

House of Representatives, U. S.

Committee on Post Office and Civil Service

Washington, D. C.

September 1, 1959


Dear Friend:

Enclosed is a copy of the Committee Report on S. 2162 and the hearings on the legislation to provide a health benefits program for Federal employees which passed the House today.

As one of those who participated in the hearings, I thought you would like to have your own copy.

With best wishes, I am

Sincerely yours,



Frederick C. Belen
Chief Counsel

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

HEARINGS
BEFORE THE
COMMITTEE ON
POST OFFICE AND CIVIL SERVICE
HOUSE OF REPRESENTATIVES
EIGHTY-SIXTH CONGRESS
FIRST SESSION
ON
S. 2162 and similar bills
BILLS TO PROVIDE A HEALTH BENEFIT PROGRAM FOR
GOVERNMENT EMPLOYEES

JULY 21, 23, 28, 30; AUGUST 4, 5, 6, 7, 11, 12, 13, 14, 1959

Printed for the use of the Committee on Post Office and Civil Service



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FEDERAL EMPLOYEES**

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HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

TUESDAY, JULY 21, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met, pursuant to adjournment, at 10:15 a.m., room 215, Old House Office Building, Hon. Tom Murray (chairman), presiding.

The CHAIRMAN. The committee will be in order.

A quorum of the committee is now present.

We are beginning hearings today on what I consider to be one of the major pieces of legislation before this committee, this Congress. It is one which proposes to establish a governmentwide hospitalization and medical program for Federal employees. It is not an easy matter to resolve.

Health insurance legislation has been before our committee recurrently since 1954. I do believe that many of the issues that heretofore have been controversial have been met in the text of the bill that passed the Senate and which is presently before our committee along with a number of bills that have been introduced by Members of the House. There are, however, some rather important details that I am sure the committee will want to work out to its satisfaction before taking action on this bill. We have arranged to hear from the authors of this legislation, other Members of Congress, and then begin with witnesses of Federal employee organizations today.

Future sessions will include testimony from additional employee organizations, representatives of the Blue Cross-Blue Shield and other organizations performing services which would be provided under the bill, representatives of the insurance companies who will also be participating under the bill, and other witnesses. It is planned that the hearings will conclude with testimony from the administration.

One of the matters which concerns me and which concerns the administration, based upon the reports which have been received covering legislation of this nature, is the matter of cost. It is estimated that this program will cost well over \$300 million. Under the terms of the bills we have before us half of this cost will be provided by the employees themselves, and the remaining half will be provided by the Federal Government. Only present employees are covered under this program but the sponsors of several bills already have announced that they are developing legislation for consideration which would apply to retired employees as well. It can be seen that the final implications of this bill are many millions of dollars.

I hope that those who will be witnesses before the committee can give us some rather definite statements concerning cost and the items which compose this cost. I also want to be sure myself that the services, outlined in the legislation to be made a part of the contract for this program, can be furnished within the cost estimates.

I would like to point out to the members that this fringe benefit will add substantially to the payroll cost of the Federal Government. Already the cost of fringe benefits is 27 percent of our Federal payroll. Payroll costs are now over \$13 billion, and except for Defense expenditures represent the largest single item of cost for the operation of our Government.

One of the Senators, when this bill was debated the other day in the Senate, said:

One point which I hope will be emphasized to the employees is that by the enactment of the bill we will be extending a benefit far greater than a 10- or 15-percent pay increase. Although the block buying of this insurance may result in a lesser cost by a considerable amount than such a pay raise, the net result for the long time security and happiness of the employees, I think, will exceed any pay increase we can give them.

I fully agree with this timely observation.

If the Federal employees agree that the enactment of this proposed legislation will be equal to a pay increase of 10 to 15 percent and will not press for legislation during the remainder of this Congress for a pay raise in addition, then I will be more favorably inclined to the enactment of a hospital and medical program for Federal employees.

I am deeply and seriously concerned with the financial condition of our Federal Government. The fiscal year just concluded on June 30 produced a deficit of over \$12.5 billion. Our total national debt is presently \$287 billion and will rise to \$292.5 billion by November 15. We are paying interest on this debt at the rate of \$8.5 billion in the current fiscal year. I do not see how we can favorably consider both a health insurance program and pay legislation in this Congress. Both will add to the national debt and resultant interest charges. If the employee groups plan to demand pay increase legislation next year in addition to this major fringe benefit now before us, they should say so now and this legislation then should be set aside.

While by the terms, these bills would propose to start this program a year from July—that is, July 1, 1960—certainly the Congress which will have to appropriate the money to carry on this program will have to consider this increased payroll cost facing the Federal Government when other costly employee benefit programs are presented for consideration. It would seem to me that there is a strong reason for waiting until we can see what the budget situation for 1960 is so that we can then determine whether or not the money is available. Also, the Federal employees could then make known to us their feeling that if the Federal Government is going to add over \$150 million a year to its payroll costs by this Government insurance, is this the way they want that money to be spent.

Of course, I may be more alarmed about the financial condition of our Government than many others, but I am seriously concerned about the solvency of our Government and where the money is coming from to pay these tremendous appropriations authorized by Congress.

(The bill S. 2162 follows:)

[S. 2162, 86th Cong., 1st sess.]

AN ACT To provide a health benefits program for Government employees.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Employees Health Benefits Act of 1959".

DEFINITIONS

SEC. 2. As used in this Act—

(a) The term "employee" means an appointive or elective officer or employee in or under the executive, judicial, or legislative branch of the United States Government, including a Government-owned or controlled corporation (but not including any corporation under the supervision of the Farm Credit Administration, of which corporation any member of the board of directors is elected or appointed by private interests), or of the municipal government of the District of Columbia, and includes an Official Reporter of Debates of the Senate and a person employed by the Official Reporters of Debates of the Senate in connection with the performance of their official duties, and an employee of Gallaudet College, but does not include (1) a member of a "uniformed service" as such term is defined in section 1072 of title 10 of the United States Code, (2) a noncitizen employee whose permanent-duty station is located outside a State of the United States or the District of Columbia, or (3) an employee of the Tennessee Valley Authority.

(b) The term "annuitant" means (1) an employee who on or after the effective date of the provisions referred to in section 16(b) retires on an immediate annuity, under the Civil Service Retirement Act or other retirement system for civilian employees of the Government, after twelve or more years of service or for disability, (2) an employee who on or after the date of enactment of this Act and prior to such effective date retires on such annuity (1) after twelve or more years of service upon involuntary separation not by removal for cause on charges of misconduct or delinquency or (ii) for disability, (3) a member of a family who receives an immediate annuity as the survivor of a retired employee described in clause (1) or clause (2), or of an employee who dies on or after such date of enactment after completing five or more years of service, (4) an employee who receives monthly compensation under the Federal Employees Compensation Act as a result of injury sustained or illness contracted on or after such date of enactment and who is determined by the Secretary of Labor to be unable to return to duty, and (5) a member of a family who receives monthly compensation under the Federal Employees Compensation Act as the surviving beneficiary of (i) an employee who dies after completing five or more years of service as a result of injury sustained or illness contracted on or after such date of enactment or (ii) a former employee who is separated after completing five or more years of service and who dies while receiving monthly compensation under such Act on account of injury sustained or illness contracted on or after such date of enactment. For the purpose of this subsection, "service" means service which is creditable for the purposes of the Civil Service Retirement Act.

(c) The term "member of family" means an employee's or annuitant's spouse, unmarried child under the age of nineteen years (including (1) an adopted child, and (2) a stepchild or recognized natural child who lives with and receives more than one-half his support from the employee or annuitant in a regular parent-child relationship), or unmarried child regardless of age who is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching the age of nineteen years and who is in fact dependent on the employee or annuitant for over one-half his support.

(d) The term "dependent husband" means a husband who is incapable of self-support by reason of mental or physical disability, and who receives more than one-half his support from the employee or annuitant.

(e) The term "health benefits plan" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract or similar arrangement provided by a carrier for the purpose of providing, paying for or reimbursing expenses for health services.

(f) The term "carrier" means a voluntary association, corporation, or partnership, or other organization (other than an agency or instrumentality of the Federal Government or of any State or political subdivision thereof) which

is lawfully engaged in providing, or paying for or reimbursing the cost of, health services under insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by a national employee organization.

(g) The term "Commission" means the Civil Service Commission.

(h) The term "national employee organization" means a bona fide labor organization, national in scope, which represents only employees of one or more departments or agencies of the Government.

ELECTION OF COVERAGE

SEC. 3. (a) This Act shall apply to any employee who, at such time, in such manner, and under such conditions of eligibility as the Commission may by regulation prescribe, elects to enroll in a health benefits plan described in section 4 either for himself alone or for himself and members of his family. Such regulations may provide for the exclusion of employees on the basis of the nature and type of employment or conditions pertaining thereto, such as short-term appointments, seasonal or intermittent employment, and employment of like nature, but no employee or group of employees shall be excluded solely on the basis of the hazardous nature of employment.

(b) (1) This Act shall apply to any annuitant who at the time he becomes an annuitant shall have been enrolled in a health benefits plan under this Act—

(A) for a period not less than (i) five years, or (ii) the period beginning on the last day of the first period, as prescribed by regulations of the Commission, in which he is eligible to enroll in such a plan and ending on the date on which he becomes an annuitant, whichever is shorter, or

(B) as a member of the family of an employee or annuitant.

(2) This Act shall also apply to any annuitant not enrolled in a health benefits plan during the period referred to in paragraph (1) if—

(A) such annuitant is (i) an annuitant described in section 2(b)(2), (ii) an annuitant described in section 2(b)(4) whose injury was sustained or whose illness was contracted prior to the effective date of the provisions referred to in section 16(b), or (iii) a member of the family of an annuitant referred to in (i) or (ii) or of an employee or former employee described in section 2(b)(5) whose injury was sustained or whose illness was contracted prior to such effective date, and

(B) such annuitant elects to enroll in a health benefits plan under this Act within such period, in such manner, and under such conditions of eligibility as the Commission may by regulation prescribe.

(c) If an employee has a spouse who is an employee, either (but not both) may enroll for himself and members of his family, or either spouse may enroll for himself alone, but no person may be enrolled both as an employee (or annuitant) and as a member of the family.

(d) A change in the coverage of any employee or annuitant, or of any employee or annuitant and members of his family, enrolled in a health benefits plan under this Act may be made by the employee or annuitant only upon application filed within sixty days after the occurrence of a change in family status or at such other times and under such conditions as may be prescribed by regulations of the Commission.

(e) A transfer of enrollment from one health benefits plan described in section 4 to another such plan shall be made by an employee or annuitant only at such time or times and under such conditions as may be prescribed by regulations of the Commission.

HEALTH BENEFITS PLANS

SEC. 4. The Commission may approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide service benefit plan under which in whole or substantial part the physicians, hospitals, or other providers of covered health services agree, under certain conditions, to accept the payment provided by the plan as full payment for covered services rendered by them.

(2) INDEMNITY BENEFIT PLAN.—One Government-wide indemnity benefit plan under which the carrier agrees to pay to the employee or annuitant or member of his family, who incurs expenses for health services covered under the conditions of the policy, or to the providers of the health service benefits, certain stipulated sums of money not in excess of the actual expenses incurred.

(3) **EMPLOYEE ORGANIZATION PLANS.**—Employee organization plans which are sponsored, contracted for, and administered in whole or substantial part, by national employee organizations, which are available only to persons who are or have been members of the sponsoring organization, and which provided benefits for health services to members of the sponsoring organization on July 1, 1959.

(4) **GROUP-PRACTICE PREPAYMENT PLANS.**—Group-practice prepayment plans which offer health services in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. Such a group shall include physicians qualified in at least three major medical specialties and receive all or a substantial parts of its income from the prepaid funds.

BENEFITS TO BE PROVIDED UNDER PLANS

SEC. 5. (a) To the extent possible with the funds available under this Act, the benefits to be provided under plans described in section 4 shall be the following:

(1) **SERVICE BENEFIT PLAN.**—

(A) **HOSPITAL BENEFITS.**—Benefits which the Commission finds to be equivalent to the full cost of hospital care in semiprivate accommodations in a general or acute special hospital for one hundred and twenty days in any period of continuous care or for one hundred and twenty days in the aggregate in any periods of such hospitalization separated by ninety days or less, except that such continuous or aggregate periods in the case of tuberculosis and nervous and mental conditions shall be thirty days.

(B) **SURGICAL BENEFITS.**—Benefits which the Commission finds to be equivalent to the reasonable, necessary, and customary charges for surgical services, and for care of abnormal deliveries, made to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes.

(C) **IN-HOSPITAL MEDICAL BENEFITS.**—Benefits which the Commission finds to be equivalent to the reasonable, necessary, and customary charges for medical services rendered during periods of hospitalization for which benefits are provided under subparagraph (A) to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes.

(D) **AMBULATORY PATIENT BENEFITS.**—Benefits for services to hospital outpatients and other ambulatory patients which the Commission finds to be practicable, reasonable, and desirable with respect to diagnostic and treatment services, surgical services, and services in cases of accidental injury.

(E) **SUPPLEMENTAL BENEFITS.**—Benefits equal to (i) 80 per centum of so much of the additional charges for health services for each individual for each illness as exceeds \$100 but does not exceed \$1,500, plus (ii) the amount of any such additional charges in excess of \$1,500 under such conditions and such maximums as may be determined appropriate by the Commission. For the purpose of this subparagraph, "additional charges for health services" means the amount by which the charges for health services for which supplemental benefits are provided exceed any cash or service benefits provided under subparagraphs (A), (B), (C), and (D). The supplemental benefits provided for under this subparagraph shall not duplicate or replace the benefits provided for under subparagraphs (A), (B), (C), and (D).

(F) **OBSTETRICAL BENEFITS FOR NORMAL DELIVERIES.**—Benefits which shall not exceed \$100 for hospital services and \$100 for professional services for normal delivery, prenatal and post partum care, and which shall be in lieu of all benefits for such services under subparagraphs (A), (B), (C), (D), and (E).

(2) **INDEMNITY BENEFIT PLAN.**—

(A) Hospital Care.

(B) Surgical Care and Treatment.

(C) Medical Care and Treatment.

(D) Obstetrical Benefits.

(E) Prescribed Drugs, Medicines and Prosthetic Devices.

(F) Other Medical Supplies and Services.

The plan may include deductible and coinsurance provisions applicable to some or all of the benefits.

(3) **EMPLOYEE ORGANIZATION PLANS.**—Benefits of the type specified in this subsection under paragraph (1) or (2).

(4) **GROUP-PRACTICE PREPAYMENT PLANS.**—Benefits of the type specified in this subsection under paragraph (1) or (2).

(b) The description contained in subsection (a) of the scope and value of the benefits to be provided under health benefits plans shall not be construed to preclude the provision of alternative benefits under such plans. The Commission may authorize, in lieu of the benefits described in subsection (a), alternative benefits which it determines to be equally acceptable under this Act and which may include deductible and coinsurance provisions applicable to some or all of the alternative benefits.

CONTRACTING AUTHORITY

SEC. 6. (a) The Commission is authorized, without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding, to enter into, or authorize enrollment under, a contract or contracts with or to purchase a policy or policies from, qualified carriers offering plans described in section 4 and providing the benefits described in section 5. Each such contract or policy shall be for a uniform term of at least one year, but may be made automatically renewable from year to year in the absence of notice of termination by either party.

(b) Any contract or policy under this Act shall contain a detailed statement of benefits offered and shall include such maximums, exclusions, and other definitions of benefits as the Commission may deem necessary and desirable.

(c) The Commission shall prescribe regulations fixing reasonable minimum standards for health benefit plans described in section 4 and for carriers offering such plans. The Commission shall not approve any plan or enter into a contract with or purchase a policy from any carrier unless such plan or such carrier, as the case may be, complies with such standards. Approval of such a plan shall not be withdrawn except after notice and opportunity for hearing to the carrier or carriers and to the employees concerned.

(d) No contract shall be made, policy purchased, or plan approved, which excludes employees or annuitants because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(e) No health benefits plan shall be approved which does not offer to employees and annuitants, whose enrollment in the plan is terminated, other than by a cancellation of enrollment, the option to convert, without evidence of good health, to individual contracts providing health benefits. An employee or annuitant who exercises this option shall pay the full cost of the individual contract, on such terms or conditions as are prescribed by the carrier and approved by the Commission.

(f) The benefits and coverage made available pursuant to the provisions of paragraph (e) shall be noncancelable by the carrier as to any individual, except for fraud, overinsurance, or nonpayment of premiums.

(g) Subscription charges and premiums under health benefits plans described in section 4 shall reasonably and equitably reflect the cost of the benefits provided.

CONTRIBUTIONS

SEC. 7. (a) (1) If an employee or annuitant enrolls in a health benefits plan under this Act for himself only there shall be withheld from the salary of such employee, or annuity of such annuitant, as his contribution an amount not to exceed \$1.75 biweekly, and the Government shall contribute a like amount.

(2) Except as provided in paragraph (3), if an employee or annuitant enrolls in a health benefits plan under this Act for himself and members of his family there shall be withheld from the salary of such employee, or the annuity of such annuitant, as his contribution an amount not to exceed \$4.25 biweekly, and the Government shall contribute a like amount.

(3) If a member of the family of a female employee or annuitant who enrolls in a health benefits plan under this Act for herself and members of her family is a husband, other than a dependent husband, there shall be withheld from the salary of such employee or annuitant as her contribution an amount not to exceed \$6 biweekly, and the Government shall contribute an amount not to exceed \$2.50 biweekly.

(b) An employee enrolled in a health benefits plan under this Act who is placed in a leave without pay status may be authorized to continue his coverage, and the coverage of members of his family, under such plan for a period not to exceed one year in accordance with regulations prescribed by the Commission. Such regulations may provide for waiving the requirement of contribu-

tions by the employee and the Government for all or any part of the period of leave without pay.

(c) The sums authorized to be contributed by the Government with respect to any employee shall be paid from the respective appropriation or fund which is used for payment of his salary, wage, or other compensation (or, (1) in the case of an elected official, from such appropriation or fund as may be available for payment of other salaries of the same office or establishment, and (2) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used for the payment of the salary of such employee if he were in a pay status). The sums authorized to be contributed by the Government with respect to any annuitant shall be paid from annual appropriations which are hereby authorized to be made for such purpose.

(d) The Commission shall provide by regulation for conversion of rates of contribution specified in this section in the case of employees paid on other than a biweekly basis, and for such purpose may provide for adjustment of any such rate to the nearest cent.

FEDERAL EMPLOYEES HEALTH BENEFITS FUND

Sec. 8. There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the "Fund", which is hereby made available without fiscal year limitation for the payment of all premiums or subscription charges under policies or contracts purchased or entered into under section 6. The amounts withheld from the salaries of employees and the annuities of annuitants, and the amounts contributed by the Government toward the cost of health benefits for such employees and annuitants, shall be paid into the Fund. The income derived from any dividends, premium rate credits or other refunds shall be credited to and constitute a part of the Fund. There shall be set aside in the Fund from time to time such amounts, not to exceed 1 per centum of the amounts paid into the Fund for any fiscal year, as may be necessary to pay administrative expenses for such year. Any amounts remaining in such Fund after all premium or subscription charges have been paid, and after the amounts referred to in the preceding sentence have been set aside, shall be retained as a special reserve for adverse fluctuations in future charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such amounts are derived, as the Commission shall from time to time determine. The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund.

ADMINISTRATIVE EXPENSES

Sec. 9. (a) There are hereby authorized to be expended from the Employees' Life Insurance Fund, without regard to limitations on expenditures from that Fund, for fiscal years 1960 and 1961, such sums as may be necessary to pay administrative expenses incurred by the Commission in carrying out the health benefits provisions of this Act. Reimbursements to the Employees' Life Insurance Fund for sums so expended shall be made from the Federal Employees Health Benefits Fund.

(b) The Federal Employees Health Benefits Fund is hereby made available, within such limitations as may be specified annually by the Congress, to pay such expenses for fiscal year 1961 and subsequent fiscal years.

REGULATIONS

Sec. 10. (a) The Commission is authorized to promulgate such regulations as may be necessary to carry out the provisions of this Act.

(b) Regulations of the Commission shall include regulations with respect to the beginning and ending dates of coverage of employees and annuitants and members of their families under health benefit plans, and for such purpose may permit such coverage to continue until the end of the pay period in which an employee is separated from service or until the end of the month in which an annuitant ceases to be entitled to annuity, and in case of the death of such employee or annuitant may permit the coverage of the members of his family for a period not to exceed ninety days.

(c) Regulations of the Commission shall provide that any employee enrolled in a plan under this Act who is removed or suspended without pay and later reinstated or restored to duty on the ground that such removal or suspension was unjustified or unwarranted shall not be deprived of coverage or benefits for the interim but shall have his coverage restored to the same extent and effect as though such removal or suspension had not taken place, and appropriate adjustments shall be made in accordance with such regulations in premiums, subscription charges, contributions, and claims.

(d) Regulations of the Commission shall provide for making available to each employee and annuitant eligible to enroll in a health benefits plan under this Act such information as may be necessary to enable such employee or annuitant to exercise an informed choice among the types of plans referred to in section 4. Such regulations shall also provide for the issuance to each employee and annuitant enrolled in such a health benefits plan of an appropriate certificate setting forth the services or benefits to which the employee or annuitant, or the employee or annuitant and members of his family, are entitled thereunder, the person or persons to whom monetary benefits shall be payable, the procedure for submitting claims, and the principal provisions, or summaries thereof, of the plan affecting the employee or annuitant or members of his family.

STUDIES BY COMMISSION

SEC. 11. (a) The Commission shall make a continuing study of the operation and administration of this Act, including surveys and reports on health benefits plans available to employees and annuitants and on the experience of such plans, with respect to such matters as gross and net costs, administrative costs, benefits claimed and provided, utilization of benefits, the extent to which the economic use of benefits herein provided is assured, and the portion of the actual personal expenditures of Federal employees and annuitants for health care which is being met by prepaid benefits.

(b) The Commission shall include provisions in contracts with carriers which would require carriers to (1) furnish such reasonable reports as the Commission determines to be necessary for the satisfactory completion of the studies enumerated in subsection (a) with respect to gross and net costs, administrative costs, benefits claimed and provided, utilization of benefits, and (2) permit the Commission or its representatives and representatives of the General Accounting Office to examine such records of the carriers as may be necessary for verification of the information contained in the carrier's reports.

(c) Employing agencies shall keep such records and furnish the Commission with such information and reports as may be necessary to enable it to carry out its functions under this Act.

ADVISORY COUNCIL

SEC. 12. (a) There is hereby established a Federal Employees Health Benefits Advisory Council which shall consist of the following:

- (1) the Secretary of Labor;
- (2) the Director of the Bureau of the Budget;
- (3) the Surgeon General of the Public Health Service;
- (4) the Chief of the Bureau of Medicine and Surgery of the Veterans' Administration;
- (5) one member to be appointed by the President who shall be representative of the public;
- (6) three members to be appointed by the President from among representatives of national employee organizations;
- (7) three members to be appointed by the President who shall be representative of university schools of medicine, hospital administration, and public health, respectively.

The Advisory Council shall select a Chairman and a Vice Chairman from among its members. Each member of the Advisory Council referred to in clauses (1) to (4), inclusive, may designate an alternate to attend meetings and participate in activities of the Advisory Council in the place of such member. Members of the Advisory Council referred to in clauses (5) to (7), inclusive, shall be appointed for terms of three years.

(b) It shall be the duty of the Advisory Council (1) to make studies from time to time of the operation and administration of this Act, (2) to receive

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

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reports and information with respect thereto from the Commission, carriers, and employees and their representatives, (3) to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances or reserves, (4) to consult with and advise the Commission in regard to the administration of this Act, and (5) to make recommendations with respect to the amendment of this Act or improvements in its administration. No contracts shall be awarded, renewed, or terminated and no regulation shall be promulgated, for the purpose of carrying out this Act, unless copies of proposed drafts thereof shall have been furnished to the Advisory Council.

(c) Members of the Council referred to in clauses (5) to (7), inclusive, who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at a rate to be fixed by the Commission, but not exceeding \$50 per diem, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

(d) The Advisory Council shall be convened by the Commission within thirty days after the members referred to in clauses (5) to (7) have been appointed, and thereafter shall meet not less often than quarterly, on call of the Commission or on request of any three members of the Advisory Council.

BUREAU OF RETIREMENT AND INSURANCE

SEC. 13. There is hereby established in the Civil Service Commission a Bureau of Retirement and Insurance, which shall perform such of the functions and duties of the Commission with respect to retirement, life insurance, and health benefits programs as the Commission shall prescribe. The Bureau shall be headed by a Director. Except as provided in the second and third sentences of the last paragraph of the first section of the Act of January 16, 1883, the Director shall be responsible only to the Chairman of the Commission with respect to the matters transferred to the Chairman by the provisions of section 2(a) (2) to 2(a) (6), inclusive, of Reorganization Plan Numbered 5 of 1949. The position of Director shall be placed in grade 18 of the General Schedule of the Classification Act of 1949, as amended. Such position shall be in addition to the number of positions otherwise authorized by law to be placed in such grade.

JURISDICTION OF COURTS

SEC. 14. The district courts of the United States shall have original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this Act.

REPORTS TO CONGRESS

SEC. 15. The Commission shall transmit to the Congress annually a report concerning the operation of this Act.

EFFECTIVE DATE

SEC. 16. (a) The Commission shall transmit to the Committee on Post Office and Civil Service of the Senate and the Committee on Post Office and Civil Service of the House of Representatives not later than May 1, 1960, copies of any contracts proposed to be entered into, policies proposed to be purchased, and regulations proposed to be promulgated, for the purpose of placing into operation health benefits plans under this Act.

(b) The provisions of this Act relating to the enrollment of employees and annuitants in health benefits plans and the withholding and payment of contributions shall take effect on the first day of the first pay period which begins on or after July 1, 1960.

Passed the Senate July 16, 1959.

FELTON M. JOHNSTON, *Secretary.*

The CHAIRMAN. We will now hear from Mr. Rees, the ranking minority member of the committee.

**STATEMENT OF HON. EDWARD H. REES OF KANSAS, RANKING
MINORITY MEMBER OF THE COMMITTEE**

Mr. REES. Mr. Chairman, I want to concur in general with the statement of the chairman of our committee. I, too, am concerned about the solvency of our Government.

I have been interested for some years in the establishment of a program, under Government sponsorship, to insure Federal employees for expenses incident to illness or injury which they or their families may suffer. As chairman of this committee in the 83d Congress I discussed the matter with representatives of the Civil Service Commission and other Government agencies, and authorized staff participation in the first conferences conducted by the Commission with representatives of employee organizations and insurers offering service or indemnity plans to the general public.

I was, and am, convinced that a sound and workable health insurance program is desirable to round out, with the Government employees' group life insurance plan, a joint Government-employee system of life and health insurance that will be very helpful to our 2 million or more Federal employees and their families.

I sponsored H.R. 10099 in the 83d Congress—the first bill to provide such a medical insurance plan—and introduced H.R. 7241 and H.R. 11633 for the purpose in the 84th Congress.

I recall, also, that the chairman and I agreed to request the General Accounting Office to conduct a special study, after the 84th Congress adjourned, with respect to the feasibility of a payroll deduction plan for health insurance. This study was completed and has clarified one of the major problem areas relating to the administration of a Government employees' health insurance program.

Although I favor appropriate legislation to establish a Governmentwide health insurance plan, I believe that certain factors must be taken into account in determining the scope and the extent of the plan and the respective obligations of the Government and the employees thereunder.

I concur in the very timely and pertinent remarks of our chairman concerning the cost of the health insurance bill recently passed by the other body and the relationship of this cost to the national budget. Facing, as we do today, domestic and worldwide commitments that already are fixed by congressional policy, any proposed new program that imposes an additional multimillion-dollar expense on the Public Treasury ought to require the utmost scrutiny to make certain that the cost is necessary and is fully justified in the national interest.

It is well to keep in mind, also, that even the \$304 million cost estimated in the report of the other body is subject to continued upward revision. There is nothing to indicate that medical, surgical, and hospital costs will level off in the foreseeable future. Thus, costs which we estimate today may be considerably higher after several years—at a time when payments of benefits under the proposed insurance program likewise will be rising.

Although precise advance determination of the costs of providing benefits of the kind contemplated by the pending legislation may be difficult, it is better to be conservative than overliberal in our esti-

mates. It has been my experience, where a completely new and untried benefit program of such broad scope and effect as this one is proposed, that advocates of the program may err, in all honesty and sincerity, on the side of relatively lower cost estimates—rather than to arrive at higher costs which might be indicated from a conservative viewpoint. With the range of benefits to be made available under the pending bills, the cost to be underwritten by the Government may be even greater than the approximation of \$145 million presented with the Senate-passed bill. There is no accurate forecast as to employee participation, plans to be made available for their choice, numbers of employees and dependents in the several eligible categories, and many other factors that will directly affect costs. The initial cost of developing preliminary data and obtaining offers of insurance options to be available for employees, as well as the continuing cost of administering the program, alone would seem to me to require substantial sums of money.

In consideration of the fact that this is a new field of endeavor, and in view of the expense, the number of employees affected, and the desirability of sound financing, it is most important that all phases of the subject matter be carefully considered before arriving at the committee's recommendation on this legislation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Rees.

We will next hear from Representative Morrison, who is the author of H.R. 208, H.R. 7712, and H.R. 8210, all relating to the hospitalization program of the Federal employee.

**STATEMENT OF HON. JAMES H. MORRISON OF LOUISIANA, A
MEMBER OF THE COMMITTEE**

Mr. MORRISON. Mr. Chairman and my colleagues on the committee, I am happy to present my views on the vitally important subject of health benefits for Government employees. For more than a dozen years I have consistently supported this type of legislation for postal workers and other employees of the Federal Government. Only July 14, 1959, I introduced my most recent bill, H.R. 8210, which is identical with the successful Johnston-Neuberger measure, S. 2162, which as you know, passed the Senate on July 16, 1959, by an overwhelming vote of 81 to 4. It is my fervent hope that H.R. 8210 will be reported favorably by this committee, with no reduction in the benefits it provides, at the earliest possible moment. Any additional delay will undoubtedly spell doom for this needed legislation in the now waning days of the 1st session, 86th Congress.

In referring to S. 2162 during the debate on the Senate floor, the distinguished chairman of the Senate Committee on Post Office and Civil Service, stated:

* * * The bill is like a finely tooled watch, one part being geared to each other part * * * The bill is not susceptible to tinkering and tampering without doing damage to the smooth working of the other provisions * * *

My views coincide completely with those so ably expressed by the Senator from South Carolina. As an example, my original bill introduced early in this session, provided that the Government should withstand two-thirds and the employee one-third of the total cost

of this legislation. My studies reveal that the plan generally prevalent in private industry provides that the costs are equally shared by employer and employee. Even though I still feel that the Government should pay two-thirds of the total cost, I now reluctantly agree to the 50-50 formula.

Under the provisions of H.R. 8210 and S. 2162, a free choice of plans is made available to Government employees. These plans are: service-type plan such as offered by Blue Cross-Blue Shield; indemnity type plan offered by the insurance industry; group practice-type plan such as offered by Group Health Association here in Washington and the Kaiser Foundation health plan on the west coast; and national employee plan offered by national employee unions. Moreover, unlike previous bills in this field, my companion measure to S. 2162 has been endorsed by the American Medical Association, the American Hospital Association, Blue Cross-Blue Shield, Federal employee unions, and group practice plans. H.R. 8210 and S. 2162 provide for withholding by the Government from employees' salaries and annuity checks, this money to be matched equally by the Government. The individual Government employee or annuitant, under the terms of the bill, pays \$1.75 biweekly, whereas a Government employee and family would pay \$4.25 biweekly. These are maximum amounts.

While the health coverage provided by the bill does not take effect until July 1, 1960, it is essential that this legislation be passed this year by Congress. My only regret is that neither H.R. 8210 nor S. 2162 cover those faithful former employees presently on the retirement rolls.

The administration has argued that coverage should not be granted these fine people since this older age group might well cost a prohibitive amount. This group of loyal retirees or annuitants should not be forgotten and I am now preparing legislation that will give them the same coverage provided for active employees.

In all fairness, it should be stated that the administration presently in power did recommend legislation of this type in 1954, 1955, 1956, and 1957. Conflicting positions on the part of the groups previously mentioned in this statement made it almost impossible to secure favorable congressional action. Those differences have been almost completely eliminated and this legislation should be expedited in the current congressional session. Any further delay will constitute a travesty on justice. More than 2 million Government employees affected by this legislation are anxiously awaiting the results of our deliberations.

The CHAIRMAN. Thank you, Mr. Morrison.

We will next hear from Representative Corbett, a fellow member of our committee, who is also the author of similar legislation, H.R. 5783.

**STATEMENT OF HON. ROBERT J. CORBETT OF PENNSYLVANIA, A
MEMBER OF THE COMMITTEE**

Mr. CORBETT. I do not have a formal statement. I asked for this time for two purposes.

One, I want to commend the chairman for bringing this important legislation before us so promptly after the Senate acted.

Secondly, I just want to say a few words in support of the general proposition. From my point of view, this is one of the most important fringe benefits that we could possibly provide for our Federal employees. In my own district, which is northern Pittsburgh, I would say that practically all of the progressive companies have these programs for their employees and in numerous cases the payments are made entirely by the employer.

Now I am not wedded to any bill or any provision of any bill. I think the committee has an enormous job here in initiating a new program to get as carefully worked-out a program as possible, fully recognizing that the test of experience will dictate amendments to that program over the years. But, I think it is regrettable that we did not get started on such a program of health insurance for employees several years ago, because since this first became feasible literally thousands of persons who have suffered catastrophic illness have been in financial distress. They have no place to turn for aid if they are not privately covered.

With as large a group as we have to work with, it would be my hope that we could either have the least costly program or the most beneficial program of any group of people in the world. And it is to that end that the committee should be devoting its efforts. I believe that we should go at this business with the idea that we are pioneering—that anything that may be part of this program now might be changed later, either in reduced cost, increased benefits, or increased Government participation, whatever may happen. I think it is highly essential that we get this program on the road to the end not only that we provide for financial help for distressed persons, but that we might provide better medical care, longer life, and less pain and suffering for all of our hundreds of thousands of employees.

So, Mr. Chairman, I again commend you on getting these hearings started, and I hope that we can diligently press on to the completion of our work so that at long last hundreds of thousands of people can face the future with more security and more confidence.

The CHAIRMAN. Thank you, Mr. Corbett.

The committee will next hear from a former valuable member of our committee whom we wish were sitting here today as a member, Representative George Miller of California.

**STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. MILLER. Mr. Chairman and members of the committee, it is always a pleasure to return to this room and to greet the members of this committee, though as I look down the table today I see fewer and fewer faces that were here when I had the privilege of sitting next to Mr. Morrison on your left, Mr. Chairman.

I, too, want to commend you for bringing this legislation up so quickly after the Senate passed it, because, having gotten it through there I am certain that you realize its importance, as has been demonstrated by your setting the hearings now, and I want to thank you for it.

This is a fringe benefit that has become the mode in industry. In this the Government has lagged behind industry in taking care of

its employees and I am very happy to know that we are now about to take the first step to bring the Government into line as an optimum employer, as it should be.

We are all concerned with the solvency and fiscal condition of the Government, but I for one am much more concerned with the health and welfare of the people who work for the Government. They can't wait. You cannot say that because we cannot afford this. Today when the gross national product of the country is higher than it has ever been, when the newspapers are telling you that there is more employment in the country, when they tell you that the economic condition of the country is better off than it has ever been, when railroads and industry are paying more dividends than they have ever paid, we cannot wait. You have tuberculosis or you have incurred a dread disease in the course of your employment but you will have to put that aside. You cannot arrest it. It is progressive. So time to me is an element in this situation.

May I point out to you, Mr. Chairman and my colleagues, that over half of the people who get their sustenance from the Federal Government are today being taken care of and receiving free medical attention, and medical attention that goes with them after their retirement, and I refer to the members of the armed services and the people in the State Department.

We know, historically, how that took place, but the conditions that made this necessary in midcentury and necessary when armies march shoulder to shoulder in the field have changed a good deal, but we have still continued it, and I am very happy we have continued it. I have no desire to take away from members of the uniformed forces the medical service that we furnished them. But I want to point out to you that we do furnish them these services and at a cost much greater than a \$150 million a year; as a matter of fact, at a cost five times that, if I remember rightly.

Mr. Chairman, I have read the Senate bill. I have not studied it. I realize the enormity of the task before you. To come here and to try and point out the technicalities that should go into such a bill, the wording of a bill is something that is going to take your combined effort over the next few weeks, and I would be presumptuous to tell you what to do.

Suffice to say that with all the sincerity and vigor I can muster, I want to subscribe in principle to the Senate bill or to the Morrison bill or the Davis bill or whatever bill has been written that has been put here. I mentioned the Senate bill because that is the one that is passed and that is the one that I have read, and I subscribe in principle to it, and I hope that this committee will report such a bill with dispatch so that we can get it enacted before Congress goes home.

I want to thank you for the privilege of being here.

The CHAIRMAN. Thank you, Mr. Miller.

The committee will hear next from Representative John Baldwin, of California.

**STATEMENT OF HON. JOHN F. BALDWIN, JR., A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. BALDWIN. Mr. Chairman, I want to express my appreciation to you and the members of the committee for the opportunity to appear

before you this morning and I want likewise to express appreciation for many of the employees in our district, Mr. Chairman and members of the committee, who are in favor of S. 2162 and of H.R. 8210 and other comparable bills.

It seems to me that with the increasing cost of medical and hospital care, that this field is probably the field where there is now the greatest worry by people who are Government employees. I noticed just within the last week an analysis of the different groups of costs as compared to a year ago and the increase in those various groups of costs, food, medical care, and all the rest. Of all the five groupings of costs the one that had increased the largest amount in the last year was hospitalization and surgical care. That increase was approximately 13 percent just in a 1-year period of time.

Before coming to Congress I served as the attorney for two hospitals, and I became very much aware at that time of the fact that hospitalization was going up at a tremendously rapid rate. It is now reaching a point where for a person who has some injury or some long illness, he may have reasonable savings but that one illness or injury cannot only completely remove all of those savings from him but may cause him to borrow a considerable sum of money and therefore go into the end part of his life with considerable financial worry. It seems to me that this is a most essential field, and I am glad the committee is taking action on it.

It seems to me that the Senate bill is a reasonable compromise of many points of view that were not reconciled up until this year. It represents one proposal that now has the greatest support of any single proposal. I think that the proposal that one-half the cost be borne by the employee and the other half by the Federal Government is reasonable in relationship to what is done in industry. It seems to me that this, once enacted into law, will constitute a most important added incentive to employees to stay with the Federal Government. We are still facing the probability of some of our most skilled employees and most trained employees having a great urge to leave the Federal service for other types of work. I think the enactment of this bill will be a large additional incentive in holding this type of employee in the Federal service where their skill is of great benefit to us.

I hope that the committee will see fit to enact S. 2162 or some similar bill. You may find modification needed, but I hope you will enact a bill that involves the principle involved in S. 2162, and I appreciate the opportunity to come and testify before the committee.

The CHAIRMAN. What will it cost the Federal Government?

Mr. BALDWIN. The total cost is estimated to be around \$300 million, Federal share estimated around a \$145 million or \$150 million.

The CHAIRMAN. I am sure you are concerned with the present condition of the Federal Treasury?

Mr. BALDWIN. I appreciate that, Mr. Chairman.

The CHAIRMAN. Where is the money coming from, this \$150 million.

Mr. BALDWIN. I think that every bill of this type has to be considered in relation to many other things. I voted for an amendment which struck \$100 million out of a mutual security bill. The bill

provided \$800 million for the Development Loan Fund, and I voted for the amendment.

The CHAIRMAN. I went further than you did. I voted against the whole thing.

Mr. BALDWIN. All I would like to say on that point is that each bill has to be considered on its own merits.

Mr. CORBETT. I think we should not pass this point without allowing Mr. GROSS to be associated with these remarks.

The CHAIRMAN. Mr. GROSS.

Mr. GROSS. I desire for the record to be associated with the statement the chairman just made.

Mr. PORTER. I support this bill.

I would like to ask the gentleman if he also supports the Forand bill.

Mr. BALDWIN. The Forand bill is still under consideration by the House Ways and Means Committee, and I would like to have the opportunity of studying the report of the committee when that report is formulated.

Mr. PORTER. In the Forand bill medical payments or care for catastrophic illness would be given to retirees over 65 although they never paid in on such a basis. That, of course, is going to be the question that will confront us here, the retirees.

Mr. BALDWIN. You are talking about Federal retirees that are now retired and therefore would not be covered under this bill?

Mr. PORTER. They would not under the bill, though I understand there are proposals that they be.

Mr. BALDWIN. It is my general feeling that we have endeavored in past years to give recognition to the needs of retired employees as we have given recognition to those who are still employed and that is the reason we have periodically passed bills to increase the retirement annuities of retired Federal employees. It is my understanding further that the State of New York has put into effect a plan involving medical care which covers not only active employees but also retired ones. This is a field that involves a lot of study from a standpoint of cost. I think something should be done in this field, and I hope that the committee will give consideration to this problem. If retirees are going to be brought in they will have to make some contribution. I do not think it would be proper to cause the now active employees to pay the full benefits for them. There would have to be some way worked out for them to make a contribution, but I hope this committee will give consideration to that problem either in this bill or some separate bill because I think it is a problem that needs to be resolved.

Mr. PORTER. Do you believe that we should strive to enact this legislation in this session or would it be all right—

Mr. BALDWIN. I think it should be enacted as soon as possible.

Mr. PORTER. Will you tell me why? The effective date is July 1960.

Mr. BALDWIN. The reason in my opinion is that this requires the issuance of rather extensive regulations by the Civil Service Commission. It requires—those regulations will have to be worked out in connection with the various participating groups. That is not going to be something that can be done overnight. It seems to me that if this is passed within the next month it will still be a challenge

for all these regulations to be worked out in detail and put into effect in time for the effective date of July 1960.

Mr. PORTER. I agree.

The CHAIRMAN. I understand that the administration proposed modification to the proposed legislation.

Are you in favor of the modification of the administration's proposal?

Mr. BALDWIN. I have read the letters that were submitted to the Senate committee by the Civil Service Commission, and the Budget Bureau. As to their recommendations on the advisory council and on the Bureau of Retirement and Insurance, I do not have any strong feelings for or against those, and I am sure that the committee will go into those in detail and come to a conclusion. I am opposed to the position that they have taken that the cost to the Government should be cut in half because I do not think it can be done and provide the program that should be provided for the Federal employees.

The CHAIRMAN. Well, I am hopeful that legislation can be reported out by the committee that will be satisfactory to both the employees and the administration. Now, if the views of the administration are absolutely ignored by this committee and the bill is not amended in some form to satisfy the administration, and if the bill should then be vetoed by the President, I am confident that the veto will not be overridden, even though some people think to the contrary. This committee ought to work out a bill that will be satisfactory to both the employees and the administration.

Mr. BROYHILL. Mr. Chairman.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. You stated that you were general counsel for two hospitals prior to coming to Congress?

Mr. BALDWIN. That is correct.

Mr. BROYHILL. Were you familiar with the health insurance programs of private industry?

Mr. BALDWIN. Generally so, yes.

Mr. BROYHILL. How would you say that this principal bill before us, the Senate bill, compares with the hospitalization plans of private industry?

Mr. BALDWIN. I think that actually in numerous cases private industry contributions are greater than this. I would say that this is no more than the standard of private industry. A considerable number of concerns actually pay the full amount. I think that the enactment of this would only be in line with what has already been done in many major industrial firms.

Mr. BROYHILL. I feel that the main objection that has been voiced to this particular compromise is the cost, the \$150 million, but that is not due to the program being overly liberal as much so as the fact that we have 2,300,000 Federal employees and any particular type of program we have is going to cost some money.

Mr. BALDWIN. That is right.

Mr. BROYHILL. It costs a lot of money to run a government of this size, but I appreciate your remark. I think it very important that we do try to arrange some type of program that is at least competitive with the type of program that has been established by private indus-

try. You state that this does not really compare favorably, is that it, with the general private industry health insurance program?

Mr. BALDWIN. It is no more than the average and would not compare favorably with some of the major industries in the country. And this is the field in which there is the greatest worry now by people nearing retirement age. This I think is extremely important to be taken care of.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. Would some of those industrial firms that you spoke of—and you, I assume, were the attorney representing hospitals in California, is that correct?

Mr. BALDWIN. I represented two hospitals in California, yes.

Mr. GROSS. Would some of those industrial firms be operating on a cost-plus-a-fixed-fee contracts?

Mr. BALDWIN. In most cases they were not.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. The question was asked of you about the cost of this program. I would like to ask you about the value of the program. You have indicated your views in support of legislation that would provide this benefit. From your standpoint, Mr. Baldwin, do you think that the value of such a medical program, putting aside for just a brief moment the cost of the program, both the social and economic value to the Federal Government would justify or not justify the costs that would be involved?

Mr. BALDWIN. I think the value would justify the cost of the program. There are two aspects of this that are of great concern. First of all this whole field of medical care has now ballooned from the point of cost. The average daily cost of hospital beds plus the special bills people get when they go into hospitals for injections, medical attention, drugs, et cetera, are such that just a couple of weeks in a hospital has practically ruined a family with minimum savings. This has become a steadily increased worry to Federal employees as to other people.

The very sense of security would increase the morale of Federal employees, and I am sure therefore mean that we would have a group of Federal employees with a better attitude toward their work. But more important than that is that the skilled employees, the people we need the most, are the ones that are getting offers from private industry that provide individuals many of these things and they are looking with favor toward those offers because they know they will be covered.

Mr. FOLEY. If I understand you correctly it is your suggestion that this committee concentrate on exploring the value of the program to the Federal Government, value from the standpoint of earlier and better medical care to its employees so they can get back on the job and provide their valuable skilled services to the Federal Government. We should not be thinking exclusively of the cost but also of the real positive value the Federal Government will be getting by dollars returned for the investment that the Government is going to make in this program. Is that a fair appraisal?

Mr. BALDWIN. Yes.

The CHAIRMAN. If this legislation should become a law, would you still favor an increase in pay for Federal employees during this Congress, that is, next year?

Mr. BALDWIN. Mr. Chairman, I have no way of knowing what the problems are that will be presented to the next session of Congress. I have no way of knowing whether there will be a depression or recession, what cost increases will occur throughout the country, and I do not think it would be proper for me to make a commitment of this kind.

The CHAIRMAN. Mr. Alford.

Mr. ALFORD. Do you not agree that any plans should permit a realistic choice on the part of the employee as to the type of plan?

Mr. BALDWIN. I think that is true, and I think the Senate bill and the comparable bill in the House provide such a choice.

Mr. ALFORD. I am entirely in agreement with that, and I would like to take your time for just a moment to say to our colleague, Mr. Porter, that I do not think we should confuse this plan of which we were speaking today with H.R. 4700 which is an entirely different type of proposition.

It is my understanding that we are merely considering a plan that is of an employer-employee relationship and is comparable to industry and should not be confused with the social security type plan.

Mr. PORTER. Will the gentleman yield?

Mr. ALFORD. I yield.

Mr. PORTER. I am interested in the parallel between the need for medical care in the Government as well as retirees' fund under social security. These proposals always are very similar. I think we are talking about the same kind of problem. Whether we should include it in this program is certainly an issue.

Mr. BROYHILL. Would the gentleman yield?

Mr. PORTER. Yes.

Mr. BROYHILL. Under the Forand bill would the health insurance features under social security be voluntary?

Mr. PORTER. There would be a choice of doctors.

Mr. BROYHILL. Is that correct, Dr. Alford? Under the Forand bill, is it not compulsory?

Mr. ALFORD. Yes. This is an entirely different proposition.

The CHAIRMAN. It is indeed. I think it will be a long, long time before the Forand bill becomes a law.

Mr. ALFORD. I would like to reemphasize, I do not think we should confuse this hearing with the type of legislation that is being considered before the Ways and Means Committee. I think it really unfair to the employees and the employer, the Government, to so confuse. I do not believe that issue is germane to what we are talking about here this morning.

The CHAIRMAN. I agree fully with the gentleman about that; there is no comparison.

Mr. PORTER. Under the Forand bill there is a choice by the retiree of the physician involved except with respect to surgical matters and emergency matters. I think they are very similar problems, and I think as we get into the proposal covering the retirees, we will see the similarity.

Mr. CORBETT. Mr. Chairman.

The CHAIRMAN. Mr. Corbett.

Mr. CORBETT. I suggest that some of us know so little about this bill that there is no use confusing it by talking about the Forand bill at the same time.

Mr. PORTER. I will go along with that.

The CHAIRMAN. I agree with that.

Any further questions of the witness?

(No response.)

The CHAIRMAN. If not, thank you very much, Representative Baldwin.

The committee will next hear from our colleague, Representative Jeffery Cohelan of California.

**STATEMENT OF HON. JEFFERY COHELAN, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. COHELAN. Mr. Chairman, I appreciate the opportunity to appear today to speak in favor of H.R. 8210, the Federal Employees Health Benefits Act of 1959 authored by the gentleman from Louisiana, Mr. Morrison.

The Seventh Congressional District of California which I represent is a metropolitan district on the eastern shore of San Francisco Bay in which are located, in addition to the usual Federal agencies, such installations as the Oakland Army Base, the Department of Agriculture's Western Regional Research Laboratory, the U.S. Forest Service California Forest and Range Experimental Station Headquarters, a Bureau of Indian Affairs Relocation Center, and other offices employing large numbers of Federal employees. In addition, many of the civilian employees at Alameda Naval Air Station which is located in the adjacent district of my senior colleague, Congressman George P. Miller, reside in the Seventh Congressional District, as do other employees at Federal installations in San Francisco and other bay area facilities.

An unusually large number of my constituents, therefore, are very much interested in the passage of H.R. 8210 which will, for the first time, enable them to enjoy health benefits comparable to those available to other large employee groups by authorizing payroll deductions and equal health benefit contributions by their employer, the Federal Government.

We are, of course, not asking for special consideration, but only for equal benefits. Over 90 million persons in the United States are already enrolled in various health insurance programs through the place they work. The same opportunity is not now offered to Federal employees.

The example of the Seventh Congressional District of California also underscores another all-important provision of H.R. 8210; that is the requirement that employee and Government contributions shall be on a 50-50 basis.

In opposing this formula the administration urged instead that the Federal Government be required to contribute only one-third of the costs of the program, as it does with the Federal employee's life insurance. In the San Francisco area such a formula would not

result in equality of benefits at all. In many private industries in our area, as elsewhere in the country, management contributes 100 percent of the costs of employee health insurance plans. In others, the basis of contributions varied downward, but as a general rule health benefit programs are supported 50 percent by management and 50 percent by individual employees.

Mr. Chairman, I believe H.R. 8210 is sound, realistic legislation, and I urge that the committee report the measure favorably. Thank you.

The CHAIRMAN. Thank you.

Mr. FOLEY. I want to commend the gentleman for the position he has taken in support of this bill, and I am very happy to see him here.

Mr. COHELAN. I thank you.

Mr. PORTER. I would like to ask the gentleman if he believes that the seat of the Government is moving to California.

Mr. COHELAN. I have no comment, Mr. Porter.

The CHAIRMAN. Thank you very much.

Mr. COHELAN. Thank you, Mr. Chairman.

The CHAIRMAN. Statements from the following Members of the House will now be inserted in the record: Representative Thomas J. Lane of Massachusetts, author of the health insurance bill H.R. 178; Hon. Isidore Dollinger, author of H.R. 2326, a health insurance bill; and Hon. Joel Broyhill of our committee, the author of H.R. 726 and H.R. 5386.

Mr. Lesinski also has a statement to place in the record at this time. Are you the author of a similar bill?

Mr. LESINSKI. Yes, sir.

The CHAIRMAN. All right, sir.

There will also be placed in the record statements of Representatives Rivers, of Alaska, and Pelly, of Washington State.

(The statements referred to above follow:)

STATEMENT OF HON. THOMAS J. LANE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Chairman and members of this committee, the Federal Government has been backward in providing the wages, and fringe benefits that are accepted as routine obligations throughout American industry. In fact, some corporations have voluntarily provided life insurance and health insurance programs for their employees because they understand the economic right of workers to these benefits, and because they know that such consideration for the welfare of their employees promotes the mutual confidence that inspires better morale and better efficiency.

A hospitalization plan for Federal employees has been studied and restudied for many years. Meanwhile, private industry has been moving forward with the times. Its prosperity has been paralleled by simultaneous economic and social progress on the part of its employees. But the turnover among Government employees continues at a disturbing rate that is both wasteful and inefficient. Why?

As the Government employees compare their lot with those who work for private industry, they see all too clearly that their relative position is steadily deteriorating. They are discontented because they do not believe that the Government is being fair with them. While the Government marks time on "studies," private industry is gradually improving the status of its own employees. There are many companies with lesser programs, but I will simply outline four of the best ones.

B. F. Goodrich Co. provides 120 days of hospitalization in a semiprivate room, and with a \$250 maximum for surgery; Minnesota Mining & Manufacturing Co., 140 days up to \$15, full cost of hospital services, with a \$300 maximum for sur-

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gery; Armstrong Cork Co., 180 days up to \$10, with further provisions for additional care, and a \$200 maximum for surgery; American Sugar Refining Co., 365 days of hospitalization at full cost, with a \$300 maximum for surgery.

In each case, the company *pays the full cost*, not only for the employee, but for his dependents, and for retired employees and their dependents as well. The steel industry and the automobile industry have 50-50 contributory programs for their employees, and this is the formula contained in Senate bill 2162, which is called the Health Benefits Program for Government Employees.

The Federal Government is the Nation's largest employer. Under the terms of this bill, more than 2 million Federal employees, plus their dependents, would become eligible for the protection enjoyed by most of those who are employed in private industry. The Government will withhold from employees' salaries, and annuity checks, sums to be matched equally by the Government. The individual Government employee or annuitant, would pay \$1.75 biweekly. The Government employee with a family, would pay \$4.25 biweekly.

Progress on this type of legislation has been delayed for many years due to sharp disagreements, but in S. 2162 we have a bill that has united the American Medical Association, the American Hospital Association, Blue Cross-Blue Shield, Federal employee unions, and group practice plans in support of it.

It is unfortunate that the bill as passed by the Senate does not cover presently retired Federal employees and it is my hope that the House will make provision for them. We are morally bound to do so because we cannot cast adrift those who gave the best years of their lives in loyal service to the Government, and have now reached the age where they have greater need of hospital, medical, and surgical protection.

Passage of this bill, at this session, will mark another milestone in our efforts to make employment with the Federal Government attractive and rewarding. Health insurance for Federal employees will be one of the most constructive pieces of legislation to be enacted at this session.

STATEMENT OF HON. ISIDORE DOLLINGER, REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman and members of the committee, your committee is considering legislation relating to a health and hospitalization program for Federal employees. Among the bills before you is my H.R. 2326, to provide for Government contribution toward personal health service benefits for civilian officers and employees in the U.S. service and their dependents, to authorize payroll deductions for participants, and for other purposes.

I am pleased that your committee has scheduled action on this long-overdue program for assistance to our Federal employees. We know that employees in the Federal service have always been underpaid; their salaries have never equalled salaries paid by private employers for comparable work; the small pay raises granted Federal workers have never been commensurate with ever-rising living costs, and at this point, living expenses have reached a new high.

Our Federal workers, with families to support or other dependents for whom they must provide, find it barely possible to meet their financial obligations; high living costs plus high taxes prevent saving for the proverbial rainy day or the day when a Federal employee or his dependents suffer a serious illness. A critical illness requiring protracted hospitalization, surgery, costly hospital facilities and medicines, nursing care, doctors' fees, not only wipes out any little savings a low- or middle-income employee may have accumulated through great personal sacrifices over a period of years but also throws him into debt for years to come. Such a burden becomes intolerable, such worry must lower the morale and efficiency of any human being. The cost of personal health service insurance is prohibitive to the millions of Federal employees in the low- or middle-salary brackets, when procured on an individual basis.

The well-being and efficiency of our Federal employees must be considered and preserved if we wish to keep our Government offices and other installations operating at the peak of accomplishment and effectuality. Large private employers have for many years helped their employees to obtain benefits which this legislation would now provide for Federal employees. To refuse to give this assistance to our Federal employees is to withhold reasonable and sound protection against the high costs of illness. Surely the Federal Government owes to its employees the same consideration which private industry, on the

whole, has found it possible to extend to its workers. The legislation before you provides the needed and necessary protection at a cost which employees and the Government can afford.

I urge your committee to take favorable action so that our Federal employees may be accorded this sorely needed assistance.

STATEMENT OF HON. JOEL T. BROYHILL OF VIRGINIA, A MEMBER OF THE COMMITTEE

Mr. Chairman, the subject before this committee—the furnishing of protection against the costs of hospital and medical care for Federal employees and their dependents—is an important one in which legislation is long overdue. This matter has been under consideration by Congress for 5 or 6 years. It is all the more regretful that nothing has yet been accomplished at a time when everyone seems to be for these health benefits and no one against them. As one local columnist commented on the Senate hearings “* * * every single witness who testified said the Government should provide a health program for its employees. They disagree only over how it should be done” (Jerry Klutz, Washington Post, May 2, 1959).

It is obvious then, that both Congress and the administration are willing and anxious to see an employee health insurance program enacted. The problem now would seem to be not “whether” but “how.” We are faced with the test of statesmanship, namely with finding a plan which will serve as a worthy compromise acceptable to the many interested groups who hold such strong views for the various plans that have been put forth. My bill, H.R. 5386, has been designed to meet these conditions and to suggest the kind of compromise needed to finally bring about agreement among these groups.

As the members of the committee know, I have introduced two bills this session providing for Federal employee health benefits. The first bill I introduced, H.R. 726, is comparable to several other proposals before the committee. My second bill, H.R. 5386, is also similar in most of its features to these other proposals. It differs from them, however, in two important details.

First, H.R. 5386 would require the Federal employees in each personnel service area to select, by majority vote, one health plan to cover all participating personnel in that area. This differs from my first bill under which an employee could be enrolled under any plan of the four different types mentioned in the bill. The distinction here is not merely that one type of plan must be selected, but that the plan of one specific carrier must be chosen. I shall explain in just a few moments why this will result in simplified administration and in monetary savings to the Government and to the insured employee.

Before going further, I would like to point out that I have drafted an amendment to this provision of H.R. 5386 which would allow coverage under either a health insurance plan of a national association of Federal employees or a group practice prepayment plan, regardless of what carrier holds the group contract. This amendment is necessary, I believe, because of the characteristics of these two types of plans. They should both be allowed to continue because they are well established in certain localities among certain groups of employees and might be preferred to the plan selected by the majority of employees in a personnel service area as the bill provides. Moreover, some of the Federal employee association plans now provide benefits for retired employees. This protection for retirees, I'm afraid, might be lost in some cases unless these plans are allowed to continue. As for the group practice prepayment plans: they seem to be preferred by some employees because they offer certain preventive medicine benefits, such as checkup visits at a doctor's office, not generally offered by the other service or indemnity plans. These added benefits should be allowed to remain available to those employees who wish to obtain them and pay for their added costs. It is my understanding that some 10,000 Federal employees are enrolled in a group practice prepayment plan in the Washington, D.C., area, and that there are around 70,000 such employees on the west coast.

