OGC Has Reviewed

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FINAL REPORT
of the
INSURANCE TASK FORCE

1 July 1954

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Approved For Release 2003/03/25 : CIA-RDP59-00882R000100260002-8

ER 5-8070 w/att

1954

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MEMORANDUM FOR: Inspector General
Assistant Director for Personnel

FROM: Chairman, Insurance Task Force

SUBJECT: Distribution of Final Report

1. At the 35th meeting of the CIA Career Service Board held on 30 June 1954, it was agreed that complete copies of the Final Report of the Insurance Task Force would be placed on file in certain strategic locations in the Agency. It has been possible to assemble eight copies from the many documents involved. These copies are to be regarded as the complete and definitive report of the Task Force. However, copies of documents contained in these eight copies of the Final Report have been distributed previously in various drafts and to many addressees throughout the Agency over a period of time.

2. The distribution of the eight copies of the Final Report is as follows:

Copy 1 - Director of Central Intelligence, Deputy Director of Central Intelligence, Executive Registry
Copy 2 - Inspector General
Copy 3 - Assistant Director for Personnel; Chief, Plans and Analysis Staff
✓ Copy 4 - Deputy Director (Administration), General Counsel ([redacted] - member of the Task Force) 25X1A9A 25X1A9A
Copy 5 - Office of Security
Copy 6 - Chief, Insurance and Claims Branch [redacted] - member of the Task Force)
Copy 7 - Chief, Career Service Staff ([redacted] member of the Task Force) 25X1A9A
Copy 8 - Chief, Management Staff ([redacted] - Chairman of the Task Force) 25X1A9A

Signed

[redacted] 25X1A9A

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5-8061

20 JUL 1954

MEMORANDUM FOR: Director of Central Intelligence

SUBJECT: Final Report of the Insurance Task Force

FROM: Chairman, Insurance Task Force

At the direction of the CIA Career Service Board there is forwarded to you for your information copy No. 1 of the Final Report of the Insurance Task Force. This report was approved by the CIA Career Service Board at its final meeting on 30 June. The contracts with the underwriting companies which put this program into effect are now in final stage of approval, and when completed will be signed by the Deputy Director (Administration). The two new plans, one for group Life insurance and one for group Health insurance, will be announced during the Career Service Conference on 3 August, and this insurance program, greatly improved over that which has been offered heretofore, will be available to all staff employees and staff agents the next day, Wednesday, 4 August.

25X1A9A Signed

Attachment - as stated

25X1A9A CS/[redacted] (19 July 54)

Distribution:
Orig & 1 - Addressee
1 - DD/A
1 - AD for Personnel
1 - Insurance Task Force File
1 - signer

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att to ER5-8070

REPORT

TO THE

CIA CAREER SERVICE BOARD

FROM

THE INSURANCE TASK FORCE

IN RESPECT TO

INDEMNITIES AND BENEFITS

FOLLOWING

DEATH AND DISABILITY

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THE INSURANCE TASK FORCE MEMBERSHIP

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Chairman:		SA - DD/P
Member and Sec'y:		PRDS - Personnel
Member:		ESD - Personnel
Member:		Deputy Gen. Counsel
Security Advisor:		Office of Security
Security Advisor:		Staff C
Security Advisor:		Chief, Plans - FI
Consultant:		
Consultant:		
Consultant:		

(All Consultants cleared Top-Secret)

25X1A5A1

25X1A5A1

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5. Conclusions
6. Recommendations

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   b. Existing available protective measures, . . . " " TAB D
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5. Conclusions
6. Recommendations

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FOREWORD

Because of the complexity of this subject, it is deemed best to make the presentation in two parts - first, as to death, and then disability.

Clearly, what the Agency should do, if anything, in these fields, is properly considered only after review of existing available protective measures. Accordingly, this presentation is so organized.

Warning is given that the statistics following in respect to death are somewhat untrustworthy in the earlier years especially and, overall, may be too meagre to be fully significant. They are, however, indicative and useful.

Agency procedures and systems in respect to records of death and disability should be tightened and so organized that continuingly in the future, this type of Agency vital statistics is immediately ready for any desired analysis by appropriate officers. This is especially important in the field of disability (hospitalization) because of the growing country-wide interest, information and change in such group plans.

Further, interpretation and application of P.L. 110 in respect to overseas illnesses must always be carefully weighed together with the employee's membership in a group hospitalization plan. Full justice to the employee includes concern not only for costs to the Government but also concern for the degree of employee participation, and his premium costs, in any group plan offered.

The Task Force finds grievous lack of knowledge in the employee group as to the individual's beneficial rights, especially under that important and excellent piece of legislation known as the Federal Employees Compensation Act. This is also true, but now less so, as to the War Agencies Employees Protective Association life insurance. It is suggested that if future disseminations of such nature are dressed up modestly, they are less likely to hit the waste basket without reading. More importantly in this connection, the Task Force directs explicit criticism to the culpable failure of the Agency and its executive or administrative officers to assure that needful information reaches all persons concerned.

All of this material should be made available to the Chief, Medical Office, for his appropriate and proper technical contribution to personnel administration.

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TO : CIA Career Service Board

FROM : Insurance Task Force

SUBJECT : Employee and Family Beneficial Coverage in Respect to Death and Disability

1. PROBLEM: What employee and family indemnity and beneficial insurance coverage should the Agency arrange to have offered in order to remedy or alleviate any possible existing injustice, to alleviate personal and family concerns which dilute or distract from attention to mission, to demonstrate community of interest, and to promote the concept of career.

2. ASSUMPTIONS: The Task Force believes:

a. That from the point of view of constructive personnel administration the Agency has a deep interest, if not obligation, to assist its employees to meet life's more serious exigencies, whether imposed by mission or not.

b. That there do exist particular security problems for the Agency in the field of life and disability insurance.

c. That the nature of CIA mission requires a quality of personal action which is founded in a well-rounded and developed career concept.

d. That the Agency, as others, desires to take advantage for its employees of existing benefits commonly extended only to groups as such - or to create appropriate new benefits.

e. That the Agency adopts the principle that over and above present available benefits, the employee is responsible for securing himself, with his own means, the needful life (and disability) protection.

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3. Facts in respect to death

a. Excerpted from Tab A are the end-product death statistics for staff employees and staff agents for the years obtainable and valid comparison with the Department of State. Because age is obviously a factor, some information on this score is also shown. A non-valid comparison with Agriculture is added as a matter of general interest. (Retirees there are permitted to keep a reduced life policy.)

Except for Agriculture, the deaths are all in service i.e., while employed, and the ratios are based on average monthly strength for the years shown.

Because the years '51, '52 and '53 are believed to provide the most trustworthy source material, an average for this period is added.

While these statistics are legitimate in perhaps all of the seven last years, there is no surety that every death shows in our records and in any event the meagreness of the death numerator strongly cautions as to attributing complete significance.

(1) Death incidence, all causes, all ages - CIA, Department of State, Department of Agriculture Beneficial Association, and U. S. Population as a whole

25X1A1A

CIA(a)	1947	1948	1949	1950	1951	1952	1953	Av. '51, '52, '53
Foreign Service(b)								
Total deaths	-	-	10	15	8	6	8	7
Deaths per 1000 (physical given)	-	-	1.86	1.90	.92	.56	1.06	.83
Departmental (State)								
Total deaths	-	-	7	18	17(d)	19	12	16
Deaths per 1000 (no physical)	-	-	.66	2.29	1.82 (1.29)(f)	1.82	1.47	1.75(d) (1.54)(f)
Agric.B.A.(c)								
Total deaths	-	-	182	234	190	217	232	213
Deaths per 1000 (no physical)	-	-	11.3	14.5	11.8	13.5	14.4	13.2
U.S. population(e)								
Deaths per 100	-	9.88	-					

(a) (b) (c) See Appendix 2, Tab E for sources
(d) Contains 5 deaths from single air crash.
(e) U.S.Public Health Service
(f) If 5 deaths from a single air crash are eliminated the ratios would be as shown

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(2) Deaths by office area for 1952 & 1953

25X1A1A

(3) Place of death, all 7 years (CIA)

72% in U.S.
15% " Far East
13% " Europe and Near East

(4) Cause of death, all 7 years (CIA)

Cause	No.	%	U.S.Pop.
Heart	25	35%	32.5%
Cancer	11	16%	13.7%
Illness, other	12	17%	
Accident in performance of duty	8	12%	
Suicide	6	9%	1.1%
Accident not in line of duty	5	7%	
Enemy action	2	3%	
Total	69		
Performance of duty	10	15%	

(5) Ages at death all 7 years, in 3 selected Categories (CIA)

(a) Heart: General progressive distribution from age 36
(b) Cancer: Middle Ages
(c) Suicide: Younger Ages

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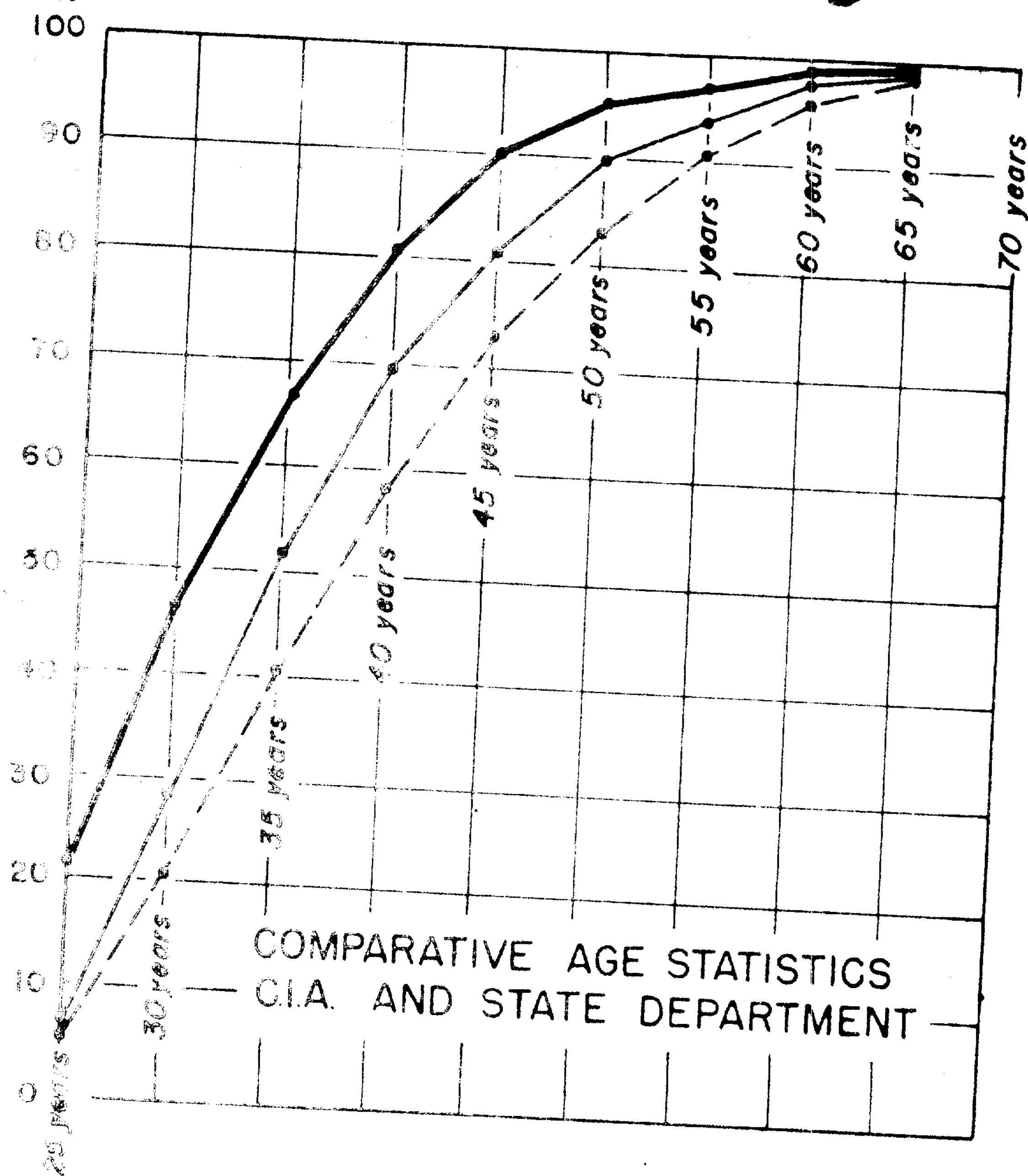

LEGEND: Cumulative % to total personnel by age groups (up to and including 25 yrs.; up to and including 30 yrs.; etc.)

CIA — Staff employees and staff agents as of 30 ~~June~~ Dec. 1953

Foreign Service — All personnel as of January 1954

Departmental Dept. of State — All personnel as of January 1954

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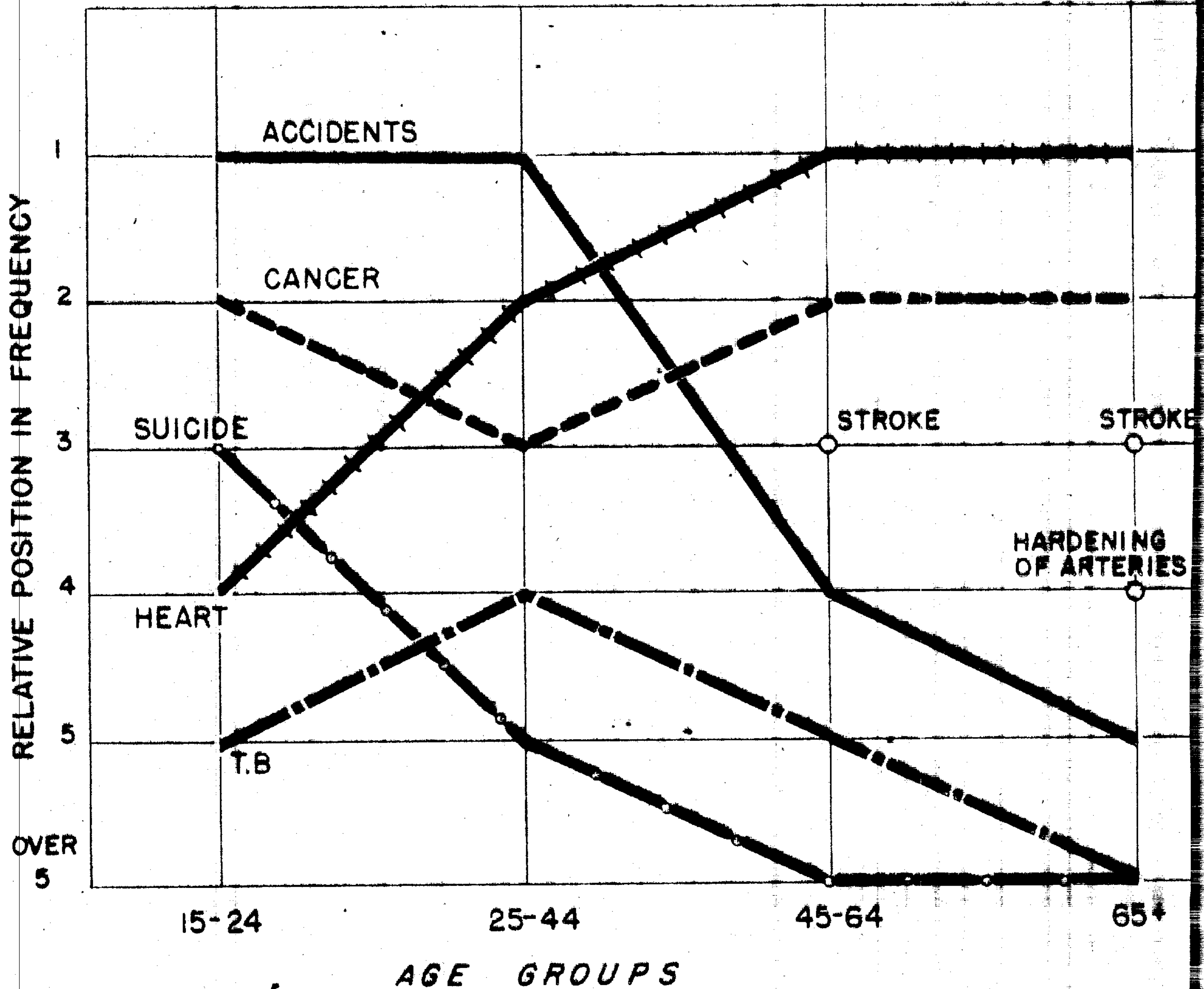

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b. Existing available protective measures in beneficiary coverage have the following aspects of most importance:

(1) Commercial Ordinary Life policies

(a) The Basic Policy (Face Amount) excludes coverage if death is occasioned by an Act of War (declared or undeclared) while the insured is in either the military or the civilian service, by air flight in either military or non-scheduled planes for purposes of training, testing, military mission or while acting as a crew member.

(b) Double Indemnity feature excludes (a) above, plus others.

(c) Policy is not obtainable if the applicant is scheduled for semi-hazardous or hazardous duty, and, once granted, is voided if the exclusions are offended.

(2) National Service Life Insurance (or U. S. Government Life Insurance)

(a) Both these policies are limited to veterans and are incontestable from date of issue for any cause except fraud - i.e. no risk exclusion.

(3) Federal Employees Compensation Act

(a) This Act is an exclusive compensatory remedy for death (and disability) resulting from injuries suffered in performance of duty or from diseases proximately caused by employment.

(b) It's maximum benefit would equal the income on a capital investment in U. S. H Bonds of about $210,000.

(c) A hypothetical application in monthly benefits is:

Beneficiary	GS-11 Employee dies in U.S.	GS-11 Employee dies in Frankfurt
Widow only	$222.75	$256.50
Widow and 2 children	328.16	399.00
2 children only	239.16	285.00

(4) Civil Service Retirement Act

(a) This is primarily a retirement act, annuity in nature, but it does provide small death (and disability) benefits without regard to performance of duty. The principal qualification is 5 years of civilian service - then military service may be added.

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PART I

(b) A hypothetical application in monthly benefits is:

Beneficiary	GS-11 Employee with 9 yrs. svc.	GS-11 Employee with 15 yrs. svc.	Payable
Widow only	$33.42	$55.69	at her age of 50
Widow & 2 children	66.84	111.39	immediately
2 children only	66.84	80.00	immediately

(5) Public Law 110

(a) Maximum death benefits are preparation and transportation of the remains of the employee or member of his family who may die in travel status or abroad to appropriate place of interment.

(6) War Agencies Employees Protective Association (WAEPA)

(a) This is excellent term life and accidental death coverage totaling now $27,000 available without medical examination or delay, for a premium cost (up to age 41) of $100.00 per year.

