. shift on February 8, 1981 indicated that the staff had found Patient D with dark purple bruises, approximately 4½ by 6½ inches on the outer side of her left breast, extending from under her arm to her back. Records indicated that the staff notified Patient D's physician of the incident on February 8, 1981 and that the physician ordered Patient D to be transferred to the hospital immediately.

An incident report, dated February 8, 1981, did not indicate the cause of Patient D's injuries or document any investigative efforts made to account for her injuries. The records do show that the incident was reported to the Administrator, Raymond Duval. I have checked the DPH records and have found no incident report on this patient's injuries filed with the Department.

I visited Patient D at Worcester Memorial Hospital on February 13, 1981. While examining her bruises, I questioned the patient about the care she received at the Park Hill Manor. Patient D responded that she was handled roughly many times at the nursing home early in the morning. She stated that staff members dragged her like a ragdoll and that they had gotten her out of bed and yelled, "now walk." Patient D stated that she could not walk too well.

I observed that Patient D had massive purple and blue bruises on her left breast, chest wall, axilla area and upper arm. These were the same injuries referred to in the incident report of February 8, 1981. On February 13, 1981, the bruises were approximately 5" x 8".

5. *Patient B* was one of the abuse allegations reported to the Department of Public Health concerning an incident which occurred in May, 1980. On February 12, 1981, I reviewed Park Hill's available records regarding the care and discharge of Patient B. (The complaint allegations concerning Patient B stated that Patient B, an 84-year-old male patient was seriously injured at Park Hill in a fall and he subsequently died at the hospital.) A review of records indicated the following: Patient B was transferred from Park Hill to the Fairlawn Hospital on April 30, 1980 at 6:30 p.m., following an accident at the nursing home on that date. He died at the hospital on May 5, 1980. I reviewed Patient B's clinical discharge record, maintained at the nursing home.

A review of the nurses' notes written on April 30, 1980 indicated that the patient got out of bed while the crib sides were up and went to a bathroom and slipped through an open hole in the bathroom floor, which was undergoing repair work. This occurred at 6:30 p.m. After being put to bed, the patient started to have difficulty in breathing and his entire body turned blue from lack of circulation (cyanosis). The patient's doctor was notified and the patient was sent to the hospital. A report of this incident was in the Nursing Home records. There was no indication on the incident report that the Administrator had been notified. An incident report was not submitted to the Department of Public Health.

6. *Patient A*—During the course of my visit on February 12, 1981, a registered nurse on duty requested to speak with someone from the Department after she finished her tour of duty at 3 p.m. that day. In accordance with her request, I called this nurse at her home on February 12, 1981 at approximately 9 p.m. She told me that on February 12, 1981, while she was on duty at Park Hill Manor as the charge nurse, it was reported to her that a maintenance man had a patient (Patient A in Affidavit of M. Bidder) in the shower, tied to a grab bar with a sheet. This nurse reported to me that she went to the assistance of Patient A and discovered that Patient A was tied to the grab bar with a sheet. The nurse told me she asked the maintenance man to leave. She told me the maintenance man refused. She also told me she completed bathing Patient A without further incident.

7. It is my professional opinion that Patients B and D have been abused, mistreated, or neglected. I have arrived at this conclusion based on the following:

(1) The type and location of the patients' bruises;

(2) Missing or inadequate documentation in the patients' records which would have supplied a different or alternative explanation for the existence of the bruises;

(3) The lack of familiarity of the Administrator with regard to the patients' bruises or his inability to give sufficient information about the bruises; and

(4) The existence and specificity of the complaint filed with the Department alleging the occurrence of patient abuse.

8. At the conclusion of the complaint investigation on February 13, 1981, Mrs. Bidder and I conducted an Exit Interview with Mr. Duval, Administrator of Park Hill Manor. We advised Mr. Duval of the patient abuse allegations and the names of patients addressed in the complaint. Mr. Duval responded with very negative comments about many of the patients at Park Hill Manor and their behavior. On at least 12 occasions, he stated he was unfamiliar with a certain patient or an incident relating to a patient.

I asked Mr. Duval what he could tell me about Patient D's injuries and whether he had investigated the incident. Mr. Duval stated he talked to the patient and as far as he knew she had fallen.

I asked Mr. Duval what he could tell me about the incident that happended to Patient B. He stated that the patient fell through an opening in a bathroom floor up to his ankles (the complaint transmitted to DPH, alleged that the patient fell through floor to mid-chest). The bathroom floor had been torn up in preparation for repairs. Mr. Duval said that the maintenance man locked the door of the bathroom before going off duty at 5 p.m. and told the nurses he had done so. Mr. Duval could not tell me how the door became unlocked. I asked Mr. Duval if he was aware of the patient's condition after the fall; i.e., cyanosis, shortness of breath, lack of attainable blood pressure. He responded that he was not aware of this.

I asked Mr. Duval if he had submitted incident reports on Patients B and D to the Department. Mr. Duval said he was not convinced that they were serious enough to report. I asked Mr. Duval if a patient was admitted to the hospital following an incident (Patient D) or was admitted to the hospital following a fall and died (Patient B), if he would consider those incidents serious enough to report under the regulations. Mr. Duval made no comment.

9. Subsequent to the Department's follow-up visit conducted on March 12, 1981, Mr. Duval started submitting incident reports to the Department in accordance with the facility's new policy on Incident Reporting. Attached to each incident report is a form entitled "Administrator's Investigation Report".

From March 12, 1981 through March 27, 1981, thirty-one incident reports were submitted. These reports were reviewed by me, and indicate the following:

(a) Reports are incomplete in that they fail to list all information such as dates, patient age, time of incident, etc.

(b) Reports contain conflicting information.

(c) Reports of those patients seen by a physician lack medical findings and physician signatures.

(d) Although the administrator documents comments on the reports, these comments do not identify that he has fully investigated the incident, by talking to staff members, examining medical records, looking for witnesses, or other investigative activities.

(e) The reports do not document that any action had been taken by him to assure fully that incidents do not reoccur.

Signed under the pains and penalties of perjury this 24th day of April, 1981.

BARBARA J. DONOVAN.

RITA M. MCPHEE,
Notary Public.

My commission expires July 2, 1982.

AFFIDAVIT OF MONTY BIDDER, R.N.

I, Monty Bidder, hereby depose and say that:

1. I am a registered nurse and have been employed by the Massachusetts Department of Public Health ("DPH") as a Health Facility Surveyor since November, 1976. As a surveyor of nursing homes and rest homes, my duties include inspecting nursing homes for purposes of state licensure, medicare and Medicaid certification, and investigation of complaints.

2. On February 10, 1981, a telephone complaint was received by the Department alleging abuse, neglect, and/or mistreatment of patients at Park Hill Manor Nursing Home, located at One Gorham Street in Worcester, Massachusetts. A written complaint was subsequently filed with the Department on February 11, 1981.

3. As a result of the filing of that complaint, I was sent to inspect Park Hill Manor, along with Barbara Donovan, R.N., Assistant Survey Administrator of the Division of Long Term Care, and Alberta Chappell, a consulting dietician for the Department. Our complaint investigation lasted for two days, February 12 and 13, 1981.

4. During the visit I observed and spoke with patients, and made physical observations of their conditions. My findings are summarized as follows. Each patient is referred to herein by letter designation rather than name in order to protect their privacy.

5. *Patient A:* The complaint received by the Department of Public Health alleged that patient A, a 63 year old male patient at Park Hill, was abused. On February 12, 1981, I observed that Patient A had bruises on both of his arms and his right hand. Patient A was alert, spoke distinctly but slowly, and his head drooped forward at all times. I asked Patient A how he got the bruises. He stated that he had been "banged around by a maintenance man because he wouldn't take a shower." In order to ascertain the circumstances relating to Patient A's injuries, I reviewed the facility's records. The nurses' notes for Patient A did not contain any reference to the bruises which I observed. I also determined that the facility did not have an internal incident report relating to Patient A's injuries. Neither was an incident report filed with the DPH. Massachusetts Long Term Care licensure regulations require that an incident report be filed in circumstances such as these. I did however find an incident report dated February 10, 1981 which indicated that Patient A had a bruise above the right knee. This report was deficient inasmuch as it failed to provide an information as to the manner in which Patient A developed or received the bruise and failed to indicate that the Administrator of the facility was notified of the fact that Patient A had received or developed bruises.

6. *Patient C:* The complaint received by the Department of Public Health alleged that Patient C, a 95 year old female patient at Park Hill Manor, was abused by a short stocky aide who worked nights, and had developed a large hematoma (bruise) as a result of such abuse. On February 12, 1981, I observed that Patient C had a black and blue area above the eyebrow and along the right side of her head. The

area along Patient C's right cheek bone was a yellowish color. Based on my conversation with her, Patient C appeared to be oriented to time and place. She answered my questions clearly and without hesitation. I asked Patient C how she got the bruises. Patient C stated that the night nurse, who was a big fat woman, caused the bruises. Patient C stated that on the day she received the bruises she had wanted to go to the bathroom, but required the assistance of an aide or nurse to do so. On this occasion she rattled the side rails of her bed and called out for assistance. Patient C stated that the nurse came in her room and pushed and pulled at her.

The facility did have an incident report on file which related to Patient C's facial bruises. The report, dated February 3, 1981, stated that the staff found that Patient C had a black and blue area above the right eye after the change of shift at 7:00 a.m. on February 3, 1981. The report indicated that no witnesses were present. There was no indication in the report as to whether the incident was fully investigated by the facility staff, whether Patient C was interviewed by the Administrator, or whether an attempt was made to identify the night nurse in question. This report was not sent to DPH at this time.

The nurses' notes for February 4, 1981, pertaining to Patient C indicated that Patient C's physician and the facility's Administrator, Raymond Duval, were notified of Patient C's injuries. The notes also indicated that an incident report had been filed in the paitent's record. When I reviewed Patient C's record on February 12 and 13, 1981, there was no written record which showed that the Administrator or staff of Park Hill had investigated the cause of Patient C's bruises which were found on February 3, 1981.

7. *Patient E:* This female, 69 years old, is a thin, frail woman who appeared much older than her stated age. I observed multiple bruises and skin tears covering both of Patient E's arms, extending from her fingers to her shoulders. At least one of these bruises was shaped consistently with marks left by fingers gripping the arm area. Her forearms were covered by bandages approximately 4 inches wide. Upon request, a nurse's aide removed these bandages and I observed that Patient E had several fresh, oozing skin tears on her forearms.

According to the available records, Patient E had a physician's written order to receive treatment consisting of Phisohex washes three times daily to open areas until clear, followed by application of a dry sterile dressing, with no adhesive. However, Patient E did not receive medical treatment in accordance with her physician's orders, according to her records. From January 5, 1981 to January 20, 1981, the patient's treatment sheet indicated that she only received the ordered treatment once in nine days and twice in seven days. In short, the full daily treatment ordered by the physician was not given during this sixteen day period. A review of facility records revealed that there were two recent incident reports available regarding Patient E, dated December 13, 1980 and January 7, 1981. The January 7th report indicated that while Patient E was restrained in a bed, with the bed's side rails up, Patient E climbed over the side rails. The report stated that the staff found Patient E on the floor, having sustained abrasions and skin tears.

Patient E's physician had written a medication order for Haldol, a tranquilizing type of drug, to be given as needed. On January 24, 1981, Haldol was given to Patient E and the documented reason was abusive treatment to nursing staff. Again on February 6, 1981, Haldol was administered to the patient because she was allegedly uncooperative, kicking and trying to bite staff who were cleaning her. In neither instance in which Haldol was administered was the effect of the drug recorded, which should have been done.

On the first day of my visit, I found patient E sitting in a chair in her room at 11:00 a.m., wearing night clothing and socks. She was restrained in the chair by a vest restraint without a physician's order. Patient E was able to tell us her name clearly, but she was unable to provide clear answers to our questions regarding how she received the bruises.

Throughout the two days of my visit, I did not observe Patient E out of her room despite the fact that her physician had ordered that she participate in activities as tolerated. On one occasion I observed two nurses' aides assist Patient E to the bathroom. I noticed that Patient E was able to ambulate. She appeared to want to walk and interact with patients and staff since she would try to stand whenever approached.

8. At the conclusion of our complaint investigation on February 13, 1981, Barbara Donovan and I conducted an exit interview with Raymond Duval, the Administrator of Park Hill Manor, from approximately 3:30 to 5:30 p.m. In the course of the interview, Barbara and I reported to Mr. Duval the incidents and facts we had observed in the course of our investigation. When we expressed our concerns regarding particular patients, Mr. Duval replied by referring to the unmanageable behavior of some patients and expressed unfamiliarity with the patients or incidents

involved in other cases. Mr. Duval was unable to describe the manner in which he investigated the cause of particular incidents. At several points, Mr. Duval stated that he had visited patients but that as far as he knew the patients were injured in falls. Mr. Duval did not provide us with any written documentation as to the actions he had taken (e.g, interviews with staff persons, conversations with patients, etc.) regarding the incidents.

9. It is my professional opinion that Patients A, C, and E have been abused, mistreated, or neglected.

I have arrived at this conclusion based on the following:

(1) the type and location of the patients' bruises;

(2) the explanation given to me by Patients A and C as to how they received their bruises;

(3) missing or inadequate documentation in the patients' records which would have supplied a different or alternative explanation for the existence of the bruises;

(4) the lack of familiarity of the Administrator with regard to the patients' bruises or his inability to give sufficient information about the bruises; and

(5) the existence and specificity of the complaint filed with the Department alleging the occurrence of patient abuse.

10. On February 26, 1981, a report of our findings was hand-delivered to the licensee of Park Hill Manor, Bernard Berkman of Six States Management Corporation, 842 Beacon Street, Boston, Massachusetts.

11. On March 12, 1981, Barbara Donovan and I conducted a follow-up visit to the facility in order to determine the condition of the patients and to obtain further information that might be available. My observations on this date are contained in the following paragraphs.

12. *Patient A* was observed sitting quietly in the dining room. The bruises on both arms had healed. The bruise above his right knee was healing. No new bruises were seen. Patient A appeared well-dressed and well groomed. He told me that the maintenance men no longer showered him and that the nurses took him to the shower. He added that it was better that way.

13. *Patient C* was sitting in her room by the window. The bruises around her right eye were healed. Patient C reaffirmed that her bruises had been caused by an employee's rough handling of her and she described the details of the event essentially the same as she had previously related to me. She further stated that the staff person had dragged her into the bathroom by the legs, gave her an awful beating and kicked her.

14. *Patient E* was observed in the activity room restrained and in a geriatric chair. She was well groomed and appropriately dressed. Although I did not observe staff ambulating Patient E, I did observe that her slacks had been changed in the afternoon. The bruises on both arms were just about healed and no new bruises were observed.

15. Ms. Donovan and I held another exit interview with Mr. Duval at the end of our follow-up visit of March 12, 1981. We apprised Mr. Duval of our findings and asked if he had followed up or conducted an investigation into those incidents occurring to the patients named in the complaint. Mr. Duval stated that he had. When we asked to see his reports Mr. Duval stated that he had not written anything down. He reported the new policy that was developed by the facility for the reporting of incidents and accidents on March 4, 1981. It was not fully implemented at the time of my visit. A Seminar was given to staff on February 23, 1981 and February 24, 1981 on documentation in Nurses notes as it related to patient abuse and the necessity of reporting falls. Mr. Duval further stated a meeting was held with all licensed staff regarding frequent falls. He told us that new restraints were purchased and that nurses' aides had been alerted to check patients in restraints frequently, to ambulate patients if possible, and to try to change patients' environment.

Mr. Duval stated that the Maintenance men no longer bathed Patient A. Mr. Duval informed us that he and the Director of Nurses had instructed the nursing staff to attempt to bath Patient A and if he refused a bath to document the information in nurses' notes.

Mr. Duval said that he had spoken to Patient C along with Mr. Berkman, and the attorney. There was nothing documented relative to this visit. Mr. Duval also stated that he spoke with the staff who said they didn't know how Patient C got the bruise around her eye.

16. Subsequent to the Department's follow-up visit conducted on March 12, 1981, Mr. Duval, Administrator at Park Hill Manor, started submitting incident reports to the Department in accordance with the facility's new policy on Incident Reporting. Attached to each incident report is a form entitled "Administrator's Investigation Report".

From March 12, 1981 through March 27, 1981, thirty-one incident reports were submitted. These thirty-one reports were reviewed by me, and indicate the following:

(a) Reports are incomplete in that they fail to list all information such as dates, patient age, time of incident, etc.

(b) Reports contain conflicting information.

(c) Reports of those patients seen by a physician lack medical findings and physician signatures.

(d) Although the administrator documents comments on the reports, these comments do no identify that he has fully investigated the incident by talking to staff members, examining medical records, looking for witnesses, or other investigatory activity.

(e) The reports do not document that any action has been taken by him to assure fully that incidents do not reoccur.

Signed under the pains and penalties of perjury this 24th of April, 1981.

MONTY BIDDER, R.N.

RITA M. MCPHEE,
Notary Public.

My commission expires July 2, 1982.

COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF THE ATTORNEY GENERAL
Boston, March 6, 1981.

Mr. RAYMOND R. DUVALL, *Administrator,*
Park Hill Manor Nursing Home,
1 Gorham Street, Worcester, Mass.

DEAR MR. DUVALL: This office has been conducting an investigation into allegations of patient abuse, neglect and mistreatment at the Park Hill Manor Nursing Home. At this time, the Attorney General has reason to believe that you, as administrator of the Park Hill Manor, have engaged in unfair and/or deceptive acts and practices in the course of administering the business of the nursing home in violation of the Comsumer Protection Act, G.L. c.93A, §2(a), and the regulations promulgated thereunder.

The specific practices the Attorney General is concerned with include but are not necessarily limited to the following:

1. failing and neglecting to care for patients properly in accordance with written physicians orders and nursing care plans for treatment of patients in violation of 105 C.M.R. 150.015(A), 105 C.M.R. 150.002(C), of 105 C.M.R. 150.014(A);

2. failing and neglecting to provide adequate nourishment to patients in violation of 940 C.M.R. 4:03(5) and (6);

3. failing and neglecting to provide adequate safety precautions when dangerous conditions were known to exist at the nursing home, in violation of 105 C.M.R. 150.014(A);

4. failing to keep the patients free from mental and physical abuse in violation of 42 C.F.R. 405.1121(K)(7) and 105 C.M.R. 150.007(G)(1)(d) and (G)(1)(e);

5. failing to report incidents of patient abuse mistreatment or neglect to the Department of Public Health when there was reasonable cause to believe that it existed in violation of G.L. c.111, §72G;

6. failing and neglecting to supervise and discipline employees who were involved in incidents of patient abuse, mistreatment or neglect, in violation of 940 C.M.R. 3:16(1); and

7. failing to investigate and/or take other appropriate action to deal with complaints of patient abuse, mistreatment and neglect, in violation of 940 C.M.R. 3:16(2) and (3).

COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF THE ATTORNEY GENERAL,
Boston, March 6, 1981.

Re Park Hill Manor Nursing Home—Worcester.

Mr. BERNARD BERKMAN, *President,*
Six States Management Corporation,
Care of Bernard Berkman Associates,
842 Beacon Street, Boston, Mass.

DEAR MR. BERKMAN: This office has been conducting an investigation into allegations of patient abuse, neglect and mistreatment at the Park Hill Manor Nursing Home located at 1 Gorham Street, Worcester, Massachusetts, and owned by Six States Management Corp. At this time, the Attorney General has reason to believe that Park Hill Manor has engaged in unfair and/or deceptive acts and practices in the conduct of its business in violation of the Consumer Protection Act, G.L. c.93A, § 2(a), and the regulations promulgated thereunder.

The specific practices the Attorney General is concerned with include but are not necessarily limited to the following:

1. failing and neglecting to care for patients properly in accordance with written physicians orders and nursing care plans for treatment of patients in violation of 105 C.M.R. 150.015(A), 105 C.M.R. 150.002(C), 105 C.M.R. 150.014(A);
2. failing and neglecting to provide adequate nourishment to patients in violation of 940 C.M.R. 4:03(5) and (6);
3. failing and neglecting to provide adequate safety precautions when dangerous conditions were known to exist at the nursing home, in violation of 105 C.M.R. 150.014(A);
4. failing to keep the patients free from mental and physical abuse in violation of 42 C.F.R. 405.1121(K)(7) and 105 C.M.R. 150.007(G)(1)(d) and (G)(1)(e);
5. failing to report incidents of patient abuse mistreatment of neglect to the Department of Public Health when there was reasonable cause to believe that it existed in violation of G.L. c.111, § 72G;
6. failing and neglecting to supervise and discipline employees who were involved in incidents of patient abuse, mistreatment or neglect, in violation of 940 C.M.R. 3:16(1); and
7. failing to investigate and/or take other appropriate action to deal with complaints of patient abuse, mistreatment and neglect, in violation of 940 C.M.R. 3:16(1) and (3).

We are aware that the Long Term Care Division of the Department of Public Health (DPH) has discussed the specific allegations of abuse and neglect in detail with you at a meeting held on March 3, 1981, at the offices of DPH. Pursuant to the requirments of G.L. c.93A, § 4 we also invite you and your attorney to meet with us to discuss these allegations. However in case negotiations fail to provide the Department of the Attorney General with adequate assurances that patients' health and safety are secure, you should consider this letter a formal notice pursuant to G.L. c.93A, § 4, of the Attorney General's intent to bring suit against Six States Management Corporation, and you, as president of the corporation, for violation of the Consumer Protection Act, G.L. c.93A, and the Patient Abuse Statute, G.L. c.111, § 72G, if this case cannot be resolved within a reasonable period of time.

We anticipate your prompt response.

Sincerely,

BERNADETTE L. SABRA,
Assistant Attorney General.

940 CMR: OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

940 CMR 4.00: NURSING HOMES

Section

The Attorney General of the Commonwealth of Massachusetts promulgates these regulations relating to nursing homes pursuant to his authority in G. L. c. 93A, s. 2(c). These regulations are designed to promote the comfort, health and well-being of consumers of services provided by nursing homes and to fill a void left by existing regulations.

In the process of promulgating these regulations, the Attorney General consulted with numerous groups and individuals, including representatives of the nursing home industry and of state agencies that currently regulate the operations of nursing homes. Also considered were the views and opinions expressed at the Public Hearings on August 11, 1975 and the recommendations subsequently made by persons interested in nursing home residents and the smooth operation of nursing homes.

The Attorney General's regulations define unfair or deceptive acts or practices. They are not intended to be all inclusive as to the types of activities prohibited by G. L. c. 93A, s. 2(a) and they do not legitimize acts not specifically prohibited by these regulations. The regulations are designed to supplement existing regulations, and the Attorney General plans to work and cooperate with other state and federal agencies in the enforcement of these and other regulations.

4.01: Definitions

(1) Administrator: the person charged with the general administration of a nursing home, his agents or employees, and as further defined in the Rules and Regulations for the licensing of Long Term Care Facilities of the Department of Public Health, as from time to time amended;

(2) Attorney General's Regulations: regulations relating to nursing homes promulgated by the Attorney General of the Commonwealth of Massachusetts on November 10, 1975;

(3) Emergency: a situation in which a resident is engaging, or is very likely to engage, in conduct that is causing, or would cause, serious injury to him/herself or to others; or, a situation in which the resident's medical condition is such as to require immediate medical attention or treatment; the existence of an emergency shall be determined by a physician, except that if a physician is not readily available, the existence of an emergency may be determined by the person on the premises of the nursing home who is in charge of the medical or nursing services in the nursing home at the time that the situation giving rise to an emergency occurs or is about to occur;

(4) Licensee: any person, corporation, or other entity that has a license to operate a nursing home, his agents or employees;

4.01: continued

(5) Nursing Home: any institution whether conducted for charity or profit which is advertised, announced or maintained for the express or implied purpose of providing three or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons, or retirement home care for elderly persons; nursing home shall include convalescent or rest homes, infirmaries maintained in towns and charitable homes for the aged;

(6) Private Nursing Home: a nursing home that admits, or provides services to, only private residents;

(7) Private Resident: a resident of a nursing home whose stay in the nursing home is not paid for, in whole or in part, by public funds pursuant to titles XVIII or XIX of the Social Security Act;

(8) Resident: any individual or patient residing in or receiving care in a nursing home;

(9) Additional Services: services provided by a nursing home that are not included in the basic per diem rate or not included under titles XVIII or XIX of the Social Security Act, as amended;

(10) Social Security Act: titles XVIII and XIX of the Social Security Act, as amended;

(11) Sponsor: a person or agency legally responsible for the well-being or support of a resident or a person or agency actually providing support to a resident whether or not legally responsible for that support;

(12) Treatment: any medication, drug, test or procedure conducted or administered for the purpose of diagnosing or treating a physical or mental illness or condition;

(13) Summary of Regulations: a summary of the Attorney General's regulations that is authorized to be distributed by the Attorney General of the Commonwealth of Massachusetts;

(14) Written Acknowledgement: a signed statement by a resident that he/she has received a copy of the document(s) required to be tendered to the resident; if a resident is unable to sign his/her name, the licensee or administrator may satisfy the requirement of written acknowledgment by placing in the resident's personal records a written and dated statement, signed by the person who tendered the required document(s) to the resident, that the licensee or administrator tendered to the resident the document(s) required to be tendered and that the resident was unable to sign his/her name indicating receipt of the document(s);

(15) Written Authorization: a written statement, signed by the resident, in which the resident authorizes the licensee or administrator to perform certain specified acts on behalf of the resident; the authorization shall be dated and shall include
(a) the specific act authorized by the resident,
(b) the period of time that the resident authorizes the particular act, if applicable, and
(c) the name of the person to whom certain records are authorized to be made available, if applicable; if the resident is unable to sign his/her name, a licensee or administrator may satisfy the requirements of a written authorization by a dated statement that contains the information in 940 CMR 4.01(15)(a), 4.01(15)(b), and

4.01: continued

4.01(15)(c) and that also includes the name and signature of the person to whom the resident made the oral authorization;

(16) Written Request: a statement signed by the resident or his/her sponsor that states that the resident requests a certain specified service for a certain period of time and that states the charge for that service; if the sponsor is not available to sign the statement and if the resident is unable to sign his/her name, a licensee or administrator may satisfy the requirements of a written request by placing in the resident's personal records a written and dated statement, signed by the person receiving the request for services, that states
(a) the services requested by the resident;
(b) the charge for the services;
(c) the period of time for which the services were requested; and
(d) that the resident was unable to sign his/her name to request those services and that the sponsor was not available to sign the request for the services.