Another major distinction between the two bills I introduced is that the second bill provides for combined basic health and major medical coverage in the same plan. This differs from most of the other bills before the committee which provide for a separate policy or policies to be purchased by the Civil Service Commission to cover major medical expenses for employees enrolled under one of the basic health plans. The most obvious advantage of this unified policy system is that there would be no argument between insurers as to whether a claim comes

under the basic or major coverage. Both coverages would be in the same policy and administered by the same company or group of companies. The local insurance carriers that provide only basic health insurance could, of course, form local combines with insurance companies which provide for major medical benefits in order to present a unified policy eligible for selection under my bill.

Getting back now to the first distinction between H.R. 5386 and the other bills, that is, employing the principle of true group underwriting by having one plan for all employees who wish to participate within a personnel area, the advantages are these:

Simplicity. This system will eliminate the possibility of a Federal agency or installation having to deal with a large number of different health insurance carriers. There are at present nearly 450 different commercial insurance companies or nonprofit group hospitalization organizations which would be eligible to offer basic group health plans under any of the bills before the committee. The administration of the health insurance program will be greatly simplified if the Federal agencies are able to deal with only one carrier rather than an undetermined number of them, depending upon how many different companies insure their employees.

One of the objections made by the Civil Service Commission against S. 94, the prototype of most of the bills before the committee, was that it allowed for a multiplicity of basic health plans. The Commission pointed out that having a minimum rather than a multiplicity of plans "would enable the Government to negotiate a few rather than a large number of contracts; it would avoid costly advertisement of competing plans and simplify the employee's choice of a plan; and, in general, it would make administration considerably less difficult and costly."

The second advantage of group selection is that it would allow for adjustment of local health conditions and medical facilities. Permitting the employees to select from health plans available in their own localities would prevent their premiums from being based on national average medical costs and would allow them to take advantage of local rates. Lower medical costs should result in lower premiums. Using the group insurance plan, where a group of employees selects one carrier, allows that carrier to compute more exactly the cost of furnishing insurance to that group.

The group insurance plan would also allow for coverage of illnesses peculiar to certain localities which might be excluded under plans directed at covering employees on a nationwide basis.

Next, competitive bidding among carriers will cause them to submit their best possible plans at the lowest possible prices. Competitive bidding allows only the minimum amount to be added on for overhead and profit without diminishing benefits. These results can only be obtained under a group selection system. For example, in the Washington area the exact same policy is 20 percent cheaper if the beneficiary is a member of a group plan as compared to the premium charged him on an individual sale.

No company is given a monopoly under my bill. No company is excluded from bidding.

Moreover, more competent selection can be made from among the plans offered in a given area. The employees will be able to form committees to give thorough and expert study to the various bids that will be made. Employees dealing individually with company salesmen cannot do this with any degree of certainty. The provisions of section 7 of the bill which allow for contract rebidding would serve to give a continuous check on benefits offered and guarantee improvement in coverages as the science of medical treatment progresses.

The Comptroller General's report on H.R. 5386 stated:

"We believe that the provisions of this bill providing a minimum number of basic plans and combining the basic and major medical plans will greatly simplify the administration of any health insurance program."

Mr. Chairman, in summary I would say that my bill, under which local conditions will govern what health insurance plan is best for the Federal employees in any particular area through their own free choice, will result in their obtaining optimum benefits at minimum costs to themselves and to the Government.

STATEMENT OF HON. JOHN LESINSKI OF MICHIGAN, A MEMBER OF THE COMMITTEE

Mr. Chairman, having for several years been interested in developing and sponsoring legislation to provide a program of hospitalization and medical benefits for employees of the Federal Government, I am pleased that the committee is moving to complete action on measures pending before us, one of which is my bill, H.R. 1141.

My bill was designed to make available to all Federal employees and their dependents, health benefits comparable to those provided employees in private industry, to be financed through payroll deductions with the Government providing a substantial contribution to the cost of the benefits.

The Federal Government should be the foremost among employers who provide progressive and enlightened programs in the field of employee-employer relations, and enactment of the subject legislation will bring the Government one step closer to the commonly accepted practices in private industry.

The principles outlined in my bill have generally been accepted, but details as to the Government's contribution and coverage of major medical expenses have been the subject of controversy. In the interest of producing from committee a bill that will be accepted, I will go along basically with Senate-passed measure.

However, I should like to recommend that the committee give serious consideration to the inclusion of retired Federal employees. We must recognize the fact that retired employees encounter ever increasing medical needs and ordinarily cannot obtain adequate health insurance protection except at prohibitive costs which their reduced incomes cannot meet. After serving their Government faithfully and well for years, the retirees, present as well as future, are deserving of inclusion under the program.

I hope that we will be able to complete consideration of these measures quickly and report out a bill which will be signed into law at the earliest possible date.

STATEMENT OF HON. RALPH J. RIVERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Mr. Chairman, I appreciate the opportunity of being heard on the matter of the various bills before this committee providing for a Federal employees' health and hospitalization program. I would like to speak in behalf of S. 2162, the so-called Neuberger bill, which recently passed the Senate by an overwhelming majority, and its House counterparts, several of which are sponsored by members of this committee.

First, I would like to congratulate the members of this committee for the fine work they have done on this measure. The fact that S. 2162 and related bills have the support of the American Medical Association, the American Hospital Association, the insurance industry, Blue Cross and Blue Shield, group practice plans, and the various Federal employee unions certainly speaks for the quality of the bill. In fact, it might be said that this bill is well worth the many years it has taken to produce it.

As I view the bill, it is a most significant piece of legislation. If enacted, Federal employees would at long last achieve the status already enjoyed by about 100 million employees of private industry who are now covered by various prepaid health insurance plans. In short, it will mean that about 2½ million American citizens, plus members of their families, will be able to have low-cost effective medical insurance.

Alaska, because of its former Territorial status, has long had more than the usual proportional number of Federal employees, most of whom will remain in the expanding Federal programs to be carried on in our rapidly growing new State. These people have been good for Alaska. They helped it grow in stature to the point that statehood became a reality. I am particularly glad that these fine Alaskans and their families—be they employees of the executive, judicial or legislative branches—would be afforded the opportunity of partaking in any one of the three low-cost plans which this legislation provides.

Thank you, Mr. Chairman and members of this committee, for the opportunity you have afforded me to submit this testimony.

STATEMENT OF HON. THOMAS M. PELLY, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF WASHINGTON

Mr. Chairman, I appreciate this opportunity to appear in support of the bill, S. 2162, passed by the Senate on July 16.

This bill is identical with bills introduced by several members of this committee and is comparable in purpose to other bills that have been introduced during this session of the Congress. I speak for S. 2162 only because that has already passed the Senate and ultimate enactment would be expedited if the House acts on that bill.

The need for legislation of this character is not seriously in dispute. President Eisenhower has on numerous occasions requested legislation on this subject and private business has for many years provided benefits of this nature. Many State, county and municipal governments have adopted hospital and health programs for their employees and the Federal Government is today probably the only large employer that has not taken some action in this field.

The costs of medical care are in many instances beyond the ability of Federal employees to pay out of earnings and savings, particularly in those instances where they are so unfortunate as to suffer or to have members of their families suffer from the results of polio, cancer, heart ailments, etc. While the average employee can usually find a way to take care of ordinary illnesses through his own efforts, some method of spreading the costs of catastrophic illness must be provided. I consider S. 2162 the best step in this direction I have seen to date to accomplish that purpose.

I am advised that this legislation has the support, not only of the employee organizations, who perhaps have the greatest stake in this subject, but also has the support of the American Medical Association and the American Hospital Association, as well as the support of those who underwrite this form of protection, which includes, in addition to the insurance companies, the Blue Cross and Blue Shield groups, as well.

I note that the bill as passed by the Senate provides for an equal sharing of the cost between the employee and the Federal Government, prescribing a maximum of \$1.75 per pay period in the case of individual coverage of an employee and \$4.25 per pay period for the coverage of an employee and his family, matched by an equal contribution on the part of the Government. Under the bill the Civil Service Commission would enter into contracts which would give the employee a choice in the kind of benefits he might select, and I have no doubt but what the Civil Service Commission will, as it has always done in the past, look to the interest of the employees and the Federal Government in the preparation of such contracts.

I note that the estimated total cost of the bill as passed by the Senate is some \$304 million per annum, which would make the Government cost in the neighborhood of \$150 million per annum, a sum I do not consider excessive. I believe rather that measured in terms of what this legislation will accomplish, it is a wise investment.

I hope this committee will move promptly to report this measure to the House of Representatives and I want to extend my assurance of support when the measure reaches the floor.

Meanwhile, I wish to thank the members of the committee for their consideration.

The CHAIRMAN. The committee will next hear from the representatives of employees' organizations, Mr. Jerome J. Keating, vice president, National Association of Letter Carriers; Mr. E. C. Hallbeck, legislative representative, National Federation of Post Office Clerks; Mr. James A. Campbell, president, American Federation of Government Employees; Mr. W. H. Ryan, president, District 44, International Associations of Machinists; Mr. Paul Nagle, president, National Postal Transport Association; Mr. Harold McAvoy, president, National Association of Mail Handlers; and Thomas G. Walters, operations director, Government Employees' Council.

STATEMENTS OF JEROME J. KEATING, VICE PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS; E. C. HALLBECK, LEGISLATIVE REPRESENTATIVE, NATIONAL FEDERATION OF POST OFFICE CLERKS; JAMES A. CAMPBELL, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; W. H. RYAN, PRESIDENT, INTERNATIONAL ASSOCIATION OF MACHINISTS; PAUL NAGLE, PRESIDENT, NATIONAL POSTAL TRANSPORT ASSOCIATION; HAROLD McAVOY, PRESIDENT, NATIONAL ASSOCIATION OF MAIL HANDLERS; AND THOMAS G. WALTERS, OPERATIONS DIRECTOR, GOVERNMENT EMPLOYEES' COUNCIL

The CHAIRMAN. Who will proceed first?

Mr. HALLBECK. I think I will start it off with your permission, Mr. Chairman.

Mr. Chairman and members of the committee, we are here representing the 600,000 members of organizations affiliated with the Government Employees' Council, AFL-CIO. The names of the organizations composing the Government Employees' Council are listed for your information: American Federation of Government Employees; American Federation of State, County, and Municipal Employees; American Federation of Technical Engineers; International Association of Bridge, Structural and Ornamental Iron Workers; International Association of Fire Fighters; International Brotherhood of Boiler Makers, Iron Ship Builders, Blacksmiths, Forgers and Helpers of America; International Association of Machinists; International Brotherhood of Bookbinders; International Brotherhood of Electrical Workers; International Plate Printers, Die Stampers, and Engravers' Union of North America; International Printing Pressmen and Assistants Union of North America; International Typographical Union; International Union of Operating Engineers; Journeymen Barbers, Hairdressers, Cosmetologists, and Proprietors International Union of America; Metal Trades Council and Central Labor Union of the Panama Canal Zone; National Association of Letter Carriers; National Federation of Post Office Clerks; National Association of Post Office and Postal Transportation Service Mail Handlers, Watchmen and Messengers; National Postal Transport Association; National Federation of Post Office Motor Vehicle Employees; Office Employees International Union; The National Association of Special Delivery Messengers; United Brotherhood of Carpenters and Joiners of America; and United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada.

This committee is the hospitalization committee of the Government Employees' Council, and for the past 5 years we have been engaged in an intensive and exhaustive study of a hospitalization program for Government employees. This committee is composed of E. C. Hallbeck, legislative representative of the National Federation of Post Office Clerks; Jerome J. Keating, vice president of the National

Association of Letter Carriers; James A. Campbell, president of the American Federation of Government Employees; William H. Ryan, president of District 44 of the International Association of Machinists; Paul A. Nagle, president of the National Postal Transport Association, and Harold McAvoy, president, National Association of Post Office and Postal Transportation Service Mail Handlers.

A number of bills have been introduced on this subject, going back as far as 10 years; hearings have been held; the administration has proposed legislation; but it was not until this year that any real progress has been made. This year for the first time, the insurers, the employee groups, the American Medical Association and the American Hospital Association have found it possible to agree on a program.

In the past, many of the proposed programs have been inadequate; each underwriter proposed his own program and the employee organizations could not fully support any of them. Likewise, the underwriters could not support the employee plans. This year, for the first time, all groups present a united front.

We are here to present evidence supporting S. 2162 as passed by the Senate. Exact duplicates of that bill have been introduced in the House by Congressmen Morrison, of Louisiana, H.R. 8210; Davis of Georgia, H.R. 8222; and Porter, of Oregon, H.R. 8211.

We want to express our most sincere thanks to the distinguished members of this committee for introducing these bills. We want to commend and compliment the able chairman of this committee for scheduling the hearings on health benefits on the very day the Senate passed S. 2162.

Many other members of this committee, as well as many other Members of the Congress, are due a special vote of thanks for their interest in hospitalization legislation, as evidenced by the bills they have introduced. Special mention must be made of Congressmen Corbett, of Pennsylvania; Broyhill, of Virginia; Lesinski, of Michigan; Foley, of Maryland; Lane, of Massachusetts; Fulton, of Pennsylvania; Kilday, of Texas, and Dollinger, of New York, as well as to the other Members of Congress who have worked on behalf of a Government contributory hospitalization program over the years.

We also appreciate the statements made by Congressmen Miller, Baldwin, and Cohelan.

Mr. Keating is going to take up the testimony at this point, and the members of the committee will, of course, be glad to answer any questions, if we can.

The CHAIRMAN. I would like to ask you a question now.

Do you agree with the statement made on the floor of the Senate last week that the approval of the proposed health bill by the Senate would equal a 10- to 15-percent pay increase for the Federal employees?

Mr. HALLBECK. I heard that statement, but do not agree with it. I think hospitalization legislation is very valuable, but not equal to a 10-percent salary increase.

The CHAIRMAN. How much would you say it equals?

Mr. HALLBECK. I would guess perhaps 2½ to 3 percent.

The CHAIRMAN. How much do you estimate as the cost of the program to the Federal Government?

Mr. HALLBECK. About \$145 million.

The CHAIRMAN. That would only amount to about a 3-percent increase in pay.

Mr. HALLBECK. Considering 2 million employees, roughly, I think that is pretty close.

The CHAIRMAN. What do you estimate the fringe benefits already in the law amount to?

Mr. HALLBECK. I have heard the statement made, and I heard it on the Senate floor by, I believe, Senator Morton of Kentucky. He stated it is 23 or 27 percent of payroll.

The CHAIRMAN. Do you agree with that?

Mr. HALLBECK. I think he is going around Robin Hood's barn to bring up that total. I do not think it quite that high. But for the sake of the argument, I am willing to admit it is reasonable. I think it could be figured less.

Mr. CORBETT. Would the gentleman yield?

The CHAIRMAN. Mr. Corbett.

Mr. CORBETT. Figuring just roughly, this bill would cost about \$65 per person per year, which is not even close to a 10-percent increase.

Mr. HALLBECK. No; not all—

Mr. BROYHILL. Would the gentleman yield on that point. I do not wish to take issue with the chairman, but he stated that the payroll costs are now over \$13 billion a year. Well, 10 percent of that would be \$1.3 billion and 1 percent of it would be approximately \$130 million. So it seems, using the figures that the chairman used in his statement, that the cost of this bill to the Federal Government would be slightly over 1 percent of the payroll, and, therefore, would be equivalent to slightly over 1 percent pay increases. That is using the chairman's figures as made in the statement.

The CHAIRMAN. I am referring to the statement made by a Senator during the debate on this subject.

Mr. HALLBECK. Senator Monroney, I think it was.

The CHAIRMAN. That is correct. I did not bring his name in, but that is correct.

Mr. CORBETT. Mr. Chairman, we frequently have to correct errors made on the other side.

The CHAIRMAN. Do you have your own health plan for employees, Mr. Hallbeck?

Mr. HALLBECK. We do.

The CHAIRMAN. What kind of a health plan is it?

Mr. HALLBECK. Ours is an indemnity plan.

The CHAIRMAN. How does it operate?

Mr. HALLBECK. The member has his choice of three different plans providing indemnity benefits in amounts based on the payment the employee makes. They run from a cost of about \$12 a quarter to \$30 a quarter. The employee can elect whatever he thinks best suits his needs.

The CHAIRMAN. What are the three plans?

Mr. HALLBECK. I could submit that for the record, if you wish, and make it more comprehensive.

The CHAIRMAN. I wish you would.

(For the information referred to, see p. 46.)

The CHAIRMAN. How many members of your association belong to any of these three plans?

Mr. HALLBECK. About 26,000.

The CHAIRMAN. What percentage is that of your total membership?

Mr. HALLBECK. About 25 percent.

The CHAIRMAN. How long have these plans been in existence?

Mr. HALLBECK. About 7 or 8 years.

The CHAIRMAN. Who is the insurer?

Mr. HALLBECK. We insure it ourselves. It is self-operating. No insurance company is in it. We operate at one of the lowest operating costs anywhere in this field. We have our own reserves that have been built up through the premiums collected.

The CHAIRMAN. What is the maximum amount paid by an employee of your organization?

Mr. HALLBECK. For family coverage it is \$30 per quarter, which is \$10 a month.

The CHAIRMAN. We will next hear from Mr. Keating.

Mr. KEATING. Referring briefly off the printed statement to the fringe benefits problem, Senator Morton did make the statement that the fringe benefits amount to 27 percent. However, the Cordiner Committee in its study pointed out that the Government employees contribute a larger percentage of pay for fringe benefits than any other group of employees. The contribution of Government employees for total fringe benefits amounts to over 7 percent, so the net cost to the Government probably is something less than 20 percent. The total cost is 27 percent.

We feel there is a very strong need for a Government sponsored health benefits program.

During the past quarter of a century, the people of America and the people of the world have become increasingly aware of the fact that the greatest single asset that any nation can possess is a healthy citizenry. During this same period medical science has made remarkable progress. With this progress has come the age of specialization and the development of complicated and expensive diagnostic techniques. New and expanded surgical procedures have been discovered. The cost of proper medical and surgical care has risen out of the financial orbit of the average individual, and just as the corporate form of business developed to meet the needs of the machine age, hospital and medical insurance has developed to spread the costs and take the burden off individuals who are so unfortunate as to become the prey of illness and disease.

The original type of hospitalization coverage founded in the depression-ridden thirties has now become outmoded. Insurance covering medical and surgical costs and catastrophic illness has become a modern necessity. New and expensive diagnostic techniques and modern drugs have greatly improved the science of medical detection and cure.

Doctors no longer are satisfied to guess; they want to be certain in their diagnosis—a marvelous development for the health of the Nation, but a most costly one to the individual. The aspirin tablet, which still performs wonders at 15 or 25 cents per tin, has been replaced to a large degree in modern medicine by miracle drugs—

miracle drugs that cost from \$7 to \$12 per treatment. Heparin, an anticoagulant used in extreme heart cases, costs as high as \$17 per dose.

A proper medical insurance program is no longer within the means of the average worker. The individual buys what he can, but frequently finds his program several thousand dollars short of meeting the cost of an illness that may beset him or his family.

As a matter of fact, Congress recognized a responsibility in this area as long ago as 1946. In July of that year, Congress passed the Railroad Unemployment Act. It provided for temporary disability benefits arising out of nonoccupational diseases. As of 1958, the contribution rate of the railroads to the plan was 2.5 percent of payroll. The employees make no financial contribution.

By 1958 four States had recognized the importance, indeed the validity, of requiring protection for disability arising out of non-occupational ailments. The first such statute was enacted by Rhode Island in 1942. California adopted a similar program in May 1946. New Jersey followed in June 1948. On April 1 this year, a similar program became operative in New York.

The first two States to adopt this program provided for employee contributions only; the last two have placed the greater share of the cost on the employer. This matches the growing trend found in private industry.

Under the New Jersey plan, the employee pays 0.5 percent of the first \$3,000 of annual earnings. The employer pays between 0.75 percent and 1 percent depending upon the firm's experience rating. If the workers are covered by a plan equal to, or better than, the State program, the employer is not required to pay the State contribution. A most interesting feature of the program is that even where workers are covered by private plans, the maximum amount they can be assessed is 0.5 percent of the first \$3,000 of annual earnings. Employers must pay any remaining costs. This is evidence of the fact that in the better programs the employers pay more than two-thirds of the cost.

To a great extent, the New York program is similar to the New Jersey plan. In New York the employees pay 0.5 percent of the first \$60 weekly wages, not to exceed 30 cents per week. Employers pay any remaining cost.

Private plans existing at the time the New York program was established may continue during the life of the contract; they may also be extended by collective bargaining agreements. Needless to say, such plans will no doubt be more liberal than the State program.

Our neighbors to the north in Canada have been very active in the field of hospital insurance. Seven Canadian Provinces have compulsory Provincial hospital plans that employers having 15 or more employees must adopt. This program is subsidized by the Dominion and Provincial Governments.

In this country, many State, county, and municipal governments have good programs; we will discuss these further in another connection.

In our country, largely through negotiated contracts, 89 million workers and dependents in private industry are currently covered.

The following data are taken from the Social Security Bulletin for March 1959:

1. On December 31, 1957, 37.1 million employees were covered for hospitalization benefits in some type of employee benefit plan. Of the total, 18.4 million were covered by commercial insurance companies, another 16.5 million under Blue Cross, and the remaining 2.2 million in employee plans or prepaid medical programs.

2. Thirty-five million one hundred thousand had surgical coverage. There were 19 million in commercial plans, 13.6 million in Blue Cross and Blue Shield, and 2.5 million in employee-sponsored or prepaid programs.

3. Twenty-five million nine hundred thousand had regular medical benefits. Of these, 11.3 million were in commercial companies, 11.1 million in Blue Cross and Blue Shield plans, and 2.5 million in employee-sponsored or prepaid programs.

4. Major medical coverage was reported for 5.1 million employees, although this is the newest type of coverage.

As previously indicated, approximately 89 million workers and dependents are currently covered under some form of health insurance from the workers' jobs. This in itself is ample evidence that the health of employees is an important consideration to employers. If it is a desirable personnel practice for profit-inspired employers, certainly it should commend itself to the Federal Government.

In all of our research on this subject, it was noted that more and more industrial employers are paying the total cost of these programs.

A study completed in November 1957 by the Department of Labor produced some interesting data on health and insurance plans established under collective bargaining procedures through 1955. The study, which included 300 plans covering 4,981,000 employees, developed the following cost figures:

1. One hundred and sixty-two plans providing benefits for employees were financed entirely by the employer.

2. One hundred and thirty-eight plans were financed by joint contributions.

3. One hundred and twenty plans providing benefits for the workers' dependents were underwritten entirely by the employer.

This study points up two significant trends:

1. The employer is more and more assuming the major portion of costs of health insurance programs.

2. Dependents are more and more being included in coverage.

We submit that the principal motivating factor behind these trends is the acknowledgment and acceptance by enlightened private employers that it does no good to have an employee physically present but mentally absent from his job because he is worried about medical bills. On that premise, it is difficult for us to conceive of Government not being equally anxious to have a similar climate for its personnel.

In our opinion, there are five requirements for a good Government contributory hospital and medical program: (1) The Government must contribute enough to be of material aid; (2) the program must be broad and comprehensive enough to attract employees—if it is to be of any material value, it must be considerably better than the programs that the employees now have; (3) the amount paid by

the individual must be within the means of the lower paid employees; (4) the plan must be workable on a nationwide basis—it must be flexible; (5) it must permit the employee to participate in the very best program available in the community in which he lives.

We believe that the Government should contribute two-thirds of the cost. However, in the interest of establishing and expediting a health benefits program, we are now supporting S. 2162, wherein the Government contributes 50 percent of the cost.

The CHAIRMAN. You would not be opposed to them paying all of the cost, would you?

Mr. KEATING. No, we would not. We would support that very cheerfully.

We cannot nor will we support a program wherein the Government makes a lesser contribution. The maximum benefits provided for in the present bill will cost the employee \$9.21 a month. That is the maximum the average employee can afford. Fifty percent of the Federal employees earn less than \$4,790 per year. This is the median pay according to the Civil Service Commission based on figures for June 30, 1958, in a report released in March of this year.

In a report published by the Department of Research and Service of the American Federation of State, County, and Municipal Employees, under date of July 1, 1959, we garner the following interesting information. Out of 316 State, county, and municipal programs, the employer pays the following:

Number of plans:	<i>Percentage paid by employer</i>
121-----	100.
137-----	50 to 88.
14-----	Less than 50.

Specified payment—percentage could range very high, usually over 50 percent.

Practices prevalent in other plans in both Government and industry indicate that the minimum amount paid by the Government should be 50 percent.

There has been a great deal of discussion relative to the need for major medical or catastrophic coverage. We believe that a good health benefits plan must include protection for catastrophic illness. While it is true that the need for this type of coverage is not as extensive as the need for basic coverage, where it does exist the need is most acute. U.S. News & World Report in the March 16, 1959, issue quoted the statistics of one major insurance company as showing that half a million American families had medical bills larger than their total income for the year.

Dr. Ungerleider, discussing major medical insurance declared:

We knew, as you knew, that a myocardial infarction is just as severe as a subtotal gastrectomy and the economic factors are not far apart.

We have known—and I am sure that the members of this committee have known—hundreds of people who have lived their entire life under the burden of a crushing debt because of a major illness in their family, and a still greater liability to the Nation is the fact that thousands of people neglect medical care and attention because they do not have the money to meet the necessary charges.

It is our carefully considered opinion after a thorough study that S. 2162 meets the criteria of an adequate program. There are many

types and forms of hospital protection; each proponent thinks his is the best. There are many fine programs that may very well be the best in a given city or metropolitan area, but S. 2162 is tailored to meet the many problems of furnishing a program that will give adequate protection to the employees of the Federal Government located in 50 different States, the possessions of the United States, and many countries all over the world.

The program is flexible. It does not conform exactly to any program that we know of now in existence; it does however, conform more closely to the plan now operating in New York State for State employees than to any other now in existence.

The description of the New York plan, as set forth by Agnes W. Brewster of the Department of Health, Education, and Welfare, will suffice as a general description of S. 2162. We are taking the liberty of paraphrasing her explanation only to the extent of substituting proper descriptive terms.

The law establishes a health insurance function within the Civil Service Commission, described in general terms the group health insurance benefits which could be provided (and the types of exclusions), indicated that proposals for insurance contracts were to be invited and indicates some of the conditions to be observed in the contracts.

The law set the maximum contribution of the Government per employee. It prescribes the persons eligible for coverage in general terms, authorized payroll deductions and the deductions from the retirement allowances of retired employees. It created a health insurance fund and gave the Commission power to promulgate necessary rules and regulations.

From this brief summary, it can be seen that the law provided only a general framework, leaving the development of the program to the Civil Service Commission.

This well describes in a few words the plan of S. 2162.

It is not our intention to discuss the provisions of S. 2162 in detail. The details of the bill are extremely well described and explained in the Senate Committee report and we do not wish to consume the time of the committee by going over this ground again. There are some provisions, however, that require further discussion.

Each employee will have at least two plans from which to make a selection; others could well have four, providing that a bona fide employee plan or a group practice prepayment plan was available to him. The benefits described in S. 2162 are maximum benefits; the payments provided in the bill are maximum payments. The method followed in determining the cost of the legislation and establishing the cost to the Government at \$145.3 million were set forth in the Senate report as follows:

Aggregate costs: Data on the number of married women working for the Government, or the number of instances where husband and wife are both Government employees, do not exist. To arrive at aggregates the cost estimates that follow assume that—

(1) Two million employees will be eligible to participate in the program.

(2) Ninety percent of them will do so—i.e., 1.8 million employees will elect coverage.

The CHAIRMAN. How many will elect coverage? I did not hear that.

Mr. KEATING. 90 percent.

(3) Forty percent will enroll as individuals and 60 percent as families.

(4) One hundred and fifty thousand women with nondependent husbands, will enroll their families.

(5) All contracts will be at the maximum biweekly contribution shown. (This assumption results in aggregate costs somewhat above those anticipated.)

On an annual basis, the assumed contributions are \$91 for single employees (\$45.50 from the Government) and \$221 for family coverage (\$110.50 from Government).

720,000 single employees × \$91.....	\$65, 520, 000
1,080,000 employees with families × \$221.....	238, 680, 000
Total.....	304, 200, 000
Government contribution.....	145, 300, 000
Employee contribution.....	158, 900, 000

The reason for the difference is the fact that in the case of women employees who include other members of the family, the Government only pays one-third; they have to pay \$6, and the Government pays \$2.50.

Mr. REES. I don't quite understand that statement. Will you repeat it?

Mr. KEATING. In the case of female employees, the bill provides that the employee can pay up to \$6 and the Government contributes, I think it is, \$2.50. Women who want to insure their husbands, that is. They do not come under the strictly benefit plan, and that, of course, results in the employees actually paying more than the Government.

The CHAIRMAN. Mr. Lesinski?

Mr. LESINSKI. Do you mean like a woman's parents?

Mr. KEATING. Well, if she wants to insure her husband, for example. Here is the exact language of the provision:

If a member of the family of a female employee or annuitant who enrolls in a health benefits plan under this act for herself and members of her family is a husband, other than a dependent husband, there shall be withheld from the salary of such employee or annuitant as her contribution to amount not to exceed \$6 biweekly, and the Government shall contribute an amount not to exceed \$2.50 biweekly.

If she wants to insure her husband she pays better than two-thirds, and the Government less than one-third and that explains why in this table here the amount of contribution made by the employees is shown as greater than that by the Government.

Mr. REES. Would that include her mother or father?

Mr. KEATING. It just says husband, specifically.

The CHAIRMAN. How about children?

Mr. KEATING. They would come under the family plan, if she had children.

The CHAIRMAN. The same premium would be paid by an employee of the Government with one child as would be paid by an employee with five children; would it not?

Mr. KEATING. That is right. It might be, Mr. Chairman. I will qualify that to this extent. These are maximum figures. What the Commission will work out in their contracts with the insurance companies, nobody knows.

The CHAIRMAN. What does that bill provide as the definition of a family?

Mr. KEATING. It provides a definition of the family, husband and wife, or husband and wife with children, and sets a maximum payment. But if the Commission can buy insurance for less than the maximum, they will do so. If an insurance company draws up a program where they would furnish insurance for a woman and one child for a lesser amount than a woman with five children, the Commission undoubtedly would take that contract, and they have the right to do so. So it is impossible to have exact estimates, and, of course, the Senate committee in making their estimate used outside figures. You are going to have a little reference to that later on.

Mr. LESINSKI. Does it mean husband and children, if she so elects?

Mr. KEATING. The family means husband and children.

Mr. LESINSKI. The immediate family only?

Mr. KEATING. That is right.

The CHAIRMAN. Does the husband have to be a dependent in order to be covered?

Mr. KEATING. No; it says other than a dependent husband. The dependent husband is covered under the regular family plan. If he is not a dependent husband, the contribution is limited. She gets 75 cents—she is allowed 75 cents a month more than the single employees.

Mr. PORTER. I agree with the gentleman's observation that the cost could be a good deal less than the maximum. I am wondering if you have an opinion as to why competitive bidding apparently was not required for these contracts.

Mr. KEATING. It is not exactly so stated. There is competitive bidding to this extent: There are four possible types of insurers—

Mr. PORTER. I did not make myself plain. It says in section 6, "Commissions authorized without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding * * *." That is pretty categorical.

Mr. KEATING. I think perhaps the reason for that, Mr. Porter, is that in letting these contracts such as they did in the group life insurance program where you had only one insurer in that case, here you have several, they have allowed four different plans.

Now, undoubtedly, the indemnity companies will have one company bid for the business, and then the business will be split up or several companies will apply—the business will be split up among different companies. They will each be given a chunk of it, so to speak.

Now, in the service plans, of course, actually only one carrier really participates in that type of program; that is, the Blue Cross-Blue Shield.

Mr. PORTER. But why shouldn't there be competition?

Mr. KEATING. I think that is to cover the problem of the indemnity companies; I think that's the reason for the provision. I haven't discussed that with the committee, but that is my guess.

Mr. LESINSKI. Would you say that the competitive bidding is there because the offer says that it shall be the program with the least cost, so the competition is there.

Mr. KEATING. I would say so.

The foregoing estimates are thought to be conservative. For example, substantial reductions in cost could result from eventualities such as the following:

1. Should one or more of the carriers offer a lower benefit program that cost single employees 20 cents less than the biweekly maximum permitted and cost employees with families 50 cents biweekly less than maximum and were this chosen by 50 percent of the participating employees, the total cost would be reduced by \$18 million annually.

2. Should 85 percent of eligible employees elect to participate (rather than the assumed 90 percent) because of other protection available through the spouse's place of employment, the total annual cost of the program would be reduced by \$16.9 million.

The CHAIRMAN. By how much?

Mr. KEATING. \$16.9 million.

Experience of similar programs suggests that participation of more than 90 percent of employees is highly unlikely.

The maximums—\$45.50 annual for single employees, \$110.50 for families, and equal amounts from Government—are consistent with costs of similar programs in private industry and in the State of New York. They are also consistent with data developed by the U.S. Department of Health, Education, and Welfare on per capita private expenditures for health services.

The Federal employees health benefits fund. The bill creates a fund which is a repository for, and keeps separate for the purposes of this bill, the amounts deducted from employees' salaries and the Government's contributions. The moneys in the health benefits fund are to be used for three purposes: (1) To pay the premiums or subscription charges under policies or contracts purchased from or entered into with carriers; (2) to pay necessary expenses incurred by the Commission in carrying out the act; and (3) to provide an adequate reserve to assure stability of subscription rates over a reasonable period.

The bill does not contemplate the accumulation of large reserves in the health benefits fund. The committee is of the opinion that a reserve of not to exceed approximately 3 percent of any 1 year's contributions or in excess of an accumulative total of approximately 10 percent should be adequate to assure stability of subscription charges over a given period of several years. The large variables most likely to affect costs do not lend themselves to precise long-range actuarial predictions.

Therefore, the accumulation of reserves in the health benefit fund is permitted primarily to assure the stability of subscription charges over a reasonable period of time.

The bill contemplates that administrative expenses incurred by the Commission should not exceed 1 percent of the amounts paid into the fund. If the program requires contributions totaling \$300 million annually, administrative expenses should be less than \$300,000 per year.

The Civil Service Commission and the Bureau of the Budget have advanced two objections to the cost figure—one is that the figure does not include the cost for retirees. According to the Commission, the first-year cost will be \$2.5 million, and in 10 years it will increase to \$25 million. The Commission also contends that there should be a larger percentage provided for reserves. Inasmuch as the estimate of cost by the committee is a maximum estimate, we are convinced that the estimate is more than ample to take care of the cost for re-

tires. We also believe that the Senate Post Office and Civil Service Committee plan provides adequate provisions for reserves.

Mr. KEATING. I might point out that actually many insurance companies operating now return better than 90 percent of the premium dollar to the insured individual, and in some instances it goes as high as 97 percent. That gives the company only 3 percent to do business on, which puts them in a rather precarious position.

The CHAIRMAN. What contribution does the employee make after he retires?

Mr. KEATING. They make the same payment as they do when they are working.

On this reserve problem, however, the insurance companies that are operating under the Civil Service Commission will assume a lot of the cost of the plan because they will investigate and pay the claims so the Commission will not have that cost saddled on them, and I think that the reserve and the estimate for the reserve is adequate.

Furthermore, we believe that the committee estimate of cost is on the high side. We base this conclusion on three facts:

(1) We seriously doubt that in entering into contracts with the insurers the Commission will make the same premium payments for benefits covering a man and wife that they will make for benefits covering a man, wife, and children. In commercial plans the rates for man and wife are 25 to 40 percent less than for a family. If this fact is valid, this one factor alone will act to greatly reduce the stated cost.

(2) There are approximately 500,000 Federal employees who earn less than \$4,000 per year. These employees will have great difficulty paying \$9.21 per month for coverage. In all probability, hospitalization programs will be available for them at a lesser figure. This, too, will reduce the overall costs.

(3) In areas where hospital costs are lower, it is most probable that some employees will elect coverage that costs less than the maximum allowed. This, too, will operate to reduce the Government cost.

The CHAIRMAN. The rates of hospital and medical charges already are increasing.

Mr. KEATING. They vary tremendously for every community, practically. But there is one thing there that I think we might caution you on, and that is that unfortunately, as far as the cost is concerned, the greater part of the Federal employees live in the higher hospital-cost areas, and I do think that the fact that some of them do not will operate to reduce the charge and costs on this bill.

We want to make it absolutely clear, however, that the hospital and medical provisions found in this bill are not excessive. The coverage provided should not be reduced. If the Government would pay two-thirds of the cost, those in the lower pay grades could purchase the type of program that they need. In our opinion, the Government payment of 50 percent is the absolute minimum that should be provided in a modern hospital-medical benefit bill.

The Civil Service Commission has agreed to the necessity of an Advisory Council, but contends that the functions of the Council should be entirely advisory. The Commission objects to the participation of the Council in an effective way. We believe that the em-

ployees on the Advisory Council have a right to a large measure of participation, particularly in the formative stages of the program.

The details of the plans to be adopted are placed almost entirely in administrative hands. To this we do not object, but we feel very strongly that the employees who are coequal partners in financing the plan should have all of the rights set forth for the Advisory Council in S. 2162. We urge this committee to make no changes in the functions of the Advisory Council.

We would like to call your attention to one grave defect in the program. S. 2162 makes no provisions for furnishing hospitalization to the 311,000 retirees, nor to the 132,000 survivor annuitants now on the rolls. This is unfortunate inasmuch as no group requires hospital protection to as great a degree. The incidence of illness is greater among those who have passed the age of 65, and a study made in 1957 showed that only three out of eight of this group had some form of hospitalization protection. That percentage of participation would be somewhat greater now. A number of those interviewed by the National Research Center of the University of Chicago reported that they had applied for hospitalization coverage but had been rejected. Recently insurers have adopted a more liberal policy toward insuring those over 65.

One of the reasons given by the committee for not including the retirees in this legislation was the difficulty of determining the cost because of lack of information on the ages and marital status of the annuitants and survivor annuitants.

Senators Johnston and Neuberger, in addressing the Senate, promised to immediately proceed to prepare a program to cover the retirees. We hope that this committee will do likewise, because the need in this area is extremely great, and has become a growing source of grave social responsibility.

The effective date of S. 2162 is July 1, 1960. The legislation will not increase the budget for the current fiscal year. We believe that the bill must be passed this year. In order to complete the necessary administrative details for a program of this magnitude, immediate passage is most necessary. The insurance carriers, as well as the Civil Service Commission, will have many administrative functions to perform, and we respectfully urge this committee to take prompt and favorable action on this legislation.

We thank the chairman and members of the committee for giving us the opportunity to present our views on this most timely subject.

The CHAIRMAN. The House will be in session in 5 minutes, and we will not have an opportunity to ask any questions now, Mr. Keating. I ask all of you gentlemen to return next Thursday at 10 a.m.

Tomorrow Judge Davis' Subcommittee on Manpower Utilization is having a hearing which was scheduled some time ago, so that the committee cannot continue hearings tomorrow but will resume hearings at 10 o'clock Thursday morning.

(Whereupon, at 11:55 a.m., Tuesday, July 21, 1959, the committee recessed, to reconvene at 10 a.m., Thursday, July 23, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

THURSDAY, JULY 23, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will come to order.

The hearings will be resumed on S. 2162, as approved by the Senate, and on other bills introduced by various Members of the House.

I will ask the Government Employees' Council witnesses to resume their seats at the table.

Mr. JOHANSEN. Mr. Chairman, with the permission of the Chair, I would like to make a statement before we proceed.

The CHAIRMAN. Very well.

STATEMENT OF HON. AUGUST E. JOHANSEN OF MICHIGAN, A MEMBER OF THE COMMITTEE

Mr. JOHANSEN. Unfortunately, I was not able to be present for the hearings Tuesday due to another committee meeting, and I would like to make a brief statement regarding the proposed Federal employees hospital and medical program.

I intend to appraise the testimony adduced in these hearings as thoroughly and conscientiously as I know how.

However, at the outset, I should like to make very clear some of the competing considerations which are going to be in my mind as I weigh the pros and cons of this matter.

First of all, let me say that I have no interest in attempting to realize any political benefit so far as the leadership of the employee unions is concerned. If there is such benefit it comes at a higher price than I am willing to pay. It requires that I accept and support the maximum demands not only at the moment but always hereafter as those demands are expanded.

In the second place, I want to repeat what I have said with respect to other employee legislation. I recognize that the Government of the United States is, among other things, an employer and as such has certain definite obligations of fairness, justice, and responsibility with respect to its employees. However, the obligations of the Government are not limited to those of an employer and cannot be governed solely by the demands of the employees or the employee organizations leaders.

The obligations of the Government relate to the total national interest, including the fiscal situation of the Government itself, the plight and problems of the American taxpayers and the necessity for retaining some right of veto on the employee demands and some measure of restraint on the pace and rapidity with which these demands are acquiesced in.

Third, because the Government cannot ignore totally the cost aspect of this and related programs, I concur completely with the view of the chairman that action on this program by the 86th Congress must be related to the demands and pressures which the same Congress may be expected to face during its lifetime with respect to further pay increases.

It seems to me that for the union leadership to reject this promise is for the union leadership to demand abdication of fiscal responsibility by the Congress.

I recognize the very strong arguments in terms of the example set by private enterprise, in terms of humanitarian consideration which can be advanced in support of this legislation. I would hope for some evidence of an awareness of the fact that the monetary value of this program to the employees, if adopted, is in fact substantially greater than the out-of-pocket cost either to the Government or to the participating employees. I will be very sorry indeed if the sponsors of this program persist in a refusal to recognize this important consideration.

I would be less than frank if I did not say that a flat rejection of this consideration could have a very decisive bearing on my vote.

Viewing the matter from a different perspective, let me say that administration objections to cost aspect of this legislation, on the one hand, lose considerable effectiveness in view of some of the other spending programs either insisted on or acquiesced in by the administration. I refer particularly to the provisions written into the Mutual Security Act of 1959 and voted by the House yesterday, respecting the so-called program of international cooperation in health. I cannot construe this action as anything other than the first step in a multimillion, and probably a multibillion, dollar program of international spending in the field of health, which, however, laudable in its purposes, takes no account of the enormity of the new financial burdens which will be placed upon the American taxpayer. I confess that I find it difficult to oppose efforts to take care of our own, while we undertake to assume the task of taking care of the entire world.

I have taken this time simply to record some of the conflicting concerns I have with respect to this legislation as the testimony is developed.

The one thing I do counsel is at least some evidence of reasonableness, moderateness, and restraint on the part of those who appear to insist on a policy approach of "All this, and Heaven, too."

The CHAIRMAN. Thank you, Mr. Johansen.

Mrs. GRANAHAN. At this point, may I make a statement for the record?

The CHAIRMAN. Mrs. Granahan.

STATEMENT OF HON. KATHRYN E. GRANAHAN, OF PENNSYLVANIA,
A MEMBER OF THE COMMITTEE

Mrs. GRANAHAN. Mr. Chairman and members of the committee, I intend to support and work actively in behalf of the legislation now before us to provide a contributory program under which our Federal employees can obtain effective insurance against high medical and hospitalization costs. I am sorry I was not able to be present earlier this week when the committee began hearings on this legislation, but as the members know, I have to attend hearings on another committee on which I serve—particularly since the witnesses that morning included the mayor of my own city testifying on the problem of cities generally. I make this statement now for the purpose of emphasizing that my absence Tuesday was not due to any lack of interest in the Federal employee health insurance legislation.

At this moment, I do not feel it is necessary for me to take the time of the committee to go into the technical phases of the health insurance legislation, since we will be considering the details of the bills in executive session following our hearings.

The near-unanimity with which the Senate passed this legislation last week—as I recall, there were only four adverse votes—indicates the broad support there is throughout the country for providing our Federal employees with this type of program. Industry has been pioneering—labor and management joining together—in adopting the prepayment method of insuring against the huge costs of prolonged illness on a mass basis, and it is obviously an area of labor-management cooperation in which the Federal Government should also be taking a leading role.

The costs of this program as they have been estimated by the actuarial experts are certainly not excessive in terms of the value such a program should provide for the Government as the largest single employer in the Nation.

We all know that with the present and steadily rising costs of medical care—chiefly due to the tremendous strides medicine has made in discovering new methods and new equipment for prolonging life and battling disease—that many people delay necessary medical care because of the fear of cost. The general adoption of group hospitalization insurance and surgical insurance has led to a vast improvement in the health of our people by encouraging and making it possible for people to obtain the care or the operations they need.

On the other hand, when it comes to the so-called catastrophic and terribly expensive drugs and medicines, and the consultation of numerous physicians and specialists as well as the use of costly equipment, the average family—and most Government employees come under the heading of average-income earners—is picked clean as far as resources are concerned and is plunged hopelessly into debt.

Thus we need for them the kind of joint contributory program called for under this legislation. As employer, the Government should provide this insurance, and pay, I feel, 50 percent of the cost of it, in order to make Federal employment desirable enough to retain our many outstanding career people who, in most cases, do a wonderful job with patriotism and devotion and skill.

Government employees, once trained in their specialized work, are continually being attracted away from Government service into private enterprise, partly by offers of higher pay but also by such fringe benefits as health insurance. We cannot compete with private enterprise in executive pay, but for the men and women who have made Government their career, and who desire to stay in Government service despite higher offers from private enterprise if it is at all possible for them to do so without being unfair to their families, this kind of legislation is a must.

Thank you.

Mr. PORTER. I would like to call to the attention of the committee the presence here today of a Member of Parliament, Mr. Wedgwood Benn, sitting down here and listening to our proceedings. He happens to be married to an American who comes from Cincinnati. His country has had some experience in this kind of thing that we are talking about here today, so he does have some interest in it. I just want to say that I know that he will be welcome to listen to our proceedings here.

I have one other thing that I would like to say. I understand this is a complex and important bill and we should have full hearings. I understand it is the chairman's intention to see that these hearings go off as soon as possible. I feel that is the wish of the majority of the committee. I realize that we cannot very well meet in the afternoon because of important legislation on the floor, especially next week, but I repeat my hope that we will be able to finish these hearings and get this matter to the floor this session.

The CHAIRMAN. The hearings will be expedited as much as possible.

Mr. MORRISON. Will the gentleman yield? I feel the same way as my distinguished colleague, Mr. Porter. I feel that unless we have full meetings every day next week, and any afternoon that we do not have a heavy schedule on the floor of the House, that it will be impossible to hear all of the witnesses that want to be heard. I would be the last person on this committee to take the position that we should not hear any responsible witness that desires to be heard. However, I think that we are all realists and we all realize that we are now nearing the end of the session, and if we are going to report out this bill we are going to have to start to speed up our procedures in every possible way. As I said, not at any time do I want to see any witnesses cut off, but I reserve my right that at the time it looks like Congress is going to adjourn before it is possible to pass on this bill I am going to move that the testimony be stopped and we go into executive session and report the bill out. I think that every possible endeavor ought to be made at this late date to hold hearings as long as possible on any day when there is nothing scheduled in the afternoon of importance. When a bill is scheduled in the afternoon for 4 hours of general debate there is no reason, in my humble judgment, why this committee could not meet for those 4 hours while that general debate is going on on the floor of the House. We could certainly hear a tremendous number of witnesses by that procedure.

Mr. GROSS. Is the gentleman going to be the judge of what is important and unimportant on the House floor?

Mr. MORRISON. No. Other committees have done that, and I see no reason why this committee cannot do it.

The CHAIRMAN. I do not propose to do that. I will tell Mr. Morrison that. These hearings will proceed as fast and as expeditiously as possible, and I trust, Mr. Morrison, that your attendance will be better than it has been in the past at these committee meetings.

Mr. MORRISON. If you want to get into that, I attend when I think it is important, and I do not attend when I do not think it is important. You brought the question up, and whether I attend or whether I do not, frankly, it is none of your business.

The CHAIRMAN. I fully realize when you attend.

Mr. JOHANSEN. I trust that we have the assurance of the gentleman from Louisiana that the decision to cut off, or attempt to cut off these hearings, will not be in advance of the testimony of the Government witnesses?

Mr. MORRISON. I reserve my right to do it at any time. I can make that motion just like you can make a motion, or anyone on the committee can make a motion.

Mr. JOHANSEN. I do not ever want to hear any more talk in this committee from certain sources about the threat of a Presidential veto. I have never heard such a threat to a committee.

Mr. MORRISON. It is no threat. I reserve my right to make a motion. I can make a motion any time I desire, and the motion that I want to, and whether the rest of the committee passes on it, or whether they do not, it is up to the committee.

The CHAIRMAN. The committee will be in order. These hearings will proceed in an orderly manner. We will expedite the hearings as much as possible. This is major legislation. It should be considered thoroughly and carefully by this committee, and I propose to do so. I do not propose to have any "snap judgment" action taken by this committee with my consent.

Mr. MORRISON. If the gentleman will yield, I certainly do not want to see these committee hearings dragged out so that it will be impossible to have the full House pass on this legislation.

The CHAIRMAN. We will resume the hearings, if the members are through with their statements.

Now, Mr. Hallbeck, you were explaining yesterday something about the health plan that your organization has.

STATEMENTS OF JEROME J. KEATING, VICE PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS; E. C. HALLBECK, LEGISLATIVE REPRESENTATIVE, NATIONAL FEDERATION OF POST OFFICE CLERKS; JAMES A. CAMPBELL, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; W. H. RYAN, PRESIDENT, INTERNATIONAL ASSOCIATION OF MACHINISTS; PAUL NAGLE, PRESIDENT, NATIONAL POSTAL TRANSPORT ASSOCIATION; HAROLD McAVOY, PRESIDENT, NATIONAL ASSOCIATION OF MAIL HANDLERS; AND THOMAS G. WALTERS, OPERATIONS DIRECTOR, GOVERNMENT EMPLOYEES' COUNCIL—Resumed

Mr. HALLBECK. Yes.

The CHAIRMAN. How many members of your organization are members of your health association?

Mr. HALLBECK. About 26,000.

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

The CHAIRMAN. What percentage is that of your entire membership?

Mr. HALLBECK. About 25 percent of the entire organization.

The CHAIRMAN. 25 percent?

Mr. HALLBECK. The reason for that is we came into the health field after a considerably large percentage of our members had already found some form of protection elsewhere. Actually we came in because a lot of our members could not find the type of protection they needed from commercial companies.

The CHAIRMAN. Do you have a maximum contribution? Do you raise or lower the contribution on the part of the employee?

Mr. HALLBECK. The contribution on the part of the employee is a matter of our constitution. It requires a three-quarters vote of our board of directors, a 75 percent vote on the part of our board of directors, to change the constitution of the hospital plan with respect to premiums or benefits.

At that point, Mr. Chairman, last Tuesday you asked me some questions about the costs and the benefits of our various plans. I believe that I told you that we had three plans and I was answering from the top of my head and I am afraid my answers were not very exact, and with your permission I would like to submit in lieu of the answers that I gave at that time a statement which actually describes the three plans as to the premium cost and the benefits for each of the plans.

The CHAIRMAN. Very well.

(The information submitted is as follows:)

Hospital and surgical benefits provided by the hospital plan of the National Federation of Post Office Clerks

	Plan A	Plan C	Plan D
Cost per quarter:			
Member only.....	\$5.20	\$7.00	\$8.40
Member and spouse.....	10.25	14.50	17.60
Family group.....	12.80	25.00	30.00
Benefits (reimbursement of actual expenses up to):			
In hospital:			
Daily room and board.....	¹ 7.00	² 10.00	³ 12.00
Special services.....	45.00	300.00	500.00
Hospital maternity costs.....	40.00	100.00	120.00
Surgery schedule (each hospital admission).....	200.00	200.00	300.00
Comprehensive polio.....		1,600.00	5,000.00
Medical (doctor's calls in hospital).....			360.00
Out of hospital:			
Surgery schedule.....	200.00	200.00	300.00
First aid after accident.....	10.00		
Diagnostic and laboratory.....			
Operating room and anesthesia.....			
		Total of \$25.	Total of \$25.

¹ Per day for first 30 days plus \$4.00 per day for next 30 days.

² Per day for first 70 days.

³ Per day for first 120 days.

NOTE.—Each individual covered is entitled to receive benefits up to the maxima shown above during any 1 certificate year except as otherwise indicated. No limit to number of admissions.

The CHAIRMAN. What is the financial condition of your plan at the present time?

Mr. HALLBECK. It is completely solvent. We are paying more than \$1.5 million in benefits each year. It is not fully funded, but it has a very adequate reserve.

The CHAIRMAN. Mr. Keating, I would like to ask you about your insurance plan.

Mr. KEATING. It has been in operation since 1950. We have well over 30,000, probably 33,000 or 34,000 members in the plan.

The CHAIRMAN. And what percent of the entire organization are those?

Mr. KEATING. They represent roughly 30 percent.

Of course, the plan is in competition with other plans where they have prepaid medical, and many plans were established before we went into the hospitalization field. There are actually six different types of programs that our members can subscribe to. They pay according to the amount of the benefit. I think one factor that is most important in the consideration before this committee is the percentage of people that subscribe according to the various dollar amounts. I think this indicates what the individuals feel they can pay for hospitalization.

We have plans that range in price, on a family basis, from \$7 to \$11.25, and the \$11.25 plan provides better benefits.

The CHAIRMAN. Per month?

Mr. KEATING. That is the monthly amount they pay for premiums.

Now, 17.6 percent of our people take the \$7 plan; 65.2 percent take the \$7.70 plan; 3.4 percent take the \$8.95 plan; 2.3 percent take the \$9.90 plan, and 1.8 percent take the \$10.35 plan, and 9.9 percent take the \$11.25 plan, which is the more liberal plan.

That indicates to me, as a general thing, that the payments that they would like to make are somewhere around \$8. That, I think, is an important thing in this legislation.

The CHAIRMAN. Mr. Nagle, does your organization have a health insurance plan?

Mr. NAGLE. We have a plan somewhat different than that described by either Mr. Keating or Mr. Hallbeck. Ours has been until recently completely a part of the National Postal Transport Association, in the section that the national members subscribe. We have a constitutional division in the sense that our hospitalization plan is situated in Kansas City, Mo., and has a constitutionally separate organization of its own. Our experience in writing hospitalization benefits roughly is closer to that presented by Mr. Hallbeck than by Mr. Keating.

Our plan has been solvent. It has a very excellent record of paying benefits. The distinct issue I wish to make is we do have a less formal tie-in than those which exist in the organizations previously declaring themselves.

The CHAIRMAN. Mr. Ryan, what about your organization?

Mr. RYAN. We do not have a plan in our organization. Most of our members employed in private industry are covered under either joint plans of management, or they are covered entirely by management contributions.

The CHAIRMAN. I call your attention to the definition of the national employee organization in section 2(h) of the bill.

Is it your construction that this definition is limited to groups including none but Government employees? Refer to section 2(h) of the Senate-passed bill.

Mr. RYAN. My interpretation of that would be that it would cover a plan underwritten by a national employees organization.

The CHAIRMAN. Is yours strictly a national employees organization? That is what is worrying me.

Mr. RYAN. The district that I represent, Mr. Chairman, is composed of local unions of the International Association of Machinists whose membership is composed either in whole or in part of Federal employees. We do not envision, as a district, taking on any sort of plan of this nature, and I have no knowledge that our international at the present time is thinking of taking on any such program.

The CHAIRMAN. Let me ask any of you this question—as I understand it, the bill fixes a maximum contribution upon the part of the employee; is that correct?

Mr. HALLBECK. That is right.

The CHAIRMAN. In other words, the amount cannot be raised except by further congressional action?

Mr. HALLBECK. That is right.

The CHAIRMAN. Now, as you know, there is constant increase in hospitalization and medical expense. I have here a telegram that I received this morning from Mr. Michael Jablonki of Pennsylvania, who says that Blue Cross rates in this area have been increased by 33 percent to 42 percent.

Now I have correspondence here from someone in Maryland saying that there has been a sizable increase in these rates, and that a further increase is being requested.

As I understand it, if these charges become so high that the Government contribution is not sufficient to meet them you cannot raise the rates under this bill but you would have to lessen the benefits; is that correct?

Mr. KEATING. There is a maximum amount, and you can only get what those dollars will purchase. In fact, there is a provision in the bill that points that out.

The CHAIRMAN. I say that under this bill the contributions of the employees could not be increased without further legislation; is that true?

Mr. KEATING. That is right, although the employee, if he so wishes, could purchase supplementary insurance but not as a part of the withholding program.

Mr. HALLBECK. If I may comment there, that is the very reason why our organization went into an indemnity type program rather than a service type program, because in an indemnity type program the benefits can be expressed in constant dollars. In the service type of benefits, which covers hospitalization regardless of the cost, you have a fluctuation due to the increase, or perhaps in some cases decrease, in costs. I do not believe that there is any program anywhere so far devised that can guard against increases or decreases in service type benefits. Certainly, this legislation does not attempt to do it.

But I think this, that the premium costs are set high enough in the bill, \$4.25 per pay period on the part of the employee and employer, and it is a very substantial premium that will buy benefits, in my judgment, far in excess of anything that the Civil Service Commission is likely to approve at this time. I do not believe that the maximum program that the Civil Service Commission is going to approve will cost as much as \$4.25 per pay period for both employer and employee, and there will naturally be a considerable leeway as a result.

The CHAIRMAN. Let me ask you about the difference, in your opinion, as to medical and hospitalization cost for retired employees as compared to the cost for those still in active service.

Mr. HALLBECK. I think statistically the cost would be somewhat higher depending upon the age of the employee. As we grow older we tend to come closer to the time when we are going to need hospital coverage.

The CHAIRMAN. It will be higher?

Mr. HALLBECK. It would or could be considerably higher, but there is this to be said: The older we get the less likely we are to have prolonged illness. Illnesses are more apt to be terminal as we get older. [Laughter.] That is a fact; it is no laughing matter. The older we get the more apt we are to die. That figures into the cost of it, because the cost of a program of this sort depends upon the length of time that you can draw benefits. Maternity costs are less. That is another angle.

The CHAIRMAN. I think that that would be conceded.

Mr. HALLBECK. That is not exactly a joke.

There are cases where they do not enter into it. For our own plan, we do charge a higher premium in some instances where a person joins the plan very late in life. He does pay a higher premium after age 65 just on that account. When they have been a member of the plan since its inception, or whenever there is 10 years' coverage, there is no increase.

The CHAIRMAN. You gentlemen are much better acquainted with this legislation than I, and you have been interested in it from the time the initial legislation was introduced several years ago.

What are the major differences between S. 94, the original bill introduced in the Senate, and S. 2162, the bill that has been approved by the Senate and which we are now considering? Briefly, what are the major differences?

Mr. HALLBECK. There are several. To my mind the most important is that the bill, S. 94, as originally introduced, gave an employee an absolute free choice of any kind of hospital benefit program that he wanted to secure. The bill as reported gives him a choice only as to the types of programs.

For example, I envision one of the types that will be approved by the Civil Service Commission is going to be an indemnity type of program, probably underwritten by a single instrumentality, or agency.

Assume for the sake of argument it is one of the larger insurance companies. Under the bill S. 94, as introduced, it could be any one of 100 insurance companies, all offering somewhat different types of programs calculated to appeal to the people they are selling to. I think that that is one of the major differences. Another is a change in the cost structure. The bill as introduced provided for a sharing of the costs on the basis of one-third of the cost paid by the employee and two-thirds by the Government.