(b) There are no exclusions in the term feature and five (5) in the accidental death category. Most importantly, in respect to air flight, any flight is fully covered if the insured proceeds under orders, directly or indirectly, of the U. S. Government as a passenger.

(c) The premiums seem out of line with experience.

(7) TAB B shows an essential summary application of all these instruments under certain assumed conditions.

4. DISCUSSION, as to death

a. As noted in the statistical compilations, because of the factors of meagreness, some untrustworthiness and incompleteness of statistics in CIA, observations drawn here are set forth as <u>indicative</u> rather than positions taken from full statistical legitimacy.

(1) The Foreign Service of State shows a better record than we do. This might be expected due to the difference in activity and their early retirement plan.

(2) The Department (headquarters of State) shows about the same record as we do.

(3) Unquestionably we present a far better risk than that with which the insurance companies generally contend. However, the assertion that because of our medical examinations (pre-employment and overseas pre-TDY and pre-PCS) and security screening we present a far superior risk potential, seems unwarranted.

(4) Whereas today, in personnel composition, we are an extremely youthful group, it may be expected that with some settling down, this condition

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will show increasing maturity.

(5) The potential of risk on the DD/P side shows up both in the ratio for 1952 and 1953 and also in the fact of 8 DD/P deaths out of 10 (for all years) in the performance of duty category. These figures are without reference to deaths arising from illness proximately caused by employment. Six of the seven suicides are on the DD/P side (one was in TSS) and in two cases of the total, it is known that Agency activities were pressing factors.

(6) The incidence of death in performance of duty is significant at 15%. However, the Task Force believes that this relatively low ratio can quickly show sharp increase due to our widespread traveling and OTR, TSS and operational activities. The potential in respect to non-scheduled aircraft will be treated verbally as appropriate.

(7) For the record, the Task Force desires to point up the ever-present problem - high lighted by death - of potential activity - attribution to the U. S. Government. This is a matter of operational security responsibility which lies in the technical or professional field. The Task Force is not professional, but holds and emphasizes the position that to deny a Staff Agent WAEPA coverage if he desires it, is no answer. The fact of his rights under FECA - which cannot be denied - contains inherently the attribution potential anyway. Perhaps our only way out is to refrain from using employees on sensitive missions. Today this may be an impracticable ideal - but there is the problem. For those interested, the position and answer to this last problem on the part of MI6 is detailed in TAB E Appendix IV.

b. From an analysis of existing available protective features, the following observations are of most importance.

(1) As to <u>commercial Ordinary Life</u> policies, unquestionably many of the hazards to which substantial numbers of our people are exposed (Ops, OTR, TSS) will void the individual's previously obtained policy and make it impossible for an applicant to obtain such coverage. This is true in respect to the Face Amount, but most especially and more broadly true of the double indemnity and disability features of these policies.

This fact is subject, in part, to cover-story modification, as dictated by security.

The probability of difficulty in respect to voiding of Ordinary Life policies is deemed small, but one case is a misfortune. In the case of employee applications to Acacia and N. Y. Life, assurances from CIA as to non-hazardous duty are routinely required and this is likely to spread. In one case, denial of applied-for insurance was given.

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(2) As to National Service or U. S. Government Life Insurance. This is handsome coverage in moderate face amount for the veteran who kept it. This insurance is really cheap with no hazard exclusions, in either death or disability features.

(3) As to FECA. This is excellent coverage for the individual (in disability) and for the family in death, arising from injuries suffered in performance of duty or from diseases proximately caused by employment. All hazardous or semi-hazardous duty is covered.

A problem may lie in sufficiency of coverage for some standards of living (the maximum is $525.00 per month regardless of size of family). However, it would take an investment of $210,000.00 in U. S. H Bonds to provide such interest income.

A second problem is security, i.e., attribution to the U. S. Government in sensitive situations - but the indemnity rights here cannot be denied. This is, however, a procedural matter in the field of security - not substantive in respect to dollars.

(4) As to Civil Service Retirement Act. This is a retirement Act, but it does provide quite inadequate benefits on too limited a basis, for death arising in line-of-duty or not in-line-of-duty-- where FECA doesn't cover.

The problem here - of insufficiency - must be taken together with other available protective features which the individual may have.

(5) P. L. 110 This Act provides a very small assist in burial only.

(6) WAEPA. This is valuable moderate face amount coverage for non-accidental death - excellent coverage for accidental death. The policy is valuable because of (a) absence of exclusions in the term feature and but small limitation in the accidental death clause; (b) ease of procurement - no physical examination and immediate availability.

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The problems here are (a) its probably somewhat too high cost - as shown from our experience; (b) the security (attribution) aspects in event of death in a sensitive situation; (c) insufficiency of coverage in certain standards of living.

5 CONCLUSIONS, in respect to death.

a. There is need to seek replacement provision for potential voiding of an individual's ordinary life policy and to counter-denial of such coverage from the commercial market.

b. There is no need to seek supplemental beneficial coverage in the field of performance-of-duty.

(1) The FECA is excellent coverage; when supplemented by the optional coverage of WAEPA, and probable ordinary life (and for a veteran, NSLI) all reasonable Agency obligation and concern is satisfied.

c. It is desirable to seek, as have others, additional, better, or cheaper life coverage outside the field of performance - of - duty. Our people are young with existing and/or potential family responsibilities.

(1) The group factor here provides the potential of about 70% saving in premium cost against commercial Ordinary Life.

d. There is need to subject our WAEPA experience to actuarial scrutiny.

e. The liberal clauses in WAEPA make it an extremely desirable offering and one not to be jeopardized.

f. There is need to facilitate the individual's procurement of single trip coverage on scheduled airlines, with arrangement for such offering through-out processing. (This facility has been agreed to by Omaha--as a convenience for us - if we desire to so place it.)

g. There is need to arrange (probably as above) for trip coverage on non-scheduled and military aircraft. (It is possible to do this securely by special arrangement.)

h. The "exclusive remedy" aspect of FECA precludes the expenditure of appropriated dollars for the individual's benefit, in either premium cost or other substantive benefit in the life field. (excepting the small benefit in PL 110).

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However, because of the nature of Agency mission - its high demand for devotion, its general and overriding security demands, the Agency must be prepared to spend appropriate needful administrative dollars to back-top all proper beneficial coverage measures.

i. WAEPA shall not be denied a staff employee or staff agent at any time. The attribution factor contained in FECA is overriding. Choice must be confined to the <u>person</u> for the mission.

j. At the present time, the Task Force is not looking to legislation for resolution of our insurance problems.

k. As fully illustrated from lack of knowledge among our employees of FECA - almost entirely, and of WAEPA - less so now, we must consider new ways and means to get information over to our employees. This is vitally important first in respect to mission, then in justice to the employee and last in respect to the importance of long-time solid career development program.

l. Many aspects of the foregoing ask for technical insurance consultation with actuarial study, to conclude in respect to appropriate existing supplemental measures or self-insurance.

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6. RECOMMENDATIONS, as to death 25X1A5A1

After consultation with the [redacted] and based upon their views as to how best approach our insurance problem in respect to death, the Task Force recommends the following plan:

a. Offer to all Agency Staff employees and Staff Agents, the opportunity to secure group term life coverage with conversion privilege and premium waiver for disability along the following lines:

(1) For salaries under $3,200 annually, an optional coverage range with a minimum to equal the nearest $1,000 of salary and a maximum of $6,000.

(2) For salaries over $3,200 annually, an optional coverage range with a minimum to equal the nearest $1,000 of salary and a maximum of $15,000.

b. Add $15,000 accidental death coverage to the foregoing in each policy.

c. Provide in the plan for the same exclusion leeway as presently in the WAEPA contract and the same procedural (security) handling

25X1A5A1 [redacted] 25X1A5A1

d. [redacted]

25X1A5A2

e. [redacted]

25X1A5A1

25X1A5A2 f. Take the product of [redacted] (and of WAEPA, if any) to the [redacted] for assessment against self-insurance on the same plan. [redacted] would then not only point up the cost advantage (premiums) of self-insurance, but also outline risks to us in so undertaking.

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3. FACTS as to disability.

a. Statistics.

Ideally an Agency review of what has happened to our people in injury and illness should contemplate incidence in performance of duty, in line of duty, and outside duty - inclusive of family involvements. Such all inclusive information is not available because:

- The Chief, Medical Staff maintains no statistics,
- The records under FECA are case files, lately in Personnel and formerly in OGC, (Personnel is about to set up an effective ledger). At any event, these are only performance of duty accidents or illnesses.
- The re-imbursement program under PL 110, approved in May 1953, still waits a regulation to disseminate the information and to govern it, hence it is estimated that there are hundreds of cases which have not come to our attention unless under an Agency hospitalization or surgical plan.

Therefore excerpted from TAB C are the most important available STATISTICS under the two hospitalization and surgical plans offered to our employees (Mutual Benefit Health and Accident Association of Omaha, Neb., and Group Hospitalization, Inc., - hereinafter designated as OMAHA and GHI respectively). GHI will not give us more information than shown, - from our own records.

OMAHA

(1) Summary of Omaha Hospitalization and Surgical claims since inception in August 1948 thru 1953.

(a) Total no. of claims 1129 (679 incurred in U.S., 450 overseas); total days in hospital, 6665; ratio of claims to total no. of policy holders is 1.0 to 4.6 during 1953.

(b)

All Claims	Benefit[1]	Actual cost paid by employee	% Benefit
Total	$115,405	$172,878	67.
Hosp. Rm & Bd.	49,744	55,580	89.
Surg.	29,044	70,683	41.
Extras	36,617	46,615	78.

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(c) Total Benefit and total actual cost to employee by Geographic location:

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1/ All figured at [redacted] increased rate as of 1 September 1953.

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	Benefit	Actual cost paid by employee	% Benefit
In U. S.	$ 77,364	$129,912	60%
Overseas	38,041	42,966	86%

(d) The total actual costs paid by the employee in respect to type of service:

		% to total
Hosp. Rm & Bd.	$ 55,580	32.2
Surgical	70,683	41.0
Extras	46,615	26.8
Total	$172,878	

(e) Omaha Surgical Benefits and Actual Cost (Based on Claims Submitted Through 1953)

	Amount	Ratio of Benefits to Actual Cost
Surgical Benefits -- Total	$29044	41.1%
Operations in U. S.	21938	39.5
Operations Outside U. S.	7106	46.9
Actual Surgical Costs -- Total	$70683	
Operations in U. S.	55533	
Operations Outside U. S.	15150	

Of the above, Omaha Surgical Benefits and Actual Cost for Pregnancy Complications.

	Amount	Ratio of Benefits to Actual Cost
Surgical Benefits -- Total	$12965	37.8%
Maternity in U. S.	9435	34.0
Maternity Outside U. S.	3530	54.2
Actual Surgical Costs -- Total	$34289	
Maternity in U. S.	27774	
Maternity Outside U. S.	65.5	

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(f) Total benefit and total actual cost experience by type of illness:[2]

	Benefit	Actual cost paid by employee	% Benefit
Pregnancy and complications therefrom	$40,222	$ 72,710	55%
Gastro-intestinal	$20,783	$ 26,140	79%
160 cases of misc. small illnesses	$13,125	$ 15,754	84%
Eye, ear, nose and throat	$ 9,511	$ 14,953	63%
Genito-urinary	$ 8,664	$ 13,076	66%
Total of largest 5 categories	$92,305	$142,633	65%
Total of remaining 8 categories	$23,100	$ 30,245	71%

(g) Days hospitalized:

Less than 5 days	47%
Less than 10 days	85%
Less than 15 days	95%

(h) Type of claim:

By policy holder only	43%
By spouse only	43%
By daughters and sons only	14%

2/ 13 categories of illness groupings were specified by our consulting actuaries. The first five largest categories are those shown.

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(i) Surgical Claims only: Distribution Range of Actual Cost to Policy Holder

(Based on 683 Incidences)

Groups	Number	Per Cent	Cumulative Ratio
Total	683	100.0	
Less than $25	91	13.3	13.3
$25 thru $49	101	14.8	28.1
$50 thru $74	99	14.5	42.6
$75 thru $99	72	10.5	53.1
$100 thru $124	81	11.9	65.0
$125 thru $149	33	4.8	69.8
$150 thru $174	82	12.0	81.8
$175 thru $199	29	4.2	86.1
$200 thru $224	45	6.6	92.7
$225 thru $249	6	0.9	93.6
$250 thru $274	20	2.9	96.5
$275 thru $299	5	0.8	97.2
$300 and Over	19a/	2.8	100.0

a/ $300 - 4
335 - 1
349 - 1
350 - 5
375 - 1
400 - 3
500 - 2
550 - 1
650 - 1

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(j) Extras Claims only: Distribution Range of Actual Cost to Policy Holder.

Extras Incidence
(Based on 871 Claims)

Groups	Number	Per Cent	Cumulative Ratio
Total	871	100.0	
$25 and less	283	32.5	32.5
$26 thru $50	220	25.3	57.8
$51 thru $75	162	18.6	76.4
$76 thru $100	96	11.0	87.4
$101 thru $125	55	6.3	93.7
$126 thru $150	21	2.4	96.1
$151 and over	34a/	3.9	100.0
a/ $151 thru $175	13		
$176 thru $200	5		
$201 thru $225	5		
$226 thru $250	2		
$251 thru $275	3		
$276 thru $300	2		
$301 thru $325	2		
$326 thru $350	1		
$668	1		

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(k) Comparison of Claims paid and Premiums paid:

(On 1 Sept 53, when approached by the Agency, Omaha raised its benefits as follows:
Hosp. $9.00 per day from $6.00.
Extras $135.00 unallocated, from $30.00 allocated in only 4 fixed categories.
Extras in maternity only, to $45.00 from $30.00.
All previous claims back thru 1948 are figured on basis of the new (1 Sept 53) rates in order to evaluate properly the existing Omaha plan. Figures are therefore calculated not actual.)

Year	Claims	Premiums	% of Premiums Returned
1948-50	$18,541.67	$40,344.59	46%
-51	18,947.29	33,716.60	56%
-52	24,506.61	51,197.35	48%
-53	27,903.27	49,787.60	56%
Total	$89,898.84	$175,046.14	51%

GHI

(2) Summary of GHI hospitalization and surgical claims accepted from GHI at inception (in March 1953) for previous claims - and thru 1953.1/ GHI pays directly to the hospital and withholds dollar costs not shown.

(a) Total no. of claims 1865, total days in hospital 8651 (8350 days allowed)2/ ratio of claims to total no. of policy holders 1.0 to 4.6 during 1953. (same as Omaha)

1/ When CIA took on GHI, that association turned over to us all previous records of our employees - whether inside or outside the Agency at the time of claim. Claims accounted here therefore include those before March 1953.

2/ The difference accounted for by: Overstaying on discharge hour, overstaying on child tonsilectomy (one day allowed) adult (2 days allowed) or maternity (8 days allowed).

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(b) All Claims	Benefit	Actual cost paid by employee	% Benefit
Total	------	------	---
Hosp.	7,999 days	351 days over	96%
Surg.	$49,779	not known	---
Extras	$15,665	not known	---

(c) Total benefit and total actual cost to employee by geographic location:

Unobtainable.

(d) Total actual costs paid by the employee in respect to type of service:

Unobtainable.

(e) Total benefit and total actual cost experienced by type of illness. (Information limited to hospital days only.)

	Benefit Days	Actual Days	% Benefit
Pregnancy and complications therefrom	2,920	3,015	94%
Other (many small misc. claims)	997	1,042	96%
Gastro-intestinal	910	982	93%
Accidents	769	779	99%
Genito-urinary	676	697	96%

(f) Days hospitalized:

Less than 5 days	58%
Less than 10 days	91%
Less than 15 days	96%

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(g) Type of claim:

By policy holder only 27%

By spouse only 43%

By daughters and sons only 30%

(h) Surgical claims only: Distribution Range of Actual Cost to policy holder:

Unobtainable.

(i) Extras claims only: Distribution Range of Actual Cost to policy holder:

Unobtainable.

(j) GHI choice of coverage by the individual as of 31 March 1954 shows the following:

GHI Hospitalization only

		Nos.	
Single	-	182	
Husband and wife	-	139	
Family	-	301	
Total			622

GHI Hospitalization and Surgical

Single	-	1440	
Husband and wife	-	619	
Family	-	1314	
Total			3373
Grand Total			3995

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(3) Financial status of GHI as shown in their last two annual reports to the D.C. Insurance Dept.

(GHI operates under an Act of Congress, is not supervised by the District Insurance Dept. or District Commissioners, but makes one annual report to these offices at "any time" during the year following annual audit.)

The Wyatt Co. was asked to try to get the last report and got a "runaround" from GHI. Accordingly, representatives of the Task Force visited the District offices, viewed the audited statements for '52 and '53 made by [redacted] 25X1A5A1

(a) Audited* Balance Sheet and Operating Statement, GHI, dated 26 March '53 and 29 March '54

	For Year 1952			For Year 1953	
Balance Sheet:					
Total Assets	$4,734,841.28			$6,603,207.74	
Total Liabilities		$2,791,720.61			$2,840,415.15
Employee Pension Reserve		8,490.00			7,940.00
Unallocated Reserve and Surplus		1,009,912.36 (as of 1 Jan. '52)			1,934,630.67 (as of 1 Jan. '53)
Excess of Income over Expenses		924,718.31 (as of 31 Dec. '52)			1,880,560.14 (as of 31 Dec. '53)
			Minus		60,338.00 Depreciation
		$4,734,841.00			$6,603,207.00
Operating Statement					
Total Income		$7,839,987.42			$8,483,876.07
Total Expenses		6,915,269.11			6,603,315.93
Excess of Income**		924,718.31			1,880,560.14
% Excess to Total Income		11.8%			22.2%

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* [redacted]

** Transferred to Unallocated Reserve

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b. Existing available protective measures as to disability - excerpted from TAB D

(1) Against permanent and total disability there are these four measures:

(a) Individual's own commercial Ordinary Life policy in which disability coverage may be secured for small additional premium, or a straight commercial disability policy.

1. Commonly these disability features cost in the neighborhood of $100.00 annually for a benefit of $200.00 per month, have "white collar" risk restriction, exclusion for military service in time of war and air flight in non-scheduled service.

(b) National Service Life Insurance to which a veteran may add some disability coverage for an additional premium. (Example: $50.00 per month benefit for a yearly premium of $14.40 on a $10,000 life policy).

(c) Federal Employees Compensation Act

1. This Act provides compensation for disability (and full medical care) resulting from injuries suffered in performance of duty or from diseases proximately caused by employment for as long as the disability continues.