4.02: Unfair or Deceptive Acts or Practices: General

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2 for a licensee or an administrator

(1) if a nursing home has policies regarding the rights and responsibilities of residents, to fail or refuse to disclose those policies in writing to a resident and his/her next of kin, guardian or sponsor or to fail or refuse to furnish a copy of those policies to a resident, as evidenced by the resident's written acknowledgment; the disclosure required in 940 CMR 4.02(1) shall be made no later than the effective date of the Attorney General's regulations, at the time that the nursing home establishes such policies, or at the time of admission to the nursing home, whichever occurs first;

(2) to fail or refuse to disclose in writing to a resident and his/her next of kin, guardian or sponsor that the Attorney General has promulgated regulations relating to the conduct of licensees or administrators or to fail or refuse to refurnish a copy of the Attorney General's regulations, or a summary thereof, to a resident, as evidenced by the resident's written acknowledgment; the disclosures required in 940 CMR 4.02(2) shall be made within thirty days after the effective date of the Attorney General's regulations or at the time of admission to the nursing home, whichever occurs first;

(3) to fail or refuse to disclose in writing to a resident and his/her next of kin, guardian or sponsor that the nursing home has written policies, in addition to those specified in 940 CMR 4.02(1), and that those policies are available to the resident and his/her next of kin, guardian or sponsor at reasonable times, or to fail or refuse to make those policies available upon request to the resident and his/her next of kin, guardian or sponsor at any reasonable time during the resident's stay in the nursing home; the disclosures required in 940 CMR 4.02(3) shall be made no later than the effective date of the Attorney General's regulations or at the time of admission, whichever occurs first;

(4) to fail or refuse to post a copy of the Attorney General's regulations and a copy of the nursing home's written policies (if any) relating to the rights and responsibilities of residents prominently and conspicuously in each identifiable unit (as defined in regulations promulgated by the Massachusetts Department of Public Health) in the nursing home;

4.02: continued

(5) to fail or refuse to disclose in writing to a resident and his/her next of kin, guardian or sponsor the levels of care provided by the nursing home and that the resident may have to be transferred from the nursing home if the resident requires a level of care not provided by the nursing home; the disclosures required in 940 CMR 4.02(5) shall be made no later than the time of admission of the resident or on the effective date of the Attorney General's regulations, whichever occurs first;

(6) in the case of a private nursing home, to fail or refuse to disclose in writing to a resident and his/her next of kin, guardian or sponsor that the resident may be transferred or discharged if the resident ceases to be a private resident; the disclosure required in 940 CMR 4.02(6) shall be made no later than the effective date of the Attorney General's regulations or at the time of admission to the nursing home, whichever occurs first;

(7) to fail or refuse to respond promptly and fully to any reasonable inquiries relating to any of the policies, regulations or procedures relating to or established by the nursing home by a resident or by his/her next of kin, guardian or sponsor at any time during the resident's stay in the nursing home.

4.03: Charges -

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2, for a licensee or administrator

(1) to fail or refuse to disclose in writing to a resident and his/her next of kin, sponsor or guardian the existing basic per diem rate, applicable to the resident, charged by the licensee and all the services included in that rate; the disclosures required in 940 CMR 4.03(1) shall be made no later than the effective date of the Attorney General's regulations or at the time of admission, whichever occurs first;

(2) except in the case of private residents, to fail or refuse to disclose in writing to a resident and his/her next of kin, guardian or sponsor the services available to the resident that are covered by the Social Security Act but that are not included in the basic per diem rate; the disclosures required by 940 CMR 4.03(2) shall be made no later than the effective date of the Attorney General's regulations, the time of admission to the nursing home, or the time that the resident ceases to be a private resident, whichever occurs first;

(3) to impose, seek to impose or collect, a charge in addition to the basic per diem rate for services included in the basic per diem rate;

(4) to charge, or collect payment from, a resident or his/her next of kin, guardian or sponsor for services covered by the Social Security Act for that resident;

(5) to fail or refuse to provide all the services included in the basic per diem rate, except where the resident does not medically require services that are included in the basic per diem rate;

(6) to charge for services not actually rendered to a resident, except that a licensee or administrator may charge for medical services included in the basic per diem rate that are not medically required by the resident during a particular billing period;

(7) to provide and charge for additional services, except for medical services required in an emergency, without prior written request for those services by the resident or his/her sponsor;

4.03: continued

(8) to fail or refuse to permit a resident or his/her sponsor to examine or receive, upon request, a reasonable explanation of the charge or bill for his/her care in the nursing home, regardless of the source of payment;

(9) in the case of a private resident, to increase the basic per diem rate without written notification to the resident and his/her sponsor of the higher rate; such notification shall be given a reasonable time prior to the effective date of the higher rate so as to insure an orderly transfer of the resident if the resident cannot afford the higher rate.

4.04: Access to Persons Outside Facility

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2, for a licensee or an administrator

(1) to fail or refuse to permit a resident to associate or communicate privately, either inside or outside the nursing home, with persons of his/her choice at reasonable hours or to permit a resident to receive or refuse visitors, unless medically contraindicated as documented by his/her physician in his/her medical record;

(2) to fail or refuse to permit a resident private and unrestricted communications with his/her spouse, physician, or attorney;

(3) to fail or refuse to assure to a married resident privacy during visits by his/her spouse, to the fullest extent possible under the circumstances;

(4) to fail or refuse to permit a resident to meet with or participate in activities of social, religious, and community groups at his/her discretion, unless medically contraindicated as documented by his/her physician in his/her medical record;

(5) to fail or refuse to permit a resident to send or receive personal mail unopened, unless medically contraindicated as documented by his/her physician in his/her medical record;

(6) to fail or refuse to assure privacy, to the fullest extent possible under the circumstances, to residents when making or receiving telephone calls;

(7) to fail or refuse to permit a resident to present grievances on behalf of him/herself or others to the nursing home's staff, to government officials, or to any other person free from restraint, interference, coercion, discrimination or reprisal;

(8) to fail or refuse to permit a resident to join with other residents or individuals within or outside of the nursing home to work for improvements in patient or resident care;

(9) to fail or refuse to provide access to the nursing home to individuals or to representatives of community groups or of other groups who seek to visit residents or to provide volunteer services to residents at reasonable hours; except that a licensee or administrator
(a) may refuse access to groups or individuals if the resident's or patient's council (if any) of the nursing home has requested that the group or individual be excluded from the nursing home;
(b) may reasonably limit the number of individuals visiting the residents at a given time; or
(c) may require a group or individual to leave the nursing home if the resident's or patient's council so requests or if the actions of

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4.04: continued

the group or individual are harmful, medically or emotionally, to the residents; or
(d) may refuse to permit a group or individual to communicate with a resident if the resident's physician has so indicated in writing in his/her records;

(10) to fail or refuse to provide access to the nursing home to individuals or representatives of community groups or of other groups who seek to provide legal services to residents without charge to the residents at reasonable hours.

4.05: Resident Care

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2, for a licensee or an administrator

(1) to fail or refuse to permit a resident to manage his/her personal financial affairs; except that a licensee or administrator may require a resident to deposit his/her private funds into an account at the nursing home for purposes of safekeeping, provided that the licensee or administrator permits the resident to withdraw any amount from his/her account at reasonable times;

(2) to fail or refuse to tender to a resident the full personal care allowance permitted by law or authorized by the sponsor at the time the nursing home exercises control over funds to which the resident is entitled;

(3) to manage a resident's personal funds without a resident's written authorization to do so; the written authorization shall contain the information required by 940 CMR 4.01(15) and shall include the specific funds over which the licensee or administrator shall have control;

(4) to fail or refuse to permit a resident to rescind at any time a written authorization by a resident that the licensee or administrator manage the resident's personal funds;

(5) to fail or refuse to provide the resident or his/her sponsor an accounting every three months of financial transactions made in his/her behalf if the licensee or administrator manages the resident's personal funds;

(6) to fail or refuse to permit a resident to retain or use his/her personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents;

(7) to require a resident to perform services for the nursing home that are not included for therapeutic purposes in his/her plan of care; this subsection shall not be construed to prohibit a resident from performing voluntary services in the nursing home or from performing services for reasonable consideration;

(8) to fail or refuse to respond promptly and fully, within the capacity of the licensee or administrator, to all reasonable requests or inquiries by a resident or his/her next of kin, guardian or sponsor;

(9) to fail or refuse to permit married residents to share a room, if such an arrangement is within the capacity of the nursing home, unless medically contraindicated as documented by the resident's physician in his/her medical record.

4.06: Medical Treatment and Information

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2, for a licensee or an administrator

(1) to fail or refuse to assure a resident privacy during medical examination or treatment or during care for his/her personal needs, except where the treatment or care can be administered without disrobing the resident;

(2) to fail or refuse to permit a resident to examine, upon request and at reasonable times, all the medical or personal records relating to that resident, unless medically contraindicated by his/her physician in his/her medical record;

(3) to fail or refuse to respond promptly, to the licensee's or administrator's best knowledge, to any inquiry by the resident relating to anything in the resident's medical or personal records, unless medically contraindicated by his/her physician in his/her medical records;

(4) to fail or refuse to permit any person who has a resident's written authorization to examine, at reasonable times and upon request, all the medical and personal records relating to that resident or to fail or refuse to respond promptly, to the licensee's or administrator's best knowledge, to any inquiry relating to anything in the resident's medical or personal records by the person who has the resident's written authorization; except that, a licensee or administrator may require such a person to sign a document stating that the person will not discuss the resident's personal or medical records with the resident if the resident's physician has indicated in writing in the resident's medical record that the resident should not be permitted to examine his/her medical or personal records;

(5) to fail or refuse to make prompt and good faith efforts to obtain information from qualified sources about the nature of the treatment and its likely effect on the resident or to fail or refuse to provide a resident with that information, as soon as possible, if the resident has requested the information, unless medically contraindicated by his/her physician in his/her medical record;

(6) if a resident refuses treatment or drugs, to fail or refuse to make prompt and good faith efforts to obtain information from qualified sources about the likely consequences of a resident's refusal to receive the treatment or drugs or to fail or refuse to provide the resident with that information as soon as possible;

(7) to release a resident's personal or medical records to any individual outside the nursing home without the prior written authorization of the resident, except in case of his/her transfer to another health care institution or as required by law or third-party contract;

(8) to fail or refuse to provide to a resident, upon request, the name and specialty of the physician or other person responsible for the resident's care or for the coordination of care.

4.07: Discharge and Transfers

It shall be an unfair or deceptive act or practice, in violation of G. L. c. 93A, s. 2, for a licensee or an administrator

(1) to transfer or discharge a resident, contrary to the resident's wishes, except
(a) upon a written order by the resident's physician, or

4.07: continued

(b) for reasons related to his/her welfare or that of other residents, as documented in the resident's personal or medical records, or
(c) for nonpayment for his/her stay, except as prohibited by the Social Security Act, or
(d) as required by state or federal agencies authorized to enforce the provisions of the Social Security Act or provisions of law relating to the conditions and quality of care in nursing homes;

(2) to fail or refuse to disclose in writing to the resident and his/her next of kin, guardian or sponsor the specific reasons for discharge or transfer;

(3) to fail or refuse to give reasonable advance written notice of the transfer or discharge to the resident and his/her next of kin, guardian or sponsor so as to insure the orderly transfer or discharge of the resident, except
(a) in emergencies, or
(b) where the resident voluntarily leaves the nursing home, or
(c) where a state or federal agency refuses, or ceases to authorize, payment for the resident, or
(d) where transfer is required by a state or federal agency authorized to enforce the provisions of the Social Security Act or provisions of law relating to conditions and quality of care in nursing homes, or
(e) for nonpayment for his/her stay, except as prohibited by the Social Security Act;

(4) if a licensee or administrator voluntarily proposes to cease to provide a level of care, to fail or refuse to give written notification to a resident and his/her next of kin, guardian or sponsor that the nursing home will cease to provide the level of care required by the resident; such notification shall be given within a reasonable time prior to the time that the nursing home ceases to provide the level of care so as to insure an orderly transfer of the resident.

4.08: Severability

If any provision of these regulations or the application of such provision to any person or circumstance shall be held invalid, the validity of the remainder of these regulations and the applicability of such provision to other person or circumstance shall not be affected thereby.

4.09: Effective Date

The Attorney General's regulations shall become effective on February 1, 1976.

REGULATORY AUTHORITY

940 CMR 4.00: M. G. L. c. 93A, s. 2(c).

APPENDIX 2

MARCH 30, 1981.

THE COMMONWEALTH OF MASSACHUSETTS

LEGISLATIVE RESEARCH COUNCIL REPORT RELATIVE TO CRIMINAL AND FRAUDULENT VICTIMIZATION OF THE ELDERLY

ORDER AUTHORIZING STUDY

(House, No. 6781 of 1980)

Ordered, That the Legislative Research Council undertake a study of Massachusetts statutes, other states' laws, federal laws, and related governmental programs designed to prevent the victimization of the elderly by fraudulent schemes and other criminal activity. Said Council shall report on the results of its study by filing a copy thereof with the Clerk of the House of Representatives on or before the third Wednesday of February in the year nineteen hundred and eighty-one.

Adopted:
By the House of Representatives, June 27, 1980.
By the Senate, in concurrence, June 30, 1980.

LETTER OF TRANSMITTAL TO THE SENATE AND HOUSE OF REPRESENTATIVES

To the Honorable Senate and House of Representatives:

Ladies and Gentlemen: In compliance with the legislative directive in House, No. 6781 of 1980, the Legislative Research Council submits herewith a report prepared by the Legislative Research Bureau relative to criminal and fraudulent victimization of the elderly.

The Legislative Research Bureau is restricted by statute to "statistical research and fact-finding." Hence, this report contains only factual material without recommendations or legislative proposals by that Bureau. It does not necessarily reflect the opinions of the undersigned members of the Legislative Research Council.

Respectfully submitted.

MEMBERS OF THE LEGISLATIVE RESEARCH COUNCIL,

Senator Anna P. Buckley of Plymouth, Chairman;
Representative Michael J. Lombardi of Cambridge, House Chairman;
Senator Joseph B. Walsh of Suffolk;
Senator John F. Parker of Bristol;
Senator Robert A. Hall of Worcester;
Representative William P. Nagle, Jr., of Northampton;
Representative Iris K. Holland of Longmeadow;
Representative Sherman W. Saltmarsh, Jr., of Winchester;
Representative Bruce N. Freeman of Chelmsford;
Representative Charles N. Decas of Wareham.

LETTER OF TRANSMITTAL TO THE LEGISLATIVE RESEARCH COUNCIL

To the Members of the Legislative Research Council:

Ladies and Gentlemen: House, No. 6781 of 1980, reprinted on the inside of the front cover, directed the Legislative Research Council to make an investigation and study of the laws of the Commonwealth, other state laws, federal laws and related governmental programs to prevent the victimization of elderly persons by fraudulent schemes and other criminal activities.

The Legislative Research Bureau submits herewith such a report. Its scope and content have been determined by statutory provisions which limit Bureau output to

factual reports without recommendations. The preparation of this report was the primary responsibility of Thomas R. Asci of the Bureau staff.

Respectfully submitted.

DANIEL M. O'SULLIVAN, *Director,*
Legislative Research Bureau.

CRIMINAL AND FRAUDULENT VICTIMIZATION OF THE ELDERLY

SUMMARY OF REPORT

Introduction

Problems confronting the elderly population have been gaining increasing amounts of attention since the early 1970's. The whole range of criminal victimization problems that are common to other segments of the population often have an acute impact upon elderly individuals when they are the victims. Well-publicized muggings and brutal beatings of elderly citizens are particularly heinous and cast an appalling mood of fear over the elderly population. Purse snatching has also gained a great deal of publicity and the elderly are statistically one of the highest segments of the population victimized in this category.

Since elderly citizens are more vulnerable and fragile both physically and economically, the impact of crime can have deleterious affects. Elderly citizens do not have the money making capacity to overcome a catastrophic loss. They are often underinsured for property and overinsured with expensive "medigap" insurance policies, which do not provide adequate coverage to warrant the high premiums charged.

Consumer related schemes such as medical quackery, hearing aid sales, eyeglass sales, retirement planning and investment swindles, land fraud, insurance schemes, auto repair, and countless other areas of complaint bilk the elderly out of billions of dollars annually.

There were hundreds of bills filed in the 1980 Massachusetts legislative session aimed directly at problems facing the elderly. These various bills were assigned to 13 different committees for consideration. Some of the subject areas which these bills covered included consumer protection, patients' and residents' rights, protective services, medigap insurance, rent subsidies, reverse annuity mortgages, and mandatory sentencing for violent crimes committed against the elderly.

Demographic trends

On a national scale the number of older persons is expected to continue to increase significantly during the 1980's. However, the growth rate will not be as marked as previous decades, because of the drop in the growth rate from 35 percent in the 1950's to 20 percent in the 1960's. From 1975 to 1990, the net increase in the over 65 population is expected to be 6.5 million, in the over 75 group, it is estimated to be 2.9 million.

On the basis of the 1970 Massachusetts state census, there were approximately 637,000 inhabitants over 65 (11.2 percent) out of a total population of 5.689 million. In 1980 the elderly population over 65 years of age reached 720,000, or 12.6 percent of a total population of 5.728 million. The Office of State Health Planning has projected an elderly population of 748,000 for 1985. Estimates prepared by the Office of State Health Planning indicate that the elderly will comprise 12.7 percent (838,000) of a state population of 6.668 million in the year 2000.

Most older persons continue to live in family settings. The single most prevalent living arrangement for the over 65 population is the two member family—husband and wife living alone. Approximately 45 percent of people 65 and over live in the six largest populated states and Florida which ranked eighth in inhabitants. The older population is becoming increasingly female dominant. In 1980 there were only 69 males for every 100 females over 65. Whites disproportionately outnumber Blacks in the older population. Whereas 11 percent of the total White population is 65 and over, only 7.4 percent of the total Black population is in this age group. By far the largest segment of the elderly population resides in urban areas of the country with large concentrations in core cities.

Economic, physical, and behavioral consequences of crime

Crime against the elderly has often been described over the past few years as a problem of crisis proportions. There is a general perception that the elderly are disproportionately victimized, due in large part to the negative image as a "dependent" sector of society that the media, especially TV, have portrayed in respect to the aged. Current research, however, indicates that this view is generally inaccurate.

The available evidence from the National Crime Panel (NCP) and other victimization surveys concludes that victimization decreases with age and that persons over 65 have a much lower incidence of criminal victimization than persons below that age. The elderly 65 years of age or older were the victims in only six percent of the total estimated number of personal crimes as opposed to 26 percent for the 20–24 age group, and 23 percent for the 25–34 age group. When crimes of violence were examined, the aged were victims in only five percent of the total estimated incidents in this category. The age group 20–24 and 25–34 were estimated to be victims in 26 to 21 percent of the incidents. In the category of crimes of theft, once again the 65 years plus group represented only seven percent of the estimated victimization as opposed to 26 percent for the 20–24 age group and 24 percent for the 25–34 group.

Elderly people are more likely to be preyed upon rather than treated violently, while the opposite is true for younger victims. Robbery and burglary are the principal crimes experienced by older people while younger people are more likely to be victims of violent crimes such as assault and rape. This observation is true for all types of personal and household victimization incidents examined in the NCP data; it is also generally true for 39 city level NCP surveys, except in a few cities where persons over 65 report more personal larceny with contact (purse snatching, pickpocketing) than persons under 65.

The evidence suggests that the elderly are less likely to be the victims of crime and that they lose less than other adults when absolute loss measures are applied, and they lose less than young people, but the same or more than other adults, when dollar losses from crime are adjusted for differences in monthly income. Also, the evidence suggests that the elderly are attacked less often than others; however, they are more likely to be injured when they are attacked. Additionally, they are more likely to experience internal injuries and cuts and bruises, and they generally incur larger medical expenses which can have deleterious affects on those living on a fixed income.

Studies indicate that the fear of crime among the elderly is much higher than among any other segment of the population. A Harris Poll revealed that, on a nationwide level, the highest concern among older Americans was the problem of crime—twenty-three percent of the respondents rated fear of crime as the most serious problem. Crime was rated higher than the problem of poor health, which followed by twenty-one percent. Fear of crime may rank highest among the elderly because they have fewer resources for coping with victimization and its consequences.

As a result of their fears, the elderly will often reduce any behavior or activity which provides a street criminal with the opportunity to victimize them. However, this reduction is at the expense of a richness of life style, such as freedom to visit friends and relatives, to sit in the park, or to take walks in the neighborhood. For those older adults who are poor or sick, the life sustaining resources of shopping and medical care may be sharply curtailed by their fear of crime. Since these losses can block important social, physical and psychological needs, the final cost to the elderly of criminal victimization is beyond measurement.

Another type of crime perpetrated on the aged which many experts believe to be very important is that of fraud. The actual extent of fraud has been difficult for researchers to measure for several reasons. Fraud has not been uniformally defined by local law enforcement agencies and, therefore, records are probably not accurate. Also, it is believed that many victims of fraud either never suspect that they have been victimized or, probably more likely, they are reluctant to report it for fear of ridicule.

Some indication of the extent of fraud can be drawn from experiences in the State of California where it was found the elderly were more vulnerable to the nonviolent crime of fraud. The San Francisco and Los Angeles Police Departments have reported that more than 90 percent of the "bunco" (swindling by misrepresentation) victims in those cities were over 65, and that the vast majority of them were women. In addition to the common swindle, investigations by the state's district attorney's consumer fraud units, local law enforcement agencies, and senior citizen committees concluded that consumer frauds involving supplementary health insurance and medical plans, mail order schemes, work-at-home offers, pyramid sales and auto and home repairs are also widespread.

Among consumer crimes, the aged, because of their unique physical problems, are more susceptible to the blandishments of vendors of medical quackery and related health schemes. In California, medical quackery was estimated to be a $50 million a year business. Older persons were the victims in seven out of every ten cases of medical fraud coming to the attention of the state's criminal justice system. According to reports from California and hearings conducted by the United States Senate

Subcommittee on Aging, the most common "get well quick" schemes included cures for cancer, arthritis, baldness, obesity and restoration of youthful vigor.

The typical environment of a current American inner city seems to be a decisive factor in determining the vulnerability of elderly people to many crimes. The general breakdown of the retail system servicing neighborhoods, declining property values and high transient rates produce fragmentation of inner city communities. The support systems that once existed in most inner city neighborhoods have been disrupted by increasingly mobile populations. Both novice and experienced offenders are aware of the opportunities such conditions offer them and take advantage of the situation.

A Kansas City study revealed that the elderly were chosen as crime targets not because of their age and perceived weakness, but because greed and speed of execution were more important to criminals when selecting victims. Age neither protects them nor necessarily makes them vulnerable unless they live in or are on the periphery of high crime areas.

Exploitation of the elderly

Stereotypes that label the elderly as gullible and particularly vulnerable to fraud and consumer abuse has been challenged by a recent research report. When complaints of older persons have been compared with a matched group of randomly selected complaints from younger consumers, the sets of complaints were found to be similar. In general, the marketplace abuses affecting older persons were no different from those affecting the general population. Complaints filed with consumer protection agencies did not present a picture of shady "con artists" who make a specialty of defrauding the elderly. Most older consumers reporting to the public agencies studied appeared self-reliant and well-informed and were less likely to be duped than they were to be dissatisfied with purchase transactions and repair situations.

While the aged should not be regarded as helpless prey for those who would exploit them, the elderly differ from their younger counterparts in the intensity of the overall impact of such abuse on their lives and also in a great reluctance to seek redress when an abuse occurs.

Monetary losses, inconveniences and hardships suffered by older persons in the marketplace seem to more seriously affect their outlook, sense of security, and well being. Their reluctance to report abuses may well be caused by the fear that they may be considered to have diminished competence because of their age.

Medicinal use by the elderly

Approximately 25 percent of all prescription medicines sold annually in the United States are purchased by persons who are 65 years of age and older. Given the fact that the elderly account for approximately 10 percent of the nation's total population, such volume indicates heavy drug usage among elderly Americans. Eighty-five percent of individuals 65 years and older suffer from one or more chronic disorders which often require one or more types of special medication.

Moreover, the elderly are the biggest users of pharmaceutical and over-the-counter drugs and this factor makes them particularly susceptible to promotional efforts by drug manufacturers and related industries, such as national and local retail pharmacy chains. The pharmaceutical industry spends about twenty cents of every dollar of sales on promotion and only about six cents of every dollar for research and development. These factors along with the elderly's relative unsophisticated view of the marketplace may account for the heavy drug consumption rate among the aged.

Insurance

The elderly are particularly vulnerable to unfair insurance promotions. They share with the general population a high level of ignorance as to what constitutes adequate coverage or what are appropriate insurance options. Adequate coverage is vital to take care of the health needs and to provide for burial expenses. Automobile insurance may be important, particularly to the disabled elderly, who heavily rely on this method of travel. The elderly may wish to leave some form of estate to their survivors and thus they may be susceptible to various life insurance promotions. Additionally, the elderly are prime targets of cancer insurance salesmen. Some four million policies were sold in 1979 and about 20 million policies are in force. Many of the 300 companies that sell the insurance rack up these impressive sales records by using scare tactics on elderly persons and high pressure advertisements.