As reported out by the committee, the bill provides for an equal sharing of the cost, and it is pretty hard to argue against a 50-50 break. That is ordinarily considered an even break, and I do not know how you can argue against it. I do think, however, there is a lot of validity in the original bill for a two-thirds payment on the

part of the employer. That is not an uncommon practice in private industry; however, at this time we are convinced, all of us, that such a program simply is not going to be enacted.

The CHAIRMAN. In private industry most of the plans are on a 50-50 basis?

Mr. HALLBECK. There are any number of plans that are paid almost entirely by the employer, and that is particularly true where you refer to the employee only. The employer in that instance pays the entire cost. In some of the plans they have variations.

Mr. Keating has some exact figures.

Mr. KEATING. We have a detail of a few plans where the employer pays the entire amount.

The CHAIRMAN. For major medical coverage as well as ordinary medical or hospital care?

Mr. KEATING. Hospital and medical. They vary according to the benefits. Some of them pay for the employee and dependents; some pay for all the retired employees and their dependents.

I would like to submit this for the record. It gives the name of the firm, the exact benefits they provide, and whom the benefits apply to.

Each one of these firms—and there is a substantial list of them—pays 100 percent of the cost. I think in our testimony yesterday we pointed out in the city and county employees, out of 386 plans there are 121 plans where the employer pays 100 percent of the cost.

(The plan referred to follows:)

Details of a few sample plans

Company	Hospitaliza- tion	Surgery	Medical	Cost		
				Employee benefits	Employee's dependents	Retired em- ployees and dependents
American Sugar Re- fining Co.	365 days. Full cost.	\$300 maxi- mum.	\$3 per home visit. Hospital, 1st day, \$10; \$5 thereafter.	Company pays full cost.	Company pays full cost.	Company pays full cost.
National Biscuit Co.	31 days. Up to \$11 per day limit. Ancillary benefits, \$110.	\$300 maxi- mum.	\$3 each day of confine- ment.	Company pays full cost.	Company pays full cost.	Company pays full cost, em- ployees only.
Brewers' Board of Trade, New York, N.Y.	21 days. 60 percent of cost of pri- vate room; full cost of specified benefits.	\$225 maxi- mum.	\$10 to \$2. Limit, \$454 per disa- bility.	Company pays full cost.	Company pays full cost.	Company pays full cost.
Armour & Co.	70 days. Full cost of specified services.	\$300 maxi- mum.	\$10, 1st visit; \$3 there- after; \$217 per disa- bility.	Company pays full cost.	Company pays full cost.	Company pays full cost, em- ployees only.
Swift & Co.	70 days. Full cost of specified services.	\$300 maxi- mum.	\$10, 1st visit; \$3 there- after; \$217 per disa- bility.	Company pays full cost.	Company pays full cost.	Company makes avail- able on a contribu- tory basis. No provi- sions.
Forstmann Woolen Co.	20 days. Up to \$14. Up to \$140 specified services.	\$225 maxi- mum.	None-----	Company pays full cost.	Company pays full cost.	No provi- sions.
Armstrong Cork Co.	180 days. Up to \$10. Up to \$75 plus 75 per- cent of next \$1,200.	\$200 maxi- mum.	None-----	Company pays full cost.	Company pays full cost.	Company pays full cost.
Bigelow- Sanford Carpet Co.	31 days. Up to \$12 plus \$120 mis- cellaneous.	\$225 maxi- mum.	None-----	Company pays full cost.	Company pays full cost.	Company pays full cost.
Brown- Bigelow, St. Paul, Minn.	35 days. Up to \$12. Full cost of specified services.	\$200 maxi- mum.	None-----	Company pays full cost.	Company pays full cost.	No provi- sions.
Minnesota Mining & Manufac- turing Co.	140 days. Up to \$15. Full cost of services.	\$300 maxi- mum.	\$3 for each day of con- finement.	Company pays full cost.	Company pays full cost.	Company pays full cost.
B. F. Good- rich.	120 days. semipri- vate room.	\$250 maxi- mum.	\$5 1st 2 days; \$3 there- after.	Company pays full cost.	Company pays full cost.	Company pays full cost.
Firestone Tire & Rubber.	31 days. Up to \$12. Up to \$180 mis- cellaneous.	\$150 maxi- mum.	None-----	Company pays full cost.	Company pays full cost.	Company pays full cost.

Mr. GROSS. Will the gentleman cite a half a dozen of the private industries he has there, the names, the locations, that are paying 100 percent of the cost?

Mr. KEATING. Most are national organizations. They are American Sugar Refining Co.; National Biscuit Co.; Brewers' Board of Trade, New York; Armour & Co.; Swift & Co.; Forstmann Woolen Co.; Armstrong Cork Co.; Bigelow-Sanford Carpet Co.; Brown-Bigelow, St. Paul, Minn.; Minnesota Mining & Manufacturing Co.; B. F. Goodrich; Firestone Tire & Rubber.

Mr. GROSS. They pay 100 percent of the cost?

Mr. KEATING. Yes.

Mr. GROSS. How do their plans compare with the proposed plan?

Mr. KEATING. Some are not as good but the American Sugar & Refining Co. paid 365 days' full cost.

The CHAIRMAN. Does that include family?

Mr. KEATING. It includes the family and retirees. They pay a maximum of \$300 in surgery. What S. 2162 provides in surgery—we do not know exactly because the formula is left up to the Commission. The American Sugar plan pays \$3 per home visit. At the hospital on the first day they pay \$10 and \$5 thereafter for calls by the doctor.

The CHAIRMAN. They charge as little as \$3 for a home visit around the country now?

Mr. KEATING. That is what they pay. What the doctor charges is something else again.

Mr. LESINSKI. The doctors around Detroit usually charge \$5.

It has come to my attention that when a person is a member of a medical plan and he transfers to another company that there is the so-called 12-month limitation which often interferes in the case of maternity. For instance, if the birth occurs within the 12-month period between the time of quitting one job and going to another, the individual is not covered. Does that come into this picture here?

Mr. KEATING. When the individual transfers there is a problem. That problem in this bill is met by requiring the insurers to give the individual the opportunity of individual coverage if he leaves the Government.

Mr. LESINSKI. If he leaves the Government he can continue it?

Mr. KEATING. He can carry the same coverage and he pays for it himself.

Mr. LESINSKI. Therefore, there is no discontinuance of coverage?

Mr. KEATING. That is right.

Mr. LESINSKI. Thank you.

The CHAIRMAN. Are optometrists included in this bill?

Mr. KEATING. I think there is no specific definition on what is included.

The CHAIRMAN. How about chiropractors and foot doctors?

Mr. KEATING. I think the essential feature of this bill is this. The administrative and controversial details—many are controversial, but many are of such type they have to be settled on the ground—they are left pretty much to the Commission.

Mr. REES. Would the Commission decide whether foot doctors or chiropractors are included?

Mr. KEATING. They would have that authority.

Mr. HALLBECK. It is the contract they would write which would determine that.

Mr. KEATING. If the insurer has a policy of paying certain groups, he would include that in his contract. Whenever you run into this problem in the medical field, you run into a lot of different types of doctors that the Medical Association does not recognize exactly as being full-fledged doctors that want coverage. The authority in this bill is in the hands of the Commission and in the hands of the companies in making their contracts.

The CHAIRMAN. What would be your reaction to removing from the bill the maximum limitation or amount that the employee can contribute? All the benefits provided for in the bill cannot be provided under the maximum contribution fixed by the bill. Do you think there should be some leeway there?

Mr. KEATING. No, I do not think so, Mr. Chairman, because actually if a Government employee wanted to get additional insurance over and above what he could purchase, he could go on the outside. The only liability to doing that would be that he would not be under the withholding program.

I do think if we declare a policy here of the Government paying 50 percent and the employee paying 50 percent, that to include a larger amount that the individual could pay would be unfair. I think that the balance should be kept at 50-50. If costs zoom way out of line, if the value of the dollar goes down, the medical dollar goes down, I think Congress should consider increasing the maximum amount.

Mr. Corbett, I believe it is pretty well established that in this legislation we are not pioneering or extending benefits beyond what has become pretty general in private business. As a matter of fact, I think we will find we have not done nearly as well as some of the better companies.

Secondly, on this point, Mr. Chairman, I am fearful that if this limitation were not there, we would have a situation where the Commission could arbitrarily increase the amount of the premiums due. This just would not be right if it were done without hearings and without consideration as to whether they want it. It might discourage people from getting into the plan.

I feel if we went along with the program as outlined here, if medical costs went up a great deal, it would be a decision of the committee and of the Congress as to whether we wanted to increase the amount of payments. Otherwise we would just be providing compensation or repayment to the extent the dollars are available and contracted for.

Mr. LESINSKI. I think we have a problem. If Congress does not act quickly enough, there might be a possibility that the insured might be jeopardized in getting his full benefits. I believe the chairman understands that feature of the bill also.

In view of that, I understand the remarks of Mr. Keating to indicate that basically the reason for that is to not allow it to get out of hand. On the other hand, we, as a committee, ought to be kept abreast of this thing, constantly informed, and if the expenses go up we should act quickly.

Mr. REES. How many members are there in your organization?

Mr. KEATING. We have roughly 117,000 now.

Mr. REES. About how many are included under your plan?

Mr. KEATING. We have 33,000 or 34,000. The number is increasing all the time.

Mr. REES. Are nearly all of your members either under your own plan or under Blue Cross and Blue Shield?

Mr. KEATING. They are covered by a variety of programs. They have a Group Health Mutual, for example, in the Twin City area established by the credit union people. A lot of them belong to that. In New York City a lot of them belong to H.I.P. Out on the coast there are 70,000 Government employees belonging to Permanente, the Kaiser plan.

Mr. REES. Almost all are covered by some plan now, are they not?

Mr. KEATING. I would say the majority, the vast majority, of them are.

Mr. REES. Under one plan or another?

Mr. KEATING. I do not presume all ever are. As a matter of fact, we have been very much interested in this field long before Blue Cross was established, trying to encourage cooperative endeavors.

Mr. REES. As I understand it, the representatives of Blue Cross and Blue Shield had considerable to do with the drafting of this legislation. Are you familiar with that?

Mr. KEATING. That they what?

Mr. REES. Representatives of Blue Cross and Blue Shield had considerable to do with the drafting of this legislation.

Mr. KEATING. I think everybody had considerable to do with it. The staff consulted with Blue Cross, they consulted with the insurance industry, they consulted with the Bureau of the Budget, they consulted with the Civil Service Commission. I think practically everybody who is interested in the field met with the staff in the drafting of this legislation.

Mr. REES. And you were consulted?

Mr. KEATING. Yes, sir, we were consulted. Most of the changes made in this bill came at the suggestion of the Government representative, such as reducing the cost and improving the flexibility of the legislation, and things of that sort.

Mr. REES. A number of these organizations you are talking about have different plans and different methods of handling this problem. Is it your opinion, in the event this legislation is enacted into law, that there be changes again in those organizations with respect to their requirements and rules and regulations?

Mr. KEATING. I do not think so.

Mr. REES. They will go on as they are now?

Mr. KEATING. I think they can all operate, that the program is flexible enough that they can move in with their present organizations.

Mr. REES. In other words, the organizations in your own group could go on as at present, except the Government would make its contribution?

Mr. KEATING. Not exactly as at present. I think it will have this very useful impact. Most of the people have programs that are not adequate. In fact, it is estimated that only 5 percent of all the people in the United States have fully paid programs. That is very expensive and this does not provide a fully paid medical program. It is

difficult to do so, but it provides a very adequate one. Most of the people now do not have adequate programs, but by virtue of the fact that the Government will contribute and the employee pays what he can, then they can have a better program.

Mr. REES. Will any of them change their programs to comply with this act?

Mr. KEATING. They will have better programs.

Mr. REES. They will continue with their own groups, except they will change their programs to comply with this law?

Mr. KEATING. Yes. In fact, we will probably devise a program that will meet their needs better.

The CHAIRMAN. I am sure you gentlemen are concerned with the financial condition of our Government today and that you are fully cognizant of the tremendous national debt and the huge deficit that occurred during the fiscal year just ended. You are fully cognizant of that, are you not?

Mr. KEATING. Yes.

The CHAIRMAN. Where do you think the money is coming from to pay for this program on the part of the Government? Would it be through additional taxes or more deficit financing, or how?

Mr. KEATING. That is a matter for Congress to decide; the matter of Government revenues goes up or down according to the tax income. Sometimes you have money to pay for it and sometimes you do not. It is entirely possible that with the business boom we have been reading about in recent months, the income of the Government may be sufficient so that it can be paid for without either deficit financing or extra taxes.

The CHAIRMAN. I hope that will be the case, but I doubt it.

Mr. MORRISON. Mr. Chairman.

The CHAIRMAN. Mr. Morrison.

Mr. MORRISON. I think there are many ways we could cut down on other expenditures of the Government, particularly foreign aid and many others, and have ample funds to pay for it.

Mr. HALLBECK. I understand one of the latest estimates made by the Bureau of the Budget indicates that with the present tax rate instead of a \$12 billion deficit, as we had in the past fiscal year, that the fiscal year 1960 is actually going to show a very small surplus without a change in the present tax rate.

The CHAIRMAN. We will hear from officials from the Bureau of the Budget on that.

Mr. MORRISON. That is what I understand that the President said, that there would definitely be a surplus.

The CHAIRMAN. We will have the Bureau of the Budget on that.

Mr. HALLBECK. I am sure the chairman understands we are not fiscal experts.

Mr. LESINSKI. You touched very lightly on the insurance companies possibly having to change their benefits. What would happen specifically to the insurance plan you have in your organization?

Mr. KEATING. Our program pays annually about \$2 million benefits to the members, but the programs we furnish them are geared according to the amount the individual can pay. With the additional money they will be able to get an expanded program. It will be

just an expansion of the program they have now. I think that will happen with a lot of other companies.

Mr. LESINSKI. You might lose a lot of your insured people.

Mr. KEATING. We might lose some, but those who are with us will get a better program.

Mr. LESINSKI. How will that come about that they will get a better program?

Mr. KEATING. At the present time an individual can afford to pay so much, but with the Government contribution and with the limitations described, he will be able to put more to his medical program. So he will be able to get better benefits.

Maybe if he has not had medical benefits, he will be able to get medical benefits, more time in the hospital, he will have major medical benefits, which very few people have at the present time.

Mr. LESINSKI. I appreciate that, but why should he be insured doubly?

Mr. KEATING. He will not be insured doubly.

Mr. HALLBECK. It will just improve his present program.

Mr. KEATING. It will improve the terms. If he has a policy, he may exchange it for a new policy with better benefits.

Mr. LESINSKI. I would prefer to have one good policy than two minor policies.

Mr. KEATING. He will turn in an inadequate one and receive an adequate one.

Mr. LESINSKI. You will lose some?

Mr. HALLBECK. No; we will gain. If we pay \$12 a day for bed care, under this program it would be simple to pay \$18. We will give him \$6 additional a day. We will not lose anybody. We will get more.

Mr. LESINSKI. The Government will pay part of it and the individual will pay part?

Mr. HALLBECK. That is right.

Mr. LESINSKI. Meantime you have the insurance program set up right now. Is the cost going to be divided between the two?

Mr. HALLBECK. Surely, under this legislation.

Mr. LESINSKI. Thank you.

Mr. HALLBECK. I could give an example. Our present average family protection costs our members \$6.88 a month. There is an income under the bill of \$9.21 a month. So that you have practically a 33-percent increase in premiums and you can readily provide a 33-percent increase in benefits to compensate for that additional income.

Mr. LESINSKI. You say the individual pays \$6-plus per month?

Mr. HALLBECK. Under our plan.

Mr. LESINSKI. Suppose the Government also pays \$6-plus for the same plan you have now. No. 1, can they, under this bill?

Mr. HALLBECK. No; they can only pay up to a maximum of \$4.25 per pay period. They could not match that \$6.88. Yes, they could, at that, because that is a monthly charge.

Mr. KEATING. It would improve the program because they would match it. Actually, there is a limitation on this that is not in the bill that I think would be a very effective limitation on the cost. That is what the individual himself can pay. Many of the individuals will

not be able to pay \$9.21 a month. There are 500,000 people who work for the Government who get less than \$4,000 a year; \$9.21 a month is pretty stiff.

The CHAIRMAN. This bill provides a maximum of \$4.25?

Mr. KEATING. There are 26 pay periods a year. It amounts, on the average, to \$9.21 a month per individual.

Mr. LESINSKI. I am trying to get this clear. You have a health insurance program of your own to which the individual pays \$6 plus per month. You say the maximum under the bill will be \$4.25?

Mr. KEATING. Per pay period.

Mr. HALLBECK. On the part of the individual and an equal contribution on the part of the Government.

Mr. LESINSKI. That would raise it to roughly \$9.50?

Mr. KEATING. \$9.21.

Mr. HALLBECK. That would make the total monthly contribution on the part of both the Government and the employee a total of \$18.42 a month.

Mr. LESINSKI. \$18.42?

Mr. KEATING. That would be the total contribution of the employee and the Government. With that you could buy very good benefits.

I think I know your question. Supposing we have someone who has a policy that pays \$10 a day hospitalization and 20 times that for miscellaneous benefits and a surgical schedule of \$200. That is a totally inadequate program, but it is what the individual can buy.

With this improved program, he can have a policy that will pay enough, pay considerably more, about what his bed cost would be. He would have one that would take care of most of the ancillary benefits. He would have a more liberal surgical schedule. He would also have medical benefits plus major medical. That would cost considerably more, but a new policy will have to be furnished that individual which he can exchange without any loss of benefits or anything else. He will get a better policy. There will be more expanded benefits.

Mr. LESINSKI. I understand that. There are two people, as a matter of fact four people involved: the individual, the Government, two insurance companies. You have one now. Another company will be involved.

Mr. KEATING. If he can go to another company, he can get a better program. He can go wherever he wants to. He has four choices if he lives in certain areas.

Mr. LESINSKI. Suppose he is with your insurance company right now and this bill goes through. What happens?

Mr. KEATING. In our company?

Mr. LESINSKI. Yes.

Mr. KEATING. He will take out the new program which will give him better benefits, or he can go to Blue Cross or he can go to the indemnity company that is selected. If he lives in New York, he can go to HIP or some other program. He can do whatever he wants to.

Mr. LESINSKI. He can go to your company, redraft, or get a new contract?

Mr. KEATING. With expanded benefits.

Mr. LESINSKI. Your company will pay the benefits?

Mr. KEATING. That is right.

Mr. LESINSKI. All the benefits?

Mr. KEATING. Yes.

The CHAIRMAN. You plan to continue your present medical plan if this legislation is enacted?

Mr. KEATING. We continue the plans we have now because we have a lot of retirees covered. We have a responsibility to them.

The CHAIRMAN. Do you charge retirees the same premium as you charge those in the active service?

Mr. KEATING. They pay a little more.

The CHAIRMAN. How much more?

Mr. KEATING. It amounts to about 24 percent more, I would say. It is not retirees. It is after they pass age 65. They have to pay about 24 percent more.

The CHAIRMAN. About how much additional?

Mr. KEATING. It varies, of course, according to the plan they have. The man with a \$7 program pays \$8.70 after he reaches 65. The man with a \$7.70 program pays \$9.55. This amounts to a 24 percent increase.

The CHAIRMAN. This bill, of course, provides for the same payment by the retirees as those still in active service, does it not?

Mr. KEATING. Yes.

The CHAIRMAN. Do you think retirees should pay a little more for coverage due to their advanced age?

Mr. KEATING. When you go to covering retirees, you have quite a problem. I think you have to study the coverage that is available. You will have to reevaluate the contribution made by the Government, in my opinion. You have an entirely different problem.

The companies providing for people over 65 have been adopting a more and more liberal program. More and more companies have been providing such a program.

The CHAIRMAN. If this legislation is enacted, do you not expect that the majority of your employees will come under the plan?

Mr. KEATING. Yes, I would say 90 percent would be a good estimate.

The CHAIRMAN. That will affect the membership of those in your plan at the present time, will it not?

Mr. KEATING. No; they will stay in our plan, most of them. They will have a different type of policy. It will improve the operation of our plan.

Mr. HALLBECK. We think we can offer better benefits.

Mr. KEATING. It will not affect it adversely.

Mr. REES. Some companies will not take you in after 65; is that right?

Mr. KEATING. That is right.

Mr. REES. How about Blue Cross?

Mr. KEATING. Blue Cross takes in those over 65 in practically every place.

Mr. HALLBECK. There was a tendency before to exclude everybody when they reached age 65.

Mr. KEATING. A company in Chicago specializes in those over 65. Here is a statement from the Employee Benefit Plan Review, a publication having to do with these subjects. It says service plans now

covering more people over 65. The medical association itself is doing something on that program.

For example, in California the doctors have agreed that they will scale their fees down to 60 percent of what the fees are for other patients. There is quite a tendency on the part of the underwriters and on the part of the medical association to try to scale down the costs for those who have passed the age of 65. I think there is a very wholesome movement along this line. Those are all factors that have to be carefully considered when you get into the coverage of retirees.

The CHAIRMAN. Is it the intention of all you representatives of the different organizations to continue your medical and hospitalization program in addition to the Government program, if approved?

Mr. HALLBECK. It would become part of the Government program.

Mr. KEATING. It is covered in the bill. Provision is made for our plans to continue as part of the Government program.

The CHAIRMAN. With the Government contribution?

Mr. KEATING. Yes.

Mr. HALLBECK. We would be in the same position as any competitive organization.

Mr. KEATING. The way the plan operates as far as the Government is concerned is the person takes out his insurance with either of the two selected plans and then withholding is made from the salary and the Government contributes a like amount and it will be transmitted to the companies.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. Then the Government would become a partner, in a manner, in Permanente [Kaiser Foundation] in California; is that right?

Mr. KEATING. To the extent that they would pay the payments for the Government people who are covered.

Mr. NAGLE. One of the original recommendations in regard to retirees was that there be a prefunding of their coverage and that all payments cease upon retirement. The Senate in its report—

The CHAIRMAN. Where is that provision?

Mr. NAGLE. One of the original recommendations, original possibilities proposed by the Civil Service Commission was that there might be a prefunding that everybody pay in anticipation of retiree costs prior to the time of retirement so that at the time of retirement all further payments would cease.

The CHAIRMAN. That is not in this bill?

Mr. NAGLE. No. When the Senate wrote its report, they anticipated the question you asked earlier about the relatively larger cost for covering retirees and they speculated upon this possibility. They said because the costs were greater after retirement, it was thought to be desirable instead of making the sort of recommendation that the Commission came in with earlier that the benefits should be paid for by the annuitants from their annuity checks.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I observe that one of the questions raised in the additional views in connection with the committee report in the other body related to the question of whether there was adequate prefund-

ing or provision of adequate reserves to avoid frequent increases in subscription rates and costs both to the Government and to the covered employee.

I wonder if any of the witnesses would like to offer any comment, in the interest of a sound plan, as to whether they feel there is any validity to that criticism.

Mr. KEATING. In our statement the other day we did touch on that subject. We stated that in our opinion the reserve that is provided is adequate. We base that on a number of conclusions.

Number one, there are many companies operating hospitalization plans that return 90 percent or better of the premium dollar to the insured person. Many of the Blue Cross plans operate right around that rate. There are indemnity companies that the record shows have returned as much as 97 percent. I do not think they can operate successfully by returning 97 percent, but they have, actually, and there are a number of others that run up in the nineties.

One additional consideration with respect to the Government operation and the reserve is the fact that probably the most expensive part of the hospitalization operation, investigating and paying claims, will be the responsibility of the insurer and will not be a cost against the Government.

Mr. JOHANSEN. It is one of the elements of cost in the total program?

Mr. KEATING. Yes; it is an element of cost but will be paid in premium to the company and will not be necessary to be covered by reserves.

Mr. CORBETT. Will the gentleman yield?

Mr. JOHANSEN. Yes.

Mr. CORBETT. This is simple, as I see it, that every company or association that sells contracts to an employee will be presently a going concern with adequate reserves now.

Mr. KEATING. That is right.

Mr. CORBETT. So that the Government does not have to have a reserve or any prefund. The companies with which we contract will already have those.

Mr. KEATING. They have the 3 percent for little fluctuations.

Mr. CORBETT. I think some people have felt that the Government itself is going to make these hospital payments.

Mr. KEATING. They indicate that when they talk about 15 percent reserve because the hospitalization companies do not attempt to collect any such amount.

Mr. CORBETT. The Government will never pay any medical bill whatsoever. It is going to pay a contract?

Mr. KEATING. That is right.

Mr. JOHANSEN. Am I correct that Blue Shield and Blue Cross, at least in some areas, have run into a problem involving higher rates in recent months? If that is true, would that problem have been obviated if there had been a more adequate or a higher prefunding?

Mr. KEATING. No, I do not think that would have anything to do with it because there is a limitation of what you can pay in premium. The people who have to wrestle with the increase in hospital costs are the people with the contracts. If they have service benefits and costs go up, it is their problem. They may come back asking for more money.

Mr. JOHANSEN. The practical matter is that if due to inflationary factors and higher costs that are evidently uncontrollable, if you get a squeeze, it is going to be inevitable, certainly—and quite properly—that you will come in and ask for a liberalization of that ceiling; is that right?

Mr. KEATING. They still could not spend their reserve for that purpose. The bill holds the Government to a certain specified premium payment. The reserve could not apply.

Mr. JOHANSEN. In other words, it does not relate to the reserve but it would relate to a subsequent request, perhaps, for increasing the ceiling.

Mr. KEATING. For increased premiums. My personal opinion is when you set forth a plan such as this, extensive as it is, that the premiums set may affect and the influence of the Government in contacting the various hospitals may very well have the effect of keeping hospital costs from going up rather than accelerating them.

Mr. JOHANSEN. Let me switch to another aspect of the matter, if I may.

Do these reserves of which we are speaking relate to the long-range coverage of subsequently retiring employees or is the financing of the long-range costs of the employees hereafter retiring and hereafter to be covered a matter involving additional appropriations by the Congress and additional charges to the covered employees?

Mr. KEATING. No, I do not see where the reserves enter that picture because when they make a contract with the insurer, he will have to guarantee, as I see it, have a decent contract, that he will cover that individual not only during his working life but also after he retires for a certain specified payment.

If the insurer makes that contract, then I do not see why the Government would require additional reserves.

Mr. CORBETT. Will the gentleman yield?

Mr. JOHANSEN. Yes.

Mr. CORBETT. I think there is a point we overlook because the history of these various hospitalization plans has always been toward increased costs. There is nothing in the world that will prevent some of these companies from rewriting contracts and decreasing benefits rather than increasing costs. Where they now permit 30 days of hospitalization at \$18, it could be reduced to 25 under some circumstances at \$15.

Mr. JOHANSEN. Does the gentleman think if that occurs that there is not going to be immediately—I am not quarreling about it—but immediately a demand that we increase the funds through appropriations?

Mr. CORBETT. I am sure the gentleman and myself are both sincere in trying to get a program here that is going to be helpful to employees. We then would have a determination as to whether or not the individuals and the Government should pay more premiums in order to hold the present benefits or whether it would be better to cut benefits. Certainly, there would be a demand from some sources to increase premiums for the Government participation.

Mr. JOHANSEN. I am certain that having put your hand to the plow and having set a standard of benefits with regard to active and retired employees, certainly the gentleman does not expect there is going to

be any step backward in terms of those benefits. Certainly, the gentleman knows all the pressure and all the logic of the argument will be on the side of increased appropriations by the Congress.

Mr. CORBETT. This I would not be as sure of as the gentleman is in regard to other matters because with the increased cost of medical care and hospitalization—I serve on the board of Suburban Hospital in Pittsburgh and we found the greatest decrease in cost has been the decrease in the period of hospitalization. There has been a definite tendency to move the patients out.

Mr. JOHANSEN. That is based on medical as well as economic situations.

Mr. CORBETT. As a member of the board, we like to have the rooms filled.

Mr. JOHANSEN. I am sure the gentleman does not have too much of a problem on that score.

Mr. CORBETT. There is no guarantee along the line. While recent history has shown medical costs mounting, even down to custodial work in the hospital, there is also a tendency for the costs of expensive drugs to go down, a tendency for these programs reducing the number of charity cases we have in the hospital. Our hospital incomes have been improving somewhat. This is very recent. We are getting more money in and hence the deficits in our hospital have disappeared.

Mr. JOHANSEN. There is no question that it has helped to stabilize the income of hospitals, the fact that you have this coverage.

Mr. CORBETT. Yes.

Mr. JOHANSEN. I want to get clear in my mind whether the estimate of \$145,300,000 annually as the cost of this program, cited in the committee report of the other body, contemplates within that figure the cost of the coverage of retired employees.

Mr. KEATING. Yes, to this extent. It does not cover those that are retired now but it covers those that retire in the future.

Mr. JOHANSEN. I certainly do not question the gentleman's word or the good faith of the statement for a moment, but I am concerned over an apparent conflict of allegations on that score.

Mr. KEATING. I think the Commission made the statement that it would cost, the fact that they have the retirees, \$2.5 million extra the first year because there will not be too many covered. The amount will increase for 10 years to \$25 million a year.

I am of the opinion that under the program as set forth within the next few years they can take up those costs without increasing that \$145 million.

Mr. JOHANSEN. The statement of the views of two of the members—again, I am seeking an enlightenment and not argument—is that this figure of \$145,300,000 includes only the Government's contribution for active employees.

Mr. KEATING. It includes those the first year.

Mr. JOHANSEN. When it reaches the \$25 million point—

Mr. KEATING. We are of the opinion that the costs are a little high, estimated a little high, for a number of reasons. No. 1, the median pay for Government employees is, according to the Civil Service Commission record here, \$4,790. In order to get the full benefit of this program, these people would have to pay \$9.21 a month. It is our opinion that a great many of these employees are not going to be able to

pay \$9.21 a month. They will not be able to secure the maximum benefits.

Mr. JOHANSEN. In other words, they will settle for something less than the maximum.

Mr. KEATING. Yes, they will settle for something less. The more people who do that the less the cost of the program. In our opinion, it is going to be substantial. In their report the staff pointed out that they had some figures that showed the reductions that would be made on various bases. I think they made a very good case for the fact that their estimates represented maximum participation and maximum payments.

Mr. JOHANSEN. I want to be completely fair about it. I recognize I am asking the gentleman to prophesy. But if, as he testifies, in his judgment there would be a substantial number of Government employees who would accept less than the maximum for financial reasons, would it be reasonable to expect that sometime thereafter there would be a strong effort to secure a substantial increase perhaps to the two-thirds figure I believe the gentleman from Louisiana mentioned in his testimony, of the cost to be borne by the Government? In other words, would that lead to an expectation—I am not speaking critically of it at the moment—but an expectation that this would be recognized as an area of unfilled need which the Government ought to meet by increasing its share above the 50 percent mark?

Mr. KEATING. I am not an economic prophet, but I know that by human nature people try to improve their position in life. If they did not do that, we would not have any progress. I do not know how long I will be here representing the people of our organization and what they are going to do next year or the year after or in 10 years. I could not predict.

Mr. JOHANSEN. I will say to the gentleman I hope he is here as long as or longer than the Member from Michigan.

Mr. KEATING. We appreciate that, but by the ordinary progress of human nature, and if you refer to history, it is quite likely that the employees of the Government will be looking for improvement in their way of life.

Mr. JOHANSEN. The only reason I raised the point, I want to make clear, is that I would like to anticipate as far as reasonably possible the impact in terms of cost to the Government.

Mr. HALLBECK. I would not foreclose the possibility of seeking improvements. I would venture the opinion that it will be many years if this program is enacted in substantially the same form as it passed the Senate; I venture the opinion that it will be many years before there are any additional benefits sought.

Mr. JOHANSEN. I am glad to have that in the record.

Mr. BROYHILL. Mr. Keating, what will happen between the time it is determined that benefits will have to be reduced or premiums increased and the time when action is taken? Take your own organization. In underwriting these benefits you have entered into a contract with the Civil Service Commission. We will say that it is determined that due to inflation or due to a mistake in figuring out the actuarial factors you have to increase the premiums. What happens in the meantime?

Mr. KEATING. Hospitalization is an open-end contract, so referred to in the insurance industry. It is limited for a period of time, gen-

erally for a period of a year. Generally, when an increase is needed the insurer can tell in advance. If we do not have enough money now in our program we have to raise the cost of the premiums. You cannot do that overnight any more than you could get an increase from the Government. It takes a matter of some months before accomplishing an increase.

Mr. BROYHILL. Is there a possibility of getting into a deadlock as to whether to decrease benefits or increase premiums?

Mr. KEATING. You would not have any more trouble than——

Mr. BROYHILL. At any time during the term of this contract that it is determined you cannot provide benefits for the premiums involved, you can renegotiate the contract and reduce the benefits. You cannot come back to Congress in the meantime and obtain more premium payment but you can by renegotiation reduce the benefits?

Mr. KEATING. Yes.

The CHAIRMAN. This bill fixes the maximum contribution of the employee, and if those contributions are not sufficient with the Government's contribution, the Civil Service Commission has to reduce benefits to correspond with the amount of money on hand; is that right?

Mr. KEATING. That is right.

Mr. JOHANSEN. Mr. Chairman, I think you gentlemen who are testifying and I will find ourselves in complete agreement on this point. I do not want to be a party to the setting up of a program which is going to very shortly thereafter or at any reasonable time thereafter shrink in terms of the benefits to the employees because I think such a thing is unfair to them and, however unintentional, is essentially a fraud on the employee. I do not want to see that happen. I want to see such safeguards set up as will minimize the possibility of that. If those safeguards are going to involve additional costs, I would like to face the fact now insofar as we can anticipate.

Mr. HALLBECK. We are working the same side of the street. We are interested in providing the same kind of permanent benefits for the employees. We would not be a party to a fraud.

Mr. BROYHILL. Then there is no risk involved insofar as the carrier is concerned?

Mr. KEATING. No, I do not think so. I think they have worked out a rather ingenious arrangement, but it is the only thing that can be practical in this field. It is a very flexible arrangement and highly practical.

Mr. CORBETT. While we cannot predict what is going to happen to medical costs, the only thing I know to give us any guidance is the fact that when the life insurance program was under consideration these same fears were expressed. The fact is regarding the life insurance program that we now have a very considerable surplus. At the time the bill was on the floor I predicted that one of three things or a combination would happen:

A, that Government participation would be reduced; B, the benefits could be increased; or, C, premiums reduced.

It is just possible with the total amount of money that will go into this fund from the Government and from the employees, that if there is any error in this bill, it is as to the size of the premiums and not the benefits. I would take the optimistic view that we are going to

find that benefits can be increased, Government participation can be reduced, or premiums can be reduced after we have had a few years' experience in this program.

Mr. JOHANSEN. I certainly hope his optimism is proven by subsequent developments, but I wonder if it is not true that the potentially variable factors of cost with respect to hospital and medical insurance may be substantially greater than the potential variance in cost based on experience in life insurance.

Mr. CORBETT. Yes, sir. I will readily admit that my example is open to a pessimistic point of view as well.

Mr. JOHANSEN. I want to say to the gentleman, and I want the record very clear, that I am not undertaking to be maliciously pessimistic. I would like to be constructively realistic about the thing. I address myself in that connection again to the fact that I do not want to see something started here that is going to shrink in the very near future and put us in the light of circumstances beyond our control, being in a sense, if I may use the phrase without violating anyone's sensitivities or civil rights, of being an "Indian giver" in the matter.

Mr. CORBETT. Finishing off my statement, I think we are dealing with reasonable people and I think we represent reasonable people.

If the budget situation became such that it was critical, that if the costs of medicine had gone way up, that while the gentleman is entitled to his opinion that he does not want to be an "Indian giver," I think it is reasonable and realistic both to go back to the employees and say, "Here, this particular benefit has proved to be so expensive that it is endangering the fund and we will have to withdraw it."

That is strikingly a difference of point of view.

The CHAIRMAN. Under this bill they have to withdraw it if they do not have money to pay for it.

Mr. CORBETT. That is exactly right. I think that approach is sound, while we are into an experimental period.

The CHAIRMAN. But not realistic.

Mr. CORBETT. I think it is extremely realistic.

Mr. JOHANSEN. The distinguished chairman, of course, realizes that there are almost unlimited resources available to pay more by drawing on the national deficit.

The CHAIRMAN. Yes. Someone referred to the insurance program proposed by Congress. It was proposed that the private insurance companies insure the Federal employees and as I recall it would take \$70 million from the insurance companies. It would practically bankrupt them.

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter.

Mr. PORTER. I would like to ask Mr. Hallbeck if the organization he represents here today believes that this bill should be enacted at this session of Congress.

Mr. HALLBECK. Very definitely.

Mr. PORTER. Will you explain the reasons for this?

Mr. HALLBECK. It will take the Civil Service Commission at least several months in order to set up the machinery to make a plan like this effective.

The effective date in the bill is July 1, 1960.

While I hate to see the effective date so long postponed, my knowledge of the subject convinces me that it will probably take a miracle to make it effective at any sooner date, even if the legislation were passed tomorrow. There is a tremendous job that the Civil Service Commission has to do in order to effectuate a program of this sort and if it isn't passed at this session, I have no hope that it could begin to operate as early as July of 1960.

Mr. PORTER. That is the opinion of the others with you?

Mr. HALLBECK. I would say that is an opinion generally shared.

Mr. PORTER. Do you have any information about the loss of services to the Government from illnesses which have come up because no such plans like these exist? Have you made a study of the loss on sick leave?

In other words, could we demonstrate that if this plan were in effect it would mean that there would be less sick leave taken?

Mr. KEATING. There are no studies. I think what you state is a fact because, very often, I know from my own personal experience, that people defer surgery because they are not economically able to pay for it. They do it for several years, when in the long run the Government has them off work for a much longer period of time than if the employee had it taken care of when he should have.

Mr. PORTER. But nobody has made a study?

Mr. KEATING. No one to the best of my knowledge has ever made a study.

Mr. PORTER. What is the position of your organization with respect to adding present retirees to this bill or having separate legislation?

What is the position of your organization?

Mr. HALLBECK. Reluctantly, I think we are in agreement that the subject is so involved that it will require further study.

Mr. PORTER. That is the same position taken by Senator Neuberger and Senator Johnston?

Mr. HALLBECK. We are in accord with that position.

Mr. REES. Not to include them in this bill.

Mr. HALLBECK. Not at this time.

The CHAIRMAN. That is for the retirees who have retired before coverage by this legislation?

Mr. HALLBECK. That is right. There are no valid figures that would tell us how much the cost would be or how many people are involved.

Mr. PORTER. I understand that medical costs and hospital costs have gone up faster than normal inflation would justify.

I believe our figures would show this. One of the reasons advanced is that doctors and hospitals have increased charges to insurance companies. I used to be a complainant's lawyer. I recognize that some people look on insurance companies as bottomless wells. This is not true.

I was wondering if there is any way we could write stronger language in this bill which would keep the costs from accelerating, as the plan goes on?

Do you have any suggestions?

Mr. HALLBECK. I do not know of any suggestions for that, but I think there is a very natural factor that will work against costs accelerating. In our own program, for example, we know that we

get a much higher percentage of bad risks than we would get if we could take the whole group, and I am sure that a program of this sort is going to take very nearly the whole group, is going to get much higher percentage of good risks as a result, which will tend to hold costs down. When you are paying only for those people who are sick or about to enter a hospital you run into costs in a hurry.

Mr. PORTER. That is not the problem I had in mind. There would be a tendency on the part of doctors and hospitals to raise their rates, as there has seemed to be such tendency in the past, and get by.

The Government Commission will have to decide on this.

Mr. KEATING. My impression from studying reports on this subject is that there has been a decisive turn in that direction of controlling costs. The medical associations in various States have set up boards to investigate doctors that charge excessive fees. The Medical Association itself is trying to police it.

In addition to that, I think these various cooperative groups that have been established, such as the plan we have here in Washington, and HIP, where the doctors set a definite specified fee, has had its repercussions and the American Medical Association for the first time has approved, at their last convention, this type of prepayment medical practice.

They gave it their blessing, so there is a very decided movement within the medical profession itself to hold down the fellow that charges excessive fees.

Mr. PORTER. This is what I had in mind. I was wondering whether we couldn't get some consumer or some representative of the consumers, perhaps your organization, who are in position to look at books and see whether margins of profits for the doctors and hospitals are way out of line in connection with charges that are made.

Mr. KEATING. I think that function could be exercised very well by the Advisory Council and by the Commission and by the Comptroller's Office.

Mr. PORTER. I was wondering if our language should be a little stronger.

Mr. KEATING. It is specified in the bill that they can look into the books.

Mr. PORTER. You think they have enough power as it is?

Mr. KEATING. I think they have a pretty good measure of power if it is administratively set up in a proper way.

Mr. PORTER. Then there is the contracting power.

On page 12 it says:

The Commission is authorized, without regard to section 3709 of the revised statutes or any other provision of law requiring competitive bidding, to enter into or authorize enrollment under, a contract or contracts with or to purchase a policy or policies from, qualified carriers offering plans described in section 4 and providing benefit described in section 5.

As I look at it this seems to be very bad because if there are several different plans I would like to have them compete and have the Commission choose one that has the best aspects to it.

Mr. HALLBECK. I think there is competition right in this bill.

Mr. PORTER. Why do they have this provision in?

Mr. HALLBECK. I think there is a natural competition that will tend to keep prices down.

Mr. PORTER. There are several here in Washington. I would think they ought to bid and the lowest bidder ought to be taken.

Mr. KEATING. I think that is for two reasons: No. 1, one of the objections, the original S. 94 did not have that provision in it but it made it possible to be in free competition, with the individual having absolute choice as to whom he purchased his insurance from, but the Commission felt, and the Government generally felt, and a lot of the insurers felt that you would have to select one plan for each type of operation, like one service plan, one indemnity plan. Now when you come to the indemnity plan, if you select one company to underwrite it and under the group insurance plan, the other companies to take a part of the business, if you have it on an absolutely competitive basis, you would have a great variety of prices.

Mr. PORTER. I do not understand this variety of prices.

Mr. KEATING. You would have a variety of bids perhaps. On the basis of the bids perhaps the company that could submit the lowest bid would not be able to handle the business properly.

Mr. PORTER. They have to. You cannot bid unless you say you are going to do what the specifications require.

Mr. KEATING. I think this particular clause, the reason it is there, is to do with working out an equitable program for the indemnity companies. That is my personal opinion, which may be a thousand percent wrong.

Mr. PORTER. I am not so concerned about that, but about the group of plans. Where here are a number of plans, and the Commission might do this anyway—

Mr. KEATING. Group plans can bid with the individual and under the terms of the law there are two groups that have to be recognized. That is the employee benefit plans and that is the group repayment plans. They are all recognized by virtue of the provisions of the bill, if the employee wants to choose them.

That provides a large measure of competition, in my opinion.

Mr. PORTER. Thank you very much.

Mr. FOLEY. Mr. Chairman.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. As I understood your testimony, Mr. Keating, you have had a program of this nature since 1950?

Mr. KEATING. Yes.

Mr. FOLEY. Do your people like it?

Mr. KEATING. Yes.

Mr. FOLEY. I believe that question could be asked of all the witnesses.

Mr. KEATING. It would be improved, of course.

Mr. FOLEY. The proposal is not what would be called a revolutionary program. It has been tested throughout private industry?

Mr. KEATING. That is right.

Mr. FOLEY. This bill would seek to extend the benefits, which you have found in your own organizations to be very helpful and salutary, to all employees of the Federal Government, regardless of whether they are members of your organization or not. Is that right?

Mr. KEATING. That is correct.

Mr. FOLEY. These technical questions that have been presented to you have all been met in the course of experience of administering your own programs by and large, have they not?

Mr. KEATING. That is right.

Mr. FOLEY. The subsequent witnesses from the insurance industry could probably shed a great deal of technical light on these problems?

Mr. KEATING. That is right.

Mr. FOLEY. What you are really proposing in supporting this bill is extension of a program you have found in your own organizations to be accepted, well received, and to have great social and economic merit?

Mr. KEATING. And a program that is being enjoyed by some 89 million people in private industry.

Mr. FOLEY. Thank you very much, Mr. Chairman.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. A while ago, Mr. Keating, my colleague from Michigan, Mr. Johansen, questioned you concerning the cost to the Government of this program. I believe you said that the cost would not be as high as some indicated it would be, \$145,300,000 or something like that

Mr. KEATING. Yes.

Mr. GROSS. That is because of the fact that some Federal employees would not take full coverage; is that right?

Mr. KEATING. That is correct.

Mr. GROSS. Did you at any time have or can you give the average payment on the part of your people today to the programs you have?

What is the average payment?

Mr. KEATING. 65 percent of our people pay \$7.70 a month.

Mr. GROSS. The top payment under this plan would be \$9?

Mr. KEATING. \$9.21.

Mr. GROSS. That would be the difference between the coverage proposed here and the coverage they are presently getting, the average of your people under your plan?

Mr. KEATING. That is right. That would be the maximum the individual could pay. There is a question in my mind whether our people would be able to pay \$9.21.

Mr. GROSS. It would be a difference of \$2 a month approximately?

Mr. KEATING. That is right. A little less; \$1.50 approximately.

Mr. JOHANSEN. If the gentleman will yield, I think the gentleman has raised a very important and enlightening point. I would like to pursue it a little further.

This \$7-some-odd figure you cite, does that represent the maximum which your plan permits?

Mr. KEATING. No. The maximum is \$11.25.

Mr. JOHANSEN. Is the remaining percentage above the \$7 figure or in part below it and in part above it?

Mr. KEATING. There is part below it.

Mr. JOHANSEN. Could you give us a further breakdown?

Mr. KEATING. 17.6 percent only pay \$7. That is for the smallest amount for family benefits. 3.4 percent pay \$8.95; 3.2 percent, \$9.90; 1.6 percent, \$10.25, and 9.9 percent pay \$11.25.

Mr. JOHANSEN. Which is the maximum.

Mr. KEATING. Which is the maximum, but there are 82 $\frac{8}{10}$ percent pay \$7.70 and less.

Mr. GROSS. Do I understand you have offered those figures for inclusion in the record?

Mr. KEATING. They are included in the record.

The CHAIRMAN. Do you agree with the report of the Senate committee that under the bill you reserve about 3 percent of 1 year's contribution and that will be sufficient to hold off rate increases?

Mr. KEATING. I think so, Mr. Chairman.

Mr. HALLBECK. I think that is demonstrated by our own experience with our own plan.

The CHAIRMAN. How much could you set aside?

Mr. HALLBECK. Approximately 3 percent.

The CHAIRMAN. I presume that all of the employee organizations represented by you gentlemen would be back here clamoring for another pay increase next year, is that correct?

Mr. KEATING. That is a question I do not believe we could answer now, Mr. Chairman, because we do not know whether we are going to be in a period of great economic activity or whether it will go the other way.

However, last night the paper carried an interesting item, that the cost of living had reached a new record high. The Tuesday paper carried an interesting item that personal income of the United States had hit the high level of \$382 billion a year, the highest in history.

It also carried a very interesting item that the Great Atlantic & Pacific Tea Co. reported earnings of \$14,638,000 and an increase in shares from 61 cents to 68 cents. National Gypsum Co. reported a 44-percent increase in sales, and Radio Corp. of America, reported an increase of 44 percent in earnings.

The Du Pont Co. had reported earnings of \$4.61 a share in common stock compared to \$3.88 for last year, so certainly if the economy continues to rise and the elevator goes up, I am sure that the Government employees will want to ride.

Mr. GROSS. If I may make an observation at that point, I would like to add to that the fact that the Department of Agriculture is predicting an 8 percent net loss in income for farmers this year.

Mr. HALLBECK. I would like to add this, Mr. Chairman. As the committee is well aware, a portion of the last increase that postal employees received was on a temporary basis that expires next year and I will guarantee we are going to be in here looking to make that permanent.

The CHAIRMAN. Certainly.

You know you won't have trouble with that.

Mr. HALLBECK. I did not want the chairman to be under any illusions.

The CHAIRMAN. There is nothing temporary about pay raises Congress has granted.

Mr. HALLBECK. We understand, Mr. Chairman.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I seem to recall that there have been instances in which municipalities and I think some in my own district, have, in order to finance a retirement program for example, submitted to the voters and have voted what in our parlance we refer to as extra millage to finance those programs. Would any of the gentlemen care

to comment on the possibility or the desirability or the undesirability of some kind of specific tax legislation addressed to the problem of financing what I think is basically a very legitimate and very sound program, but which might at least set forth to the Congress and for some of my colleagues in Congress the example of honestly facing up to the fact that good things cost money and ought to be honestly met as a legitimate cost and provided for?

Mr. HALLBECK. I would say that I would hesitate to answer your question a flat yes or no without giving it some consideration. I am sure, though, that we all agree that good government is expensive but good government is also worth what it costs.

The CHAIRMAN. The taxpayers realize that very fully.

Mr. HALLBECK. I think they fail to recognize at times, Mr. Chairman, that it is worth what it costs.

Mr. JOHANSEN. Mr. Hallbeck, would the gentleman add just one further proposition, and that is that the interests of good government and of these good activities of government and of this fiscal integrity and responsibility would be well served if the American people would accept the self-discipline of paying for what they provide?

Mr. FOLEY. Will the gentleman yield?

Sir, following the line of inquiry, I am sure you do not mean to imply that the Government employee should become a sacrificial lamb.

Mr. JOHANSEN. Of course I do not imply that, but I imply that somewhere in this Government we have to start facing up to the fact that we have to pay for what we get. I do not want to make them sacrificial lambs, but I find on everything we seem to have an incredible capacity to spend more than we are willing to vote to pay for.

Mr. KEATING. Mr. Chairman, in answer to Mr. Johansen's question, I think that the Government has a very definite responsibility to pay the employees a proper wage. I think it has a very definite responsibility to give them working conditions in keeping with those in private industry. I do not think that it is the responsibility of the employees to raise that money any more than any other citizen. I think they should pay their taxes and contribute.

I wouldn't suggest they be salesmen for a tax program. I don't think that is a proper request to make to the employees. We, too, are much concerned about the economic conditions during the last few months.

The interest rate has gone at an enormous rate. A 1-percent increase in the interest rate means an expenditure of approximately \$2.89 million.

Mr. JOHANSEN. Since the gentleman has raised the matter of interest rates, so far as the marketing of Government bonds is concerned, I confess to not being an economist, but I am not sure the solution is to pass a law requiring investors to buy it at a specific rate.

Mr. KEATING. I do not know whether that is the solution or not but I do know there are many other factors in the Government outside of hospitalization plans and Government wages that have to do with the enormous deficit. This year we are spending \$40 billion in defense.

We are spending over \$8 billion in interest. We are spending, if you put all the security programs together, I imagine another \$8 billion there, and that is a total of \$56 billion.

If the total expenditure is \$77 billion, that allows \$21 billion for all other operations of the Government, including veterans' benefits. There are a lot of programs in this area.

Mr. JOHANSEN. I trust the gentlemen all understand that not for a minute would I single out provisions involving costs relating to Government employees for this kind of treatment. I would not do that for a minute, but I am concerned about it with respect to this and the other aspects of the cost to Government.

I am concerned with the totality of the expenditures in relation to the totality of the revenue.

Mr. NAGLE. Mr. Chairman.

The CHAIRMAN. Mr. Nagle.

Mr. NAGLE. I believe perhaps we are assuming that the \$145 billion outlay is a completely out-of-pocket cost. Actually, the U.S. Government has two stakes in the national health: one, the general pattern of the populace as a group and, secondly, it has a distinct stake in the general health of the members of its employee family and of their domestic family, and surely this \$145 million outlay would bring tangible returns in the form of lower expenditures elsewhere.

The CHAIRMAN. Of course, I am sure you gentlemen would like the legislation to be approved by the President. In view of the situation, don't you think that it is a matter of give and take, and that some consideration should be given to the views of the administration before a bill is sent to the White House?

Mr. KEATING. We have given a great deal already, Mr. Chairman, from the original program. Most of the changes have been suggested by the administration and most of their suggestions have been complied with. It seems to me that if they get 70 percent compliance with their suggestions and the Congress is satisfied, the administration ought to be satisfied, too.

The CHAIRMAN. Mrs. Granahan.

Mrs. GRANAHAN. I cannot quite understand how we are sitting here quibbling about these prices for hospitalization for the Government employees. I think they deserve everything. \$5 million was just sunk. They built a hospital in France and couldn't use it. We are spending \$2 million a day in Vietnam, and many millions in Bolivia, which is under the Communist regime. I do not think we are going to break this country by giving the Government employees these benefits, by any chance whatsoever. There is a great deal of money that we could save, I agree. I think this is not the proper place to go into that.

Mr. REES. I agree with the gentlewoman and we ought not waste money in France or Bolivia or anywhere else.

Mrs. GRANAHAN. I think we could get the return from this money we are going to spend because I thoroughly agree that these older people in the Government, who are getting near the age of retirement, do hesitate to go to the doctor. It is very expensive.

Mr. JOHANSEN. Will you yield?

Mrs. GRANAHAN. I yield.

Mr. JOHANSEN. I share the exact feelings she has. At the risk of sounding self-righteous, which I do not intend to, I did not vote to appropriate the money that made that waste.

Mrs. GRANAHAN. Thank you, Mr. Johansen.

The CHAIRMAN. How much reserve do you think should be set aside by the Civil Service Commission each year to take care of future contingencies regarding increased costs of medical care and hospitalization?

Mr. KEATING. I think the figure presented in the bill, 3 percent, would be adequate.

Mr. HALLBECK. I think that is reasonable. That is based on our own experience.

The CHAIRMAN. Any other questions?

Mr. MORRISON. If there are no other questions, Mr. Chairman, I would like to take this opportunity to commend and express our appreciation for the very excellent and expert testimony that these gentlemen have given this committee. I think it has been extremely helpful and very valuable, and I think they have certainly explained this bill to the fullest extent as far as their respective organizations and employees are concerned.

Mr. BROYHILL. Would the gentleman yield?

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. In line with the observations made by the gentleman from Louisiana earlier about an effort being made to get this legislation disposed of before the adjournment of this session of Congress, without meaning in any way to limit any witness from wanting to testify, I notice that there are several more employee representatives who are scheduled to testify. I am wondering if some of these witnesses might want to consider whether or not their prepared testimony is repetitious and might want to consider merging the testimony or submitting it for the record. It might help the committee in expediting these hearings, to perhaps assure that the legislation would be passed before this session of Congress. We do not want to overlook any witness but we might avoid as much repetition as possible and expedite consideration of the legislation.

The CHAIRMAN. How many witnesses scheduled for today are from out of town?

I see Mr. Moore from Nashville is here. Before we adjourn, would you like to make a brief statement, Mr. Moore? We do not want to have you come back from the great State of Tennessee to appear.

**STATEMENT OF LEWIS E. MOORE, CHAIRMAN, LEGISLATIVE
COMMITTEE, NATIONAL ASSOCIATION OF POSTMASTERS**

Mr. MOORE. It is an honor to be here this morning to hear the testimony given. I am the chairman of the legislative committee of the National Association of Postmasters. Insofar as the testimony we have heard is concerned, we of the committee agree with the statements made by Mr. Keating and Mr. Hallbeck. If it is agreeable with you, Mr. Chairman and your committee, we would like to file our statement with you as our testimony in this case.

The CHAIRMAN. Very well, sir. That permission will be granted.

Mr. MOORE. There is only one thing I would like to add to it, and that is the fact that our national president, Mr. Ed Baker, could not be here today because of a previous commitment, and our national secretary-treasurer, Mr. Chuck Puskar, could not be here because of illness in his family. They fully agree with the statements made.

Mr. HALLBECK. May I express our thanks to the committee on the part of the Government Employees' Council for the consideration we have had before your committee.

The CHAIRMAN. The statement of Mr. Lewis E. Moore, postmaster of Nashville, Tenn., and chairman of the Legislative Committee, National Association of Postmasters, will be inserted in the record at this point.

(The statement of Mr. Moore follows:)

STATEMENT OF LEWIS E. MOORE, POSTMASTER OF NASHVILLE, TENN., CHAIRMAN OF THE LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF POSTMASTERS

Mr. Chairman and members of the committee, my name is Lewis E. Moore, I am postmaster at Nashville, Tenn., vice president and chairman of the Legislative Committee of the National Association of Postmasters. Our membership consists of more than 32,000 postmasters, or over 91 percent of the total number of postmasters in the Nation.

We appreciate the opportunity of appearing before you today in wholehearted support of our health benefits bills, H.R. 8210, 8211, 8222, and S. 2162 which passed the Senate by the decisive vote of 81 to 4 on last Thursday, July 16, 1959.

As a further attest of our intense interest in this legislation, my colleagues, Charles D. Hertzog, manager of the health insurance plan of our association, and Roy M. North, former postmaster of Washington, D.C., our legislative representative, personally join with me in the presentation of this testimony.

At the outset, Mr. Chairman, please permit me to express the deepest appreciation of our association for the many fine things that you and members of your committee have done for us in the past. We are particularly grateful for the splendid accomplishments and benefits coming our way in 1958. We have always found you and your outstanding group of legislators friendly and keenly aware of the needs of postmasters and postal employees.

We feel that we have always been conservative in our appeals to you and your associates on the committee and in that spirit, we today, without hesitation, endorse the sound proposals and plans for health benefits embodied in the bills described.

In our opinion, these are the most important legislative measures that have been presented to Congress in many years. On April 21, 1959, our association testified in favor of the principles of S. 94 and related bills on health insurance, before the Neuberger subcommittee. That bill provided for the Government to assume two-thirds of the cost and the employee one-third. We recommended, however, that the employee should share equally with the Government in the cost of the program. This new bill now before us, S. 2162—improved piece of legislation—after many days of hearings, exhaustive conferences and a tremendous amount of study, was reported by the Senate Committee.

These bills stipulate a 50-50 sharing of the cost, which is in keeping with the health programs of many large industrial concerns. Certainly, if it does not see fit to actually lead in this field, the Government should at least do as much for its employees as that provided by industry.

S. 2162, as conceded by its sponsors, is not a perfect measure. It may well be amended from time to time, particularly after experience of operation. It does not take care of the 400,000 retirees—our senior citizens, who devoted many years of their lives unselfishly to dedicated Government service. In fact, it seemingly leaves in the lurch, those thousands of former faithful employees who are at present members of many existing health programs. These people now enjoy nominal premiums by reason of membership in large groups of various ages, which plan, of course, is the very heart and substance of insurance business.

We have the assurances of both the chairman of the Senate committee, Senator Olin D. Johnston, and Senator Richard Neuberger, head of the insurance subcommittee, on the floor of the Senate, July 16, 1959, that they are cognizant of the need—study is being continued—and an additional bill will shortly be introduced providing for health insurance for those already retired.

While we shall not take the time to discuss the many features of these important measures, we are satisfied that they are a splendid beginning in the

field of health benefits and a health insurance program should be enacted into law. We commend them to you for favorable consideration and passage at an early date.

Again, Mr. Chairman and members of the committee, thanks for the privilege of presenting this testimony.

The CHAIRMAN. The House will not be in session tomorrow. A number of the Members who live within a reasonable distance will go to their homes over the weekend. For that reason, the hearing will be continued Tuesday morning at 10 o'clock.

(Whereupon, at 12:05 p.m., the committee adjourned to reconvene at 10 a.m., Tuesday, July 28, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

TUESDAY, JULY 28, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be resumed on the various health and hospitalization insurance bills now pending before the committee, and especially on the Senate-passed bill, S. 2162.