2. The maximum monthly benefit provides two-thirds of the employee's salary up to and including GS-13, 58% of a GS-14, and 53% for a GS-15.

(d) The Civil Service Retirement Act

1. This Act provides disability benefits for life without regard to performance of duty, provided the employee has a minimum of 5 years civilian service and is totally disabled.

2. The benefits are based on salary and length of service. A GS-9 with 8 years service (including military) would receive $50.00 per month. A GS-13 with 14 years service would receive $146.00 per month.

(2) Against temporary disability, there are these four measures:

(a) Federal Employees Compensation Act
(see b(1)(c) above)

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(b) Public Law 110

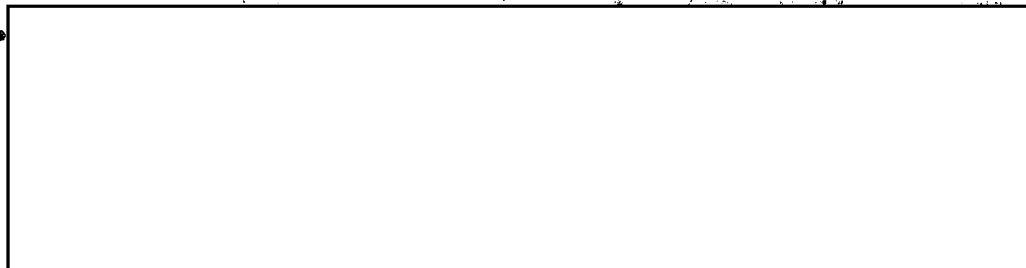
1. This Act provides benefits to employees (only) assigned to permanent duty stations outside the Continental U. S., its territories, and possessions for illness or injury requiring hospitalization and which occur in line of duty.

2. The benefits are payment of travel expenses to and from an appropriate hospital or clinic and payment of cost of treatment.

(c) A group hospitalization and surgical benefit plan administered under Government Employees Health Association (CIA), underwritten by Mutual Benefit Health and Accident Association of Omaha, Nebraska.

(d) A group hospitalization and surgical benefit plan administered under Government Employees Health Association (CIA), underwritten by Group Hospitalization, Inc.

(e) These general observations are pertinent here in respect to these two plans.

1. 

25X1

2. Both plans confine eligibility to Staff Employees and Staff Agents.

3. Omaha is superior on the whole as it stands, for the overseas employee who has his dependents with him.

4. GHI is superior on the whole for the employee resident in the U. S. but, because of the nature of the GHI hospitalisation plan, a dollar value is impossible to obtain, in the domestic cases.

5. Omaha is cheaper than GHI even if the surgical benefits were matched. (per Omaha's firm offer to match - see page 16)

6. Neither plan pays off if FECA does.

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7. Neither plan meets the criterion set by Dr. George Baehr, Medical Director of the Health and Insurance Plan of Greater New York - HIP. (See TAB E, Appendix XI for his Congressional testimony and Appendix XII for description of HIP.) i.e. benefits are almost entirely confined to hospital and surgical costs. Dr. Baehr holds that 90% of the costs of illnesses arise outside a hospital - in the doctor's office and in the home. This view suggests remedying our unsatisfactory situation as to a hospitalization and surgical plan as such and then dealing with outside hospital costs separately.

8. Neither plan offers catastrophe insurance which, written on a "deductible" basis (the same principle as in automobile collision insurance), is a relatively cheap addition.

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(f) **Detailed comparison of Omaha and GHI**

1.

OVERSEAS	OVERSEAS
OMAHA — Hospitalization	GHI — Hospitalization
1. Hosp. Board & Room: $9 per day for 31 days with no limit on frequency, plus $135 for hospital extras.	1. Hosp. Board & Room: $10 per day for 21 days with 90 day interval on frequency, plus $64 for hospital extras.
2. Plus surgical as shown below.	2. Plus surgical as shown below.
3. Plus out-patient emergency up to.......... $ 135 within 24 hours of accident	3. Plus out-patient emergency up to... $ 10 within 2 hours of accident
4. Effective date. 1st of the next month.	4. Effective date. 1st of the next month.
5. Waiting period. Maternity only. 9 months but coverage extends 9 months beyond termination of contract.	5. Waiting period. None if participation is 75% of GEHA and no extension beyond termination of contract for pregnancy.
6. Maternity. $9 per day for 14 days plus up to $45 total for Hosp. extras.	6. Maternity. $9 per day for 8 days except Caesarean, termination of ectopic pregnancy and miscarriage, for which hospitalization benefits are 1. above
7. T.B., mental and nervous disorders and quarantinable diseases - same as No. 1. above.	7. T.B., mental and nervous disorders and quarantinable diseases - 10 day limit in any 12 month period for No. 1. above.

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2. WASHINGTON

OMAHA **Hospitalization**

1. Hosp. Board & Room: $9 per day for 31 days with no limit on frequency Plus $135 max. for hospital extras

2. Plus surgical as shown below ---

3. Plus out-patient emergency up to within 24 hours of accident $135

4. Examples (Hospitalization only):

Bd. & Room		Normal
$ 90		appendectomy
270		comp. fracture
126	Plus a maximum of $135	bilat. hernia
90	to cover all hospital	unilat. hernia
126	extras	hysterectomy
90		hemorrhoidectomy
27		tonsillectomy

5. Same as overseas

6. Same as overseas

7. Same as overseas

WASHINGTON

GHI **Hospitalization**

1. Hosp. Complete Service for 21 days (semi-private. partic. hospital) with 90 day interval on frequency $10 per day if in private room. Plus $5 per day for additional 180 days

2. Plus surgical as shown below ---

3. Plus out-patient emergency up to within 2 hours of accident $10

4. Examples (Hospitalization only):

	Bd. & Room#1 (diff.)		
10 days	$ 135	(/ 45)	Plus the hospital extras,
30 "	405	(/135)	(16 listed) which range
14 "	189	(/ 63)	from $50 for the simplest,
10 "	135	(/ 45)	uncomplicated appendectomy
14 "	189	(/ 63)	to very substantial
10 "	135	(/ 45)	amounts for the serious
3 "	40	(/ 13)	or complicated case.

Net = 50% greater on Board & Room than OMAHA

#1 - Basic costs of Board & Room @ $13.50 per day (typical presently) is absorbed by GHI completely.

5. Same as overseas

6. Same as overseas

7. Same as overseas

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3.

Overseas and Domestic

OMAHA **Surgical**

$ \$ \frac{1235}{16} = \$ 77 $

This is 60% of GHI

(Example)

OMAHA	Procedure	GHI
$ 50	Hernia Ing. util	$ 100
75	Hernia Ing. bilat	140
100	Appendectomy	100
100	Radical Mastectomy	175
50	Fracture of spine	125
35	Hip dislocation	75
150	Prostatectomy	200
50	Normal delivery	80
100	Caesarean	150
150	Removal of Kidney	175
50	Removal of Cataract	150
100	Gastrectomy	250
25	Tonsillectomy	55
25	Adenoidectomy	55
25	Hemorrhoidectomy	60
150	Hysterectomy	165
$1235		$2055

(The above, of course, disregards frequency of occurrence - is set forth as a quick look.)

GHI **Surgical**

$ \$ \frac{2055}{16} = \$ 128 $

N.B. The surgical fees scheduled are accepted by the surgeon as full payment for a single participant if his income does not exceed $3000.00 and, for a family participant, if the family income does not exceed $5500.00.

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4. OMAHA Premiums (monthly) — GHI Premiums (monthly)

OMAHA Hosp.	OMAHA Surgical	OMAHA Total		GHI Hosp.	GHI Surgical	GHI Total	Diff.
--	--	$1.60	Individual contract..........	$1.70	$1.00	$2.70	+ 1.10
--	--	4.75	Individual & spouse contract.	3.70	3.20	6.90	+ 2.15
--	--	6.00	Indiv. & spouse & children...	3.70	3.20	6.90	+ .90

If OMAHA should match GHI on surgical, monthly total premiums would be:

Total	Total	Diff.
$1.60 + .16 = $1.76	$2.70	+ .94
4.75 + .89 = 5.64	6.90	+ 1.26
6.00 + .80 = 6.80	6.90	+ .10

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(g) Summary comparison of these two plans:

1. Overseas general hospitalization
OMAHA is far superior to GHI.

2. Overseas maternity hospitalization
OMAHA is substantially superior to GHI in normal pregnancy. In the cases involving Caesarean, termination of ectopic pregnancy and miscarriage (av. 10%, per Dr. Tietjen), GHI is substantially superior.

3. Overseas surgical
OMAHA is only 60% as good as GHI.

4. Domestic general hospitalization
OMAHA is substantially INFERIOR to GHI in either a normal or abnormal case.

5. Domestic maternity hospitalization
OMAHA is substantially superior to GHI in normal pregnancy. In 10% of the cases involving Caesarean, termination of ectopic pregnancy and miscarriage, GHI is substantially superior.

6. Domestic surgical
OMAHA is only 60% as good as GHI.

7. Fees are the same in each plan as between overseas and domestic. However, OMAHA's fees are all lower than GHI. For individual contract OMAHA charges 60% of GHI; for individual and spouse OMAHA charges 70% of GHI; for individual, spouse and children OMAHA charges 88% of GHI, but GHI doesn't offer just an individual and spouse contract at a lower rate than one inclusive of children.

8. Net on the above - if OMAHA's surgical could meet GHI, it is a better plan than GHI for overseas if the dependents are with the employee. Even if OMAHA's surgical meets GHI, it is not as good a buy for domestic assignment.

9. As to hospitalization, the two plans are strictly comparable in respect to an overseas location of the individual with family, but impossible of comparison in the domestic situation. This is because the GHI hospitalization benefit is buried under the completely untranslatable "full service benefits" with participating hospitals. While the non-complicated case calls for a minimal few hospital extras, the complicated case under GHI gets 16 of them free and as many times as necessary. These variables cannot be assessed dollar-wise for purpose of comparison with OMAHA.

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Even though it is true that the seriously complicated case is statistically in the low frequency category, the great dollar benefits under GHI are nevertheless there for the individual who wants to insure against precisely such a risk.

It may be held that benefits in a serious case ride on the backs of the non-complicated majority in respect to fees, and also that throwing in "the works" for every member is misleading persuasion. However, the minority who do get caught in heavy extras can't pay with statistics. The simplest and blandest appendectomy calls for about $50.00 in hospitalization extras. From there it could go anywhere in cost while the patient still lives.

a. Pregnancy hospitalization contains the same problem but not as seriously so. In 90% of pregnancy cases - the normal ones - OMAHA is a better buy, but not so if one wishes to insure against costs arising out of the minority of cases (i.e. Caesarean section, termination of ectopic pregnancy or miscarriage). Here GHI is superior.

b. Again in the domestic hospitalization field GHI adds a fillip for the unusual case and offers $5.00 per day for 180 days on top of the 21 "full" service benefit days. (Room and board plus 16 named extras.) Strictly from the point of view of frequency statistics, this might be labeled a "come-on".

c. Also, in the GHI brochure is seen the same hand as immediately above, i.e., the illustrated cases are not the usual ones. They are in the relatively infrequent category, but because there are but three of them, the coloration seems to be present. These cases are cancer ($1449.15 benefits), fractured vertebrae ($337.05 benefits) and gall stones ($518.90 benefits).

d. GHI requires a 90 days interval between discharge and re-entry to a hospital. OMAHA requires one day. Here GHI is inconsistent with the preceding tactics as to minority occurrences.

e. OMAHA's fee schedule is superior both in dollars.

f. GHI, being so firmly enmeshed in legislation and so integrated with the large and necessarily unwieldy Blue Cross, presents practically no possibility of modification in plan to suit us, whereas OMAHA is completely flexible - even to a tailored plan.

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g. OMAHA's service to us in the settlement of claims (per [redacted]) is "vastly better" than GHI. Mr. [redacted] characterizes GHI as a "bickering, negotiating outfit".

25X1A9A

h. "Fine Print".
Comparison of these two plans in some small items is important also because of the effect in irritation and dollars.

25X1A9A

-- Ambulance.
GHI won't pay to and from a hospital; Omaha will.

-- X-Rays.
GHI won't pay unless the X-Ray is in connection with surgery performed within three days' time. Omaha will pay with no surgery nor time restriction if the X-Ray is taken in a hospital or clinic.

-- Hospital Extras.
GHI will pay on sixteen specific hospital extras without limit. Omaha pays on all extras up to their established maximum of $135.00.

-- Type of Hospital.
GHI's reimbursement is dependent upon type of hospital, as follows:

Participating hospital - full benefit; member hospital of another hospital service plan gets the prevailing service of that plan; non-participating hospital gets only up to $10.00 per day for 21 days, plus $64.00 for hospital extras (the same as the GHI overseas rate). Omaha on the other hand reimburses the same all over the world in any hospital of the individual's own choice.

-- Room and Board.
The "full service benefit days" under GHI pertains to a semi-private room, but if the individual chooses or really needs a private room, GHI allocates only $10.00 per day. Omaha on the other hand pays the contract guarantee for any accommodation.

-- Dependent Children.
Under GHI, they are added when 90 days old, and carried to the 18th birthday. Under Omaha, they are added when 14 days old and carried to the 19th birthday. This may well be important in connection with congenital anomalies.

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-- Tuberculosis and Mental or Nervous Disorders.
Under GHI, these are covered for only 10 days during any 12-month period. Under Omaha, they are covered for the same number of days and same frequency (one day break only) as all other accidents or illnesses.

-- Congenital Anomalies. (viz: cleft palate, congenital hernia)
Under GHI, not covered at all. Under Omaha, full coverage at any age, after 14 days from birth.

-- Outpatient Emergency First Aid.
GHI requires reporting within two hours of accident, else they won't pay. Omaha allows 24 hours.

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4. DISCUSSION.

a. Noting: that there exists in the commercial market beneficial coverage for permanent and total disability, as well as various and sundry plans for individual purchase in temporary disability; that FECA is excellent coverage for either permanent or temporary disability occurring in performance of duty; that CSRA is poor coverage for an agency the personnel of which is young, outside of performance of duty; - the Agency is properly concerned to offer its employees the benefit of group rates for temporary disability that includes family protection. This coverage is found in a hospitalization and surgical plan.

b. It is possible to buy practically anything in this field - at a price. The problem is - what coverage features should we offer and how far should they go.

(1) The latter brings to mind the importance of the principle of co-insurance, as to catastrophic or low-incidence excessive costs where-in given features are covered up to a normal or average-circumstances extent and from that point on the insurer carries the larger burden with the individual sharing a part of it. The philosophy is roughly that of automobile collision insurance with a $50.00 or $100.00 deductible clause.

c. The Agency's offer of two largely non-comparable hospital and surgical plans to its employees is failure to meet its proper personnel responsibility. It is rolling with whatever an outsider has to offer. It fails to utilize Agency strength to get a one best plan which defers to operational and security circumstance, and to the facts of illnesses.

d. Omaha's original grievously inadequate plan - in effect until 1 Sept. '53 - and improved somewhat then, is a sad reflection on us. Their improved plan is some better, but not nearly enough so.

(1) Then to offer GHI, - by and large poorer than Omaha overseas - in this heavily overseas business is to compound our error. This is particularly so in light of Omaha's flexibility i.e. complete willingness to tailor a plan, and its 100% security. (Omaha will accept Agency certification of circumstance and pay to anyone to whom and how we designate.) The Agency also forgot that this rigid association - GHI prevents us from gaining the advantage of our own experience (presumably better); hence in our premium rates we carry poorer risks than we, and deprive ourselves of downward adjustment as deserved.

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e. It is suggested that the Omaha experience is statistically sufficient to provide a critical basis for assessing our coverage needs. Accordingly these general conditions seem indicative.

(1) The incidence of actual cost hits heaviest in the surgical field (41%), Hospital board and room is next (32%) and hospital extras are seen not to occupy as great importance as often thought (27%).

(2) Pregnancy and complications therefrom, stand out with heavy incidence. 42% of the employees' total actual costs are in this one field.

(3) Hospitalization coverage beyond 15 days is for the last 5% of incidence, but the insurance company knows its premium rate carries no real burden when coverage extends from 15 to 31 days. (Experience identical under GHI).

(4) The same observation, - as in (3) above obtains in respect to surgery. Total actual costs are almost entirely below $300. - (97%). One can cover the unusual, even beyond actual incidence for no real premium burden.

(5) Equally so - as in (3) and (4) above, the picture of total hospital Extras cost conforms. 96% are covered in a plan embracing up to $150.

(6) Indeminification return of premiums paid at 50% under the present Omaha plan is woefully insufficient. Omaha admits it.

(7) Indeminification return of actual costs to the employee at 67% is not enough.

(8) Omaha admits that its surgical coverage with 41% indemnification on actual costs is poor.

f. GHI's attitude is that of doing us a favor. When 25X1A9A [redacted] (Task Force member and Chief, Insurance and Claims Branch, Employee Services Division, Office of Personnel), approached them for some modest statistics concerning our own experience the response was: "If you require this kind of information, it might be better for you to take your business elsewhere." Also they refused us and Wyatt a balance sheet.

g. GHI's balance sheet and Operating Statement reveal a reserve accumulation that might be warrantable in a catastrophic-coverage situation - which they don't have. Liabilities under their plan are predictable, by and large; the premium rates, producing a 12%

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gross profit in 1952, and a ratio of assets to liabilities of nearly 2 to 1 seem out-of-line with true risk assumed.

h. Under the GHI plan, if an employee cannot reveal Agency affiliation, indemnification is at the poor overseas rate - poorer than the existing Omaha inadequate rate. The employee cannot get the "full-service benefit" day as in an overt domestic situation.

i. GHI's plan means that we will never know where we stand - experience versus premiums and never get the benefit of our experience if it proves better than others. Omaha offers to do this.

j. GHI's inter-plan feature (wide-spread Blue-Cross tie-in) is countered by Omaha's willingness to continue coverage for the terminated individual at a non-group rate without medical examination or statement of health, - as long as he wishes - or until he acquires membership in a new group plan. (The non-group premium is 20% higher.)

k. With the differing benefits of Omaha and GHI, overseas versus domestic, the employee is pulled about in his attempt to secure adequate coverage. This is highly unsatisfactory.

l. The 3 types of contract offered by Omaha show these premium differentials - :

(1)	Individual contract premium	\$1.60 (monthly)
(2)	Individual and spouse contract premium	\$4.75 (monthly)
(3)	Individual, spouse and children contract premium	\$6.00 (monthly)

GHI combines the 2nd and 3rd groups above into a single premium rate which means that 758 #2s are carrying part of the cost for 1615 #3s. Perhaps the #1 rate contains a cut of this burden also.

The youth of our Agency (2/3 under 35 years of age) suggests that the single individual plus individual and spouse help carry, in premium rates, some of the family contract burden.