Older Americans are sick three times as often and experience periods of suffering and recuperation by three times that undergone by younger people. Their health bills, on average, are three times greater than younger Americans. These staggering

health costs come at a time in life when having retired, senior citizens can expect to receive only half the income of their younger counterparts. While younger adults typically may spend 10 percent of their income for health care, it is not uncommon for older Americans to spend 30 percent of their income in pursuit of needed health care.

Because of Medicare's restricted benefits, older Americans are fearful that catastrophic illnesses will wipe out their meager savings and leave them destitute. There is a great fear that even the cost of medication and treatment for chronic illness will become too large a burden to carry. They are concerned that they may become a burden to their families and loved ones. There is a fear of going on welfare—even though an increasingly large number of Americans must turn to Medicaid, the welfare medical program, to pay for the cost of their health care. This is particularly true for those who need nursing home care. Nursing home care is so expensive that most elderly quickly use up their assets and depend on Medicaid to defray future costs. Medicaid pays for about 46 percent of the nation's total nursing home bill.

Two thirds of American elderly have at least one "medigap" supplemental health insurance policy, many have two or more policies. There are an estimated 19 million such policies in force at the present time. Based on an average premium cost of $200 a year, the elderly will spend almost $4 billion on such policies annually.

Unfortunately, few elderly understand that the multiple policies they buy often contain a clause which says only one policy will pay. Very frequently the policies which they have purchased are worthless. It is quite common for senior citizens to pay $200 a year in premiums for a policy which will pay them no more than $80 in benefits.

The simple fact is that no policy covers all of Medicare's gaps. Actually, the benefits of Medicare supplementary policies are rather limited. They account for only five percent of the average payment for health care. There are often long waiting periods before the elderly are eligible for full benefits, in addition to standard exclusions for various illnesses or diseases. It is quite common for insurance companies to reject a claim on the grounds that the claim is attributable to a prior disease or condition.

Supplementary policies have spawned numerous complaints to state departments of insurance and the Congress, particularly from senior citizens. Nearly a third of the complaints received by the Pennsylvania Department of Insurance in 1974 related to health insurance; only auto insurance generated more complaints. The Commissioner of Insurance in that state reported that 46.9 percent of the complaints were valid and that the elderly account for a disproportionate share of these complaints. In 1977, New York and Florida received 57,000 and 34,000 complaints respectively, about 40 percent of which related to the sale of health insurance.

Massachusetts statutory provisions

The Attorney General's Office indicates that Massachusett's aged are particularly vulnerable to incidents and episodes of vendor fraud especially relative to nursing home operators, doctors and pharmacists, medicaid fraud, patient abuse, medigap insurance, home improvement schemes, arson and violent crime. The Commonwealth has been a pioneer in the development of both consumer protective and "civil" rights legislation and as a consequence there is a variety of legal remedies and enforcement mechanisms available to the criminal justice system and regulatory agencies and the consumer. Some of the Commonwealth's General Laws which have greater application to the elderly and their specific problems are (1) regulation of business practices for consumer protection (G.L. c. 93A); (2) regulation of hearing aids (c. 93, 71 et seq.); (3) sale of generic drugs (c. 112, s. 12D); (4) compensation for victims of violent crimes (c. 258A); (5) insurance policies cancellable at age 65 (c. 175, s.110H); (6) reduction in motor vehicle insurance rates for the elderly (c. 175E, s. 4); (7) speedy trial for persons 65 years of age or older (c. 231, s. 59E); (8) patients and residents rights (c. 111, s. 70E); and (9) readability of insurance forms (c. 173, s. 20)

There is a relative absence of age specific law here in the Commonwealth. The approach that has been taken by Massachusetts and other states' lawmakers has resulted in enactment of consumer protection laws of general application, devoid of any bias or preference in the case of age, sex or other considerations. In the final analysis the elderly are not victims of any crime or fraudulent activity that cannot also happen to any other age group. Therefore, specific statutory protection may be unnecessary. In fact, in some cases it may be so discriminatory as to invite constitutional challenge on the grounds of denial of the equal protection of the law guaranteed by both the State and Federal constitutions.

In February of 1981 Governor Edward J. King submitted to the Massachusetts Legislature a comprehensive anti-crime package. Included in this legislation is a bill

requiring minimum mandatory sentences of imprisonment for repeat offenders convicted of certain violent street crimes committed against persons 65 years of age or older. It is the goal of this legislation to emphasize the "certainty" of punishment rather than the "severity" of punishment. Its proponents maintain that mandatory sentences will have greater deterrent affect than harsher penalties which have been construed to be "excessive" punishment by some state courts.

As of mid-1980, at least eight states had statutes which imposed greater penal sanctions on offenders convicted of certain crimes against the elderly (Colo., Ha., Ill., La., Nev., R.I., Tenn., and Wis.).

Department of Elder Affairs

The Department of Elder Affairs is charged by statute with overseeing a number of programs for the elderly. It is the state's chief public advocate for the aging population. The Department coordinates its programs with other state agencies including the Department of Public Health, Mental Health, Public Welfare, Social Service, Communities and Development, Energy, and Manpower Development. It assists in, and reviews, the drafting of regulations for programs such as long-term care facilities and nursing homes, medical care and public assistance, state aided housing for the elderly, homemaker agencies, transportation and services for the handicapped.

The Department of Elder Affairs is responsible for carrying out the mandates of the Older Americans Act of 1965 (as amended), the federal government's chief source of support for state and regional elder services. As the state agency designated to meet the responsibilities of the Act, the department has established 23 Area Agencies on Aging to plan and coordinate services for elders in cooperation with other appropriate elder advocacy groups and Councils on Aging. A 1978 amendment to the Older Americans Act mandates that each Area Agency on Aging in a state expend some portion of its federal dollars allocation on legal services for the elderly. These services are generally furnished to those with greatest need. Among specific services provided are those dealing with guardianship, conservatorship, consumer protection, tenant and landlord issues, and individual's rights under such public benefit laws as Medicaid, Social Security and Supplemental Security Income. Through the Departments Legal Services Division, this activity has been fashioned into a formal state network of service sources.

Two major projects organized by the Department of Elder Affairs in 1980 was the Silver-Haired Legislature and the Conference on Crime and the Elderly. The Silver-Haired Legislature was a mock legislative session held in the State House, where elderly activists were given a forum to discuss, propose and act on issues of concern and interest to the contemporary Massachusetts elderly population. The Conference on Crime and the Elderly developed policy recommendations concerning crime and the elderly in preparation for the 1981 White House Conference on Aging.

CRIMINAL AND FRAUDULENT VICTIMIZATION OF THE ELDERLY

Chapter I. Introduction

Origin of study

This report is submitted by the Legislative Research Council pursuant to House, No. 6781 of 1980, which was filed by Representative Michael J. Lombardi of Cambridge, House Chairman of the Legislative Research Council. That legislative directive, reprinted on the inside cover of this report, required the Council to make a study and investigation relative to the laws, practices and procedures of Massachusetts, other states, and the federal government designed to prevent victimization of the elderly by fraudulent schemes and other criminal activities. The order reflects increasing legislative concern relative to crime and other forms of injustices perpetrated against elderly citizens.

Problems confronting the elderly population have been gaining increasing amounts of attention since the early 1970's. The whole range of criminal victimization problems that are common to the other segments of the population often have an acute impact upon elderly individuals when they are the victims. The well-publicized muggings and brutal beatings of elderly citizens are particularly heinous and cast an appalling mood of fear over the elderly population. Purse-snatching has also gained a great deal of publicity and the elderly are statistically one of the highest segments of the population victimized in this category. Purse-snatchings are classified as misdemeanors in most states but these crimes often result in a frightening face to face encounter between an elderly woman and a vicious juvenile who is only concerned with the speed of execution of the crime. This often results in broken limbs, financial loss, and psychological stress. However, these crimes are only part of the picture and the whole range of criminal and consumer problems hold particular relevance for the elderly.

Since elderly citizens are more vulnerable and fragile both physically and economically, the impact of crime can have deleterious effects. Elderly citizens do not have the money-making capacity to overcome a catastrophic loss. They are often under-insured for property loss and over-insured with expensive "medigap" insurance policies, which do not provide adequate coverage to warrant the high premiums charged for such policies.

Other consumer-related schemes such as medical quackery, hearing aid sales, eyeglass sales, retirement planning and investment swindles, land fraud, insurance schemes, auto repair, and countless other areas of complaint bilk the elderly out of billions of dollars annually, the fact that most elderly are living on fixed incomes adds to the burdens posed by this problem.

These are some of the reasons why the Legislature has directed the Council to study this issue. The purpose of this report is to outline and review the problems as they currently exist and relate some of the statutory and programatic remedies available.

Prior legislative proposals

There were hundreds of bills filed in the 1980 session aimed directly at problems facing the elderly. These various bills were assigned to 13 different committees for consideration. The subject area which these bills covered included Consumer Protection, Patients Rights, Protective Services, Age discrimination, and many other areas of special interest. Some of the more relevant bills concerned with criminal and consumer problems of the elderly will be categorized and examined in the following paragraphs in order to illustrate the magnitude of elderly-related issues and the trends and focus of those groups and individuals who are making an effort to amend current statutory law.

Consumer Protection. Senate, No. 84 and House, Nos, 3533, 4653, 5014 and 5067 were concerned with improving the readability of various types of "consumer contracts" an individual may enter into or sign. The various contracts mentioned in these bills are agreements or application forms for consumer credit, mortgages, retail installment sales or agreements, consumer loans or notes, personal, family and home-improvement loans, lease agreements and real estate sales.

House, Nos. 33, 42, 447 and 6960 were bills designed to make corrective changes in the law relative to cancellation of certain contracts signed at a place other than the seller's place of business. This is to protect the consumer from unfair sales pressure tactics used by many door to door salespersons.

House, No. 700 would require reasonable reimbursement to rest homes for services provided. It would have prevented the nursing home rate setting commission from imposing ceilings or maximum rates of payment which do not reflect the actual costs of rest home providers. Senate, No. 504, alternatively, would have

increased consumer participation in hospital and nursing home rate setting. It also would have established a formula to levy an assessment against hospitals and nursing homes in order to pay for the expenses incurred by consumer groups in connection with matters pending against such hospitals or nursing homes.

Medigap Insurance. House, No. 3015 limited the commission paid to an insurance agent to 25 percent of the annual premium paid during the first year of the policy and to 15 percent of the premium in any subsequent year.

Rent Increases. House, Nos. 4080 and 1195 would have prohibited rent increases to government subsidized elderly housing tenants due to cost of living increases in social security benefits. Housing authorities, when determining net income for the purpose of computing the rent of an elderly person of low income, could not apply increases in state supplemental payments and federal supplemental security income benefits received as a result of a rise in the United States Consumer Price Index.

Increased Penalties for Crimes Against the Elderly. Senate, Nos. 885 and 902 and House, Nos. 2630, 2640, 3607, 4171, 4197, 4338, and 4721 provided for various modifications in the penalties imposed for crimes against the elderly. This group of bills is one of the few age specific pieces of legislation which place the elderly in a distinct legal category based solely on their age. There is some uncertainty as to whether such age specific penalties are constitutional. Some sources contend that penalties required by these proposals are in violation of the Equal Protection Clause of the 14th Amendment of the Federal Constitution.

Some of these measures call for mandatory sentences for assault and battery and other crimes, and increased penalties in the form of longer sentences. A few bills include handicapped people under the same classification as the elderly. Other proposals require mandatory sentences for purse-snatching, and one bill, House No. 4338, would exempt certain persons voluntarily assisting elderly persons from civil liability as a result of rendering emergency care.

Compensation to Victims of Violent Crime. Senate, Nos. 804 and 1012 and House, No. 1628 would have amended Chapter 258A of the General Laws which provides for compensation for victims of violent crimes. These bills would require local law enforcement agencies or the relevant governmental units to inform the victim of the existence of the compensation programs. One bill would prevent rape victims from collecting any award under Chapter 258A while another bill would include the loss of personal property as a legitimate claim. Presently the law does not cover the loss of personal property, only out-of-pocket loss. This legislation would also require that unpaid bills for necessary medical or other services rendered to or for the victim of a violent crime be deducted from an award of compensation and paid directly to the person or institution rendering such service.

Reverse Annuity Mortgages. Under the terms of Senate, No. 19 and House, Nos. 446, 2171, 3132, and 5646 banks or credit unions were authorized to issue reverse mortgages up to 80 percent of the value of the real estate to home owners who are 62 years of age or older and who occupy their homes. Such arrangements must conform to the rules and regulations promulgated by the Commissioner of Banks and Banking and the terms of these loan agreements would be subject to that official's approval.

The purpose of this legislation is to permit elderly homeowners to convert the equity in property to liquid assets. Many elderly persons own a mortgage free house, and yet have such little income that they cannot afford to pay their taxes and general living expenses. This legislation would allow the elderly homeowner to collect a periodic payment from the bank based on the value of his/her real estate. In return the bank would have a claim on the property equal to the amount of money borrowed plus interest. Many problems would arise from these types of agreements in the event of neglect of the property, death of one of the mortgagors, or expiration of the loan period, which may result in the forced sale of the home and dislocation of the elderly resident.

Cashing Government Checks. House, No. 2561 would have required all banks doing business in the Commonwealth to cash government checks of persons over the age of 59 who provide identification that indicates they are senior citizens and residents of the community which the bank is located, whether or not they are customers of the bank.

Elderly Abuse and Protection. The issue of elderly abuse has been gaining increasing attention in the past several years, as indicated by the large number of bills filed on this subject annually. Some of the more comprehensive 1980 bills in this area include Senate Nos. 490, 491, 515, 528, 541, 546, 548, 921, 2162, and House Nos. 74, 1455, 1638, 2016, 4525, 4708, and 4907.

None of the above proposals became law.

The problem of elderly abuse has prompted a number of studies, one of which was sponsored by the Department of Elder Affairs in 1979 entitled "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals." Abuse is often caused by neglect of family members of staff in long-term care facilities, nursing homes or hospitals. Abuse can be violent or nonviolent; it can take the form of patient isolation, abandoment, drug misuse, nutritional neglect, mental harrassment and countless other ways.

Overview of the problem

Since the early 1970's, increasing emphasis has been placed on the issue of criminal victimization of elderly Americans. Concern at the national level was first prominently voiced at a 1971 hearing conducted by the Senate Subcommittee on Housing for the Elderly, a subcommittee of the Special Senate Committee on Aging. Although this committee focused only on the problems of the elderly in federally funded housing projects, during the next year's subcommittee hearings speakers went beyond public housing and agreed that elderly persons "in private and public housing . . . are the most vulnerable victims of theft, violence, rowdyism, and outright terrorism." [1]

Crime against the elderly has often been described over the past four years as a problem of crisis proportions. Legislators, criminal justice system officials, and the media have asserted that the elderly are disproportionately victimized, that crime against older persons is frequent, and that it is increasing. The impression that is often given is that the problem is a quantitative one: that large (and increasing) numbers of crimes are being committed against the elderly, and that crime intrudes on their lives more frequently than on the lives of younger persons.

Current research, however, indicates that this view is generally inaccurate. The best available evidence—from the National Crime Panel (NCP) and other victimization surveys—is that victimization rates decrease with age and that persons over 65 have a much lower incidence of criminal victimization than persons below that age. This observation is true for all types of personal and household victimization incidents examined in the NCP national data; it is also generally true for 39 city-level NCP surveys, except in a few cities where persons over 65 report more personal larceny with contact (purse-snatching, pickpocketing) than persons under 65.[2]

Notwithstanding the fact that the elderly are the least likely age group to be victimized, the current consensus is that attention must remain focused on criminal victimization of the elderly because, among other things, the physical, economic and behavioral consequences of crime are greater for them than others. It is assumed (1) that, being frailer on the average than younger people, the elderly suffer greater physical harm when they are victimized; (2) that, having fewer resources, they incur greater economic costs from crime; and (3) that, being isolated from the workforce, family contacts, and other social support mechanisms that mainstream members of society benefit from, the aged are more vulnerable to psychological stress caused by the fear of crime.

One crime-related problem which is very special for the elderly is that of fear. Using national probability samples during 1965, 1968, 1973 and 1974 the National Opinion Research Center's "General Social Surveys" revealed that the elderly are more fearful of crime than other age groups and that this fear seems to be increasing over time.[3] In 1975, the Chicago Council on Aging reported that 23 percent of adults, 65 and over, report fear of crime as a major social problem. Crime is more often identified by the aged as a "very serious" problem than ill health, loneliness, and lack of sufficient money.[4] Therefore, the question may be raised, how reality-based is this fear of crime? Statistics do not support the perception of higher victimization rates for elderly populations. However, this "fear" may well be reality-based in terms of the consequences of crime whether it is physical, economic, or both.

Demographic Profile [5]

Growth Factors. American population is aging rapidly. By the year 2000, 30.6 million people will be age 65 or over. One in eight Americans will have reached that

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[1] Proposed Statement of Professor Fay Lomax Cook, Joint Hearings of the Senate Select Committee on Aging and the House Select Committee on Aging, "Research Into Crimes Against the Elderly Part II," 95th Congress, 2nd Session, February 1, 1978, pp. 63-73.

[2] The National Crime Panel of the Law Enforcement Assistance Administration undertook several victimization surveys in the 1970's. These reports constitute the most extensive attempt to document the risk of being victimized that different groups in our society encounter.

[3] Ibid., p. 64.

[4] Louis Harris and Associates, "The Myth and Reality of Aging in America," (a study for the National Council on Aging) 1975, p. 137.

[5] This section on demographic profile has been drawn largely from the statistical research presented in the "fact Book on Aging: A Profile of America's Older Population," prepared by the National Council on the Aging, 1978, pp. 3-30.

age group, making an increase of eight million, or 35 percent, over the current older adult population of 22.4 million.

Since 1900 the nation's elderly population has grown sevenfold. Population figures for this group have risen at the rate of three to four million per decade since 1940. The growth during the 1970's exceeded earlier projections as it climbed at the annual rate of 460,000.

The numerical growth in the over 65 population can be primarily attributed to three factors: (1) the high birth rate of the late 19th and early 20th centuries; (2) the high immigration rate prior to World War I and (3) dramatic increases in life expectancy during the 20th century. The increase in life expectancy is actuarily projected at birth rather than at upper age levels. In 1900, a person could expect to live approximately 12 more years on reaching age 65. In 1974, the figure was 15.6 years.

Future Trends. The number of older persons is expected to continue to increase significantly during the 1980's. However, the growth rate will not be as marked as previous decades, because of the drop in the rate from 35 percent in the 1940's to 20 percent in the 1960's. From 1975 to 1990, the net increase in the over 65 population is expected to be 6.5 million, in the over 75 group, it is estimated to be 2.9 million. These numerical projections have taken the anticipated decline in mortality rates into account. But should the reduction be greater than anticipated, and medical science makes significant progress in controlling the major killers of old age, heart disease and cancer, the number of older persons would increase substantially.

The future proportion of older persons in the population is somewhat more difficult to estimate than the numerical growth, because it is dependent on future birth rates. Assuming a stable birth rate in the next 15 years, the percentage of older persons in the population will increase considerably. The U.S. Census Bureau anticipates that the 65 plus population will increase from its current estimated level of 11.0 percent of the total population to 11.7 percent by 1990; the 75 plus population will advance from 4.0 percent to 4.7 percent of the total population.

Most experts estimate there will be 43 million persons 65 and over by the year 2020, constituting about 15 percent of the total U.S. Population. By 2030, the ratio is expected to peak at 17 percent and decline somewhat thereafter.

Sex distribution

The older population is becoming increasingly female dominant. Federal census officials estimate that in 1980 there will be only 69 males for every 100 females over 65. At age 75, the ratio decreases to only 59 males for every 100 females.

The male-female differential has been progressively widening for years. In 1900, males of 65 years actually outnumbered females by 102/100 but by 1960 the 65 year old female group exceeds its male counterpart by 17 percent. By 1990, the ratio is expected to decrease to 66 males for every 100 females.

The widening sex differential in the older population is attributable to the differing trends in mortality rates for males and females, particularly in relation to two major causes of death, heart disease and cancer. Reports issued by the United States Public Health Service reveal that both sexes have evidenced declining mortality rates in recent years; however, the decline for females has been dramatic while that of males has been slight.

Racial distribution. Whites disproportionally outnumber blacks in the older population. Both white and black population 65 years of age and over have increased at a dramatic rate since 1900. But proportionate to their numbers in the general population, a substantially higher percent of older persons are white than are black. Whereas 11 percent of the total white population is 65 and over, only 7.4 percent of the total black population is in this age grouping.

Living Arrangements. Most older persons continue to live in family settings. The single most prevalent living arrangement for the over 65 population is the two-member family—husband and wife living alone.

As noted in Table I, the percentage of older females living alone is much greater than that of males (37 percent vs. 15 percent). Even in the 65–74 years bracket the differences are substantial. For the majority who continue to live in a family setting, the patterns for males and females are also quite different. Sixty percent of all males over 75 live with their spouses and 14 percent with other relatives; only 19 percent of females live with a spouse and 35 percent with other relatives.

TABLE 1.—LIVING ARRANGEMENTS OF MEN AND WOMEN 65 AND OVER: 1975

[In Percent]

Years	Male			Female		
	Family	Alone	Institutionalized	Family	Alone	Institutionalized
65 to 74	85	12.1	2.9	64.6	32.9	2.5
Over 75	74.5	18.2	7.4	49.4	40.6	10.0

Source: U.S. Bureau of the Census, "Current Population Reports Special Studies," series P–23, No. 59, May 1976, p.48.

Geographic distribution. The older population is geographically distributed in roughly the same manner as the general population. High concentrations of the elderly are found in those states with the greatest population density. As indicated below, in 1970, approximately 45 percent of people 65 and over lived in the six largest populated states and Florida which ranked eight in inhabitants.

TABLE 2.—NUMBER AND PERCENT OF TOTAL POPULATION 65 AND OVER IN SELECTED STATES (1970)

State	Number over 65 years, (in millions)	Percent 65 and over
New York	2.030	11.2
California	2.056	9.7
Pennsylvania	1.377	11.6
Florida	1.347	16.1
Illinois	1.153	10.3
Texas	1.158	9.5
Ohio	1.066	9.9

Source: U.S. Bureau of the Census, "Current Population Reports Special Studies," Series P–23, Mo. 59, May 1976, p. 19.

In terms of percentage of individual state populations, a somewhat different picture emerges. Florida is an exception, with an extremely high concentration of older persons (16.1 percent). However, the midwest farm-belt region and border states have concentrations of older persons well above the national average of 9.8 percent (Ark.—12.3 percent, Iowa—12.7 percent; Neb., Mo., and Kans.—12.6 percent; S.D.—12.5 percent; and Okla.—12.3 percent).

By far the largest segment of the older population resides in urban areas of the country. Over one-half, or 11 million of the 20 million persons 65 and over in 1970, lived in the urbanized centers of the country. Another 3.5 million lived in smaller urban areas (population classifications of 2,500—10,000 plus). Approximately one-fourth, or 5.4 million, lived in rural areas, chiefly on farms. Of those residing in urbanized centers, over 60 percent, or about one-third of all older persons, lived in central cities. Compared to the general population, the elderly are disproportionally represented in both the central city areas and in the smaller towns.

Massachusetts statistics

On the basis of the 1970 state census, there were approximately 637,000 inhabitants over 65 (11.2 percent) out of a total state population of 5.689 million. In 1980 the elderly population over 65 years of age reached 720,000, or 12.6 percent of a total population of 5.728 million. The Office of State Health Planning has projected an elderly population of 748,000 for 1985. This increase in population is attributed to the decrease in the infant mortality rate in the post-World War I era rather than to any dramatic increase in life expectency.

Estimates prepared by the Office of State Planning indicate that the elderly will comprise 12.7 percent (838,000) of a state population of 6.668 million in the year 2000.

Chapter II. Criminal Victimization of the Elderly

Problems with crime statistics

The general conclusion that the elderly are statistically less likely to be victims of crime needs several important qualifications. The first concerns the accuracy of victimization survey data. It is known that such surveys tend to underestimate victimization, since some respondents forget things which have happened to them; there is also a tendency for people to forget exactly when an incident happened, and to report it as having happened more recently than in fact it did. Little is known, at the moment, about how these biases in the survey data affect estimates of victimization for different age groups—for example, whether the elderly are more or less likely to report incidents accurately to interviewers than younger people.

Second, the statistic used to measure victimization in the survey reports published by the Federal Law Enforcement Assistance Administration (LEAA), the victimization rate, is very misleading. The victimization rate equals the total number of incidents reported to interviewers by the persons in a particular group (for example, those 65 and over), divided by the number of persons in that group. But a small proportion of the population is victimized more than once, in any given six-month or one-year period. An individual who is victimized four times would thus be counted four times in the numerator of the rate, but only once in its denominator. The result is the rate is artificially inflated, and should not be used as a measure of risk.

On the one hand, the true risk for the majority of the population would be much lower; on the other hand, a small proportion of the population would have a very much higher risk than the rate would suggest. This is a general point about victimization rates and does not apply only to the elderly.[1]

Third, though there are some data available from National Crime Panel (NCP) surveys, there has been very little analysis of the qualitative aspects of victimization, especially against the elderly; for example, an aged person jostled by a group of teenagers might interpret the situation as an assault or attempted robbery, whereas a younger person might shrug it off as a normal act of juvenile mischief.