At this point in the record I will insert a statement by our colleague and former member of the committee, Representative Frank M. Karsten, of Missouri. Also a statement of Representative B. F. Sisk, of California.

(The statements follow:)

STATEMENT OF HON. FRANK M. KARSTEN, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MISSOURI

Mr. Chairman, my name is Frank M. Karsten. I am a Representative from the State of Missouri, and I wish to express my support of legislation to provide a program of health benefits for Federal and postal employees.

Having served as a Federal employee myself for many years, one of the first committee assignments I sought after I was elected to Congress was the privilege to be a member of the Post Office and Civil Service Committee. My service here was a wonderful experience, and I cherish the associations and friendships I made as a member of this great committee. Because of this background I naturally have a deep interest in the work of the Committee on Post Office and Civil Service, and I appreciate the opportunity to appear this morning in support of legislation to provide a program of health benefits for Federal and postal employees.

From my own experience as a Government employee, I know there has long existed a need for a health program. The U.S. Government is the biggest business in the world and the biggest employer. Yet, we have not kept pace with private industry in the field of health insurance for our employees. Private industry long ago recognized the value of such programs. Studies by the Department of Labor disclose that the majority of nongovernmental workers are presently participating in health insurance programs financed either in whole or in part by their employers.

In my opinion we should, at this time, take steps to bring the Government service up to the general standards which are followed by private industry. We could do this by enacting a program as provided in the recently enacted Senate bill, S. 2162, which provides medical care under an employer-employee program.

I have received a great many letters from Federal employees in St. Louis, and they want such a plan. Their salaries are modest and for a great many a plan such as this one is their best opportunity to secure health protection. While the employees who participate in such a program will be direct beneficiaries, the Government itself will also gain immeasurably by improved health of its employees and improved morale.

The Committee on Ways and Means, of which I am a member, recently held some preliminary hearings on the broad general subject of health insurance. While the committee has come to no resolution on this matter witnesses who testified in support of a general program based their arguments on the high cost of medical treatment. It is undoubtedly true that a great many people simply live with symptoms of illness or disease instead of having them treated because of cost factors.

One of the studies brought to the committee's attention was made by the Michigan State College. It disclosed that 45 percent of the people with income of less than \$1,000 had one or more untreated symptoms; 27 percent of the people with a \$1,000, but less than \$2,000; 23 percent of the people with \$2,000, but less than \$3,000; and so forth up to the people with \$5,000 or more, 10 percent of whom had untreated symptoms.

Expense is perhaps not the only reason why people do not secure treatment that they need. However, if the Michigan study were to be applied to governmental employees on the basis of income, it would indicate that perhaps about 10 percent of Government workers may presently have untreated symptoms. Such a high percentage would naturally reflect itself in decreased efficiency on the part of the individual as well as the department in which he is employed.

I urge the committee to favorably consider a health insurance program for Federal employees. There is a real need for it, both from the standpoint of the Government as well as the individual employee. Finally, the enactment of such a program will bring the Federal service up to the general standards which are followed in private industry.

STATEMENT OF HON. B. F. SISK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I appreciate the opportunity to express to the committee my vigorous support of an effective, overall hospital and health benefit act covering active and retired Federal employees.

In considering this legislation, I believe we are following in the proven path of enlightened private industry rather than embarking on an untried course. The proposal before your committee would achieve prepaid health benefits through the combined contributions of the employee and the Government on a sharing basis. In my opinion, this plan is far more modest in its demand on the public treasury than would be those in many branches of industry which pay all or the major portion of employee medical and hospital costs at company expense.

The Federal employee, and particularly the retired employee, is included in that great group of citizens who are today denied participation in the advances of medical science because they cannot afford to pay for adequate care and are not eligible for free care. The position of the wage earner faced with illness in his family is desperate today unless he can participate in a sharing of costs through some type of group insurance plan. The plans in general use are limited by the amount the average salaried person can pay in premiums and do not cover major or long lasting illness—which becomes literally a tragedy.

In my opinion, the enlightened self-interest of every employer, including the Federal Government, as well as that of the employee, requires the employer to sponsor and contribute to health protection for the men and women who keep the wheels of his factory or office turning. And we certainly also owe continued protection to those who have faithfully served into retirement.

I consider the proposed Federal Employees Health Benefit Act of 1959, with provisions for equal sharing of costs, an equitable and practical approach to the solution of one of the most serious problems of Government today, and I heartily endorse it.

The CHAIRMAN. The first witness this morning is Mr. J. D. Colman, vice president and secretary, Blue Cross Association. Also, Dr.

Donald Stubbs, chairman of the board, Blue Shield medical care plan. I will ask you two gentlemen to come to the table.

On July 22, 1959, I sent the following letter to Mr. J. D. Colman of the Blue Cross Association:

(The letter referred to follows:)

HOUSE OF REPRESENTATIVES, U.S.,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C., July 22, 1959.

Mr. J. D. COLMAN,
Vice President, Blue Cross Association,
55 East 34th Street,
New York, N.Y.

DEAR MR. COLMAN: Further reference is made to my letter to you of July 20 with respect to your testimony at our hearings on S. 2162 and similar House bills, which began yesterday with testimony by Members of Congress and some of the members of employee organizations.

It is clear to me at this point that these hearings would be more productive of necessary information if the committee had available testimony from the standpoint of a section-by-section analysis of S. 2162 and detailed comments with respect to the types of services contemplated and the costs allocable thereto. The committee certainly will want to know, as just one example, the services contemplated, and the costs allocable to such services, under subparagraph (D) of section 5(a) (1) of S. 2162.

Since the Senate committee staff has advised that you are the one perhaps most familiar with the bill's terms, I would appreciate your presenting testimony along that line and at an early point in the hearings. For that reason, I am setting aside next Tuesday, July 28, for your testimony, along with that of Dr. Donald Stubbs who has asked to appear representing Blue Shield.

I would appreciate your being prepared to give the committee, in addition to an analysis of the bill, full and specific information with respect to the costs, including the costs (projected over the next 20 years) which would be allocable to annuitants and to employees, assuming that the current level of employment and rate of annual retirements are continued.

Further, in view of the statements contained in the Senate report and testimony of representatives of employee organizations before this committee, it is clear that efforts already are afoot to extend the benefits of this legislation to annuitants already on the rolls and their survivors—that is, to some 375,000 present annuitants who are not covered by the Senate-passed bill. I am sure the committee will desire information with respect to projected services and costs if the benefits of S. 2162 are extended to this large additional group in the near future, as has been indicated.

Also, I would like to have you include in your testimony information on the annual rates of increases in charges for hospital, medical, and surgical services, for the past 3 years and for a period projected at least several years into the future. I believe that this necessarily will involve consideration of the effect of increase in the costs of these services in relation to either future reductions in benefits or increased premiums under this legislation.

The committee also will desire information as to the number of Federal employees presently covered by Blue Cross or Blue Shield plans, or both, including the numbers of such employees having "major medical" or extended coverage.

If in the preparation of your testimony you find that you require any statistical or other information available in the Government, please feel free to call on Mr. Frederick C. Belen, chief counsel of the committee, who will be glad to cooperate.

Sincerely yours,

TOM MURRAY, *Chairman.*

The CHAIRMAN. We will be glad to hear from you now, Mr. Colman. As I understand it, your organization, Mr. Colman, and also the organization represented by Dr. Stubbs, were both active in the preparation of the initial legislation?

STATEMENT OF J. D. COLMAN, VICE PRESIDENT, BLUE CROSS ASSOCIATION, ACCOMPANIED BY DR. DONALD STUBBS, CHAIRMAN OF THE BOARD, BLUE SHIELD MEDICAL CARE PLAN

Mr. COLMAN. By "initial," you mean S. 94?

The CHAIRMAN. S. 94.

Mr. COLMAN. I had nothing to do with that.

The CHAIRMAN. I understand that after S. 94 was introduced you then made a very elaborate report pointing out certain changes you would like to see made in the legislation?

Mr. COLMAN. Yes.

The CHAIRMAN. I wish you would pick up the bill passed by the Senate and elaborate on the various provisions for the committee.

Mr. COLMAN. Yes. I will be very happy to do so, and I appreciate the opportunity to be here. If I may, I will skip through a portion of the prepared paper in order to save time.

The CHAIRMAN. Of course the full statement will be included in the record. You may elaborate on it as you see fit.

Mr. COLMAN. Mr. Chairman and members of the committee, for the record, my name is J. Douglas Colman, vice president and secretary of the Blue Cross Association. I appear on behalf of this association and of the 78 Blue Cross plans in the United States through which some 53 million Americans place hospital care in their family budgets.

For more than 25 years Blue Cross plans have pioneered in the provision of prepaid hospital service to the American people. They are today the largest single source of this service. For 25 years Blue Cross plans have pioneered in providing this service to Federal employees through the difficult means of volunteer group treasurers. Despite such handicaps, approximately one-half of the Federal employees in the United States now receive prepaid hospital service through Blue Cross. This represents some 1 million persons, and a total of some 3 million persons, including dependents. This is clear evidence of the need for a program as contemplated by H.R. 8210 and similar House bills. Also, it is evidence of the interest and effectiveness of Blue Cross in providing such service. We therefore speak with some experience both in the provision of the prepaid hospital service, and with the problems of providing this to Federal employees.

DEFINITION AND SCOPE OF BLUE CROSS PLANS

Each Blue Cross plan is a nonprofit community service corporation, governed by a board on which are represented the public, participating hospitals, and the medical profession. Members of these governing boards receive no remuneration and serve in the same manner as trustees of a hospital, university, or church. The administrative functions of Blue Cross plans are discharged by salaried employees under policies determined by the governing board.

The prepaid hospital service offered by these plans is in most instances supplemented by medical and surgical benefits offered through associated, medically sponsored plans. Typically, the hospital service benefits offered include care in semiprivate accommodations for varying periods depending on the subscription charges paid, and including the full range of hospital services.

To earn the right to use the Blue Cross symbol a plan must comply with the standards of the approval program administered by the American Hospital Association. These include bona fide nonprofit operation, free choice of hospital, hospital guarantee of service benefits, representation of both public and hospital interests on the governing board, and fiscal responsibility adequate to protect the interests both of subscribers and member hospitals.

In addition, most plans are supervised by some State agency, usually the State department of insurance, and in most States must comply with statutory requirements specifically applicable to such plans. Through a series of joint programs, plans bring to all of their subscribers the benefits of their day-to-day working relationship with the hospitals which actually admit and care for patients. These include the Interplan Service Benefit Bank, providing service benefits in one plan area to Blue Cross subscribers of another area requiring hospital care away from home. Subscribers moving their residence from one area to another may transfer their membership under the interplan transfer agreement.

Attached as table I¹ is the most recent report of Blue Cross enrollment in the various States. Blue Cross is clearly the method of choice of Federal employees and is the largest single source of prepaid hospital service.

PRINCIPLES AFFECTING THE PROVISION OF HEALTH SERVICE BENEFITS TO
FEDERAL EMPLOYEES

(a) *The Nation's largest employer should aid its employees in securing needed health services.*—The United States is the only large industrial Nation in which personal health services are not a major governmental responsibility. This is true largely because workers, employers, and the providers of health services, through Blue Cross and Blue Shield, made it possible for the average worker to budget for large segments of health service costs. Encouragement of this voluntary program is in the interest of all employers, especially the Nation's largest.

Contribution to the cost of health service benefits is increasingly a standard part of the benefits offered by private employers with whom the Federal Government competes for competent personnel.

(b) *Federal Government has a responsibility beyond that of other employers.*—Health service is a necessity. To the extent citizens do not, or cannot provide it for themselves, health costs become a responsibility of tax funds. Defense and other needs already impose substantial drains on available tax funds. To the extent workers and their employers meet health costs through their joint efforts, tax funds are freed for other purposes. Therefore, the Federal Government should give leadership in fostering the development of voluntary health insurance.

(c) *Reasonable choice.*—Federal employees are located in every town in the land. The use of health service, and its cost, vary widely in different sections of the country. Employees should be free to choose the type of program best suited to their needs.

¹ Tables referred to in statement will be found at pp. 108, 109.

(d) *Government contribution to all authorized programs should be in equal proportion.*—Any other decision would use public funds to foster or hinder the development of a particular pattern of health service prepayment.

Mr. JOHANSEN. With regard to item (d), I may be obtuse this morning but I do not understand the second sentence, the one after the italic sentence. Would you comment on that for a moment?

Mr. COLMAN. If the employer subsidy to one type of program under a health benefit program is different proportionately than it is to another type of program it would be in a sense a special employer dispensation to, and support of, some particular pattern or method of doing the job.

(e) *Health service not cash should be the objective.*—The services needed by a particular patient vary widely as to type, cost, and frequency. The benefits provided should be broad enough, and flexible enough to absorb these variations.

(f) *Delivery of service at the time of illness should be prompt and without procedural barriers or complexities.*—Blue Cross is uniquely qualified to provide subscribers and hospitals with prompt information on benefits available while the patient is in the hospital.

(g) *Wise use of community health resources should be encouraged.*—The local structure of Blue Cross enables it to work with hospitals to channel available funds into the areas of patients' greatest health service needs, and to discourage the development of services tangential to the primary needs of patients. Funds available for hospital service are insufficient to meet all the demands of patients. Such funds as are available should first be used to satisfy the essential needs of patients.

(h) *Use available funds for benefits, not for needlessly complex administration.*—Administrative costs are incurred in enrolling subscribers, collecting and paying subscription charges, and in providing service or paying claims. Costs in the first two categories tend to be centralized and appear large. Administrative costs in the last category are dispersed among thousands of hospitals and physicians and tend to be forgotten. In total they are by far the largest segment of administrative cost and inevitably contribute to the total cost of the program and to the public's total health bill. The benefit pattern of the program should be simple to administer at the time service is used under the program if total costs are to be minimized.

HOW AN EMPLOYEE HEALTH BENEFIT PLAN OPERATES

Employees and members of their families need, and usually receive, health services consistent with the advancing state of medical science. In 20th century United States, needed health services are usually available. The problem is the sacrifices entailed in making them available—personal financial hardship of recipients who pay their health bills—financial stringency in institutions and their employees when bills are not paid. But, in general, the service is given and the costs incurred. The question is, how can these total costs best be met? The dollar cost of these services, in the aggregate, are influenced by—

- (a) the purchasing power of the dollar,
- (b) the type of services available,
- (c) the frequency of use of services, and
- (d) the cost of, or charges for, the services rendered.

A health benefits plan considers the effect of each of these variables on the set of benefits offered during the time period for which cost projections are being made. Then the aggregate cost of the benefits offered, plus administrative costs and contingency reserves are apportioned among the participants. Excluding necessary health services from the plan does not reduce the aggregate costs to participants. The costs of services not covered are simply transferred from the plan to those of its members who are sick, and imposed upon them when they are sick.

Hence, to accomplish its purpose, a health benefits plan must provide a broad spectrum of benefits, and equalize the costs of these among its participants. Even brief consideration of the primary variables mentioned above suggests wide cost variation over long periods of time. As Members of Congress, you are well aware of the likelihood and range of fluctuations in purchasing power. Examples of the other three factors mentioned are:

(b) *Type of services available.*—Ten years ago open-heart surgery was undertaken in only a few pioneering teaching centers; now it is available in many metropolitan hospitals. Another example is the variety of radiation sources such as radioactive cobalt that now supplement the more usual deep X-ray therapy. Another is the frequent and involved laboratory procedures necessary to permit the safe use of the powerful new chemotherapeutic agents. Another factor has been the construction, often with Federal assistance, of hospitals in areas where none existed previously.

(c) *Frequency of use of services.*—In the years since a health benefit program for Federal employees was first discussed there has been a marked increase in the proportion of births occurring in hospitals, conversely, fewer pneumonia patients are admitted for short stays. In the same period the length of the hospital stay of surgical patients has decreased dramatically, despite the increasing complexity of the procedures undertaken. The composite effect of these and other factors is shown in table II attached. This shows the admissions per person per year, the days of hospital care per person per year, and the annual percent of change in these items during the period 1950 through 1957. Data from all voluntary, short-term general and other special hospitals are used as being most typical of the type of service to be provided under H.R. 8210.

I did not mention table I specifically. That shows simply the enrollment in Blue Cross plans by States and the proportion that bears to the total population in those States.

Table II shows you what has happened to the admissions per person to short-term and other special hospitals in the United States during the 7-year period, 1950-57, and the annual rate of increase—or decrease in one instance—of the admissions per person per year as related to the general population and the days of care per person per year.

As you will see the admissions have gone up rather substantially in proportion. The days of care per person have not gone up quite so much.

The CHAIRMAN. The number of admissions per person is on the increase and the number of patients has gone up appreciably. What about the increase?

Mr. COLMAN. The first two columns on table II, I think, give that. The admissions per person per year have gone up from 0.077 to 0.091 in this period, and the annual rate of increase averages 2.4 percent during those years. It varies considerably. You will see in 1 year it is as low as 1.2 percent and in another it is as high as 4.7 percent.

In the next column you have the days of care per person and that has gone from 0.600 to 0.676, and again at a variable rate. In 1 year it actually decreased.

The CHAIRMAN. The number of days of care per person from 1950 through 1957 is approximately the same. There is not much variance.

Mr. COLMAN. There is a total there of about 10 percent.

The CHAIRMAN. From 1950 through 1957 it goes from 6 days to 6.76 days.

Mr. COLMAN. That is right. That deals with the frequency of the use of service and the changes that have taken place in this period.

Mr. PORTER. What do you see coming out of this? What do the figures demonstrate to us?

Mr. COLMAN. Trying to make predictions as to what is going to happen in the amount and kind of health services to be used by large numbers of people I consider to be a very hazardous occupation. The dramatic change that took place in the length of stay of surgical admissions in the 1940's is something that caught most of us by surprise. The whole question of early ambulation came in there, and had it not we would have had a financial crisis in hospital care of serious magnitude.

There is another type of thing that can happen. For example we all hope and trust in the very near future there will be some kind of a generalized diagnostic test for cancer. Nobody knows what that is going to involve in terms of procedure and care, but let us suppose it would involve 1 day of hospital care. Any prediction that you might have made as far as hospital service in the future is concerned is going up the flue on one such situation as that.

I think that I would be presuming if I were to lead you to believe that I could make any valid predictions of what hospital care in terms of usage is going to be over a 5-year period.

Mr. PORTER. One thing seems certain from these figures—the admissions will be more per person and the days of care will be more per person. That much at least seems to be obvious.

Mr. COLMAN. It would seem so.

Mr. PORTER. So as far as costs go, because of what you cannot predict, it would increase the number of persons to be admitted and the days of care.

The CHAIRMAN. In other words, hospital costs per patient day have increased from \$16.89 to \$26.81 in the period 1950 through 1957.

Mr. COLMAN. I will come to that in my next paragraph. The one comment I did want to make in extension of the question that was just asked by Mr. Porter is that if you had looked at these figures in 1940, or in the 1940's, the days of care per person would have been going down. It is a question as to which decade you want to look at. My judgment is that for the immediate foreseeable future something like these trends are going to continue.

Mr. PORTER. Because there are more things to do in the hospital?

Mr. COLMAN. That is right.

Now I will proceed with the comments on table III to which you referred.

(d) The cost of services rendered in hospitals has increased rapidly under the influence of many of the foregoing changes and in response to other internal and national forces. Changes in the costs of other types of health services have not been documented with accuracy and less is known about the changes that have taken place in them. As you will see from table III, during the period 1950 through 1957, average costs have been increasing at a substantial, though varying rate. Some of the major reasons for these increases are as follows: Decreasing purchasing power of the dollar, increased salary rates, better accounting for capital charges, and the addition of new and more complex services, which are compressed into approximately the same or shorter average stays during this period.

These variables force anyone thoughtfully developing a health benefits plan to make a major policy decision, namely: Is the plan to attempt to project a level premium for an extended period such as 10 years, or is it to be paid for on a "pay-as-you-go" basis with charges adjusted to experience over relatively short time periods of 2 or 3 years? Almost universally the pattern in private industry has been the "pay-as-you-go" basis whether benefits were purchased from private insurance or from Blue Cross. No one in 1954, for example, came any closer to predicting 1959 hospital costs than they did to predicting the 1959 interest rates on current Federal borrowing.

Therefore, the choice must be between a plan whose cost varies gradually with the costs of services needed and used by its participants or a plan whose cost is stable but either too high or too low in relation to the continuing costs of health services used by its participants. We urge adherence to, and strongly support the approach used in H.R. 8210 and the similar House bills. It is realistic and straightforward. The alternative level-premium-prefunding approach is complex, unsuited to this purpose, and will involve the accumulation by Government of large pools of employee contributions, the necessity for, and amount of which will be subject to continuing question and attack.

To discuss table III further, this reflects a series of forces that have taken place in hospital care during this period. It is a composite of pluses and minuses. You will see also there is an appreciable variation in the rate at which this takes place—the high of 8.6 percent increase in the period 1950 to 1952, the low of 3.5 percent in the period 1955 to 1956.

Again in anticipation of the same kind of question that Mr. Porter asked awhile ago on admission rates, I would expect for the immediate foreseeable future that these trends would continue at some such level as this for a year or two. Where they are going to go beyond that I do not know. The forces that are at work at the moment suggest no difference in this for the next 2 or 3 years.

Mr. PORTER. Some of these factors you mentioned as causing the change, such as more realistic appraisals of capital costs will shake down sooner or later?

Mr. COLMAN. Yes.

Mr. PORTER. There will be increased salary rates at the hospitals?

Mr. COLMAN. On the question of increased salary rates, I think it can be defended that, in general, rates paid in hospitals are, for the bulk of their employees, below rates paid in private industry for comparable employment. I do not think that lag can exist forever. I think it is going to be closed and that is why that statement is in there.

Mr. PORTER. So that is why this 6- to 8-percent increase every year is due, and it will affect any plan we adopt.

Mr. COLMAN. Eventually the gap will be closed, and then the increase will be more or less proportionate to all salaries.

Mr. PORTER. If we adopt this bill with particular contributions are we not liable to have to revise it often if we have this kind of increase every year?

Mr. COLMAN. Carefully administered I do not think it is going to have to be revised very often. If I may, sir, I would like to come back to that question because there are some other factors that affect it.

The CHAIRMAN. Do you look for further increases in hospital costs in the next 2 or 3 years?

Mr. COLMAN. Yes.

The CHAIRMAN. How much of an increase do you expect?

Mr. COLMAN. Of this order of magnitude.

The CHAIRMAN. Around 6 or 7 percent?

Mr. COLMAN. I would expect 6 percent; something like that as an average.

Now continuing with my statement:

GENERAL STATEMENT ON H.R. 8210 AND SIMILAR HOUSE BILLS

We support wholeheartedly the provisions of H.R. 8210 and urge its early passage in substantially its present form.

The CHAIRMAN. Is that the same as the Senate-passed bill?

Mr. COLMAN. Yes.

The CHAIRMAN. The first bill introduced and considered by the Senate was S. 94.

Mr. COLMAN. That is right.

The CHAIRMAN. You offered a good many suggestions for amending the bill.

Mr. COLMAN. Yes.

The CHAIRMAN. Were all of those amendments included in the new Senate-passed bill?

Mr. COLMAN. No, sir.

The CHAIRMAN. Can you give us a list of those proposed revisions that you made to the Senate committee with regard to S. 94?

Mr. COLMAN. I will be happy to; as a matter of fact that is included in the testimony given before the Senate and I will supply a full copy of that to this committee.

The CHAIRMAN. Can you give us some brief, concise account of what your proposals are?

Mr. COLMAN. The changes we proposed in S. 94 I do not think are relevant to the bill that is currently before you. There have been substantial changes in the bill by the Senate committee since S. 94 was first written.

The CHAIRMAN. Can you list the proposals which you made to S. 94 and which were not included in the Senate-passed bill?

Mr. COLMAN. I do not have them in my mind, but if I may, I will supply that for the record. (See p. 133.)

Mr. JOHANSEN. Do I understand from your statement to Mr. Porter that you will be coming back to this question later in your testimony—as to the frequency of adjustment of rates?

Mr. COLMAN. Yes. I will continue with my statement.

From the legislative history to date, the committee is doubtless aware that the bill represents a compromise between, and a reconciliation of, many divergent views. Such a program for Federal employees is long overdue and H.R. 8210 is the first such measure to have the united support of employees, carriers, and the providers of health services. We earnestly hope it will merit the support of this distinguished committee and your colleagues in the House of Representatives.

COMMENTS ON SPECIFIC ASPECTS OF H.R. 8210

Perhaps the major compromise represented in H.R. 8210 is in relation to the proportion of the cost borne by employees and by Government. As one of the potential carriers under the bill, this is not a matter on which we can appropriately take a position. However, it may help the committee to know that the 50-50 sharing contemplated by H.R. 8210 is a common pattern in many large industries such as steel and auto, for example. Among the large groups enrolled in Blue Cross, the proportion borne by the employer varies from about 30 percent to 100 percent, but 50 percent applies to the largest number of employees currently enrolled. It is perhaps worthy of note that there is one precedent on this question. The one health benefits program already in effect for a large group of Federal employees, namely, the Tennessee Valley Authority program, provides for an approximately equal sharing of cost between employer and employee.

The report on the bill submitted by the Senate Committee on Post Office and Civil Service is most complete. We are not competent to comment on all of its aspects, but the portions which our experience gives us the background to judge, are valid and have our concurrence and support. The section on page 14 entitled "How the Program Would Operate" has pertinence to some of the questions earlier in these hearings concerning the elimination of the usual requirement for competitive bids from carriers. The contracts with Government under this bill would be carefully developed, negotiated contracts. The bill requires that each employee have at least two and often four choices of program. Hence, the element of competition and free choice is inherent in the right the bill gives the employee to make an informed choice among competing plans.

It should also be clear that the bill does not establish specifications precise enough to permit sound competitive bidding. Properly the bill gives the administering agency considerable leeway to negotiate benefits that are consistent with the continuing needs of Federal employees. As pointed out earlier, the many variables in health services make this flexibility imperative. In this sense, the act is an enabling act. Benefits are strongly implied, but wisely are not frozen, and accommodation to some change can be made without congressional action. Section 16 does, however, require that your committee be

kept currently informed of major steps taken in implementing the program.

So the competition comes in when the employee makes his choice, not when the carrier negotiates a contract with the administering agency. He has to offer the best contract he can, or he is not going to get anybody to choose it, so competition is inherent in the bill. As you will see later, those contracts are going to have to be carefully negotiated by the administering agency.

Mr. PORTER. I see your next statement about not establishing specifications precise enough to permit sound competitive bidding. I do not understand this. It seems to me there are other people who compete with Blue Cross, are there not?

Mr. COLMAN. Surely.

Mr. PORTER. I do not see why the Government could not set up a list of precise specifications, submit them to two or three in a particular community, and say, "What is your bid?" What is wrong with that?

Mr. COLMAN. There are two problems. First of all, the primary competition is between the so-called service benefit plans, the Blue Cross and Blue Shield plans, and the plans as offered by the insurance industry. Specifications that would apply to one would not be appropriate to apply to the other.

Mr. PORTER. But as between plans such as your own why cannot there be competition?

Mr. COLMAN. By and large, our plans are only authorized to operate in a specific geographical area. The Blue Cross plan in New Jersey does not compete with the one in New York.

Mr. PORTER. There are other organizations in Washington who compete along these lines.

Mr. COLMAN. Again, any specifications that would be appropriate for Blue Cross would be entirely inappropriate for group practice prepayment, and vice versa. Each of these patterns, each of these major sources of health services is challenged by this bill to produce the best program it can to lay on the line for Federal employees, and the employee chooses. He chooses between Blue Cross and the insurance industry in every case. He chooses between either of those two and group practice prepayment in the areas where those programs are available such as Washington, New York, most of the west coast, and one or two other areas. And he chooses between any one of those three and a program sponsored by his employee association, if he belongs to an association that has a sponsored program. So the specifications that we are going to have to meet are specifications drawn up by the Civil Service Commission, the administering agency under this bill, of the basis on which we are going to be permitted to do business with the Government. And within those, we are going to have to do the best job we can in competition with the other three possible sources the employee may choose from.

Mr. PORTER. I do not quite see why competition at one stage should rule it out at another. Let us say that the employee wants group practice, he wants that kind of plan. The Civil Service Commission is looking for the best plan to give them the alternative. Why cannot they at that point have various group practice people, including Blue Cross, submit their bids with respect to specifications for services?

Mr. COLMAN. The reason is that here in Washington there is a group health organization which is the group practice organization here in Washington. There is no one that competes with that on its terms. It is the only one that provides a group practice prepayment program in Washington that I know of, so there is no one that is going to compete with that organization in Washington to participate under this bill as a group practice prepayment program. There is no one that is going to compete with Blue Cross in Washington to provide service benefits for Government employees under this bill under the service benefit provision. An employee belongs to only one employee association, so the only program he is going to have to choose from among the employee association sponsored programs is the one sponsored by his association, so that within these patterns, within these four segments that are in the bill, there is no competition.

Mr. PORTER. Now you are raising the more fearful specter of monopoly.

Mr. COLMAN. I can assure you, sir, there is no monopoly in this field.

Mr. PORTER. If there is no monopoly in a particular field, why is there not competition?

Mr. COLMAN. There is between the four different approaches.

Mr. PORTER. Why in the particular approach is there not competition with regard to group plans?

Mr. COLMAN. Let us take the group practice prepayment programs. By definition they involve the establishment of a group of physicians who give a full range of medical service practicing as a group. The problem of establishing such a group of physicians competent and qualified to give a full range of service is a very difficult one and you cannot just say—let us start another group practice prepayment plan in Washington tomorrow. This is a life's work. The fact of the matter is there is one. There is no competition.

Mr. JOHANSEN. In the field of private insurance companies is not the situation different than in these other three categories?

Mr. COLMAN. Yes.

Mr. JOHANSEN. With respect to potential competition?

Mr. COLMAN. It certainly is.

Mr. JOHANSEN. Because of the number and diversity of such private companies, which situation is not matched in other fields?

Mr. COLMAN. That is right.

The CHAIRMAN. You do not think there can be any competitive bidding?

Mr. COLMAN. Not in that sense. The competition will be between the programs.

The CHAIRMAN. I received a letter from Mr. John Bremsteller of the Association Group Insurance Agency which I will read into the record.

(The letter was read as follows:)

ASSOCIATION GROUP INSURANCE AGENCY,
Washington, D.C., July 27, 1959.

DEAR CHAIRMAN MURRAY: My name is John D. Bremsteller, 500 Walker Building, Washington, D.C. I am an independent insurance broker licensed under the laws of the District of Columbia. My chief source of income is derived from selling association health and accident coverage to Federal employees. If Senate bill 2162 before your committee is enacted, its effect will essentially wipe out

my present source of livelihood. I therefore feel that I have a valid right to testify before your forum.

My chief objection to the bill, as now written, is section 4, provisions 1, 2, 3, and 4. This section will distribute the business to a select few insurance carriers; completely ignoring the fact that there are programs now existent in Government agencies and associations which are not only lower in cost, but which are more definitive and comprehensive in benefits than those standards set forth in S. 2162. I have one such program now in effect in the Geological Survey of the Interior Department which after 6 months of active solicitation has reached a participation rate of better than 65 percent.

I believe that if you and the members of your committee are sincerely interested in adding employee fringe benefits, and at the same time holding Government expenditures to a minimum, it is incumbent upon the committee to hear testimony that purports to do both.

If it is too late to testify, I request that section 4, provisions 1, 2, 3, and 4 be amended to include those programs now available to Government agencies and associations which meet the standards to be set down by the Civil Service Commission.

I will be available at your convenience to testify on the contentions made in this letter.

Very truly yours,

JOHN D. BREMSTELLER.

The CHAIRMAN. What do you have to say about his comments?

Mr. COLMAN. I would refer you to the report of the Comptroller General of a few years ago, I forget its exact date. The problem that is raised by this letter is that there are many sources through which health benefits could be purchased. There are individual insurance brokers such as he, the many individual insurance companies, each of which might operate individually or together, the various Blue Cross plans, and so forth.

When this plan was first considered administratively from the standpoint of the Federal Government, the Comptroller General wrote a report on the subject and said that if you are going to authorize the granting of payroll deduction for the payment of these subscription charges—I do not think he got into the question of employer contribution—if you are going to authorize payroll deductions, you should do it by requiring each of the types of carriers to set up a clearinghouse so that instead of the Federal Government having to do business with hundreds of segments of the insurance industry or with 78 Blue Cross plans, they would do business with one representative of 78 Blue Cross plans or one representative of the insurance companies.

Then he said we can live with it and do it that way. To my mind, it was a very practical and a very reasonable approach. I think he suggested the setting up of four or five clearinghouses, as he called them, so that the agencies of Government would not be deluged with complexities and could have one source to go for each major branch of this industry. I think, from Government's point of view, that is the only type of approach you can take. It is the one contemplated by this bill.

If that report has not been put in the record, I would urge you, sir, that it be made part of the committee's deliberations. It is a very helpful report, from Government's point of view, on the administrative problems involved.

The CHAIRMAN. I am sure that will be presented by the Civil Service Commission when their representatives testify.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. Is it true, as alleged in the letter that the chairman read, and if true, is it unavoidable that the particular individual and firm responsible for that letter would be frozen out of the business and out of the field under this legislation?

Mr. COLMAN. Sir, I would suggest that that is a problem that is primarily the problem of the commercial insurance industry and should be addressed to their representatives. I have some opinions on it.

Mr. JOHANSEN. Is this particular inquirer a segment of the commercial field?

Mr. COLMAN. As far as I know, he is. He is a licensed insurance broker. I would assume so.

Mr. JOHANSEN. His problem would be identical with that of all other commercial brokers. Am I correct that within that area under this bill there would be competition?

Mr. COLMAN. I do not know.

Mr. JOHANSEN. What would be the procedures under this legislation, in your judgment, with respect to what I understand is the one category in which there is a multiplicity of competing firms? What would be the procedure?

Mr. COLMAN. The administering agency under this bill is authorized to negotiate a contract providing indemnity benefits. How it chooses to go at that with the insurance industry is not spelled out in the bill. I think it has been everyone's presumption—and certainly mine—that the way in which it would be done is that the insurance industry would select some representative or representatives to work with it in the development of such an offering and that there would be one primary carrier responsible to Government for that offering, and that the insuring responsibility under it would be prorated among the various segments of the insurance industry on some basis agreeable to them.

Mr. JOHANSEN. In other words, it would be a pool operation?

Mr. COLMAN. That is my presumption of the way it would work.

Mr. JOHANSEN. Would you feel anything would be contributed to the strengthening of this legislation and to the avoidance of anything undesirable if it were spelled out with respect to that category of coverage? I mean spelled out within the law and not left to administrative decision.

Mr. COLMAN. I think the Senate committee report discusses this in terms of congressional intent with sufficient detail to safeguard the interests of employees in Government. I cringe a little at the problems of trying to write specific legislation that would cover all the problems related to contract negotiation. I am not a lawyer, but I know a little bit about it.

Mr. JOHANSEN. I think we can profitably pursue this when the Civil Service Commission representatives appear.

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter.

Mr. PORTER. I do not see Blue Cross or Blue Shield mentioned in the bill. Are they mentioned by name?

Mr. COLMAN. No, sir.

Mr. PORTER. On page 7, the No. 1 service benefit plan, on page 14 of the Senate report when it goes over the various proposals, it does mention as, A, a national Blue Cross-Blue Shield offering. They are using that in the general sense, I suppose, of the fact that Blue Cross has come to mean hospital benefits and Blue Shield has come to mean medical benefits.

Mr. COLMAN. I think it is a perfectly valid statement that under the terms of the service benefit plan as outlined in H.R. 8210 the only organization that could offer a service benefit plan of that scope are Blue Cross and Blue Shield.

Mr. PORTER. I had understood that there were alternative organizations, especially in some communities, that could do approximately the same thing in terms of hospital and medical benefits.

My question was directed at whether or not those groups were going to be allowed an opportunity to participate on the basis of competitive bidding.

Mr. COLMAN. As far as I know, they are not. I do not know of any other organization that could offer a national service benefit plan, a single program for all Federal employees, other than Blue Cross and Blue Shield.

Mr. PORTER. Under the terminology of the bill of one government-wide service benefit plan, and so forth. What are the assurances, aside from negotiating ability, that the price the Government would pay would be the best price available?

Mr. COLMAN. There are a series of them, sir. The first is, as you undoubtedly know, Blue Cross and Blue Shield plans are nonprofit community service agencies, administered by responsible local citizens. There is provision in the bill for continuing study and report. Anybody participating in this program lives in a goldfish bowl.

The provisions of that section of the report are as sweeping as I think they could possibly be made to be. The full record of the operation will be under constant scrutiny by the General Accounting Office, Civil Service Commission, the Comptroller General, Bureau of the Budget, and so forth. I cannot imagine anybody living under this program without having to defend his operations continually.

Mr. CORBETT. Will the gentleman yield?

Mr. PORTER. Yes.

Mr. CORBETT. I think you left out one safeguard, namely, certain members of this committee.

Mr. COLMAN. Yes, sir. I am sorry. That is a very important one. I am glad you called that to my attention, sir.

The bill provides that these contracts are to be referred to the committees of both the Senate and House before they are entered into.

Mr. PORTER. Thank you very much.

The CHAIRMAN. Is it your contention that Blue Cross has a monopoly in its particular field?

Mr. COLMAN. It is the only way in which service benefits of the type described here are available on a national basis. There just is not anybody else operating with that degree of coverage throughout the entire country. There are programs in individual localities, usually fairly small, but each plan is independent, serves its own locality, has its own local responsibilities and roots.

The CHAIRMAN. How many Blue Cross associations do you have?

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Mr. COLMAN. Seventy-eight. Some of them serve complete States, some of them serve metropolitan areas.

The CHAIRMAN. Do they all have the one single plan?

Mr. COLMAN. No.

The CHAIRMAN. Do they all have the same rate?

Mr. COLMAN. No, sir; their rates vary depending on local hospital costs, benefits offered—benefits offered are different in different places, and there are variations. One of our real problems under this is going to be to meet the challenge of the bill in providing one uniform program for all Federal employees.

The CHAIRMAN. This bill just provides for a maximum?

Mr. COLMAN. Yes.

The CHAIRMAN. And it cannot be exceeded under this bill?

Mr. COLMAN. That is right.

The CHAIRMAN. And if the various benefits outlined in this bill cannot be paid for by this contribution, then the benefits would have to be lessened; is that right?

Mr. COLMAN. That is right, sir. What we anticipate doing under this bill is to provide a single uniform program for all Federal employees in which all the Blue Cross plans will join in offering to the Federal employees in their area so that there will be a single rate and single set of benefits offered to all Federal employees.

The CHAIRMAN. In all localities?

Mr. COLMAN. In all localities.

The CHAIRMAN. Hospital costs are much less in some communities than in others; is that right?

Mr. COLMAN. That is right.

The CHAIRMAN. You do not make any distinction about that?

Mr. COLMAN. No, sir. They are appreciably different in a single State.

The CHAIRMAN. That is true. As a general rule in your smaller localities the hospital costs are lower than in the metropolitan centers; is that correct?

Mr. COLMAN. And for the same reason the people in the smaller communities sometimes go to the larger communities to get their hospital care when they have a serious illness for which hospital care is not available in the local communities. The minute you restrict this you restrict the services. You cannot provide the services of a big metropolitan medical center at the cost level of a small rural hospital.

The CHAIRMAN. You say you have 78 different Blue Cross organizations?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. They charge varying or different rates?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. Do all those who belong to it get the same benefits?

Mr. COLMAN. No, sir. The benefits vary. They can be standard and we propose to make them standard under this bill. The offer we are going to make to Federal employees is going to be a standard offer.

Mr. REES. Mr. Chairman.

The CHAIRMAN. Mr. Rees.

Mr. REES. I am sorry I was not here when you began your testimony, but I was appearing before another committee. As I understand it, you helped write this bill, did you not?

Mr. COLMAN. No, sir. I was consulted on it. As a matter of fact, there were more people consulted on this bill—

Mr. REES. I am not criticizing you. I am just asking you.

Mr. COLMAN. No, sir. I was consulted on it, along with a lot of other people.

The CHAIRMAN. You did assist in it very materially?

Mr. COLMAN. Certainly.

Mr. REES. That is what I am asking you. You did help write the bill?

Mr. COLMAN. When you say "write the bill," I do not think there is one sentence in it that I wrote in the way the bill is now worded.

The CHAIRMAN. I wish you would furnish the committee with the various objections you had to S. 94, the original bill, and all those suggested changes incorporated later into the bill that passed the Senate, S. 2162.

Mr. COLMAN. No, sir, they were not. S. 2162 is an entirely different bill from S. 94. It follows the same general pattern.

The CHAIRMAN. I said in the beginning you did not approve of the original bill, S. 94.

Mr. COLMAN. That is right, sir.

The CHAIRMAN. You suggested various amendments and revisions in it. I want you to furnish a copy of those suggested amendments or revisions and let us know if they are all included in the bill that did pass the Senate.

Mr. COLMAN. I will do that, sir. (See p. 133.)

May I try to make this crystal clear? We supported S. 94 in principle. We requested a series of relatively minor changes but there was one major change. As S. 94 was originally written, it provided for a separate offering of major medical benefits. We urged that major medical benefits be included with and related to the basic benefits of the four segments.

That was the major change we suggested in S. 94. That change has been incorporated in this bill.

I think that is the major record of our participation in the transition between S. 94 and S. 2162.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. Just to clarify the record a little bit on the allusions to possible monopoly, there is nothing so far as you know, is there, that would prevent a possible development in the course of human events of a Green Cross and Green Shield program, and if in the course of that development it reached a stage where, upon periodic review of these programs—is there anything in the law that would permit a request for and a right to consideration for the substitution of the Green Cross and the Green Shield for Blue Cross and Blue Shield at the discretion of the Civil Service Commission?

Mr. COLMAN. There is no specific language of that sort that refers to Blue Cross and Blue Shield. The only reference is to the types of programs offered.

Mr. JOHANSEN. So that if there were such a Green Cross and a Green Shield program, it could become a competitor for consideration at a subsequent time?

Mr. COLMAN. Right.

The CHAIRMAN. Did S. 94 have certain deductible provisions, such as a \$50 deductible or a \$100 deductible?

Mr. COLMAN. I do not think there was any permission of those in S. 94. I think S. 94 was a straight service benefit program.

The CHAIRMAN. I noticed you gave to the Senate committee a marked copy of S. 94 which contained all the suggested amendments by you.

Mr. COLMAN. That is right.

The CHAIRMAN. Will you furnish this committee a copy of that?

Mr. COLMAN. That is what I proposed to do earlier. That is what I meant when I said it was all in writing, and I will be glad to give it to the committee. I do not have one with me.

The CHAIRMAN. How many of those suggested amendment were included in the new bill?

Mr. COLMAN. It was not approached that way. S. 2162 was a new start. As I pointed out, the one major amendment that we requested was incorporated in the way in which S. 2162 was drafted. That is the one about the major medical.

The CHAIRMAN. I see you estimate the cost of the bill at \$313 million.

Mr. COLMAN. That was S. 94.

The CHAIRMAN. What do you estimate the cost of the bill as passed by the Senate, S. 2162, to be?

Mr. COLMAN. May I proceed, sir? The next section speaks of cost.

Mr. PORTER. I have one more question.

Mr. COLMAN, I understand the salaries and allowances of employees of Blue Cross and Blue Shield will be a matter of public record.

Mr. COLMAN. Yes, sir.

Mr. PORTER. Could you tell the committee what the highest salary is paid in Blue Cross or Blue Shield?

Mr. COLMAN. I do not know.

Mr. PORTER. Do you have any idea?

The CHAIRMAN. You are of the association, are you not? Can you not tell me what the highest salary is paid by your association?

Mr. COLMAN. No, sir; we do not pay them. These are all local plans.

The CHAIRMAN. Are you not familiar with all your local plans?

Mr. COLMAN. Yes, sir; but I did not ask all the people I work for how much they make.

Mr. PORTER. It is a matter of record that you probably have.

Mr. COLMAN. We do not have it.

Mr. PORTER. Could you get it without too much trouble?

Mr. COLMAN. I think I could.

Mr. PORTER. I think it would be helpful when we are trying to explain the bill, I am more sympathetic to it, but we have to demonstrate when we deal with one group that made a good record that some of the profits are not going into excessive salaries. That information would help the bill.

Mr. COLMAN. All right.

Mr. JOHANSEN. Would it be in order, Mr. Chairman, to have similar salary figures on the other type of insurance coverage that would be provided under this bill? I am agreeable to having the information

regarding Blue Cross and Blue Shield, but I see no reason to single them out for that information.

Mr. PORTER. I did not think this gentleman would have access to that information.

The CHAIRMAN. I agree that all should give it.

Mr. COLMAN. We will abide by your wishes in that, sir.

(The information follows:)

The highest salary known to be paid currently to a Blue Cross plan employee is \$47,500 annually paid to the executive vice president of the largest plan, which has 7 million members and a gross annual income of \$127 million.

Of the reporting plans: 17 report a highest salary of \$25,000 or more; 11 report a highest salary between \$15,000 and \$25,000; 15 report a highest salary between \$10,000 and \$15,000; and 25 report a highest salary below \$10,000.

Mr. COLMAN. As the Senate committees' report on the bill points out, in any bill of this type, one section is closely related to many other sections. For example, the Civil Service Commission suggested, and we did not oppose, a language change in section 4 to make clear that only one offer was intended under section 4(1) and only one under section 4(2). Now we are advised that a rigid interpretation of the present language might require service benefit plans to have contracts with providers of health services in every location where Government employees are stationed. Desirable as this is, as an objective, a requirement to negotiate service contracts with physicians and hospitals in every city throughout the world where even one Federal employee is located, would make the offer of a service benefit program under the bill impossible. We trust you will see fit to make the relatively minor change necessary in this section. However, the incident illustrates the intimate and involved relationship between the language of the bill and the details of the operation of the program authorized by the bill. In its present form the bill has had intensive scrutiny by representatives of all major groups affected. Further revisions should have equally careful scrutiny to insure a practical and effective program.

COSTS

To make an accurate estimate of the total cost of the program in its first year, one must have the following information:

(a) a detailed statement of the benefits to be provided under each of the four types of programs authorized, and

(b) a reasonably accurate estimate of the number, age, sex, residence, and marital status of the Federal employees who will enroll in each of the four programs authorized.

Mr. PORTER. The number of children makes no difference?

Mr. COLMAN. If you want to expand the notion of marital status, I think of it as marital and family status, and include that under that general heading. However, if you just had marital status, I could do no better than I can right now because we do not know the marital status of the employees of the Federal establishment.

Mr. PORTER. I understood part of this does not take into account the number of children, the payments made.

Mr. COLMAN. That is right.

Mr. PORTER. I wondered how that is figured actuarially.

Mr. COLMAN. On the average, the persons without children are in the older age groups and in that age the adults use more hospital care than the younger adults with children. It about washes itself out. As a matter of fact, I know of one group of fairly substantial size where the two-person family uses more hospital care than the families with children on the average. It is very largely a question of differential age.

The CHAIRMAN. I had a telephone inquiry yesterday from a lady who is a Federal employee. She says that this bill is discriminatory in that it charges married women with dependents more than married men with dependents. The woman whose husbands are dependent on them will be the same but the women whose husbands are working would have to pay more than men with families would have to pay. How about that?

Mr. COLMAN. This is a policy decision of what you want to do as an employer.

The CHAIRMAN. Is it true the married woman with children has to pay more than the husband who is working?

Mr. COLMAN. A married female employee of the Federal Government under this bill who has a nondependent husband is not given as much of a Government contribution, employer contribution, toward the cost of her program as the married male employee who has presumably a dependent wife.

The CHAIRMAN. Is that fair or just?

Mr. COLMAN. The rationale behind it, as I heard it discussed—

Mr. CORBETT. What was that?

Mr. COLMAN. The reasoning behind it, as I heard it discussed, was that unless you did that, the Government would be assuming some portion of the responsibility for the costs of children of a man who did not work for the Government and should be held responsible for the expenses of bringing up his own children. So that the concern was with the responsibility of the husband of such a woman and not with the woman herself.

Mr. CORBETT. Right at that point, Mr. Chairman, if the husband were a dependent, her costs would be identical with the male?

Mr. COLMAN. That is right.

Mr. CORBETT. In other words, what you are trying to get at, as I understand it, the difference in these rates, it is the fact that the non-dependent husband is working and has a degree of responsibility for providing for this care which should not be assumed by the Federal Government.

Mr. COLMAN. Exactly, sir. That is the reasoning behind it.

Mr. JOHANSEN. That means then we men do not have exactly equal rights with the women.

Mr. COLMAN. That is right.

Mr. CORBETT. You can get them by staying home and doing the dishes.

Mr. JOHANSEN. I am not complaining.

Mr. COLMAN. That does not come as any news to you, does it, sir?

The detailed statement of benefits to be provided will grow out of the negotiations with the Civil Service Commission, as authorized by the bill. The number of employees who will enroll in each of the four programs and their characteristics cannot be known until an enrollment offer has been made to them and they have made their informed choice. Hence, at the outset, one can only rely upon the dollar maximums stated in the bill and multiply these by crude estimates of the number of Federal employees who may participate. For the first year the cost of the program to Government should not be higher than the estimate of \$145,300,000 given on page 17 of the Senate committee's report and could be substantially lower. So long as participation in the program is not compulsory for all employees, the dollar maximums in the bill provide the only starting point for cost estimates.

I can state, however, that since the bill was reported by the Senate subcommittee, we have analyzed, as carefully as available data permit, what benefits can be provided within the maximums stated. It is our judgment that a program consistent with both the letter and spirit of the level of benefits outlined in the bill can be offered to Federal employees within the maximums stated in the bill.

Mr. CORBETT. May I interrupt? This has been a matter of much speculation. Would the gentleman guess that because of the large number participating in this program that the benefits could be substantially higher than Blue Cross and Blue Shield offer to private individuals?

Mr. COLMAN. Yes.

Mr. CORBETT. That is very important.

Mr. COLMAN. I would qualify that, however, by saying there are other large groups of employees to whom we offer benefits that will be somewhat comparable to these.

Mr. CORBETT. I carefully in my question avoided the group and said individuals.

Mr. COLMAN. That is right.

Conversely, for any group of Federal employees distributed geographically, as are all Federal employees, amounts not appreciably below the maximums stated in the bill will be necessary to provide the benefits outlined in the bill. In other words, we believe there is a realistic relationship between the benefits described in the bill and the maxi-

mums stated. Material changes in either would require a change in the other.

I would like to refer you to table IV, which is the best I could do in meeting one of your requests in your letter. Any attempt to put a dollar cost on a statement of benefits as general as those in the bill would involve making assumptions that I think are unwarranted. To try to give the committee some basis for understanding of the relative costs of these segments of the bill, I did the best analysis I could of the proportionate relationship between the four paragraphs in section 5 on hospital benefits, surgical benefits, in-hospital medical, ambulatory patient benefits, supplemental benefits, and obstetrical benefits, and that proportionate cost is outlined on page 14.

These proportions can change a little bit as the specifications for these sections are refined, but this is an order of magnitude figure that will give you, I hope, the kind of information that you need to judge these as to relative importance.

The chairman has asked that we comment specifically on subparagraph (D) of section 5(a)(1) of the bill. We would expect that under this paragraph benefits would be provided for minor surgery performed in a hospital outpatient department or in a physician's office and for services rendered in the case of accidental injuries. We would not anticipate that benefits could be provided, within the cost maximums stated in the bill, for routine home and office visits of physicians.

I described here the limits of what we would propose to do in that section, where you would go within those limits to fill it out or exclude it would depend entirely on what you did with the other segments of the benefits.

FUTURE COSTS

For the reasons previously stated, future cost projections cannot be conclusively supported. The record of America's expanding economy and the improvement and expansion of health services over the last 20 years suggests a gradual rise in the dollar cost of these benefits. It is doubtful if this rise will be at an even rate. It is almost certain that it will not be.

The CHAIRMAN. I understand you just previously referred to certain surgery permitted to be paid for under this bill. This bill would cover oral surgical services performed by a dentist, would it not?

Mr. COLMAN. It could.

The CHAIRMAN. But would it?

Mr. COLMAN. It is not spelled out in detail, but presumably it would.

The CHAIRMAN. The bill does not cover ordinary dental service such as removal or filling of teeth?

Mr. COLMAN. That is right.

The CHAIRMAN. Would this oral surgery have to be performed in a hospital?

Mr. COLMAN. Probably. The usual practice in programs of this sort is to include oral surgery performed in a hospital.

The CHAIRMAN. All right.

Mr. COLMAN. The rapid rise in the past 5 years has already set in motion forces tending to limit future cost increase. One may rea-

sonably expect future increases to bear a constant proportionate relationship to salaries and wages.

Mr. PORTER. Your own figures on increased patient days of care and hospital costs all seem to be going up regularly and substantially.

Mr. COLMAN. That is right.

Mr. PORTER. I appreciate this might be a little contradictory to the linear trend of those figures. You are going to have more patients with more days of care and the costs of hospital treatment are going to go up.

Mr. COLMAN. Yes, sir.

Mr. PORTER. It seems to me that will mean greater expense of the program—ever greater.

Mr. COLMAN. I am sure the dollar cost of the program will rise over a period of time. It always has.

The CHAIRMAN. For what length of time would you agree to a contract? Would you agree to a contract for 3 years at the same rate?

Mr. COLMAN. I think it would depend entirely on whether you talked of the first 3 years or the second 3 years. I think that is a question that ought to be seriously considered as you get into the program. To begin with, there are so many unknowns in terms of the number of Federal employees who are going to participate, what kind of people they are; I think both from the standpoint of the carriers under this program and from the standpoint of Government you will want to take a good, careful look at the end of the first year's contract. I would urge the first year's contract to be a 1-year contract.

Mr. CORBETT. Granted that overall there will be an unsteady increase, is it not also true that there are factors working the other way to decrease the costs?

Mr. COLMAN. Yes, sir.

Mr. CORBETT. One you mentioned is that the period of hospitalization is going down pretty rapidly.

Mr. COLMAN. Steadily down.

Mr. CORBETT. Second, with all your so-called miracle drugs—and they will probably continue—as they are developed their cost tends to go down.

Mr. COLMAN. That is right.

Mr. CORBETT. Thirdly, if there are other discoveries in medicine, particularly as regards heart disease and regards cancer, you could look for factors reducing the total cost.

Mr. COLMAN. That is right.

Mr. CORBETT. It is not all just an uphill climb.

Mr. COLMAN. That is right.

Mr. PORTER. Did I understand the gentleman from Pennsylvania to say the period of hospitalization was decreasing?

Mr. COLMAN. The average stay per patient.

Mr. CORBETT. Yes.

Mr. PORTER. Days of care per person on your table, that figure seems to have gone up.

Mr. COLMAN. That is per person, per year.

Mr. CORBETT. That is a total thing. There are more individuals going in and there are more days of hospitalization totally at any hospital, but the length of stay of any person is going down.

Mr. PORTER. The cost is the number of people in the hospital in any 1 year.

Mr. CORBETT. If they are covered by this program. I am not challenging the notion at all that in the future, as we go on, either the dollar cost will go up or the services have to be reduced. I do not believe we should lose sight of the fact that there are factors that are tending to keep the costs reasonably level for the carriers of the program.

Mr. PORTER. Are you familiar with the figures in the Senate report about the cost of the program?

Mr. COLMAN. Yes, sir.

Mr. PORTER. We had some testimony here that that cost is probably the outside cost or stated very generously. Is that your opinion also?

Mr. COLMAN. The only variation there could be in those cost figures under the bill is either you could have more married people, a higher proportion of married people joining than is assumed in the computation of those costs, or you could have a higher proportion of Federal employees joining. I do not think either of those eventualities is likely.

My assumption is, my personal opinion is that the first year costs will be lower than those figures stated in the Senate report.

Mr. PORTER. Would you say substantially or would you be in a position to say?

Mr. COLMAN. This is a wild guess. How many of the 2,300,000 Federal employees are going to join? I do not know.

Mr. PORTER. That is your business. I thought that is why you might know.

Mr. COLMAN. I think the costs will be lower than those stated.

Mr. PORTER. 10 percent, 5 percent, 20 percent?

Mr. COLMAN. I would be beyond my competence if I gave you a stated figure.

The CHAIRMAN. How many Federal employees belong to your association?

Mr. COLMAN. About a million. With the members of their families, it is about 3 million people.

The CHAIRMAN. You still estimate the cost of this legislation to be \$313 million?

Mr. COLMAN. No. The \$304 million, as it is revised, is the figure; \$313 million was our guess for S. 94.

The CHAIRMAN. The Civil Service Commission, in its testimony before the Senate committee, estimated the cost to be \$405 million, I believe.

Mr. COLMAN. I think they revised that, sir. I think there was a different assumption on that when they made that estimate. I think you will find a revision of that in the later testimony.

The CHAIRMAN. All right.

Mr. CUNNINGHAM. Mr. Chairman.

The CHAIRMAN. Mr. Cunningham.

Mr. CUNNINGHAM. On Blue Cross and Blue Shield you still operate nationwide under the group plan, or do I recall some advertising that indicates an individual can buy Blue Cross or Blue Shield now?

Mr. COLMAN. In most States, yes.

Mr. REES. What is the difference between the States in that regard?

Mr. COLMAN. These are all independent organizations. Their decision as to how they operate their program in their own State within the general standards of approval to qualify for the use of the Blue Cross—

The CHAIRMAN. You do not have uniform plans and uniform costs for all your 78 associations?

Mr. COLMAN. No, sir. Uniform rate, no. Some of the original State enabling legislation authorizing the development of these plans required them to enroll only groups of employees and did not permit them to enroll individuals. Most of those have now been liberalized and most Blue Cross plans do enroll individuals, but their initial start was groups of employees.

Mr. CUNNINGHAM. There is nothing in here, then—if an employee leaves a service, there are some places he would then be without this protection; is that right?

Mr. COLMAN. No. The bill requires that—I misunderstood your question—from the very inception Blue Cross plans have encouraged persons who left their place of employment to continue on as individuals. I thought you were talking about the enrollment of new individual subscribers rather than groups.

The bill requires, sir, that any carrier participating under this program must permit a person leaving the employ of the Federal Government to continue under the program as an individual. Unless you are willing to do that, you cannot qualify under this bill.

Mr. JOHANSEN. He can do that regardless of the State in which he resides?

Mr. COLMAN. That is right. Any carrier who participates under this bill has to do that. The bill requires it.

Mr. CUNNINGHAM. If he left the service and did not become employed by somebody who had a similar plan but wanted to carry it on his own, he is permitted to do so?

Mr. COLMAN. Yes, sir.

Mr. CUNNINGHAM. His rates would be adjusted, I presume, upward because you do make a saving in a group arrangement which would not be true of the individual?

Mr. COLMAN. That is right; his rate would be presumably the same as all others who left the employ in that locality.

Mr. CUNNINGHAM. But he can do that?

Mr. COLMAN. Not only that, but the carrier is required to offer the opportunity.

The CHAIRMAN. Does he have any maximum age limit?

Mr. COLMAN. Again the bill requires that you cannot impose a limitation.

The CHAIRMAN. I mean the Blue Cross plan now.