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5. CONCLUSION

a. Both the Omaha and GHI plans are entirely unsatisfactory.

(1) Neither plan offers enough.

(2) Neither plan offers opportunity to relate premiums to our experience.

(3) Neither plan takes advantage of actual previous experience in its coverage features.

(4) Neither plan takes advantage of the co-insurance philosophy to base premium rates in the higher incidence circumstances and still protect the minority substantially.

(5) Security-wise only Omaha offers - or can offer a completely satisfactory situation for the employee who cannot admit Agency affiliation.

(6) The Agency must offer <u>one</u> <u>best</u> plan.

(7) Adding the tangibles and intangibles in the forgoing comparisons, Omaha offers excellent and the only potential for improvement.

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6. RECOMMENDATION

a. The Agency accept and offer to its staff employees and staff agents, the new Omaha plan (next hereto) proposed by the Task Force and worked out with the local Omaha office together with Mr. A. W. Randall, head of the Omaha Company's Group Insurance Department, and Mr. Gale Davis, Omaha's No. 1 vice-president.

b. That the DD/A and General Counsel proceed from here on to embody this plan in a contract.

c. That AD Personnel take over responsibility for appropriate Agency publicity on the plan and continue the study of any possible amendment for coverage of home and doctor's office costs.

d. That the Task Force go out of business in respect to disability insurance.

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Present Omaha Contract

OVERSEAS

e. OMAHA — Hospitalization

1. Hosp. Room & Board: $9.00 per day for 31 days with no limit on frequency, (1 day break) plus $135.00 for hospital extras except maternity - see #5 below.
2. Plus out-patient emergency up to............. $135 within 24 hours of accident
3. Effective date of Contract - 1st of next month
4. Waiting period. Maternity only. 9 mos., but coverage extends 9 mos. beyond termination of membership
5. Maternity - $9.00 per day Room & Board for 14 days plus up to $45.00 total for Hosp. extras
6. TB, mental disorders, nervous disorders and quarantinable diseases - same as #1 above
7. Ambulance - pays
8. X-ray - pays - no restriction if in hospital or clinic
9. Dependent Children - added after 14th day to 19th birthday
10. Congenital Anomalies - full coverage at any age after the 14th day following birth
11. Pre-existing conditions - covered
12. Laboratory tests - all covered

Present GHI Contract

OVERSEAS

f. GHI — Hospitalization

1. Hosp. Room & Board: $10.00 per day for 21 days with 90 day interval on frequency, plus $64.00 for hospital extras (16) except maternity see #5 below.
2. Plus out-patient emergency up to.............. $ 10 within 2 hours of accident
3. Effective date of Contract - 1st of next month
4. Waiting period. None for the applicant who joined initially in March 1953 or for the EOD since then. Otherwise 10 months for maternity, tonsillectomy, adenoidectomy and 1 year for all pre-existing conditions.
5. Maternity - $9.00 per day Room & Board for 8 days except Caesarean, termination of ectopic pregnancy and miscarriage, for which hospitalization benefits are 1. above
6. TB, mental disorders, nervous disorders and quarantinable diseases - 10 day limit during any 12 month period for #1 above
7. Ambulance - doesn't pay
8. X-ray - pays only if connected with surgery within 3 days and in a hospital
9. Dependent Children - added after 90th day to 18th birthday
10. Congenital Anomalies - not covered
11. not covered if membership falls below 75%
12. only initial test - urinalysis and blood count only

The New Omaha Plan

OVERSEAS

g. NEW OMAHA — Hospitalization

1. Hosp. Room & Board: $9.00 per day for 90 days with no limit on frequency (1 day break) plus Hosp. Extras: $135.00 unallocated, except maternity - see #5 below.
2. Plus out-patient emergency up to............. $135 within 24 hours of accident
3. Effective date of Contract - 1st of next month
4. Waiting period. None if participation of members is 75% of GEHA, and none on transfer from GHI, except for maternity wherein in all cases waiting period is 9 months, but coverage extends 9 months beyond termination of membership.
5. Maternity - $9.00 per day Room & Board for 8 days, except Caesarean, termination of ectopic pregnancy and miscarriage, for which hospitalization is #1 above (Omaha's National average for normal delivery is 6.6 days)
6. ~~Same as Present Omaha Contract.~~ Same as No. 1 above
7. Ambulance - pays
8. X-ray - pays - no restriction if in hospital or clinic
9. Dependent Children - added after 14th day to 19th birthday
10. Congenital Anomalies - full coverage at any age after the 14th day following birth
11. covered
12. all covered

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No.			
14.	Diagnosis - covered	not covered	covered
15.	Service connected disability - covered	not covered	covered
16.	Physical therapy - covered	not covered	covered
17.	Specify members of family for coverage - No	Yes - Name and date of birth must be sent in, otherwise not covered	No specification
18.	Private nurses - not covered	not covered	not covered
19.	Premium based on experience - Yes	No	Yes, yearly modification possible
20.	Rest cures - covered	not covered - a named exclusion	covered #1 above
21.	Plastic surgery - covered	not covered unless the injury is received after individual is a subscriber	covered regardless of when injury was received
22.	Dental surgery	if hospitalized will pay only if performed by an M. D.	if hospitalized will pay if performed by a dentist, a dental surgeon or an M. D.

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WASHINGTON

OMAHA — Hospitalization

1. Hosp. Room & Board: $9.00 per day for 31 days with no limit on frequency (1 day break) plus $135.00 max. for hospital extras

2. Plus out-patient emergency up to............. $135 within 24 hours of accident

3 thru ~~18~~ 22. Same as Overseas

Same as Washington

WASHINGTON

GHI — Hospitalization

1. Hosp. Room & Board plus 16 named extras for 21 days (Semi-pri. - Partic. Hospital) with 90 day interval on frequency plus $5.00 per day for additional 180 days. If private room, $10.00 per day only for Room & Board.

2. Plus out-patient emergency up to.............. $ 10 within 2 hours of accident

3 thru ~~19~~ 22. Same as Overseas

DOMESTIC U.S. OUTSIDE WASHINGTON AND CANADA
- If in participating hospital, the benefits are those of local Blue Cross in the area
- If in non-participating hospital, the benefits are the same as the overseas rates

WASHINGTON

NEW OMAHA — Hospitalization

1. Hosp. Room & Board: $13.50 per day for 90 days with no limit on frequency (1 day break) plus hosp. extras of $202.50 unallocated plus 75% of the next $5,000.00 of hosp. extras

2. Plus out-patient emergency up to............. $202.5[illegible] within 24 hours of accident

3, 4, 6 thru 10. Same as Overseas

5. Maternity - $9.00 per day for 8 days except for Caesarean, termination of ectopic pregnancy or miscarriage for which hospitalization is the Washington #1 above

Same as Washington

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$ 50	Hernia Ing. unil	$100.	$100.
75	" " bilat	140.	140.
100	Appendectomy	100.	100.
100	[illegible]ectomy	175.	187.50
50	Fracture of spine	125.	93.75
35	Hip dislocation	75.	43.75
150	Prostatectomy	200.	187.50
50	Normal delivery	80.	80.00
100	Caesarean	150.	150.
150	Removal of kidney	175.	250.
50	" " cataract	150.	187.50
100	Gastrectomy	250.	250.
25	Tonsillectomy	55.	55.
25	Adenoidectomy	55.	55.
25	Hemorrhoidectomy	60.	62.50
150	Hysterectomy	165.	165.
50	Amputation-arm, foot	85.	125.
50	Skull fracture-compound	200.	250.
50	Fracture of base of spine	35.	62.50
35	Branchoscopy	25.	50.
25	Varicocele removal	50.	62.50
75	Thyroid removal	200.	187.50
75	Mastoidectomy, Simple	150.	125.
100	" , radical	200.	187.50
$1695.		$2920.	$3158.50
Average $71. 58% of GHI		Average $122.	Average $132.

OMAHA Premium (monthly) Hosp.	Surgical	Total		GHI Premium (monthly) Hosp.	Surgical	Total	NEW OMAHA Premium (monthly) Hosp.	Surgical	Total	Diff.
----	----	1.60	individual contract	1.70	1.00	2.70	----	----	2.70	----
----	----	4.75	indiv. & spouse contract	3.70	3.20	6.90	----	----	7.98	+1.08
----	----	6.00	indiv. & spouse & children	3.70	3.20	6.90	----	----	7.98	+1.08

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DEATH STATISTICS
STAFF EMPLOYEES AND STAFF AGENTS FOR CIA AND STAFF EMPLOYEES FOR STATE AND AGRICULTURE

1. A Comparison of death incidence with the Foreign Service, and Departmental, Department of State; and with Department of Agriculture Beneficial Association; and with U. S. mortality tables.

	1947	1948	1949	1950	1951	1952	1953	Average '51 '52 '53
CIA e/								
Total in service deaths								
Av. Monthly Strength								
Deaths per 1000 (physical given)								
State b/ - Foreign Serv.								
Total in Service deaths	-	-	10	15	8	5	8	7
Av. Monthly Strength	-	-	5378	7898	8692	8993	7562	8416
Deaths per 1000 (physical given)	-	-	1.86	1.90	.92	.56	1.06	.83
State - Departmental								
Total in Service deaths	-	-	7	18	17d/	19	12	16
Av. monthly strength	-	-	10630	7870	9316	10046	8166	9176
Deaths per 1000 (no physical exam	-	-	.66	2.29	1.82d/ (1.29)	1.82	1.47	1.75 d/ (1.54)
Agriculture Ben. Assn. c/ (includes Retirees)								
Total deaths incl. sep'd	-	-	182	234	190	217	232	213
Strength of Ass'n.	-	-	16122	16193	16161	16045	16080	16095
Deaths per 1000 (no physical exam)	-	-	11.3	14.5	11.8	13.5	14.4	13.2

25X9A2

U.S. population as a whole (deaths per 1000)

(1) Estimate for 1951 by the World Almanac 9.7
(2) U.S. Public Health Service for 1952 . . . . 9.6

a/ b/ and c/ - See Tab E for sources.
d/ Contains 5 deaths from single plane crash. If not included, the ratio is shown in ( ) above.
e/ Not separated from service.

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2. Comparison by Office (CIA) (37 Total for years '52 and '53 only)

	DD/P	DD/I	DD/A	COMMO	OTR
1952	10	6	2	0	1
1953	6	3	5	2	2
Total	16	9	7	2	3
Average	8	4.5	3.5	1	1.5

Average Monthly Strength

Deaths per 1000

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*Statistically Insignificant

3. Comparison by Office (69 Total all years)

DD/P	DD/I	DD/A	COMMO	OTR	REGISTRY DCI
26	22	14	3	3	1

4. Place of death (CIA) (69 Total - all years)

25X1

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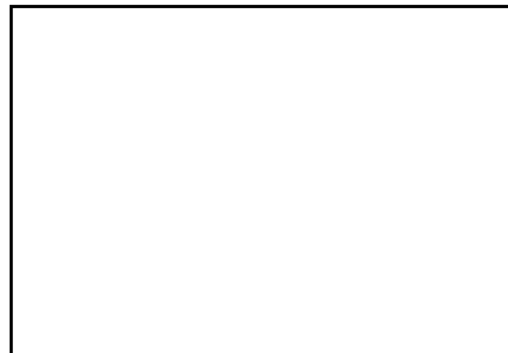

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5. Causes (CIA):

				U.S. Pop. a/
a.	Heart	25	(35%)	32.5%
b.	Cancer	11	(16%)	13.7%
c.	Suicide b/	6	(9%)	1.1%
d.	Ulcers, Obstruction, Peritonitis	6	(9%)	
e.	Polio (3) Diphtheria (1)	4		
f.	Complications following operation	2		
g.	Accident not in line of duty	5	(7%)	

By fire while trysting 1
By air crash on LWOP 1
By mountain climbing 1
By auto collisions 2

h. Accident in performance of duty 8 (12%)

By explosion of gasoline 1
By air crash (Sched.) 3
By air crash (Non-Sched.) 1
By boom of crane 1
By ship sinking 1
By shooting (2nd party) 1

i. By enemy action 2

TOTAL 69

(PERFORMANCE OF DUTY TOTAL: 10 (14.7%) c/)

6. U. S. Public Health Service 1948 Vital Statistics for U. S. Population as to death from "selected causes" (most). Rates per 1,000 of mid-year population.

All Causes	All Ages	9.885
Heart	" "	3.227
Cancer	" "	1.349
Suicide	" "	.112

Ages	15-24	25-34	35-44	45-54	55-64	65-74
All Causes	1.424	1.977	3.976	9.048	19.358	44.035
Heart	.085	.208	.854	2.918	7.259	17.908
Cancer	.056	.168	.598	1.718	3.789	7.347
Suicide	.047	.090	.147	.208	.255	.288

a/ U. S. Public Health Service 1948
b/ 5 suicides in DD/P
c/ 8 Performance of Duty in DD/P

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7 CIA ages at death for all cases (49) in the years 1951, 1952, 1953

Age	Cumulative Totals	Percent of Grand Total
Under 25	4 cases	8
" 30	14	28
" 35	19	38
" 40	23	46
" 45	29	58
" 50	33	66
" 55	40	80
" 60	44	88
" 65	47	94
" 70	47	94
" 75	49	100

8. CIA ages related to total deaths for the same age groups (Cumulative % to total in both cases)

	Age Distribution a/	Death Distribution b/
Under 25	16%	8%
" 30	42%	28%
" 35	64%	38%
" 40	79%	46%
" 45	89%	58%
" 50	95%	66%
" 55	97%	80%
" 60	99%	88%

a/ As of 30 June 1953 (no significant change as of Jan. '54)
b/ 3-year totals - 1951, 1952, 1953.

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9. Ages at death in 3 categories (Total Agency S.E. & S.A. '47-'53, incl.)

Note: Total of 42 in these 3 categories is 62% of grand total)

Age	Heart (25)	Cancer (11)	Suicide (6)	(Location)
24		1		
25				
26				
27			1	
28				
29			1	
30	1			
31				
32				
33	1		1	
34				
35			1	
36	1			
37				
38	1			
39	11			
40	1	11		
41			1	OTR US
42		1		
43			1	FE US
44	1	1		
45		1		
46	11			
47				
48		1		
49	1	1		
50	1			
51	111			
52				
53	1			
54	1			
55				
56				
57	1			
58		1		
59	1 1			
60				
61	1			
62				
63		1		
64	1			
65	1			
66				
67				
68				
69				
70		1		
71	1			
72	1			

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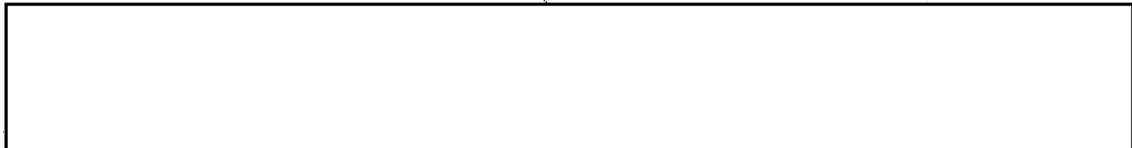
AGES OF EMPLOYEES (STAFF EMPLOYEES AND STAFF AGENTS ONLY)

	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	No. Over 65
State Foreign Svc.	396	1225	1294	1017	598	438	287	208	92	≠ 29
Cum. No.		1621	2915	3932	4530	4968	5255	5463	5555	
Cum. %	7.1	29.	52	70	81	89	94	98	99	
Departmental	337	710	952	866	713	515	358	257	130	≠ 56
Cum. No.		1047	1999	2865	3578	4093	4451	4708	4838	
Cum. %	6.9	21.4	41.	58.5	73	83.2	91.	96.	99	

CIA a/
Cum. No.
Cum. %



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a/ CIA [redacted] Figures are as of 31 Dec. 1953 from Research Branch, Plans, Research & Development Staff, Office of Personnel.

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TAB B

1. Facts in respect to death - as to existing available protective features in beneficiary coverage. These are:

a. Commercial Ordinary Life policies*

(1) Most importantly for us is the matter of exclusions from coverage - and here the policies vary considerably. However, some aspects which are generally common are these:

(a) The incontestibility period for all features of the policy is 2 years (all of those listed except New York Life, which is 1 year).

(b) The Basic (Face amount) Policy contains airflight exclusion as follows:

Any flight operated for military purposes or where the insured individual acts as a crew member, has duties aboard, parachutes or participates in a flight having testing, experimental or training purposes.

Non-Scheduled Airlines are not dealt with explicitly as such except by Prudential which won't cover any such flight.

(c) Invariably, all flights as a passenger in commercial scheduled airlines of any country are covered risks today. **

(d) The Basic (Face amount) Policy contains war exclusions (declared or undeclared war) as follows:

Death arising from an act of war while in either military or civilian service outside the Home Areas or within 6 months after return to Home Areas. ***

* Examination was made of sample policies from: Acacia, John Hancock, N. Y. Life, Omaha Un. Ben. Life, Guardian, Prudential, Travelers, Lincoln Nat'l., Penn Mutual.

** "Scheduled Airlines" are commonly defined as follows: "Aircraft operated on schedule for commercial purposes by an incorporated and governmentally certified Scheduled Commercial Air Carrier over an established route between specified airports."

*** The Home Areas are commonly defined as the U.S., Canada, Panama, D. C., T.H., Puerto Rico and Virgin Islands.

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(e) The Double Indemnity (twice the Face Amount) accidental death feature contains all the foregoing exclusions plus self-inflicted cause, illness or disease, gas or fumes, assault or felony, war, insurrection, riot, military service during time of war, and air flight in non-scheduled airlines.

(2) The risks of Agency hazardous and semi-hazardous duty <u>not</u> covered by Ordinary Life policies are:

(a) In respect to the Basic (Face Amount) policy:

<u>1</u>. Air flight in military or non-scheduled planes for the purpose of testing or training (TSS and TRS), for military purposes (OPS), acting as a crew member or with duties aboard, parachuting (OPS), and in some cases as a passenger in non-scheds (TRS, TSS, OPS).

<u>2</u>. Exposure to an act of war (declared or not), military or civilians while outside home areas or during six months after return.

(b) In respect to the Double Indemnity Accidental Death feature:

<u>1</u>. All of the above plus exposure to disease, illness, gas or fumes, assault, felony, riot, insurrection, military service, and air flight in non-scheds as a passenger.