Fourth and finally, it should be noted that the degree of underreporting also appears to vary over time. As the reporting procedures for crimes change, and as the composition of the classification system of crime is revised, the level of reported crime can change to a great extent. This variability in classification over time makes comparisons of crime rates almost impossible.[2]

The normal categorization procedures of the FBI's Uniform Crime Reports (UCR) and local police records cover the seven "most serious" crimes of murder, assault, rape, robbery, burglary, larceny and auto theft. Crimes to which older people may be especially vulnerable, such as abuse or neglect in an institution, consumer fraud and medical quackery, are not included. The best example of the concerns of older adults getting lost in this classification scheme is the case of purse snatching. This offense is variously classified according to the amount stolen or the amount of force used. In law enforcement records, it may be subsumed under the category of misdemeanor or felony, larceny or robbery. Thus, the police have no readily available information to draw upon with regard to purse snatchers. An index that more accurately reflects the nature of crime against the elderly would greatly enhance the knowledge of the situation.

The most serious drawback of official crime statistics is the oversimplification that results from the fact that these statistics do not allow for the analysis of qualitative aspects of crime.

Nonetheless, despite these qualifications, the findings of the NCP and other victimization surveys to date are broadly correct. The weight of the current available evidence is that the elderly are, if anything, less likely to be victims of crime than younger persons. The problem of crime against the elderly is not, in purely quantitative terms, a large problem. This is not a kind of crime which is so frequent, so widespread, that the police and other agencies of the criminal justice system cannot cope with it.

Kansas City, Mo., study

A comprehensive three-year study, "Crimes Against the Aging: Patterns and Prevention," was released on April 18, 1977 by the Midwest Research Institute (MRI). The study, supported by a grant from HEW's Administration on Aging and

[1] Richard F. Sparks, School of Criminal Justice, Rutgers University. Prepared statement for the Joint Hearings of the Senate Select Committee on Aging and House Select Committee on Aging, Part I, 95th Congress, 2nd Session, January 31, 1978, p. 57.

[2] Robert J. Smith, Crime Against the Elderly, International Federation on Aging, 1979, p. 23.

funds contributed by MRI, represents one of the most definitive investigations of elderly victimization to date.

In order to fill a major gap in the systemic knowledge of what makes an elderly person particularly vulnerable to specific types of crimes, what they fear, how crimes are committed against them, with what frequency and to what general effect, MRI conducted an 18-month investigation of all major crimes committed against elderly persons in the Kansas City, Missouri area.

Much of this information was gathered from the victims themselves through personal interviews. As a corollary to this study of elderly victims, MRI investigators also interviewed offenders known to have committed the types of crimes under study. This approach helped to define victim vulnerability as perceived by the offenders and to provide insights into effective crime prevention measures for the elderly.

Based on the results of these interviews and analyses of police reports and census tract data, victimization patterns were developed for (1) the victim, (2) the environments, (3) the crimes, (4) the offender, and (5) the consequences of victimization.

Specific findings include the following:

"Older people are often trapped in circumstances which make them exceptionally vulnerable to crime. Living on limited, fixed incomes, over half of the elderly victims in this study reside alone in deteriorating neighborhoods in juxtaposition to those persons found most likely to victimize them—young, unemployed males. Many of the victims cannot afford to take even minimal home security precautions to protect themselves.

"Over half of the crimes against the elderly were burglaries, followed by robbery, purse snatch, assault, fraud, homicide, and rape according to numbers of offenses committed. The incidence and effects of strong-arm robbery (by physical force) were especially significant for the over 60 age group.

"The elderly's fear of crime, reported as their most serious concern, was found justified: one in three black victims and one in four white victims had been previously victimized within two years of being interviewed for this study.

"Offenders did not necessarily perceive the elderly as particularly attractive targets for victimization due to their physical or psychological status, but rather because their vulnerability was enhanced by their situations or activities (e.g., living alone or being careless with money).

"With an overall median income of only $3,000 per year, elderly victims were likely to suffer severe consequences from financial losses. Losses were computed as a percentage of one month's income to determine immediate aspects; overall, victims lost 23 percent of a month's income, but in the lower income categories, losses were over 100 percent. In many cases, these losses forced victims to cut back on or forego basic necessities.

"Property losses often deprived victims of the few "luxuries" they had, such as television and radios, and which they could not afford to replace. In addition, victims often lost items of great sentimental value, such as jewelry given to them by a now-deceased spouse.

"Consequences of victimization could not be totally quantified. In addition to financial and material losses, physical injuries and measurable behavioral changes, there were further impacts on quality of life which could not be precisely delineated in this study. The anxiety exhibited by many victims and the fear of some to return to their homes can only suggest the actual impact of criminal victimization on the elderly." [3]

The crimes, and the results of them, that are described within the MRI report constitute far more than a single agglomeration of individual criminal acts. They reflect a very pervasive and vicious process of social and economic deprivation of the elderly citizenry, particularly the elderly poor. Of all the persons who, in one way or another, become targets of a criminal act, the elderly usually suffer most, and for some very basic reasons. Like many other Americans who are street crime victims, most are poor, both relatively and absolutely. However, unlike their younger counterparts, most elderly victims have little hope of recouping financial loss through later earnings. They usually have relatively little physical and emotional resiliency, thus, the physical and psychic injuries incurred through victimization can leave a more lasting mark. Many live alone, and this physical isolation is compounded by the fact that they have few persons on whom to rely for immediate aid, compassion or companionship. Some have none. Thus, although the elderly experience lower victimization rates than other age groups, the effect of such victimization—finan-

[3] Midwest Research Institute, "Crimes Against the Aging: Patterns and Prevention," Kansas City, Mo., 1977, pp. S-1, S-2.

cially, physically and psychologically—can be far more devastating to the older Americans than to younger members of society. This phenomenon has been defined in terms of the "relative deprivation" experienced by many elderly.

Types of crime

Data compiled relative to the types of crimes experienced by older people probably reflects more accurately the types of studies conducted rather than the reality of victimization. The bulk of the information available is from traditional crime statistics and victimization studies which record the criminal acts in categories which may not accurately mirror the types of crimes most often suffered by older people.[4]

In addition to the traditional classifications of homicide, assault, rape, robbery, burglary and fraud, one expert in the area, Jack Goldsmith, has suggested that such crimes as purse snatching, medical quackery, "con" games, pension frauds, retirement and land sale swindles, vandalism, and abuse or neglect in nursing homes be included in order to gauge the full impact of crime on the elderly.[5]

An additional pathological form of behavior that is just beginning to be considered a crime category involves the "battered parent", i.e., the abuse of frail and vulnerable old persons by their adult children or other close persons, such as spouse, housekeeper or neighbor. Although relatively little is known about the origin of such behavior, some sources indicate that the motivation for such abuse might be to make an older person change his mind about a will or some aspect of financial management; or it might be the release of frustration from the stress of taking care of an infirmed individual; or it may represent the release of lifelong anger towards the parent which now becomes feasible because of the latter's weakness.[6] Such abuse reflects a wide range of misbehavior, from physical assault and life or health endangering neglect to abandonment of financial exploitation. Some commentators include psychological or emotional abuse as part of the "battered parent" syndrome. However, the extent of such abuse is not known. However, one authority, Marvin Ernst, believes that if battering is taken to include all forms of abuse suffered by the elderly, then parent battering is probably as common as child abuse.[7]

The Kansas City study provides some of the best information on the comparative frequency of the more traditional crimes against the elderly. Researchers found that burglary was the most frequent offense (55.9 percent), followed by robbery (24.6 percent), larceny (13.9 percent), assault (2.5 percent), fraud (2.3 percent), rape, homicide and all other crimes (under 0.52 percent). The high incidence of burglary and robbery were also reported in a number of other studies. Robbery rated first in Washington, D.C., Detroit, and Buffalo, while burglary was number one in Omaha.[8]

Another offense often mentioned was that of purse snatch. While most purse snatch victims appear to be over 50 years of age, the frequency of this crime has not been accurately estimated. The problem is that this crime has not been as systematically and closely defined as burglary and robbery have been. Purse snatch has been subsumed under thefts or larcenies, and sometimes has even been considered a misdemeanor. Also frequently mentioned were the thefts of social security, public assistance and pension checks. Again, these types of crimes that may be of particular importance to older people are not treated systematically in the usual crime statistics and victimization studies.

George Antunes has drawn a distinction between predatory and violent crimes that is useful in summarizing the situation of older people with regard to the traditional categorization of crimes. He argues that elderly victims are more likely to be preyed upon rather than treated violently, while the opposite is true for younger victims. Robbery and burglary, the principal crimes suffered by older people, are predatory crimes in which the object is to obtain another's property with or without the threat of force. Crimes of which younger people are more likely to be victims, such as assault and rape, are violent, with their primary purpose to injure or harm another.[9] Although at the present time, crimes of violence are not numerically the most significant, it is a category of crime with potentially serious consequences that should be considered in any future policy planning.

[4] Smith, supra, p. 9.
[5] "Crime and the Elderly: An Overview." Crime and the Elderly: Challenge and Response, Jack Goldsmith and Sharon Goldsmith, eds., Lexington Books, D.C. Health and Co., Lexington, Mass. 1975, p. 2.
[6] Michael Briley, "Battered Parents." Dynamic Years, January-February, 1979, pp. 24-26.
[7] Ibid., p. 25.
[8] Smith, supra, p. 9.
[9] George Antunes, Fay Lomax Cook, Thomas D. Cook, and Wesley G. Skogan. "Patterns of Personal Crime Against the Elderly: Findings from a National Survey." Gerontologist, Vol. 17, No. 4, August, 1977, p. 324.

Another type of crime perpetrated on the aged which many experts believe to be very important is that of fraud. The actual extent of fraud has been difficult for researchers to measure for several reasons. Fraud has not been uniformally defined by local law enforcement agencies and, therefore, records are probably not accurate. Also, it is believed that many victims of fraud either never suspect that they have been victimized or, probably more likely, they are reluctant to report it for fear of ridicule.

Some indication of the extent of fraud can be drawn from data collected in California. In that state, it was found that while older adults were experiencing increased incidence and fear of crimes of force, or street crimes, they were in fact, more vulnerable to nonviolent crime of fraud. The San Francisco and Los Angeles Police Departments have reported that more than 90 percent of the "bunco" (swindling by misrepresentation) victims in those cities were over 65, and that the vast majority of them were women. In addition to the common swindle, investigations by the state's district attorneys' consumer fraud units, local law enforcement agencies, and senior citizen committees concluded that consumer frauds involving supplementary health insurance and medical plans, mail order schemes, work-at-home offers, pyramid sales and auto and home repairs are also widespread.[10]

Among consumer crimes, the aged, because of their unique physical problems, are more susceptible to the blandishments of vendors of medical quackery and related health schemes. In California, medical quackery was estimated to be a $50 million a year business. Older persons were the victims in seven of every ten cases of medical fraud coming to the attention of the state's criminal justice system. According to reports from California and hearings conducted by the United States Senate Subcommittee on Aging, the most common "get well quick schemes" included cures for cancer, arthritis, baldness, obesity and restoration of youthful vigor.[11]

The elderly are victims of all the types of crimes that affect other members of the community. There is enough evidence now available, however, to draw tentative conclusions as to the special nature of the sort of crimes most common to older adults. Although it is the brutal and often sensational acts of violence that receive the most publicity and generate the most fear, these crimes are probably not numerically the most important. This quantitative conclusion should not diminish attempts to prevent such offenses. It can, however, make all concerned with the overall problem more sensitive to the less sensational, but numerically more important and often socially, psychologically, and physically damaging nonviolent crimes.

In order to cope successfully with the criminal victimization of older people, much more has to be known than merely the quantitative extent of the problem and the types of crimes most often perpetrated against them. Crime is a social process in that it consists of the interaction of individuals and groups in which some are exploited and injured by others within a particular setting. It is necessary, therefore, to go beyond the crimes themselves and explore the participants and setting. The social and physical environment in which criminal victimization occurs is of crucial importance. The elderly are an extremely heterogeneous group and only a portion of them are seriously vulnerable to crime. Environment appears to be the major explanatory factor in accounting for why some older people, more than others, are victimized by certain types of criminals for particular sorts of crime.[12]

Environment

Current research offers little comparative evidence on the victimization of the elderly in any environment other than major urban areas. It has been generally assumed that the crime problem in rural areas does not warrant statistical analysis.

Crime studies of urban areas have indicated the presence of a general pattern of victimization of the elderly. Some areas of the city are more conducive to criminal activity than others and particular environments seem to be associated with particular crimes. This factor holds particular relevance for the elderly population since they inevitably are concentrated in the inner city, where crime rates are generally higher.

Why do the elderly live in these high crime areas? It is obviously more than a matter of simple choice. Many are original residents of a particular neighborhood and are reluctant to leave decaying inner city areas. Others come to the inner city

[10] Evelle J. Younger, "Prevention of Criminal Victimization of the Elderly." The Police Chief, vol. 43, No. 2, February, 1976, pp. 29-32.
[11] Ibid., p. 31.
[12] Smith, supra, pp. 11-12.

because of the supply of low cost housing and services. Still, some may wish to leave, but simply cannot because of lack of resources.

The typical environment of a current American inner city seems to be a decisive factor in determining the vulnerability of elderly people to many crimes. The general breakdown of the retail system servicing neighborhoods, declining property values and high transient rates produce fragmentation of inner city communities. The support systems that once existed in most inner city neighborhoods have been disrupted by increasingly mobile populations. both novice and experienced offenders are aware of the opportunities such conditions offer them and take advantage of the situation.

The Kansas City study revealed that the elderly were chosen as crime targets not because of their age and perceived weakness, but because greed and speed of execution were more important to criminals when selecting victims. Age neither protects them nor necessarily makes them vulnerable unless they live in or are on the periphery of high crime areas.

In the case of a purse snatch, it most often occurred near the victim's home. About 80 percent of the serious crime incidents (purse snatch included) occurred in the homes of the aged victims or in the immediate vicinity. This result is partially due to the fact that burglary was the predominant crime although 60 percent of the assaults, robberies, and thefts were also committed in or near the home.

The fact that so much of the victimization of the elderly usually takes place in or near the home adds to the trauma of victimization, since the home is usually regarded as a refuge. This situation undoubtedly contributes to the great fear of victimization expressed by many older people.

Economic consequences of victimization

When measuring the economic consequences of criminal victimization of the aged, three related questions are generally raised: (1) What are their losses? (2) How are those losses distributed across the age groups? (3) Are the economic hardships imposed by crime losses relative to income greater among the elderly than other age groups? [13]

Professor Fay Lomax Cook of Loyola University of Chicago posed these three questions in a statement before congressional committees. Her research outlined in the following passages on economic and physical consequences of victimization indicates that the elderly are not a highly victimized segment of our population in purely numerical terms. However, this is not to say that the overall impact may not be greater on elderly citizens.

Monetary losses result from household crimes (burglary and larceny) or personal crimes (robbery, personal larceny with or without contact of an offender). The distinction between robbery and personal larceny with contact is that robbery involves the use of force, or threat of force, whereas personal larceny does not. Personal larcenies with contact are the oft-discussed purse snatchings and pickpocketing. Personal larceny without contact is theft without direct contact between victim and offender, and it can occur in any place other than the victim's home (e.g., an unattended bicycle, or a theft in a public restroom). The distinction between robbery and personal larceny with contact is that robbery includes unlawful entry of a residence, whereas household larceny does not.

The most recent data available relative to monetary losses experienced by victims of the above cited criminal offenses is based on reported incidents for 1973 and 1974. In the case of household crimes for those years, persons over 65 were less likely than adults of any other age to be victimized. Relative to the personal crimes of robbery, larceny and assault, the data indicates that, in 1974, persons over 65 were less likely than adults of any other age group to be victimized by robbery, and, for 1973, they were one of the two least victimized groups. For personal larceny with contact, there seems to be no marked relationship between age and victimization, the most victimized being persons 16 to 24 and the least persons 25 to 49. In respect to personal larceny without contact and assault, victimization decreases with age, and the elderly are less likely to be victimized than other age groups.

Moreover, the data does not indicate any dramatic shift in victimization rates among the elderly from 1973 to 1974. Rates from the first year to the second year decrease as often (in three categories) as they increase, and only household larceny rates appear to have risen substantially for the elederly in 1974, as they did for every age group.

[13] Prepared statement of Professor Fay Lomax Cook, School of Social Work, Loyola University of Chicago, Joint Hearings by the Senate Select Committee on Aging and the Select Committee on Aging of the House of Representatives, "Research Into Crimes Against the Elderly Part II," 95th Congress, 2nd Session, February 1, 1978, p. 65.

Household crimes

Economic loss from household crimes includes the amount of cash taken in burglaries and larcenies, as well as victims' estimates of the value of the goods stolen. The data [14] presented in Table 3 is based only on cases in which something of value was taken, thus excluding, for example, attempted burglaries. (The median rather than the mean is used in the following tables since extreme cases make the mean an inaccurate estimate.)

TABLE 3.—MEDIAN VALUE OF PROPERTY LOSS IN HOUSEHOLD CRIMES

Age of head	Burglary				Larceny			
	1973		1974		1973		1974	
	Median	Number	Median	Number	Median	Number	Median	Number
17 to 20	$27	232	$50	184	$25	812	$24	873
21 to 26	100	584	100	554	20	2,536	22	2,732
27 to 32	80	440	98	560	20	2,236	20	2,472
33 to 39	50	452	100	440	15	2,940	15	2,969
40 to 49	75	744	74	618	13	4,584	15	4,351
50 to 64	65	712	98	668	14	3,496	18	3,316
65 plus	60	432	50	350	15	980	14	976

As shown in Table 3, the data does not suggest that the elderly are particularly prone to large losses in property crimes. Based on absolute losses, elderly victims are at or near the bottom of each dollar loss category. Across the two years, the median senior victim lost about $55 per burglary and $15 per simple theft.

A more significant way to measure the true impact of theft is to examine patterns of loss relative to income. Here, to utilize as a measure of economic hardship imposed by crime, the ratio of net dollar losses to victims' monthly incomes is expressed as a percentage. Net losses take into account both the value of goods stolen and property damages incurred in the course of a crime. In the case of burglary, the latter may be considerable. From this total is subtracted the value of any goods recovered by the police or others, and any insurance payments covering either the remaining property or the physical damages. The denominator of the measure, monthly income, is simply 1/12 of a victim's yearly family income.

TABLE 4.—THE IMPACT OF PROPERTY LOSS IN HOUSEHOLD CRIMES: NET LOSS AS A PERCENT OF MONTHLY INCOME

Age of head	Burglary				Larceny			
	1973		1974		1973		1974	
	Median	Number	Median	Number	Median	Number	Median	Number
17 to 20	24.0	204	24.0	160	11.5	736	12.0	796
21 to 26	13.1	516	16.8	450	3.2	2,248	3.4	2,334
27 to 32	13.1	396	12.0	404	2.1	1,976	1.9	2,128
33 to 39	5.5	396	8.0	390	1.2	2,532	1.4	2,504
40 to 49	7.1	660	7.2	582	1.0	4,016	1.2	3,710
50 to 64	6.2	568	10.1	570	1.7	3,056	1.6	2,842
65 plus	10.7	380	13.7	372	3.2	836	2.4	878

As indicated in the table, burglarized households headed by persons 17 to 26 lost a larger proportion of their monthly income (15 percent) than did other age groups. These percentages remain fairly constant at approximately 6–8 percent in the instance of households headed by 33 to 64, then rise slightly among senior citizens

[14] Unless otherwise noted, the tables in the following sections of this chapter were prepared by Professor Fay Lomax Cook of Loyola University of Chicago and were incorporated in her written testimony delivered before the Senate Select Committee on Aging and the House Select Committee on Aging on February 1, 1978. These tables appear on pages 66 to 79 of the committee's report. The author's source for the data presented is the National Crime Panel.

to 12 percent. However, the elderly are not dramatically headed by persons under 21.

Another test of hardship involves victims who suffer a "catastrophic" property loss. A definition of "catastrophic" is necessarily somewhat arbitrary; however, the index applied in the following table is the net loss of more than a household's total monthly income. The households which suffered the highest percentage of catastrophic losses from burglary in 1973 and 1974 were those with heads in the 17–20 and 21–36 age brackets (see Table 5). Large losses continued to decline in frequency, then leveled off through the 50–64 group; among senior citizens, the percentage losing "catastrophic" amounts again showed some increase in 1974. The average level was higher among the elderly than for any other age group over 32, with 12 percent of the elderly burglary victims suffering catastrophically in 1973 and 1974. Again, the youngest age group had the highest percentage of "catastrophic losses" (14.6 percent in 1973 and 15.5 percent in 1974); and again, the percentage decreased with age until about 65, when it began to rise.

TABLE 5.—PERCENTAGE OF VICTIMS OF HOUSEHOLD CRIMES WHO SUFFERED CATASTROPHIC PROPERTY LOSS

Age of head	Percentage of net losses above 1 month's income			
	Burglary		Larceny	
	1973	1974	1973	1974
17 to 20	20.9	23.3	8.3	7.8
21 to 26	17.5	18.0	2.4	.7
27 to 32	17.3	13.1	1.3	.7
33 to 39	3.4	12.7	.9	.7
40 to 49	8.7	7.3	.3	1.0
50 to 64	8.7	9.2	.9	.9
65 plus	7.3	15.8	1.9	2.7

The crimes against the elderly which garner the most notoriety are usually those which occur on the street, personal larceny with contact (purse snatchings and pickpocketings) and robbery.

Of all age groups, teenagers lost least, a median amount of $5.37 for teenagers 12–16, and $22.02 for those 17–20. Among adults over 21, the elderly lost the least. Elderly victims of robbery or larceny lost $34.49, in contrast to persons 33 to 39, who lost a median of $69.91.

TABLE 6.—FINANCIAL LOSS IN PERSONAL CRIMES: 1973 AND 1974 MERGED DATA

Age of victim	Median loss 1973–74	Median loss as percent of montly income	Percent of losses catastrophic	1973–74 number
12 to 16	$5.37	0.6	0.1	291
17 to 20	22.02	4.1	6.2	255
21 to 26	45.33	9.6	9.6	316
27 to 32	50.08	7.7	5.5	165
33 to 39	69.91	11.4	7.9	113
40 to 49	50.20	7.9	5.2	194
50 to 64	41.75	9.6	6.5	285
65 plus	37.49	10.1	7.9	184

Again, looking only at the median amount lost tells little about the impact of financial loss on the victims. A more sensitive measure of the meaning of the theft would be the loss as a percent of monthly income. Thus, among these over 20, there appears to be no marked relationship between age and loss. The highest losers, persons 33 to 39, also lost the largest percent of their monthly income (11.4 percent). Although the elderly are the lowest losers among adults, they have the dubious distinction of ranking second to persons 33 to 39 when the hardship imposed by that loss is considered. However, the differences among the percentages for adults are, for the most part, fairly small, ranging from 7.7 percent to 11.4 percent.

On the matter of "catastrophic" losses from personal crime, no marked relationship between age and hardship appears among adults over 20. About 8 percent of the losses experienced by elderly victims of personal crimes were "catastrophic," similar to persons 33 to 39. A slightly larger percentage of victims, 21 to 29, suffered "catastrophic" losses.

In summary, the elderly are less likely than others to be victims of crime; they lose the same or less than other adults when absolute loss measures are employed, and they lose less than young people, but the same or more than other adults, when the dollar losses from crimes are adjusted for differerences in monthly income.

Physical consequences of crime

When measuring the physical consequences of victimization, the following five questions were raised by Professor Cook:[15]

(1) Whether a victim is or is not attacked;
(2) Whether the attack does or does not lead to injuries;
(3) Whether the injury is of a more or less serious type;
(4) Whether or not the injury warrants medical attention;
(5) Whether that medical attention is or is not protracted and costly.

As it is shown in the following tables, the number of person who are injured by criminals and require hospitalization is quite small. Adults over the age of 40 are the least likely age group to be attacked. When only victims who have been injured as a result of an attack are considered, persons 40–49 are most likely to be injured, followed by the elderly, then by victims 33–39 and 50–64. Of all age groups, persons 12 to 16 are least likely to be injured.

The elderly are clearly unique in the types of injuries they receive. Colums 3–6 of Table 4 present the relevant data, and it can be seen there that the elderly are much less likely than other age groups to suffer from knife or gun wounds and from broken bones or teeth. However, they were more likely to suffer from internal injuries or become unconscious or receive bruises, cuts, scratches, and black eyes. However, the cost for the resultant medical treatment may be more burdensome to the aged citizen. The elderly group's median medical expenses of $109 is surpassed only by that of the 33–39 year old class ($149), but as a percentage of monthly income, the aged experience the greatest loss by far (25.7 percent vs. 12.6 percent for all other adults).

TABLE 7.—PATTERNS OF PERSONAL ATTACK AND INJURY

Age of victim	Base number	Percent attacked	Percent injured of those attacked	Type of injury—if injured, percent who had[1]—			
				Knife or gun wounds	Broken bones or teeth	Internal injuries; unconscious	Bruise, cut, black eye, scratches
12 to 16	2,098	55.8	48.2	4.4	4.3	3.9	93.0
17 to 20	1,835	47.7	56.6	7.3	6.9	6.0	90.4
21 to 26	2,054	44.6	56.9	10.2	8.2	7.0	88.6
27 to 32	1,154	38.3	59.5	8.2	9.5	6.2	88.8
33 to 39	719	39.7	61.4	6.4	12.0	9.9	86.8
40 to 49	880	34.3	68.9	7.3	9.9	16.1	90.4
50 to 64	880	33.6	61.3	8.2	17.4	11.4	85.9
65 plus	469	32.9	66.2	1.8	6.7	19.5	94.5
Total	10,089	44.0	56.5	7.1	8.2	7.8	90.0

[1] Does not sum to 100 percent as victims could receive multiple injures.

TABLE 8.—FINANCIAL COSTS OF INJURY

Age of victim	Base number	Percent injurcd who needed medical care	Those who needed care who received some at some expense		Median medical expense	Median medical expense as percent of monthly income
			Number	Percent		
12 to 16	565	28.8	101	63.4	$34.80	4.4
17 to 20	496	33.9	84	53.1	50.32	10.4

[15] Ibid., p. 68.