Mr. COLMAN. Many of them do not. For new subscribers, a few do. We have never canceled subscribers because of age.

The CHAIRMAN. Suppose an employee who is 60 or 62 years old wants to join. Can he join under Blue Cross in all different plans?

Mr. COLMAN. Yes. And may continue on through life, and we now have—

The CHAIRMAN. Is he charged the same rate as the young employee of 25?

Mr. COLMAN. After he leaves his place of employment he is charged

the same rate as all other people who have left their place of employment, regardless of age. There is no special age rating.

The CHAIRMAN. I notice in your testimony before the Senate you said, I believe, that persons over 65 used hospitals three times as much as those under 65.

Mr. COLMAN. That is right.

The CHAIRMAN. Where did you get those figures?

Mr. COLMAN. From our own records.

The CHAIRMAN. A survey you made?

Mr. COLMAN. Yes.

Mr. REES. Do I understand that persons more than 65 years of age presently can join Blue Cross?

Mr. COLMAN. In some States. As a matter of fact, especially in Kansas. I think Kansas put on a special program for people over 65.

Mr. REES. I hope you are right.

Mr. COLMAN. I think so. Yes, that is correct.

Mr. CORBETT. I think the question might not have been entirely answered. Will not any Federal employee regardless of age be able to participate in this program without any differential in cost?

Mr. COLMAN. Yes, sir.

Mr. REES. Irrespective of what State he lives in?

Mr. COLMAN. Right. That is a requirement of the bill.

The CHAIRMAN. If he has reached the compulsory age of retirement of 70, he is charged the same rate as an employee 21 years of age?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. He gets the benefits after retirement at the same rate?

Mr. COLMAN. Yes, sir; as long as he meets the definition in the bill of a Federal annuitant. Those are specifically defined in the bill.

The CHAIRMAN. It would be very attractive to those employees between 65 and 70, it seems to me, to enroll.

Mr. COLMAN. I think it will. May I just say the next section of the testimony deals with them.

There is one aspect of the future costs of the program of which the committee should be aware. Government's contribution toward the cost of the program for active employees will be, in a sense, buried in the appropriations Congress makes for the payroll costs of the employing agencies. It does not require a separate congressional appropriation. However, Government's share of the costs for future annuitants will require a separate appropriation that will grow as the number of eligible annuitants grows. Precise data as to the number of annuitants who are eligible under the terms of the bill, and the rate at which this number will grow each year, are not available. However, the number is not insignificant and the Government's share of their costs may increase as much as \$2 million per year until a stable annuitant population is covered by the program.

There are many compelling reasons for encouraging retirees to continue in the program. If this is done, these costs will have to be met in some manner. The cost of the Government's share of the program is not reduced by prefunding these costs for annuitants. It is merely transferred to the payroll budgets of the employing agencies where it does not stand out as sharply as it does when a special appropriation is required each year for this purpose.

So that this appropriation that will have to be made for the cost of annuitants to meet the Government's share of their participation in this program is not an added cost, it simply is handled as a special appropriation instead of loading it over the rate paid by active employees through the employing agency. It does not stand out separately if you did it the other way.

Mr. JOHANSEN. What is meant by reaching a stable annuitant population, and how soon could it be presumed that would occur?

Mr. COLMAN. The direct answer to your question of how soon it would occur would have to be the result of a careful actuarial study of the average distribution of the annuitant population that qualified under the terms of this bill. So far as I have been able to determine, there are no age data on annuitants that would permit that kind of analysis because the definition of annuitants as included in here limits it to people who have had at least 12 years of service. That kind of age data has never been required before and it is not yet available. I think that is a question that had best be referred to the people who are concerned with the retirement program.

Mr. JOHANSEN. I confess that I am not sure I understand the technical term of stable annuitant population. The point I am groping for is whether it is going to be a matter of 5 years or 10 years or an indefinite period of a \$2 million per year increase.

Mr. COLMAN. Technically, the term "stable population" means when you arrive at a population where the number of people dying is about the same as the ones coming in, and that has been true long enough so that you have a level age distribution within the group. That is a complex actuarial computation, and you need a lot of data to start with to do it, which at the moment is not available to do it, at least to my knowledge.

Mr. JOHANSEN. Is there any basis for an educated or uneducated guess as to how many years this substantial amount of increase would be recurring?

Mr. COLMAN. I should think it would begin to level off in about 10 years, but this is a horseback guess.

Another thing that will affect it—this is another big unknown—is the size of the Federal establishment 10 years hence. It is related to the number of new annuitants coming in.

Mr. JOHANSEN. I hope some day in the Federal Government—I wish Judge Davis were here to comment on it—we might reach a stable population in terms of the number of Federal employees related to the population of the country, or to some figure. I recognize it is not going to be an absolutely stable figure. We do not seem to be headed in the direction of any modest reduction in the population of Federal employees.

Mr. REES. Mr. Chairman.

The CHAIRMAN. Mr. Rees?

Mr. REES. On page 8, in the second paragraph, you say:

There are many compelling reasons for encouraging retirees to continue in the program.

Would you like to tell us what those reasons are?

Mr. COLMAN. I think one of the most important reasons is involved in a hearing that has been going on in another section of the House of Representatives on the Forand bill. Here you have a wide public in-

terest in developing a public program for the hospital care of the aged that would impose major responsibilities on tax funds for this group. Unless employers and employees are encouraged to pick up this load themselves, the health needs of the aged are going to become so acute that this demand for a public program will grow. That is one compelling reason, in my opinion.

Mr. REES. Which will create a greater cost to the Government?

Mr. COLMAN. I think it would be a substantially greater cost.

Mr. CORBETT. Will the gentleman yield?

Mr. REES. Yes.

Mr. CORBETT. I believe another reason is that certainly the Government as the largest employer in the world, I do not believe it wants to have a situation develop where any large number of persons reaching an advanced age become charity cases. This is all contrary to what we are trying to do, to produce a better life in America. It is one of the things that appeals to me that with our retirement program people who have had long service with the Government certainly could out of their retirement benefits provide this protection for themselves.

Mr. REES. Let us be realistic. It does mean a greater cost to the Government. If they stay in, the Government cost is greater. I was asking the gentleman if that is correct.

Mr. COLMAN. Yes, that is correct. If you are going to include annuitants either on the basis proposed in the bill, on a pay-as-you-go basis, or a prefunding basis or any other basis, there will be a cost to Government for their share.

Mr. REES. You are saying it is another way of taking care of these people.

Mr. COLMAN. You are encouraging them to take care of themselves.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen?

Mr. JOHANSEN. There has been some question raised, I think in these hearings, as I am sure there was in the Senate hearings, as to the ability of the retirees to carry their share of the cost out of their retirement benefits.

Do you have any experience with respect to your covered Federal employees that would shed any light on the extent to which and the ability with which annuitants are currently continuing and meeting the cost of their own group program?

Mr. COLMAN. My immediate answer to you, sir, is that in Blue Cross we now have, of our 53 million, about 3½ million persons enrolled who are over 65 years of age. It is the largest single segment of older people who are covered for prepayment health services.

The reason we think this is true is because we have encouraged them to do it at the same rate as the rest of the population and spread their added cost over the rest of the population. It has met, I think, with a wholesome response.

In specific answer to your question on Government employees, I would like to consult a moment with Mr. Rawlings from the District of Columbia, who may have some experience I do not have.

Mr. Rawlings informs me that here in Washington they have about 35,000 Federal employees who had previously been enrolled in the

Blue Cross program, retired from Government, and are now in the program continuing to pay the full way themselves.

Mr. JOHANSEN. Is there any way percentagewise to relate that to the total number of retirees? In other words, to relate that to the dropout. What I am trying to get at is whether there is experience which encourages the confidence that with a 50-50 sharing of the cost by the Government there will be a substantially larger proportion of retirees who continue under the program.

Mr. COLMAN. Sir, I do not know of any specific experience in terms of historical record. The logic of the situation is that the retired person can go nowhere to get coverage of this sort at this kind of rate. It just is not available.

Mr. JOHANSEN. Certainly he is going to do it if possible.

Mr. COLMAN. It is a good buy. If he does not buy it, he has the problem of providing for the cost of that care or else becoming an object of charity, one of the two. So that everything we know about indicates there is a real interest on the part of retirees in this kind of offer.

Mr. REES. If the Government makes a contribution as provided under this bill, of course, he would be encouraged to carry on.

Mr. COLMAN. That is right.

The CHAIRMAN. I just received a letter from J. Edgar Hoover, Director of the Federal Bureau of Investigation, which reads as follows:

HON. TOM MURRAY,
House of Representatives,
Washington, D.C.

MY DEAR CONGRESSMAN: We have reviewed the Federal Employee Health Benefit Act of 1959, S. 2162, with considerable interest inasmuch as we have at the FBI an employee organization identified as the Special Agents Mutual Benefit Association (SAMBA). SAMBA is an association for all FBI employees, national in scope, and organized and operated as a mutual benefit association to provide hospitalization and medical insurance for FBI personnel, regardless of their position or where they are assigned.

SAMBA provides a comprehensive hospital, surgical, and major medical expense policy underwritten by the Prudential Insurance Co. of America. The association has enjoyed a history of improved benefits each year since it was organized in 1948. There are approximately 9,200 members, and including dependents about 28,000 people come under the protection provided through SAMBA. During the last fiscal year claims paid totaled approximately \$830,000.

In reviewing the Federal Employee Health Benefit Act of 1959, S. 2162, it appears that SAMBA satisfies the language therein as an employee organization except for the restrictive definition of such an organization as a "bona fide labor organization" in section 2(h). I am taking the liberty to bring this to your attention with the hope that if amendments are made in the bill it may be possible to include such wording as would make it possible for SAMBA to qualify as an employee organization under the bill.

With best wishes and kind regards,
Sincerely yours,

J. EDGAR HOOVER.

If his organization is not included in this section, it certainly should be, it seems to me.

Mr. COLMAN. That is primarily an administrative problem. I would personally take no position on it. I would caution you, however, that if you make enough exceptions for special programs of that sort in addition to the programs authorized by the bill, each such exception compounds the problem of the administering agency. My initial reaction would be that ways be explored by which that program could be included under the appropriate clearinghouse arrangement that is authorized by the bill. I think that might be possible.

The CHAIRMAN. This organization certainly should be included in any bill reported out by this committee. That is my opinion. You may proceed.

COVERAGE OF PRESENT ANNUITANTS

Mr. COLMAN. As stated previously, not enough is known about the age, sex, residence, eligibility, and marital status of present annuitants to permit calculations of the cost of a program for present annuitants. However, from what is known, it would seem impractical to try to include these persons under the provisions of the present bill. They have special health service needs which should be recognized in the development of the benefit pattern. They have not made contributions toward the program during their working lifetime, and in several other respects their problem is different from that of the active employees and future annuitants.

Inclusion of past retirees in a program with employer contributions is the exception rather than the rule in private industry programs. Such large programs as those for coal and steel workers did not include past retirees. The few programs which have included them usually do so for very low or materially reduced benefits. It should be noted, however, that since inception Blue Cross has encouraged retirees to continue their coverage as individuals and we now serve some 3,500,000 persons over 65 years of age, thus making a major contribution to the health needs of the Nation's retirees.

Accordingly, we concur in the recommendation that the development of a program for this group be the subject of a separate study.

CONCLUSION

(a) We urge the passage of H.R. 8210 in substantially its present form. We have offered one suggestion of change which we hope you will consider.

(b) We believe its provisions will result in great benefit to Federal employees, to the Government, and to the health services available for all citizens.

(c) We stand ready to assist the committee and its staff to the full extent of our capabilities.

(The tables referred to in Mr. Colman's statement follows:)

TABLE I.—Blue Cross enrollment—United States, as of Dec. 31, 1958

State	Total enrollment, Dec. 31, 1958	Estimated civilian population, July 1, 1958	Percent of State population enrolled in Blue Cross
Rhode Island.....	618,585	841,000	73.55
District of Columbia.....	783,115	¹ 1,085,000	72.18
Delaware.....	271,213	446,000	60.81
New York.....	9,423,946	16,184,000	58.23
Connecticut.....	1,200,000	2,304,000	52.08
Ohio.....	4,741,263	9,323,000	50.86
Pennsylvania.....	5,556,012	11,081,000	50.14
Massachusetts.....	2,318,215	4,813,000	48.17
Michigan.....	3,678,281	7,850,000	46.86
New Hampshire-Vermont.....	391,446	917,000	41.34
New Jersey.....	2,204,968	5,697,000	38.70
Maine.....	353,457	935,000	37.80
Colorado.....	616,715	1,677,000	36.77
Maryland.....	1,018,265	2,890,000	35.12
Minnesota.....	1,143,467	3,370,000	33.93
Indiana.....	1,426,215	4,574,000	31.18
Missouri.....	1,283,574	4,241,000	30.27
Kansas.....	627,464	2,079,000	30.18
North Dakota.....	188,514	649,000	29.05
Illinois.....	2,754,411	9,839,000	27.99
Tennessee.....	924,350	3,451,000	26.78
Iowa.....	718,542	2,820,000	25.48
Wisconsin.....	932,383	3,932,000	23.71
Kentucky.....	710,775	3,034,000	23.43
Alabama.....	730,553	3,185,000	22.94
Oklahoma.....	493,469	2,250,000	21.93
Wyoming.....	68,412	316,000	21.65
Virginia.....	717,857	² 3,501,000	20.50
Florida.....	842,290	4,348,000	19.37
Utah.....	166,134	861,000	19.30
Arizona.....	206,780	1,118,000	18.50
North Carolina.....	807,255	4,471,000	18.06
Nebraska.....	234,081	1,444,000	16.21
West Virginia.....	293,610	1,968,000	14.92
Mississippi.....	314,656	2,169,000	14.51
Arkansas.....	227,647	1,749,000	13.02
Texas.....	1,157,926	9,206,000	12.58
California.....	1,661,328	14,025,000	11.85
Louisiana.....	358,722	3,077,000	11.66
Georgia.....	425,046	3,749,000	11.34
Oregon.....	174,769	1,768,000	9.89
South Carolina.....	211,788	2,346,000	9.03
New Mexico.....	68,851	816,000	8.44
Alaska.....	14,068	167,000	8.42
Washington.....	196,038	2,706,000	7.24
Idaho.....	43,437	658,000	6.60
South Dakota.....	40,588	692,000	5.87
Montana.....	10,912	682,000	1.60
Nevada.....	(³)	258,000	-----
Total United States (excluding Hawaii) served by Blue Cross.....	53,351,386	171,601,000	31.09

¹ Includes 281 residents of Virginia served by the Washington, D.C., plan.
² Represents Virginia population less 281,000 served by the Washington, D.C., plan.
³ Blue Cross enrollment shown under adjacent States.

TABLE II.—Hospital admissions and days of care per person¹ per year in United States voluntary short term general and other special hospitals, 1950-57

Year	Admissions per person	Annual rate of increase (per cent)	Days of care per person	Annual rate of increase (per cent)	Year	Admissions per person	Annual rate of increase (per cent)	Days of care per person	Annual rate of increase (per cent)
1950.....	0.077	-----	0.600	-----	1955.....	0.085	1.2	0.639	2.1
1951.....	.079	2.6	.621	3.5	1956.....	.089	4.7	.662	3.6
1952.....	.082	3.8	.626	.8	1957.....	.091	2.2	.676	2.1
1953.....	.083	1.2	.632	1.0	7-year period.....	-----	2.4	-----	1.7
1954.....	.084	1.2	.626	.9					

¹ In U.S. civilian population.

Source: Annual Aug. 1 guide issues of Hospitals, and Statistical Abstracts, 1958.

TABLE III.—Hospital costs per patient day in U.S. voluntary short-term general and other special hospitals, 1950-57

Year	Hospital costs per patient day	Annual rate of increase (percent)	Year	Hospital costs per patient day	Annual rate of increase (percent)
1950.....	\$16.89	-----	1955.....	\$24.15	6.0
1951.....	18.01	6.6	1956.....	24.99	3.5
1952.....	19.55	8.6	1957.....	26.81	7.3
1953.....	21.09	7.9	7-year period.....	-----	6.8
1954.....	22.78	8.0			

Source: Annual Aug. 1 guide issues of Hospitals.

TABLE IV

Elements of cost of benefits as outlined in H.R. 8210, section 5(a)(1)

	Percent
(A) Hospital benefits (excluding maternity).....	49.8
(B) Surgical benefits ¹	18.1
(C) In-hospital medical benefits ¹	7.2
(D) Ambulatory patient benefits.....	3.1
(E) Supplemental benefits.....	15.1
(F) Obstetrical benefits for normal deliveries.....	6.7
Total	100.0

¹ Includes related professional services such as: anesthesiology, pathology, radiation therapy, etc.

The CHAIRMAN. I will insert in the record at this point a letter presented by Representative Donald J. Irwin, of Connecticut, from the National Association of Post Office and Postal Transportation Service Mail Handlers, Watchmen, and Messengers, Local No. 85, Bridgeport, Conn., and also a letter presented by Representative Charles M. Teague, of California, from the California Association of ASC County Office Employees.

(The letters referred to follow:)

LOCAL NO. 85, NATIONAL ASSOCIATION OF POST OFFICE AND
 POSTAL TRANSPORTATION SERVICE MAIL HANDLERS,
 Bridgeport, Conn., July 18, 1959.

Hon. DONALD J. IRWIN,
 House Post Office and Civil Service Committee,
 House Office Building, Washington, D.C.

DEAR CONGRESSMAN IRWIN: We have received information stating that the House Post Office and Civil Service Committee will begin hearings on Tuesday, July 21, 1959, on the Federal employees health and hospitalization program. The Senate has already approved, by a vote of 81 for and 4 against, a hospitalization bill (without amendments) which provides that the employee shall pay one-half and the Government one-half of the costs involved in the proposed hospitalization plan.

We, naturally, are very pleased and heartened by the action of the House committee, of which you are a member, in scheduling hearings on this legislation. As you know from our recent correspondence to you, we are favoring and urging your support of H.R. 7712.

We are hopeful that the committee will approve the provisions of H.R. 7712 and that the House will follow the Senate in voting overwhelmingly in favor of this very important and essential legislation.

The postal employees who have signed this letter to you are urging your support and action in favor of H.R. 7712 when the committee begins hearings. We cannot emphasize too strongly our interest in this proposed legislation. All postal and Federal employees are vitally concerned with the possibilities of a health and hospitalization program to be enacted this year. We know of the

needs for enactment of this worthy legislation. We are certain that you are familiar and sympathetic to our requests for support and action pertaining to this very beneficial legislation. Thank you from the officers and members of local No. 85.

Respectfully yours,

LOCAL No. 85.

Gilbert W. Buckley, 442 Mount Grove Street, Bridgeport, Conn.; James N. Jackson, 195 Taylor Drive, Bridgeport, Conn.; Herman Bader, 60 Karen Avenue, Stratford, Conn.; Charles W. Meane, 15 Walnut Avenue, Trumbull, Conn.; John C. Brodrick, 41 West Avenue, Devon, Conn.; Dominick De Profio, 112 Stratfield Place, Bridgeport, Conn.; Robert Rainey, 25 Revere Street, Bridgeport, Conn.; John R. Hill, 200 Newfield Avenue, Bridgeport, Conn.; Harold U. Blackwell, 1118 Stratford Avenue, Bridgeport, Conn.; Alfred D. Gordon, 40 Meadowview Avenue, Stratford, Conn.; Charley C. Young, 904 Havilu, Bridgeport, Conn.; Frank Fourtine, 30 Clearview Court, Bridgeport, Conn.; Frank Rescsanski, 35 Ridge Avenue, Bridgeport, Conn.; James B. Lowry, 313 California Street, Stratford, Conn.; Francis B. Rooney Sr., 147 Jones Court, Bridgeport, Conn.; Ralph Bciant, 306 Brenell, Bridgeport, Conn.; Melvin Kobay, 146 Parrott Avenue, Bridgeport, Conn.; John Ferraro, 355 Trumbull Avenue, Bridgeport, Conn.; Stephen J. Hantowshif, 74 Plainview Drive, Stratford, Conn.; George J. Stalin, 83 West Klund Avenue, Stratford, Conn.; Joseph C. Korser, 1630 Main Street, Stratford, Conn.; Raymond C. Bobho, 79 Sixth Street, Bridgeport, Conn.; Hoston M. Perry, 1 Fulton Court, Bridgeport, Conn.; Robert L. Gillin, 284 Bruce Avenue, Stratford, Conn.; John Wright, 774 Seaview Avenue, Bridgeport, Conn.; William E. Powell, 263 Beardsley Street, Bridgeport, Conn.; Salvatore P. Cavallan, Building 69, Apartment 78, Success Park, Bridgeport, Conn.; Joseph T. Krupski, 168 Beach Street, Bridgeport, Conn.; Warren J. Ford, 35 Sunset Avenue, Milford, Conn.; Andrew Behuncik, 21 Barrows Street, Stratford, Conn.; Paul M. Johnson, 516 Harral Avenue, Bridgeport, Conn.; Roland F. Ferguson, 1116 Stratford Avenue, Bridgeport, Conn.; Julian Medvin, 433 Golden Hill Street, Bridgeport, Conn.; Cornelius P. Kollov, 551 Cavern Road, Stratford, Conn.; John M. Kennedy, 174 Lenox Avenue, Bridgeport, Conn.; Lawrence Cirhala, 41 Cannan Court, Stratford, Conn.; Willie A. Dyer, 706 Trumbull Avenue, Bridgeport, Conn.; Albert J. Sidlousky, 445 Cannan Road, Stratford, Conn.; Cyrel M. Yuno, 51 Fox Street, Bridgeport, Conn.; Stephen Semenkovich, 225 Bruce Avenue, Stratford, Conn.; John F. O'Donnell, 52 Whiting Avenue, Bridgeport, Conn.; Arthur C. Cook, Box 186, Bridgeport Avenue, Stratford, Conn.; Vincent P. Feraco, 406 Dover Street, Bridgeport, Conn.; Steve Bene, 41 Butler Avenue, Bridgeport, Conn.; Milton Angell, 57 Alanson Road, Bridgeport, Conn.; Aaron O. Fast, 277 Success Avenue, Bridgeport, Conn.; J. C. Cummings, 255 Coleman Street, Bridgeport, Conn.; J. Avlio, 11 Datura Avenue, Milford, Conn.; J. J. Madden, 95 Buena Vista Road, Bridgeport, Conn.; John Tamas, 151 May Street, Fairfield, Conn.; Stanley Berthouse, 315 Teaisey Avenue, Bridgeport, Conn.; Franklin J. Peet, 695 Merritt Street, Bridgeport, Conn.; Lizzie W. McFadden, 470 Broad Street, Bridgeport, Conn.; John J. English, 820 Nallett Street, Bridgeport, Conn.; Paul J. Maco, 299 Dover Street, Bridgeport, Conn.

CALIFORNIA ASSOCIATION OF ASC COUNTY OFFICE EMPLOYEES,

Whittier, Calif., July 21, 1959.

HON. CHARLES M. TEAGUE,
House of Representatives,
Washington, D.C.

DEAR MR. TEAGUE: This refers further to the request of county employees of the Agricultural Stabilization and Conservation Service, USDA, to be brought under the life insurance and health and medical insurance plan for Federal

employees, and more specifically it is a commentary on the report made to the Committee on Post Office and Civil Service on May 20, 1959, by Mr. Roger W. Jones, Chairman, U.S. Civil Service Commission, and by the Bureau of the Budget on May 19, 1959. We believe in answering Mr. Jones' comments we will also cover the Bureau of the Budget report.

We, as county office employees, still contend that we work largely as Federal employees, but inasmuch as we have been considered by some as non-Federal it appears necessary that Congress enact legislation declaring the employees to be Federal to make the contention come true. Throughout the County Administrative Handbook, 1-CA, issued by the Commodity Stabilization Service, USDA, for the operation of county ASC offices, county office employees are considered Federal employees in every instance where it is to the advantage of the Government for them to be so considered. Please note the following:

The regulations of the Secretary of Agriculture governing ASC county and community committees (see Federal Register of November 2, 1956 (F.R. 8385), May 8, 1957 (22 F.R. 3222), and November 1, 1952 (22 F.R. 8802), November 13, 1958 (23 F.R. 8775), and December 10, 1958 (23 F.R. 9534)), provide--

Section 7.3 "That the purpose of committees shall be to direct the administration of sections 7 to 17, inclusive, of the Soil Conservation and Domestic Allotment Act of 1936, the Agricultural Adjustment Act of 1938, the Sugar Act of 1948, the Soil Bank Act and any amendments to such acts, and such other acts of Congress as the Secretary of Agriculture or the Congress may designate. This shall be done through community committeemen and other personnel responsible to the county committee and in accordance with applicable laws, regulations, and official instructions. The county and community committees shall not engage in other activity." Committees, therefore, do not have authority to do as they please as indicated.

Section 7.20 "The county committee, subject to the general direction and supervision of the State committee * * * shall be generally responsible for carrying out in the county the program * * * and in so doing the committee shall * * * employ the county office manager subject to the standards and qualifications of the State committee (Federal employees) and to serve at the pleasure of the county committee, except that incumbent managers shall not be removed other than under the provisions of section 7.29, until all members of the county committee have been in office for at least 60 days * * * fix the rate of compensation for all personnel in accordance with schedules or instructions approved by the Deputy Administrator" * * *

Section 7.26 of these regulations restrict private business activity of both committees and employees; section 7.27 restricts political activity of both committees and employees; section 7.29 provides for removal of county office personnel by the State committee (Federal employees) in the event it is not done by the county committee or county office manager, where necessary; section 7.31 sets the annual and sick leave (not the committee).

Section 7.34 provides that all books, records, and documents used by the county committee in the administration of programs assigned to it by the Secretary of Agriculture or Congress shall be the property of the Department of Agriculture and shall be maintained in good order in the county office. Section 7.35 provides that they shall be available to any other person only in accordance with instructions issued by the Deputy Administrator.

To answer the statement made by Mr. Jones on the bottom of page 3 we would like to make the following observations:

1. While county office employees are not technically hired by Federal officers, they must meet standards set by Federal officers in official management guides, and each appointment is reviewed by a Federal officer to see that these standards have been met and that the rate of compensation is in accordance with instructions approved by the Deputy Administrator.

2. It can be clearly determined from the above quotations from the Secretary's regulations that county office employees work directly under the supervision and direction of a Federal officer.

Farmer fieldmen visit county offices at least once every 10 days to supervise and assist in county office work and work plans. State office reviewers examine, for corrective action, the county office operations at least once every 2 years, in most cases much more often. CSS auditors perform complete audits and determine the adequacy of county office operations annually. General Accounting Office auditors perform a 10 percent annual audit of county office operations. Performance specialists from the State office closely check the work of each

performance reporter (part-time employees) and determine whether or not his work is acceptable and upon his findings that the work of said part-time employee is not acceptable his employment must be terminated.

The hours of work, amount of leave, and salary schedule are set out in 1-CA, issued by USDA, CSS, Washington, D.C., as prescribed by the Secretary's regulations.

Would you consider this supervision of direction of a Federal officer?

3. We have quoted many paragraphs of the Secretary's regulations which set up the functions under authority of an act of Congress or Executive orders through the Secretary of Agriculture's office in which county office employees are engaged.

We contend that we do not only meet a single one of these requirements, but in fact we meet all of them.

With reference to the last half of page 4 of Mr. Jones' report, counties are required to, and do, withhold social security and Federal income tax deductions and maintain the necessary records of deductions. As before mentioned, the employee-employer contributions are made in this connection. The Secretary's regulations and instructions require the keeping of all records designated by said regulations and instructions.

As a further example, the county agricultural agents who receive only approximately one-third of their salary indirectly from Federal funds, do make contributions for both their retirement (State and Federal) and for the life insurance premiums. This program is authorized by the Congress.

If the Civil Service Commission did not concur (reference is made to p. 6, par. 2) in the legislation enabling county extension agents to be covered under Federal retirement and Federal life insurance, then the Congress must have enacted the legislation over the Commission's objections. We see no reason why we should not also have this coverage. County extension agents are employed subject to the will of county boards of supervisors or county commissioners who are elected by voters of the counties without regard to farming interests. They also perform some functions authorized by Congress, but none of their services are directed by Federal officers. These employers have authority to, and do, set salaries for these employees so long as 50 percent of their salary is paid by said county board of supervisors or commissioners.

The precedent of this proposed action, in our opinion, has already been established in the county extension agents' case of county ASC employees.

Most county office managers and many other county office employees are career employees, and we believe that Congress would not be going beyond the obligations of the United States to afford staff retirement security for these employees who are employed under the same personnel management guides as other Federal employees. In fact, when county office employees are separated they are issued Standard Form 8, "Notice to Federal Employees About Unemployment Compensation." This is another of the many cases where we are "Federal employees" up to retirement and insurance benefit applications.

The proposed health program for Government employees (the bill does not say "Federal") defines "annuitant" as * * * (p. 2, line 22) "an employee who receives monthly compensation under the Federal Employees Compensation Act as a result of injury sustained or illness contracted * * *." County ASC employees are covered under the act; in fact, many county employees have been treated at U.S. Public Health Service hospitals for injuries incurred in the performance of their duty and have received compensation under the act for lost time.

How can we be defined as an "annuitant" and yet be declared as not under this program?

We work alongside the above-mentioned county extension agent, the local SCS personnel, who operate under a local board of commissioners also elected by farmers, and FHA personnel, all of whom are civil service employees; work with the same group of farmers and perform generally similar services for the farmer. In view of all this, it is hard for us to reconcile the finding of the Civil Service Commission with the facts.

We should now like to highlight some of the instances in which county office employees are considered Federal employees:

1. Appointment subject to approval of Federal officers.
2. Hours of duty, salary schedule, leave earnings and supervision of work in accordance with Federal regulations and instructions.
3. Personnel management in accordance with standards for Federal employees.

4. Performing only those functions authorized and/or directed by acts of Congress or Executive order.

5. Covered under Federal Employees Compensation Act.

6. Excused from duty on other than legal holiday when the holiday falls on Saturday, by Executive order applicable to certain Federal employees. (Example, July 3, 1959, Executive order of June 12, 1959.)

1. Salary compensation received from Federal funds authorized by Congress.

8. Restrictions on private business and political activity imposed by the Secretary's regulations.

9. May be removed from employment by Federal officer.

10. Afforded legal assistance by Federal attorneys in case of suit against a committee or employee when acting in their official capacity in behalf of the Secretary of Agriculture in the performance of assigned duties.

11. Space is provided in U.S. post office buildings (Federal, of course) for ASC offices wherever such space is available.

12. Agricultural conservation program funds are used, up to 5 percent of each county's allocation, to pay salaries of Soil Conservation Service employees, who are registered civil service employees, to carry out a part of the agricultural conservation program on a local level. The major part of this same program is administered by county ASC employees.

13. County office manager trainees are on county ASC payrolls while training for an office manager position and are under the full supervision and control of State office personnel who are Federal officers.

From the foregoing it should be concluded that the only areas in which county office employees are not considered Federal employees are those dealing with retirement, life insurance, health insurance, and job security benefits.

We again respectfully request that you carefully consider the status of the approximately 15,000 county ASC employees so that they may be given equal opportunity for job security as other Government employees. We believe that the Congress has an obligation to see that the existing inequity be eliminated. We do not believe the cost involved would be prohibitive. We especially urge that, at this time, we be included in the health bill and Government life insurance program.

If, at any time, the county employees, either collectively or individually, can furnish you additional information, we will make every effort to see that it is promptly and accurately provided for you.

Sincerely yours,

IRA D. CATE,

President, California Association of ASC County Office Employees.

The CHAIRMAN. The House is now in session. I am sure the members have certain questions to ask Mr. Colman before he is dismissed as a witness. For that reason, the committee will not proceed further at this time.

Unfortunately, the committee cannot meet tomorrow. Mr. Davis, chairman of the Subcommittee on Manpower Utilization, has scheduled a hearing for tomorrow, which hearing was scheduled about 3 weeks ago. He made all plans for the meeting and has invited the various witnesses to be here tomorrow.

For that reason the hearing will have to go over until 10 a.m., Thursday. I hope the members will be here. The committee now will stand in recess.

(Whereupon, at 12:05 p.m., the committee recessed, to reconvene at 10 a.m., Thursday, July 30, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

THURSDAY, JULY 30, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m. in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be resumed on various bills relating to health and medical insurance.

Before we resume the testimony of Mr. Colman of the Blue Cross Association and Dr. Stubbs of the Blue Shield medical care plan, we have two Members of the House here this morning to make statements. I think we will accommodate them by hearing them first and then letting Mr. Colman and Dr. Stubbs take the stand.

I am very happy to present our colleague, Mr. Fulton of Pennsylvania, a former member of this committee and the author of H.R. 6167.

STATEMENT OF HON. JAMES G. FULTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. FULTON. I am glad to see my old friends again, and if the Foreign Affairs Committee had not snagged me I probably would be sitting by my good friends, Mr. Corbett and Mr. Rees, on this committee, as I previously had been a member of the previous Civil Service Committee.

I am supporting this legislation and believe it should be passed.

Provision for health insurance benefits for Federal employees should be enacted into law at the current session of Congress. The urgency of such a program appears to me to be so great that we cannot afford further time to make additional studies or to collect additional information.

The CHAIRMAN. What is that last statement?

Mr. FULTON. The urgency of such a program appears to me to be so great that we cannot afford further time to make additional studies or to collect additional information.

The CHAIRMAN. You do not want this committee to take snap or hasty action without due consideration, do you?

Mr. FULTON. I do not think this committee has ever taken snap or hasty action, and I do not think I need caution this committee on that. I think you have a good record of always acting on the facts and when the facts are produced I do think you take quick action.

The CHAIRMAN. All right.

Mr. FULTON. Already a great deal of factual material has been amassed and its general tenor is that the Government is lagging behind other large employers who already have provided extensive programs of health benefits for their employees. This material which has been gathered and analyzed by congressional committees, Government agencies, insurance organizations, and the unions demonstrate rather conclusively that the benefits of such a program are so advantageous to the Government as well as to the employee that there is no sound reason for delay.

When I introduced my bill, H.R. 6167, it represented my thinking on this subject. I am still of the belief that the program comprised in that bill is sound and is more nearly proportioned to the need for medical care and to the financial circumstances of the greater number of Federal employees. However, I realize that it would be more practical to put into effect as soon as possible even a partial program than to delay legislation by striving for terms which seem to be more nearly adequate. Government employees as a group are so much in need of these benefits that early action is imperative.

As you recall, I represent part of the city of Pittsburgh, with Congressman Corbett. We are in a high wage area there and a high expense area, so that it is very hard for Government employees to exist on the pay which they receive at the present time.

It is with that purpose in mind that I support the proposal which was approved by the Senate and is presently pending before the House committee. The equal division of cost between the Government and the employees would still be a real step toward the establishment of health benefits in keeping with the Federal Government's role as the largest single employer in our good country.

Employers in private business have found it to their own as well as to the employee's advantage to inaugurate a health insurance program and continually improve it. The fact that so many of these firms provide this benefit on a noncontributory basis is in itself impressive evidence that it must be materially worth while. It is evidently profitable for the employer to relieve his employees of the worry which accompanies family illness in particular. Then too the employee's own health is important because it is so closely related to his efficient performance.

An employee with a relatively small income, and this is true of the majority of Federal employees, may be able to budget his outlays for ordinary medical care out of his regular income, but it so often happens that the need becomes unusually great and costly. Then, too, an unexpected need for surgery or for special types of therapy may develop at any time. Such things are entirely unpredictable, and the only solution that is of any great benefit to the individual is to be covered by a systematic prepayment plan.

The health insurance program which is established now should cover the major part of hospitalization, medical, and surgical expenses. It should also make some substantial provision for those long illnesses which may entirely deplete a person's savings and then leave him with a huge debt. Whatever is done in this regard will be tremendously helpful.

I believe, therefore, that a health insurance program for Federal employees should be established immediately, and that, if there cannot be agreement on a program as liberal as in my bill H.R. 6167, the terms of the bill approved should be such that it can gain wide support and early enactment.

I would say that I believe, since talking to my good friend, Attorney McCracken, he has pointed out to me that an optometrist and a dentist should be placed on the board so that we can have a broad board.

The CHAIRMAN. Who made that recommendation?

Mr. FULTON. I have a good friend who is an attorney and he pointed that out to me.

The CHAIRMAN. I did not get his name, though.

Mr. FULTON. His name is McCracken.

The CHAIRMAN. Where does he reside?

Mr. FULTON. He is in Washington, D.C., and he called that to my attention. He called it to my attention that the board be broader, and I think that is a good idea.

The CHAIRMAN. William P. McCracken?

Mr. FULTON. Yes.

The CHAIRMAN. I know him. You may proceed.

Mr. FULTON. Hospitalization and other types of health care are as necessary as adequate food, clothing, and housing. They are among the basic necessities of life. It is with that in mind that I urge immediate action on this legislation.

I do feel, since we are on the advisory board, that it should be broad and should have on it representatives of the various groups and professions and should not be restricted to any kind of group or professional men in this field. Under those circumstances, I think it is a fine idea and it is my judgment, since it has been called to my attention. I do know Mr. McCracken well and his wife, and I happen to be in the same group with them that does square dancing, so we have many other interests other than the joint interest in the law.

Any questions?

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter?

Mr. PORTER. I have just had a chance to look over the gentleman's bill. It is similar to H.R. 8210?

Mr. FULTON. Yes, it is.

Mr. PORTER. In regard to coverage, the first part of H.R. 8210 defines the term "employee" as being "an appointive or elective officer or employee in or under the executive, judicial, or legislative branch of the U.S. Government, including a Government-owned or controlled corporation."

In your opinion, should this bill cover Members of Congress?

Mr. FULTON. I would say that if we are going to have a broad bill it should be discretionary within this committee as to the groups that it would cover. There is the problem of the continuity of employment for a Congressman or an elected official. I can see where they could by this committee be put in a separate group from people employed by the Government on a career basis. In fact, many Congressmen, as myself, have outside income. I publish six weekly papers in addition to my service as a Congressman. We are here, some of us,

giving our time and taking away from our own businesses and professions, but it also means that we have other sources of income that other Government employees cannot have. I think there is a valid reason for distinction if the committee wishes to make a distinction between what you could call political employees at a high policy level and elective Government employees who are of a public nature and whose service is more of a policy or public nature than it is of an administrative or detail nature in the Government service.

Mr. PORTER. Did I understand the gentleman to say the need is not as great for Congressmen as other Government employees?

Mr. FULTON. I think any employee limited in income and who perforce must pay attention only to his one job has a greater need because when he loses that job or becomes disabled he has no other resource on which to rely.

Mr. PORTER. Then I heard the gentleman say he thought the bill should be enacted as soon as possible.

Mr. FULTON. May I comment a little further on your other point, because I think it is a good one.

Being an employer of some size myself, I am always looking around to get ambitious young people to work and to stay with the newspapers. I think that same thing should apply to the Government. We want these young people to come with the Government and come at an early time, especially when they are raising their families and having their responsibilities. But that is the time in Government when their pay is lowest, and obviously they need to be protected against these serious illnesses that might destroy the families of these Government employees. I think this legislation will help attract fine young people to the Government service.

Mr. PORTER. Now let me get back to the question, does this bill cover Congressmen?

Mr. FULTON. I think if you press the point it could cover anybody who works for the Government.

Mr. PORTER. The next question is, should it cover Congressmen?

Mr. FULTON. I would probably include them, but I can see that Congressmen are a separate group of cats.

Mr. PORTER. Do you agree with one of our colleagues who, I read in the paper this morning, is not going to take the additional \$600 stationery allowance that was voted to us?

Mr. FULTON. Let me say I am one of the people who more than use up the expense allowance and I have already used my stationery allowance. I have just sent out 130,000 questionnaires to my district and am getting quite a few answers and I will use my expense allowance. I think if it is given to us it should be well used and used for the purpose for which it is given, to give better service.

Mr. PORTER. Regardless of what outside income the Congressmen may have, do you think this boon should also be given to them?

Mr. FULTON. I do not look at it as a boon. If you can get better Congressmen I would favor looking into it.

Mr. PORTER. You would get healthier Congressmen.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen?

Mr. JOHANSEN. I am sorry I was late. In a facetious mood I would like to say—and this is not said critically—the gentleman's

reference to square dancing may have more significance to Mr. Lesinski than to myself. In my district square dancing has a distinct political connotation.

Mr. FULTON. I am afraid this is a mixed crowd, men and women and Democrats and Republicans, that I belong to in Washington.

Mr. JOHANSEN. I would say square dancing in my district has a distinct political connotation.

Mr. FULTON. May I ask, it does not mean dancing by "squares" in Michigan, does it?

Mr. JOHANSEN. I will not answer that.

Seriously, I do not know of anyone in this room or on this committee that does not recognize there is a need for this program, that it is very desirable, and that we would like to see it. There is one problem that does concern some of us very, very deeply, and that is, Where is the money coming from? What is it going to do in terms of more deficit financing?

Does the gentleman have any comment on that score?

Mr. FULTON. I will say I am paying my income taxes both on my congressional salary as well as my other income, and I pay it with no dependents whatever, so I pay one of the highest rates of anybody in the room.

Second, I think it is not a matter of just economy, but it is a matter of seeing what we get for the money that Congress is spending. When we are giving services that are really necessary, that we have not been able to give before in this country, I do not look at that as a bad thing. I am in the progressive group of Republicans who feel that the Government expenditures in and of themselves are not bad if they are done right and efficiently administered.

I am very willing to pay every dollar for the almost \$40 billion for defense that is my share. But I certainly feel that many of these Federal subsidies should be stopped. I know if we would simply stop the subsidies in the farm program, that everybody who pays more personal income tax than 20 percent could get his money back.

Mr. JOHANSEN. I am sorry the gentleman from Iowa is not here, due to his necessary attendance today at another committee meeting.

Mr. FULTON. I might say to the gentleman from Michigan that compared to the gentleman from Iowa, although I am said to be a liberal, my voting is more in line with that of Senator Byrd's budget.

The CHAIRMAN. That is news to me.

Mr. FULTON. May I point to the budget. If you will look at the budget you will find the exact amount spent by the U.S. Government per year for farm subsidies is the exact amount of surtax paid by everybody in this country on their personal income taxes. If we got some freeloaders off our back the income tax would come down.

Mr. JOHANSEN. While I do not go along with some of the scandalous agricultural programs, I do not go along with the idea that farmers are freeloaders.

Mr. FULTON. I do not say they are. Some agricultural programs are good.

Mr. JOHANSEN. You would cut that out and I would cut something else out, but the truth is none of us will cut anything out and we will add more and increase the deficit. I respect the gentleman

because I think he would vote to increase taxes to pay for those things he believes in.

Mr. FULTON. I certainly would, but I would cut the budget first.

Mr. JOHANSEN. But the gentleman and I cannot persuade our colleagues to do the same.

Mr. FULTON. I am on the Foreign Affairs Committee and I voted to cut \$800 million out of the \$3.9 billion mutual security program. Would the gentleman cut the agricultural program by that much?

Mr. JOHANSEN. The gentleman has voted to reduce the whole thing at every opportunity. But the fact still remains that we still go on our way, as in the past year just ended, with a \$13 billion deficit, and we have no assurance that we will have a balanced budget this year. We either have to do some cutting this year, and cut out some programs that are commendable such as this one, or add to the tax revenues. We have those choices. What hope does the gentleman have in this regard?

Mr. FULTON. To the gentleman from Michigan, a good friend of mine, I will say I get tired of complaints of what people are doing for this Government, or that they are paying taxes. When I go around some places in this country I feel actually poor because I see these people living high and enjoying every luxury which I cannot afford. How do they do it? Go to some of these resort places and see the money being thrown around on useless things and tell us why we should not have these necessary things the Government can provide, for example, to help some family that had a tremendous siege of illness or accidents. That is the kind of people I want to help.

Mr. JOHANSEN. I do too. My point is why should we not pay for their having it with tax revenues rather than deficit financing?

Mr. FULTON. May I say to the gentleman, Mr. Porter, because I do not want him to think I was placing my hand on \$600 extra, that I have given more than 10 percent of my salary for public uses in addition to what I do for religious purposes.

Mr. PORTER. Most Congressmen are not in a position to do that.

Mr. CORBETT. I wanted to say a word about the cost of this program, because it will keep recurring.

Let us assume we are going to spend on an average \$75 billion a year for the predictable future. This item of approximately \$150 million, which is less than \$1 per person per year, in my mind—and I can buy everything the gentleman said—but in my mind this is one of the expenditures that ought to be a very high priority. I believe that the gentleman and any other member of this committee, in setting up a budget and including those things which are most necessary and desirable at the top of the list and coming down to the bottom of the less desirable and less necessary things, could readily find, out of \$75 billion annually, \$150 million a year to take care of the lives and comfort of the Federal employees of these United States, and I do not know of any program that we have, outside of those that are contractual promises, that could not be cut some amount; and I feel that the worry here about, "where is the money coming from?" is the least important argument against this bill. I know the gentleman's very fine concern for a balanced budget and reduced taxes, and that is fine.

Mr. JOHANSEN. The gentleman did not mention reduced taxes. I do not kid myself. I am talking about increased taxes if we are going to increase expenditures.

Mr. CORBETT. Does the gentleman believe we will have a balanced budget this year?

Mr. JOHANSEN. God only knows. I have not the remotest idea. I know if we continue voting more and more expenditures without increasing revenues, I know if we do the one and fail to do the other, and if we simply limit ourselves to talking about how we could cut this and how we could cut that when we know we cannot rally the votes to do it, I know we will not have a balanced budget.

Mr. CORBETT. Apparently the votes are being rallied to hold down a lot of expenditures and sometimes cutting them. But would the gentleman agree if we are to hold the line for a balanced budget there are many items that could be eliminated?

Mr. JOHANSEN. Certainly, but may I say to the gentleman I cannot help distinguishing between what could be eliminated and any prospects that they will be, which is the source of my concern.

I have no desire to make this very commendable program the whipping boy, but everything that comes up, the argument is made that it is the most important and most urgent thing.

Mr. FULTON. May I agree with the gentleman from Michigan on his concern, because when I first looked into this I felt it would have cost each taxpayer 84 cents a year.

Mr. JOHANSEN. I do not care if it costs the taxpayer 84 cents or 84 dollars. This Government cannot go on spending on every program saying that this is mandatory and ever achieve fiscal stability.

Mr. FULTON. Do you not think that 84 cents per year per person is worth while against the risk of bankrupting and destroying these families, because I have seen it.

The CHAIRMAN. On what do you base this 84 cents per year per person?

Mr. FULTON. I took the figure of 175 million people in the United States. At \$1 per person annually for this program that would be \$175 million. But the cost of the program is estimated at \$150 million a year. I did it by mental arithmetic, using a system of 25's. There are seven 25's in 175, so I took one 25 off. That was one-seventh off the dollar for each person in the United States annually, which gave me 86 cents per person in the country for an annual program of \$150 million. Then I took 2 more cents off, because the program might not run as high as we thought because of the current economy wave, and made it 84 cents cost for each person in the United States for each year.

Mr. JOHANSEN. Mr. Chairman, may I just address myself to one point the gentleman makes when he talks about bankrupting families. I am not an unfeeling ogre who has no concern for catastrophic illnesses in families. I have raised a family. I know what it means. But I cannot help being concerned about what the bankruptcy of this Nation can mean to every family in this Nation.

Mr. FULTON. But maybe part of my concern, which I should not speak of, is that we had a member of our family who was an invalid for 20 years, so we know what it is. Then I had a young employee who came back from the service unable to move from his neck down with

a service-connected injury and he cannot work and somebody had to take care of him, so he is a member of our family. We had that for 10 years. Now a family who has had 30 years of severe illness would possibly have a different appreciation, so when I come up with 84 cents per person per year, maybe people should not buy that extra piece of candy or the extra movie or extra 5 gallons of gasoline and put it to something more important. That is where I agree with Congressman Corbett, it is the decision of which is the most important. To me this is one of the basic needs in this country, to help folks who otherwise would go bankrupt through no fault of their own.

Mr. JOHANSEN. I have as much sympathy with the problem as the gentleman has.

The CHAIRMAN. What do you estimate the cost of this program to the Federal Government would be?

Mr. FULTON. Between \$125 million and \$150 million a year.

The CHAIRMAN. We had an estimate of \$200 million a year.

Mr. FULTON. It would run, under your figures, \$1.14 for each American, and under my figure it runs 84 cents to 86 cents; and even on your figure of \$1.14, I will pay that and pay it gladly.

The CHAIRMAN. Are you not deeply concerned over the Federal debt? I think most of us are.

Mr. FULTON. I think we ought to pass legislation to pay for what we spend, although I say this, that when we are protecting future generations maybe they ought to pay some of it. A little bit of our current defense should be paid from bonds.

Mr. JOHANSEN. I have heard for almost 30 years now about the "terrible Hoover depression," and I think I know something about what that did to families and what the consequences were to homes and to people in terms of human suffering, but the "terrible Hoover depression" did not involve, to my knowledge, the good faith and credit of the United States. If we have another blowup, which heaven forbid, I am not sure but that it will involve the credit and good faith of the United States.

Mr. FULTON. I would like to hire you for my newspapers, someone who is as concerned as you are. I think the gentleman from Michigan is exactly right on that, that we should pay for this program.

Mr. REES. Returning to this 86 cents per person, that might amount to \$4 or \$5 a family. Is that not the way it might work out?

Mr. FULTON. Actually, what we are doing is we are spreading the risk. So the loss due to illness is going to be there but the way the loss will be placed will be different under this legislation.

This committee should recognize we are simply insuring against losses of certain types. The losses are there anyway and they will cut in the economy regardless of whether this bill is enacted or not. Somebody will pay them. The question is, Should the tremendous loss fall on a few people or should it be spread more evenly so that it amounts to between \$1.14, based on the estimate of the cost of the program of the gentleman from Tennessee, or 84 cents based on my figures?

I strongly favor the spreading of the loss so that these families are not bankrupted and destroyed. I do not think the 84 to 86 cents a person will either make or break the budget of this Federal Government.

Mr. REES. I do not either. I am just suggesting, when you talk about 84 or 86 cents a person, you must consider what that would amount to for a family.

Mr. FULTON. I believe you are right, that it might run about \$4.30 for a family of five.

Mr. REES. For the average family it would be \$3 to \$4.

Mr. FULTON. It would run between my figure of \$4.30 a family a year and on Mr. Murray's figure it would be \$5.70.

Mr. REES. I don't know that that is pertinent to the discussion.

Mr. LESINSKI. I want to commend the gentleman from Pennsylvania on his forthright statement.

I requested the gentleman from Michigan and others to report on the legislation that I have in the hopper, one in conjunction with Mr. Fino of New York, which would pay for this program time and time again.

Another is to take out the so-called loopholes in the tax law which would affect what you are talking about, where people have a lot of money to spend at the resorts, meaning it is taken off the expense account of the corporations and it is not income to them.

You would have more than enough funds in the Treasury if we got together and took out some of these loopholes in the tax structure.

Mr. DULSKI. I never thought the first time I spoke in the committee it would be with words of praise. I think Mr. Fulton has expressed the importance of this bill, faced up to all the problems involved, without flinching. He has been very, very candid. This kind of discussion is of tremendous help.

I might say I am also impressed by the fact the committee seems to be largely in favor of the bill and I hope we can get done with our hearings as soon as possible so we can get this legislation this year.

Mr. FULTON. I thank the gentleman. I want to congratulate the committee. It is always a challenge and pleasure to appear before you.

Mr. FOLEY. I want to associate myself with the comments just made.

As I understand your testimony, you are giving us very wise and prudent investment counsel.

As I understand you, Mr. Fulton, you are advising the Federal Government to invest so many dollars in the health and well-being of the Government worker.

My question is this: In your analysis and appraisal of the proposal, is it your conclusion that this investment would be a giveaway or that the return, both from a monetary standpoint and the human value standpoint, would either match or exceed the value invested by the Federal Government?

Mr. FULTON. I believe you have an excellent point there—that it is not any giveaway, nor is it just putting money down the drain that is a drain on our economy.

The first point I made as an employer was that I believe if the Federal Government has this as part of its employment package that it will attract young people, get better employees, and make them want to stay longer.

I think it is an excellent policy on that score.

Secondly, there is the drain on the economy of these long and severe illnesses, regardless of whether we pass legislation in the Congress, or this committee approves legislation or not.

This bill will provide a policy to prevent destruction of Government workers' families by broadening the base of the risk by this health program. I strongly favor the program.

The question then comes, "Will they get better care?" I believe on your point my answer would be, "Yes, with this kind of help, they will get better care." The illnesses will be shorter, so that there is a personal gain as well as an economic gain.

I would agree with you on both points.

The CHAIRMAN. Thank you very much, Mr. Fulton.

The committee will hear next from our colleague, Representative Paul A. Fino, of New York.

**STATEMENT OF HON. PAUL A. FINO, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK**

Mr. FINO. Mr. Chairman and members of the committee, I deem it a privilege and a pleasure to be given an opportunity to testify in support of legislation now before this committee which would set up a Federal employees' health insurance program.

I consider this type of legislation not only important but necessary, and I sincerely hope it will receive immediate and favorable consideration.

Legislation to provide health benefits to Federal employees has been considered for a long time—for 12 years, to be exact. The time is now ripe for consideration and approval of this kind of program for our Government workers.

Equal in importance to the wide acceptance of this particular kind of legislation is the nationwide acceptance of prepaid health benefits. These are available to 123 million persons in the United States today. More than 75 percent of those participating in prepaid health plans are enrolled through their place of work. Surely employees of our Federal Government need be no exception. It is indeed shocking that for so many years the Federal Government has not made available to its employees the minimum benefits taken for granted by employees in private industry.

In my own State of New York the employees of our State government have been eligible to participate in a contributory health insurance program for well over a year. The plan has been described as one of the most liberal and comprehensive programs of its kind. Just over a year ago 77,239 State employees were enrolled in the plan, and this number has undoubtedly increased since that time.

We have the opportunity to offer this type of generous and workable program to 2 million civilian employees of the Federal Government and their families throughout this country and overseas. They can face the future with the assurance that their membership will not be canceled, that they will have the opportunity to continue coverage on an individual contract basis even after termination of Federal

employment, and that their coverage will continue when they retire through payment of their contributions for which they can plan ahead.

We are all aware of the limited salaries upon which great numbers of Federal employees are required to support their families. We have also heard a great deal of talk about constantly rising medical costs. It is our duty, our responsibility, to provide the employees of the Federal Government with an opportunity for reasonable protection against these health costs at a reasonable price. I, therefore, urge this committee to give its approval to this much-needed legislation.

Mr. Chairman and members of the committee, I am grateful for this opportunity to present my views, and I commend my colleagues for their hard work on this type of legislation. I know that the legislation which this committee finally reports will be a bill which will enhance the public interest and promote the general welfare of our Federal public servants.

The CHAIRMAN. Questions?

Mr. JOHANSEN. What is the basis of the plan in New York? Is it a 50-50 plan?

Mr. FINO. To be honestly frank with you, I am not too familiar with the mechanics. It is a new plan which has only been in operation a short time.

Mr. JOHANSEN. But the State does participate?

Mr. FINO. There is a partial participation there.

Mr. PORTER. I appreciate the gentleman's statement. I want to ask him about this New York plan, though.

As I understand the present bill, the Federal Government could not deal with the same group which gave you a liberal and comprehensive plan. Under the provisions of this act it would have to be one service-benefit plan.

I was wondering whether or not my colleague had considered whether or not there should be competition, in New York and elsewhere, where there were plans, bidding to give the same medical services as Blue Shield, and so on?

Mr. FINO. That goes into the mechanics of it, and as I said I am not interested at this point in the mechanics of these plans. I am interested in the principle.

Mr. PORTER. The principle here is competition, where there can be competition you think there should be competition. You pointed out that in New York this plan is giving liberal and comprehensive service?

Mr. FINO. That is right.

Mr. PORTER. On that basis you think the bill ought to allow that plan, to bid in New York and elsewhere, for the right kind of competition by the right kinds of groups with sufficient reliability to furnish the same type of service?

Mr. FINO. I do.

The CHAIRMAN. Other questions?

(No response.)

The CHAIRMAN. Thank you very much, Representative Fino.

At this time I will place in the record the statement of Representative Seymour Halpern, of New York.

(The statement follows:)

STATEMENT OF HON. SEYMOUR HALPERN, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF NEW YORK

Mr. Chairman and members of the committee, thank you for the opportunity to present my views on legislation for a Federal employees' health benefits program. I support this legislation wholeheartedly and have introduced H.R. 8352 in this respect.

The committee is well acquainted with the efforts to secure such legislation since 1947. Now that fundamental agreement has been arrived at among the major parties interested in such legislation, the opportunity to carry it through to effective culmination is more propitious at this time than ever before.

The rapid growth of programs of prepaid health benefits throughout the Nation, particularly in private industry, has left the Federal Government as one of the largest remaining employers failing to offer such a service to its employees.

The adoption of such a program by the Federal Government is long overdue. The proposed legislation does for the employees of Uncle Sam what has been done by many enlightened private employers. The cost of illness can and often does impose ruinous financial burdens. The proposed legislation will mitigate this for the Government worker and his family.

The proposed legislation offers a reasonable approach to the problem and involves the widest possible use of private insurance facilities, whether of the Blue Cross-Blue Shield type, or private carrier plans, with an elective choice at the discretion of the employees.

I believe that the principles underlying the proposed legislation are highly commendable. They include coverage of as many Federal employees as feasible, coverage for the families of such employees, coverage for oversea employees, some freedom of selection by the employees, an adequate medical expense insurance program at a reasonable cost, sufficient flexibility to allow for consideration of additional benefits as major breakthroughs in medicine occur in the next few years, and, a reasonable sharing of the costs between the Government and its employees on a 50-50 basis.

I do regret that presently retired Federal employees are not included in the legislation, particularly since this group, as older citizens, is confronted with heavier medical expenses than younger people. I understand that statistics and data are being analyzed on this problem and I hope that legislation for this group will be proposed soon.

The plan to let Federal employees get the type of protection which the employees of some of the more populous States and cities are now getting represents a long-desired Government reform.

The adoption of such legislation will certainly offer a stimulus for career Government service and should assure the Government of more efficient service from its several million employees. As a consequence, the entire Nation will also benefit.

Not to give the Federal employees the same kind of health insurance opportunities and health benefits which are available in the best plans for private employees and those of some State and local governments would be unsound from the point of view of national justice and unwise in terms of making certain that the Government has an opportunity to recruit a very high level of employees.

Cost estimates run in the neighborhood of \$146 million for the Government. It is entirely possible, however, that the carriers might offer programs with certain cost reductions that could result in cutting the expense to the Government below this figure.

The creation of a fund as a repository of the moneys for the health benefits program will assure separate accounting, the payment of administrative expenses, and the establishment of a reserve to provide for stability of subscription rates over a reasonable period.

Finally, the establishment of an advisory council including representatives of the employees, and, public experts, will assure adequate consideration to all interested parties and result in proper administration of the program.

Mr. Chairman, I believe that the proposed legislation serves the best interests of the Federal Government, its employees, and the public. It provides for a system allowing for reasonable competition among the different types of programs which should result in a better program for the employees.

This initial start does not mean that this will constitute the final form of the program. Continuing study, after it is effectuated, should suggest possible improvement and change.

I respectfully request that the committee report out the legislation in substantially the same form in which it has been submitted. Thank you for your courtesy in permitting me to testify on this matter.