(3) It is to be noted that in addition to the above listed risks, there are 16 hazardous duty risks which, if revealed in the candidate's application for insurance or ferreted out by the agent, would probably either exclude acceptance or provide coverage, in some cases, at an excessive premium. However, given acceptance of the candidate on a non-hazardous occupation description, the policy is insecure for two years (the contestibility period). The insurance companies are already suspicious of us.

b. <u>National Service Life Insurance or U. S. Government Life Insurance</u>

(1) Both of these policies are GI - the latter available in World War I, and since, to <u>that</u> veteran if in active service, and NSLI during and since World War II without previous service. The only difference is that U. S. Government Life has a double ability feature for a small additional premium - NSLI does not.

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TAB B

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(2) Both of these policies are incontestible from date of issue for any cause except fraud, in both death and disability features. i.e., NO exclusions.

c. Federal Employees Compensation Act

(1) This act provides compensation for disability, death and medical care (including hospitalization) resulting from injuries suffered in performance of duties or from diseases proximately caused by employment. Exclusions from coverage are disabilities or death resulting from willful misconduct, self-inflicted action, or intoxication.

(2) FECA - as to death benefits *

(a) Burial expenses up to $400.00 plus transportation of remains to home.

(b) Widow, no other dependents. 45% of pay ** not to exceed $525.00 monthly until her death or remarriage.

(c) Widow with 2 unmarried children under 18 years of age. 40% of pay to widow plus 15% for each child (total 70%) not to exceed (75% of pay in any case) $525.00 total per month until death or remarriage of widow and until children marry, die, or reach 18 years of age as to their part.

(d) No widow, 2 unmarried children under 18 years of age. 35% of pay for one child, 15% for the other not to exceed (75% of pay in any case) total of $525.00 per month until children marry, die, or reach 18 years of age.

(3) In summary, continuing death benefits to beneficiaries arising from injuries suffered in performance of duty or from disease proximately caused by employment are these - for the situations illustrated:

* The statement of benefits below is translated later here with chosen examples.

** The pay or salary rate for this purpose includes all amounts withheld for tax and retirement purposes plus value of subsistence, quarters and other considerations as part of pay.

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	Beneficiary	GS-11 Employee dies in U. S.	GS-11 Employee dies in Frankfurt*	
(a)	Widow only	$222.75	$256.50	(monthly)
(b)	Widow and 2 children	328.16	399.00	(monthly)
(c)	2 children only	239.16	285.00	(monthly)

(4) This act is an exclusive remedy, but does not prevent the beneficiary from electing to receive the benefits of the Civil Service Retirement Act if she so desires, but she cannot receive such benefits concurrently with those under FECA.

(5) All hazardous duty or semi-hazardous duty risks run by Agency employees are covered by FECA under the conditions of performance of duty or proximate cause resting in employment.

d. Civil Service Retirement Act

(1) This Act provides death and disability benefits to employees of the U. S. Government with and without performance or line of duty qualification provided the employee has acquired minimum eligibility of a total of five years of civilian service ** - intermittent or otherwise. As noted in the previous analysis of FECA, no continuing benefit under this Act can run concurrently with FECA benefits. The individual concerned (employee or beneficiary) may choose.

(2) Exclusions from coverage are common with FECA, i.e., willful misconduct, vicious habits and intemperance, with respect to disability only.

(3) The continuing benefits are annuity, in nature, computed as a percentage of the highest five-year average base salary modified by the years of creditable service. Military service can be added to the civilian years for this computation. No additions for overseas allowances are permitted as in the case of FECA.

* "Pay" includes the addition of $900.00 quarters allowance annually.

** Under 5 years of service, or more than 5 years with no widow or dependent children, the Act provides for a lump sum of amount paid-in, plus interest.

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(4) As to death benefits: *

(a) Widow - no other dependents.

50 % of employee's then annuity benefit, attainable when widow reaches age 50, and terminable when she dies or remarries.

(b) Widow and 2 children. Immediately payable.

50% of employee's then annuity benefit, plus to each child 50% of the widow's annuity, not to exceed $900.00 annually, divided by the number of children, or $360.00 annually, whichever is lesser - terminable to each child on death or marriage or attainment of age 18, except that if such child is incapable of self-support, terminable on death, or marriage or recovery. Upon death of widow, recompute as in (c) below.

(c) No widow, 2 children only. Immediately payable

50% of employee's than annuity benefit to each child not to exceed $1200.00 annually divided by the number of children or $480.00 annually, whichever is lesser - terminable as above in (b) and, in case of termination to one child, recompute as if that child had not survived the annuitant, i.e., a case of one child only.

(d) In summary, as to continuing benefits to dependents.:

	Employee GS-11	Employee GS-11
Category	9 yrs. svc.	15 yrs. svc.
Widow only	$33.42	$55.69 monthly (at age 50)
Widow plus 2 children	66.84	111.39 monthly (immediately)
2 children only	66.84	80.00 monthly - max. (immediately)

* The statement of benefits below is translated later here with chosen examples.

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e. Public Law 110 as to death - on PCS abroad

(1) Pay the cost of preparing and transporting the remains of an employee, or member of his family, who may die in travel status or abroad ..... to appropriate place of interment .....

f. War Agencies Employees Protective Association (WAEPA)

(1) This is a non-profit association independent of the U. S. Government, which provides death benefits only, in two (2) categories - term life insurance and accidental death, and only to civilian employees of the U. S. Government.

(2) This insurance is effective only when the individual is actively employed, not including terminal leave. Eligibility extends to age 60 and membership in the Association terminates at age 65 or upon entry into the Armed Forces of any country. Membership is open to any employee of this Agency "who may go overseas at some future time." (see Appendix II) and without a medical examination, if he applies within 60 days "after becoming eligible." If application is later than these 60 days a "statement of health" is required. Eligibility extends to any individual paid from appropriated funds of this Government (see Appendix III). On termination of government service the term life feature may be converted into one of the Underwriters standard ordinary life policies, without medical examination.

(3) The policy is effective on the date of application if the application is acceptable to the Association. There is no contestible period as in Ordinary Life policies and, in respect to the term insurance part of the policy, no exclusions of any kind. The accidental death feature has these five (5) exclusions:

(a) Bacterial infections (except pyogenic infection arising from accidental wound).

(b) Any kind of disease.

(c) Medical treatment (except from accidental injuries).

(d) Suicide

(e) Air flight in non-scheduled flight, unless under orders of the U. S. Government, and in any flight as a crew member of the plane (see WAEPA letter 15 January 1953, Appendix I herewith).

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(4) Death benefits now are:

Salary*	Term Life Ins.	Accidental Death	Total
3200 or over	12,000	15,000	27,000

(5) Costs are:

Age up to 41	$8.33 per month	25.00 Quarterly	100.00 Annually
Age 41 to 51	10.42 per month	31.25 "	125.00 "
Age 51 to 65	12.50 per month	37.50 "	150.00 "

(6) The underwriters are:

(a) Equitable Life Assurance Society of the U. S. as to the term feature.

(b) American Casualty Company of Reading, Pa. as to the accidental death benefit.

(7) Our experience with WAEPA is as follows:

(a)

	Total Premiums Paid Total	Total Benefits Paid Total
1947	7,915.25	0
1948	11,630.00	0
1949	14,615.50	0
1950	20,299.43	0
1951	55,400.82	27,000.00 1 death
1952	117,437.29	12,000.00 1 death
1953	156,547.46	18,103.00 2 deaths
	383,845.75	57,103.00

(b)

	Total Premiums Paid Av. per month	Number of Persons Insured
1947	791.00	79
1948	969.00	116
1949	1,218.00	146
1950	1,691.00	203
1951	4,616.00	554
1952	9,786.00	1,174
1953	13,045.00	1,565

* This salary is about GS-4; for salaries below this figure ($3200), the benefits and costs are approximately one-half of the amounts shown above. See rates in Brochure.

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(c) Length of time contracts in force 1947-1953 inclusive.

	Cancelled Contracts	Existing contracts in force as of 1 Jan. 1954
Up to 3 mos.	56 (10%)	113 (7.7%)
" " 7 "	169 (30%)	201 (13.7%)
" " 13 "	119 (22%)	197 (13.5%)
" " 19 "	70 (13%)	259 (17.7%)
" " 25 "	60 (11%)	258 (17.7%)
" " 31 "	45 (8%)	201 (13.7%)
" " 37 "	20 (3.6%)	127 (8.7%)
" " 43 "	7	73 (5.0%)
" " 49 "	1	9
" " 55 "	0	4
" " 61 "	3	5
" " 67 "	2	7
" " 73 "	1	5
" " 79 "	0	1
" " 85 "	0	1
Total	553	1461

(d) Modifying factors in the above are:

1. in 1950 WAEPA added $2000 to the term coverage

2. in 1951 " added $15,000 accidental death coverage

3. in 1953 WAEPA added eligibility liberalization to read: "... available to anyone (in CIA) who may go overseas at some future time." Previously, overseas orders had to be out.

4. Bad Agency publicity.

(8) DDI reports no interest in risk coverage on the part of his people but a good interest in group life (term) coverage. They feel that with 99% of them not going overseas at any time, they would be straining the truth to apply for WAEPA.

(a) He also reports that they don't know the exclusions in their O. L. policies. Nor do they know anything about F.E.C.A.

g. Recapitulation as to continuing benefits after death.

(1) In order to assess practically the asset values to the beneficiary in existing available protective measures, certain assumptions as to asset (or proceeds) disposition-methods are utilized as follows:

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(a) The widow's age is assumed at 30 years (because of the general youth of the Agency employees) in both examples to follow, i.e., widow is the only beneficiary in the first case, and widow and 2 children in the second - ages 5 and 6 years.

(b) As to Ordinary Life Insurance. There is assumed a policy of $10,000 face with double Indemnity for accidental death.

The widow chooses to receive the proceeds immediately in the form of a monthly life income (20 years certain) in both examples. Disposal of these proceeds is illustrated by utilizing option 4, under an Ordinary Life policy written by United Benefit Life Insurance Co. of Omaha, Nebraska. The benefit is $30.50 per month for the face of policy, or $61.00 per month with the Double Indemnity feature.

1. The proceeds of this policy are not taxable as income unless left with the company at interest. Such interest is taxable.

(c) As to FECA, in the summary following here, the examples shown in the analysis heretofore are used.

1. The benefits here are not taxable as income.

(d) As to CSRA, it is seen that its value is small - is of no consideration in the case of death in performance of duty, and is applicable under line-of-duty or not, to a widow alone only when she reaches 50 years. To a widow with children benefits are applicable immediately but are small.

1. The benefits here are taxable as income under the annuity rule. (3% of total salary deduction until tax equals deduction, then all taxable.)

(e) As to WAEPA in the term feature, it is assumed that the employee chose proceeds disposal on the basis of monthly installments payable immediately on his death for the 15-year period. This pays $6.53 per month per $1,000 of policy face ($12,000 now), i.e., a total of $78.36.

1. The proceeds here are not taxable as income, in the same way as Ordinary Life.

(f) As to WAEPA, in the accidental death feature, which must be paid in a lump sum ($15,000 now), it is assumed that the single beneficiary (wife only, age 30) is better served by her purchase of a single premium Deferred,

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Refunding Life Annuity payable in 20 years at her then age of 50 years (or earlier for less amount if she chooses or needs). On this basis, Guardian Life of N.Y.C. will, in 20 years, accumulate a cash value for her of $24,135 and then pay her $94.13 monthly for life and also refund the unused balance to her specified beneficiaries.

However, under this feature, in respedt to the second example (the employee's beneficiaries are wife and 2 children, ages 5 and 6), it is deemed the part of wisdom for her to use the principal as she chooses under a Trust Fund arrangement, for a minimum of 12 years (until the children are 18 years old). The trusts now pay about 4% average on the investment and charge 5% on the fund earnings. This will net the beneficiary additional earnings over 12 years of about $3,000 total, or an average earning of about $250 per year. She takes out $125.00 per month average for 12 years and uses up the principal.

1. The proceeds under WAEPA accidental death feature are not taxable as income, except as to interest or earnings.

(g) As to CSRA (Civil Service Retirement Act) benefits, even though the beneficiary can choose as between CSRA and FECA, there is really no competition between the two. Each was designed for a different purpose. However, outside of performance of duty death, the sole beneficiary (widow only) waits until she is 50 years of age to benefit in a small way under CSRA. The widow with 2 children secures somewhat larger, though relatively small, benefits immediately following death, under CSRA. Here again there's no competition with FECA, hence the great importance of interpretation as to "performance of duty." The two cases used in the analysis proper are again utilized in the following summary.

1. The proceeds are taxable as income under the annuity rule.

(h) In respect to National Service Life Insurance (veteran), the 15-year installment method of paying proceeds is choosen @ $6.11 monthly per $1000 of policy face. This is $61.10 monthly.

1. These proceeds are not taxable as income.

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SUMMARY OF EXISTING AVAILABLE PROTECTIVE ASSETS IN TERMS OF THE PROCEEDS - DISPOSAL PLANS CHOSEN
(MONTHLY PAYMENTS)

ASSUMPTIONS:

1. DEATH OF A GS-11 WIT
   9 YEARS SERVICE
2. BENEFICIARY - AGE 30

BENEFICIARY	ASSET	PERFORMANCE OF DUTY: WITH ORDINARY LIFE		PERFORMANCE OF DUTY: WITHOUT ORDINARY LIFE		LINE OF DUTY OR NOT*: WITH ORD. LIFE	LINE OF DUTY OR NOT*: WITHOUT ORD. LIFE	
WIFE ONLY	ORDINARY LIFE INSURANCE (FACE)	30.50		—		30.50	—	
	" " " (D.I.)	30.50		—		30.50	—	
	FECA (FRANKFURT)	222.75	(+ 34.00)	222.75	(+ 34.00)	—	—	
	CSRA	—		—		—	—	+ 33.42 AT AGE 50
	WAEPA (TERM)	78.36		78.36		78.36	78.36	+ 94.13 AT AGE 50
	" (ACCIDENTAL DEATH)	—		—		—	—	
	TOTAL (FRANKFURT)	362.11	(+ 34.00)	301.11	(+ 34.00)	139.36	78.36	+127.55 AT AGE 50
	NSLI	61.10		61.10		61.10	61.10	
	TOTAL (FRANKFURT)	423.21	(+ 34.00)	362.21	(+ 34.00)	200.46	139.46	+127.55 AT AGE 50
WIFE AND TWO CHILDREN	ORDINARY LIFE INSURANCE (FACE)	30.50		—		30.50	—	
	" " " (D.I.)	30.50		—		30.50	—	
	FECA (FRANKFURT)	328.16	(+ 71.00)	328.16	(+ 71.00)	—	—	
	CSRA	—		—		66.84	66.84	IMMEDIATELY AT DEATH
	WAEPA (TERM)	78.36		78.36		78.36	78.36	TRUST FUND
	" (ACCIDENTAL DEATH)	125.00		125.00		125.00	125.00	
	TOTAL (FRANKFURT)	592.52	(+ 71.00)	531.52	(+ 71.00)	331.20	270.20	
	NSLI	61.10		61.10		61.10	61.10	
	TOTAL (FRANKFURT)	653.62	(+ 71.00)	592.62	(+ 71.00)	392.30	331.30	

* ANY DEATH OUTSIDE OF PERFORMANCE OF DUTY

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Summary Analysis of Coded Omaha and
GHI Hospital and Surgical Claims

I. General

A. Coverage: The survey included 1129 Omaha claims and 1865 GHI claims covering illnesses which commenced prior to 1954.

B. Illnesses: Types of illnesses for which claims had been submitted have been categorized into thirteen (13) groupings. Codes and definitions are included as Attachment 1.

C. Ratio of Claims to Policy Holders (1953): Comparing the claims for illnesses commencing in 1953 with the policies in force as of 31 May 1953, the following has been determined:

Insuror	Calendar Yr 1953 Number of Claims	Policies in Force 5/31/53	Ratio of Claims to Policy Holder
Omaha	239	1100	1 to 4.6
GHI	822	3800	1 to 4.6

II. Omaha Claims

A. Coverage: A total of 1129 claims had been submitted through 1953, resulting in 6665 days of hospitalization. Of the 1129 claims, 679 were for illnesses incurred in the United States and 450 claims were for illnesses incurred outside the United States.

B. Actual Expense Compared to Indemnity: The actual expense to Omaha policy holders approached 1/3 more than the indemnity; pregnancy claims cost the policy holder about 44.7 per cent more than the indemnity, while the indemnity for TB claims was about 10.9 per cent more than the actual cost. (See page 10)

C. Days Hospitalized: Approximately 84.6 per cent of the Omaha claimants were hospitalized less than 10 days, with about 47.1 per cent hospitalized less than 5 days, and 15.4 per cent were hospitalized 10 days or more. (See page 19)

D. Type and Sex: Of the 1129 Omaha claims, 489 (or 43.3 per cent) were for illnesses incurred by the policy holder, wives accounted for 485 (43.0 per cent) of the claims, and daughters, sons and husbands accounted for 155 claims or 13.7 per cent.

About 52 per cent of the claims were for illnesses incurred by females, and 47.9 per cent of the illnesses were for male personnel and 0.1 per cent of the claims were of an undetermined sex.

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E. Actual Surgical Cost to Policy Holder: Of the 683 claims involving surgical costs to the policy holder, 91 policy holders (or 13.3 %) paid less than $25.00, 192 policy holders (or 28.1%) paid less than $50.00, but 206 (or 30.2%) paid $150.00 or more.

F. Extra Cost: Of the 871 policy holders paying "extras", 283 policy holders (or 32.5%) paid $25.00 or less, 503 (or 57.8%) paid $50.00 or less and 34 policy holders (or 3.9%) paid $151.00 or more.

III. GHI Claims

A. Coverage: A total of 1865 GHI claims had been submitted through 1953, for 8651 hospitalized days, of which 8350 days (or 96.5%) were covered by benefits. The difference is accounted for by: overstaying discharge hour (not allowed), overstaying child's tonsilectomy (1 day allowed), adult (2 days), overstaying maternity (8 days allowed).

B. Actual Expense Compared to Benefits: Due to insufficient GHI data, it is impractical to present any actual expense information compared to benefits.

C. Claims by Year of Illnesses: Of the 1865 GHI claims, 632 (33.9%) illnesses commenced prior to 1952, 411 (22.0%) illnesses commenced in 1952, and 822 (44.1%) illnesses commenced in 1953.

D. Type and Sex of Claimant: Of the 1865 claims, 505 claims or about 27.1% were by the policy holder, 747 claims or 40.1% were for the wife of the policy holder and 613 claims or 32.8% were for sons, daughters and husbands.

Male claimants accounted for 729 claims (39.1%) of the illnesses, the women accounted for 1091 (58.5%) of the claims, and 45 (2.4%) were undetermined.