TABLE 8.—FINANCIAL COSTS OF INJURY—Continued

Age of victim	Base number	Percent injured who needed medical care	Those who needed care who received some at some expense		Median medical expense	Median medical expense as percent of monthly income
			Number	Percent		
21 to 26	521	42.4	118	58.7	62.95	12.0
27 to 32	263	39.9	53	54.1	79.97	10.6
33 to 39	175	41.7	29	44.2	149.73	17.8
40 to 49	208	56.2	61	53.6	64.94	12.0
50 to 64	181	54.1	41	45.6	50.42	10.7
65 plus	102	47.0	26	56.7	109.56	25.7

An important question is what percentage of these medical expenses actually came out of the pockets of elderly victims and what proportion was paid by Medicare and other insurance programs. Since Medicare paid a little less than half the medical costs of the average elderly person in 1974, it is reasonable to assume that Medicare paid only a portion of these costs incurred through victimization.

In summary, the evidence suggests that the elderly (1) are attacked less often than others; (2) are among the more likely to be injured when they are attacked; (3) are more prone to experiencing internal injuries and cuts .and bruises; and (4) generally incur larger medical expenses.

Behavioral consequences

An examination of existing evidence regarding the fear of crime in America seems to indicate clearly that the elderly bear the heaviest psychological costs of crime. Despite the indications of current evidence the behavioral consequences or impact of victimization remain difficult to assess. Why do the elderly seem so fearful of crime, when several studies have concluded that in fact the elderly are one of the least victimized segments of our population? Perhaps a simple answer can be given to this question: The aged fear crime because they have fewer resources for coping with victimization and its consequences.

Fear of crime in the older population has been the most pervasive and consistent finding of major research studies. A Harris Poll revealed that, on a nationwide level, the highest concern among older Americans was the problem of crime—twenty-three percent of the respondents rated fear of crime as the most serious problem. Crime was rated higher than the problem of poor health, which followed by twenty-one percent. In 1971, the Los Angeles Times conducted a poll which showed fear of crime was second only to economics in causing stress.[16]

Two national surveys sponsored by the National Retired Teachers Association and the American Association of Retired Persons discovered that the fear of crime ranked only behind the problem of food and shelter.[17]

A study of the urban aged in Wilmington, Delaware, determined that 65 percent of the population were alarmed over their personal safety.[18] An extensive survey by the Chicago Planning Council on Aging reported that fear of crime represented the most significant problem, with forty-one percent of the city's 518,000 residents over 60 selecting it as the major issue.[19] Similar findings emerged from another Chicago study, using a much smaller number of respondents (516), as indicated in the following table.

[16] "In Search of Security: A National Perspective on Elderly Crime Victimization". Report by the Select Committee on Aging, 95th Congress, First Session, April 1977, p. 38.
[17] Robert J. Smith, "Crime Against the Elderly," the International Federation on Aging, 1979, p. 21.
[18] Ibid.
[19] "The Elderly: Prisoners of Fear," Time, November 29, 1976, p. 22.

TABLE 9.—PROBLEMS: COMPARISON OF CHICAGO SURVEY GROUPS WITH NATIONAL SAMPLE

[In Percent]

Problem	65 years and over	
	Total of Chicago survey (groups N=516)	National
Fear of crime	41	23
Poor health	37	21
Not having enough money to live on	22	15
Loneliness	10	12
Not enough medical care	10	10
Not enough education	4	8
Not feeling needed	4	7
Not enough to do to keep busy	4	6
Not enough friends	4	5
Not enough job opportunities	3	5
Poor housing	7	4
Not enough clothing	3	3
Not seeing children or grandchildren or other relatives enough	8	.....
Not being able to get places—good transportation not available	9	.....

Source: B. Havighurst, "Senior Citizens in Great Cities: the Case of Chicago," Gerontologist, vol. 16, No. 1, pt. 2, 1976, pp. 47–52.

Variables that affect fear

It should be noted that some segments of the elderly population, especially low income people living in metropolitan centers, who express greater fear, do in fact have a higher probability of being victimized. The four primary variables which have the most influence on this score are sex, economics, race, and community size.

Sex. Women generally have greater apprehension towards crime than men regardless of age. This pattern holds true for the elderly. Data from the 1973 and 1979 General Social Surveys, conducted by the National Opinion Research Center (NORC) at the University of Chicago, indicated that while 34 percent of aged males reported fear of crime, the figure rose to 69 percent in the case of aged females.[20]

Economics. People at lower income levels express more fear of crime than those in higher economic strata. A 1975 Louis Harris poll reported that 31 percent of people with incomes under $3,000 per year felt that fear of crime was a major social problem as compared to 17 percent of those with incomes of $15,000 per year or more.

An article written by Frank Clemente and Michael B. Kleiman also shows a relationship between fear of crime and income. Of the elderly population with incomes of $7,000 per year or less, 51 percent indicated fear of crime while 43 percent of older Americans with annual income above $7,000 expressed significant fears.[21]

This relationship between economics and fear may be justified in light of the fact that poorer people generally live in the inner cities and experience higher victimization rates than their wealthier suburban peers.

Race. Virtually all studies indicate greater alarm relative to crime among the elderly black population than in their white counterparts. The 1975 Louis Harris survey showed that of those people over 65, 21 percent of the white population as compared to 41 percent of the black population identified crime as a "serious problem for them personally."[22] A further refinement of these statistics shows a correlation between race and income. Of those 65 and older with incomes under $3,000 a year, 28 percent of the whites and 44 percent of the blacks listed fear of crime as a very serious social problem. These rates declined to 18 percent for the white population and 33 percent of the black population when incomes were over $3,000.[23]

[20] Frank Clemente and Michael B. Kleiman, "Fear of Crime Among the Aged," Gerontologist, June 1976, p. 208.
[21] Ibid.
[22] Louis Harris, "The Myth and Reality of Aging in America," the National Council on Aging, 1975, p.133.
[23] Ibid., p. 135.

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The Clemente and Kleiman study indicated that while approximately 47 percent of the elderly white population was afraid to walk alone in their neighborhoods at night, this figure increased to 69 percent in the elderly black population.[24]

Community. Community size is directly related to a person's fear of crime.[25] The greater the size of the community, the higher the level of fear, according to the Harris polls of 1964, 1966, 1969 and 1970 and the Gallup polls of 1967, 1968 and 1972. This fact holds true for all age levels in the population but is most acute among the elderly.

The Clemente and Kleiman study shows that fear in the elderly "decreases in a clear step pattern as one moves from large cities to rural areas."[26] The study produced the following data showing the percent of elderly (over 65) who expressed fear in localities of various sizes:

[In percent]

Community	Elderly	Nonelderly
Larger cities (250,000 plus)	76	57
Medium cities (50,000 to 250,000)	68	47
Suburbs of large cities	48	39
Small towns (2,500 to 50,000)	43	40
Rural locations (under 2,500)	24	25

Impact of fear of crime

Fear of crime in the elderly population has been well substantiated. Even if this phenomenon is out of proportion to the statistical probability of being victimized, or without foundation due to local environment, the effects are just as debilitating as if the fears were justified.

Generally, older people cope with their fear of victimization by limiting their behavior. The elderly in urban areas are afraid to leave their homes, particularly at night. They limit their exposure to crime by avoiding places they consider dangerous, even if it is the bus stop. Housing choices by the elderly have also been found to be significantly affected by fear of crime. Such fear also impacts the general social behavior and morale of the aged and prevents satisfaction in most other areas of their lives. Many tend to withdraw from the fearful environment of their community and remain behind locked doors, staying home from church or abandoning shopping trips. This virtual "house arrest" for many elderly is accompanied by many mental and physical problems and possibly even a higher depression rate due to such isolation.

As a result of their fears the elderly will often reduce any behavior or activity which provides a street criminal with the opportunity to victimize them, however, this reduction is at the expense of a richness of life style, such as freedom to visit friends and relatives, to sit in the park, or to take walks in the neighborhood. For those older adults who are poor or sick, the life sustaining resources of shopping and medical care may be sharply curtailed by their fear of crime. Since these losses can block satisfaction of important social, physical and psychological needs, the final cost to the elderly of criminal victimization is beyond measurement.

Policy implications

One policy regarding crime victims may be suggested, based on current research. On the one hand, it may be argued that the crime problem of the elderly is not an age-related problem but rather a condition-related problem. The condition is one of poverty. The basis for this argument is the observation that the consequences of crime against the elderly are most serious when one examines not absolute monetary loss, but losses in terms of their incomes.[27]

When compared to all other age groups in the population, aged citizens have the highest incidence of poverty. Whereas one in nine persons under age 65 lived in poverty in 1974, one in every six persons aged 65 or older lived in poverty. In fact,

[24] Clemente and Kleiman, supra, p. 208.

[25] Sarah L. Boggs, "Formal and Informal Crime Control: An Exploratory Study of Urban, Suburban, and Rural Orientations," Sociological Quarterly, Summer 1971, pp. 320–326.

[26] Clemente and Kleiman, supra, p. 209.

[27] Joint Hearings before the Senate Select Committee on Aging and the House Select Committee on Aging. Research Into Crimes Against the Elderly Part II, 95th Congress, 2nd Session, February 1, 1978, p. 78.

the situation may be worse than the figures indicate, for the estimate of 3.3 million elderly poor exclude many living in public facilities and more than one million others whose own incomes would classify them as poor but who lived in nonpoor households.[28]

One policy approach that has been suggested is a compensation program specifically targeted at the elderly who live on subsistence level income. Compensation survey data indicates a sharp drop-off in insurance coverage of property losses among the elderly, paralleling their income level. As indicated in Table 6, both young household heads and the elderly were substantially "underinsured" for burglary losses. This contributed to their relatively high net financial losses to property crime.

TABLE 10.—PERCENTAGE OF VICTIMS INSURED FOR BURGLARY LOSSES

Age of head	All losses (percent insured)		Losses over $100			
			1973		1974	
	1973	1974	Percent insured	Number	Percent insured	Number
17 to 20	18.2	20.7	24.2	272	36.0	64
21 to 26	16.2	16.8	31.7	396	28.0	224
27 to 32	17.9	29.9	31.4	294	41.3	202
33 to 39	28.9	39.5	48.4	244	49.5	210
40 to 49	35.3	37.8	43.3	456	51.2	292
50 to 64	41.0	38.9	50.0	412	52.3	308
65 plus	25.4	22.8	40.0	124	33.5	162

Boston elders' attitudes towards crime[29]

Boston elders' perception of neighborhood crime and their perception of the most important crimes affecting their population was included in a report prepared by the Center for Survey Research in 1978. Out of a total elderly population of 86,330 (65 years of age or older) in Boston, 3,300 of whom live in elderly public housing, 1,000 respondents answered the questionnaire distributed by the Center for Survey Research. The percentage of elderly persons questioned was proportionate to the number of people in each area according to the 1970 Federal Census.

Neighborhood Satisfaction and Crime. When asked how satisfied they were in general with their neighborhood, three out of five elders (60 percent) reported that they were "very" satisfied, and another 23 percent were "somewhat" satisfied. A total of 13 percent reported that they were either "somewhat" or "very" dissatisfied with their neighborhood.

Forty-two percent of Boston elders reported some kind of neighborhood compatibility dimension as the primary source of neighborhood satisfaction, including 14 percent who reported that neighbors help each other and 9 percent who reported that the thing they liked best was that neighbors mind their own business. Another 34 percent of Boston elders reported that neighborhood accessibility was their primary source of satisfaction in their neighborhood including 9 percent who reported that their house was near transportation, 5 percent who reported that their house was near stores, and 19 percent who reported that their house was near other facilities, such as places of worship and community centers. An additional 13 percent of Boston elders reported that their primary source of neighborhood satisfaction was that it was quiet and safe.

When asked how safe their neighborhoods were, 69 percent of Boston's elderly reported "very" or "reasonably" safe, compared to 31 percent who reported either "somewhat" or "very" unsafe. The aged living alone, those elders living in Allston-Brighton or the downtown area, and the frail elders were more likely to report that their neighborhoods were very unsafe. Elders from West Roxbury, Roslindale or South Dorchester—East Boston were more likely to report that their neighborhoods were "very" safe.

[28] Ibid., p. 79.

[29] The statistical information in this section was obtained from the following report of Lawrence G. Branch, "Boston Elders: A Survey of Needs 1978," Center for Survey Research, a facility of the University of Massachusetts/Boston and the Joint Center for Urban Studies of M.I.T. and Harvard University, and the Boston Observatory of the University of Massachusetts/Boston. This report was prepared for the City of Boston Commission on Affairs of the Elderly.

When questioned as the crime level in their neighborhoods, three out of five Boston elders surveyed (61 percent) answered that the crime level had remained the same over the past year, while 22 percent reported that it had gone up compared to 17 percent who indicated that the crime level had ebbed. Elders who were more likely to report that the crime level had gone up over the past year included those aged 75 or more, those with low income in general, residents of Allston-Brighton, and the frail elders. Residents from Back Bay—Beacon Hill, Chinatown—North End—South End—and Fenway were more likely to report that crime had gone down in their neighborhood over the past year.

On the matter of restricted activities due to fear of crime, nearly two out of three elders (64 percent) reported that they "hardly ever" limited their activities due to their fear of crime. Elderly persons who were more likely to report "frequently" limiting their activities due to their fear of crime included the residents from Allston-Brighton and those living in households composed of non-family members.

When asked what were the three most important crimes affecting Boston elders, approximately 22 percent responded that there were no particular crimes affecting Boston elders. Of the remaining 78 percent, burglary and purse snatching were each mentioned most often (27 percent and 26 percent respectively). Muggings and robberies accounted for nine percent of the crimes. Elders from South Boston—Charlestown were particularly concerned with burglary, while residents of Upper Roxbury—Mattapan and South Dorchester—East Boston as well as those living with unrelated others were most distressed about purse snatching.

Criminal victimization survey in Boston

The crime statistics and findings presented in this section are derived from a victimization survey conducted early in 1974 under the National Crime Survey Program. Since the early 1970's victimization surveys have been designed and carried out by the Law Enforcement Assistance (LEAA) and by the Bureau of the Census for the purpose of developing information that permits detailed assessment of the character and extent of selected types of victimization.

The victimization surveys conducted in Boston and 12 other central cities in 1974 enabled measurement of the extent to which city residents age 12 and over were victimized by selected crimes, whether completed or attempted.[30] The individual offenses covered were rape, robbery, assault and personal larceny; burglary, household larceny and motor vehicle theft constituted the yardstick for "household" crimes.

In addition to gauging the extent to which the relevant crimes happened, the survey permitted the examination of the characteristics of victims and the circumstances surrounding criminal acts, exploring, as appropriate, such matters as the relationship between victims and offender, characteristics of offenders, extent of victim injury, economic consequences to the victims, time and place of occurrence, use of weapons, whether the police were notified, and, if not, reasons advanced for not informing them.

The surveys in Boston were carried out in the first quarter 1974 and covered criminal acts that took place during the 12 months prior to the month of interview. Information was obtained from interviews with the occupants of 9,290 housing units (19,186 residents age 12 and over). This data only covers the geographic area of Boston, which in 1975 contained 12.9 percent of the state's elderly population (65 years of age and older).

The data presented in the report are only "estimates" based on a smaller limited sample. It is not based on actual incidents recorded but is a statistical rendering because, especially in the over 65 category, enough sample cases could not be documented in order to provide an accurate estimate of the elderly's victimization rates in various crime categories.

The crime trends for the aged in Boston were generally consistent with victimization surveys conducted elsewhere in the United States. The conclusion that the aged are one of the least victimized segments of the population has been affirmed by these statistics. For example, the elderly 65 years of age or older were the victims in only six percent of the total estimated number of personal crimes as opposed to 26 percent for the 20–24 age group, and 23 percent for the 25–34 group.

When crimes of violence are examined, the aged were victims in only five percent of the total estimated incidents in this category. The age groups of 20–24 and 25–34 were estimated to be victims in 26 and 21 percent of the incidents. In the category of crimes of theft, once again the 65 years plus group represented only seven

[30] U.S. Department of Justice, Law Enforcement Assistance Administration, National Criminal Justice Information and Statistics Service, "Criminal Victimization Surveys in Boston: A National Crime Survey Report", July 1977.

percent of the estimated victimizations as opposed to 26 percent for the 20–24 age group and 24 percent for the 25–34 groups.

The data presented in the following tables indicates that those 65 and over are generally the least victimized segments of the population in the categories of robbery, assault and theft, with a few exceptions; males in the 65 and over category were victims of robberies more often than some of the younger categories. Also, males 65 and over suffered the highest rate of injuries during a robbery. This higher injury rate for the men does not hold true for the female population. This difference can be attributed to the tendency for men to confront an assailant and give a struggle which often leads to injury as opposed to the more passive reaction of women who do not often struggle with a street criminal.

The general observation that the elderly do not experience greater impact from crime is reinforced when burglary, household larceny, and motor vehicle theft are analyzed.

TABLE 11.—HOUSEHOLD CRIMES: VICTIMIZATION RATES, BY TYPE OF CRIME AND AGE OF HEAD OF HOUSEHOLD

[Rate per 1,000 households]

Types of crime	12 to 19 (6,500)	20 to 34 (74,400)	35 to 49 (41,000)	50 to 64 (45,600)	65 and over (40,800)
Burglary	174	208	145	119	74
Forcible entry	59	88	61	53	30
Unlawful entry without force	86	64	37	26	20
Attempted forcible entry	[1] 29	57	47	40	23
Household larceny	116	113	119	64	29
Less than $50	65	54	60	35	20
$50 or more	32	46	50	21	[1] 4
Amount not available	[1] 3	5	[1] 4	[1] 2	[1] 1
Attempted larceny	[1] 16	9	5	7	[1] 4
Motor vehicle theft	63	111	103	78	35
Completed theft	43	65	61	48	26
Attempted theft	[1] 20	46	42	31	9

[1] Estimate, based on about 10 or fewer sample cases, is statistically unreliable.

Note.—Detail may not add to total shown because of rounding. Numbers in parentheses refer to households in the group.

TABLE 12.—PERSONAL CRIMES: VICTIMIZATION RATES FOR PERSONS AGE 12 AND OVER, BY SEX AND AGE OF VICTIMS AND TYPE OF CRIME

[Rate per 1,000 resident population in each group]

Sex and age	All personal crimes of violence	Crimes of violence				Crimes of theft	
		Robbery		Assault			
		Robbery with injury	Robbery without injury	Aggravated assault	Simple assault	Personal larceny with contact	Personal larceny without contact
Male:							
12 to 15 (19,100)	115	11	54	25	23	[1] 3	61
16 to 19 (19,600)	147	15	46	51	34	16	109
20 to 24 (33,600)	143	14	44	46	39	14	150
25 to 34 (35,900)	101	8	25	31	37	8	139
35 to 49 (33,400)	55	10	21	13	11	9	84
50 to 64 (32,100)	54	14	24	[1] 6	10	12	59
65 and over (22,000)	47	19	20	[1] 4	[1] 4	25	42
Female:							
12 to 15 (18,500)	61	[1] 6	13	[1] 9	33	[1] 5	49
16 to 19 (24,100)	71	[1] 3	24	22	17	44	123
20 to 24 (41,300)	71	7	17	14	23	47	154
25 to 34 (42,600)	62	[1] 4	19	16	18	39	130

TABLE 12.—PERSONAL CRIMES: VICTIMIZATION RATES FOR PERSONS AGE 12 AND OVER, BY SEX AND AGE OF VICTIMS AND TYPE OF CRIME—Continued

[Rate per 1,000 resident population in each group]

Sex and age	All personal crimes of violence	Crimes of violence				Crimes of theft	
		Robbery		Assault		Personal larceny with contact	Personal larceny without contact
		Robbery with injury	Robbery without injury	Aggravated assault	Simple assault		
35 to 49 (38,900)	36	6	14	7	8	38	86
50 to 64 (42,500)	30	9	9	5	7	38	48
65 and over (37,000)	13	[1] 5	[1] 4	[1] 2	[1] 1	36	24

[1] Estimate, based on about 10 or fewer sample cases, is statistically unreliable.

Note.—Detail may not add to total shown because of rounding. Numbers in parentheses refer to population in the group.

Media's Bias Against the Elderly. After a thorough review of the statistics concerning elderly victimization, the question may be asked, why is the popular perception of the elderly so heavily negative? Why do so many continue to believe that the elderly are living in constant danger of victimization? Why do so many elderly live in constant fear of crime when the statistics do not indicate that a serious crime problem exists for them?

One explanation for these misperceptions can be attributed to the negative image of the aged fostered by the media, especially television. There is probably no other identifiable segment of the population, aside from criminals, that is so consistently portrayed in a negative fashion. Most TV news stories depict the elderly as (1) victims of crime; (2) victims of circumstance; and (3) recipients of social services. When a story is not negative it is allotted into a category labeled "human interest" i.e., "Margaret Hennessey was honored on her 100th birthday by her friends and neighbors." The most striking aspect of these stories is that one constantly is viewing a group of people having things done to them or for them. They are people who are in effect portrayed as having lost control of their lives. The TV camera seems to overemphasize the physical deterioration of old age and an unspoken value judgment of the hopelessness and uselessness of old age is conveyed. Only infrequently is an elderly person portrayed as a vibrant and contributing member of society.

There are some signs that the media are aware of this negative stereotyping and are actually trying to correct it. The popular actress, Helen Hayes, appeared in a film about the trauma of being sent to a nursing home. "Over Easy" is a weekly TV program aimed at an elderly audience and has a very high rating. Many newspapers have added a regular column dealing with issues of special interest to the elderly, such as the column "Senior Set" in the Boston Globe. Under pressure from the Gray Panthers Media Watch Project, there have been improvement in television advertising and situation comedies.

The area of least improvement according to Lydia Bragger, who heads the Media Watch Project, is television news. She contends that representatives of local and network television are much more receptive to complaints about entertainment appearing on the tube than to those involving news programs.

Victim profile

Economic Factors. In 1973 almost half of the population 65 and over were retired, and living on a fixed income at or below the poverty level. The poverty threshold for a couple was set at $4,505 and at $1,974 for an individual. In older families, 12 percent were below the poverty level; in the instance of the older person living alone or with nonrelatives, 37 percent were below the poverty level. The Bureau of Labor Statistics indicated that in 1973 it cost a retired couple a minimum of $5,414 a year to maintain an "intermediate" standard of living in an American city. Half the aged couples could not afford this "modest but adequate" standard of living.[31]

Elderly crime victims are poor both relatively and absolutely. The theft of $20.00 from an elderly person on a fixed income represents a much greater relative loss than when the same amount is stolen from an employed person. Many older people have no bank accounts from which they can withdraw funds in an emergency, e.g.,

[31] "In Search of Security: A National Perspective on Elderly Crime Victimization," Report by the Select Committee on Aging, 95th Congress, First Session, April 1977, p. 24.

if robbed. They must wait until their social security, pension or supplemental security income checks arrive the following month.

This protracted loss also occurs when an older person's property is stolen or damaged. The elderly generally do not have the financial capability to replace or repair the property. The dollar loss or theft of a television set may not appear significant in terms of FBI crime statistics but the consequences of the loss for the elderly person may be dramatic. The losses experienced by the elderly victim can have implications that are far more dramatic than a simple economic evaluation would reveal.[32]

Physical Factors. There are some normal conditions in the aging process which cause the older person to be more vulnerable to criminal abuse. Diminished physical strength and stamina are experienced by all older people. With advanced age there is also a greater possibility of incurring physical ailments such as visual or hearing losses, arthritis and circulatory illnesses. Another condition of advanced age is osteoporosis which causes bones to be more brittle, more easily broken, and less quick to heal.[33]

Criminals, particularly teenagers, are aware of the diminished strength and physical weaknesses in the aging population and often seek this more vulnerable group as targets. If the older person is physically harmed as the result of crime, it is difficult to assess the full extent of the injury.

Environmental Factors. One of the key factors in the elderly's vulnerability to crime stems from their location in urban areas, and particularly, their residence in neighborhoods with high crime rates. More than 60 percent of the elderly live in metropolitan areas, and most of these reside in the central city. Many have been living in an area for decades and either for cultural, emotional or economic reasons have not moved. Many older people live in the central city because they cannot afford housing in the surrounding areas or suburbs. They are often people who are dependent on public transportation. For whatever reason the urban elderly often find themselves in close proximity to the people most likely to victimize them—the unemployed and teenage dropouts. The dates that the elderly receive social security, SSI, and pension checks are well known in these areas. Criminals know the most likely days that the elderly will have large sums of cash on their person and in their homes. Older people are also more likely to be victimized repeatedly by the same offender.[34] Because older persons are often unable to move from the area, they do not report the offender for fear of reprisals.

Social Factors. There are some social conditions, more prevalent among the aging population, which increase their chances of victimization. Statistically, elderly people are more likely to live alone. The criminal is more apt to select a home for a burglary that is inhabited by only one elderly person. Older persons are frequently alone on the streets and on public transportation. This again makes them easy targets.