The CHAIRMAN. Next we will hear Mr. Colman, vice president of the Blue Cross Association, and Dr. Donald Stubbs, chairman of the board of the Blue Shield medical care plan.

STATEMENTS OF J. D. COLMAN, VICE PRESIDENT, BLUE CROSS ASSOCIATION; AND DR. DONALD STUBBS, CHAIRMAN OF THE BOARD, BLUE SHIELD MEDICAL CARE PLAN—Resumed

The CHAIRMAN. Mr. Colman, I believe you testified yesterday there were 78 different Blue Cross plans throughout the United States. Is that correct?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. Are they all operated separately and independently so far as rates and benefits are concerned?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. There is no uniform plan for all your different Blue Cross organizations?

Mr. COLMAN. They are independent organizations established under State law and usually responsible to the insurance department of the State for supervision.

The CHAIRMAN. What kinds of reserves do these different Blue Cross plans have?

Mr. COLMAN. Provisions of the State laws vary very widely on that. I could furnish you with a memorandum of that if you wish, sir. There is a great variation. Without getting into three or four pages of tabular material I could not give it.

The CHAIRMAN. The cost of your service has been increasing all over the country, however. Is that not correct?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. I noticed in last night's edition of the Washington Evening Star, with regard to the Baltimore, Md., Blue Cross plan, the following statement:

The Blue Cross executive director yesterday termed unfounded charges the hospital insurance program is wasteful.

He says in this article:

We have all heard charges that some subscribers are abusing Blue Cross benefits, and that hospital services are being used excessively or uneconomically. Much of the comment on this subject, I believe, has been made recklessly, without foundation.

The story goes on to say that last year the Blue Cross plan in Maryland was given an increase of 13.9 percent, and now, this year, Blue Cross is asking for a further increase of 24.5 percent.

Are your rates increasing likewise in all 78 plans?

Mr. COLMAN. This question of rates is related to a series of factors other than hospital service, sir. It involves the question of the use made of hospitals. It involves the cost of hospitals, and it also involves the time period over which you are considering the increase.

One of the functions of the reserves which you mentioned earlier is to level out the fluctuations so that the time period over which you consider increases has to reflect the time period in which you were

dipping into reserves and the time period you want to project before dipping into them again.

This question of the rate at which these changes take place is a very complex one and it includes, also, the benefits provided and the changes made to bring the benefits comparable with current practices and hospitals.

All of those are involved in that change.

The CHAIRMAN. And does each Blue Cross plan set its own rate and do they vary from one State to another?

Mr. COLMAN. Yes, sir; they do.

Mr. REES. Why the discrepancy among the States in the cost and operation of the Blue Cross plan? Is it management?

Mr. COLMAN. No. The cost of operation are quite comparable, if you mean administrative costs.

For the past year the administrative costs of all Blue Cross plans in the country were 5.6 percent of the total income of the plans. It is 5.52 percent, the figure for the first 3 months of 1959; 5.84 percent was the figure for the year 1958.

Mr. REES. That is across the board?

Mr. COLMAN. Across the board for all.

Mr. REES. What would it be in Maryland? Maryland would be one of the higher ones?

Mr. COLMAN. No, Maryland is one of the lower ones, sir.

Mr. DAVIS. Where a person who is covered by these programs of Blue Cross and Blue Shield in one State, if he has an attack of illness while in another State, is he covered for the expenses to that State?

Mr. COLMAN. Yes, sir. We have developed a program of which we are very proud.

As the chairman has pointed out, these are local organizations responsible to local authorities, and yet the American populace, with its propensities for travel, is likely to get sick almost anywhere.

We have developed a program we call the Interplan Service Benefit Bank, whereby a subscriber in one Blue Cross plan who is cared for in the member hospitals of another Blue Cross plan, gets treated just as though he were a member of the plan where he is being cared for.

We have a leased wire service which clears these admissions overnight, and the whole thing is on a coordinated basis so that there is no break in the continuity of coverage provided these people, no matter where they are.

It is a coordinating job of which we are very proud.

Mr. DAVIS. To be a little more specific about it, if a member who is covered, for instance, here in the District of Columbia, should be traveling in Georgia and should have an attack of illness or some injury occur there which might necessitate surgical attention and hospitalization, he then would be covered by his Blue Cross plan?

Mr. COLMAN. Yes, sir. Even more specifically, under the proposal that is contemplated in this bill the benefits would be entirely uniform no matter where he was.

This bill requires us to go one step further than our standard program for people being cared for out of State and give entirely uniform benefits no matter where they are covered.

We have done that in several large employee groups—the steelworkers, autoworkers, and so on.

The CHAIRMAN. Would this apply if this employee were taken ill some place else and goes to a hospital not covered by a Blue Cross plan?

Mr. COLMAN. There are very few that are not, sir. In those cases we would provide an indemnity benefit.

The CHAIRMAN. You do that now?

Mr. COLMAN. Yes, sir.

Mr. LESINSKI. I was looking over the breakdown of the payments of individuals by locations. The gentleman from Michigan, Mr. Johansen, is from Battle Creek, and I am from Dearborn, Mich., and the figures are the same, \$16.70.

On the other hand, Dearborn and Detroit is a high wage area and expenses would be higher.

Pittsburgh is \$10.15 and I assume their wages are quite high there, too. Why the difference? It is \$6.50 difference.

Mr. CORBETT. If the gentleman would yield, according to these figures we have here, and according to my memory of what I pay in Pittsburgh, that \$10.20 figure is wrong.

Mr. LESINSKI. It depends on the plan. Mine is \$33 plus cents.

Mr. CORBETT. On these figures before you for July 15, 1959, it gives the average cost in Pittsburgh as 29.8 to 33.3 and not \$10.20.

Mr. LESINSKI. I am going by the first sheet.

Mr. CORBETT. Is the fact right?

Mr. COLMAN. Might I have a crack at this?

The CHAIRMAN. Yes.

Mr. COLMAN. I think I know the table that is being discussed. I think it is headed "The average subscription charges for the most widely held certificate." Is that the table?

Mr. LESINSKI. Blue Cross and Blue Shield rates. These are the rates.

Mr. PORTER. Give the witness a copy.

Mr. CORBETT. This deals with average increases. He has a rate figure of \$10.15 for a family plan.

Mr. LESINSKI. That is the increase, Mr. Corbett. I am talking about actual rates.

Mr. JOHANSEN. \$10.15 for Pittsburgh is the actual rate.

Mr. LESINSKI. You are talking about rates and I am talking about increases.

Mr. CORBETT. You were right the first time. My interruption was in error.

Mr. COLMAN. This table from which the gentlemen are commenting is headed "Combined Blue Cross/Blue Shield rates for most common plans." This should be headed "For the most commonly held coverages in these areas."

The types of benefits offered under the most commonly held and used certificate in the specific areas vary widely from one area to another, so these areawide differentials reflect two factors. They reflect the differential cost factor which you mentioned. I think you will find the average cost of Michigan hospitals is appreciably higher than the average cost of hospitals in Pittsburgh. That factor is in here.

The other factor is that the benefits being provided are substantially different under these various programs.

Mr. JOHANSEN. Would that fact with relation to Michigan derive in part, at least, from the fact that it was one of the pioneering States in this program and that because of a longer history and perhaps expanding types of benefits due to the experience with the program this might have been brought about?

Mr. COLMAN. The auto industry was one of the early large groups to interest itself in health benefits, and as a result they have broader benefits available than in most other areas.

Mr. LESINSKI. Would you say that facilities are more up to date and more modern and that is why they actually cost more? Does that have a bearing?

Mr. COLMAN. I wouldn't think there was a great differential there. Furthermore, that is a question which would be almost impossible to analyze because you would have to do it hospital by hospital.

Mr. LESINSKI. I appreciate that. On the other hand would you say that the income in the area has a bearing upon the type of insurance that the people buy?

Mr. COLMAN. The most direct bearing is on salary levels. About 65 percent of hospital expenses are for salaries, so that the key factor in hospital costs are the salary levels in the community in which the institution is operated.

The CHAIRMAN. Do you have an idea how many Federal employees now are covered by your plan?

Mr. COLMAN. About one million.

The CHAIRMAN. Nearly half of them?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. Do you have a Blue Cross plan covering U.S. employees who reside outside the United States and work for the Government?

Mr. COLMAN. No, sir, we do not.

The CHAIRMAN. Is there any plan covering them at the present time?

Mr. COLMAN. The only one that I know of is a program, an indemnity program developed in the State Department for the State Department overseas employees which we do not write.

We do have some overseas employees covered through establishments that have been enrolled in this country and have been transferred. Many of our subscribers are overseas at the present time and eligible for their nonparticipating hospital benefits which you mentioned earlier.

The CHAIRMAN. How would you propose to provide service benefits under your plan to Government employees living overseas?

Mr. COLMAN. We do not, sir.

As I pointed out in my testimony, it would be impossible and in many cases unwise to require that we negotiate service benefit agreements with hospitals and physicians all over the world.

When there are concentrations of employees in areas where this is practical and reasonable we will do it, but for the most part overseas employees will be given indemnity benefits.

The CHAIRMAN. I believe you estimate the cost of this legislation to be \$317 million. Is that correct?

Mr. COLMAN. That was the estimate we gave on S. 94. In my testimony the other day I accepted the estimate in the Senate committee report. I believe that is a valid first year estimate. That is \$304 million total.

The CHAIRMAN. The Civil Service Commission estimates the cost to be \$405 million. Is that correct?

Mr. COLMAN. I don't think they have made an estimate on S. 2162, have they, sir?

The CHAIRMAN. I don't know. I am asking you.

Mr. COLMAN. I don't think so, sir.

The CHAIRMAN. This bill provides the maximum rate that can be charged. Is that correct?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. If that rate does not bring in sufficient revenue, the benefits would have to be reduced?

Mr. COLMAN. That is right.

The CHAIRMAN. Do you approve of that plan?

Mr. COLMAN. There are two ways to approach this problem; three, I guess.

You could have the employers' contribution fixed and the employees' contribution variable. You could have the employees' contribution variable and the employers' contribution fixed.

You could have both fixed, and each of these presumably would be in relation to a stated set of benefits, the cost of which is likely to vary.

If you fix both of the contribution rates and you presume that you are going to have a stated set of benefits, the cost of which will vary, there will have to be continuing revision to bring those two into relationship with each other. I anticipate such revision.

With careful administration the adjustment of the contributions to the benefits through the years can be done in an orderly fashion that will not create a serious problem in the program.

The CHAIRMAN. Do you approve of the maximum that is in this bill?

Mr. COLMAN. Yes, sir. I think it is a realistic starting maximum in this bill.

The CHAIRMAN. You do not have any maximum in your various Blue Cross plans, do you?

Mr. COLMAN. Yes, in this sense—

The CHAIRMAN. Can you increase or decrease the contribution each year?

Mr. COLMAN. Only with the approval of the State insurance department.

The CHAIRMAN. That is what I mean.

Mr. COLMAN. That is right. Each time this is done it comes up for careful review and careful scrutiny, and the basis on which it is done is subject to the same kind of scrutiny you would have here.

The CHAIRMAN. There is no maximum contribution fixed on any of your plans?

Mr. COLMAN. Not in that sense. It is fixed by action of the State insurance department until they revise their action. We are not free to change any time we want to.

The CHAIRMAN. Who assisted you in making your computation in the cost of this legislation? I cannot understand the variance be-

tween you and the Civil Service Commission. You say the cost will be \$304 million and the Civil Service Commission says \$405 million. That is quite a variance.

Mr. COLMAN. The cost computations which we made were made with the assistance of our own staff and two consulting actuaries, and the basis on which they were made was stated in our testimony, the assumptions we made, and I think the same is true of the Civil Service Commission's estimate. To my knowledge the Commission is not yet on record with a statement of the cost of S. 2162. Presumably they will be when they testify. Our estimates on S. 94, I think, are a different issue from our estimates on S. 2162.

The CHAIRMAN. How much do you estimate you differ in the cost of the two bills?

Mr. COLMAN. We estimated \$313 million on S. 94 and we subscribed to the estimate in the Senate report of \$304 million on S. 2162.

The CHAIRMAN. That is a difference of \$9 million.

Mr. COLMAN. That is right, sir.

The CHAIRMAN. Section 5 of the Senate bill provides maximum hospitalization for 120 days but only 30 days for TB or mental disorders.

Do you think employees hospitalized for nervous disorders or TB should get less in the way of benefits than an employee suffering from a heart attack?

Mr. COLMAN. Yes, I do, because these are benefits being provided in short term general hospitals.

Most of the long-term care of mental disease and tuberculosis has, through the years, been given in State hospitals and is very largely supported by tax funds rather than by the payment of the individual patient.

The purpose of including that benefit is to insure that the subscribers, that the Federal employees participating under this program, will have available to them the emergency diagnostic and surgical care that might be necessary in connection with tuberculosis and mental disease but not to encourage a complete shift in the function of the two types of institutions, the State hospital system for TB and mental disease and the voluntary and general hospital system for acute illness.

The CHAIRMAN. I wish you would turn to section 5 (a) of the Senate passed bill which provides for hospital benefits being the equivalent of the full cost of hospital care in semiprivate accommodations in a general or acute special hospital.

What is meant by an acute special hospital?

Mr. COLMAN. That is, for example, an eye, ear, and nose hospital. It cares for acute illness but for only one category of disease.

The CHAIRMAN. Is your organization covering employees who are overseas, Federal employees?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. You do not cover them now, however?

Mr. COLMAN. Yes, but not on any organized program related only to them. We cover them when they enroll through the employing establishment and they are provided indemnity benefits.

The CHAIRMAN. How many overseas Federal employees do you think you have enrolled under your plan now?

Mr. COLMAN. I have no way of knowing, sir. I would suspect it was a substantial number but I have no way of knowing.

Their enrollment is either paid for through a group treasurer in an employing establishment in this country or else they have converted to a direct payment certificate and they are dealt with no longer as Federal employees but individuals on a direct payment basis. They are not identified separately as Federal employees.

In our last testimony you asked that I supply the committee with a marked copy of S. 94 with the changes we suggested. I have that here. If I may I would like to insert it in the record.

The CHAIRMAN. Very well. You may do so.

(The bill S. 94, with changes suggested by Mr. Colman, follows. The language to be omitted is enclosed in black brackets, new matter is printed in italic, language in which no change is proposed is shown in roman:)

[S. 94, 86th Cong., 1st sess.]

A BILL To provide for Government contribution toward personal health service benefits for civilian officers and employees in the United States service and their dependents, to authorize payroll deductions for participants, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Employees' Health [Insurance Act] Benefits of 1959".

SEC. 2. In view of the demonstrated values of prepaid health service to the well-being and efficiency of employees, and the widespread practice, on the part of large private employers, of participating with their employees in obtaining such benefits, the Congress enacts this Act in order that the Federal Government shall measure up to the standards now commonly set by private employers in this regard, by making available to Federal employees and their dependents the maximum financial protection against sickness costs, and the most comprehensive preventive, diagnostic and curative medical care, obtainable for practical financial outlays by employees and by the Government.

SEC. 3. As used in this Act—

(a) The term "United States" includes the Territories and possessions of the United States.

(b) The term "Commission" means the Civil Service Commission.

(c) The term "carrier" means a voluntary association, corporation, or partnership, or other organization which is lawfully engaged in providing, or paying for or reimbursing the cost of, personal health services under insurance policies or contracts, membership contracts, or the like, in consideration of premium payable to the carrier, including a health insurance plan duly sponsored or underwritten by a national association of Federal employees.

(d) The term "Advisory Council" means the Federal Employees' Health Benefits Advisory Council created by section [17] 16 of this Act.

(e) The term "dependent" means an employee's spouse; an unmarried child under the age of nineteen years, an unmarried child under the age of twenty-three years who is enrolled in a full-time course of study at an educational institution and who is in fact dependent on the employee for over one-half of his support, or an unmarried child who is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching the age of nineteen years and who is in fact dependent on the employee for over one-half of his support; or such other persons as are included in such terms by or pursuant to regulations prescribed by the Commission after consultation with the Advisory Council. The term "child" includes an adopted child or a stepchild.

(f) The term "head" in reference to an employing establishment means (1) the President with respect to the Executive Office of the President; (2) the Secretary of an executive department with respect to his department, and the highest administrative and policymaking officer or body of any other independent establishment in the executive branch with respect to such an establishment, except that in the case of any establishment governed by a board, commission, or other plural-member body, where the presiding officer of such body is by law designated as the chief executive and administrative officer of such body, he shall be deemed to be the head of such establishment for the purpose of this

Act; (3) the Administrative Officer of the United States Courts with respect to the judicial branch; (4) the Comptroller General of the United States with respect to the General Accounting Office; (5) the Librarian of Congress with respect to the Library of Congress; (6) the Public Printer with respect to the Government Printing Office; (7) the Architect of the Capitol with respect to the Office of the Architect of the Capitol; (8) with respect to officers and employees of the legislative branch not under the jurisdiction of any other aforementioned officers, the Speaker of the House of Representatives and the President of the Senate jointly, or such other officer or officers as may be specified by concurrent resolution of the Congress, or, with respect to officers or employees under the jurisdiction of either House, by resolution of such House; and (9) the Board of Commissioners of the District of Columbia with respect to the municipal government of the District of Columbia.

SEC. 4. (a) Except as provided in subsection (b) of this section, each appointive or elective officer or employee (hereinafter called "employee") in or under the executive, judicial, or legislative branch of the United States Government, including a Government-owned or controlled corporation (but not including any corporation under the supervision of the Farm Credit Administration, of which corporation any member of the board of directors is elected or appointed by private interests), and of the municipal government of the District of Columbia shall, if the official station of such employee is within the United States (including the Canal Zone) at such time and under such conditions of eligibility as the Commission may by regulation prescribe, come within the purview of this Act. Such regulations may provide for the exclusion of employees on the basis of the nature and type of employment or conditions pertaining thereto such as short-term appointments, seasonal or intermittent employment, and employment of like nature, and shall be issued only after consultation with the head of the department, agency or establishment, and with the Advisory Council: *Provided*, That no employee or group of employees shall be excluded solely on the basis of the hazardous nature of employment.

(b) This Act shall not apply to any individual by reason of his status or service as a "member" of a "uniformed service" as such terms are defined in the Career Compensation Act of 1949, as amended.

SEC. 5. The provisions of this Act for a Government contribution toward the cost of prepaid health benefits and for payroll deductions shall be applicable to any employee within the purview of the Act who elects, for himself or for himself and his dependents, to enroll (subject to the enrollment requirements of the applicable plan) in any one of the following plans approved by the Commission, after consultation with the Advisory Council:

(a) Plans for health benefits which are provided, to the maximum extent practicable, on a service basis (that is, a basis whereby [premium] payments by plans shall constitute full payment to the providers of the services stipulated in the contract, without additional charges by the providers) pursuant to [a contract] contracts entered into by or through the Commission in accordance with section [9-(a)]; 8 and the non-occupational group major medical expense benefits specified in section 8(c);

(b) Plans for [basic] health benefits on a cash indemnity basis (that is, a basis whereby the carrier agrees to pay certain stipulated sums of money, not to exceed the actual costs incurred, to the employee or dependent who incurs costs or charges under the conditions of the policy) pursuant to [a policy] policies purchased by the Commission in accordance with section 8 [9(a)]; and the non-occupational group major medical expense benefits specified in section 8(c);

(c) Plans of hospital, surgical, medical, or other personal health services (or any combination of such services) and the non-occupational group major medical expense benefits specified in section 8(c) duly sponsored or underwritten by a national association of Federal employees of which the employee is a member;

or

(d) Group practice prepayment plans, including the non-occupational group major medical expense benefits specified in section 8(c).

SEC. 6. (a) Each employee to whom this Act applies will be enrolled, for himself or for himself and his dependents, for the nonoccupational group major medical expense insurance for benefits provided in paragraph (c).

(b) The Commission, after consultation with the Advisory Council, is authorized, without regard to section 3709 of the Revised Statutes, as amended, to purchase from one or more insurance companies, as determined by it, a policy or policies of insurance to provide the nonoccupational group major medical

expense insurance benefits specified in this Act: *Provided*, That any such company must meet the following requirements: (1) Be licensed under the laws of thirty-six out of the forty-nine States of the United States and the District of Columbia to issue group health insurance; it shall be further required that the thirty-six States shall have at least 60 per centum of the population of the United States; and (2) its total group health insurance benefit payments incurred in the United States, excluding loss of income payments, during the most recent calendar year for which information is available to the Commission shall equal at least 1 per centum of all such payments incurred in the United States by all domestic companies during such year.

[(c) Nonoccupational group major medical expense insurance shall provide the following benefits for medical, surgical, and hospital expenses incurred in a calendar year by each individual covered by the policy:

[(1) 75 per centum of the amount by which the covered medical, surgical, and hospital expenses exceed the sum of any cash or service benefits provided to such covered individual for covered medical, surgical, and hospital expenses under any other policy or contract of insurance under this Act and the applicable medical expense deductible. The medical expenses deductible shall be as follows:

Annual Salary	Medical Expenses Deductible
Under \$6,000	\$100
\$6,000 through \$10,999	200
\$11,000 and over	300

[(d) The additional extended or major medical benefits offered under subsection (a) above shall not, however, duplicate, replace, or substitute for the basic benefits offered under section 9(c), nor shall any carrier curtail the scope or amount of the protection afforded by programs now in existence in consideration of the fact that extended or major medical benefits are to be made available to Federal employees.

[(e) The premium rates established under the major medical contract referred to in this section shall, with respect to classes of subscribers enrolled in the alternative plans of basic benefits provided for under section 5, take into account the scope of basic benefits provided by such plans.]

Sec. [7] 6. A written notice by an employee to whom this Act applies, to the head of his employing establishment, or by an annuitant to the Commission, on a form prescribed by the Commission, stating that he has enrolled or desires to enroll under a plan or policy of his choice under section 5 shall, subject to [the employee's] his right to withdraw such notice in accordance with the regulations of the Commission, be deemed to authorize deductions from the employee's pay in accordance with section 9 [10] (a) or from his annuity in accordance with section 12 (d). If a person [an employee] to whom this Act applies has a spouse [who is also an employee] to whom this Act also applies, either spouse (but not both) may file a notice of enrollment for self and dependents under this Act; or either spouse (or both) may enroll for himself or herself alone.

Sec. [8] 7. On each anniversary of his enrollment under section 7 of this Act, but not earlier, [7]. At intervals established by the Commission after consultation with the Advisory Council, each employee may exercise the right to transfer from one plan or policy offered under section 5 to another, subject to the enrollment requirements of the respective plans or policies [and] the regulations of the Commission and subject to the provisions of section 12. The exercise of this right shall require formal notice on a form prescribed by the Commission, which must be submitted to the head of the employing establishment [within a reasonable period] on dates reasonably in advance of its effective date, as determined by the Commission, prior to the anniversary date.]

Sec. [9] 8 (a) The Commission is authorized, without regard to section 3709 of the Revised Statutes, to enter into, or authorize enrollment under, a contract or contracts with qualified carriers offering plans described in section 5 and providing the benefits described in this section. [with one or more carriers which provide health benefits primarily through contracts or agreements with physicians or hospitals for the provision of prepaid basic health benefits to be furnished to the maximum extent practicable on a service basis; and to purchase from one or more carriers an insurance policy for the provision of such basic benefits on a cash indemnity basis.] Each such contract or policy shall be for a term of not to exceed one year, but may be made automatically renewable in the absence of notice of termination by either party.

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

(b) Subscription charges and premiums for benefits elected under section 5 shall reasonably and equitably reflect the cost of the benefits provided.

(c) **Basic benefits** Benefits, for the purpose of this section, shall consist of:

(1) Benefits which the Commission, after consultation with the Advisory Council, finds equivalent to the full cost of hospital care in semiprivate accommodations for one hundred and twenty days in any period of continuous hospitalization, or for one hundred and twenty days in the aggregate in any periods of hospitalization separated by ninety days or less;

(2) Benefits which the Commission, after consultation with the Advisory Council, finds to be reasonable and desirable with respect to medical and surgical services during such periods of hospitalization; and

(3) Such benefits with respect to services to hospital outpatients and other ambulatory patients as the Commission after consultation with the Advisory Council, finds to be reasonable and desirable, including diagnostic and treatment services, surgical services, and services in cases of accidental injury.

(4) *Nonoccupational group major medical expense benefits which shall provide the following benefits for medical, surgical, and hospital expenses incurred in a calendar year by each individual covered by the policy:*

(i) *75 per centum of the amount by which the covered medical, surgical, and hospital expenses exceed the sum of any cash or service benefits provided to such covered individual for covered medical, surgical, and hospital expenses under any other contract or policy of insurance under this Act and the applicable medical expense deductible. The medical expense deductible shall be as follows:*

Annual salary :	Medical expense deductible
Under \$6,000	\$100
\$6,000 through \$10,999	\$200
\$11,000 and over	\$300

The nonoccupational group major medical benefits offered hereunder shall not duplicate, replace, or substitute for the benefits offered under section 8(c) (1), 8(c) (2), and 8(c) (3).

(5) **The** All benefits referred to above may be subject to such exclusions as the Commission, after consultation with the Advisory Council, finds to be necessary and desirable to avoid duplication of services or benefits otherwise available or for other reasons.

SEC. **10** 9. (a) For each employee for whom there is in effect a notice of enrollment in a plan in accordance with section **7** 6 there shall be contributed by the Government an amount equal to (1) two-thirds of the premium or subscription charges for the plan selected **basic insurance coverage and the full cost of the extended or major medical insurance benefits,** or (2) an amount equal to \$2.50 biweekly for an employee or \$7 biweekly for an employee and his dependents (or corresponding amounts in the case of employees paid on other than a biweekly basis); whichever is the lesser. The remainder of such subscription charges or premiums shall be withheld from payments of salary to the employee.

(b) The sums contributed by the Government and the sums withheld from salaries under the foregoing subsection shall be paid by the heads of the respective establishments to the Health Benefits Fund established under section **10** **11**.

(c) Appropriations available to each of the employing establishments and to the Commission for salaries and expenses shall be available for necessary administrative expenses of carrying out the purposes of this Act. There are hereby authorized to be appropriated, to the employing establishments and to the Commission, such sums as may be required under this Act for expenses of administration.

SEC. **11** 10. There is hereby created a "Federal Employees' Health Benefits Fund," hereinafter referred to as the "Health Benefits Fund," from which all premium or subscription charge payments shall be made to such central agencies as may be established by the participating carriers, and approved by the Commission, after consultation with the Advisory Council, to facilitate the administration of this Act. The amounts withheld from the salaries of employees and the annuities of retired employees, and the amounts contributed by the Government toward the cost of health benefits for such employees, shall be paid into the Health Benefits Fund. The income derived from any dividends, premium rate credits or other refunds, or from interest earnings on amounts held in reserve shall be credited to and constitute a part of the Health Benefits

Fund. Any amounts remaining in such fund after all premium or subscription charges have been paid shall be retained as a special reserve for adverse fluctuations in future charges, or for the advance funding of the cost of [insurance coverage] *health benefits* for retired employees, or may be applied to reduce the premium or subscription cost of, or to increase the benefits provided by, the plan or plans from which such proceeds are derived, as the Commission, after consultation with the Advisory Council, shall from time to time determine.

SEC. [12] 11. (a) The Commission, after consultation with the Advisory Council, shall prescribe regulations fixing *reasonable* minimum standards for participating [prepaid health plans] *carriers*, and it shall not enter into any contract or purchase any policy under section [9] 8, or approve any plan for purposes of section[s 5 and 6] 5, which does not comply with such standards. Approval of such a plan shall not be withdrawn except after notice and opportunity for hearing to the carrier or carriers and to the employees concerned.

(b) No contract shall be made, policy purchased, or plan approved, which excludes employees because of race or sex or, at the time of the first opportunity to enroll, because of age.

(c) No contract shall be made, policy purchased, or plan approved which does not offer to employees, whose employment under the purview of this Act is terminated, the option to convert their health benefits coverage to an individual contract. The terminated employee who exercises this option shall pay the full cost of the individual contract, on such terms or conditions as [may be] *are prescribed by the carrier and approved by the Commission, after consultation with the Advisory Council.*

(d) The benefits and coverage made available pursuant to the provisions of this Act shall be noncancellable by the carrier as to any individual subscriber, except for fraud or nonpayment of premiums on the part of the subscriber.

SEC. [13] 12. (a) No contract shall be made or policy purchased under section [9] 8 which does not provide that, as long as the contract or policy is in effect, the stipulated benefits will be provided, *in accordance with this section, to retired employees and to the survivors of the deceased employees enrolled thereunder at the time of retirement or death [in accordance with this section].* The provisions of this section shall also be applicable to any other plan approved by the Commission [including any plan for extended or major medical benefits referred to in section 6].

(b) The benefits provided pursuant to this section [to retired employees] shall be available [under any plan to any] *to a retired employee and his dependents enrolled hereunder at the time of his retirement* who (1) is retired on an immediate annuity under the Civil Service Retirement Act or other retirement system for Government employees, (2) has made contributions to [an] *such approved plan either (A) for the entire three years [during the last year] of his creditable civilian service immediately preceding his retirement, or (B) during the entire period of his creditable service after December 31, 1959, until his retirement, and (3) elects to enroll for such benefits [, for himself or for himself and his dependents].*

(c) The benefits provided pursuant to this section [to survivors of deceased employees] shall be available [under any plan] to [any survivor] *the survivors of a deceased employee if (1) [the] a survivor is entitled to an immediate annuity under the Civil Service Retirement Act or other retirement system for Government employees, (2) the employee has contributed to [an] such approved plan either for the last year of creditable service immediately preceding his death or during all of his creditable service from December 31, 1959, until his death, and during such period the survivors (if then living) [was] were covered as [a] dependents of the employee, and (3) [the] a survivor elects to enroll for such benefits. Entitlement of a survivor under this subsection shall cease when he ceases to be entitled to an annuity under the Civil Service Retirement Act or other retirement system for Government employees.*

(d) The amount of subscription charge or premium to be paid by a retired employee or a survivor of a deceased employee under this section shall not exceed the amounts paid by active employees in the same region enrolled for the same health benefits; and the amount to be paid by the retired employee or the survivor shall be withheld from his annuity and paid into the Health Benefits Fund. The remainder of the cost of the benefits, and any amounts which may be allocated to finance such benefits in advance for employees to be retired in the future, shall be contributed by the Government to the Health Benefits Fund.

SEC. [14] 13. Any employee enrolled in a plan under this Act who is removed or suspended without pay and later reinstated or restored to duty on the ground that such removal or suspension was unjustified or unwarranted shall not be deprived of coverage or benefits for the interim but shall have his coverage restored to the same extent and effect as though such removal or suspension had not taken place, and equitable adjustments shall be made in premiums, subscription charges, contributions, and claims.

SEC. [15] 14. Each employee enrolled in accordance with this Act shall receive either a contract or certificate, as specified in the plan or policy, setting forth the services or benefits to which the employee, or the employee and his dependents, are entitled thereunder, to whom monetary benefits shall be payable, the procedure for submitting claims, and containing or summarizing the principal provisions of the policy or plan affecting the employee or the employee and his dependents.

SEC. [16] 15. The Commission is authorized to prescribe such regulations as it finds necessary, after consultation with the Advisory Council, for the administration of this Act, including regulations with respect to the manner in which employees shall give notice of enrollment under section [7] 6, regulations governing continued coverage during temporary absence without pay, and the conditions (relating to reasonable notice to the employees affected) under which a plan approved by the Commission may be withdrawn. Regulations, procedures, and forms relating to the fiscal and accounting aspects of the administration of this Act shall be subject to the approval of the Comptroller General.

SEC. [17] 16. There is hereby established a Federal Employees Health Benefits Advisory Council, to be appointed by the President and to consist of not more than fifteen persons, one of whom shall be designated to serve as Chairman of the Advisory Council. At least nine of the members of the Advisory Council shall consist of representatives of bona fide Federal employee associations, and shall serve without compensation, except for actual and necessary travel and subsistence expenses while so serving away from their places of residence. The other members of the Advisory Council, shall be persons experienced in the administration of prepaid health benefits or in the rendition of services under prepaid health benefit plans, and shall be compensated while serving on business of the Council, at such rate, not in excess of \$50 per day, as the Chairman of the Commission may determine, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence. It shall be the duty of the Advisory Council to review from time to time the operation and administration of this Act; to receive reports and information with respect thereto from employees and their representatives; to consult with and advise the Civil Service Commission, and when it deems necessary the employing establishments, in regard to the administration of this Act; and to make recommendations to the Commission with respect to the amendment of this Act or improvements in its administration. Each member of the Advisory Council shall hold office for three years; except that of the members first appointed, one-third shall hold office for one year and one-third for two years; and that a member appointed to fill a vacancy occurring prior to the expiration of a term shall hold office for the remainder of such term. The Council shall meet not less often than quarterly, on call of the Chairman of the Civil Service Commission or on request of any three members of the Council. The Commission shall provide the Council with the secretarial and clerical staff necessary and appropriate to the performance of its functions.

SEC. [18] 17. The Civil Service Commission shall make a continuing study of the operation and administration of this Act; including surveys and reports on health [insurance] benefit plans available to employees and on the experience of plans receiving contributions under this Act, with respect to such matters as gross and net cost, administrative cost, benefits, utilization of benefits, and the portion of the actual personal expenditures of Federal employees for health care which is being met by prepaid benefits. The Commission shall from time to time make reports to the Congress and to the Advisory Council, on the results of such studies, and recommendations with respect to the amendment of this Act. The Council shall make such reports and recommendations available generally to employees to whom this Act applies, and to carriers providing benefits under this Act.

SEC. [19] 18. The district courts of the United States shall have original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this Act.

SEC. [20] 19. This Act, including provisions for withholding and contributions, shall become effective on July 1, 1959, or to the extent so provided in regulations of the Commission, on the first day of the first pay period after that date.

The CHAIRMAN. Benefits offered by the various Blue Cross plans throughout the country differ considerably as to charges. Will employees get the same benefits under this bill regardless of where they are located or will they have to take benefits offered by the local plan?

Mr. COLMAN. The provisions of this bill requires that we offer a set of uniform benefits to the employees throughout the country.

Mr. REES. Uniform for everybody in every State?

Mr. COLMAN. Yes, sir.

Mr. REES. How would that affect the contributions? I notice in Lyon County, Kans., for example, family contribution now is \$9.80 while the contribution in this bill shows \$18.40. There is a difference there.

Mr. COLMAN. You are referring to the rate that is paid by the people in Lyon County for the benefit program that is most generally offered to the people in that community. I am sure that is not the only rate being paid in Lyon County for different sets of benefits offered in that community. The comparison of the rate has to be, as I pointed out earlier, related to benefits provided under the program and to the differential cost factor.

Mr. REES. They would pay \$9.80 under this bill. Under the proposed combined Blue Cross-Blue Shield rate program the total would be \$18.40—almost twice as much money, so when they pay their share they gain only about 60 cents.

Mr. COLMAN. As I pointed out earlier, I do not think the two figures are comparable because benefits to which they are entitled are entirely different.

Mr. REES. Are you going to have similar benefits across the country?

Mr. COLMAN. Yes, sir.

Mr. REES. They will all be alike?

Mr. COLMAN. Yes, sir.

Mr. REES. So the fellow who pays \$11.90 in Georgia will get the same benefits as a man paying \$16.87 in Battle Creek, Mich.?

Mr. COLMAN. I am not getting my point across to you.

Mr. REES. Battle Creek pays more than anybody else in this list.

Mr. COLMAN. This table, sir, is what individuals are paying in those communities for the type of program which is most generally accepted in those communities under Blue Cross. There are other Blue Cross subscribers in these communities paying different rates from these because they are getting larger benefits, different benefits, and there are others paying smaller amounts than these because they are getting fewer benefits.

Mr. REES. Battle Creek does get more benefits than they do in my county in Kansas.

Mr. COLMAN. Under the Blue Cross program most widely in effect in those two areas.

Mr. REES. When this bill becomes effective they will get the same benefits?

Mr. COLMAN. The table to which you are referring has no relationship to what will be provided under the bill. When this bill becomes

effective there will be a uniform program for all Federal employees and their rates of payment will be exactly the same.

Mr. REES. His benefits may be less and mine more?

Mr. COLMAN. His benefits will be the same.

Mr. REES. Less than they are now?

Mr. COLMAN. Oh, no. The program contemplated in this bill, I think in every instance, will be greater than the benefits that are routinely available under the most commonly held certificate in these areas.

Mr. CORBETT. Did not the gentleman testify in his last appearance that in all probability the program contemplated by this legislation would include more benefits than are included in most other programs?

Mr. COLMAN. Except for some of the large employer group programs I think this is a more liberal program than is routinely available to small groups.

Mr. REES. Will the benefits be similar and uniform?

Mr. COLMAN. I am talking about benefits.

Mr. REES. They will be uniform?

Mr. COLMAN. Yes, no matter where they are, and those uniform scales of benefits will be higher than the benefits that are routinely available to most small groups now.

Mr. FOLEY. If I understood Mr. Rees' reference, he said in his home community they are paying \$9 and some cents for a program now. The figure of \$18 and some cents was cited.

As I understand your testimony, the \$18, half of which would be paid by the Federal Government, would provide that particular family he is thinking of with a higher level of benefits than the family now is receiving on its own paying the \$9 and some cents. Is that it?

Mr. COLMAN. Exactly.

Mr. REES. We pay \$9.80 now.

Mr. FOLEY. Yes.

Mr. REES. Under the bill the family contribution will be \$18.40.

Mr. FOLEY. The family contribution would be one-half of that as I understand it.

Mr. REES. They would pay almost the same thing they are paying now.

Mr. FOLEY. The \$18 figure is the maximum total Federal and individual family contribution?

Mr. COLMAN. Yes.

Mr. FOLEY. It would be half of \$18 that the family would pay and the Government will pick up the tab for the rest.

Mr. JOHANSEN. As I understand it, it would be \$9.20 as the beneficiaries' portion as against \$9.80.

Mr. FOLEY. But the level of benefits would be much higher because the Government is paying the balance.

The CHAIRMAN. As you know, costs of hospital services have been increasing over the past several years. Do you look for a further increase in the next few years?

Mr. COLMAN. I would assume that.

The CHAIRMAN. In all services—medical, surgical, and general hospitalization?

Mr. COLMAN. I am most at home in the field of hospital care, and if I may I would like to restrict my comments to that. Perhaps Dr. Stubbs will want to talk about the other aspects of it.

As far as hospital care is concerned I would expect that for the next 2 or 3 years there will be some continuing increase in the cost of hospital care of the order of that which has been shown in recent years.

Mr. DAVIS. Why is that?

Mr. COLMAN. There is a series of factors which I referred to in my prepared statement.

The first factor is that I believe average salaries paid in hospitals will continue to increase. There seems to be nothing that would suggest that they would stay level. That factor alone represents approximately 65 percent of their total expenditures.

The services being provided in hospitals are constantly changing. I made reference to the question of open heart surgery. This is a very complex procedure that involves a team of people. It is being undertaken in more hospitals than ever before. A few years ago it was being done in only a handful of institutions. It is now much more general as more people are trained in it and compete in it. Operations last 6 hours, with sometimes a shift of surgical teams, highly skilled people tied up on one operation, so that the unit cost of hospital care begins to mount as you undertake these more involved and complex procedures.

The other question is the purchasing power of the dollar to which I referred.

Another is better accounting for capital charges.

In the late thirties the capital costs of hospitals were very largely met from philanthropic funds. A new building was almost always paid for by philanthropy.

This is less and less true and hospitals have begun to account for the capital charges that are involved in this.

Mr. PORTER. I would like to ask if the figures to which you are referring having to do with dollars, where you said 65 percent of the costs was due to salary increases, whether those figures can be broken down. Have there been studies made which would show what percentage of these salaries were administrative in the sense of executive and clerical, which were operational in the sense of semiprofessional, professional, menial, and so on?

I would like to have the facts wherever interpretations are available and look at them from the standpoint of control.

In some institutions costs can get out of hand. I think you have agreed to furnish information about salaries generally. I would like to have you enlarge on that if you can do it.

Mr. COLMAN. I can tell you offhand from my own knowledge that of the order of 90 percent of that cost is represented by housekeeping, maintenance, nursing personnel, things of that sort.

Mr. PORTER. I take it studies have been made which can be made available to the committee showing what these salaries are and breaking it down and interpreting it?

Mr. COLMAN. Yes.

Mr. PORTER. And showing specifically the executive salaries to see whether or not they would be out of line?

Mr. COLMAN. That is right.

Mr. PORTER. I assume the insurance commissioners look at these from time to time?

Mr. COLMAN. Not hospital salaries; no.

Mr. PORTER. But we will have those figures?

Mr. COLMAN. That is right.

Mr. PORTER. Are executive salaries looked at by insurance companies when the matter of rates comes up?

Mr. COLMAN. No.

Mr. PORTER. What controls are there on executive salaries?

Mr. COLMAN. For the most part these are voluntary nonprofit agencies responsible to a board of unsalaried persons who have no financial stake in their operation. Distinguished citizens in the community are involved who accept that responsibility and have it.

Mr. PORTER. We will get that information, however?

Mr. COLMAN. Not the executive salaries of hospitals, sir. I don't have it and I don't know whether I can get it.

Mr. PORTER. It does not exist so far as you know?

Mr. COLMAN. Not that I know of on any collective basis.

Mr. PORTER. On any individual basis, is there any information available of this kind?

Mr. COLMAN. Not that I know of, sir.

Mr. PORTER. I take it you know the salaries of your own organization.

Mr. COLMAN. Yes, sir.

Mr. PORTER. Could we have those?

Mr. COLMAN. Yes, sir. I would be glad to give you mine, if you want it.

Mr. PORTER. I want them in connection with the others. I see no reason to single out the gentleman, who apparently earns whatever he is getting.

Mr. COLMAN. At least this morning.

Mr. PORTER. I would like to go into the matter of competition, which we talked about briefly the other day. I understand there is a medical service group in New York, which Mr. Fino mentioned this morning, which does serve the New York employees and is an alternative to Blue Shield. Is that your understanding?

Mr. COLMAN. Yes, sir.

Mr. PORTER. What I am getting at is, why can we not change this portion of the act? What are the objections—I assume there are some because I assume the matter has been discussed—to one Government-wide service benefit plan? In this case and in others where competition exists, why can there not be an alternative for the Government to choose on a competitive basis?

Mr. COLMAN. A comment was made which I would like to pass on to you before I answer your question. I felt from the earlier comments about the New York State program that there might be some misunderstanding about that. The bulk of the employees in New York States are covered by Blue Cross and Blue Shield under the New York State program.

Mr. PORTER. Do they have a choice of this other one?

Mr. COLMAN. They have a choice of the group practice prepayment program which is provided for in this bill. That is the item 4.

Mr. PORTER. But do they have a choice between this organization whose name I do not remember, and yours and Blue Shield?

Mr. COLMAN. So far as I know, sir, they have exactly the same choice that would be available under this bill. They can choose the

Blue Cross or Blue Shield program, or they can choose the health insurance program of New York, which is a group practice prepayment program.

Mr. PORTER. I understand we are going to hear one of these gentlemen next Tuesday, so I shall not labor this matter right now, but it did seem to me that under a service benefit plan, alternative groups now exist which could bid, and I was wondering what objections there would be to that.

Mr. COLMAN. I think where we are having trouble, sir, is that we have service benefit plans and group practice prepayment plans mixed up together.

Mr. PORTER. It is nice of you to say "we." It must be just me.

Mr. COLMAN. No, because we are both in this together. I think the organization you are talking about in New York State is the Health Insurance Plan of Greater New York. It is a group practice prepayment plan, and presumably it would be one of the plans which would make an offer under section 4, subsection (4), on page 8 of this bill, as well as the Blue Cross-Blue Shield program which would be offered under section 4, subsection (1), on page 7 of the bill.

I think that is correct, sir.

Mr. PORTER. We do not need to speculate, because on Tuesday we will know.

Mr. JOHANSEN. Will the gentleman yield for a moment?

Mr. PORTER. Of course.

Mr. JOHANSEN. Do I understand the point of apparent uncertainty concerning the plan the gentleman from New York referred to in his testimony, and which I understand the gentleman from Oregon is referring to, is whether that is of the Blue Cross-Blue Shield variety or whether it is of a different category?

Mr. COLMAN. That is correct.

Mr. JOHANSEN. It seems to be the impression that it is of a different category.

If the gentleman will yield further, do we not come back to the question I asked on Tuesday, to wit, that if there is a Green Shield and Green Cross program, there is nothing in this legislation which prohibits the consideration in advance of the awarding of the contract any time it is up for consideration?

Mr. COLMAN. That is correct.

Mr. JOHANSEN. So the element of competition, if competition is available, is written into this legislation.

Mr. COLMAN. Yes.

Mr. JOHANSEN. Then what is the shouting about?

Mr. COLMAN. I do not know.

The CHAIRMAN. Is it true that you have the contracts with hospitals which you now use so tied up that no other competitive organization can come into the hospital? Is that true or not?

Mr. COLMAN. No, sir.

The CHAIRMAN. It is wide open now in all the hospitals?

Mr. COLMAN. The hospital can contract with anybody it wants to.

The CHAIRMAN. There is nothing in your contract which gives you exclusive rights?

Mr. COLMAN. Even if there were, I do not think it would be sustained in court.

Mr. JOHANSEN. That would be monopolistic, would it not?

Mr. COLMAN. Yes.

Mr. PORTER. A couple more questions, if I may, Mr. Colman.

On page 3 it says:

The term "member of family" means employee's or annuitant's spouse, unmarried child under the age of 19 years * * *.

I am interested to know if 19 is the usual age that is used.

Mr. COLMAN. Yes.

Mr. PORTER. That is normal among the plans?

Mr. COLMAN. Yes. In further reference to that, sir, there is a little discussion of that in the Senate committee report. The reasoning behind the choice of 19 was that at that age children either go to college or go to work, as a general rule. If you vacillate on that point, you begin to treat people who go to college differently from people who go to work. Nineteen is the age at which people usually graduate from high school, and it seems to be the most appropriate age.

Mr. PORTER. You define the term "dependent husband" but you do not say "dependent child." You just cut them off at 19.

Mr. COLMAN. That is true.

Mr. PORTER. On page 9 is a phrase that I wish you would interpret for me. It is used a couple of times in lines 14 to 16, and then in lines 21 to 23.

Persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes.

Does that mean an average or a mean, with incomes less than those of the one-quarter? Do you go down the line of all the incomes and then come down one-quarter, and right at that point it would have to be less? In other words, the three-quarters lowest? Is that what it is?

Mr. COLMAN. I would defer to people with more experience than I in interpreting legislative language, but it was my interpretation of that, sir, that you would go down the line until you came to that point.

I looked up some records as to where that would occur, and I believe it occurs somewhere between \$5,000 and \$6,000 annual income.

Mr. PORTER. In other words, this goes back to the so-called sliding scale that doctors sometimes use. If they see somebody in their office, sometimes they do not investigate and find out what he has, but if his suit looks like it and he looks like it, they charge him one fee. On the other hand, if he looks as if he could stand more, they charge him more. That is what this is?

Mr. COLMAN. This does not affect Blue Cross. This is primarily Blue Shield, the medical care benefit programs.

Perhaps Dr. Stubbs will want to comment on that in respect to the whole medical program.

Mr. PORTER. I would be glad to have light on it. It looks to me to be very much at large. I realize the Commission finds it, and it is just a guideline for them. I would be glad to have any more light on it.

The CHAIRMAN. You look for an increase in hospital and medical care expenses for how many years in the future? How far ahead can you predict?

Mr. COLMAN. During the next 3 years I see nothing which will change the trend appreciably.

The CHAIRMAN. Would you be willing to enter into a contract with the Government for the next 3 years at a fixed price?

Mr. COLMAN. We have, I think, a couple of States where we might have legal difficulties with that. Whether we could overcome that or not, I do not know. There are one or two States where I think the individual plans would want to have an annual contract. Whether we could provide a way around that for a national contract by having that proportionate liability picked up elsewhere, I am not prepared to state at the moment. I would strongly urge that in a program of this sort where the number of participants is a matter of their choice and not a matter of statistical determination, both the carriers and the Government would be well advised to enter into at least the first year's contract on an annual basis, and then take a good, careful look at it at the end of the year and decide then what you want to do about the term of the contract.

Mr. JOHANSEN. Right at this point, one of the areas of greatest concern to me is expressed in the individual views of two members of the other body in the report. I want to read those.

S. 2162 contains no provision which would clearly permit adequate prefunding for the purpose of avoiding frequent increases in subscription rates.

Continuously increasing utilization of health facilities plus the steady growth in the cost of these facilities will very soon cause the subscription charges under S. 2162 to rise. This is evidenced by the fact that plans with unlimited liability to pay for health services have had their reserves depleted and have been constantly plagued by price increases during the last few years.

To stave off frequent increases in contract rates, S. 2162 should explicitly provide for setting aside an adequate reserve. The reserve of 3 percent of 1 year's contributions plus income derived from any dividends, premium rate credits, or other refunds which S. 2162 relies on to provide the necessary reserve is totally inadequate for the purpose.

A health insurance program cannot subsist on a hand-to-mouth basis.

I realize that some of this may not be relevant to your type of program, but the problem of changes in rates or reductions of benefits and the problem of anticipating those deeply concerns me.

I wonder if you would care to comment on the whole statement I quoted.

Mr. COLMAN. Yes, sir.

It raises a very real issue to which I think the committee should address itself. The minute you start to provide for the establishment of prefunding of liabilities within the structure of Government, you are assuming the responsibility of estimating the amount of those liabilities. If your guesses are wrong, you will have to underwrite them.

Mr. JOHANSEN. You mean if the guesses are low.

Mr. COLMAN. That is right. If the guesses are high and, I strongly suspect, no matter what the guesses are, the amount of the reserve for really unpredictable, unknown future variations will be subject to continuing question and attack for every year that it sits there.

The notion of collecting payments from employees and from Government and setting them aside for a very indeterminate liability is something that I think the committee ought to give very careful consideration to.

Mr. JOHANSEN. We have had some very unhappy experience in that area.

Mr. COLMAN. That is right. Our strong urge was that in the long run the safest way to go at this was on a pay-as-you-go basis, and a good, careful look at it every year.

The CHAIRMAN. Should we not set up a reserve each year to provide against further increases in costs for hospital and medical care or reduction in benefits?

Mr. COLMAN. I think the negotiation of the contract and the period for which it is negotiated will have to take all of this into account, but the notion of setting up a specific reserve for a liability over a long period of time which is, to my mind, indeterminate, is a questionable approach to the problem.

Mr. JOHANSEN. May I pursue this suggestion? Do I understand you to suggest that there should be, at least at the outset, an annual review?

Mr. COLMAN. Yes.

Mr. JOHANSEN. Where would you perceive the responsibility would lie if at the time of the annual review it was determined that either premiums, both to the beneficiaries and to the Government, would have to be increased or benefits reduced? Could that decision possibly be administrative? Would it not be legislative?

Mr. COLMAN. If it was within the maximum limits of the bill, it could be administrative. If it exceeded the maximum limits of the bill, it would have to be legislative.

Mr. JOHANSEN. Is it your anticipation that frequently the problem would be of such scope that it would not be within the maximums and, therefore, would be a legislative decision?

Mr. COLMAN. The frequency with which that occurred would depend entirely on how closely you approached the maximums the first year. In other words, if the first year you negotiated the program it hit right on the nose of the maximums, and you used the \$304 million that it is estimated this will cost the first year—

The CHAIRMAN. Do not leave out the Civil Service Commission's estimate of \$405 million. Yours is not the only estimate on this cost.

Mr. COLMAN. Mr. Chairman, inasmuch as, to my knowledge, the Civil Service Commission has not made an estimate on this bill, whose terms are different from S. 94, I respectfully point out, sir, that that \$405 million referred to S. 94.

The CHAIRMAN. What do you estimate the cost of S. 94 to be?

Mr. COLMAN. \$313 million.

The CHAIRMAN. All right. What is the estimated cost of the bill as it passed the Senate?

Mr. COLMAN. \$304 million.

The CHAIRMAN. A difference of only \$9 million.

Mr. COLMAN. Yes, sir.

Mr. JOHANSEN. I am concerned about this thing on several scores. One, as I observed the other day—I do not think to this witness—I do not want the Federal Government or the Congress to be in the role of an Indian-giver, in the sense of seeming to grant something to the employees and then, due to factors beyond our control, the employees' control and the control of anyone else, either it shrinks or the employees have to pay more along with the Government.

I am concerned also about how frequently the Government may be faced with an unanticipated increased cost. I am concerned about

how frequently we may have opened the question of whether, by reason of these unanticipated increased costs, the Federal share ought to be increased so it will be absorbed. I am just wondering how perennial a problem this will be and whether your experience in terms of other groups casts any light on this.

Mr. COLMAN. There is nothing in the last 10 years' experience in the development of health services which suggests that this is not something which will have to be looked at periodically through the years. The question of whether you look at it every 3 years or every 1 year or every 5 years depends on the care with which you go into it in the first place.

From all that I know, I think after you get by the first hurdle and have some understanding of how many employees are going to take advantage of this program, from there on you can begin to develop an orderly approach to it. We have been able to do it with other large groups. The steel program is on a 3-year basis. It is not an easy problem, because the inherent factors in it are not easy, but it is not an impossible problem.

Mr. JOHANSEN. How does the problem which is reflected in the statement I quoted differ with respect to the other alternative types of coverage as against your type of coverage?

Mr. COLMAN. I think the factors are substantially the same as they affect group practice prepayment. They could be the same as they affect the indemnity benefit program. It would depend entirely on the terms in which the indemnity benefit program was written.

I do not pretend to know about all of the employee association programs, but most of those I do know about are written in such terms that this would not be a substantial factor as far as the employee association programs are concerned.

Mr. JOHANSEN. Why is that so?

Mr. COLMAN. Because I believe most of their programs are written in rather strict indemnity terms. The program discharges its responsibility by paying out so many dollars. The only thing that affects the fluctuation there is frequency of use. You do not have the question of changing costs involved in it.

Mr. JOHANSEN. I see.

Mr. FOLEY. Will the gentleman yield there for a question?

On the frequency of use, could we translate that into claims experience. When you say "frequency of use," are you not thinking in terms of the beneficiaries using the program?

Mr. COLMAN. That is right, and the types of services they use, too.

Mr. FOLEY. In connection with Mr. Johansen's question, does that factor of claims experience not run through all types or programs, yours as well as others?

Mr. COLMAN. Yes, sir.

Mr. FOLEY. So, considering a fixed-cost item, your forecast as to the claims experience could be wrong, and even with the \$18.40 maximum payment now, your estimate as to the claims experience for the level of benefits or benefit schedule you provide could be wrong, even at the end of 1 year, could it not?

Mr. COLMAN. That is correct.

Mr. FOLEY. If a 3-year contract were signed under that program, you would have to absorb out of your own extra reserves elsewhere for

the 3-year period if, in fact, you made a mistake in the forecast of claims. Is that not correct?

Mr. COLMAN. Yes, sir; but it is not the estimate of claims that bothers me. That one we can estimate pretty accurately.

Mr. FOLEY. From an actuarial standpoint?

Mr. COLMAN. Yes.

Mr. FOLEY. The actuarial prediction is fairly accurate. So the uncontrollable factor is the claims experience inherent in all programs, plus the other uncontrollable factor, namely, the rising cost of the services outside, doctors and hospitals.

Mr. COLMAN. Yes, sir.

I might make one other point on this. Even in the indemnity programs where indemnities do not create a problem over a short period of time, if there gets to be too much of a differential between the indemnities provided in the program and the actual expenses which people incur when they get sick, eventually you have to change the indemnity. So the factor is at work in all the programs if you really do the job of providing the services which are in general use.

Mr. JOHANSEN. Because they are getting a lesser service.

Mr. COLMAN. Yes.

The CHAIRMAN. Mr. HARMON.

Mr. HARMON. Mr. Colman, I have been covered by the Blue Cross and Blue Shield plan in Muncie, Ind. I believe my half of the premium under the family plan when I first had it was \$1.85 a month. I worked for General Motors Corp. at that time. I believe the literature indicated that after we had more members maybe the cost would not be that much; but it has increased every year. It was always said, "You get more benefits," but I always noted that you got a little more here but lost a little there in regard to the benefits.

Today, I think it says here, the premium is \$12.17. Half of that is \$6.08. I think mine today is more than that under General Motors. You mentioned the steelworkers, who have different coverage. I think they have medical payments under Blue Shield in theirs.

What I am getting at is this. This thing has grown tremendously in the years which have gone by. I have yet to see the first time that anyone has ever had to pay less. It always has been more.

You say that the hospital costs were 65 percent labor. Today in Muncie or anywhere else, they do not pay too much for labor in hospitals, even the skilled help, the nurses, and that type of personnel. I still would like to know why, since we have so many more people covered, the cost is so high. Have you an answer to that?

Mr. COLMAN. I will try.

When I first started in Blue Cross, the average salary to a graduate nurse was about \$85 a month. At the moment it is about \$300 a month.

Mr. HARMON. Not in the hospital in Muncie, but go ahead.

Mr. COLMAN. I bet it is \$275, is it not, for a graduate nurse?

Mr. HARMON. It is very poor. I will have to check on it to be sure, but I know the girls complain.

Mr. COLMAN. I am sure of that.

That is the range of variation that there has been since 1946 on that one item, to my personal knowledge.

On the question of Blue Cross charges, the first family rate that I know of was put in operation in Newark, N.J., in 1935 or 1936. It was \$2 a month per family. It stayed the same until well into the war. During that period some benefits were added at no change in the rate. It was not until the impact of the war economy that these changes began to move.

I think what we are looking at here is, in a very concentrated, magnified way, the net result of a whole series of changes which have taken place in the economy of this country. It operates in such a way that you see it in one indicator. It is just as much an economic indicator as the cost of living index or the gross national product or one of the other standard indicators.

Mr. HARMON. Last year, in August, I was in the hospital for 4 weeks. You could hardly find a registered graduate nurse in that hospital, and I suspect that is true all over the country. They may have 1 for 100 patients or 50 patients. Then they have a lot of free workers like the Red Cross Gray Ladies. Then they have nurse's aids and people like that.

Incidentally, due to the lack of nurses, I was given too much of a drug and almost died. I got five more grains than I should have gotten of a certain potent drug. Maybe somebody was trying to get rid of me, I do not know.

Anyway, I still cannot see why it costs so much.

Mr. COLMAN. It is no mystery to those of us who have lived with it. I do not know any way to understand it other than to be right in the middle of it and feel it. There certainly is no scandal involved in it. This does not come out anywhere. There have been all kinds of investigations and legislative inquiries and all sorts of things. You cannot find anything of that sort.

You find a group of relatively low-paid, dedicated people trying to do a job under very difficult circumstances.

Mr. HARMON. May I ask one more question. This is a nonprofit corporation?

Mr. COLMAN. Yes, sir.

Mr. HARMON. You do have a lot of real estate holdings, do you not?

Mr. COLMAN. Very few. A few of the plans own their own buildings in which they operate.

Mr. HARMON. Did not Blue Cross buy a big building in Chicago?

Mr. COLMAN. No, sir. They rent that.

Mr. HARMON. The whole building?

Mr. COLMAN. No; just the two floors they occupy.

Mr. HARMON. They have two floors?