E. Days Hospitalized: Of the 1865 claimants, 1705 or 91.4 per cent were hospitalized less than 10 days and about 8.6 per cent (160) were in the hospital 10 days or more. (See section I)

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Glossary of Terms Used in Attached Analysis of Omaha and GHI Hospital and Surgical Claims

Benefits: (OMAHA) Monies paid to policy holder members at the rate of $9.00 per day for room and board regardless of room and board cost, and reimbursements paid for dependency room and board. Reimbursements is the term used for monies paid for dependency room and board at the actual cost rate, if less than $9.00 per day; the maximum is $9.00 per day. This rate of $9.00 per day changed from $6.00 per day as of 1 September 1953.

Extra benefits changed as of 1 September 1953 from $30.00 (allocated) to $135.00 (unallocated).

Claims Commencing: Table headings reading "Illnesses Commencing", means that the illness commenced prior to 1952, in 1952 or in 1953 as the case may be.

Surgical Cost: (OMAHA) Means the gross amount of money expended by the policy holder to satisfy the surgical bill.

Percent of Claim Covered by Benefits: (OMAHA) The ratio of benefits to the actual expenses.

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Hospital and Surgical Codes

Code	Definition
01	Eye, ear, nose, and throat.
02	Genital and urinary.
03	Heart and circulatory.
04	Pregnancy and complications therefrom.
05	Cancer (including tumors, etc.).
06	Tuberculosis and tests therefor.
07	Accidents.
08	Other (including childhood diseases, bone and muscular, hernia, surgery, etc.).
09	Digestive, from stomach on out.
10	Respiratory (including colds, pluerisy, etc.).
11	Dermatology (including cysts, etc.).
12	Mental, nervous, brain, etc.
13	Undefined.

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Actual Surgical Cost to Omaha Policy Holders

(Based on 683 Incidences)
Selected Groupings

Groups	Number	Per Cent	Cumulative Ratio
Total	683	100.0	
Less than $25	91	13.3	13.3
$25 thru $49	101	14.8	28.1
$50 thru $74	99	14.5	42.6
$75 thru $99	72	10.5	53.1
$100 thru $124	81	11.9	65.0
$125 thru $149	33	4.8	69.8
$150 thru $174	82	12.0	81.8
$175 thru $199	29	4.2	86.1
$200 thru $224	45	6.6	92.7
$225 thru $249	6	0.9	93.6
$250 thru $274	20	2.9	96.5
$275 thru $299	5	0.8	97.2
$300 and Over	19 (a)	2.8	100.0

(a) Distribution:

$300——4
$335——1
$349——1
$350——5
$375——1
$400——3
$500——2
$550——1
$650——1
19

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ACTUAL SURGICAL COST TO OMAHA POLICY HOLDERS
(Based on 683 Incidences)
Selected Groupings

Less than $25

$25 thru $49

$50 thru $74

$75 thru $99

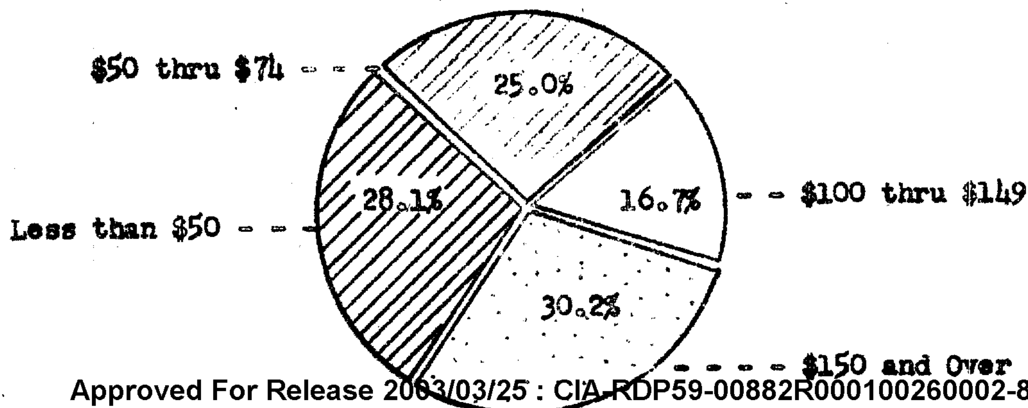
$100 thru $124

$125 thru $149

$150 and Over

0 5 10 15 20 25 30 35 40 45 50 55 60

PERCENT



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HOSPITAL EXTRAS PAID BY POLICY HOLDER
UNDER OMAHA CONTRACT

Extras Incidence
(Based on 871 Claims)

Groups	Number	Per Cent	Cumulative Ratio
Total	871	100.0	
$25 and less	283	32.5	32.5
$26 thru $50	220	25.3	57.8
$51 thru $75	162	18.6	76.4
$76 thru $100	96	11.0	87.4
$101 thru $125	55	6.3	93.7
$126 thru $150	21	2.4	96.1
$151 and over	34 (a)	3.9	100.0

(a) Distribution:

$151 thru $175	13
$176 thru $200	5
$201 thru $225	5
$226 thru $250	2
$251 thru $275	3
$276 thru $300	2
$301 thru $325	2
$326 thru $350	1
$668 only	1

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HOSPITAL EXTRAS
PAID BY OMAHA POLICY HOLDERS
(Based on 871 Extra Incidences)
(Selected Groupings)

$25 and Less

$26 thru $50

$51 thru $75

$76 thru $100

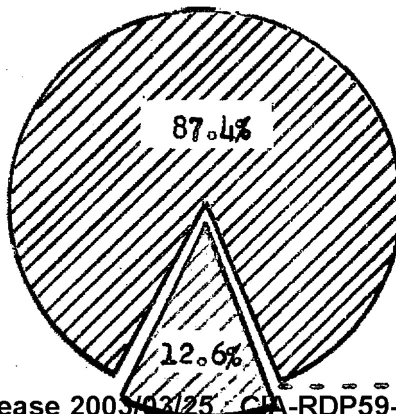
$101 thru $125

$126 thru $150

$151 and Over

0 5 10 15 20 25 30 35 40 45 50 55 60

PERCENT



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Number of Days Omaha Claimants Hospitalized

Days Hospitalized	Total	Per Cent	Cumulative Ratio
Total	1129	100.0	XXXX
Less than 5	532	47.1	47.1
5 - 9	423	37.5	84.6
10 - 14	116	10.3	94.9
15 - 19	21	1.9	96.8
20 - 24	7	0.6	97.4
25 - 29	8	0.7	98.1
30 and over	22	1.9	100.0
Ave. no. of days	7.5	XXX	XXXX

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OMAHA CLAIMANTS
NUMBER OF HOSPITALIZED DAYS
(Selected Groupings)

Less than 5 Days

5 - 9

10 - 14

15 - 19

20 - 24

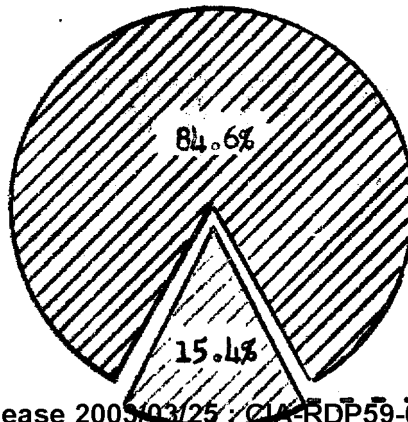
25 - 29

30 and Over

0 5 10 15 20 25 30 35 40 45 50 55 60

PERCENT

Hospitalized less than 10 days - - - - - - -



- - - - Hospitalized 10 days or more

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Summary of Omaha Hospital and Surgical Claims

Through 1953

By Type of Claimant

TOTAL	1129	100.0%
Policy Holder	489	43.3
Others	640	56.7
Wife	485	43.0
Daughter	52	4.6
Son	102	9.0
Husband	1	0.1

By Sex of Claimant

Total	1129	100.0%
Adults	974	86.3
Male	489	43.3
Female	485	43.0
Children	154	13.6
Male	52	.6
Female	102	9.0
Undetermined	1	0.1

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GHI CLAIMANTS
NUMBER OF HOSPITALIZED DAYS
(Selected Groupings)

Less than 5 Days

5 - 9

10 - 14

15 - 19

20 - 24

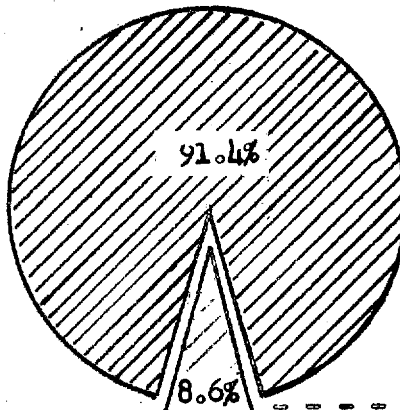
25 - 29

30 and Over

0 5 10 15 20 25 30 35 40 45 50 55 60

PERCENT

Hospitalized less than 10 days



Hospitalized 10 days or more

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1. Existing available protective measures as to disability.

a. Against Permanent and Total Disability:

(1) Individual's own commercial Ordinary Life policy which may have a disability feature contained for an extra premium, or a straight commercial disability policy.

(2) National Service Life Insurance or U. S. Government Life Insurance which may have a disability feature added for an extra premium.

(3) Federal Employees Compensation Act.

(4) Civil Service Retirement Act.

b. Each of the above measures or instruments is analysed herewith:

(1) Individual's own commercial policies

(a) A typical Ordinary Life policy with disability (and premium waiver) inclusion is that of Guardian Life of New York, N. Y.

1. For an annual premium of $5.63 at age 35, Guardian will pay $10.00 per month per $1,000 of policy face-amount.

2. Exclusions are self-inflicted injury, military service in time of war and air flight except on commercial scheduled air lines.

(b) A typical commercial straight disability policy is that written by Mutual Benefit Health and Accident Association of Omaha, Nebraska.

1. The benefit from an accident:

$100.00 per month for life
(40.00 " " " partial disability for 3 mos.)

2. The benefit from sickness:

$100.00 per month for life
(50.00 " " " partial disability for 3 mos.)

3. The premiums: $50.00 per year to a preferred white collar risk.

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$40.00	if	benefits	start	on	the 8th	day
35.00	"	"	"	"	" 16th	"
32.50	"	"	"	"	" 31st	"
30.00	"	"	"	"	" 61st	"
27.50	"	"	"	"	" 91st	"

4. The above benefits can be purchased in multiples of $50.00 with proportionate difference in premiums.

5. The policy is issued annually so that the Company may refuse renewal if initial benefit-days provision is abused.

6. Until 6 months ago, air flight in non-scheduled service was excluded. Now it is included for an additional annual premium of $3.00 per $100.00 benefit.

(2) National Service Life Insurance or U. S. Government Life Insurance

(a) This legislation permits the World War II G.I., on return to inactive duty, to purchase life insurance in one of seven different policies to which he may add disability coverage for an extra premium. Example: Term life policy of $10,000 face-amount at age 35 can add a disability feature paying benefit of $50.00 per month for an annual additional premium of $14.40.

(b) U. S. Government Life Insurance before World War II permitted a veteran to keep a policy containing disability provisions and add more if he chose for additional premium. Such a policy is no longer available.

(3) Federal Employees Compensation Act.

(a) The Federal Employees Compensation Act provides compensation for disability (and full medical care) resulting from injuries suffered in performance of duty or from diseases proximately caused by employment, for as long as the disability continues.

1. This Act is an exclusive remedy, but does not prevent the beneficiary from electing to receive the benefits of the Civil Service Retirement Act if he so desires but he cannot receive such benefits concurrently with those under FECA.

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2. All hazardous or semi-hazardous duty risks are covered.

3. Exclusions are disabilities resulting from willful misconduct, self-inflicted action, or intoxication.

4. The monthly schedule of benefits are:

   a. To individual with no dependents: 66-2/3% of salary* loss not to exceed $525.00 monthly. This maximum benefit of $525.00 provides a benefit of 66-2/3% up to the maximum salary of GS-13, 58% of maximum salary of GS-14 and 53% of maximum salary of GS-15.

   b. To individual with one or more dependents: 75% of salary* loss on salary up to $5040 annually; 66-2/3% of salary* loss on salary above $5040. The total benefit not to exceed $525.00 per month (this maximum is an annual salary rate of $6300 - about the middle of the GS-11 scale).

   c. In either case above, plus varying specific number of weeks of compensation @ 66-2/3% of the salary rate, for permanent anatomical losses.

   d. In either case above, plus $75.00 per month, if an attendant is required, plus $50.00 per month for rehabilitation training *if* needed.

5. Clearly, this is excellent coverage in the performance of duty area.

(4) Civil Service Retirement Act

(a) The Civil Service Retirement Act provides disability benefits to employees of the U. S. Government with and without performance or line of duty qualification, provided the employee has acquired minimum eligibility of 5 years of civilian

* Salary rate includes amounts withheld for tax and retirement purposes plus value of subsistence quarters, etc.

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service,* and is totally disabled.

1. Exclusions are injuries or disease due to vicious habits, willful misconduct or intemperance.

2. The benefit is based on base salary and length of service. This latter factor, of course, automatically describes the nature of the plan and hence, for an agency made up so heavily of youth, we find but small compensatory contribution. This is illustrated as follows:

	Min. GS-13	Min. GS-9
Highest av. 5 yr. salary	8360.00	$5060.00
Civilian creditable service	12 years	5 years
Military service	2 years	3 years
	8360.00	5060.00
	x 1.5%	x 1.5%
	125.40	75.90
	x 14	x 8
	1755.60 annually	607.20
	146.30 monthly	50.60

c. Against Temporary Disability

(1) Federal Employees Compensation Act

(2) Public Law 110

(3) The group hospitalization and surgical plan administered under Government Employees Health Association** CIA), underwritten by Mutual Benefit Health and Accident Association of Omaha, Nebraska (hereinafter designated OMAHA).

(4) The group hospitalization and surgical plan administered under Government Employees Health Association** (CIA), underwritten by Group Hospitalization Inc., (hereinafter designated GHI).

* Under 5 years of civilian service or more than 5 years with no widow or dependant children, the Act provides for a lump sum of the amount paid in, plus interest.

** Government Employees Health Association. This is an incorporated association within CIA, with officers elected annually by its Board of Directors, organized in August 1948 for the purpose of administering a hospitalization and surgical benefit plan underwritten by Mutual Benefit Health and Accident

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d. Each of the above measures is analyzed herewith:

(1) Federal Employees Compensation Act (see b. (3) above)

(2) Public Law 110

(a) This Act provides substantial disability benefits to employees of the Agency assigned to permanent duty stations outside the Continental U. S., its territories, and possessions; for injuries or illness requiring hospitalization and which occur in line of duty.

1. Exclusions are injuries or illness resulting from vicious habits, misconduct, or intemperance.

a. Also, as shown above, TDY (refer to recommendations of the Legislative Task Force).

2. The benefits are:

a. Payment of travel expenses to and from an appropriate hospital or clinic (including an attendant, if necessary).

b. Payment of the cost of treatment.

(3) and (4) OMAHA and GHI hospitalization and surgical plans

(a) There are two hospitalization and surgical plans available to Staff Employees and Staff Agents (only) under procedures which are designed to protect security. Both plans pay substantial benefits to help meet hospital and surgical expenses arising out of injuries and illness.

(b) The first plan made available to employees (in August 1948) is OMAHA. It presents a straight indemnification arrangement, i.e., explicit cash reimbursement.

(c) The 2nd plan, made available in March 1953, is GHI. This plan is one of 80 Blue Cross plans in the U. S. and Canada, which have Inter-Plan service (reciprocal) Benefit Agreements with 4500 participating hospitals. If the admitting hospital is accredited but not participating in the Inter-Plan Agreement, cash allowances are provided. GHI is partially a benefit and partially an indemnification arrangement.

(d) Omaha combines in one contract specific surgical benefits within the Hospital Service Plan. GHI separates the

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Hospital Service Plan from the Surgical Service Plan, and for separate fees the individual buys one or both.

Both OMAHA and GHI provide coverage for the family for differing fees. The same benefits are extended to the family as to the individual contracting - if so contracted.

Both OMAHA and GHI exclude coverage for injuries or illness arising out of or in the course of employment, i. e., where FECA coverage obtains.

(e) Each plan is analyzed and compared herewith, separately as to overseas and domestic situation.

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OVERSEAS

1

OMAHA — Hospitalization

1. Hosp. Board & Room: $9 per day for 31 days with no limit on frequency, plus $135 for hospital extras
2. Plus surgical as shown below.
3. Plus out-patient emergency up to $135
4. Effective date. 1st of the next month
5. Waiting period. Maternity only (see below).
6. Maternity. Waiting period 9 months and coverage extended 9 months beyond term of contract.
   (a) $9.00 per day for 14 days plus up to $45 total for Hosp. extras.

OVERSEAS

GHI — Hospitalization

1. Hosp. Board & Room: $10 per day for 21 days with 90 day interval on frequency, plus $64 for hospital extras
2. Plus surgical as shown below.
3. Plus out-patient emergency up to ....$ 10
4. Effective date. 1st of the next month.
5. Waiting period. See #1 below.
6. Maternity.#1 Waiting period - none.#1 No extension beyond term of contract.
   (a) $9.00 per day for 8 days except Caesarean, termination of ectopic pregnancy and miscarriage, for which hospitalization benefits are 1. above

#1 As of 5 Feb 1954 GHI eliminated all waiting periods for members currently insured and for EOD's who accept GHI within the 1st 60 days of employment. These waiting periods were: Pre-existing conditions - 1 yr. Maternity, tonsillectomy, adenoidectomy - 10 months.

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OMAHA Surgical

(Example)

GHI Surgical

OMAHA	Procedure	GHI
$ 50	Hernia Ing. unil.	$ 100
75	" " bilat.	140
100	Appendectomy	100
100	Radical Mastectomy	175
50	Fracture of spine	125
35	Hip dislocation	75
150	Prostatectomy	200
50	Normal delivery	80
100	Caesarean	150
150	Removal of Kidney	175
50	" " Cataract	150
100	Gastrictomy	250
25	Tonsillectomy	55
25	Adenoidectomy	55
25	Hemorrhoidectomy	60
150	Hysterectomy	165
$1235		$2055

$\frac{\$1235}{16} = \$77$

This is 60% of GHI

$\frac{\$2055}{16} = \$128$

(The above, of course, disregards frequency of occurrence - is set forth as a quick look.)

N.B. Below the 5th step increase of a GS-9 and including the minimum of GS-10, the surgical fees scheduled are accepted by the participating surgeon as full payment.