There is indication that older people are particularly susceptible to fraud, bunko, and confidence games. This may be related to the social isolation experienced by many older Americans.[35]

Offender profile

Studies indicate that the typical person who commits street crimes against the elderly as well as most other age groups is a young black unemployed male living in the inner city who preys on older blacks and whites alike, particularly women, and whose principle motivation is greed and opportunity.[36]

The most common characteristic of those who commit crimes is their youth. The youthfulness of most offenders is, in turn, related to the social environment and the type of crime. In 1967, the President's Crime Commission reported that crimes of violence against elderly persons were committed predominantly and increasingly by young adults 18 to 24 and that about one-half of all reported street crimes (robbery, burglary, larceny and auto theft) were committed by persons under 18.[37] In the City of Detroit, it is estimated that some 66 percent of offenders involved in street crimes

[32] Ibid., pp. 24–25.
[33] Ibid., p. 25.
[34] Jack Goldsmith, "Community Crime Prevention and the Elderly: A Segmental Approach, Crime Prevention Review, California State Attorney General's Office, July 1975, p. 19.
[35] In Search of Security, supra, p. 26.
[36] Midwest Research Institute,"Crimes Against the Aging: Patterns and Prevention," Kansas City, Mo. 1977, VI–2, VI–3, VI–6.
[37] Ibid., I–3.

against the elderly were between the ages of 13 and 18, with 32 percent in the 19 to 25 age group and only 2 percent older than 25.[38]

In Philadelphia, two-thirds of the offenders were reported as adolescents, one-fourth as adults, and one-tenth as children.[39] In Kansas City the vast majority, nearly 90 percent, were younger than 30; most offenders were estimated by their victims to be teenagers (59.7 percent). An additional 29.5 percent were said to be in their twenties.[40]

As noted, research reveals that the typical offender in the United States can be characterized as a young unemployed black male. For instance, in Detroit, it was found that about 98 percent of the suspects arrested for street crimes were males, and approximately 82 percent were blacks.[41] This data, however, should not be construed to indicate that young blacks are predominately criminal. The variable of environment must be taken into consideration, for both the poor, elderly and unemployed black youths are concentrated in the inner city. When race of victim and race of offender were paired it was found that the majority of crime was intraracial. The findings in the Kansas City study support the contention that crime is more frequently a case of young blacks victimizing older blacks and young whites victimizing older whites.[42]

Statutory trends in Other States

Violent crime has gained a great deal of attention from lawmakers in various states. It is one of the few areas where states have enacted age specific legislation aimed directly at the elderly. In June of 1980 the Massachusetts Legislative Service Bureau conducted a survey aimed at determining which states have increased penalties for assaults against the elderly. The results of this survey showed that eight states have recently amended statutes, increasing penalties. A brief capsulization of these amendments will be provided here in the following paragraphs.

Colorado. In 1979 the Colorado General Assembly enacted legislation which mandated greater penalties for the crime of robbery of the elderly by providing that conviction of such an offense shall carry the penalty of a Class 3 felony, a sentence of four to eight years.[43] Normally, the crime of robbery would be a Class 4 felony carrying only a two to four year sentence.

Hawaii. In 1978 Hawaii revised its penal code to include an extended term of imprisonment for certain offenses attempted or committed against the elderly (murder, rape, robbery, felonious assault, burglary, kidnapping and inflicting serious bodily injury). The amendment increased the maximum term of imprisonment: from 20 years to life for a Class A felony; from 10 to 20 years for a Class B felony; and from 5 to 10 years for a Class C felony.[44] Imposition of the extended term is within the discretion of the court. The length of actual imprisonment is determined by the Hawaii parole authority, and the offender may be paroled before the maximum term expires.

Illinois. The Illinois Legislature in 1979 increased the penalty for battery committed against the elderly, providing that any person who causes bodily harm to an individual of 60 years or older shall be guilty of aggravated battery.[45] Whereas a simple battery is only a Class A misdemeanor and carries a sentence of not more than one year, aggravated battery is a Class 3 felony and conviction thereof requires a sentence of not less than two and not more than five years.

Louisiana. In 1977 the Louisiana Legislature enacted legislation providing that any person convicted of (1) manslaughter, (2) simple rape, (3) forcible rape, (4) aggravated assault, (5) aggravated battery, (6) simple battery, (7) aggravated kidnapping, (8) simple kidnapping or (9) false imprisonment against a victim 65 years of age or older would be subject to, in addition to any other additional penalty imposed, five years imprisonment without the benefit of parole, probation or suspension of sentence.[46] However, on March 3, 1980, the Louisiana Supreme Court

[38] Wayne W. Bradley, "Cass Corridor Safety for Seniors Project", The Police Chief, Vol. 43, No. 2, February 1976, p. 43.

[39] Powell M. Lawton, Lucille Nahenow, Selvia Yaffe and Steve Feldman, "Psychological Aspects of Crime and Fear of Crime", as presented in chapter 3 of "Crime and the Elderly: Challenge and Response," Jack Goldsmith and Sharon S. Goldsmith, eds., Lexington Books, D.C. Heath & Co., Lexington, Mass., 1975, p. 25.

[40] Carl L. Cunningham, "Pattern and Effect of Crime Against the Aging: The Kansas City Study", as presented in Crime and the Elderly, supra; p. 41.

[41] Bradley, supra, p. 43.

[42] Midwest Research Institute, supra, V-14.

[43] Colo. Rev. Stats., s. 18-4-304.

[44] Hi. Rev. Stats., ss. 706-661 and 706-662 (3).

[45] Ill. Rev. Stats., c. 38, ss. 12-1 to 12-4.

[46] La. Rev. Stats., c. 14:50.1.

declared the statute unconstitutional on the grounds that the punishment was excessive under the provisions of Article I, Section 20 of the Louisiana Constitution.[47]

Nevada. A 1979 enactment by the Legislature stipulated that any person who commits the crime of (1) assault, (2) battery, (3) kidnapping, (4) robbery, (5) sexual assault, (6) taking money or property from any person 65 or older is subject to imprisonment for a term equal to and in addition to the terms of imprisonment prescribed by statute for the crime.[48] The sentence prescribed by this section must run consecutively with the sentences prescribed by statute for the crime. This section does not create a separate offense but provides an additional penalty for the primary offense.

Rhode Island. In 1980, the Rhode Island Legislature enacted two bills relative to crimes against the elderly. House, No. 7545 provided for additional prison term of up to five years for any person convicted of committing the following crimes against the resident of an elderly housing project or while on the premises of said project: (1) assault and battery, (2) statutory burning of personal property, (3) larceny of property or money of a value not exceeding $500, and (4) other crimes excluding motor vehicle offenses, which result in personal injury or death. However, this act shall not apply in instances where a maximum sentence of greater than five years is provided elsewhere in the general laws. The second enactment, House, No. 7639, stipulated that assault and battery upon a person 60 years or older shall be deemed a felony and punishable by imprisonment for not more than five years and/or a fine up to $1,000.

Tennessee. In 1977 the Tennessee Legislature passed an amendment to the Tennessee Code to provide that when assault with intent to rob is committed against a person 65 years of age or older or a person with a permanent mental or physical impairment, the jury may fix the length of imprisonment, upon conviction, at double the usual maximum term.[49] Thus, a person convicted of assault to commit robbery upon a person 65 or older is subject to a term of imprisonment of up to 30 years. If the assault is committed by means of a deadly weapon, the maximum sentence rises to 42 years.

Wisconsin. In 1980 the Wisconsin Legislature approved special penalties for battery on the elderly by specifying a new class of battery. Specifically, the terms of the new statute provided that whoever intentionally causes bodily harm to another which creates a high probability of great bodily harm to a person of 62 years of age or older is guilty of a Class E felony.[50]

Persons convicted under this statute are subject to a fine not to exceed $10,000 and/or imprisonment not to exceed two years. This statute does not provide greater penalties for battery since the existing statute regarding aggravated battery carried penalties of a fine not to exceed $10,000 and/or imprisonment not to exceed 10 years. Rather its intent was to provide an alternative to prosecution for simple battery (fine not to exceed $10,000 and/or imprisonment not to exceed 9 months) in cases where an instance of battery against an elderly person could not be successfully prosecuted as an aggravated battery.

[47] *State of Louisiana* v. *Robert H. Goode, Jr.*, Supreme Court of Louisiana, No. 65879, March 3, 1980.

[48] Nev. Rev. Stats., c. 193, s. 1.

[49] Tenn. Code, s. 39-607.

[50] Wis. Rev. Stats., s. 940.19(1) and (2).

Chapter III. Fraudulent Schemes Directed at the Elderly

Vulnerability of elderly consumers

Many older people have common concerns that make them particularly easy prey for swindlers. Worries about finances and their health, and problems involved in keeping up their homes provide fertile grounds for unscrupulous individuals to offer a wide variety of money-making or money-saving schemes, cheap and continuing health cures, and home improvement plans which sound very tempting.

In many cases, it is the convenience of the offer, as well as the price, which the older victims find most attractive. For persons who cannot check out either similar or alternate plans because of limited access to transportation or physical disabilities, the claims of companies who advertise through the mail frequently go unchallenged. If people could make money in their own homes, or receive relief from various ailments without having to go to the doctor, it would be a tremendous asset for many household elderly people living on meager incomes. Unfortunately, legitimate plans of this kind are practically nonexistent.[51] Such phoney money-making schemes and quack medical cures are among those referred to by the President's Crime Commission as being "particularly pernicious, attacking, as they do, people who can least afford financial losses of any kind.[52]

At hearings conducted by committees of the U.S. Senate dating from 1962 on fraud and exploitation of the elderly several psychologists testified as to the reasons for the susceptibility of older people to these inducements.[53] In brief these reasons include:

1. There is a close relationship between lack of income and susceptibility to fraud and deception. Due to low income, older persons tend to grasp at any opportunity guised in terms of helping supplement meager incomes.
2. The average educational level of the population 65 and older is less than eight years of public schooling. The elderly are often ill informed.
3. The desire for security and stability is an extremely important human motivation which is exploited in sales spiels.
4. Older persons may tend to feel helpless which leads to suggestibility and gullibility. Psychologists have found that low self-esteem is correlated with high suggestibility. In other words, when persons lack confidence in their own ability to make decisions, they are more likely to accept the decisions and persuasion of others.
5. Lonely people are susceptible to the blandishments of salesmen because they receive attention and a sort of pseudo-friendships which allay suspicion and doubt.
6. Another problem with living alone exists—the "feedback" problem. Consumer decisions, particularly major decisions, are discussed between husband and wife and perhaps with children; the experience of friends and neighbors is sought. Even relative strangers are asked about their experiences with an intended purchase. To the degree that older persons are isolated from communication opportunities of this type, particularly from those trusted information sources, they lose the advantages of this "feedback" process.
7. The desire for health and the avoidance of pain and suffering on the one hand and to accomplish this at as little cost as possible on the other hand also contribute to this susceptibility. For example, it is estimated that 57 percent of arthritic patients continued to use various kinds of fake nostrums and home remedies, indicating the susceptibility to quackery when faced with continuing pain.

Consumer Agency Surveys. In 1973 the National Retired Teachers Association and the American Association of Retired Persons (NRTA/AARP) surveyed the Attorney Generals of the states and consumer protection agencies throughout the country to determine the kind and scope of consumer complaints they received from older persons. Of the 88 sources queried, none of the 55 respondents categorized consumer complaints by age and at best they could give only vague observations concerning the most serious kinds of complaints affecting older consumers. The following activities accounted for a larger majority of the complaints from the aged:

1. Home repair and improvement schemes.
2. Deceptive sales practices.
3. Hearing aid sales practices.
4. Land sale schemes.
5. Automobile (purchase and repair.)
6. Credit problems (including incorrect billing and credit cards).
7. Pyramid schemes and franchises.
8. Mail order.
9. Health foods and medical quackery.
10. Insurance.

The NRTA/AARP Consumer Office also surveyed 92 state and local commissions on aging to determine what consumer programs were being offered or planned for older persons and what specifically was included in such programs. Twenty-six of the 42 agencies responding identified a specific program, most often nutritional programs. Many of the commissions on aging reported that they had not initiated any type of consumer program; however they indicated activity in the following areas would produce more significant results in addressing the consumer protection needs of the elderly:

1. Designating a local agency or person for assistance.
2. Publishing a free directory of state and local consumer services.
3. Assigning consumer experts to address meetings.
4. Preparing program suggestions and a bibliography of materials.
5. Distributing consumer education pamphlets and materials.

To assemble further data relative to the matter of consumer protection for the aged, the Consumer Office canvassed the 287 NRTA/AARP members who attended area conferences at San Francisco and Atlanta in August and September of 1973. This survey addressed not only the kinds of personal consumer problems experienced by those attending the workshops but also the effects of, and their reaction to, inflation. The survey was structured along lines similar to one conducted by Changing Times magazine in April 1971. The Changing Times survey elicited some 25,000 responses from among its readers. Although the NRTA/AARP survey was in no way a representative sampling of all older Americans, it did reveal some clues regarding the major consumer problems and concerns of older persons. A comparison of the findings of the respective surveys presented in the following table.

TABLE 13.—SPENDING AREAS REDUCED IN RESPONSE TO INFLATION

Spending area	Rank order		Percentage price rise, 1971
	Changing Times	NRTA/AARP	
Recreation	1	3	10
Food away from home	2	1	14
Purchased appliance and furniture	3	2	3
Clothing	4	12	9
Purchase of auto	5	6	11
Food at home	6	4	8
Operation of auto	7	7	14
Homeownership	8	10	21
Medical care	9	9	14
Public transportation	10	8	22
Education	11	13	9
Fuel and utilities	12	5	9
Rent	13	11	9

The NRTA/AARP survey supported the observation that inflation forces older consumers to cut back on an already limited style of life, and that they cut back first in areas of discretionary spending rather than in areas of greatest price rise. Problems with the costs of food, medical care and housing predominated for the retired persons in this survey.

[51] Midwest Research Institute, "Crime Prevention Handbook for Senior Citizens," prepared for the Administration on Aging, Department of Health Education and Welfare, 1977, p. 45.

[52] The President's Commission on Law Enforcement and Administration of Justice, "The Challenge of Crime in a Free Society," U.S. Government Printing Office, Washington, D.C., 1967, p. 10.

[53] Hearings before the Senate Committee on Aging, "Frauds and Quackery Affecting Older Citizens," Part I, January 15, 1963, Part II, January 16, 1963. Hearings before the Senate Committee on Aging, "Frauds and Deceptions Affecting the Elderly," January 31, 1965. Hearings before the Subcommittee on Consumer Interests of the Elderly of the Senate Committee on Aging, Part II, February 3, 1967.

Major consumer problems of the attendees surveyed at the area conferences were, in order of importance, the costs of: (1) food, (2) doctor/dental care, (3) fuel and utilities and (4) drugs and medicine.

The survey further indicated that in trying to cope with inflation 74 percent of the NRTA/AARP respondents returned to work compared with 45 percent of Changing Times respondents. It also indicated that older consumers do not know where to obtain reliable consumer information and referral services in their communities.

The most frequent action taken by the respondents when confronted with a consumer problem was to contact (a) the dealer or manufacturer (55 percent), (b) the Better Business Bureau (9 percent), (c) an attorney (6 percent), and (d) the federal agency or consumer office (4 percent). About 25 percent indicated that they did nothing to relieve their discontent.

As a result of these actions, complaints were satisfactorily resolved 37 percent of the time, not resolved in 35 percent of the instances and 27 percent were still pending.

NRTA/AARP maintains a National Consumer Assistance Center in Washington and formerly operated local Consumer Assistance Centers in various parts of the country. In 1974 some 4,119 contracts were received by these centers of which 2,678 were complaints. As shown in Table 10 mail order transactions provoked the most complaints, from the elderly, followed by problems with housing, automobiles and parts and appliances. The main reasons for these complaints were failure to provide, followed by repair and service difficulties, quality defects and delays in delivery.

TABLE 14.—CONSUMER COMPLAINTS RECEIVED FROM OLDER PERSONS BY NRTA/AARP CONSUMER ASSISTANCE PROGRAM

[In percent]

A. Type of complaint:		B. Reason for complaint:	
Mail order	34	Failure to provide	23
Housing (owner & rental)	12	Repair and service difficulties	16
Automobiles and parts	9	Quality defects	9
Appliances	7	Delay in furnishing	9
Medical and dental	3	Overcharges	4
Insurance	3	Cost	3
Furniture	3	Billing and collection practices	3
Public utilities	2	Sales procedures	2
Food	1	Warranty	2
Clothing	1	Inadequate information	2
Moving	1	Advertising-labeling	1
Credit and loans	1	Safety	1
Hearing Aids	1	Product substitution	1
Heating and air-conditioning	1	Inadequate coverage	1
Land sales	1	Over-indebtedness	0.4
Investments/stocks	1	Other	20
Legal services	1		
Drugs	1		

Source: 1974 Report of the NRTA/AARP consumer assistance program, Washington, D.C.

This action by the NTRA/AARP represents the first effort to identify and analyze consumer complaints lodged by aged citizens. There is still, however, a great lack of reliable data on the consumer problems of the elderly. Such research is essential if consumer and other educational, legislative and programatic needs of older persons are going to be accurately identified.

Extent and impact of consumer fraud

Stereotypes that label the elderly as gullible and particularly vulnerable to fraud or consumer abuse were challenged by the findings of a two-year research project conducted by a decision of the Battelle Human Affairs Research Center of Seattle.[54]

Among its many conclusions, the resultant report noted that when the complaints of older persons were compared with a matched group of randomly selected complaints from younger consumers, the two sets of complaints were similar. In general, the marketplace abuses afflicting older persons were no different from those affecting the general population. Complaints filed with consumer protection agencies did not indicate a sinister picture of shady "con artists" who make a specialty of defrauding older people. Most older consumers reporting to the public agencies studied appeared to be self-reliant and well-informed and were less likely to be duped than they were to be dissatisfied with purchase transactions and repair situations.

While the aged should not be regarded as helpless prey for those who would exploit them, the research noted that the elderly differ from their younger counterparts in the intensity of the overall impact of such abuse on their lives and also in a greater reluctance to seek redress when an abuse occurs.

Monetary losses, inconveniences and hardships suffered by older persons in the market place seem to more seriously affect their outlook, sense of security, and well being. Their reluctance to report abuses may well be caused by the fear that they may be considered to have diminished competence because of their age.

The California experience

While California senior citizens are experiencing increased incidence and fear of crimes of force, they are even more vulnerable to certain nonviolent crimes. "Bunco" and "confidence games" are almost exclusively directed toward the senior citizen. The San Francisco and Los Angeles police departments report that more than 90 percent of the "bunco" victims are over 65 years of age and are mainly women. In California, the predominant "bunco" schemes victimizing elderly citizens are the "Bank Examiner" scheme, the "Pigeon Drop" scheme, and welfare, social security and pension check frauds. In one six month period, the Los Angeles Police Department reported that almost twice as much money was lost by seniors through the "Bank Examiner" and "Pigeon Drop" con games as was lost by banks through robberies.[55]

The vulnerability of seniors to "bunco" and "con games" results from their isolation, their economic distress, and the fact that their life savings are usually readily accessible in bank or savings and loan accounts. Law enforcement effort to curtail "bunco" activity include teaching the elderly to recognize the (MOs) methods of operation of current "bunco" schemes and emphasis on strict adherence to a few simple rules:

1. Never discuss personal finances with strangers.
2. Don't expect to get something for nothing.
3. Never draw cash out of a bank or a savings account at the suggestion of a stranger.
4. Always check on anyone who claims to be an FBI agent, bank official, official inspector or representative of any public agency.
5. Call police and report any bunco MO approaches.

The California Attorney General's Office have also trained personnel of banking and savings institutions on bunco MOs and victimization patterns, and have enlisted their cooperation in public education programs at various bank branches.

In California, medical quackery is estimated to be about a $50 million a year business. Common "get well quick" schemes include cures for cancer, arthritis, baldness, obesity, restoration of youthful vigor, and an infinitive variety of other remedies for various maladies.[56]

[54] Herbert Edelhertz, "Consumerism and Aging," Battelle Law and Justice Study Center, Seattle, Washington, 1979.
[55] Evelle J. Younger, "The California Experience: Prevention of Criminal Victimization of the Elderly," "Police Chief," V. 43, No. 2, February 1976, pp. 28-32.
[56] Ibid.

Economic loss is often substantial and delay in receiving proper medical treatment as a result of dealing with the quack may lead to even more serious problems.

The primary target of the medical quack is the senior citizen. Vulnerability arises out of the obvious fact that as the aging process unfolds, a concommitant deterioration of physical condition and increase of health problems occur. Further the more serious the health problem, and the less susceptible to cure or amelioration by legitimate medical services, the more desperate the sufferer becomes and the more likely he or she is to resort to "miracle" cures.

Seniors were the victims in approximately seven out of ten cases of medical quackery fraud coming to the attention of the California consumer protection agencies and judicial authorities.[57]

Confidence games

The term "confidence game" is an apt description of the way in which swindlers operate—gaining both the confidence of the victims and their money before the victims realize they have been tricked. As part of the game, the swindler takes a calculated risk that the victim will not report the crime, at least in time for him or her to be caught—a gamble which usually pays off because most victims are very reluctant to admit that they have been swindled, and they either fail to report the incident at all or postpone it until the chance of apprehending the culprit is minimal.

Not only financial loss, but the mental stress suffered by an individual who has been taken in by a "con artist" can be much more devastating for an older victim than for a younger one. Unlike younger persons who could eventually replace any monetary losses through future earnings, the older victim has little hope of regaining financial resources once they have been lost. In addition, the lasting effects of anxiety and remorse are likely to be much more severe for the older victim when he or she realizes the extent of the loss.

There is an infinite variety of confidence games which have proved to be successful, and no two "games" are played in exactly the same way. However, several of the most successful schemes—those which have claimed the most victims—have features in common and are described in the following section.

Home Improvement Contractors. Senior citizens are particularly susceptible to the unscrupulous door-to-door contractor who tends to canvass a neighborhood attempting to gather deposits and initial payments on unnecessary home repairs. Frequently, an associate will beforehand scatter the consumer's front lawn with what appear to be bricks from the chimney, or he may even climb to the roof of the consumer's house and dislodge some chimney bricks, throwing them in the front of the house. The contractor then rings the consumer's door bell and points out the "hazardous" condition of the chimney, roof, siding, etc. The senior citizen having no means of easy access to the allegedly affected area of the house and disturbed by the possibility of greater damage if the defect is not corrected will frequently sign a contract for immediate repairs. Invariably, the agreement will be couched in terms which insulate the contractor against liability for non-performance. Moreover, he will attempt to extract as large a deposit as possible. In some cases, some minor work, or the appearance of work tools on the front lawn, will begin. A further payment for continued work may then be extracted. Before the senior citizen has a chance to realize what has happened, the "fly-by-night" contractor is gone—to repeat the same procedure in another neighborhood.

Labor Charges for Work or Services. The senior citizen may find himself/herself a particular target of attempts to inflate charges for labor or service, either in terms of the amount of work done, or the amount of time spent doing work. This type of ballooning may take place in a variety of situations, including warranty work of various kinds in which only the cost of parts is covered, e.g., home repair, T.V. or appliance service, automotive work or household moving. It is frequently assumed that the senior citizen will not be sufficiently alert to take note of the discrepancy between the actual time and labor invested and the notation of same on any billing statements.

Mail fraud

Every year 750 million sales are made by mail in the United States. The ease and convenience of shopping by mail particularly appeals to the less mobile members of society—the elderly, the infirm and the handicapped. The mail order field is one of the leading sources of consumer complaint in the nation. It is a natural haven for a fly-by-night promoter whose sole asset is the possession of a post office box. In 1975,

[57] Ibid.

known losses to the general public from mail fraud exceeded $395 million up from $194 million in 1974.[58]

The consumer's problems with mail order firms are exacerbated by the fact that a seller who is far away can simply ignore complaints, secure in the knowledge that the consumer may never find him or her.

The most common complaints against mail order sellers are (1) failure to deliver merchandize ordered and paid for; (2) late delivery of items ordered, often rendering them useless to the buyer; and (3) refusal to resolve or acknowledge customer problems with delivered merchandise. A less common tactic is to mail unsolicited goods to the consumer who is then billed and harrassed to pay for the merchandise. This practice has been curtailed by federal and state[59] laws that deem any unsolicited merchandise a gift, to be disposed of by the consumer as he pleases, with no obligation whatsoever.

The Federal Trade Commission has promulgated a Trade Regulation rule[60] governing all sales by mail throughout the country. The rule requires mail order sellers to fulfill orders within 30 days or refund the consumer's money. The seller must give the customer a postcard which he can use to cancel the order if it is not delivered within 30 days.

Fraudulent tactics by mail order vendors are prohibited by the federal mail fraud statute.[61] The statute generally prohibits the use of the mail in "any scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises . . ." Violation of the statute is a criminal offense, punishable by a $1,000 fine or five years imprisonment, or both. Problems of proof, however, make mail order cases difficult to prosecute. Moreover, while most states have enacted statutes making deceptive advertising[62] and sales practices unlawful, relief thereunder is difficult to obtain as most transactions involving mail fraud are committed in the course of "interstate commerce", an area primarily within federal jurisdiction.

Fraudulent schemes are often skillfully disguished as genuine business transactions—a ploy that depends for success upon the victims' tendency to accept at face value claims of quality, to neglect to read the fine print, or to consider all the factors involved in a transaction. Such approaches may operate technically within the law, in which case the burden of responsibility is on the buyer to decide if the product—whether it be real estate, a business franchise or a hearing aid—is overpaid or appropriate for his or her own individual needs.

In addition to the above-cited deceptive practices, the following is a partial list of schemes, most of which are mail frauds, which government officials say cheat older Americans out of millions of dollars annually:

1. Phony insurance claims, some related to health insurance.
2. "Debt consolidation" offers.
3. Magazine subscription contracts.
4. Land sales, homesites, retirement estates, condominium schemes.
5. Worthless stock, bonds, oil and gas leases.
6. Business franchise of distributorship promotions.
7. Work-at-home plans.
8. Book publishing schemes.
9. Home improvement schemes.
10. Medical remedies (including hearing aids), fake laboratory tests, miracle cures.
11. Chain referral schemes—buying a product and earning money by showing it to new customers.
12. Membership in "discount clubs"—where savings would be too good to be true.

The U.S. Postal Service maintains a special unit to investigate fraudulent schemes that make use of the mails. Administrative sanctions such as the suspension or termination of mail delivery may be imposed. However, more flagrant perpetrators are turned over to the Justice Department for prosecution under the mail fraud statute.[63] The postal inspector has no legal authority to compel a refund, although on occasion he may be able to secure one for a complainant.