Mr. COLMAN. Yes.

Mr. HARMON. Do you invest any of your money reserves and make it bring in more money?

Mr. COLMAN. We try to.

Mr. HARMON. That is all.

The CHAIRMAN. Would you be willing to enter into a contract under this bill for a period of 3 or 4 years at fixed costs?

Mr. COLMAN. I am not qualified to speak on that, sir. I would say that if the administering agency under the bill wanted a 3-year contract, which we have done in some national programs, we would

certainly do our best to deliver that kind of contract. I think that 3 years probably is as long as we would be qualified to consider it.

The CHAIRMAN. In a 3-year contract, you would anticipate the increased costs of hospitalization?

Mr. COLMAN. Yes, sir, we would try to.

The CHAIRMAN. What kind of reserve do you think should be set up under this plan, if it is approved and becomes law, to absorb rate increases for hospital and medical care for the next 5 years?

Mr. COLMAN. As I stated earlier, sir, the notion of setting up reserves within the structure of the health benefits fund as provided by this bill, I think has great hazards in it.

The CHAIRMAN. Why is that? I wish you would elaborate on that.

Mr. COLMAN. If you ask us to give you a contract over a period of time, we give you a contract, and if we are wrong that is our problem, and that is the end of it. If the attempt is made to set up the reserves within the structure of Government and any underestimate is made, I think then it becomes an added cost to Government and the liability comes back to you on the basis of appeal and need. You cannot quite make it so final and so terminal if it is done within the structure of the health benefits fund.

As I said earlier, the adequacy of that reserve, remembering that half of it is coming from employees, will be under constant question and attack, and I think it would be an uncomfortable thing for Government to try to administer. In a sense, it would be putting the executive branch of Government into the position of carrying an insurance responsibility under this act.

The CHAIRMAN. I think a reserve should be set up so contingencies in the way of increases for the next 3 to 5 years could be met. The Senate recommended a 3-percent reserve. You do not approve of that?

Mr. COLMAN. Yes, sir, I do. I think you do need a reserve of that order of magnitude, but I do not think that reserve alone will protect against all the contingencies which may be required during that period.

I think your major protection, sir, on this point, is to make sure that the initial entry into the program is as careful and as modest as possible, and that we do not try to spend all the maximum that is in the bill for the first year. I think that is the important consideration. I think it is for that reason that the bill wisely provides that the initial contract comes back to this committee for review.

The CHAIRMAN. What has been the increase in hospital care for the last 3 years, let us say?

Mr. COLMAN. That appears in table 3—3 percent, 3.5 percent, 7.3 percent.

The CHAIRMAN. Making a total of how much?

Mr. COLMAN. In those years, 13.8 percent.

Mr. REES. Do I understand that under this plan, surgical benefits would be uniform across the board?

Mr. COLMAN. Yes, sir. Mr. Rees, you are getting into the Blue Shield aspect of it, which Dr. Stubbs, I think, would be better qualified to testify on than I.

Mr. REES. I would like to nail that down. Your position is that surgical benefits will be alike everywhere?

Mr. COLMAN. Yes.

Mr. REES. They will cost the same everywhere?

Mr. COLMAN. Yes.

Mr. REES. I want to go back just briefly to take another State in this table we have talked about, entitled "Combined Blue Cross/Blue Shield Rates." We discussed Kansas a while ago. Let us go to another one. I will take Tennessee, where the charge per family is \$8.30. According to this statement, if this bill should go into effect, the family costs will be \$18.40 and the family will pay, not \$8.30, but \$9.40. In other words, they will pay more than they have before, even though they are expected to contribute half of the costs. What becomes of the rest of the money?

Mr. COLMAN. That is assuming, sir, that the Federal employees in Tennessee are enrolled under the most commonly held certificate in that area.

Mr. REES. I assume they are all the same certificate.

Mr. COLMAN. No, they are not. That is the point, sir. Those are all different benefits in those areas.

Mr. REES. In other words, what you are telling us is that a family will get more benefits under the new plan than they do now.

Mr. COLMAN. I think they will, yes.

Mr. REES. You have no way of knowing that, because the benefits are uniform, is that not correct?

Mr. COLMAN. The benefits are uniform under the new plan. They are not uniform under the programs they have now.

Mr. REES. All families are treated alike as far as benefits are concerned.

Mr. COLMAN. Yes, sir.

The CHAIRMAN. That is a quorum call. The committee will have to adjourn.

Tomorrow, Mrs. Granahan's subcommittee has a hearing which has been scheduled for the last couple of weeks, and we shall have to give way to Mrs. Granahan. The next hearing on this legislation will be next Tuesday. We hope to continue hearings throughout Tuesday, Wednesday, Thursday, and Friday, if we can, if no other special committees have hearings next week.

I shall ask Mr. Colman and Dr. Stubbs to return next Tuesday at 10 a.m.

The committee stands adjourned.

(Whereupon, at 12:05 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, August 4, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

TUESDAY, AUGUST 4, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will proceed with hearings on the Senate-passed bill on medical-hospital legislation and similar bills of the various House Members.

We will ask Mr. Colman of Blue Cross and the representative of Blue Shield to come to the table, please.

Dr. Stubbs, I believe, is the representative of Blue Shield, is that correct?

Dr. STUBBS. Yes, sir.

The CHAIRMAN. All right, Dr. Stubbs, we will be glad to hear from you. We have already heard from Mr. Colman.

Dr. STUBBS. Thank you, Mr. Chairman.

STATEMENT OF DR. DONALD STUBBS, CHAIRMAN OF THE BOARD, BLUE SHIELD MEDICAL CARE PLANS, ACCOMPANIED BY JOHN W. CASTALLUCCI, EXECUTIVE VICE PRESIDENT, AND EDWIN R. WERNER, MANAGER FOR NATIONAL ENROLLMENT

Dr. STUBBS. Mr. Chairman and members of the committee. I am Dr. Donald Stubbs, a private practitioner of medicine in the District of Columbia. However, I am appearing here today as the chairman of the board of directors of the National Association of Blue Shield Medical Care Plans. I am accompanied by Mr. John W. Castellucci, executive vice president, and Mr. Edwin R. Werner, manager for national enrollment, of our national association.

During the 3 years since my appearance in the spring of 1956 before this committee to discuss this subject, Blue Shield has grown by the addition of more than 7 million subscribers making a total of nearly one-fourth of all the people in the country. Each of these is covered for more services than before. One hundred and twenty thousand doctors are participating physicians in Blue Shield. More significant than this growth, however, is our enhanced ability to give service and our increased stature as the fiscal arm of the medical profession which is so important as the keystone in the stability of the entire voluntary health insurance system in this country. Although we have retained the advantages of local, nonprofit control of our

plans and deal at the grassroots with individual patients and their doctors who sponsor our plans, we now are able through such mechanisms as our national accounts agreement to offer uniformity of benefits very widely. For these reasons we believe that our experience and ability to help do the job under study by this committee should be made fully available to you and this we gladly do.

BLUE SHIELD SUPPORTS DEVELOPMENT OF LEGISLATION IN THIS FIELD

At their annual conference last April Blue Shield Medical Care Plans renewed their support of legislation which would lend assistance to the financing of health care benefits for Federal employees. The National Government is the largest employer which does not now provide some form of health benefits for its employees. This form of fringe benefit has become a condition of employment for a large segment of the population and in this respect the Government has fallen behind the times by not helping to provide for the better health care of its employees. Blue Shield plans—and Blue Cross plans are presently serving hundreds of thousands of Federal employees by providing them with a prepayment mechanism which, lacking a Government contribution, is being paid for out of the employee's own funds. We believe that these hundreds of thousands of Government employees who are now participating in these programs give clear testimony to the need for all Government employees to enjoy similar protection against the cost of ordinary or catastrophic illness expense.

BLUE SHIELD SUPPORTS FREE CHOICE OF QUALIFIED CARRIER

We believe that all qualified carriers should have an opportunity to offer coverage to Federal employees; and that Federal employees should have a free choice, subject only to the enrollment requirement of the carrier, to select the plan of coverage which seems best to fit his needs. We recognize that an individual employee may wish to obtain health benefits through a national association of Federal employees of which the employee is a member; or through group practice prepayment plans; or from an insurance company on a cash indemnity basis; or, as so many already have done, through plans for health benefits which are provided, to the maximum extent practicable, on a service basis.

In the final analysis all health care is at the individual patient-doctor level. Blue Shield has been able to preserve this freedom of choice and yet simplify administration so that a single national contract can now control uniformity of benefits at the local level.

BLUE SHIELD'S OUTSTANDING CHARACTERISTIC IS PHYSICIAN PARTICIPATION LEADING TO SERVICE BENEFITS

A prepayment program for health care benefits for Federal employees should be readily acceptable to the medical profession and to hospitals. The understanding and interest of those who provide health services to Federal employees is an extra dividend in health care benefits which is available to those who are members of Blue Shield plans. Blue Shield plans are organized and operated for the purpose of providing individuals with a method by which they can

budget and prepay medical-surgical expenses. Each plan is a non-profit organization. With the exception of necessary administrative expenses, all of the amounts paid to the plans by their members is used to pay for medical services given the members and to maintain a reasonable reserve. The participation of physicians in the organization and development of Blue Shield plans demonstrates their interest in helping the people obtain a prepayment mechanism for health care benefits, and they continue to have a corresponding interest and concern about the welfare of the people who are enrolled in Blue Shield. The objective of Blue Shield is to supply service-doctor care rather than health dollars—and this difference makes Blue Shield more than simple insurance. Service plans are those having agreements with doctors whereby the doctor agrees to accept a stipulated sum in full payment for his services in those instances where the member's income does not exceed a specified annual sum. For example, the plan's scheduled fee for an appendectomy may be \$120 and the surgeon will accept this as full payment in those cases where the income of the patient's family does not exceed \$6,000 per year. Of the 64 Blue Shield plans in the United States, 50 are service plans. In the areas where Federal employees live and work, 56.28 percent of Blue Shield plans guarantee that the payment made by Blue Shield to the physician will be payment in full for families with incomes of less than \$6,000 a year. And it is readily apparent that the pattern of service which does exist in Blue Shield is stabilizing in its influence on the indemnity area and the same is true for Blue Cross. While we recognize the value of such insurance mechanisms as deductibles and coinsurance in controlling unnecessary utilization, we know that such control is relative and often is much weaker than anticipated. On the other hand, the service benefits and their accompanying indemnity schedules for the remaining fraction of our program are much more effective cost controls because they are based upon agreement with the purveyors of the services themselves, both doctors and hospitals.

BLUE SHIELD HAS THE ABILITY TO SERVE IN THIS PROGRAM

The capacity of Blue Shield to provide a program of health care benefits with built-in cost controls based upon local fee schedule agreements with physicians, is expressed by the successful servicing of Blue Shield medical care prepayment programs for the more than 40 million Americans. Federal employees also deserve the opportunity to participate in a program which provides physicians' services for which the basic benefit costs are related to the economy of the community in which such costs originate, and in which such costs can be computed by reference to a fee schedule. The cost of medical care is of serious concern to the people of America, just as it must be for those who hope to alleviate it for Federal employees. Suitable legislation should reflect this concern to support, or at least not damage, the best elements in our already existent system of voluntary health insurance. Blue Shield is an expression of physician interest in relating existing costs in a given community to a prepayment program for medical expense which reflects local charges and is accepted as full payment in many cases. Fortunately, the Blue Shield reflection of local fees by local community practice can be incorporated into a program for na-

tional accounts such as the proposed Federal employee health benefit program. Blue Shield has the capacity and the mechanism for consolidating favorable medical care cost factors in all communities and offering a uniform package of physician services at a single rate.

It seems to us that the bills introduced by Mr. Morrison and others, as well as S. 2162, which has passed the Senate, incorporate the principles and objectives which Blue Shield has long supported and advocated. We are particularly gratified that these bills afford Federal employees a large degree of freedom to select the kind of plan that they deem most suitable for their needs. As was said in the report filed by the Senate Post Office and Civil Service Committee:

The Federal Government has a greater opportunity than other employers to influence soundly the development of health services and ways of financing their costs. This opportunity should be used to encourage all responsible and promising efforts and not be arbitrarily limited to any single approach. Reasonable competition among different types of programs will provide Federal employees with a better program. However, unrestricted competition could make the program administratively unwieldy and ineffective.

In this connection we suggest a clarification in the language of the bills before you which we think is desirable to effectuate the intent of the free choice principle.

Section 4(1) of S. 2162 provides that the Civil Service Commission may approve certain health benefit plans, including:

One governmentwide service benefit plan under which in whole or substantial part the physicians, hospitals, or other providers of covered health services agree, under certain conditions, to accept the payment provided by the plan as full payment for covered services rendered by them.

If the phrase "one governmentwide service benefit plan" means that the Commission cannot approve a service benefit plan unless there is one organization offering service benefits for every Federal employee everywhere, then the effect will be to eliminate service benefits from among the choices available to Federal employees. The reason for this is that full service is not available for all Federal employees for all of the health benefits provided under the bill. Some of the benefits will have to be supplied on an indemnity basis in combination with service benefits.

We are confident that it is not intended to deny Federal employees the advantages of service benefits to the very large extent that they are available simply because such benefits are not universally prevalent. Therefore, we suggest that section 4(1) be revised so as to make clear that Federal employees may be assured the opportunity to select Blue Cross and Blue Shield coverage under this bill just as approximately one million have already done on their own initiative.

Thank you, Mr. Chairman, for permitting us to be heard. We sincerely hope that our testimony will be helpful.

The CHAIRMAN. When was Blue Shield organized?

Dr. STUBBS. In 1939. It is about 20 years old.

The CHAIRMAN. You say you have 78 different branches or local organizations?

Dr. STUBBS. We have 64 in Blue Shield scattered over the country at the present time.

The CHAIRMAN. There are 78 in Blue Cross, I believe.

Dr. STUBBS. Yes, sir.

The CHAIRMAN. What is the difference between Blue Shield and Blue Cross?

Dr. STUBBS. In the development of these locally controlled programs hospital care was the first thing that was brought in and that was brought in under Blue Cross, which is an older program.

Blue Shield soon was added to the prepayment picture by the instance of local physicians, but it has generally been at a later date in each given locality.

In the beginning most of the Blue Shield plans were without dollar assets of any appreciable degree and so it was natural for them to rely on Blue Cross plans to administer the program that was supported by the local physicians.

And so it has come about that both of these programs, Blue Cross for providing hospital care and Blue Shield for physician services, have grown side by side, and in most instances in the beginning Blue Cross was the administering or business agency. As they grew larger there tended to be a separation of certain of their activities. Some of the Blue Shield plans are entirely separated from Blue Cross, but in general they work closely together and the administration frequently is in Blue Cross hands.

The CHAIRMAN. The organization is a nonprofit organization so far as individual benefits are concerned?

Dr. STUBBS. Yes, sir. It is provided in our bylaws and in the standards at the national association level, which must be met by local plans to join the association, that their boards operate without salary or without profit monetarily of any kind and that the plans themselves operate as nonprofit plans.

The CHAIRMAN. You do not have an overall plan for all your separate groups or organizations?

Dr. STUBBS. No, sir. In Blue Shield we grew up somewhat like you and I did in the South believing in local rights, and so our separate plans are associated at the national level for the exchange of information and for aiding one another but they are autonomous in their control.

The CHAIRMAN. Do you have a Blue Shield plan covering Federal employees who are overseas?

Dr. STUBBS. We have no specific coverage for Federal employees at all. They come into Blue Shield at this time—

The CHAIRMAN. Do you have Blue Shield plans operating overseas for the benefit of Federal employees?

Dr. STUBBS. There are many Federal employees who join their local plan in this country of their own volition and when they go overseas they retain their coverage. We have no plan overseas except in Hawaii, which is now the 50th State.

The CHAIRMAN. So you do not have a plan for Federal employees overseas unless they joined a plan in the United States; is that correct?

Dr. STUBBS. That is correct, yes, sir.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. GROSS.

Mr. GROSS. How do you provide benefits overseas?

Dr. STUBBS. On an indemnity basis. We pay our fee schedule allowance.

Mr. DAVIS. Mr. Chairman.

The CHAIRMAN. Mr. Davis.

Mr. DAVIS. Is the Blue Shield organization accumulating any assets, Dr. Stubbs?

Dr. STUBBS. We have a reserve that averages out to enough money to continue operations for three and a fraction months if our income were to stop. Those assets are kept liquid to a great extent. They are invested in a safe and prudent manner, usually under the regulations that are provided for insurance company investments generally.

Mr. DAVIS. Are those the only assets you are accumulating?

Dr. STUBBS. They are the only assets although in some instances the building in which the operation is carried on is owned by the Blue Shield or Blue Cross plan. Most of the plans rent their space.

The CHAIRMAN. How do you intend to provide benefits for Federal employees overseas if this legislation is approved?

Dr. STUBBS. We do not expect to provide service benefits overseas.

The CHAIRMAN. How would they be covered; do you know?

Dr. STUBBS. They would be covered by an indemnification to the extent of the fee schedule, and with that they would cover their medical care.

The CHAIRMAN. Section 5 (a) of the bill reads:

To the extent possible with the funds available under this act, the benefits to be provided under plans described in section 4 shall be the following: * * *

As I understand it, there is a maximum charge to be paid by the employee and matched by the Government. If the amount is not sufficient to cover all the benefits, then, as I understand the bill, the Civil Service Commission will have to lessen the benefits.

Dr. STUBBS. I believe they would have to make the benefits conform to the money available; yes, sir.

The CHAIRMAN. Section 5(a), subparagraph (1) (A), headed "Hospital Benefits," provides for 120 days' hospitalization for all employees except those with tuberculosis or mental disorders, and they are only given 30 days' hospitalization. Why should they not be given the same hospitalization benefits as other employees who are suffering other physical disabilities?

Dr. STUBBS. In most instances they have the possibility of obtaining care for those ailments in institutions especially designed to take care of them and under community funds at the present time. The provision in the bill and in most Blue Cross and Blue Shield programs is to take care of the acute care and to see that they are taken care of until long-term care can be arranged.

The CHAIRMAN. I wish you would turn to the Senate bill, section 5(a), subparagraph (1) (B), which is entitled "Surgical Benefits." It provides:

Benefits which the Commission finds to be equivalent to the reasonable, necessary, and customary charges for surgical services, and for care of abnormal deliveries, made to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes.

I believe the limitation is \$6,000 in the bill; is that correct?

Dr. STUBBS. That would figure out, we think, to close to \$6,000.

The CHAIRMAN. Just read that section about that salary limitation.

Dr. STUBBS. Shall I read it out loud?

The CHAIRMAN. Yes, sir.

Dr. STUBBS. It is on page 30 of my copy of the bill, section (B), "Surgical Benefits," and reads as follows:

Benefits which the Commission finds to be equivalent to the reasonable, necessary, and customary charges for surgical services, and for care of abnormal deliveries, made to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes.

The CHAIRMAN. How do you construe that provision?

Dr. STUBBS. That would mean that the Commission would set up provisions to provide a scope of benefits that are available under the funds available, and that these would be offered under this option as service benefits for approximately three-fourths of Federal employees.

The CHAIRMAN. That would mean that certain surgical benefits would not be available to Federal employees in the top fourth; would it not?

Dr. STUBBS. No. It would mean those in the upper fourth might have an additional charge. We would pay the same but it might not be the full bill. In the case of those who get it as a service benefit there would be no additional charge. That would be by contract. But if the employee made an income above that specified in the contract, then he might be subject to an additional charge by the physician rendering the service.

The CHAIRMAN. If the fee schedule for surgical benefits is charged, I suppose the lower income employees would have the full bill paid, but the higher income employees would be subject to having the physicians charge them more than the fee schedule?

Dr. STUBBS. Yes, sir. That is the way they operate now.

The CHAIRMAN. Do you suggest a system to check on where doctors charge a higher rate to Federal employees?

Dr. STUBBS. I do not know how you would do it. That would be an individual agreement between the patient and his physician and whether they chose to disclose it would be up to them, I should think.

The CHAIRMAN. Do each of your organizations in the field operate separately?

Dr. STUBBS. Each operates on its own, but we have overlapping activities through agreement to do certain things for people who travel into other areas.

The CHAIRMAN. What requirements do you have about setting up reserves or about your local groups setting up reserves?

Dr. STUBBS. We have a requirement that the local groups be financially able to meet their obligations, and we like to see them have a reserve that would enable them to operate as much as 3 months on the reserve alone if necessary.

The CHAIRMAN. You do not have a fixed percentage that must be set aside as a reserve?

Dr. STUBBS. It is not specified as a fixed one. If the local plan has an adequate reserve and maintains that, it does not have to add anything at all.

The CHAIRMAN. Has there been a trend toward an increase in surgical or medical costs over the last several years?

Dr. STUBBS. I believe there has been a trend toward increase in costs generally in the health care field. I believe that the data that are available indicate that the physician's side of these costs has

increased relatively less than the other costs. The Blue Shield increases have not been so noticeable as those in Blue Cross because of this factor, I think.

The increases that we have had in Blue Shield have more commonly been from increasing the amount of benefit, the number of things included, rather than from increasing fees to physicians. Changes in schedules of physician fees have tended to lag behind other changes in this field.

The CHAIRMAN. Do you look for increases in doctor and surgeon fees in the next 5 years?

Dr. STUBBS. Very little. I think that will depend on the changes in the economy, but in general the doctors are not changing their fees unreasonably in this respect.

We have had only two changes in the fee schedule here in Washington, where more Federal employees are affected than elsewhere, since 1947. At that time the fee schedule came into being as an estimated two-thirds of the going fee for individuals of average income, and it has been increased, as I said, two times since then; so that statistically the fee schedule at this moment for Federal employees earning less than \$6,000 a year is approximately what was estimated to be the going charge 12 years ago here in the District of Columbia.

So our fee schedules themselves have been subject to very reasonable modification, we think. An increase in subscription cost is due to the inclusion of many more benefits than we included earlier.

The CHAIRMAN. Do all your separate Blue Shield organizations have identical provisions about medical care?

Dr. STUBBS. They have overall standards of care which are required to be met, but as to the individual procedures that are covered in a local area and the fee schedule in that local area, each plan has its own arrangement.

The CHAIRMAN. I notice a list here of the rates charged by the combined Blue Shield and Blue Cross plans in various sections of the country, and I notice they vary from a low of about \$2.30 up to a high of \$6.33. In Hammond, La., the individual is charged \$2.30, and in Battle Creek, Mich., he is charged \$6.33. What about this wide variance in cost to the individual?

Dr. STUBBS. There is a variance in the services given to the individual and there is a variance in the cost of medical care in those localities as well. Since these plans cover varying amounts of services, their rates vary. It may be that a plan with a high rate covers a large proportion of the bills for medical care in its area and that the patients in that area have relatively little additional payment to make.

It may be that a plan with a low rate covers a low proportion of the bills for medical care and that the patients make up a greater proportion or share of the payment directly. We are not in position to compare accurately the value of these rates unless we also compare the percentage of the total care that they meet, and that is a very complicated matter and would require considerable study to compare only two plans. To compare all of the plans under that basis of comparison would be difficult and not profitable here because we are discussing a comprehensive type of program which would be evened out in the locality as to the benefits provided.

The CHAIRMAN. If this legislation is enacted and you make the contract with the Civil Service Commission, how would you provide service benefits to employees living in areas where your plan is not in operation?

Dr. STUBBS. We would not.

The CHAIRMAN. You would confine it to areas where you are now serving?

Dr. STUBBS. We would give service benefits wherever we could. We are now giving them in more than half the areas to the extent of the \$6,000 level. We would expect, in view of the way Blue Shield has grown in the last decade, that this area would increase in size. But for those areas where we do not have service benefit arrangements, as for the oversea employees, we would pay the indemnification required by the fee schedule, and if the doctor made additional charges it would be between him and the patient to make satisfactory arrangements.

The CHAIRMAN. I would like to know why higher paid Federal employees who pay the same rate as the lower paid Federal employees cannot get the same benefits.

Dr. STUBBS. They would get the same benefits moneywise required by the contract. It would be a question of the locality where the patient lived as to whether he would have to pay an additional sum.

At the present time Federal employees living in various parts of the country have to pay different amounts because of the locality in which they are living. That is beyond our control, as part of the varied cost of living.

Mr. PORTER. Will the chairman yield?

The CHAIRMAN. Mr. Porter.

Mr. PORTER. I am very much interested in this problem, and I would like to ask: Apparently Blue Shield pays on a sliding scale, charging so-called what the traffic will bear?

Dr. STUBBS. I do not like that definition of it.

Mr. PORTER. Is there a better one?

Dr. STUBBS. Yes, permitting those who are unable to pay a normal charge to have a lesser one so that there is variation in the charge. Those who can pay the regular charge do so.

Mr. PORTER. How is that done? Say a man gets \$7,000 a year. How is that fact determined? Is his income tax return turned over to the doctor?

Dr. STUBBS. That is between the patient and the doctor. That has been a method described as existing in American medical practice for generations. Blue Shield has not sought to change that but only to conform as well as we could to give the benefits as well as we could.

Mr. PORTER. I am asking how it can be justified, regardless of the fact it may have been in existence for generations. How can it be justified?

Dr. STUBBS. I think it can be justified on the basis that doctors have found over the years that many of their patients could not pay for the care they received at even a reasonable rate, and that therefore some have even paid more than they necessarily would have paid if everyone had been able to pay his full fee.

We believe that without much question there is a tendency to level out the fees in medical practice and that the very high fees are now

rare, few, and far between; that because prepaid mechanisms have brought many more of our people into areas of payment for their medical care, the necessity for this wide range of fee charges is not as great as it was. We may look forward to its being narrowed considerably more. But at this time it still does exist in some degree.

Mr. PORTER. What I am trying to get at is, how does a doctor who makes the charges, or his business agent, first of all how does he know whether the patient makes \$6,000 or more or less?

Dr. STUBBS. If he knows, he probably asks.

Mr. PORTER. Does he ask?

Dr. STUBBS. Doctors have been encouraged by their medical organizations to discuss fees with their patients and come to an arrangement about them. I believe the courts, in their attitudes on charges where they have gone into litigation, have encouraged those previous arrangements.

Mr. PORTER. Do doctors ask their patients how much they make?

Dr. STUBBS. I do not know what all doctors do. I myself discuss fees with patients.

Mr. PORTER. Do you discuss their income?

Dr. STUBBS. Rarely, because I do not like to go into the upper range of charges. I am more satisfied to put it on the evened out schedule basis.

Mr. PORTER. You think doctors can make a living doing that?

Dr. STUBBS. Yes, sir.

Mr. PORTER. May I say one other thing about income. If a patient has a service benefit type program with a specified income level below which service benefits exist, when the patient fills out his part of the claim form he indicates whether he is above or below income level in the space provided on the form. So that is specifically asked. I interpreted your question to mean does a doctor ask each and every patient, "How much do you make?"

Mr. PORTER. Mr. Chairman, I do not want to take up too much time.

The CHAIRMAN. Go right ahead.

Mr. PORTER. If the income of a patient makes a difference in the charge, it seems to me the doctor would have to know what his income is.

Dr. STUBBS. If the doctor knows he is above the \$6,000 level he may add a small charge.

Mr. PORTER. In other words, there are two rates, one below and one above?

Dr. STUBBS. There are at least two. Many Blue Shield plans have several different levels of schedules with a different qualifying income level for each.

Mr. PORTER. How do the hospitals deal with that?

Dr. STUBBS. The hospitals are dealing, for the most part, with known costs. Doctors' fees are like lawyers' fees. Also, the doctor can waive his charges completed, if he chooses to do so, much more readily than a hospital can. If a hospital waives a charge it has to find that amount of money from some other source in order to pay salaries to its working groups and pay for the drugs and so on. If a doctor has a consultation with a patient and gives advice, he can give his personal service free of charge, and there is not too much overhead involved in the procedure.

Mr. PORTER. Is it not true that doctors today are becoming less and less personal in their relationships with their patients, and they are using business agents—that is true in my area in Oregon, I know—and they are more impersonal today than when I was younger. Is that not true over the country?

Dr. STUBBS. It is possible that as the science of medicine advances that the personal relation suffers. It may be that the business side of medicine being cared for by agents gives the doctor a better chance to conduct his professional business.

The CHAIRMAN. What do you mean by business agents? You cannot advertise for business?

Dr. STUBBS. Collecting the bills.

The CHAIRMAN. And setting the fees?

Dr. STUBBS. They can do that better than most doctors. Doctors are generally known to be poor businessmen. For example, I would not like to charge any of you distinguished gentlemen for my services. I would rather do it out of love. A business agent would believe I should collect from you.

Mr. PORTER. The provision in the bill relating to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes, I understand that means about \$6,000, from what I am informed. But those earning over that amount would be charged whatever the doctor would decide should be charged according to these traditions that are somewhat hazy but well settled?

Dr. STUBBS. I believe so.

I believe it might be worth a moment's comment on that part of the program. Blue Shield is desirous of continuing to give service benefits as broadly as it can. The alternative to that is an indemnity dollar in which the patient gets the money and negotiates with the doctor at all levels of income. We think it is a good thing to furnish services instead of dollars, especially for the low-income group. We contend also that a fee schedule is good as a guide or yardstick. If the fee schedule permits a patient with a \$5,500 family income to get such and such care without additional charge, and then if that patient becomes a \$6,500 employee and gets a very notably higher bill from his doctor, he would have strong grounds for saying, "This seems out of line because I formerly got such and such care for such and such charge." So we believe it has a good effect. But we do not want the whole program. We want others also to be in there doing their best job.

Mr. PORTER. On a community basis is it not impossible to determine what a particular medical service is worth? The medical services in the case of one broken arm would be worth more or less than in another case of a broken arm so that it would wash out. Do you think that is impossible, to set that down?

Dr. STUBBS. I believe it is impossible when we have a complicated mixed up system of paying for the medical care such as we do now. At the present time some patients pay the whole bill themselves. Some get some insurance to help them pay the bill. Some others get a service benefit payment for the bill. Others pay nothing and it comes out of public assistance. It would be possible to add all of those together and come up with a fair community rate which would average out for everything, but until you had a mechanism for paying that

fair community rate in every instance, it becomes something that we might look toward approaching but which we have not reached.

Mr. PORTER. It may be something we cannot do anything about in this bill.

Mr. DAVIS. Mr. Chairman.

The CHAIRMAN. Mr. Davis.

Mr. DAVIS. Doctor, you mentioned that you did not want to monopolize all of this program but you wanted your share of it. I do not understand exactly what you mean by that. Could you explain that a little?

How can this program be divided up under this legislation between Blue Shield and possibly other organizations?

Dr. STUBBS. I think the provision of the law requiring the Civil Service Commission to consider four different prepayment groupings gives a competitive background to the whole program.

In saying Blue Shield would not like to have all of it, I merely meant we were paying full tribute to the idea of competition and of free enterprise, which we have always supported.

Mr. DAVIS. Where would the competition arise?

Dr. STUBBS. The competition will arise mainly in the choice that the Federal employee as an individual exercises in deciding what kind of program is best for him.

Mr. DAVIS. Do you anticipate that there will be four different plans available to the individual employee to choose from and he may select any one of the four?

Dr. STUBBS. In some localities there may be no more than two, but there may even be more than four. In the case of the Federal employee programs under organizations of Federal employees it will depend on the employee himself being in an organization that has a program as to whether he has one of these types of coverage.

Mr. DAVIS. Will you give us some illustrations?

Dr. STUBBS. Here in Washington, I am sure, there are a number of different employee programs available to certain individuals in the Federal Government. There is the Group Health Association program available to Federal employees and there would be the Blue Cross-Blue Shield program which is now already covering almost half of the Federal employees in this locality, and there would be the insurance industry programs of indemnification available. All of those would be available to Federal employees in the Washington area.

Mr. DAVIS. There would be two types of coverage, then, available to employees in Washington?

Dr. STUBBS. Four.

Mr. DAVIS. Four?

Dr. STUBBS. Yes, sir.

Mr. DAVIS. They have now the Blue Cross and Blue Shield coverage which you said about half of them now are in?

Dr. STUBBS. Yes, sir.

Mr. DAVIS. Then, they would have the insurance indemnification plan by which they would not get services but they would get some certain prescribed amounts?

Dr. STUBBS. Yes, sir; and those amounts might substantially cover the service.

Mr. DAVIS. Then, what other choice would they have?

Dr. STUBBS. Group Health Associations' group practice program.

Mr. DAVIS. What does that mean? I do not understand that.

Dr. STUBBS. This is a program that was established some 20 years ago, I believe, under the Home Loan Bank Corporation to furnish prepaid medical care by a group of physicians joined together in a clinic-type operation to furnish this care for Federal employees on a prepaid basis.

Mr. DAVIS. How does that differ from the Blue Shield?

Dr. STUBBS. It differs from Blue Shield in that it has a specified limited panel of physicians and it has a different range of benefits. The local Blue Shield program has as participating physicians about 2,300 doctors residing in this general locality and a patient may call any one of these doctors for any service in the schedule and the Blue Shield plan will pay the specified fee to him upon evidence that the service has been rendered.

In Blue Shields there is a free choice of physicians, a much broader choice, and a choice of any hospital or any type of care benefit that the patient wants.

Mr. DAVIS. You have told us about three possible exceptions. What is the other one?

Dr. STUBBS. The postal employees, for example, have a program, the details of which I am not familiar with, but it is a prepayment health benefit program sponsored by the postal employee group.

The CHAIRMAN. What organization did you say?

Dr. STUBBS. The postal employees, I believe, I would not like to be specific about a Federal employee group, because I am sure you have had and will have testimony on that point from the Federal employees.

Mr. DAVIS. I wanted to understand the four possible choices, and if I understand them, they are the Blue Cross, Blue Shield, the insurance indemnity and the group prepayment plan? Is that the fourth one?

Dr. STUBBS. The fourth group consists of the various types of prepayment programs, which I believe are commonly indemnifications, that are sponsored by employee union groups.

Mr. DAVIS. Thank you.

The CHAIRMAN. Mr. Rees?

Mr. REES. Are all of those covered under the Blue Shield plan or are they also covered by Blue Cross?

Dr. STUBBS. I do not know that absolutely all are, but very nearly 100 percent; yes, sir.

Mr. REES. And about what percentage of those under Blue Shield are covered by Blue Cross?

Dr. STUBBS. Just about all of them.

Mr. REES. What share of Blue Cross people are covered by Blue Shield?

Dr. STUBBS. About 90 percent.

Mr. REES. I notice in your testimony you make a statement about this fee business which was discussed a while ago, and you say there that you charge for an appendectomy operation \$120 if a man gets a salary of not over \$6,000 a year.

If his salary is more than that would you charge more than \$120?

Dr. STUBBS. It would depend on the surgeon doing it. It might or might not be more. It would be by agreement between the surgeon and the patient.

Mr. REES. Does a member of the Blue Shield know about this?

Dr. STUBBS. He knows whether the patient is above or below the income level.

Mr. REES. Does he have a policy that indicates the cost?

Dr. STUBBS. Yes, sir; all the physicians have information sent to them regularly. They have the fee schedule and all of that data. The patients themselves have information going to them regularly.

Mr. REES. And the patient knows about that?

Dr. STUBBS. Yes, sir.

Mr. REES. Of course, if the husband earns \$6,000 and the wife earns \$5,000, I suppose you take that into consideration?

Dr. STUBBS. Yes, sir. It is family income that determines the status of the contract.

Mr. GROSS. Will the gentleman yield?

Mr. REES. Yes, sir.

Mr. GROSS. In the case of a person having an appendectomy, suppose I had a ruptured appendix? How much arguing would I do over the fee in advance?

Dr. STUBBS. You seem like a very reasonable man. I would not suppose very much.

Mr. GROSS. Thank you, Doctor. But, I do not think I would be in any position to do much arguing over the fee, would I?

Dr. STUBBS. I think the discussion of fees in the last analysis is apt to be when you are feeling much better. I do not think the surgeon would argue over it while you were very sick.

Mr. GROSS. I would not want to argue with him before the operation.

Mr. CORBETT. I would like to raise the question as to whether or not in existing contracts there is a provision in there that Blue Cross or Blue Shield would not pay for any medical services rendered by a U.S. Government hospital, military or otherwise.

Dr. STUBBS. I think that the present regulations would vary on that point with the different plans, and under their different contracts, but in general it would be under the idea of providing a community service and a community rate by a locally controlled organization such as Blue Cross and Blue Shield, and the conservation of funds in the plan would dictate that if the Federal Government or any community agency were caring for this patient that the plan should not pay for it additionally.

Mr. CORBETT. All right, now. I think possibly—and I have not read your specific current plan, but one that I studied very recently had that provision.

I suppose there are tens of thousands of Federal employees who are veterans and some large percentage of those have service-connected disabilities and are therefore eligible to go to a veterans hospital. Now, presently, as that proviso is in your contract they cannot be indemnified or the services paid for in whole or in part?

Dr. STUBBS. I think that in general we would expect to pay if the service were rendered in a hospital where there was a charge, and if the patient were put into a Government hospital and were given the care,

we would not expect to pay the Government hospital. I believe that would be the position, but if this patient—

Mr. CORBETT. But there would be no charge to pay.

Dr. STUBBS. That is right; we would have no payment but if he went into a private hospital or a community hospital and there was a charge for the hospital care and for the physician's services, I would think that the provisions of the contract, as the Civil Service Commission will work them out, would be that this care would be covered exactly as in any other case.

Mr. CORBETT. Presently—and I am sorry I do not know the current figure because I am happy not to have been there recently—I think that at Bethesda a civilian employee eligible to go there, including Members of Congress, pays in the neighborhood of \$12 a day for hospital service and a room.

The CHAIRMAN. I think they pay more than that.

Mr. CORBETT. Well, as I said, I have been fortunate enough not to have paid anything recently.

The CHAIRMAN. My information is that it is about \$20 a day.

Mr. CORBETT. Suppose a Member of Congress gets in this plan and if this proviso is still there, Blue Cross could say "We are exempt from payment of any part of the \$20."

Dr. STUBBS. Mr. Farver here, from the Washington plan, tells me that they do pay that now, the cost in the hospital.

Mr. CORBETT. The reason I brought the matter up at this time was to simply emphasize that there is a point here for consideration because I think that the new plan that is being sold by the Secretary's Club—and I studied through it pretty definitely and that exemption is there. It is in that plan and it is something that ought not to be overlooked. That is my whole reason for bringing it up.

Dr. STUBBS. I am glad that you brought it up, and I would certainly expect that the Civil Service Commission would bear that point in mind in drafting its regulations, but we do pay that now under the local Blue Cross-Blue Shield program.

Mr. CORBETT. Thank you.

The CHAIRMAN. I do not presume you have very many service-connected, disabled veterans in your plans, do you, since they can get free surgical and hospital care?

Dr. STUBBS. I suppose we do not really know. If we get them in our own or in private hospitals or community hospitals, we do not inquire into that aspect of it, and their dependents, of course, would be covered by us under the family plans.

The CHAIRMAN. Let me ask you about setting up a reserve under this program: As you know, medical and hospital expenses have been increasing over the last several years. That is true; is it not?

Dr. STUBBS. Yes, sir.

The CHAIRMAN. Do you not look for a further increase in medical and surgical and hospital expenses in the next 5 years?

Dr. STUBBS. So far as we can tell, it is very apt to come.

The CHAIRMAN. What kind of reserve do you think the Civil Service Commission should set up now after this plan becomes operative in order to take care of these increases?

Dr. STUBBS. I would doubt whether the Civil Service Commission would be any better off to have a reserve large enough to take care

of significant increases years in advance than they would to have a reserve only large enough to take care of minor fluctuations in short-term programs. There would be the problem of management of the reserve and of determining its size ahead of time so that it would not seem to be too large, and that kind of thing. I would not feel myself competent to offer an intelligent assessment of this matter, except on one point: That it ought not to be too large but instead should be checked carefully at the end of a year, and adjusted.

The CHAIRMAN. Well, it appears to me, if the Commission does not set up some reserve in order to take care of these future increases in medical and hospital costs, that the only alternative left would be for the Commission to reduce the benefits to the employees; is that correct?

Dr. STUBBS. Unless the amount of money provided by the law were changed by the Congress; yes, sir.

Mr. DAVIS. Would the chairman yield to me at that point?

The CHAIRMAN. Yes, sir.

Mr. DAVIS. The answer to that would be, then, to increase the charge, would it not, so as to give an increased benefit? I mean to increase the contribution by the employee and the Federal Government?

Dr. STUBBS. That would be a mechanism by which it could be done. As I understand, the bill at this moment, it provides a fixed maximum for the contribution by Government and by the employee.

Mr. DAVIS. And, if experience shows that that is not a sufficient charge to furnish the desired benefits, you have a choice of two things: Either cut down the benefits or increase the charge; is that right?

Dr. STUBBS. That is quite correct. I think, again, it might be worth mentioning that this bill in itself will not control the cost of medical care to Federal employees. This bill will determine what proportion of those costs are being paid out of a prepayment mechanism. If we cut back benefits under the law, it does not mean that we are cutting back medical care of necessity, but that we are shifting more of the cost over onto the employee himself.

This latter change is a means of giving the employee a greater concern about his medical care.

Mr. DAVIS. I do not express myself accurately. I did not mean to cut down the service, but to cut down the benefits that would be paid for.

Dr. STUBBS. Quite correct. I wanted to emphasize that the problem is the overall cost of medical care, and the extent to which we expect to cover it by prepayment.

Mr. BROYHILL. Will the gentleman yield?

Mr. DAVIS. Yes, sir.

Mr. BROYHILL. With reference to the question asked by the chairman concerning the limitation for mental illnesses and tuberculosis, I think the answer that you gave—and also Mr. Colman last Thursday—was due to the fact that the States generally provide hospitalization for mental cases, and that would be limited in this plan.

Do you feel that that is a satisfactory answer, or satisfactory provision or limitation?

I ask the question because I see on the schedule here where a witness is going to be testifying in that respect, asking that the allow-

ances for mental illnesses be made the same as for the other illnesses, and I am wondering whether these State hospitals are of sufficient capacity to treat all these illnesses.

I know in Virginia we have difficulty getting people in there some-time. Some of our people have a psychological reaction to going into a State institution as such, and there might be a limited illness or minor illness that does not require severe treatment. I am wondering whether we are being fair by having that limitation on mental illness; whereas, if a person has a limited illness and did not want to go into a State institution whether we could make some provision to provide care for that person?

Dr. STUBBS. I believe it would be largely a matter of cost, plus the fact that at the present time the facilities in private institutions for acute care are very limited themselves for this special need.

Mr. BROYHILL. I notice in both respects—both State institutions and private institutions—

Dr. STUBBS. Unquestionably that limitation would be a factor in providing the service even if you provided the money to pay for it under this program, but it would affect the cost of this program very significantly.

Mr. BROYHILL. Then, that is the primary reason for it?

Dr. STUBBS. I would believe so; that, plus the question of overlapping and double payment. That—if the employees were entitled to it under another system and the funds presumably have been provided through a community, State or some other sort of arrangement—whether they are inadequate or not is not the question in this law, but if they are to be provided elsewhere and we provide them here also we are making double provision.

Mr. BROYHILL. And the cost would be substantial?

Dr. STUBBS. The cost would be substantially increased, I am sure.

The CHAIRMAN. How many different plans do you have throughout the country?

Dr. STUBBS. In Blue Shield we have 64.

The CHAIRMAN. And I presume that all of those 64 plans are not exactly uniform or similar in the way of benefits?

Dr. STUBBS. They vary enormously. Our largest plan has over 5 million employees. Our smallest has only about 10,000, but the smallest ones have the same rights of operating in an autonomous way as the largest.

The CHAIRMAN. Under this program all employees would receive the same benefits regardless of where they reside in the United States?

Dr. STUBBS. Yes, sir. We feel sure on the basis of our national accounts agreement, which was arranged at the Blue Shield national level, that through negotiations with these plans we can bring together the elements of similarity that exist among them and come up with a uniform range of benefits that will be paid for at the local rate of fee schedule. In addition, we can arrange a rate which is a single one applicable to all Federal employees if that is the desire of the Congress or the Civil Service Commission, in the interest of efficient operation.

Mr. DAVIS. Will the chairman yield?

The CHAIRMAN. Yes, sir.

Mr. DAVIS. What then determines the area or the jurisdiction of the individual plan? You say you have 64 of them throughout the coun-

try. What determines the area or the jurisdiction of each one of those?

Dr. STUBBS. Each plan is organized under the provisions of State law which vary widely. In most instances a plan will cover a statewide area, but there are some States such as West Virginia and your and my State of Georgia where the legal provisions make it possible for a single city to have a plan. So, there is a plan in Atlanta, one in Columbus and one in Savannah. There are nine plans, I believe, in West Virginia. Most of the plans, however, are statewide. The small plans tend to vary even more from the average or the norm than the large plans because often in a small community a single individual may feel that it is a move in a dedicated direction to set up a locally controlled, nonprofit plan and, as the plan executive, he may even carry the checks to the local hospital on foot in order to save postage if the need arises.

Mr. DAVIS. Thank you.

The CHAIRMAN. How often, and by what percentages, have your various plans throughout the country had to raise their subscription costs during the past 5 or 10 years?

Dr. STUBBS. We could give you a listing of the changes. I do not have it available today. I would say that the major factor involved in increasing rates in Blue Shield plans has been increasing the scope of benefits rather than changing fee schedules. Our costs have not increased notably on a fee schedule basis, but we have broadened them out to cover many things which 10 years ago we did not cover.

Mr. GROSS. Mr. Chairman, will you yield to me at that point?

The CHAIRMAN. Yes, sir.

Mr. GROSS. Doctor, I noticed in the papers a day or two ago articles to the effect that a fee is now being charged for a telephone conversation by certain doctors. Certain doctors are charging fees for telephone conversations not previously charged for. Is that something new?

The CHAIRMAN. Is that a prescription over the telephone?

Dr. STUBBS. I do not know how prevalent it is, and I do not know how new it is. I suppose some doctors have charged for such things and, perhaps, if they know the patient well and feel that that is the only control they have over abuse of telephone time, that they have to employ it. We do not have it in our fee schedule.

Mr. GROSS. According to these stories they are charging \$1 or \$2 per telephone call and in some cases, as the chairman suggested, they are charging for prescription telephone calls also to the drug stores.

Dr. STUBBS. I am sure the telephone charges are rare and, as I said, they are not in the Blue Shield fee schedule.

Mr. GROSS. I was going to ask that question. They are not in your schedule as of now; is that correct?

Dr. STUBBS. No, sir.

Mr. GROSS. How would they be covered then?

Dr. STUBBS. Well, we do not pretend to cover everything.

The CHAIRMAN. I would like to read you a letter from Mr. Harmon E. Monroe, the president of the Tennessee State Medical Association, Nashville, Tenn., addressed to me, as follows:

This letter is one primarily of information to advise you of a recent action of the Tennessee State Medical Association to try and solve some of the abuses involved in health insurance. This association has established a consultative

committee on administration of voluntary medical prepaid care plans, to study and recommend steps to be taken where abuses of health insurance occur, whether they be on the part of physicians, hospitals, the general public or others. It was felt by members of the committee that the Members of Congress should have this information to be informed of the willingness and efforts of organized medicine to take action in these controversial matters.

I am happy to state that the physicians of Tennessee are taking the lead to further protect the public and preserve the best type of medical care to our citizens. This is a step that not many State medical associations have taken. We believe that we are pioneering in a most important field. It was the thought of our committee that you would be glad to know that such steps are underway.

Assuring you of our continuing cooperation in matters pertaining to health—, and so forth.

Do you agree with this letter?

Dr. STUBBS. It is a fine letter, sir, and I am glad it came from your State. It is the measure of a trend that is developing in all our organized medical circles.

Two weeks ago I attended a meeting in Denver where a discussion was held as to the need for this kind of thing to be developed. Here in Washington, again, where so many Federal employees reside, there has been for years a grievance committee of the medical society which could receive complaints of the type mentioned.

The CHAIRMAN. I believe Mr. Wallhauser has a question.

Mr. WALLHAUSER. In your study of this legislation has your organization given consideration to the establishment of the Advisory Council which is in the bill and its composition, its duties and so forth?

Dr. STUBBS. We have discussed it some, sir.

Mr. WALLHAUSER. Is it your conclusion that it is fairly arrived at—its composition and duties?

Dr. STUBBS. It has a widely spread composition. I would feel that the need for an Advisory Council would be especially to act as a group offering through their own varied connections, the special advantages or any information or any studies or service that could be helpful in the administration of this program, and secondly, it could help maintain good public relations for this program if there were questions raised. For this latter reason, especially, it would seem desirable to have a committee of widely based personnel composed of (1) members who would represent purveyors of the services which could be very helpful in taking care of the technical aspects of the program, (2) those who are familiar with the prepayment mechanism would be helpful and, (3) certainly, it is good to have from the standpoint of the Federal Government itself, not only on the question of supervision but of maintaining interest, Members of Congress and members of the Government departments.

I believe that at the present moment there is no specific specification for a physician on the Council. One of our State groups has called attention to that fact. We feel that this is something which the committee can judge better than we can.

Mr. WALLHAUSER. It calls for a representative of the school of medicine. Of course, that does not necessarily mean that it must be a physician but it indicates that he would be.

Dr. STUBBS. Yes, sir; that is correct.

Mr. WALLHAUSER. And it also calls for the appointment of the Surgeon General and the Chief of the Bureau of Medicine and Surgery of the Veterans' Administration.

Dr. STUBBS. I had reference especially to a practicing physician, one in private practice.

Mr. WALLHAUSER. You feel that the Advisory Council will serve a very useful purpose even though it apparently does not have any specific authority or duty?

Dr. STUBBS. I am sure that in a democratic process such as the one under which this would operate, the mere matter of public information has a great influence on the operation.

Mr. WALLHAUSER. Thank you.

Mr. SCOTT. Mr. Chairman, I have a question at this point.

The CHAIRMAN. You may proceed.

Mr. SCOTT. Dr. Stubbs, did I understand you to testify in response to the question by Mr. Corbett that in case a Member of Congress or a veteran got into a Government hospital and a charge was made, a Blue Cross or Blue Shield policy would cover any charge that was made?

Dr. STUBBS. No, sir; I did not intend to say that, sir. My specific comment was that I had heard from Mr. Farver, sitting behind me, who is the representative of the local Blue Cross plan, that in the specific instance Mr. Corbett mentioned of going to the naval hospital and having a per diem charge, Blue Cross does pay it at this moment.

I said, secondly, I thought that this matter ought to be considered in the establishment of the regulations by the Civil Service Commission for this program, so that if the patient were cared for in private institutions, of course, he would be covered; and they might also consider the matter of paying a per diem rate of this kind.

Mr. SCOTT. Why would not Blue Cross and Blue Shield appropriately cover any charge that was made at any of these hospitals, whether it is a Government hospital or not?

Dr. STUBBS. Well, I think that this entire prepayment mechanism would be intended to operate outside the Government area and within the voluntary areas and that it would be purely a matter again of conserving funds. The Government hospital is established to do a certain job. If they have additional people to take in—civilians—for care, that is a somewhat unmeasurable cost to them, and they would have to provide it regardless. We would be doubling the payment.

Mr. SCOTT. Under the proposed legislation do you not think any plan should cover the people who find it necessary to go to a Government hospital and have to pay some part of the charge?

Dr. STUBBS. I think it would be difficult for us to make arrangements to do that unless the specification were carefully written into the regulations drawn by the Civil Service Commission.

Mr. SCOTT. Well, a Government employee or a veteran or a Member of Congress would have to be careful of what hospital he went to, would he not, if he holds a Blue Cross or Blue Shield policy?

Dr. STUBBS. I do not believe he has the opportunity to go into a Government hospital many places.

Mr. SCOTT. I know, but the policy does not cover all of the cost. What if your policy did not pay any part of the cost?

Dr. STUBBS. What of the policy?

Mr. SCOTT. What if the policy did not pay any part of the cost? What would be the use of his having it?

Dr. STUBBS. He can go to any of the community hospitals or any of the private hospitals wherever he chooses.

Mr. SCOTT. But if he happened to be a veteran and entitled to surgical benefits then he ought to be able to go to a veterans hospital.

Dr. STUBBS. I believe that question can and should be settled in the regulations.

Mr. SCOTT. I have in mind a Member of Congress who went out to Bethesda Naval Hospital and stayed out there for several months at a cost of \$21 a day. He held a Blue Cross-Blue Shield policy and after he got out, to his surprise he was not covered on any of the expenses or to any extent.

What do you propose to do about a situation like that? What do you think should be done?

Dr. STUBBS. I think it should be considered in the regulations and if it is desirable to write in and if the Government feels it is desirable to write in a provision of that kind it easily could be done.

Mr. SCOTT. If that Member of Congress had gone to a private hospital under his policy he would have been entitled to collect the benefit; would he not?

Dr. STUBBS. If he went within the range of his policy; yes, sir.

Mr. SCOTT. I simply cannot see the reason for that distinction.

The CHAIRMAN. I agree with the gentleman from North Carolina. You mean if a Member of Congress belongs to your association and pays his monthly contribution and goes to a Government hospital and has to pay \$21 a day for his hospital room, he is not covered by Blue Shield-Blue Cross?

Mr. SCOTT. That is right, and I have the policy here before me and a letter from the company.

The CHAIRMAN. That is a matter for Mr. Colman to answer.

Dr. STUBBS. It has been a long time since you have been on, Mr. Colman.

Mr. COLMAN. The provisions with regard to care in Government hospitals vary among the Blue Cross plans and vary among the contracts of the individual Blue Cross plans. It is a very complex question. The first thing to be clear about is whether we are talking about service-connected or non-service-connected disability, and the second thing to be clear about is whether this comes as a right to the individual under the Veterans' Administration program or whether it comes in some other fashion.

I support Dr. Stubbs' position that in connection with the benefits provided under this program it will have to have special study because it is a peculiarly acute problem to this group of employees and much more general and acute than it is in most of our other employee groups.

If any of you have looked through the regulations as to what benefits people are entitled to in the Government hospitals, it is not a simple problem. It is a very complex one, best dealt with in regulation. It can be equitably solved.

The benefits provided here should not cover benefits for care in Government hospitals to which the participant would otherwise be eligible without charge to him.

The CHAIRMAN. Doctor, they charged \$21 a day in this case.

Mr. COLMAN. I understand, sir, and I am saying what I think the regulations ought to be under this program. This issue is not covered in the bill and I do not think it should be settled in the bill because it is altogether too complex. You would have to add another chapter to the bill in order to cover it.

The CHAIRMAN. I am talking about your association. Why was not this Member covered, and why was he not entitled to payment on his hospital bill, leaving out the fact that he is a Member of Congress?

Mr. COLMAN. This would depend entirely on the provisions of his contract, and these vary. They vary in individual plans in the different contracts that they write and they vary among plans.

Mr. GROSS. Would the gentleman yield?

The CHAIRMAN. Yes, sir.

Mr. GROSS. Do you have a plan which provides for that kind of payment?

Mr. COLMAN. Yes, sir.

Dr. STUBBS. Mr. Chairman, if I may get back onto this question I was being questioned officially for the record, I would like to offer Mr. Scott to check into this case, because Mr. Farver reassured me during Mr. Colman's soliloquy here that the provisions of our current program here in Washington would require us to pay the naval hospital; and we would like very much, sir, if you would let us, to investigate it.

Mr. SCOTT. You say they would be required to pay it?

Dr. STUBBS. We would like to check your specific situation.

Mr. SCOTT. I will certainly be happy to give you that information.

Dr. STUBBS. We are most desirous of having the Members of Congress maintain their good health, even in Government facilities, sir.

The CHAIRMAN. Mr. Harmon is recognized.

Mr. HARMON. Doctor, I have been a member of this plan ever since it started—Blue Shield-Blue Cross—for my own protection and for my family, and I have been hospitalized at various times. The one thing that I would like to bring out here is that when we first went into Blue Cross and later into Blue Shield we had a schedule of payments for surgical work done. It was all very fine. Then I discovered—at that time I worked for General Motors, Delco Battery Division—that they had another schedule and it was not like mine. Then I discovered that the doctor had another one, and then I discovered that in Indianapolis they had another one.

Is there any explanation of this?

Dr. STUBBS. A very good one, sir, because all of these programs grew up in local communities according to the searching but sometimes fumbling efforts of individual people and small groups to develop plans. We did not all start at the same point and did not aim in the same direction because we did not know as much as we do now.

Mr. HARMON. I am talking about when you first sold the plan you were going to have so many benefits for this job, and you did not have them, when it came time to pay the bill. Here, for instance, is Joe and George and John, friends of mine, who thought they would be taken care of by the same doctor, but they have different payments and not only that, but some of them do not get anything. Why?

I think your organization needs a good investigation.

Dr. STUBBS. We are getting one right now.

Mr. HARMON. Well, I think you ought to have it. Another thing is this. I would like to ask why that recently in Indiana, in lieu of increasing premiums, you now only pay 75 percent? How do you do that? They said your costs went up. This is not the group plans. These are the individual plans for the poor, distressed people in my district that complain to me about your program.

The CHAIRMAN. Is that both groups or just one group, Mr. Harmon? Is it Blue Cross or Blue Shield? Does that apply to both?

Mr. HARMON. Yes, sir; and even that is true in hospitalization, but more so with the Blue Shield.

The doctor has a fee, but if he finds out you have Blue Cross, the fee is something else. If he finds out you have Aetna, it is higher, and if he finds out you make so much a week it is still a little higher. There ought to be happy medium somewhere.

Dr. STUBBS. I think we are better than we were when Chevrolets were selling for \$490.

Mr. HARMON. Why would that enter into it?

Dr. STUBBS. It illustrates that the cost of everything is raised.

Mr. HARMON. We did not have any insurance then.

The CHAIRMAN. Do you not think that there should be some competition in awarding these different plans?

Dr. STUBBS. I think there will be, sir.

The CHAIRMAN. It seems to me there should be considerable competition. In other words, I do not want to see anyone get a monopoly.

Dr. STUBBS. We do not, either.

Mr. HARMON. They have a monopoly right now.

Mr. SCOTT. Dr. Stubbs, to whom should we submit the information we have with respect to this case I mentioned?

Dr. STUBBS. If you have it there, sir, I will be glad to take it, or it can be addressed to Mr. F. P. Rawlins, president, Group Hospitalization, Transportation Building, Washington, D.C.

That is where you send your money.

Mr. SCOTT. I will confer with you right after the hearings.

The CHAIRMAN. I believe Mr. Porter has a question.

Mr. PORTER. I agree with you that this section 41 about one governmentwide benefit plan should probably be amended.

I wonder if you have a particular proposal to make in regard to the language so that it would include all of the possible competing organizations that might give service?

Dr. STUBBS. The one thing that we questioned was the phrase "on governmentwide program."

Mr. PORTER. Just say service benefit plans.

Dr. STUBBS. If the chairman would permit, we would like to submit a possible change of language for the consideration of the committee.

The CHAIRMAN. Yes; I would appreciate your doing so.

Mr. HARMON. I want to know why in Indiana you keep canceling my coverage.

Dr. STUBBS. I will try to find out.

Mr. HARMON. I want to know why I could not continue to carry that with the company I worked with when I am still on the payroll, and if I had an opportunity I would be back there working right now.

I want to know why you canceled it out without any notification to me. I just talked to my wife a couple of days ago, and that has happened, and my family does not have any coverage and neither do I.