3

OMAHA Costs (monthly) Hosp.	Surgical	Total	Contract	GHI Costs (monthly) Hosp.	Surgical	Total
--	--	$1.60	Individual contract	1.70	1.00	2.70
--	--	4.75	Individual & Spouse contract	3.70	3.20	6.90
--	--	6.00	Indiv. & spouse & children	3.70	3.20	6.90

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WASHINGTON

OMAHA — **Hospitalization**

1. Hosp. Board & Room: $9.00 per day for 31 days with no limit on frequency Plus $135 max. for hospital extras
2. Plus surgical as shown above
3. Plus out-patient emergency up to $135
4. Examples (Hospitalization only):

WASHINGTON

GHI — **Hospitalization**

1. Hosp. Complete Service for 21 days (semi-private, partic. hospital) with 90 days interval on frequency. $10.00 per day if in private room.
   Plus $5 per day for additional 180 days (See below)
2. Plus surgical as shown above
3. Plus out-patient emergency up to $ 10
4. Examples (Hospitalization only):

Bd & Room (OMAHA)			Normal	Bd. & Room *1 (diff.)
$ 90		appendectomy	10 days	$ 135 (+ 45)
270		comp. fracture	30 "	405 (+135)
126	(Plus a maximum of $135	bilat. hernia	14 "	189 (+ 63)
90	(to cover all hospital	unilat. "	10 "	135 (+ 45)
126	(extras	hysterectomy	14 "	189 (+ 63)
90		hemorrhoidectomy	10 "	135 (+ 45)
27		tonsillectomy	3 "	40 (+ 13)

Plus the hospital extras, (16 listed) which range from $50 for the simplest, uncomplicated appendectomy to very substantial amounts for the serious or complicated case.

Net = 50% greater on Board & Room than OMAHA

*1 - Basic costs of Board & Room @ $13.50 per day (typical - presently) is absorbed by GHI completely.

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(f) Summary comparison of these two plans:

1. Overseas general hospitalization
OMAHA is far superior to GHI.

2. Overseas maternity hospitalization
OMAHA is substantially superior to GHI in normal pregnancy. In the cases involving Caesarean, termination of ectopic pregnancy and miscarriage (av. 10%, per Dr. Tietjen), GHI is substantially superior.

3. Overseas surgical.
OMAHA is only 60% as good as GHI.**

4. Domestic general hospitalization
OMAHA is substantially INFERIOR to GHI in either a normal or abnormal case.

5. Domestic maternity hospitalization
OMAHA is substantially superior to GHI in normal pregnancy. In 10% of the cases involving Caesarean, termination of ectopic pregnancy and miscarriage, GHI is substantially superior.

6. Domestic surgical
OMAHA is only 60% as good as GHI.**

7. Fees are the same in each plan as between overseas and domestic. However, OMAHA's fees are all lower than GHI. For individual contract OMAHA charges 60% of GHI; for individual and spouse OMAHA charges 70% of GHI; for individual, spouse and children OMAHA charges 88% of GHI, but GHI doesn't offer just an individual and spouse contract at a lower rate than one inclusive of children.

8. Net on the above - if OMAHA's surgical could meet GHI, it is better than GHI for overseas if the dependents are with the employee. Even if OMAHA's surgical meets GHI, it is not as good a buy for domestic assignment.

** OMAHA has offered to match GHI surgical benefits with small increase in premium as follows: single contract, plus $.16; individual and spouse, plus $.89; family, plus $.80. See Appendix XI.

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9. As to hospitalization, the two plans are strictly comparable in respect to an overseas location of the individual with family, but impossible of comparison in the domestic situation. This is because the GHI hospitalization benefit is buried under the completely untranslatable "full service benefits" with participating hospitals.

While the non-complicated case call for a minimal few hospital extras, the complicated case under GHI gets 16 of them free and as many times as necessary. These variables cannot be assessed dollar-wise for purpose of comparison with OMAHA.

Even though it is true that the seriously complicated case is statistically in the low frequency category, the great dollar benefits under GHI are nevertheless there for the individual who wants to insure against precisely such a risk.

It may be held that benefits in a serious case ride on the backs of the non-complicated majority in respect to fees, and also that throwing in "the works" for every member is misleading persuasion. However, the minority who do get caught in heavy extras can't pay with statistics.

The simplest and blandest appendectomy calls for about $50.00 in hospitalization extras. From there it could go anywhere in cost while the patient still lives.

a. Pregnancy hospitalization contains the same problem but not as seriously so. In 90% of pregnancy cases - the normal ones - OMAHA is a better buy, but not so if one wishes to insure against costs arising out of the minority of cases (i.e. Caesarean section, termination of ectopic pregnancy or miscarriage). Here GHI is superior.

b. Again in the domestic hospitalization field GHI adds a fillip for the unusual case and offers $5.00 per day for 180 days on top of the 21 full service benefit days. Strictly from the point of view of frequency statistics, this might be labeled a "come-on".

c. Also, in the GHI brochure is seen the same hand as immediately above, i.e., the illustrated cases are not the usual ones. They are in the relatively infrequent category, but because there are but three of them, the coloration seems to be present. These cases are cancer

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(1449.15 benefits), fractured vertebrae (337.05 benefits) and gall stones (518.90 benefits).

d. GHI requires a 90 day interval between discharge and re-entry to a hospital. OMAHA requires one day. Here GHI is inconsistant with the preceding tactics as to minority occurrences.

e. OMAHA's fee schedule is superior both in form and in dollars.

f. GHI, being so firmly enmeshed in legislation and so integrated with the large and necessarily unwieldy Blue Cross presents practically no possibility of modification in plan to suit us, whereas OMAHA is completely flexible - even to a tailored plan.

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g. OMAHA's service to us in the settlement of claims [redacted] is "vastly better" than GHI. Mr. [redacted] characterizes GHI as a "bickering, negotiating outfit."

10. "Fine Print"

Comparison of these two plans is important also because of the effect of small items in irritation and dollars.

a. Ambulance

GHI won't pay to and from a hospital; Omaha will.

b. X-Rays

GHI won't pay unless the X-Ray is in connection with surgery performed within three days' time. Omaha will pay with no surgery nor time restriction.

c. Hospital Extras

GHI will pay on certain specific hospital extras without limit. Omaha pays on all extras up to their established maximum of $135.00

d. Type of Hospital

GHI's reimbursement is dependent upon type of hospital, as follows:

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Participating hospital - full benefit; member hospital of another hospital service plan gets the prevailing service of that plan; non-participating hospital gets only up to $10.00 per day for 21 days, plus $64.00 for hospital extras (the same as the GHI overseas rate). Omaha on the other hand reimburses the same all over the world in any hospital of the individual's own choice.

e. Room and Board

The "full service benefit days" under GHI pertains to a semi-private room, but if the individual chooses or really needs a private room, GHI allocates only $10.00 per day. Omaha on the other hand pays the contract guarantee for any accommodation.

f. Dependent Children

Under GHI, they are added when 90 days old, and carried to the 18th birthday. Under Omaha, they are added when 14 days old and carried to the 19th birthday. This may well be important in connection with congenital anomalies.

g. Tuberculosis and Mental or Nervous Disorders

Under GHI, these are covered for only 10 days during any 12-month period. Under Omaha, they are covered for the same number of days and same frequency (one day break only) as all other accidents or illnesses.

h. Congenital Anomalies.

Under GHI, not covered at all. Under Omaha, full coverage at any age after 14 days from birth.

i. Outpatient Emergency First Aid

GHI requires reporting within two hours of accident, else they won't pay. Omaha allows 24 hours.

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C O P Y

APPENDIX III

WAR AGENCIES EMPLOYEES
PROTECTIVE ASSOCIATION

Room 1040-1043 Washington Bldg.
15th & New York Ave., N.W.
Washington 5, D. C.

Address Communications to Stacey K. Beebe, Manager

November 29, 1950

The Central Intelligence Agency

Gentlemen:

You have inquired about the definition of eligibility relating to the term "employee." The question is raised, we believe, because there are certain personnel connected with your agency which do not clear through the normal procedures of Government employment. I am therefore quoting an excerpt from an amendment to War Agencies Employees' Protective Association contract No. 7671, dated July 21, 1949, as follows:

"The term 'employee' as used herein shall mean an individual whose compensation or expenses are derived in whole or in part directly from the United States Government for services performed directly for the United States Government in any capacity."

We believe this definition is broad enough to cover all of the questions which you have posed to us.

Very truly yours,

/s/

STACEY K. BEEBE
General Manager

C O P Y

SKB/es

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APPENDIX IV

The attribution factor to the U. S. Government with death in a sensitive mission -

(1) Regardless of W.A.E.P.A. insurance, the individual's rights as an employee of the U. S. Government cannot be denied and contribute direct attribution to his employer. (FECA)

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J.E.O.

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APPENDIX V

EMPLOYEE GROUPS

DEFINITION: By CIA regulation (CFRs, Section 14) the following four categories of employment are employees of the U. S. Government, and no employee rights as specified in legislation can be denied them.

1. Staff Employees

2. Staff Agents

3. Career Agents

4. Contract Employees

The Contract Agent is not an employee unless control of his activities is close and continous in which case he might be able to prove qualification.

In respect to Career Agents CFR 14.7 - deductions from salary are made for Civil Service Retirement Act and ...the Career Agent ....."will automatically come under the coverage of FECA and PL 110. Benefits of the Missing Persons Act may also be granted, and where compatible with security and operational standards, career agents may subscribe, if eligible, to hospitalisation and life insurance plans which are available to Agency employees." # 1

In respect to the Contract Employee, CFR 14.8 - no deductions will be made from salary under the Civil Service Retirement Act...however, "such periods of service would be available as creditable service for retirement purposes upon deposit by the individual of a sum equalling the deductions based upon salary paid during that period." Also, (the Contract Employee) "will be entitled to the benefits of FECA and PL 110, and his contract shall so state. Benefits of the Missing Persons Act may also be granted and, where compatible with security and operational standards, the Contract Employee may subscribe, if eligible, to hospitalisation and life insurance plans which are available to Agency employees." # 1

#1 Per COPS - DD/P January '54, all four categories eligible for life insurance; only Staff Employees and Staff Agents eligible for Agency hospitalisation.

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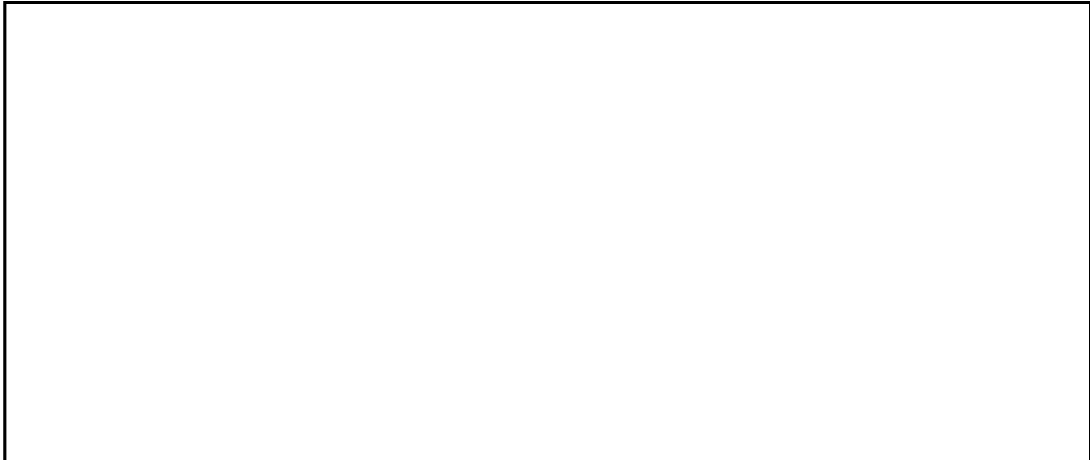

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APPENDIX IX

C O P Y

October 1953

Miscellaneous Expressions of Interest in Insurance from Random Selection of DD/P Officers

1. Good hospital and surgical benefits plans for overseas dependents - this inclusive of proprietary companies. [redacted] 25X1A9A

2. Raise WAEPA basic limits of group insurance coverage.

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3. Policy to cover transportation risks per se - all kinds.

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4. Mutual type insurance group operated by Agency similar to that of Army and Navy - would be best as far [redacted] go re [redacted] 25X1A1C 25X1C4A

5. Investigate Blue Cross, believes offers more coverage overseas than company we now subscribe to.

6. Something to cover hazardous duty. (He never heard of FECA)

7. Protection for injury or death in line of duty which would provide living expense for family in the states.

8. Something similar to Trip Insurance obtainable at Airport - at reasonable rate; would be benefit to have included in regular processing routine, sometimes forget to pick up at Airport - method to be as simple as possible.

9. Accidental death and injury in line of duty.

10. Health, physical, mental and injury coverage overseas other than in line of duty - CIA unlike the State Department does not cover employees for illness or injury incurred other than in line of duty.

11. Travel insurance, short term.

12. Transportation insurance - employees should not have to afford this.

13. Re WAEPA - Too high for short period; too long minimum period. Follow-up on return for possible interest in keeping WAEPA. Have WAEPA also cover personnel who do not anticipate travel. WAEPA requires too many forms being filled out.

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APPENDIX X

PROCEDURE AND SOURCES IN OBTAINING
CIA AND OTHER DEATH AND DISABILITY FIGURES

The method of arriving at the CIA figures is noted for the record as follows:

With respect to death, a clerical task force (up to 4 people) supervised full-time by a borrowed intelligence officer from PP - (Mrs. [ ] examined every card in the Inactive Service Record Card file, to spot postings of "termination by death". The name of each person so terminated was noted on an inventory sheet (sample attached) together with other personal data shown as called for by the inventory sheet. (Data called for was specified by [ ] Cause and place of death - not showing here, was sought in the individual's personnel folder (where for the most part it didn't show either). Search then went to the offices and division. The inventory sheets were all completed.

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In respect to the statistics on death, in one known case the personnel file (the card file of personnel actions) showed no card at all for the employee. (This was a 1953 death). In another instance, the card showed "resignation". This, of course, raises the question of other possible missing or mis-leading cards, most especially for the earlier years. In another case the clerical task force missed the record entirely because the notation of termination by death showed on a second attached card underneath the first, in spite of plenty of posting room remaining on the upper card. Of course the task force could have missed for other reasons too.

As to disability, the same task force and supervisor examined all records of hospitalization and surgical instances as shown in the Omaha and GHI files of the Insurance Branch of the Personnel Office. Desired information as called for on a disability inventory sheet was posted (specifications on this sheet obtained from Mr. [ ] - each case to a separate sheet. (Sample attached) Then these sheets were coded for IBM.

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All of this disability work was under the general supervision of [ ] Chief, Research Branch, Plans, Research Development Staff, Personnel Office.

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With respect to Staff Agents, the records were set up properly in February 1953. Previous to that, for a little time at least, on the occasion of death, a [ ] was supposed to have been made and sent to the Inactive Service Record file. Of four known Staff Agent deaths, only one such card was found. Then, at another time, the Service Record Card held by the Personnel Office responsible for its original creation, was sent with the individual's personnel folder to archives, hence is buried with thousands of others,

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who are inactive for any cause.

For the years desired, 1947-1953 inclusive (in respect to death), dependence had to be placed on memories. Four memories from OGC were substantiated. The Agency Security Office, Medical Office and Divisions of DD/P were circularized. and brought forward no new names.

In addition, the action file of Fiscal, to the Civil Service Commission, was checked. This process produced ten fewer names than Personnel's Inactive Service file but included two new ones.

In addition, Personnel's Inactive Service file was thoroughly checked through again. Sixty-seven records of death were turned up against the original sixty-two, but this included corrections made since the first effort. One new name was turned up. (but this process missed four names caught originally!) This re-check was supervised personally by [redacted]

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The employees' personnel folders are in generally poor shape, filled with duplicate papers, somewhat inconsistent in arrangement of material, and incomplete as to cause and place of death. In many cases the information as to cause and place of death had to be obtained from individual memories or records within the operating branches. Such memories were accepted because in each case an informant was found who could assert with complete confidence of accuracy. With due use of cryptonyms in those few cases where necessary, there is no reason why the "termination by death" record on Form 50 can't show cause and place. (This has been informally agreed to by Personnel Relations Section).

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Sources of Figures for CIA, Dept. of Agriculture
and Department of State

CIA - Average Monthly strength for the year. This method was specified by [redacted] 30 December 1953. The figures came from Research Branch, Plans, Research and Development Staff, Personnel Office.

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In respect to the CIA strength reports, one can take the years 1951, 1952 and 1953 as solid and correct. For the earlier years shown, there is unquestionably some--probably small--variation as to what is included and what not and when. All figures come from official reports.

State - These figures are from Howard Mace, Chief of the Placement and Career Development Branch, Personnel Operations Division, Office of Personnel, Department of State.

The population or strength figures for the Foreign Service are averaged for the year from monthly figures except for 1949 - which year is a "budget average." The Departmental yearly averages are also "budget averages" except 1953 which is averaged from monthly postings.

Agriculture - These figures are from Mr. J. M. Kemper, Secretary-Treasurer of the Department of Agriculture Beneficial Association. The "strength" is total membership as of 15 September of each year. ("Deaths" include 10-12 cases of permanent and total disability which Kemper estimates is correct for the total in these 5 years and also include membership and deaths of retirees who kept their policies.) T. Roy Reid, Personnel Director of the Department, estimates that Agriculture has about 56,000 employees - thus making Kemper's membership 29% of the total eligible group. This fact, plus inclusion of retirees, plus the unchanging yearly level of memberships, leads to the suspicion that the age level of this membership is high. (Kemper was uncooperative when asked if he could supply age data.)

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Re : Deaths (Staff Employees)

Name ____ Sex ____________

Date of Employment _____________________________

Last Office ____________________________________ Title ____________

Last Assignment (nature)

When so assigned ________________ How many others so assigned ______

Date of birth ________________________________

Date of death ________________________________

Place of death (country) _________________________

Cause of death ____

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POLICY NO.

CLAIM NO.

VOUCHER NO.

Re: Hospitalization & Surgical (Staff Employees & S.A.'s)

Name ______________________________ Sex ____________

Assignment (Office)

Date of Birth ______________________________

Nature of Illness ______________________________

____

Place of Illness (Country) ______________________________

Period of Illness ______________________________

Benefits Paid By ______________________________ Actual Cost

	New	
Hospital		H.
Surgical		S.
Extras		E.

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Appendix XI

14 January 1954

MEMORANDUM FOR: Members of the Insurance Task Force

25X1A9A

SUBJECT : Exploratory discussion with representatives from OMAHA on 14 January 1954 by [redacted]

1. In regard to OMAHA's matching GHI surgical benefits, the actuary stated that their premium rates would change as follows:

	From	To	Additional
Single Contract	$1.60	$1.76	$.16
Individual and Spouse	4.75	5.64	.89
Family	6.00	6.80	.80

2. Please note that the increase in the family rate is less than that for an individual and spouse. This is due to the fact that previous rates were incorrect, and the actuary wiped out the inconsistency in proposing us the new rates.