Before contacting the FTC, the Post Office Department or state and local consumer protection agencies, the consumer may profitably seek assistance from two private sources. One is the particular magazine, newspaper or other medium which

[58] W. Lissner, "23 percent of U.S. Mail Frauds Originate in Local Area." New York Times, February 25, 1976.
[59] 39 U.S.C.A. s. 3009 (1975), G.L. c. 93, s. 43.
[60] 40 Fed. Reg. 49592, 53383, 53557 (1975).
[61] 18 U.S.C.A. s. 1341 (1975).
[62] G.L. c. 93A, s. 1 et seq; c. 266, ss. 91-92.
[63] 18 U.S.C.A., s. 4005 (1975).

carried the mail order firm's advertisement. Reputable magazines intervene on behalf of their readers to resolve complaints against advertisers.

Another source of aid is the Direct Mail Marketing Association, a trade association of companies doing business through the mails, which directs complaints to the appropriate person at the responsible mail order houses.

Land sales

Fraud and abuses in the sales of land have been widespread.[64] Many of the victims are older American who hoped to move to a warm climate where they can enjoy a pleasant retirement, free of the worries and anxieties of their working lives. Thousands of people buy land, sight unseen, at free dinners given by land dealers. Sales prospects, who come on the assurance that there is no obligation to buy, are pressured by salespeople offering phony "special discounts," free gifts and other inducements to sign the contract immediately using tactics designed to discourage careful consideration of the purchase. Some developers offer free weekend accommodations to lure potential purchasers to the site in question but they may charge the prospect if a sale is not consummated.

To curtail such tactics, a number of states have enacted information disclosure laws for land sales. Sellers are required to file detailed written property reports, which are available to any prospective buyer wishing to examine the report.[65] In New York, the report must contain a statement not only on the land itself (terrain, sewage, water supply, proposed improvements, etc.), but also data on the assets and liabilities of the subdividers.[66]

A similar property report must also be filed with the Office of Interstate Land Sales of the U.S. Department of Housing and Urban Development. The filing of these reports, however, does not constitute approval by the government of the seller of the offering. Unfortunately, consumers are told by some owners that the government has conducted an exhaustive investigation of their operations and that they have met the necessary requirements to engage in such business.

Some states go beyond mere information disclosure and give the consumer who signs a contract to buy land a "cooling off" period in which he may cancel the sale with no obligation. In Michigan, this period is five days; in New York, ten days.

Hearing Aids

Hearing loss affects more Americans than any other chronic condition, with persons over 65 most often affected.

Too often, consumers do not visit a doctor or trained audiologist, but go instead to a hearing aid dealer. Dealers frequently offer free hearing tests to attract potential customers hoping to save on physician's fees. Investigations have revealed that many dealers advise the consumer that he/she needs a hearing aid when such is not the case,[67] the without an aid the person's hearing will worsen,[68] and that the aid will restore to the purchaser perfect normal hearing.[69] Tests often are improperly conducted in nonsoundproof environments. Salesmen attempt to sell the most expensive models, whether the expense is justified or not.

Consumers are mistakenly instructed to replace their aids at frequent intervals and salesmen have been accused by some public interest organizations of selling duplicate and unnecessary appliances.[70]

In Massachusetts the sale of hearings aids is regulated by statutory law. Chapter 93, section 7 et seq. provides that a person must first obtain medical clearance and a hearing test evaluation from a physician, audiologist, or otolaryngologist before entering into a contract for the sale of a hearing aid.

Funeral services

Perhaps in no other major purchase is a person in so vulnerable a position as he/she is when purchasing funeral services. The bereaved is not only emotionally

[64] In 1972, the U.S. Department of Housing and Urban Development held nationwide hearings on land sales fraud which produced testimony of widespread abuses. See New York Times, Sept. 20, 1972, p. 32; Sept. 21, 1972, p. 37.

[65] See, e.g., Mich. Stat. Ann. s. 26.1286 (1973).

[66] N.Y. Real Property Laws, s. 337-6 (McKinney 1968).

[67] A survey of hearing aid dealers in Baltimore, Maryland disclosed that in nine out of twenty-one visits (42 percent of all visits) dealers recommended hearing aids when trained audiologists of the John Hopkins Hospital did not recommend them. See Public Citizen's Retired Professional Action Group, "Paying Through the Ear," I-5, 1973.

[68] New York Public Interest Research Group, "Stop, Look & Listen Before You Buy a Hearing Aid: Buyer's Guide to Hearing Aids." 1974.

[69] Ibid.

[70] Pay Through the Ear, supra, III-3.

distressed, but also is under extreme time pressure to complete the necessary arrangements. Without time to consider calmly and carefully other possible arrangements, the spouse or next of kin must rely heavily on the professional judgment of the funeral home director. Sadly, governmental investigations have unearthed evidence that funeral directors have exploited this advantage to increase their profits.[71] Substitutions in quality of materials or workmanship, or failure to install contracted for monuments, frequently take place when an elderly person is responsible for the necessary arrangements. In some extreme examples, the unscrupulous mortician will arrange "time payments" on pre-burial arrangements. He will conveniently forget to give the other party an itemization of payments and the latter may continue to make periodic payments in fixed amounts well in excess of any mutually agreed price or actual costs for such services.

Another problem confronting the family or survivors is the unavailability of basic price information on funeral services. State laws, state regulatory boards and industry trade associations all combine to prohibit the advertising of funeral prices in numerous states.[72] Furthermore, funeral directors regularly refuse to give price information to potential customers over the phone.[73] In one New York study, almost two-thirds of the funeral homes contacted declined to divulge prices on the telephone.[74]

In Massachusetts Chapter 112, section 84B of the Genenal Laws provides that all comsumers be given, prior to any service rendered by the mortician, an itemized statement showing, to the extent known, the price of merchandise and service that the customer has selected. Also, state regulations require that prices must be placed in a conspicious manner on every casket offered for sale. However, there is no regulation or statutory provision that requires funeral homes to relay price information over the phone.

Medicinal use by the elderly

Approximately 25 percent of all prescription medicines sold annually in the United States are purchased by persons who are 65 years of age and older.[75] Given the fact that the elderly account for approximately 10 percent of the nation's total population, such volume indicates heavy drug usage among elderly Americans.[76] Eighty-five percent of individuals 65 years and older suffer from one or more chronic disorders which often require one or more types of special medication.[77]

Moreover, the elderly are the biggest users of pharmaceutical and over-the-counter drugs and this factor makes them particularly susceptible to promotional efforts by drug manufacturers and related industries, such as national and local retail pharmacy chains. The pharmaceutical industry spends about twenty cents of every dollar of sales on promotion and only about six cents of every dollar for research and development.[78] These factors along with the elderly's relative unsophisticated view of the market place may account for the heavy drug consumption rate among the aged.

Despite the fact that we live in a drug-oriented society, the benefits clearly outweigh the tendency to emphasize drugs and their healing powers. However, there are many problems relating specifically to the processes of aging that impact on the use of medication. Some of these effects may be minor, but some can involve life and death consequences. Two relatively new areas of pharmacy study, biopharmaceutics and pharmacokinetics, determine how well medications are absorbed by the body. It has been found that chemical properties of certain medications are altered in older persons.[79]

[71] Federal Trade Commission, "Funeral Industry Practices—Statement of Reason for Proposed Rule," 40 Fed. Reg. 39904 (1975).

[72] Ibid., 39905.

[73] B. Kronman, "A Death in the Family: Guide to the Cost of Dying in New York City, Nassau & Suffolk," New York Public Interest Research Group, New York, N.Y., 1974.

[74] Ibid.

[75] M. Silverman and P. R. Lee, "Pills, Profits and Politics," University of California Press, Berkeley, Calif., 1974, p. 19.

[76] A. S. Ostfeld and D. C. Gibson, "Epidemiology of Aging," U.S. Department of Health, Education and Welfare, National Institute of Health No. 75-711.

[77] R. C. Atchley, "The Social Forces in Later Life," Wadsworth Publishing Co., Belmont, Calif., 1977, pp. 106-109.

[78] R. L. Kayne, "The Elderly and the Drug Culture," in "Aging Prospects and Issues," 2d ed., R. H. Davis, ed., University of Southern California Press, Los Angeles, Calif., 1976.

[79] R. Weg, "Drug Interaction with the Changing Physiology of the Aged: Practice and Potential," in "Drugs and the Elderly," R. H. Davis, ed., Ethel Percy Andrus Gerontology Center, Los Angeles, Calif., 1973, pp. 71-91.

Metabolic changes experienced by the elderly slow down or alter the absorption, circulation and excretion of drugs. Therefore, the toxicity level is often lower among elderly patients than their younger counterparts. Adding to this problem is the multiple drug use by elderly patients who have other chronic or serious maladies.[80]

The more that become available the more complex and serious becomes the problem of unwanted interactions between medications. Most drug interactions are predictable and preventable with proper evaluation by a patient's doctor or pharmacist. Nevertheless, adverse drug reactions are very common among the elderly. Patients 60 to 70 years old have almost twice the likelihood of experiencing an adverse drug reaction as adults of 30 to 40 years.[81]

The dependence on both prescription and over-the-counter medicines has prompted legislatures to respond with proposals designed to protect the health of the populace at large.

The State of Washington was the first to require pharmacists to consult with every patient receiving a new prescription.[82]

The States of Delaware and Kansas have recently passed similar legislation, and other States are considering following suit. Under previous practice, a clerk usually gave the prescription to the patient. Under new regulations, a pharmacist must communicate with the patient.

Some states require pharmacies to post prescription prices so that patients know in advance how much they w'll be charged for prescriptions. This may represent a potential cost savings which is an important consideration for those on fixed incomes. The elderly consumer should be aware that included in that prescription price is the cost of medication plus the professional services provided, which may vary considerably between pharmacies.

In recent years, many states have passed "generic drug" laws to ameliorate the economic impact of the costs of medication. Under such statutes, a pharmacist is authorized by the attending physician to substitute a "generic equivalent" in lieu of the brand drug. Generic drugs invariably are less costly than brand name medications.

In Massachusetts, the generic drug statute gives the prescribing practitioner the right to authorize an equivalent interchangeable substitution, if applicable, of any drug he/she prescribes, as long as it is so noted on the dispensing instructions to the pharmacist.[83] In cases where interchange is permitted, the pharmacist must dispense a less expensive reasonably available interchangeable drug product as listed in the most current drug formulary.

Housing

Another important issue for the elderly is housing. In 1973, 23 percent of an aged individual's budget supported housing costs. The elderly seek housing which is affordable, secure, free of physical obstacles, and which permit maximum independence. For many citizens this has meant home ownership. However, while home ownership affords rent-free living and a degree of independence, the concurrent burdens of rising insurance rates, utility bills, taxes and home deterioration coupled with a reluctance to leave a changing, albeit familiar, neighborhood present special problems for the elderly citizen. The media equity of homes owned by the elderly in 1973 was $18,531 compared with an equity of $24,100 for the total adult population. Notwithstanding benefits in the form of real estate tax abatements mandated by statute, elderly homeowners pay 8.1 percent of their income on property taxes, more than twice the proportion of those under 65.[84]

Despite these factors, the elderly appear satisfied with their current housing. The National Council on Aging/Harris survey of 1975 disclosed that only 4 percent of the elderly were dissatisfied with their housing. The apparent satisfaction with current housing has been explained by suggesting that the elderly attribute housing problems to other factors, such as income, and do not focus on actual housing dissatisfaction. Satisfaction may also be attributable to the realization that there are few affordable or problem-free alternatives. Nevertheless, some elderly seek other forms of living accommodations such as life care facilities. The desire for alternatives to ownership may be prompted by such concerns as a desire to elimi-

[80] J. W. Smith, L. G. Seidl, and L. E. Cluff, "Studies on the Epidemiology of Adverse Drug Reactions," "Annals of International Medicine" 65, October 1966, 629-640.
[81] K. L. Melman, "Preventable Drug Reactions—Causes and Cases," "New England Journal of Medicine" 284, June 1971, 1361-1368.
[82] Title 69.41.130.
[83] G.L. c. 112, s. 13D.
[84] Thomas C. Nelson, "Consumer Problems of the Elderly," Federal Trade Commission, August 1978, pp. 53-54.

nate maintenance responsibilities, have medical care readily available or enjoy the good life with extensive recreation facilities.

In all housing situations, the elements of reduced income, limited mobility, susceptibility to pressure sales techniques and physical impairments which interfere with purchase or rental negotiations place the elderly consumer in a disadvantaged position.

Apartments. While elderly tenants may be subjected to the same abusive practices as other tenants at the hands of unethical landlords, the difficulty which the aged have in relocating exposes them to continued exploitation. Studies indicate that they change residences at half the rate of the total population. Landlords who lure elderly tenants with promises of low rent can raise the rent after the tenant has settled in, since they are unlikely to move or complain. One New York City landlord reportedly sent recruiters directly to senior centers with offers of low rent. Similarly, rent increases which are allegedly pegged to improvements or other benefits are easily perpetrated on elderly tenants who cannot readily cope with moving. Apartment tenants may also find themselves no longer eligible for long-term leases upon turning 65, even if they are long-time residents who, prior to age 65, have had such leases.[85]

Condominiums. One form of housing which is popular with the financially secure elderly is the condominium, which offers an investment opportunity, facilities ranging from recreation rooms to swimming pools, and minimal upkeep responsibilities. However, elderly condominium owners will be beset by the same problems which confront condominium owners of all ages when facilities which are promised are not provided, management costs escalate, or recreation usage fees are not justified by the facilities which are actually built.

Conversions of rental apartments to condominiums present unique problems for the elderly. Because of limited resources they may be unable to assume the financial obligations associated with ownership. Heavy demand for the converted quarters will result in early evictions. Many states are considering safeguards such as the right of first refusal to purchase to protect the rights of elderly tenants.[86]

Boarding Homes. Another type of housing arrangement which has created interest among the elderly is the small proprietary boarding home. These facilities, which are generally not subject to state or federal regulation but may be licensed by local governments, provide housing, meals and often minimal personal care for approximately 10 individuals per home. The proprietors of these facilities frequently have themselves designated as the "representative payer" for the resident, thereby receiving and controlling the resident's resources. While obtaining "representative payer" status is easy to accomplish, requiring only support from one physician, undoing the arrangement may require more resources than the disadvantaged resident can muster, especially since he/she is without funds.[87]

Insurance

The elderly are particularly vulnerable to unfair insurance promotions. They share with the general population a high level of ignorance as to what constitutes adequate coverage or what are appropriate insurance options. Adequate coverage is vital to the aged in order to take care of health needs and to provide for burial expenses. Automobile insurance may be important particularly to the disabled elderly, who may rely on this means of movement as the primary means of transportation. Finally, the elderly may wish to leave some form of estate to their survivors and thus may be susceptible to various life insurance promotions relative to estate planning. The elderly person may be quicker to place their trust in a salesperson and are less likely to perceive unfair sales practices.[88]

Life Insurance. There is a high level of consumer ignorance regarding various types of life insurance coverage. The most common shortcoming in this area involves the payment of premiums over an extended period of time which far exceeds the face value of the policy and benefits thereunder.

Promotion of life insurance among the elderly may emphasize the desire to provide for one's survivors. Salespersons may play upon the elderly person's parental feelings while ignoring the fact that the individual's children are full grown, employed and financially secure. Life insurance needs of the elderly, particularly the widowed, may be minimal or nonexistent. The widowed person does not have a spouse to provide for. For a couple, except when the death of the spouse results in loss of pension benefits, the death of one's spouse may not result in income loss.[89]

[85] Ibid.
[86] Ibid., pp. 57-58.
[87] Ibid., p. 60.
[88] Ibid., p. 61.
[89] Ibid., pp. 63-64.

Automobile Insurance. Individuals over 65 may be unable to obtain, or renew, motor vehicle insurance policies because of discriminatory cancellation practices or high rates. This may be one reason why 40 percent of the over-65 households do not own an automobile. Carriers may refuse to renew policies when age 65 is reached purportedly because of an accident which occurred 20 years before and which had not previously affected coverage. Moreover, the elderly may be substantially disadvantaged in the case of companies who refuse to insure older vehicles (above 10 years old). Such discrimination, like high rates, is not based on driving records or actuarial data, but unfairly discriminatory policies.

Cancer Insurance. In 1980, a comprehensive study[90] by the House Select Committee on Aging concluded that state and federal officials need to improve regulations governing the sale of cancer insurance to prevent elderly persons from being swindled.

The study stated that cancer insurance is the fastest growing insurance line; some four million policies were sold in 1979. About 20 million policies are in force overall. Many of the 300 companies that sell the insurance rack up these impressive sales records by using scare tactics on elderly persons and high pressure advertisements. Some ads use picture endorsements of famous entertainers to lend legitimacy to their policies. Other ads exaggerate the costs of cancer treatment by two to three times and contend that the actual rate of incidence for the disease is higher than reported.

The committee reported that companies frequently mislead consumers on the total amount of benefits available. While ads may claim benefits up to $250,000, the few who actually receive any benefits at all usually get only $1,200.

The report indicates that the companies make 60 to 80 cents on each dollar of premiums, an amount that is especially striking considering that legitimate health insurers return all but 20 cents on the dollar to policyholders in the form of benefits and claims paid each year.

The report calls on the states to review their insurance laws to better protect consumers, especially the elderly. Several states allow mail-order policies that do not require the approval of the state insurance commissioner. It also calls for congressional action to forbid the sale by mail of policies that cannot be sold by agents in person. Congress was urged also to require that Medicare supplemental policies, underwritten by private insurance companies, cover a broad range of health problems and not just a single "dread disease" such as cancer.

Problems with medicare and supplemental insurance[91]

Research undertaken by Congress in 1965 revealed that older Americans are sick three times as often and experience periods of suffering and recuperation by three times that undergone by younger people. Their health bills, on average, are three times as great as those of younger Americans. These staggering health costs come at a time in life when having retired, senior citizens can expect only half the income of their younger counterparts. While younger adults typically may have spent 10 percent of their income for health care, it was not uncommon for older Americans to have spent 30 perent of their income in pursuit of needed health care.

In passing the Medicare Act, the Congress took note of these inequities. It declared in the preamble to this historic legislation that access to health care was a right for all Americans. Congress declared that there should be no discrimination with respect to access to the finest health care America has to offer.

As conceived, the Medicare program was a true national insurance program for the elderly. It was to be financed by taxes paid by employees and employers with minimum supplementation by Government. The accumulated money would be held in a trust fund. Workers who contributed during their working years could draw from the trust fund to finance the health care costs they would incur in their later years.

From the beginning there was a misunderstanding about the extent of Medicare's coverage. Partly the result of wishful thinking and partly the result of the distribution of misleading publications which trumpeted Medicare's virtues, senior citizens were left with the impression that Medicare offered them comprehensive coverage and would pay 80 percent of their health care costs. This was not the case, nor was it the intent of Congress. Medicare explicitly excludes from coverage an array of

[90] Report of the House Select Committee on Aging, "Cancer Insurance: Exploiting Fear For Profit," March 25, 1980, 96th Congress, 2nd Session.

[91] The information contained in this section was drawn largely from a staff study by the Select Committee on Aging, "Abuse in the Sale of Health Insurance to Elderly in Supplementation of Medicare: A National Scandal," U.S. House of Representatives 95th Congress, Second Session, November 28, 1978, pp. 1–39.

vital services used by the elderly, such as: (1) self-administered drugs; (2) dental care (except jaw surgery), (3) eyeglasses or eye examinations, (4) hearing care or examinations, (5) custodial nursing home care, (6) home health care, and (7) routine physical examinations. In the years following enactment, millions of senior citizens have had their illusions rudely shattered, having been left with sizeable bills which Medicare refused to pay.

In terms of Medicare, the escalating costs of health care have meant that America's aged population have had to pay more out of their own pockets to participate in the medicare program. Moreover, they have assumed an increasingly larger share of total health care costs because of the exclusion of certain medical services and drugs from coverage. Furthermore, it has been increasingly difficult for them to find a doctor who will accept what Medicare has to offer as full payment. Most physicians refuse to take "assignment," the technical term for billing Medicare directly and accepting payments based on a fee schedule. Instead, they bill and collect from the patients, leaving the elderly to fill out the paperwork and seek repayment from medicare. The paperwork generally confounds the elderly—so much so that for-profit firms are springing up all across the country offering the service of helping the elderly fill out their Medicare forms. Collection from Medicare is a slow process and inevitably older Americans are left with a large portion of their medical bill for which Medicare will not provide reimbursement.

Because of medicare's restricted benefits, older Americans are fearful that catastrophic illnesses will wipe out their meager savings and leave them destitute. There is a great fear that even the cost of medication and treatment for chronic illness will become too large a burden to carry. They are concerned that they may become a burden to their families and loved ones. There is a fear of going on welfare—even though an increasingly large number of Americans must turn to Medicaid, the welfare medical program, to pay for the cost of their health care. This is particularly true for those who need nursing home care. Nursing home care is so expensive that most elderly quickly use up their assets and depend on Medicaid to defray future costs. Medicaid pays for about 45 percent of the nation's total nursing home bill.

It is partly out of the wisdom that comes from experience and partly out of fear that senior citizens have purchased health insurance policies to supplement Medicare. It is wisdom that motivates them to buy one policy to help pay Medicare's copayments and deductibles. It is fear that motivates them to buy two, three, four or sometimes as many as 30 policies from various insurance carriers in the hope of insulating themselves against catastrophic illness and dread diseases such as cancer, or to pay for the costs of a stay in a nursing home, or perhaps to meet their burial expenses.

Unfortunately, few elderly understand that the multiple policies they buy often contain a clause which says only one policy will pay. Very frequently, the policies which they have pruchased are worthless. It is quite common for senior citizens to pay $200 a year in premiums for a policy which will pay them no more than $80 in benefits.

The simple fact is that no policy covers all of Medicare's gaps. Actually, the benefits of Medicare supplementary policies are rather limited. They account for only five percent of the average payment for health care. There are often long waiting periods before the elderly are eligible for full benefits, in addition to standard exclusions for various illnesses or diseases. It is quite common for insurance companies to reject a claim on the grounds that the claim is attributable to a prior disease or condition.

Two-thirds of America's elderly have at least one such supplementary insurance policy; many have two or more policies. There are an estimated 19 million such policies in force at the present time. Based on an average cost of $200 a year; the elderly will spend almost $4 billion on such policies annually.

Supplementary policies have spawned numerous complaints to state departments of insurance and the Congress, particularly from senior citizens. Nearly a third of the complaints received by the Pennsylvania Department of Insurance in 1974 related to health insurance; only auto insurance generated more complaints.[92] Commissioner William Sheppard stated that 46.9 percent of the complaints were valid and that the elderly account for a disproportionate share of these complaints. In 1977, New York and Florida received 57,000 and 34,000 complaints respectively, about 40 percent of which related to the sale of health insurance.

[92] Select Committee on Aging, supra, pp. 251–318.

Government oversight of supplementary policies [92]

The states have almost exclusive authority to regulate the insurance industry. The Federal Government largely relinquished its responsibility for regulating the field of private insurance when Congress enacted the McGarran-Ferguson Act in 1945.[93] The law states that no act of Congress, unless specifically relating to the business of insurance, shall be construed to "invalidate, impair or supersede" any state laws regulating the business of insurance.

However, Congress did not close the door to federal regulation completely—it reserved the right to regulate through anti-trust laws and the Federal Trade Commission "to the extent that such business is not regulated by State law." Even though this reservation of power exists in law, it has never been exercised; hence, when one speaks of the regulation of insurance, the appropriate reference is to the state insurance departments.

In order to determine the extent of state regulation in the area of Medicare supplementary policies, a comprehensive questionnaire was sent to every state insurance commissioner on July 18, 1978 by the Select Committee on Aging of the U.S. House of Representatives. The responses indicated that the regulatory provisions of state laws vary greatly. However, in 39 states insurance commissioners possess wide authority to regulate the industry. In the broadest reach, state laws authorize the insurance commissioner to require every company to file their policies with, and gain the commissioner's approval before such policies may be sold. The commissioner may also specify standards and regulations which must be compiled with by companies and their agents who do business in the state. Absent specific statutory provisions, he/she may adopt rules and regulations which govern such subjects as: (1) readability of the policy and key terms; (2) conditions of eligibility, exceptions, preexisting conditions and minimum benefits; (3) nonduplication of coverage; (4) cancellation rights, termination and renewability; (5) unit pricing, rates, commissions, and unfair trade practices and (6) minimum loss ratio and replacement requirements. Moreover, the commissioner is empowered to disapprove any policies offered for sale if he finds premiums excessive, inadequate or unfairly discriminatory.

The report pointed out that the average state insurance department has oversight responsibilities in respect to operations and activities which generate almost $4 billion in insurance premiums yearly. The average department is responsible for licensing 36,483 agents. Every year the typical department must review 6,127 health insurance policies before they can be offered for sale in the state. The department will receive and respond to 9,641 complaints relative to health insurance, but the average state will have one investigator for every 643 complaints it receives.

Given these facts, it should be little surprise that the average state will revoke the licenses of only five agents each year for violations in conjunction with the sale of health insurance. No state fined or disciplined any insurance companies for similar practices. In fact, officials in only 11 states reported that they fined or formally disciplined companies during the period of 1975–1978, for a variety of irregularities not associated with health insurance specificially.

Among other findings, the committee report noted a distinct absence of the exercise of rule-making authority by state insurance officials in the average state. A majority of states have adopted regulations in only two areas—26 states had regulations allowing the policyholder to cancel within 15 days after issuance without obligation for any payment and 33 states reported rules covering minimum benefits.

[93] U.S.C.A. Title 15, ss. 1011–1015.

Chapter IV. Masssachusetts Developments

Related Massachusetts statutory provisions

The Attorney General as the chief law enforcement agent in the state has taken the lead in the protection and enforcement of the rights of elderly citizens. Knowledgeable staff at the Attorney General's office indicate that the state's aged are particularly vulnerable to incidents and episodes of (a) vendor fraud, especially nursing home operators, doctors, and pharmacists, (b) Medicaid fraud; (c) patient abuse, (d) medigap insurance, (e) home improvement schemes, (f) arson, and (g) violent crime. The Commonwealth has been a pioneer in the development of both consumer protection and "civil" rights legislation and as a consequence there is a panoply of legal remedies and enforcement mechanisms available to the criminal justice system and to regulatory agencies to protect the public health, safety and welfare of the state's citizenry. The following sections are devoted to brief descriptions of the more important relevant statutes, with emphasis on those laws which have greater application to the elderly.

Regulation of the Sale of Hearing Aids (G.L. c. 93, s. 71 et seq). This statute requires that a person must first obtain medical clearance and a hearing test evaluation from a physician, audiologist or otolarynogolist: before entering into a contract for the purchase of a hearing aid unless the prospective purchaser has obtained the proper medical clearance in the past. No physician, otolarynogolist or audiologist may have any interest in a business which fits and sells hearing aids for a profit; and no person may offer an inducement, monetary or otherwise, to a physician, otolorynogolist or audiologist to influence a patient's purchase of a particular hearing aid. These provisions among others provide comprehensive protection to all those who would enter into a contract to purchase a hearing aid. Violations of these sections constitute an unfair and deceptive trade practice under the provisions of Chapter 93A of the General Laws.

Regulation of Business Practices for Consumer Protection (G.L. c. 93A). This statute is often referred to as the "Baby" Federal Trade Commission Act for the consumer and small businessman. It provides legal protection to individual citizens against the whole range of potential abuses that may occur within the marketplace, such as unfair selling tactics, bait and switch advertising, "tie-in" arrangements, deceptive advertising, misleading identification of goods or services and nondisclosure of defects in merchandise.

Chapter 93A was initially enacted as a consumer protection act. It was amended in 1972 by adding Section 11 to give it broad application to a wide range of business disputes.[94] The effect of Section 11 is to give aggrieved parties a private right of action for conduct violating the Federal Trade Commission Act.[95]

Section 2 defines the mercantile or trade actions which constitute violations of Chapter 93A. Section 2(a) stipulated that "unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce" are unlawful. Section 2 further provides that in construing the provisions of Section 2(a) the courts are to be guided by decisions of the Federal Trade Commission Act. In addition, Section 2 gives the Attorney General authority to make rules and regulations interpreting Section 2(a) so long as such rules and regulations are consistent with Federal Trade Commission and Federal court interpretations of the Federal Trade Commission Act.

Sale of Generic Drugs (G.L. c. 112, s. 12D). This statute empowers the prescribing practitioner to authorize the pharmacist to make an equivalent interchangeable substitution, if applicable, of any drug he/she prescribes as long as it is so noted on the dispensing instructions to the pharmacist. In cases where interchange is permitted as indicated by the practitioner, the pharmacist shall dispense a less expensive reasonably available interchangeable drug product as listed in the most current

[94] Section 11 gave a private right of action to "any person who engages in the conduct of any trade or commerce and who suffers any loss of money or property, real or personal, as a result of the use or employment by another person who engages in any trade or commerce, of an unfair method of competition or an unfair or deceptive act or practice declared unlawful by Section 2 (or rules promulgated under Section 2).

[95] The Federal Trade Commission Act does not provide for a private right of action; it provides for enforcement proceedings by the Federal Trade Commission (15 U.S.C. 45[b]).

drug formulary. As has been noted in the previous chapter of this report, the elderly are heavily dependent on drugs and various forms of medication. Thus, this procedure offers opportunities for substantial savings to the aged.

Compensation for Victims of Violent Crimes (G.L. c. 258A). The purpose of this law is to provide victims of violent crime with compensation for loss of earnings or support and out-of-pocket loss for injuries sustained as a direct result of the crime. Out-of-pocket loss means reasonable medical care or other services necessary as a result of the injury. In the case of the death of a victim as a direct result of the crime, a dependent may file a claim.

The process originates with the filing of a petition in the district court where the claimant lives within one year after the occurrence of the crime, or not later than 90 days after the death of the victim, whichever is earlier. The court may, upon a showing of good cause, extend the time for filing. After the appropriate filing has been completed, the district court notifies the Attorney General of the claims. The Attorney General then conducts an investigation and files his report with the court. A hearing is then held and a finding made by the district court judge. The court may allow reasonable attorneys' fees, not to exceed 15 percent of the amount awarded. These fees are paid from the award and are not in addition thereto.

Up to a maximum of $10,000 can be recovered. There is a $100 deductible and a further deduction for amounts received or to be received as a result of the injury (a) from or on behalf of the offender, (b) from insurance programs, or (c) from public funds.

In the period between 1969, when the program was created, and 1980 there were 1,579 claims awarded for a total of $5,836,125, the average claim being $3,696. Some criticism of this program has focused on the delay involved in the actual payment of awards. Often there are delays of up to four months from the time of the award decision to payment. This delay is usually caused by the depletion of the program's budget before the end of the fiscal year, thereby requiring the filing of a supplemental budget with the Legislature. This delay in awarding legitimate claims will usually have a more deleterious effect upon the elderly claimants who are generally less able to recover from substantial out-of-pocket loss.

Insurance Policies Cancellable at Age 65 (G.L. c. 175, s. 110H). This statute provides that every company which issues a policy of insurance under the provisions of Section 108 of Chapter 75 which is cancellable when the insured reaches age 65 shall, 60 days prior to the date of intended cancellation, notify the insured that such policy will be cancelled and the date thereof. If the company fails to notify the insured, the policy will remain in effect until such notification or until 90 days after the insured reaches age 65, whichever comes first.

Reduction in Motor Vehicle Insurance Rates for the Elderly (G.L. c. 175E, s. 4). This section sets standards for the regulation of rates for motor vehicle insurance. Under paragraph (d) of Section 4, motor vehicle insurance rates for insured citizens age 65 years or older, who otherwise qualify for the lowest rate classification applicable to drivers generally, shall be asessed at 25 percent less than the applicable rate for such classification.

Speedy Trial for Persons 65 Years of Age or Older (G.L. c. 231, s. 59E). In any civil action in any court in the Commonwealth in which one or more of the parties (plaintiff or defendant) is 65 years of age or older, the court shall, upon motion of such person, advance the proceeding for speedy trial so that it may be heard and determined with as little delay as possible.

Patients' and Residents' Rights (G.L. c. 111, s. 70E). This statute guarantees certain rights and privileges to every patient or resident of a convalescent or nursing home, rest home, charitable home for the aged or other facility licensed by the departments of public health or mental health. Some of the patients' rights include (a) confidentiality of all records, (b) right to prompt life-saving treatment in an emergency without discrimination, (c) right to privacy during medical treatment within the facility, (d) right to receive a copy of all charges submitted to a third party, and many other rights as described in the statute. Every patient or resident of any facility except a patient who is a member of the health maintenance organization which owns or operates the institution must receive a written notice thereof.

In addition, the patient's "bill of rights" must be conspicuously posted in the facility.

Readability of Insurance Policy Forms (G.L. c. 175, s. 2B). This statute, although not age specific, does protect the elderly from having to deal with unnecessarily confusing insurance forms. The text of all insurance forms must obtain a "Flesch" scale of readability score of fifty. This measuring procedure is explained in the text of the statute. Also, this law allows the commissioner of insurance to impose additional readability tests if he finds that such tests are equivalent in function. This statute does not apply to any casualty or property insurance which is issued to

insure a business, professional or governmental operation or any form of life insurance, accident or health insurance, or annuities which is issued in connection with any employee benefit plan. There are other exceptions, but generally this statute can be applied to all "individual" insurance policies issued here in the Commonwealth.

As the preceding capsulization indicates, there is a relative absence of age specific law in the Commonwealth. The approach that has been taken by Massachusetts and other states' lawmakers has resulted in the enactment of consumer protection laws of general application, devoid of any bias or preference in the case of age, sex or other considerations. In the final analysis, the elderly are not victims of any crime or fraudulent activity that cannot also be committed against any other age group. Therefore, age specific statutory protection may be unnecessary, in fact, in some cases, it may be so discriminatory as to invite constitutional challenge on the grounds of denial of the equal protection of the law guaranteed by both the State and Federal constitutions.

Proposed crime legislation

On February 27, 1981, Governor Edward J. King submitted to the Massachusetts Legislature a comprehensive anti-crime package. Included in this legislation is a bill requiring minimum sentences of imprisonment for repeat offenders convicted of certain violent crimes committed against persons 65 years of age or older (House, No. 6318).

In the Governor's accompanying message to this legislation, he made the following statement of intent:

"This bill is designed to single out senior citizens for special legal protection so that they may live free from violent street crime. Those who commit crimes of violence against senior citizens will be targeted for new criminal penalties, with mandatory minimum sentences of imprisonment to be imposed on those who are convicted of such crimes two or more times. The principal focus of this bill is violent street crime—purse snatchers, muggers, strong-arm robbers—in short, those who rob, beat or assault our senior citizens. There are the kinds of crimes which affect the elderly disproportionately, with generally greater resultant physical harm, financial loss and emotional trauma for this age group than any other: physically, because senior citizens may be far less able to defend themselves from physical assault and recover less easily from bodily injuries; financially, because they are more likely to be on low or fixed incomes and can least afford to lose their savings to a mugger or robber; and emotionally, because long after the crime has been committed, senior citizens must live with the lingering fear of crime, a fear which pervades and indeed may paralyze their lifestyle. This state of affairs is unacceptable."

Governor King's crime bill would apply mandatory sentences for five different offenses perpetrated against the aged. Assault and battery with a dangerous weapon, assault with intent to rob while being armed, and unarmed robbery all would carry a minimum two-year sentence; assault with a dangerous weapon and larceny from a person would both carry a minimum one-year sentence. These sentences would be imposed only if the defendant had committed at least one prior offense of a similar nature against an elderly person. Also, no parole, probation, suspended sentence, continuance without a finding or filing of the criminal charge would be allowed under this statute.

The goal of this legislation is to emphasize the "certainty" of punishment rather than the "severity" of punishment. Its proponents maintain that mandatory sentences will have a greater deterrent affect than harsher penalties which have been construed to be "excessive" punishment by some state courts.[96] Also, age specific legislation that mandates harsher penalties for victimizing the aged may discriminate in favor of the aged and may be in violation of the equal protection clause of the Fourteenth Amendment although this issue is yet to be judicially determined.

In addition to the Governor's bill 12 measures which also propose increased penalties for victimizing the aged are awaiting consideration by the Legislature:

[96] In 1977, the Louisiana Legislature enacted legislation providing that any person convicted of (1) manslaughter, (2) simple rape, (3) forcible rape, (4) aggravated assault, (5) aggravated battery, (6) simple battery, (7) aggravated kidnapping, (8) simple kidnapping, or (9) false imprisonment, when the victim of such crime is 65 years or older would be subject to, in addition to any other additional penalty imposed, five years imprisonment without benefit of parole, probation or suspension of sentence (Chapter 14:40.1). However, on March 3, 1980, the Louisiana Supreme Court declared the statute unconstitutional on the grounds that the punishment was "excessive" under the provisions of Article I, Section 20 of the Louisiana Constitution "State of Louisiana vs. Robert H. Goode, Jr.," Supreme Court of Louisiana No. 65879).

Senate, Nos. 1792, 1793, 1839, 1905 and 1906; House, Nos. 5419, 5426, 5513, 5521, 5605, 5648 and 6969. Five of the bills call for mandatory sentences for various street crimes, violent crimes, and for breaking and entering into a senior citizen's home. Some of the bills include the handicapped under the same special category as the elderly. Seven of the remaining proposals would set various grades of increased penalties or longer sentences for various street crimes, violent crimes, purse snatching and breaking and entering.

Massachusetts Department of Elder Affairs

Specialized and official state activity and programs to assist the elderly has been undertaken for at least the past 27 years. In 1954, a Governor's Council on Aging was formed and renamed the Commission on Aging in 1964. In 1968, the Commission became part of the new Department of Community Affairs under the executive reorganization law.[97]

With the establishment of the Executive Office of Elder Affairs in 1970,[98] a separate and distinct agency was created to deal with the problems of the aging and the elderly population. The executive office was elevated to cabinet status in 1973, and since that time, the Department of Elder Affairs, headed by the Secretary, has been responsible for program development, planning and advocacy for the Commonwealth's older citizens.

Charged by statute with overseeing a number of programs for the elderly, the Department of Elder Affairs, as the Commonwealth's chief public advocate for the aging population, coordinates its programs with related activities undertaken by other state agencies including the departments of Public Health, Mental Health, Public Welfare, Social Services, Communities and Development, Energy and Manpower Development. The Department assists in, and reviews, the drafting of regulations for long-term care facilities and nursing homes, medical care and public assistance, state-aided housing for the elderly, homemaker agencies, transportation and services for the handicapped.

Under Chapter 19A of the General Laws, the Department has certain responsibilities, including:

Providing assistance to local cities and towns and helping identify and coordinate local resources.

Facilitating a free flow of communications important to the elderly throughout the state.

Acting as a "clearinghouse" for information and materials relating to the elderly.

Initiating and developing research to aid in solving local, regional and statewide aging problems.

Coordinating, as public advocate, programs of other state agencies to improve services to the elderly at all levels.

Assisting communities to plan, develop and implement home care programs.

Facilitating the work of government and private agencies to improve conditions for the older citizens.

Seeking federal aid for programs and services for the elderly and working with state and local governments and public and private educational institutions and agencies to maximize federal assistance.

Programs for older persons are as varied as the sources of financial support and their basis of administration. At the local level, most cities and towns have established a Council on Aging funded in large part by those communities as part of their local budgets. The Department of Elder Affairs, which provides some assistance to local councils, is responsible for carrying out the mandates of the Older Americans Act of 1965 as amended (most recently in 1978), the federal govenment's chief source of support for state and regional elder services. As the state agency designated to meet the responsibilities of the Act, the Department has established 23 Area Agencies on Aging (AAA) to plan and coordinate services for elders in cooperation with other appropriate elder advocacy groups and Councils on Aging. In addition, the Department has designated 27 home care corporations to receive state funds and has approved nutrition programs serving over 300 sites, utilizing state and federal monies.

Legislation. Through its legislative liaison staff, the Department both prepares and supports legislation on behalf of the elderly. Among successful efforts of the 1980 legislative session were:

(1) A major housing bond issue act to expand public housing for elderly residents.

[97] G.L. c. 23B, s. 1.
[98] G.L. c. 6A, s. 2.

(2) A state program for emergency fuel assistance, one of the only such programs in the United States.

(3) Legislation protecting the rights of elder tenants in cases of condominium conversion.

(4) An increase in monthly allowances for members of the Volunteer Elder Service Corps, which will expand in size by 50 percent during 1980-81.

(5) A 16 percent increase in the Department's budget.

In addition, DEA's Office of Advocacy monitors national legislative issues such as fuel assistance, age discrimination regulations and changes in the Older Americans Act and its implementing regulations.

Abuse of the Elderly. After a study sponsored by the Department of Elder Affairs documented physical and emotional abuse of older citizens as a serious problem, DEA began a series of steps to combat the problem in Massachusetts. Departmental efforts have ranged from public education in making the extent of the problem known to development of legislation that would require health professionals to report abuse.

Legal services development

A 1979 amendment to the Older Americans Act mandates that each Area Agency on Aging in a state expend some portion of its federal dollars allocation on legal services for the elderly. Although there is no statutory proscription for a "means test" or income eligibility guideline, it is anticipated that those services will be furnished to people with the greatest need. The program of legal services development in Massachusetts has made significant progress in a short time.

During 1979 and 1980, legal services for the elderly such as assistance in the probate process and filings for guardianship proceedings took on new importance. Following completion of a statewide survey by the Department to identify legal assistance services currently available as well as existing service gaps, the Advocacy Assistance Legal Services Development Program accelerated its efforts to link those in need of legal services with agencies throughout the Commonwealth that provide such assistance at no charge. Among specific services provided are those dealing with guardianship, conservatorship, consumer protection, tenant and landlord issues, and individual's rights under such public benefit laws as Medicaid, Social Security and Supplemental Security Income.

During 1980, completion of the state legal services network was achieved. Program staff of the Department of Elder Affairs, working comperatively with area agencies on aging, assisted the latter in the process of identifying, and contracting with, various legal service providers.

A model legal services contract was also developed. The demonstration contract may be utilized by area agencies in their contracts with legal service providers. The DEA's Legal Services Developer also provides instruction and technical assistance in various areas of the law affecting the elderly to numerous groups of elders throughout the Commonwealth.

Information Services. During 1979-80, major steps were taken by the Department of Elder Affairs to increase the level of information services provided to the public. At the same time, the members of the Elder Services Network throughout the state met the challenge of new issues, needs and problems, such as the growing demand for emergency fuel assistance, by upgrading the level and increasing the amount of their public service, media, brochure and outreach materials, and the implementation of regional telephone hot lines.

In October 1979, the Department established a toll-free Hot Line. That service and the on-going public information lines at DEA's Boston headquarters respond to nearly 10,000 questions, concerns and requests for information from elders, elder advocates, public officials, community leaders and students.

In line with the inauguration of the Hot Line, the statewide circulation of the bimonthly Department newspaper, Elder Affairs, was expanded in 1980 from 1,500 to 4,500 senior citizens, elder advocates, local officials, schools, public libraries and programs affecting elders. This publication provides detailed information on programs and services of the Department of Elder Affairs, issues of statewide significance to elders such as the state budget, Governor King's comprehensive housing, crime and fuel programs, federal government developments, and issues papers on subjects for the future.

Recently, the Massachusetts Nursing Home Ombudsman Program developed and produced two important handbooks for elder advocates: The Legal Handbook for the Elderly and The Legal Resources Handbook for the Elderly. The first publication examines the areas of most common need for legal services. The second volume is a comprehensive directory listing names of persons, agencies, publications and documents that can assist older advocates in finding help and information. Topics

covered include discrimination, consumer protection, health programs, housing issues (including landlord-tenant relations), public welfare, Social Security, unemployment insurance and vetrans' benefits.

Crime Prevention Assistance. In every state and in each of more than 550 communities throughout the country, an agency on aging has been designated unde Title III of the Older Americans Act to serve as an advocate for older persons, to coordinate activities in their behalf, and to provide information about services and opportunities for them.

Another source of information is the Massachusetts Committee on Criminal Justice. Equivalent agencies operate in all states and territories of the United States. Each agency receives federal block grant funds from the Law Enforcement Assistance Administration (LEAA) of the Department of Justice, pursuant to the Omnibus Crime Control Act. These funds are used in designing and developing improved methods of dealing with the nation's problems of crime and delinquency, including crimes against older persons, which is a specific priority area included in the 1976 revisions of the Omnibus Crime Control Act.

Funding for a wide range of activities, which might include activities pertaining to security against crime for the elderly, is made available through Community Development Block Grants administered by the Department of Housing and Urban Development. The grants are paid to local governments and spending priorities are determined at the local level. Programs assisted could include home improvements or neighborhood facilities for the elderly. Funds for housing repair assistance are made under the Home Improvement Loan Insurance program, Title I of the Housing and Community Development Act of 1974. The general objectives of the program include provision of adequate housing, a suitable living environment and expanded economic opportunities for lower income groups.

Under Title III of the Older Americans Act, which authorizes support for state and community programs for the elderly, the Administration on Aging allocates funds to designated state agencies, which in turn make awards to area agencies on aging to foster the development of comprehensive and coordinated services to the elderly. Home repair services for older Americans constitute one of the program areas given priority status under the 1975 amendments to the act. Although home repair assistance is not intended primarily to improve security of homes against crimes, this can be one of the benefits of such home repairs.

Silver-haired legislature

In November 1980, Governor Edward J. King and the Department of Elder Affairs sponsored the first session of the Massachusetts Silver-Haired Legislature. Earlier in the year, elderly citizens throughout the Commonwealth were elected to their respective senatorial and representative districts by a popular vote of their peers. These delegates held a mock legislative session in the State House for three days, discussing, proposing and acting on issues of concern and interest to the contemporary Massachusetts elderly population.

A modified set of parliamentary rules were devised to regulate procedures and six committees were organized to initially consider the various proposals brought before the session (Commerce and Labor, Education and Housing, General Legislation, Health, Human Services and Elder Affairs, and Ways and Means). The Silver-Haired Legislature acted on 12 priority proposals over the course of three days, including one proposal which would provide mandatory sentencing for a violent crime committed against a senior citizen. These proposals which represent issues of primary concern to the elderly population in the Commonwealth relate to:

Fuel adjustment surcharge
Tuition exemption for Senior Citizens (60+) attending state colleges.
Security protection at elderly housing developments.
Mandatory sentence for violent crime committed against Senior Citizens.
Intervention by the Attorney General and Department of Public Health to protect nursing home residents if nursing home is in danger of closing.
Use of the Living Will.
Funding of municipal Councils on Aging.
Nutrition programs for the elderly.
Home care service.
Tax exemption on property tax for certain persons over 65.
Motor vehicle license and registration fees for individuals age 65+.
Reductions in the taxation of interest and dividends for persons age 65 and over.

Crime and the elderly conference

The Massachusetts Committee on Criminal Justice (MCCJ) in cooperation with the Massachusetts Department of Elder Affairs, and the Executive Office of Public

Safety presented a statewide conference on Criminal Victimization of Older Americans on December 10, 1980. The primary goal of the conference was the development of policy recommendations concerning crime and the elderly. These recommendations will be incorporated into the policy platform to be developed in April 1981 for the Massachusetts White House Conference on Aging and will be presented to the National White House Conference on Aging which will be held in December 1981.

Governor King addressed the conference and announced that shortly he would be sending legislative proposals on crime to the General Court. Attorney General Francis X. Bellotti, another featured speaker, also acknowledged the need for increased penalties for offenses committed against the elderly and he outlined the current efforts of his office in combating crime against the aged.

At the conference, it was announced that an "Elder to Elder Escort Assistance Program" is expected to begin in the Spring. This program will offer the use of volunteer retirees to escort and assist other elder citizens to and from various local destinations such as supermarkets, shopping malls and hospitals. The program will be sponsored by the Department of Elder Affairs and administered through the MCCJ.

APPENDIX 3

HOLYOKE CHICOPEE REGIONAL SENIOR SERVICES CORP.,
Holyoke, Mass.

The Holyoke Chicopee Regional Senior Services was incorporated in August of 1974 as a Home Care Agency, and in 1977 was designated as an Area Agency on Aging under the Older Americans Act by the Massachusetts Department of Elder Affairs. The experiences of our staff with several thousand elderly clients over these years have revealed many areas of unfair practices and fraud which remain of grave concern to us. The following list brings these to your attention:

INSURANCE POLICIES

1. Although promises to simplify the language and form of insurance policies have been heard for years, no laws, no regulations have been promulgated to guarantee clear, simple English, so that our elders, and all of us, understand the terms of insurance being offered or purchased.
2. All charges on monthly insurance bills should be clearly identified, so that the elder consumer cannot be billed more than once for any installment. Rate increases and surcharges especially should be identified as such.
3. Consumer protection agencies are not created to assist the elderly consumer in making knowledgable decisions about the purchase of insurance; rather, they exist to intercede after the unfortunate and often disastrous results of misinformation and malpractice have brought the tragic cases of cheated elders to their attention. How many of our elders buy duplicative and unnecessary insurance, beggaring themselves to maintain payments and often going without food, fuel and warm clothes to meet the demands of the insurance companies?

DRUGS AND MEDICATIONS, SIGHT AND HEARING AIDS

1. Advertisements for over-the-counter drugs which promise miraculous relief from the many symptoms to which our elderly are particularly prone are misleading, and, in many cases, dangerous, as the drugs described, particularly on the television screen, are often counter-indicative to the medications prescribed by physicians. Warnings to check with one's physician should be clearly included in each commercial.
2. In the case of generic drugs, which would save our elderly and the third party reimbursement agencies much money, we often find elders bringing their prescriptions for generic drugs to a local pharmacist and being told the drugs are not available. This is often untrue, but the elders will consequently pay for the more costly name brands. Why shouldn't all pharmacists be required to stock and advertise generic brands of drugs?
3. Hearing aids and other similar devices are another area for grave concern. Legislation should be passed which prohibits the agency which tests for hearing impairment from also selling hearing aids. Too many of our elderly clients have purchased hearing aids which are ill-suited to their needs, do not function well, and cost a great deal. There is no "return" policy on such devices. Only trained audiologists should test for hearing, and they should recommend only types of hearing aids rather than name brands.

CONSUMER AIDS

1. Elders are often not aware of exactly what Medicare pays for, and what acceptance and non-acceptance of assignment by a provider means to them financially. The Social Security Administration should be responsible for educating the elderly about Medicare functions, at the time the elderly apply for their Medicare cards.
2. Unit pricing in grocery stores and supermarkets is a valid and useful mechanism for those who can read and understand the labels. For the elderly, whose eyesight is often not up to deciphering small shelf labels at a distance, a system which labels *each package* simply would be much better. The elderly shopper could then bring the package up close to the eyes before making a decision to purchase.

3. The last area which concerns us here is the availability of information on Senior Citizen Discounts. An example of this is in the auto insurance industry in Massachusetts. While we are all billed extra in our premiums prior to age 25, we do not as surely receive the benefits of the State's insurance "discount" or "rebate" to its "over 65" citizens. Where financial or other benefits accrue to the elderly, such benefits should be advertised, and the agencies responsible for disbursing them should be *required* to carry them out!

Thank you for your attention to this testimony, and for including it in your records.

Respectfully submitted.

PRISCILLA L. CHALMERS,
Executive Director.

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