3. In regard to OMAHA's complete matching of GHI, they need certain dependency figures for overseas, now in process of preparation by Research Branch, PRDS. This information will be given in percentages only (approved by the Director of Security personally.)

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[redacted]

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Dr. George Baehr, Medical Director of the Health Insurance Plan of Greater New York, Testifies Before the House Interstate and Foreign Commerce Committee

EXTENSION OF REMARKS
OF

HON. CHARLES A. WOLVERTON
OF NEW JERSEY
IN THE HOUSE OF REPRESENTATIVES
Thursday, January 14, 1954

Mr. WOLVERTON. Mr. Speaker, the testimony of Dr. George Baehr before the Committee on Interstate and Foreign Commerce at its hearing to develop a health program is very important. Dr. Baehr was chief of medical service and director of clinical research at Mt. Sinai Hospital in New York City. He was chairman of the technical advisory committee, Department of Health, New York City, 1933–41, and consultant, Department of Hospitals, New York City, 1933–45. He has been a member of the public health council of the State of New York since 1935 and is past president of the New York Academy of Medicine.

Dr. Baehr made the following statement on prepaid medical care plans and the health-insurance plan of Greater New York:

TESTIMONY PRESENTED BEFORE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON JANUARY 14, 1954, BY GEORGE BAEHER, M. D., PRESIDENT AND MEDICAL DIRECTOR, HEALTH INSURANCE PLAN OF GREATER NEW YORK

In all considerations of health insurance, the basic and interrelated issues are (1) the method of providing medical services to the insured, (2) the scope and quality of the services, and (3) the method of payment to physicians.

LIMITED COVERAGE BY MEDICAL EXPENSE INDEMNITY INSURANCE

Medical expense indemnity plans pay individual physicians on a fee-for-service basis. For this reason, they must limit the scope of their benefit coverage for the most part to diseases requiring admission to a hospital, the frequency of which is predictable within reasonable limits. Benefits outside of a hospital are generally excluded because the number of professional and laboratory services which physicians may choose to render outside of a hospital is unpredictable when physicians are paid a fee for each service by a third party. Even when some medical benefits outside of a hospital are included under medical expense indemnity contracts, they are sharply limited in amount and leave the insured families widely exposed to additional medical bills. Comprehensive benefit coverage is impossible under these indemnity, fee-for-service plans because it inevitably results in a rapid increase in medical bills and the progressive pyramiding of costs to the insurance company.

The inadequacy of in-hospital medical coverage as a means of protecting the family budget is revealed by the experience of such comprehensive programs of medical care as the health-insurance plan of Greater New York, which find that only 10.7 percent of all professional services are rendered to such insured persons in hospitals and 89 percent in their homes and doctor's offices. With fees for home and office visits and for X-rays, technical laboratory work, and other diagnostic and therapeutic procedures now rising to the point that care even for ambulatory patients may cost a week's wages, there [illegible] ambulatory as well as hospital care. Extra-hospital medical care is continually being needed by all families; hospital care is often not required for 20 or 30 years.

COMPREHENSIVE MEDICAL CARE THROUGH PREPAID GROUP PRACTICE

During the past 25 years, local plans for providing comprehensive medical care on a prepaid basis have been established in various parts of the country under the sponsorship of medical groups, industrial organizations, labor unions, farm cooperatives, and other local agencies. These independent plans are able to provide medical care of comprehensive scope in return for the collective per capita premium income only because the services are rendered to the insured by physicians engaged in organized group practice, who together comprise all the required professional, laboratory, X-ray, and other specialty branches of medicine and surgery. Under this system of completely prepaid group practice, financial barriers to prompt utilization of the needed medical, laboratory, and X-ray services can be eliminated and the insured families are able to enjoy all the major benefits of modern medicine, including prevention and early disease detection. In our aging population, disease prevention and early disease detection as well as medical care during chronic illness must be included in a medical-insurance program if it is to meet the needs of the public.

In this age of highly specialized professional skills and medical technology, the total medical needs of an insured population can best be met by such balanced teams of physicians, specialists, and technicians trained in the great variety of skills and technics which today constitute modern medicine. The comprehensive-prepayment plans combine these medical skills and technics in the form of group practice and place them freely at the disposal of people of moderate means in return for the per capita income derived from insurance premiums. Each insured family has a family doctor who has been selected by the subscriber from the family physicians on the staff of a medical group. The clinical laboratory, X-ray diagnosis and therapy services, pathology, physical therapy, and visiting nurse services of the group are freely at the disposal of the family physicians as are all the consulting services of the group's specialists in the various branches of medicine and surgery without financial deterrents to their full use.

An argument commonly advanced by opponents of prepaid group practice is that it does not give subscribers free choice of any licensed physician in the community. From the standpoint of a subscriber, this has absolutely no validity, for he exercises his choice when he decides to join the plan as a member of his enrolled group of insurees and he is at liberty to drop out of the plan at any time. He is also at liberty to consult any other physician at any time that he wishes. It is certainly desirable that families of low and moderate income be given the opportunity to enjoy the benefits of comprehensive-medical care through prepaid group practice if they prefer it to so-called free choice of individual physicians and specialists whose services they cannot afford on a fee-for-service basis.

Families that receive all their medical services from a prepaid medical group can completely budget the costs of their total medical care throughout the year. If satisfied with the full scope and quality of the care provided for them by the medical group, the insured population has no need to purchase medical care from any other physician. Therein lies the cause of complaint and resistance by the opponents of prepaid group practice in every part of the country in which it has been established.

Local medical societies consist largely of [illegible] economic and professional competition of

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group practice and will tolerate only a fee-for-service method of solo medical practice in insurance plans. Medical societies are therefore prevented by their membership from taking any part in modernizing the organization of medical care into group practice even though it is required by the high degree of specialization characteristic of the times in which we live. Because of local resistance to progress, programs of comprehensive medical care through prepaid medical group practice have grown very slowly and have as yet reached only 4 million people.

At the national level, the American Medical Association has accepted the principle that independent groups of physicians and community leaders should be permitted to experiment with newer patterns of prepaid medical care and group practice. State and county medical societies cannot or will not initiate or operate such experiments because of their political composition. A widespread spirit of intolerance to change pervades the thinking and actions of their leaders and in some States laws have been enacted at the instigation of medical societies which actually prohibit prepaid group practice. Some local physicians are even now seeking to alter or reinterpret the Code of Professional Ethics for the purpose of obstructing the development of the only form of voluntary health insurance which has thus far been able to provide comprehensive medical care at a cost which people of low and moderate income can afford on a prepaid basis.

On July 16, 1946, an editorial in the Journal of the American Medical Association warned that such obstructive behavior by physicians may itself be unethical.[1] In spite of these pronouncements, the conflict at the local level remains unchanged and now calls for more positive action by national authorities within the profession itself or else intervention by Government in the public interest.

ORIGIN OF HIP

In 1947, after a 4-year study of the problems of medical care, the New York Academy of Medicine concluded that prepaid group practice is the logical and evolutionary development of medicine in the changing order. In 1942 and 1944, the mayor of the city of New York, the Honorable Fiorello H. LaGuardia, announced that the city would pay half the premiums of nonprofit group health insurance for municipal employees and their families if insurance coverage could be made truly comprehensive and employees and their families would be protected against additional medical bills. In order to make it possible for the city to pay half the premium cost, permissive legislation was enacted by the State legislature in 1946. Following a prolonged study of nonprofit medical insurance plans in various parts of the country, the founders of the health-insurance plan of Greater New York were convinced that medical society sponsored plans, because of the current political structure of the societies, could not change the current pattern of medical practice so as to provide the public with an opportunity to purchase comprehensive medical care. HIP was therefore established on March 1, 1947, as an independent nonprofit medical insurance plan under a board of directors composed of representative community leaders from labor, business and industry, Government, and the medical profession. It was designed to serve wage earners employed in private business and industry as well as governmental employees. The board of directors operates the plan as a community trusteeship. As in the case of voluntary hospitals, the entire responsibility for medical matters and the determination of all professional standards are delegated to a medical board and the medical aspects of the program are supervised by a medical director and his staff.

Footnotes at end of speech.

Working capital was required during its formative period and the first year of operation. As this was the first experimental demonstration of comprehensive medical care under community-wide sponsorship, several philanthropic foundations supplied loans, which are being rapidly repaid out of premium income. From our experience it is evident that similar projects cannot be established without financial aid in the form of grants or loans either from industry, labor groups, consumer, or farm cooperatives, or, if it is to be under community sponsorship, from government. The role of government in the promotion of plans for comprehensive medical care through prepaid group practice was suggested in the 1947 Report on Medicine in the Changing Order of the New York Academy of Medicine.[2] Once established, such plans can become self-supporting, paying adequate remuneration to their physicians and repaying the initial loans.

After 7 years of operation, the health-insurance plan of Greater New York is providing comprehensive medical care to almost 400,000 insured persons. As a nonprofit agency established under the State's insurance law, it is operated in the black and has accumulated ample financial reserves as required by the State's superintendent of insurance. The services are provided by 30 medical groups, 29 of which are located in various sections of the city and 1 in an adjacent county. The medical groups are autonomous and are independent contractors. Each group includes an adequate number of family physicians proportionate to its enrollment size and a complete roster of qualified specialists representing the 12 basic specialties of medicine and surgery. They comprise altogether about 1,000 physicans, of whom about 450 are family doctors and about 550 are qualified specialists. The required professional qualifications for membership in a group are determined by an impartial medical control board of 15 representative physicians. The quality of medical care is supervised by the medical department of HIP.

Under a family-type contract, the cost for an individual subscriber without dependents is $42.72 a year, for a couple $85.44 a year, and for a family of any size $128.16 a year.[3] A family with 12 children pays no more than a family with 1 child. Allowing for large families, the average cost per individual is $36.36 a year. Employers are required to pay at least half the premium so that the weekly contribution of a single employee is $0.41, of a couple $0.82, and of a family of 3 or more, $1.23.

For providing all the care which may be needed by the insured families, HIP pays each medical group a capitation of $29.40 per annum for all persons on its rolls. After deduction of the cost of operating its medical group center and of retirement benefits, the remainder of the capitation income is available to a group for the payment of salaries of its participating physicians, most of whom are partners in the group. When a group reaches an average enrollment (14,000), the remuneration of its physicians is at least as high as the average reported incomes of other physicians and specialists in the community and the physicians enjoy added benefits of security not possible for the solo practitioner.

There are no deterring extra charges for any medical services which the insured may require in their homes,[4] in physicians' offices, medical group centers, or in hospitals. Every kind of medical and surgical service is available to them, including X-ray diagnosis and therapy, radium and radio-isotope therapy, diagnostic laboratory services, physical therapy, visiting nurse services, and even ambulance transportation without extra charge.

Footnotes at end of speech.

The plan erects no barriers by reason of age, sex, or preexisting illness, injury, physical defect, or pregnancy, either to admission to its rolls or to utilization of services thereafter. There are no waiting periods for medical care for preexisting illness or pregnancy. Reliance is placed solely upon group enrollment to protect the plan against the adverse experience to which unguarded individual enrollment would expose it.

Since the first day of operation of the plan, a division of research and statistics in HIP has recorded every medical service to every enrollee. By means of modern statistical machinery, these data can be thoroughly recorded, analyzed, and evaluated. The utilization rates of medical, surgical, and laboratory services by all age groups and especially the plan's experience with old people and with maternal and infant care will provide valuable data for future programs of medical care. An intensive study of the experience of the plan during its first 5 years is now being made by a special committee of impartial experts under the chairmanship of Dr. Lowell Reed, president of Johns Hopkins University, which is being financed jointly by the commonwealth fund and the Rockefeller Foundation. In addition to a longitudinal study of the plan's experience with its insured population, the special research project conducted by Dr. Reed's committee has included an investigation of the sickness and medical-care experience of large and representative samples of households in New York City and in the HIP population, totaling more than 25,000 persons. The publications emanating from the research division are available to you as well as all of the plan's recorded experience.

HIP also maintains a division of preventive medicine and health education as one of its important activities. It is the responsibility of the expert staff of this division to promote adequate utilization of medical services by the insured population, especially preventive services and those concerned with early disease detection. The objective is to have every family select a family doctor and use him and the specialists and laboratories of their medical group for the prevention and the early detection and treatment of illness. The effect of this wide exposure of the insured population to medical care can be measured by the fact that at least 74 percent of the enrolled members of the insured families are now using their physicians' services within a year and this rate is rising as our health education program takes hold. The average rate of utilization of physicians' services by the entire insured population is 5.3 services per year per person. The lack of financial barriers to complete medical care has not led to any significant amount of needless use of the services by the insured. Subscriber abuse is minimal and easily corrected.

The experience of HIP and of many similar plans throughout the country is now sufficiently voluminous to demonstrate that comprehensive medical care through prepaid group practice is professionally feasible and financially practical from the standpoint of both the doctors and the public. There can also be no question of the importance of prepaid comprehensive medical care to public health.

To facilitate its growth, two things are necessary: (1) Elimination of interference by local professional societies with prepaid group practice; (2) financial assistance by Government through loans to encourage the wider extension of prepaid comprehensive medical care throughout the country under local community sponsorship.

Government at all levels may also help through the purchase of prepaid medical care for its own employees and wards. It should follow the accepted practice of purchasing medical care under group contract from the prepayment organization which

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produces the best values for the price charged.

ROLE OF FEDERAL GOVERNMENT

The role which the Federal Government should take in promoting and extending adequate medical care to the insurable population of the country might well follow that which it has already taken to promote and extend adequate hospital care under the Hill-Burton Hospital Survey and Construction Act. Federal assistance to the States might first be limited to grants-in-aid to encourage the States to survey existing deficiencies in medical care within the State and to determine:

1. The extent to which the insurable population is not covered by prepayment for medical and for hospital care.
2. The gaps in benefit provisions under existing prepayment programs.
3. The means whereby the gaps in population coverage and the gaps in benefit provisions under existing programs may be eliminated.
4. The availability of voluntary insurance plans which provide comprehensive benefits for medical care in the homes, in doctors' offices, in diagnostic laboratories and X-ray services, as well as in hospitals.
5. The desire of the public for prepayment plans which will provide comprehensive medical services.
6. The existence of State laws which prohibit or make it impossible for physicians to provide such comprehensive medical care through prepaid group practice of medicine.

The State surveys should also include:

1. A determination of the nonwage and low-income group in the population which cannot afford to prepay their medical care through the purchase of voluntary health insurance.
2. The possibilities of experimentation by State and local governments with coverage of some or all of this group by voluntary medical-insurance plans.
3. The degree to which Federal assistance might be required to enable State and local governments to provide medical and hospital care to persons in the nonwage and low-income groups (the medically indigent) through prepayment.
4. The possibilities of experimentation by State unemployment funds or other State agencies with the provision of medical care for temporarily unemployed persons and their dependents through continuing the prepayment of premiums for the unemployed for care which may be needed during periods of temporary unemployment.

Small Federal grants could be employed most effectively to assist States in carrying out experimental programs designed to extend prepayment plans and comprehensive coverage under these plans to the part of the population within the State which is at present not covered or inadequately covered under such plans. In recognition of the fact that comprehensive medical service coverage under any voluntary prepayment plan requires economies and increased efficiency in operation which can be achieved only by organization of medical services as group practice, Federal aid to State and local communities is needed to encourage the establishment of prepaid group practice of medicine under local community sponsorship.

The organization of medical practice along such modern and more efficient lines requires loans to medical groups for the construction of the required physical facilities, to be repaid by them out of future earnings. Such loans for the purpose of encouraging local prepayment programs for comprehensive medical care should be limited to the acquisition of medical group centers, the purchase of X-ray, laboratory, and other professional equipment required for group practice, and the administrative expenses of the medical group center during the first years of operation. The annual appropriations for this purpose need not be large nor would they be needed for more than 5 or 10 years, for as the loans are repaid they may be used as a revolving fund.

It can be predicted that rapid progress in the extension of prepaid comprehensive medical care will not be made until (1) such loans are made available, (2) hampering State laws are repealed wherever they exist, and (3) effective steps are taken by higher professional authorities to eliminate interference by members of the local medical profession in restraint of change from the present costly and disorganized methods of medical practice to a more modern and more economical pattern.

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[1] "Instances have occurred in which physicians, for political, commercial, or emotional reasons, have endeavored to utilize the principles of medical ethics as a means of producing embarrassment, distress, or loss of reputation of other physicians whom they envy or whose open competition they fear. The principles of medical ethics were not designed for any such purpose, and the attempt to utilize the principles of ethics for such purposes may well be in itself unethical." Editorial, JAMA July 16, 1949 (vol. 140, No. 11), p. 960.

[2] "The committee recommends that comprehensive medical services be extended by the use of voluntary, nonprofit insurance, using group practice units wherever feasible, and Government subsidy wherever necessary." Medicine in the Changing Order, Commonwealth Fund, 1947, p. 56.

[3] Subscribers to the health insurance plan must also have Blue Cross or other hospital insurance.

[4] Except a permissible $2 charge for night calls requested and made between 10 p. m. and 7 a. m.

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APPENDIX XIII

Excerpt from Today's Woman, 1953 (Fawcett Publications, Inc.)
Written by Jack Harrison Pollack

"Perhaps the most satisfactory health insurance today is found in the seventy odd comprehensive non-profit plans throughout the United States. Usually sponsored by co-operatives and built around the group-medical-practice idea which made the Mayo Clinic famous, they furnish in a single package virtually all of the medical and surgical care you and your family may require. When held along with Blue Cross they offer nearly complete health coverage.

'From the patient's point of view they're better because they emphasize preventive medicine,' a top doctor told me.

Typical of these plans are San Francisco's Permanente Health Plan; the Seattle and St. Louis Group Health Associations; the Elk City, Oklahoma, Farmers' Co-operative Plan; New York City's bustling Health Insurance Plan (HIP).

HIP is America's outstanding comprehensive prepaid medical plan. Terming it "the finest experiment of its kind," The New York Times editorialized: "For actuarial and medical soundness, HIP has no superior. It is unique, a model for the country." In 1951 HIP received the Lasker Award for distinguished public-health service.

Designed mainly for families with incomes under $6,500, HIP members never see a doctor's bill nor are they saddled with extra charges. There are no age limits or waiting periods and you can be treated for anything from a common cold to the most complicated surgery. HIP's 400,000 members include employees of the City of New York, the United Nations and over 300 business firms, unions and social agencies - and their families. Their employers pay half the cost, employees pay the rest. The total cost ranges from $42.72 a year for one person to $128.15 a year for three or more persons."

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