Dr. STUBBS. I think they should be covered and we would be glad to look into it, sir.

Mr. HARMON. Will you please do that?

Dr. STUBBS. We certainly will. We are always glad to investigate questions of this kind.

Mr. HARMON. I am going to check into it when I go back home.

Dr. STUBBS. Since I am working without salary, I am delighted to do it.

Mr. HARMON. You and General Motors had better come up with an answer.

Mr. GROSS. Mr. Colman, with reference to the veterans' hospital case, you referred to service-connected disability.

Mr. COLMAN. Yes, sir.

Mr. GROSS. Is it not true that there are thousands of servicemen treated in veterans' hospitals on a non-service-connected disability basis?

Mr. COLMAN. Yes, sir. This is a right, as I understand it, that Congress has permitted to the veterans, and there is no charge made for that service to the patient.

Mr. GROSS. On the non-service-connected disability basis?

Mr. COLMAN. That is right.

Mr. GROSS. If this program is adopted, you would expect to have the heads of families of a large number of veterans in this program; would you not?

Mr. COLMAN. Yes, sir.

Mr. GROSS. But up to this point there is no provision in your plan for the payment of medical care at veterans' hospitals?

Mr. COLMAN. No, sir.

Mr. GROSS. Do you not think it ought to be given consideration?

Mr. COLMAN. No, sir.

Mr. GROSS. Why not?

Mr. COLMAN. Because if the Government is going to give that free care to all veterans, I do not think they ought to penalize the people who want to belong to a prepayment plan and make them pay for it.

Mr. GROSS. If they are going to pay into this plan why should not the veterans' hospitals be reimbursed?

Mr. COLMAN. It is perfectly all right, but it will raise the cost of the plan to the participants in this program inequitably and not against those who do not participate, but who are getting it free.

Mr. GROSS. Probably some of the people that you have insured in the past in your plans have been going to veterans' hospitals and, therefore, they have been paying for something that they have not been getting? Is that not true?

Mr. COLMAN. No, sir.

Mr. GROSS. You have not been reimbursing the veterans' hospitals for the treatment?

Mr. COLMAN. No, sir; and that all reflects itself in the rates that we charge.

Mr. PORTER. Will the gentleman yield?

Mr. GROSS. Yes.

Mr. PORTER. I understand that Dr. Stubbs received no salary but I assume there are people in the Blue Shield operation who do receive salaries for doing administrative work?

Dr. STUBBS. A few; yes, sir.

Mr. PORTER. Could you supply the committee with those salaries?

Dr. STUBBS. I can tell you that the national office of the Blue Shield is operating in its entirety, including all personnel and all other expenses, at a cost of less than 1 cent per year to each of the members of Blue Shield in all the plans.

Mr. PORTER. How many are there in Blue Shield?

Dr. STUBBS. 43 million.

Mr. PORTER. You mean somebody gets or could get 43 million cents?

Dr. STUBBS. If he can persuade all of the others in Blue Shield who work for Blue Shield to do it for nothing, he is entitled to that.

Mr. PORTER. We should not speculate about it. You do have those salaries, I assume?

Dr. STUBBS. I do not have the salaries myself in all or any of these things, but we can give you a range of salaries. I think it is fair to say that all of the evidence we do have in this area is that those in the health-care field in hospitalization and Blue Cross and Blue Shield are generally below what are thought to be comparable salary levels in industry and organizations of this type, because it is true that for those working in locally controlled nonprofit groups where all of the boards are required by regulation to be unsalaried and without remuneration, the atmosphere is one of dedication. Also we get in this outfit a lot whom some would call cranks who are willing to work for nothing, or at least no salary.

Mr. PORTER. Who sets the salaries?

Dr. STUBBS. They are set by the boards.

Mr. PORTER. By the doctors themselves?

Dr. STUBBS. No, sir; by the board of directors of the plans.

For example, take the local board here in Washington. The treasurer of it is Mr. Bruce Beard, nominated by the District Commissioners; and we have Mr. Philip Talbott, who is past president of the chamber of commerce; Mr. Robert McCann, the vice president of the Telephone Co.; Mr. Robert Holmes, who is the Personal Director for the Library of Congress; and Dr. Halsey Hunt, who is the head of the Aging Division of the National Institutes of Health. Men of that sort are public members of our board, and they have control of the fiscal policies of the medical service plan in the District of Columbia. It runs that way all through the Blue Shield program setup.

On the question of executive salaries, we are quite sure they are not a matter of question or consequence, but we would be very happy to try to give you some range on it. But, as I said earlier, every one of our plans is locally autonomous and they do not have to tell us anything beyond their own legal requirements of public recording except how much money they spend for operating a Blue Shield plan on the average. The national average is 10 percent of the income for operating costs.

The CHAIRMAN. What is the highest salary paid to any full-time employee?

Dr. STUBBS. I have no idea.

The CHAIRMAN. I would like to have that information.

Mr. PORTER. I would like to have that information specifically.

The CHAIRMAN. We would like to have the information on Mr. Colman's organization and also for your organization.

Dr. STUBBS. Yes, sir.

The CHAIRMAN. Mr. Colman, you will give us that information?

Mr. COLMAN. Yes, sir.

The CHAIRMAN. I understand you have pretty high-salaried employees in both groups.

Mr. COLMAN. Well, I am perfectly willing to defend them.

(The information with respect to Blue Shield, represented by Dr. Stubbs, follows. The information with respect to Blue Cross, represented by Mr. Colman, appears at p. 96.)

SALARY RANGES OF CHIEF EXECUTIVES OF BLUE SHIELD PLANS

Ten plans having over 1 million subscribers: Total subscription income, \$313 million; lowest salary, \$17,000; highest salary, \$33,000; average salary, \$25,773.

Thirteen plans having 500,000 to 1 million subscribers: Total subscription income, \$166 million; lowest salary, \$7,000; highest salary, \$27,500; average salary, \$18,250.

Seventeen plans having 200,000 to 500,000 subscribers: Total subscription income, \$110 million; lowest salary, \$7,125; highest salary, \$19,000; average salary, \$12,488.

Ten plans having 100,000 to 200,000 subscribers: Total subscription income, \$37,500,000; lowest salary, \$6,250; highest salary \$21,000; average salary, \$11,642.

Ten plans having less than 50,000 subscribers: Total subscription income, \$2,820,000; lowest salary, \$2,400; highest salary, \$6,426; average salary, \$4,320.

Mr. GROSS. I would like to pursue this veteran question a little further.

What about a lower premium for veterans, Mr. Colman?

Mr. COLMAN. If they want to use the veterans care facilities, they do not have to pay.

Mr. GROSS. Well, of course, we are speaking now of the head of a family who would come under this proposition.

Mr. COLMAN. Yes, sir.

Mr. GROSS. Without the head of of the family coming in, the family would not be covered; would it?

Mr. COLMAN. No, sir.

Mr. GROSS. Do you not think it is inequitable to charge a veteran the same rate?

Mr. COLMAN. No, sir; I do not. I think the inequity would be the other way. I think that if you were to provide that participants in prepayment programs who received care in veterans' hospitals would have the program pay for that care, you would be forcing that group of participants to pay for a benefit that the Government has offered to give free to anyone else, and you are imposing an added charge on the people who want to take care of their own for the care that is otherwise available to them.

Mr. GROSS. I do not follow that reasoning at all. If he has already paid, why should you not reimburse the hospital?

Mr. COLMAN. By paying for what, sir? He is paying for the care.

Mr. GROSS. For protection.

Mr. COLMAN. But not for care in veterans' hospitals, and you can add that in as a benefit if you want to.

Mr. GROSS. What difference does it make what hospital he goes to?

Mr. COLMAN. Provided it is not a veterans' hospital, if you want to add that in as a benefit it is going to increase the rates.

Mr. GROSS. He is supposed to have the benefit of hospitalization wherever he may be.

Mr. COLMAN. If you write in a proviso that the prepayment program will provide for payment to the Government for care rendered in veterans' hospitals, it will increase the total cost of the program substantially and every one is going to have to pay for it.

Mr. GROSS. They are already paying for it.

Mr. HARMON. Do you have in your contracts a specification that if you go to a certain hospital you will not be paid?

Mr. COLMAN. Yes, sir; as far as veterans' hospitals are concerned.

Mr. HARMON. Why do you do that?

Mr. COLMAN. For the reason I just outlined.

Mr. HARMON. Yes; but those people have to pay when they go to veterans' hospitals, as has been brought out.

Mr. COLMAN. No, sir.

The CHAIRMAN. Not a veterans' hospital?

Mr. COLMAN. Not a veterans' hospital; no, sir.

Mr. HARMON. How many crooks and racketeers have you had to send to the penitentiary in the last 20 years that have made off with some money?

Mr. COLMAN. Well, I am happy to answer that question. To my knowledge, none.

Mr. HARMON. Well, I happen to know a little differently that in these days when they are talking about racketeers in labor, I find there are more bankers in the penitentiary than there are members of labor in the penitentiary, but that is neither here nor there.

Mr. COLMAN. Well, sir, I was responsible for the Blue Cross plan in New Jersey for 2½ years, and in Maryland for 14 years, and in that time there was never a criminal suit or a civil suit against those two organizations.

Mr. HARMON. I would say that knowing people as I know people, you just have not caught up with them, because without a doubt there are some.

Mr. REES. I was going to ask the doctor this question.

According to a combined Blue Cross-Blue Shield rate schedule as of July 1—to go back to Georgia, because that was mentioned a while ago—the combined family cost is \$7.44. That is the figure I have before me.

Under this proposed legislation it is \$18.40.

Dr. STUBBS. That would be the maximum; yes, sir.

Mr. REES. So, the family in Georgia will pay \$9.20 or half of that instead of \$7.54.

Dr. STUBBS. They get much more benefits. It would take care of a much higher proportion of the cost of their medical care.

Mr. REES. I notice in Oregon that your total cost would be \$12.61, and again, it is more for a total family under the figure of \$18.40 in the bill.

Dr. STUBBS. It is a question of the amount of benefits that they would receive, and this bill would provide a broader coverage than is now available to Federal employees in nearly all the areas.

Mr. REES. What you are doing, really, is charging more in these more expensive areas?

Dr. STUBBS. That, and it also may be that they are getting more benefits. It may pay a larger proportion of the medical bill.

Mr. REES. Do you not think that a family in Pittsburgh, Pa., gets more benefits than one does in Emporia, Kans., because there is twice as much cost involved?

Dr. STUBBS. It is possible, and it is possible that it costs more for each unit of care in Pittsburgh.

Mr. HARMON. I would like to make one other comment. I expect I have been in the hospital more than the average person. I am 56 years old, and I expect I have been in the hospital more than anyone on the Hill. I have spent at least 5 years in hospitals, and I have never been sick. However, I have had many accidents, and I have been close to death several times. I have had quite a bit of experience with hospitals and hospitalization, and Blue Cross and Blue Shield and I have yet to see the time when I did not always have to pay.

The reason I am in such a poor financial condition today is because of these sicknesses. I have been trying, since I have been down here in the past several months, to pay my hospital bills and doctors' bills back home. However, that is neither here nor there, but I will say I know quite a bit about the procedure of Blue Cross and Blue Shield through the years, and believe me, there is plenty of room for improvement. I made that observation the other day. Since I first joined the plans I have gotten less and less and they always get more. It looks like, if you were going to get more people into it, they already say that you buy these coverages for protection and you hope you are not going to be sick and will not need to use it, but with the insurance companies and with the Blue Cross and Blue Shield there is no gamble with them.

That is all, Mr. Chairman.

The CHAIRMAN. Are there any further questions?

If not, we thank both Dr. Stubbs and Mr. Colman very much. We regret that we have had to keep you here so long, but we thank you for your cooperation.

Dr. STUBBS. Can I go back to practice, now?

The CHAIRMAN. Are you engaged in private practice?

Dr. STUBBS. Yes, sir.

The CHAIRMAN. I asked you probably more questions than in the past because I have never had any kind of medical insurance, or hospital insurance, in my life, and I know very little about the program. I always pay my own bills, and I have been in the hospital several times. However, I do believe in the principle that those who are able to pay should pay more than those who are unable to pay, so as to try to give lower and lower cost to the underpaid by charging more to those who are able to pay.

I have always believed in that. I believe that those who are in the higher brackets should pay more than those in the lower brackets, so as to equalize the cost.

Dr. STUBBS. Well, I am sure that is a medical philosophy that has been widespread over this country.

The CHAIRMAN. Thank you, sir.

Dr. STUBBS. Thank you, Mr. Chairman, and members of the committee.

The CHAIRMAN. Is Mr. Arthur H. Harlow, Jr., present? Are you the gentleman that wanted to be heard?

Mr. HARLOW. Yes, sir.

The CHAIRMAN. How long will it take you?

Mr. HARLOW. Ten minutes.

The CHAIRMAN. All right; go ahead. We will indulge you and try to finish with you this morning.

Mr. HARLOW. Thank you very much.

STATEMENT OF ARTHUR H. HARLOW, JR., PRESIDENT, GROUP HEALTH INSURANCE OF NEW YORK

Mr. HARLOW. My name is Arthur Harlow, and I am president of Group Health Insurance, Inc., of New York. Thank you for this opportunity to testify before you today.

First, I want to emphasize that I support this bill. It will bring to Federal employees advantages already enjoyed by a great many employees of private industry. You may remember also the publication a few years ago of a booklet by the National Association of Manufacturers which concluded that employer expenses of this kind more than pay for themselves—in the form of lowered absenteeism and improved morale.

My principal purpose in testifying is to suggest a change in the bill which would allow the Civil Service Commission to include group health insurance among the choices to be offered Federal employees in the New York area. I not only believe this should be noncontroversial, but also I hope that this committee will agree that it will improve the bill.

For this purpose, I would like to describe group health insurance briefly and give the committee some data about its operations.

GHI is the oldest nonprofit, medical care insurance organization in the northeastern part of the United States. It operates in the 18 southern counties of New York State, under the supervision of the New York State Insurance Department. No commissions are paid to agents, brokers, or employees.

The board of directors is divided equally between doctors and laymen. The latter include representatives of business management, organized labor, and the community at large.

The current volume of annual premiums in force is \$15 million. More than 550,000 people are insured through group enrollment. Among the union welfare funds whose members subscribe to GHI as the result of collective bargaining agreements are printers, machinists, office workers, painters, iron workers, teamsters, bakers, meatcutters and fur workers. Organizations which contract with us directly for coverage include the A. & P., American Iron and Steel Institute, American Tobacco, Bank of New York, Book of the Month Club, International Nickel, Macy's, Newsweek magazine, Helena Rubenstein, and Sullivan & Cromwell.

Our largest group of subscribers—and most relevant to this hearing—consists of approximately 50,000 civil service employees and dependents of the State of New York and local subdivisions in our area

of operation. The State program was launched through a bipartisan commission when Mr. Harriman was Governor of the State. Now Mr. Rockefeller has included in his letter to employees a quote from the Department of Health, Education, and Welfare that it is "the most liberal and comprehensive program enacted by a government body to provide its employees with protection against medical costs." So it is certainly nonpartisan.

The State program offers employees three choices of medical care plans, each the best of its kind. Blue Cross hospitalization goes with each. The first plan for doctor services is like the plan provided for in paragraph 1 of section 4 of the proposed bill; the second is the Health Insurance Plan of Greater New York, which fits into paragraph 4 of section 4; and the third is our GHI family doctor plan, which would not be eligible for inclusion in the Federal program under the bill as drawn. Almost 40 percent of eligible New York State employees chose GHI at the time of the first enrollment in December 1957. Now the program is being reopened to those who did not choose to be covered in 1957 and to allow others to switch from one plan to another if they care to do so. Final figures are not yet available, but the indications are that of those who are enrolling for the first time—with the advantage of knowing the experience of their co-workers during the last year and a half—between 80 percent and 90 percent are choosing GHI. Of those who are switching, about two-thirds seem to be coming to GHI. It is interesting, I think, that an analysis of the choices made in 1957 shows that workers in the lower income brackets and particularly those with larger families chose GHI.

Plans of insurance offered by GHI range in comprehensiveness from coverage only of surgery to the family doctor plan which provides benefits, in addition to payments for in-hospital care, for an unlimited number of home and office calls for general care, for out-of-hospital diagnostic X-ray and laboratory tests, specialist consultations, and such preventive services as annual physical examinations, well-baby care and immunizations. In addition, there are riders to cover anesthesia and private duty nursing and drugs.

Medical care insurance offers two great advantages. First, it helps its subscribers to meet their doctor bills. Second, by removing the financial barrier between patient and doctor, it encourages the prompt diagnosis and early treatment which are essential to the best of modern medical care. That is why this coverage by our family doctor plan of general care for minor illnesses in the home and office is so important.

All these benefits are provided on a free-choice-of-doctor basis. A subscriber may choose any doctor anywhere in the world and receive benefits from GHI. It is a "service benefit" plan in that 11,000 doctors in the New York area agree to accept GHI payments as their full fees in medical or surgical cases in a hospital if the patient applies for and uses semi-private accommodations—regardless of his income. In addition, 5,000 of these doctors—general practitioners whom we call participating family doctors—agree to accept GHI payments as their full fees for out-of-hospital care—for home and office calls and X-ray and laboratory tests, as well as for maternity care—also regardless of income.

It is worth stressing that service benefits represent the most effective way we have of controlling medical costs. GHI has not increased its surgical schedule since 1950 or its payments for home and office calls since 1955. Of course, no organization can stand alone against the tide of inflation, but I do think this is an important indication of stability.

GHI is the broadest, free-choice-of-doctor, service benefit plan in the United States. Like previous witnesses, I cannot detail too precisely at this stage just what benefits we can offer to Federal employees under this program. We must know more about the distribution of costs and certain other details which are to be worked out by the Civil Service Commission. However, I can assure you that within the costs established in this bill, GHI can provide a plan that offers a great many more benefits than those set forth as minimum standards.

I told you that GHI is the oldest plan in its area, but we feel we are still pioneering. The proper function of a nonprofit organization in this field is, we believe, to continue to seek ways of making medical care insurance more useful to its community.

Recently, we launched a "sister" corporation—Group Health Dental Insurance—which was the first nonprofit, communitywide, service-benefit dental insurance plan in the United States. And just this year—with the aid of a grant from the National Institute of Mental Health—we have undertaken a research project to investigate the insurability of short-term psychiatric treatments.

I believe that GHI offers the kind of insurance the Federal Government wants to give its employees a chance to choose. Civil servants in New York State like it and choose it when they have the chance. The bill as drawn, however, limits choices for Federal employees to one governmentwide service benefit plan, one governmentwide indemnity benefit plan, employee organization plans, and local group practice prepayment plans. It thus leaves out GHI in New York, which is not a group practice plan. While its range of benefits is just as broad, it offers its subscribers free choice of doctor.

I would like to stress that the inclusion of GHI would mean no increase in cost to the Federal Government. It would merely enrich the program for Federal employees in the New York area. I ask, therefore, that the bill be amended to make this possible.

Mr. Chairman, I have attached to the copies of my statement—which I believe have been distributed to members of the committee—some folders giving more information about our organization and about the New York civil service employees plan. I do not wish to burden your record with an undue amount of data, but I thought that the committee members might like to look at these folders—and, of course, we will be glad to have all or any part of them printed in the record if you see fit.

I wish to thank the committee again for this opportunity to testify and I would be glad to answer any questions.

The CHAIRMAN. Where does the bill restrict hospitalization to just one governmentwide service benefit plan? What section of the bill is that?

Mr. HARLOW. There are four types of plans in the bill. One is a governmentwide service benefit plan, one a governmentwide indemnity benefit plan, and there are the organization employee plans, and finally the local group practice plans.

The CHAIRMAN. Why can you not qualify under the bill?

Mr. HARLOW. Because we are not a group practice plan.

Group practice plans require that you go to a group of doctors operating from some local, common office. We do not make any such requirement. We are a free choice plan. We pay benefits anywhere in the world.

The CHAIRMAN. Under this bill you could not make any kind of a bid to the Civil Service Commission?

Mr. HARLOW. The Civil Service Commission would not consider us and we would like the chance, if our plan is as good as we hope it is, to let them include us in the bill.

How old is your organization?

Mr. HARLOW. We celebrated our 20th anniversary last year.

The CHAIRMAN. How many members do you have?

Mr. HARLOW. About 560,000 people.

The CHAIRMAN. I do not understand why you should not be allowed to come under the bill.

Mr. WALLHAUSER. Does the gentleman have any language he could suggest?

Mr. HARLOW. I have a draft. I think it could be done in a couple of ways, but I would be glad to submit suggestions.

The CHAIRMAN. I wish that you would.

Mr. WALLHAUSER. We accept that.

(The material referred to follows:)

PROPOSED AMENDMENT TO S. 2162

At the end of section 4, add the following new paragraph:

"(5) LOCAL OR AREA SERVICE BENEFIT PLANS.—Service benefit plans, serving a particular locality or area, which allow subscribers a free choice of physician and under which in whole or substantial part the physicians, hospitals or other providers of covered health services agree, under certain conditions, to accept the payment provided by the plan as full payment for covered services rendered by them: *Provided*, That the carrier offering the plan must have provided health services under a health benefits plan for a period of at least five years."

At the end of section 5 (a), add the following:

"(5) LOCAL OR AREA SERVICE BENEFIT PLANS.—Benefits of the type specified in this subsection under paragraph (1) or (2)."

The CHAIRMAN. Mr. Rees?

Mr. REES. I was going to suggest that you submit a formal amendment for us to consider and look over.

Like the chairman, I do not understand why you do not come under the bill.

Mr. HARLOW. We are not governmentwide. We are a local plan.

Mr. REES. That is right.

Mr. HARLOW. We are not a plan of Federal employees that they run for themselves.

The CHAIRMAN. But you have a good many Federal employees, did you say?

Mr. HARLOW. Not many Federal, but we have many State and local government employees. Very few Federal employees.

Our largest single group is civil servants of the State of New York, of the subdivisions, counties, school boards, and such.

The CHAIRMAN. How many Federal employees do you have?

Mr. HARLOW. Very few.

The CHAIRMAN. About how many?

Mr. HARLOW. I would say probably less than a thousand, because this is a group enrollment plan and we only take groups as they come.

The CHAIRMAN. Any other questions?

Mr. REES. Just one more question.

You say that the difference between this bill and your proposal is that you may select any doctor you want?

Mr. HARLOW. That is the fourth type of choice.

Mr. REES. Under the fourth type?

Mr. HARLOW. That is because for a group practice prepayment plan, like the group health plan here in Washington—

Mr. REES. Do you follow the fourth choice, if you could select any doctor you want?

Mr. HARLOW. The wording here is, "local prepayment service benefit plans" that allow freedom of choice.

Mr. REES. With freedom of choice you come under the bill?

Mr. HARLOW. Yes; and we would like to add a short paragraph, that is all.

Mr. WALLHAUSER. You mentioned that you only accept group applications. Under your proposal would an individual Federal employee have the right to join?

Mr. HARLOW. Yes; we participate in these choice programs very broadly in private industry as well as from the State of New York. Any member of a group that is going into this program would be eligible, whether only a few chose, or a great many chose us.

The CHAIRMAN. Any other questions?

If not, thank you very much.

Your statement will be covered in full in the record.

Mr. HARLOW. Thank you.

The CHAIRMAN. The hearing will now be adjourned until 10 a.m. tomorrow.

Dr. BABCOCK. Mr. Chairman, could I see you just a moment later? I have made two trips here from Portsmouth and I would like to present my brief to you. I would like to talk to you after these people are dismissed.

The CHAIRMAN. Very well.

If you want to take the stand now we will take 2 or 3 minutes because the House is now in session.

Dr. BABCOCK. It will not take very long.

The CHAIRMAN. State your name for the record.

STATEMENT OF DR. JOSEPH M. BABCOCK, DIRECTOR, DEPARTMENT OF NATIONAL AFFAIRS, AMERICAN OPTOMETRIC ASSOCIATION, PORTSMOUTH, OHIO

Dr. BABCOCK. Mr. Chairman and members of the committee, my name is Joseph M. Babcock. I reside in Portsmouth, Ohio, where I have been engaged in the practice of optometry for more than 40 years. I have been in charge of the Department of National Affairs of the American Optometric Association for the past 17 years, during which time I have also served as secretary of the Ohio State Optometric Association.

Our national association, like most others in the health field, is composed of individual members in each of the 49 States and the District of Columbia. In most instances the individual joins the local or State association and at the same time becomes a member of the national organization.

Our interest in S. 2162 and the companion House bills which are being considered by the committee is twofold, first: to make certain that Government employees who elect to avail themselves of the benefits sought to be provided by these bills, shall be free to consult a member of the optometric profession for their vision care if they so desire, and, second, to have on the Advisory Council a representative of one of our schools of optometry.

It was my privilege to appear before the Senate subcommittee which held the hearings as the result of which S. 2162 was drafted. In the preparation of the Senate bill S. 2162 they did adopt some of our recommendations, namely, those pertaining to the use of the word "health" rather than the word "medical." The use of the latter term universally results in the exclusion of optometrists from the program, even though the individual patient may prefer to have an optometrist perform the services to which that individual is entitled.

Before going further, it might be well if I briefly described the qualifications and functions of the two groups which provide the professional service essential to the care and preservation of the vision of the American peoples. They are the optometrists and the ophthalmologists.

The optometrists constitute the group especially trained to examine the eyes of their patients for defects in vision. When these are caused by conditions which either partially or wholly require medication or surgery, the patient is referred to a physician. In civilian life between 60 and 70 percent of those seeking professional advice for their visual problems consult optometrists. In each of the 49 States and the District of Columbia, a person now seeking an original license to practice optometry must be a graduate of an approved school or college of optometry which requires a minimum of 5 years of study at the college level, three of which are devoted to the optometric specialty. They are also required to pass a State board examination. There are in the United States somewhere in the neighborhood of 18,000 practicing optometrists. They specialize in refractions, prescribing and fitting spectacles, contact lenses, orthoptics, subnormal vision aids and visual problems of schoolchildren, motorists, aging, and the employed.

The other group is known as ophthalmologists. Some of these have been certified by the American Board of Ophthalmology and others use the term without being certified. They are all physicians. Those certified have taken postgraduate work in the field of eye care, have completed a residency in an eye hospital, and passed the examinations given by the American Board of Ophthalmology. They are especially trained to perform eye surgery and to treat diseases of the eye, as well as to refract.

There is no statutory regulation of an ophthalmologist and any physician, even with a general medical education which includes only a smattering of training in the care of the eye, may if he so desires call himself an ophthalmologist, an oculist, or an eye specialist.

Congress, on numerous occasions in the last 15 years, has enacted legislation recognizing the professional status of optometrists. One example was the passage, in 1947, of the Medical Service Corps Act as the result of which optometrists are now accorded commission status in the Army, Navy, and Air Force. There are some 350 optometry officers on active duty in the three services with ranks ranging from ensign or 2d lieutenant to colonel or its equivalent in the Navy which is captain. There are also a substantial number of civilian optometrists who are employed by the three services either on a part- or full-time basis.

The 1950 amendments to the social security law expressly provided that the services of optometrists should be made available to recipients of the aid to the blind program in the several States in order that the States could qualify for Federal funds.

The 1958 revision of the laws relating to the Veterans' Administration expressly included optometrists in the Medical Department.

The American Optometric Association has a standing committee known as the committee on social and health-care trends. One of the principal functions of this committee has been to work with labor organizations, employers, and others interested in group health with a view to including vision care in these programs. As a result, the Federal Safety Council in California which, if I am informed correctly, would qualify as a carrier under the provisions of these bills, has a contract with the California Vision Service to provide optometric services for the beneficiaries of the Federal Safety Council program, who desire them.

It is also my understanding that the Group Health Association in the District of Columbia, of which many Federal employees are members, provide optometric services as part of their coverage.

It would unduly impose upon the time of the committee if I attempted to give you, even in summary form, some of the accomplishments of our profession in providing vision care for the partially blind, for the aging, for industrial workers, and for children and youth.

The primary reason for my appearing before this committee is to recommend that the bill be amended by enlarging the membership of the Advisory Council as contained in section 12(a)(7). Subparagraph (7) now provides for three members of the Council to be appointed by the President who shall be representative of university schools of medicine, hospital administration, and public health, respectively. Our recommendation is that this paragraph be amended so as to provide for five members to be appointed by the President, one of the additional members to be a representative of the schools of optometry and the other of the schools of dentistry.

The bill also provides for at least two other medical members, one the Surgeon General of the Public Health Service, and the other the Chief of the Bureau of Medicine and Surgery of the Veterans' Administration.

The university schools of medicine, hospital administration, and public health are all under the control of the medical profession, which means that that group will have at least five members on the Council. We submit that it is only reasonable that representatives of both optometry and dentistry should be included on the Advisory Council.

There are 10 accredited schools and colleges of optometry in the United States. Five of these are connected with universities, the other five, while duly accredited, are not connected with universities and are sometimes referred to as independent schools. The university schools are located at: University of Indiana, Bloomington, Ind.; University of Houston, Houston, Tex.; Pacific University, Forest Grove, Oreg.; University of California, Berkeley, Calif.; and Ohio State University, Columbus, Ohio. The so-called independent schools are: Massachusetts College of Optometry, Boston, Mass.; Pennsylvania State College of Optometry, Philadelphia, Pa.; Southern College of Optometry, Memphis, Tenn.; Los Angeles College of Optometry, Los Angeles, Calif.; Illinois College of Optometry, Chicago, Ill.

It is generally recognized that vision is an important factor in our national defense, but people are sometimes slow to recognize the importance of vision in the performance of everyday tasks of all our Government employees. A few months ago a case came to my attention of a Government employee who had been to some of the top medical practitioners in the District of Columbia, both in the field of eye care and mental hygiene. Her visual problem had been so acute that it affected her nervous system and her general health. She was on the verge of self-destruction when she was referred to a local optometrist who was able to fit her successfully with a pair of contact lenses. This not only solved her vision problem but restored her physical and mental health. Management and labor are becoming more and more cognizant of the importance of vision of the employees to the satisfactory performance of their tasks as well as to their safety.

In a program which is contemplated to involve the expenditure of hundreds of millions of dollars, it would seem the height of folly to set up an Advisory Council which did not have on it at least one vision specialist. The best way to provide for that is to have on the Council a representative of one of our schools or colleges of optometry.

Mr. REES. I understand the main thing you want is a member on the Board?

Dr. BABCOCK. And a dentist should be on the Board.

The CHAIRMAN. You mean the Advisory Council?

Dr. BABCOCK. Yes.

The CHAIRMAN. Are there not 11 there now?

All right; it will be considered.

Dr. BABCOCK. Thank you very much, Mr. Chairman.

The CHAIRMAN. At this point I will insert in the record statements of persons representing various organizations interested in the health insurance program.

(The statements referred to follow:)

STATEMENT OF ALFRED F. BEITER, PRESIDENT, NATIONAL CUSTOMS SERVICE ASSOCIATION

Mr. Chairman, the National Customs Service Association, which I represent, is composed entirely of Government employees, the great majority of whom are long-time career employees in positions subject to the Classification Act. The membership is distributed throughout the United States, and we also have members in Alaska, Puerto Rico, and the Virgin Islands.

I am most grateful to the committee for giving me this opportunity to appear and represent our association at this hearing in active support of S. 2162. Since 1947, our association has exerted every possible effort in behalf of legislation which would provide health insurance benefits to Federal employees and

their dependents. We know and appreciate the urgent need for enactment of a health insurance program of this type. In the past, our association has made comments on bills introduced in the Congress which dealt with health insurance. In studying the legislative history of such bills, we now feel that the provisions of S. 2162, as it passed the Senate, is a fair compromise of the provisions contained in all other bills previously introduced. We also believe that S. 2162 conforms in many respects to the wishes of the administration. Any further compromises with respect to benefits, and costs to the employees, should be strongly resisted.

It is common knowledge that the administration objects to the 50-50 sharing of the costs, but would prefer to see the employees paying two-thirds and the Government one-third of the costs. We believe a 50-50 arrangement is most fair and equitable to all concerned. The Federal Government should be the leader in the field of providing health service benefits to its employees. As things now stand, the Federal Government is lagging far behind private industry in this field. It is a well-known fact that most large private concerns are presently underwriting the entire costs of health insurance benefits for their employees. This bill, if enacted into law, would provide Federal employees with health insurance benefits comparable to those presently being enjoyed by employees of most other large employee groups.

The Federal Government and the employees will equally benefit by the enactment of S. 2162. For the very first time, Government employees and their dependents would be able to secure adequate medical, surgical, and hospital care through the medium of payroll deductions. The employees would have the peace of mind in the knowledge that they could obtain the types of coverage most suited to their individual needs. Employees and their families could enjoy a better and fuller life due to improved health, and also because it would no longer be necessary for them to accumulate funds to pay the costs of a possible expensive illness.

The enactment of the provisions of S. 2162 will be a step in the right direction for the Federal Government toward measuring up to the standards set by private industry in providing health insurance benefits for its employees and their dependents. This bill has the support of employee groups and private insurance companies, and we sincerely hope it will be enacted at this session of Congress.

Once again, Mr. Chairman and members of the committee, I want to express my thanks and the appreciation of the National Customs Service Association for allowing me to appear before you in support of this legislation.

STATEMENT OF J. B. COBB, PRESIDENT, NATIONAL ALLIANCE OF POSTAL EMPLOYEES

Mr. Chairman and members of the committee, my name is James B. Cobb. I am president of the National Alliance of Postal Employees whose home office is located at 1644 11th Street NW., Washington, D.C. I represent a membership which is a cross section of all operating categories in the postal service throughout 36 States. Appearing with me is Charles R. Braxton, research director of our organization.

I wish to express my appreciation and that of the organization which I am privileged to represent, for the opportunity to appear before you and to communicate the views of a laboring people on this crucial piece of legislation.

Mr. Chairman and members of the committee, we find ourselves in accord with this legislative proposal, H.R. 8210 and similar bills, and the principle of health insurance which it clearly enunciates. However, there are some alterations which we would favor and which we think would make the legislation more meaningful. I refer to section 2, paragraph (c), line 4, which concludes with the term "support." We feel that additional language should be inserted to cover children abiding with the employee and dependent upon him and who may or may not be relatives. This would cover situations where by reason of death or other family disruption, a child living with an employee as a part of his family may be covered even though the adoption process had not occurred.

We come now to what in our opinion is a potential hardship to the great body of employees in the lower brackets. We refer to section 5, paragraph (e), lines 6-12.

The requirement that an out-of-pocket expenditure of \$100 by the employee, be made in addition to the provision of other insurance he may carry and in

addition to that 20 percent of the balance, plus an undetermined amount over \$1,500 in the case of a catastrophic illness could create an insurmountable problem.

Obviously, the requirement is directed at the possible abuse of the provisions of the insurance program. On the other hand, we are here seeking to overcome the underuse of prevailing medical facilities by those who hesitate because of the uncertainty of costs.

In 1932, the Committee on Costs of Medical Care conducted a survey which revealed that the amount of medical care received mounted rapidly with income. And even then, the care received in the upper income brackets was less than "adequate" as defined by the committee.

It is well to note that the inference can logically be drawn that the income group which can afford medical care may suffer tremendous inconvenience because of the unpredictable nature of medical costs. Those in the lower income brackets who underuse medical care because of shortsightedness and costs prohibition do not avail themselves of preventive care. The importance of this act cannot be emphasized too much, when the group to which this measure applies is considered. For when we consider the concern of the executive agencies with the use of sick leave, and rightly so, we may well look to the active application of preventive care. However, the initial costs must be conducive to the participation in such a program.

With reference to section 7(a)3 we feel that the increase in the family plan costs and the reduction in the share of the costs borne by the Government is in sharp contrast to the provision of paragraphs (a)1 and (a)2, in which the costs are equally shared by the Government.

We respectfully request that the Government's share of the cost be made more commensurate with the needs of an employee who is responsible for a family—and not, by inference, penalize him for the same.

In section 12, paragraph (b), we are concerned with the role of the Commission in its relation to the Advisory Council. The language, as used in this bill, empowers the Council only to advise and to consult. Moreover, the language of the bill requires the Commission to consult with the Advisory Council after which it can proceed to reach its own findings and conclusions. We respectfully suggest that the consent of the Council in the decisions of the Commission at least on the broad framework of overall policy would provide an equitable procedure.

In support of the principle embodied in the bill, we would like, briefly, to present some argument as to the basis of our reasoning.

We feel that many Federal employees are not availing themselves of the available medical care because of limited income, because of confusion stemming from the claim of the numerous competitors in the field, and because of obligations incurred for a minimal standard of living. As we see it, this proposal goes a step further than programs now existing to eliminate the dollar barrier between the Federal employee and the physician. We further feel that the doctor also faces the dollar barrier, with the knowledge of the patient's need and some hesitation with reference to his ability to pay the cost. With the elimination of this obstacle, the patient and the doctor can come together on the basis of need and need alone.

It is worthy of note that the bill before this committee takes care to preserve the doctor-patient relationship in the alternative plans advocated. While recognizing the reality of a well-defined custom such as this relationship, the opposition to applying the insurance principle to a social and economic need cannot go unheeded. In this regard let me state the view which we direct to this question. Medicine and the healing arts must ever remain the servant of the society of which it is a part. Those who feel that this approach to the catastrophe of illness must adjust their thinking to that role and rededicate themselves to the how of providing for the health needs of society. We feel that the relative importance of status of this profession, as other professions whose purpose is the advancement of mankind, must not outweigh the purpose of its origin.

These thoughts place the invective of "socialized medicine" in proper perspective with emphasis on the qualitative gains to the Nation and its people and its economy. Professor Galbraith in his "Affluent Society" has this to say: "The test ahead of us will be less the effectiveness of our material investment than the effectiveness of our investment in man." That point is well applied here as opposed to those who see the factor of health as a worthy sacrifice to the god of the dollar and personal or institutional aggrandizement. We foresee a more

stable work force and a more stable family structure in the release from this phase of concern and worry which accompany the threat of illness and disease.

Thank you, Mr. Chairman and members of the committee, for the attentiveness and courtesy which you have shown to our presentation. It is our hope that we have contributed in some small way to the deliberations which you are entering into on this measure; and finally, may I, on behalf of our laboring people, wish you the best of health and an enriched life.

I thank you.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., July 21, 1959.

HON. TOM MURRAY,
Chairman, Post Office and Civil Service Committee,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter outlining the position and recommendations of the American Medical Association with respect to S. 2162, 86th Congress, is respectfully submitted for the consideration of your committee. We are presenting our views in a written statement rather than through oral testimony so that the committee may be able to accommodate all who have applied to testify. If, however, any members of the committee have specific questions which they would like to direct to the American Medical Association, be assured that we will do our best to supply an answer.

For many years the American Medical Association has been active in encouraging the extension of coverage and the improvement of benefits under Blue Cross-Blue Shield, and commercial health insurance programs. Our interest in the overall field has included serious consideration of the health insurance program for the benefit of Federal employees and their dependents. For at least the last 5 years we have followed with interest the bills that have been introduced in Congress in this regard and have worked with the U.S. Civil Service Commission and other interested agencies, inside and outside of Government, in an effort to devise the most satisfactory arrangement.

At its meeting on March 19-20, 1955, our board of trustees voted to approve legislation which would authorize the Civil Service Commission to make available, on a voluntary contributory basis, group hospital, surgical, medical, and other personal health benefits for civilian officers and employees in the Federal service. This is still the official position of the association.

As a result of a more detailed consideration of pending legislation by our council on medical service and our council on legislative activities, it has been suggested that the plan finally agreed upon should—

- (a) Permit a realistic choice of plan on the part of the individual employee.
- (b) Permit all qualified carriers to offer coverage.
- (c) Require financial participation by the employee in the payment of premiums under any plan or plans selected.
- (d) Provide for a minimum of governmental regulatory authority over participating carriers or plans.
- (e) Provide a method by which the person who retired before that date can participate on a contributory basis.

It is our further belief, however, that the American Medical Association should not attempt to offer suggestions as to—

- (a) The specific amount of the Government contribution to the program.
- (b) The maximum benefits payable under a basic or major medical program.
- (c) The formula to be applied for determining the eligibility of an insurer to participate in underwriting basic or major medical benefits.

In applying these policy statements to S. 2162, the pending legislation it is our belief that satisfactory amendments can be made rather easily within the framework of this legislation.

Section 2.—It is noted that the Senate-passed bill provides eligibility for individuals who retire after the date of enactment and before the effective date of the bill. While we feel that this provision is desirable, we regret that the bill does not provide for the already retired. We are heartened by the knowledge that the Senate Post Office and Civil Service Commission is presently considering a program under which health insurance will be offered to this group. While recognizing that such a program represents somewhat of a

deviation from past precedents, we sincerely believe that the participation of these individuals on a voluntary and contributory basis is desirable.

Sections 4 and 5.—These sections describe the basic health plans and the major benefits covered by the bill. Section 4 requires that there be one governmentwide service benefit plan. We feel that the phrase "one governmentwide," while intended to eliminate the necessity of the Civil Service Commission to enter into contracts with individual service benefit plans, is unfortunate. We know of no nationwide service benefit program which could meet the requirement of providing service to all Federal employees. In a number of States, the Blue Shield programs operate indemnity plans. We, therefore, recommend that section 4(1) be amended by striking the phrase "one governmentwide."

In conclusion and on behalf of the American Medical Association, I would like to express our appreciation for the opportunity to present our views on S. 2162, 86th Congress. If the committee is desirous of additional comments or information, please feel free to call on us.

Sincerely yours,

F. J. L. BLASINGAME, M.D.,
Executive Vice President.

STATEMENT OF FRIEDA REICHER, PRESIDENT, FOUNDATION FOR COMMUNITY AID TO MENTAL PATIENTS

It would appear that the intent of Congress in its consideration of the House and Senate bills on health insurance for civil service employees is to provide a way for the Government to help protect its employees from the economic hazard of catastrophic illness. This principle, embodied in both the House and Senate bills, is wholeheartedly endorsed by intelligent taxpayers of the United States.

Commercial and voluntary hospital insurance are beginning to expand coverage for psychiatric care in community general hospitals. The Congress would give further impetus to expanding coverage for psychiatric care by providing the same benefits as the House bill provides for other illnesses.

Mental illnesses have been historically discriminated against in health insurance plans. The Senate bill, S. 2162, although a sound piece of legislation, discriminates against psychiatric disability to the extent that it limits the allowable period of hospitalization to 30 days. The House bill, although not specifically discriminatory, could be interpreted as such. Voluntary and commercial health insurance plans have only in a few instances provided limited coverage for psychiatric disability, generally at an additional premium cost.

The Congress should make certain that insurance carriers include in coverage made available to Federal employees under this legislation care for psychiatric disability under the same conditions as all other illnesses covered.

Health insurance which covers the cost of catastrophic illnesses can no longer be confined to physical ailments. Illnesses of psychogenic origin are just as disastrous to the individual in terms of loss of wages and costs of medical care. We can no longer continue to afford the cost to taxpayers of discriminating against illnesses of psychogenic origin if we are to reduce the costs of institutionalization of patients. The average cost per admission in a mental institution is \$3,600. Psychiatric patients in community general hospitals stay an average of 21 days. The cost per admission is about \$350. Moreover, the evidence is becoming available that early treatment at the community level reduces the need for prolonged institutionalization and repeated hospitalization.

As a community organization in nearby Virginia devoted to the problems and needs of mental patients, the Foundation for Community Aid to Mental Patients is especially concerned that protection be extended to cover mental as well as physical illness.

The modern psychiatric treatment services possible in our general hospitals are handicapped in their development because hospital insurance plans so often discriminate in their coverage. It is conceivable that nearly all of our huge, wasteful, overcrowded State hospitals might be replaced in the future with a relatively small number of psychiatric beds in our general hospitals. At the present time, less than 10 percent of our general hospitals have psychiatric services, and their total number of beds is only one-thirtieth the number in our State mental hospitals. Nevertheless, in 1958 there were more psychiatric patients (225,000) treated in these general hospitals than in all the State mental hospitals combined. The reason for the better record was simply that treat-

ment, not custody, was provided, and the turnover of patients was so much greater that 20,000 beds were able to do a better job than the 550,000 mental hospital beds.

The future of the psychiatric services in our general hospitals will depend, to a very large degree, upon hospitalization insurance coverage. So far they have developed within the limits imposed by the common practice of discriminating against psychiatric patients. It would be to the eternal credit of the 86th Congress if it helped established a new and progressive precedent in this respect when it prepares its final legislation on health insurance for Federal employees.

Federal employees who are committed to mental hospitals because of their inability to pay for psychiatric treatment in the early stages of their illness pay a double penalty for an illness which may be job connected. A record of a commitment to a mental hospital is a severe handicap to the patient who makes a sufficient recovery from his illness to be released from the hospital. Many are forced to accept work below their capability because they cannot call on their records of training and experience without revealing their commitment for mental illness.

Specifically, it is recommended that the final bill make clear that the intent of Congress is to provide health insurance protection against catastrophic illness, in all its possible clinical manifestations.

PROGRAM OF THE FOUNDATION FOR COMMUNITY AID TO MENTAL PATIENTS

1. To establish convalescent homes at a community level for the use of mental patients during the probation period as centers for fellowship, and as centers for vocational rehabilitation and job placement through existing agencies;
2. To give material aid to individual recovered patients in time of need;
3. To eliminate jail commitments except when unavoidable as to the criminally insane;
4. To establish psychiatric wards in community general hospitals for the observation, short-term treatment, and outpatient care of mental patients, and where needed, for the commitment of such patients to mental hospitals for protected care;
5. To provide legal aid as needed for the benefit of the patient and his family, and to speed up the process of communication between the courts and the mental hospital authorities in order to restore legal sanity and full citizenship to medically recovered mental patients;
6. To arouse public support for the appropriation of funds adequate to meet the minimum standards for medical care in mental hospitals, based on the standards set by the American Psychiatric Association; and
7. To study problems affecting the full recovery of mental patients; such as the study of commitment laws, special requirements with reference to driver's license, coverage of hospitalization and medical care insurance plans, and studies and evaluation of programs in operation in local communities for the benefit of recovered mental patients.

The program of the Foundation for Community Aid to Mental Patients is intensely practical and concrete. It will supplement the educational preventive program of the National Association for Mental Health.

The Foundation is registered with the united community services at Washington, D.C., nearby Virginia, and Maryland. All contributions are tax free.

WASHINGTON, D.C., July 29, 1959.

Hon. TOM MURRAY,
Chairman, Post Office and Civil Service Committee,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN MURRAY: I am Joseph E. Jones, a general insurance agent with offices in the District of Columbia, serving the metropolitan area, nearby Maryland, and Virginia for 22½ years. As long ago as 1942, I was privileged to serve as underwriter for large groups of Government employees and since that time have written many Government agencies, including the Central Intelligence Agency, the National Security Agency, the American Foreign Service Protective Association, and others. The total number of Government employees, including dependents, insured by my organization is well over 100,000.

My agency pioneered the development of group hospitalization coverage for Government employees at a time when other companies and service organizations showed no interest in providing this protection. I was successful in securing an underwriter who was willing to pioneer this type of coverage with me.

In serving the needs of these organizations and others over the years I have been called upon to provide unique services peculiar to these agencies. For instance, claims incurred in foreign countries are paid in my office and benefit checks are mailed the same day the claim papers arrive to claimants throughout the world. Further, any security regulations required have been fully met by my agency while providing this important protection.

These plans have been in operation for a number of years and have built up reserves which, according to my interpretation of S. 2162, will be lumped in the general fund and thereby taken away from these Government employees who had the foresight to band together for their mutual protection and by so doing accumulate these reserves.

I have been advised by these agencies that they are completely satisfied with the services rendered and that they are anxious to continue with their present underwriter, thereby protecting the investment they have built up over the years. While many existing plans are protected by the proposed legislation and will be able to continue, the above listed agencies and others will be denied this opportunity.

For 20 years I have devoted my financial resources, time, and effort in pioneering and developing excellent coverage for Government employees. While I endorse the spirit and intent of the legislation you are considering, I respectfully ask that the committee give consideration to a proposed amendment which would allow me to continue to provide these services to these agencies if they so desire and to offer my services to any other Government agency that would desire it.

Respectfully yours,

JOSEPH E. JONES.

U.S. CUSTOMS INSPECTORS' ASSOCIATION,
PORT OF NEW YORK,
New York, N.Y., July 31, 1959.

POST OFFICE AND CIVIL SERVICE COMMITTEE,
House Office Building,
Washington, D.C.

GENTLEMEN: I am the president of the U.S. Customs Inspectors' Association of the Port of New York. My organization was founded in 1893 and is one of the oldest employee associations in continuous existence. We are an independent association—not affiliated with any union or group whatever. We do though enjoy cordial relations with all employee organizations. The members of my association are all members of the customs inspectional personnel in the Port of New York from the trainee inspector to the deputy collector.

This association asks that your committee act favorably on the companion bills to S. 2162: H.R. 8210 by Congressman Morrison of Louisiana; H.R. 8222 by Congressman Davis of Georgia; and H.R. 8211 by Congressman Porter of Oregon, all exact duplicates of the Senate bill. The bills as written contain many desirable features, and if enacted into law will be a most welcome piece of legislation.

Respectfully,

WILLIAM J. HARRINGTON, *President.*

NATIONAL SECURITY AGENCY,
Fort George G. Meade, Md., July 31, 1959.

HON. TOM MURRAY,
House of Representatives,
Washington, D.C.

DEAR MR. MURRAY: Thank you for your letter of July 23, 1959. We have taken a considerable interest in the Federal Employee Health Benefit Act of 1959, S. 2162, especially as it pertains to our health insurance program.

We have here at NSA an employee organization known as "GEBA," Government Employee Benefit Association, Inc. GEBA is an association organized and operated as a cooperative endeavor to provide hospitalization and surgical insurance for NSA employees no matter where they may be located.

GEBA provides a comprehensive low-cost hospital and surgical program underwritten by Mutual of Omaha.

Our experience with the program since its inception in 1957 has been excellent with considerable benefits and returns for those covered, who number about 15,000 individuals including dependents. In addition to paying approximately one-half million dollars in claims, we have accumulated a considerable reserve in the relatively short period of operation.

There is a strong desire that there be appropriate provision made in the pending health insurance legislation to permit continuance of this program.

We will be happy to have an official of this Agency available to answer any questions you may have concerning our plan.

Sincerely,

LOUIS W. TORDELLA,
Deputy Director

CANAL ZONE GOVERNMENT,
OFFICE OF THE GOVERNOR,
Balboa Heights, C.Z., July 30, 1959.

HON. TOM MURRAY,
*Chairman, Post Office and Civil Service Committee,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: Reference is made to H.R. 7712 which was introduced by Representative Morrison on June 12, 1959, and referred to the Committee on Post Office and Civil Service.

The purpose of this bill is to provide for Government contribution toward a voluntary health insurance program for Government employees. This office has no comment to make on the provisions of the bill generally. However, I would like to point out one feature of the bill which I believe would unfairly discriminate against certain employees of the Canal Zone government and the Panama Canal Company.

Section 2(a) of the bill provides in part as follows:

"The term 'employee' * * * does not include * * * (2) a noncitizen employee whose permanent-duty station is located outside a State of the United States or the District of Columbia."

This provision would have the effect of excluding noncitizen employees of the Canal Zone government and the Panama Canal Company from the benefits which would be provided by the proposed legislation.

I believe that because of unique conditions which exist in the Canal Zone there are compelling reasons why any health insurance program which is enacted for Federal employees should apply to noncitizen as well as U.S. citizen employees of the Canal Zone government-Panama Canal Company. The canal enterprise has approximately 10,000 noncitizen employees and only about 3,600 U.S. citizen employees and the canal enterprise provides hospital facilities for its noncitizen employees as well as its U.S. citizen employees. Such a practice is to the definite advantage and benefit of the canal enterprise in keeping a healthy working force available at all times to operate the canal. Likewise, I believe that it would be to the best interests of the canal enterprise if any health insurance program which is enacted were available to both noncitizen and U.S. citizen employees. At the present time, both U.S. citizen and noncitizen employees of the canal enterprise participate in a voluntary group health insurance program which is, of course, maintained at the present time without any government contribution.

Further, if the bill were enacted in its present form I believe that it would conflict with certain established policies under and in relation to treaty commitments to the Republic of Panama in regard to the equality of treatment of U.S. citizen and noncitizen employees of the canal enterprise. In an ancillary note to the 1936 treaty between the United States and the Republic of Panama the United States stated as follows:

"With reference to the representations made by you during the negotiation of the treaty signed today, regarding Panamanian citizens employed by the Panama Canal or by the Panama Railroad Company, I have the honor to state that the Government of the United States of America, in recognition of the special relationship between the United States of America and the Republic of Panama with respect to the Panama Canal and the Panama Railroad Company, maintains and will maintain as its public policy the principle of equality of opportunity and treatment set down in the order of December 23, 1908, of the Secretary of War.

and in the Executive orders of February 2, 1914, and February 20, 1920, and will favor the maintenance, enforcement, or enactment of such provisions, consistent with the efficient operation and maintenance of the canal and its auxiliary works and their effective protection and sanitation, *as will assure to Panamanian citizens employed by the canal or the railroad equality of treatment with employees who are citizens of the United States of America.*" [Emphasis added.]

The above-quoted language technically applies only to noncitizen employees of the Canal Zone government and the Panama Canal Company; however, in the interest of uniformity and because of the principle of uniform application of employment standards in the Canal Zone established by the Canal Zone Wage and Employment Practices Act of 1958 (Public Law 85-550; 72 Stat. 405), it is considered that the language should be applied as if it included all noncitizen employees of any agency of the Federal Government in the Canal Zone.

In accordance with the views expressed above it is suggested that H.R. 7712 be amended so as to make it applicable to noncitizen employees in the Canal Zone. Specifically, it is suggested that section 2(a)(2) be amended by inserting the words "the Canal Zone," immediately after the words "a State of the United States."

The Bureau of the Budget has advised this office that it has no objection to the submission of this report.

Sincerely yours,

JOHN D. McELHENY,
*Acting Governor of the Canal Zone,
Vice President, Panama Canal Company.*

STATEMENT OF FORDYCE W. LUIKART, PRESIDENT OF GROUP HEALTH ASSOCIATION,
INC.

Mr. Chairman and members of the committee, my name is Fordyce W. Luikart, president of the board of trustees of Group Health Association, Inc., Washington, D.C. Of the four health benefit plans provided in section 4 of S. 2162 our association's plan would be classified as a group practice prepayment plan.

The association was founded 22 years ago by Government employees of the Federal Home Owners Loan Corporation who were determined to obtain quality medical care for their families on a prepaid basis. This member-owned, non-profit medical organization has grown to a current enrollment of some 33,000 participants, and has the most comprehensive medical service plan in the Washington metropolitan area.

Group Health Association has several distinguishing characteristics. These are:

1. Group practice which brings together the family physician and a variety of specialists into a medical team serving the members. Advances in the American medical scene have been so extensive that pooled knowledge and the judgment of several physicians, working together, assure quality medical care with advantages to patient as well as to physician.

2. Preventive medical care which gives attention to health maintenance as a day-by-day matter. This emphasis is not only a medical good but also an economic good for the member in terms of less hospitalization and less loss of productive time.

3. Prepayment which permits the member to budget expenditures for medical, hospital, and surgical care.

4. Membership control which gives assurance that the wishes of the members are fully considered in major policy and program decisions.

At the present time there are 74 physicians, surgeons, and dentists either on the staff or retained as consultants. Medical care is rendered in such diverse fields as pediatrics, adult medicine, obstetrics, gynecology, allergy, dermatology, neurology, ophthalmology, orthopedics, and radiology. The association employs 185 persons on its supporting staff. We operate two medical centers: one in downtown Washington, D.C., and one in nearby Takoma Park, Md. In addition to housing, the medical and dental departments there are such auxiliary services as physical therapy, optical, and X-ray. There is a pharmacy at the downtown center which affords savings on drugs and medicines.

To become a member there is a \$50 membership fee, payable \$2 a month for 25 months and a nominal \$5 application fee. The monthly dues for a family of two adults and one child is \$12. Of course, the composition of the family de-

termines the total monthly rate. Each adult is \$4.50; each child is \$3. There is no charge for more than three children. The basic dues rate covers doctor, hospital, and surgical care. There are extra charges for certain type services rendered in the medical centers: e. g. \$3 for X-ray or EKG. There are other nominal charges for special tests or laboratory procedures.

About half of our members are Federal employees who have all joined the association voluntarily. They have chosen the Group Health plan, I believe, because it combines the full scope of medical and surgical services—preventive, diagnostic, and therapeutic—available as needed in home, office, or hospital—under the standards of a qualified professional staff.

For several years we at Group Health have followed the various bills proposing that the U.S. Government contribute financially to Federal employee health plans and have consistently maintained that the individual employee should have the right to choose the health plan that best suits his needs. This right is very important to GHA's members who work for the Federal Government and who have already made their choice. For them there is no substitute for the integrated health program that I have described above. We therefore strongly approve the provision of S. 2162 allowing for freedom in selection of a health plan.

The provisions of S. 2162 provide a broad framework of a "flooring" on benefit levels and a dollar "ceiling" amount on cost within which the Civil Service Commission can develop specific contracts with carriers and plans such as ours. This is the only practical legislative approach, we believe, in dealing with the advancing and complex health field. We have related our plan and the cost to the types and level of benefits provided in the bill. It is our belief that within the dollar ceiling we can develop a proposal for the consideration of the Commission that is acceptable to our Federal employee members. However, any significant reduction in the maximums would not permit us to make an offering matching our present comprehensive plan which provides—for unrestricted members—almost unlimited medical and surgical care as well as 6 months' hospitalization a year in semiprivate accommodations.

Many of our members are subject to some "restriction on medical service." In other words, "service at cost" is provided for ailments which existed before their enrollment in our plan. This practice would be discontinued under our proposal in response to S. 2162. Such a change would shift the costs for treating restricted conditions of our Federal employee members from the individual member to the plan as a whole, and would tend to raise the group rate.

Though we have no direct supporting data to offer, we believe that our plan, because of its comprehensive scope, may be attractive to those most in need of day-to-day health care; i.e., families with children as well as those in the older age brackets. This care will tend to be costly.

I am sure, Mr. Chairman, that your committee is aware that the cost of the proposed health program cannot be estimated with preciseness, either for our plan or the whole program, until the detail of benefits to be provided is worked out and the number of employees who will enroll is known.

The bill provides that the enrollment of employees and annuitants in health benefit plans and the payment of contributions shall take effect early in July 1960. The time elapsing from date of enactment to July 1960 is to allow for implementing actions; i.e., the development of proposals by carriers, negotiations between carriers and the Civil Service Commission, and employee election of plan. It is important that group practice medical organizations such as ours know as soon as possible the probable number of employees who will select our respective plan. For group practice plans this is a very real consideration if additional facilities and staff beyond existing capacity are required to render adequate service. To arrange for the latter is not an overnight matter. Therefore it is to be hoped, Mr. Chairman, that by legislative intent it be indicated that tentative employee selection of plan be permitted early in the "tooling up" period.

The cost of medical care continues to rise. Our hospitalization experience since 1955 is given in the table attached to my statement. It will be seen that the average per diem cost has increased from \$31.06 in 1955 to a figure of \$37.89 in 1958, and that the average cost per hospital episode has increased from \$193.58 to \$248.73. The average annual increase has been over 6½ percent.

This is not the isolated experience of GHA—it is true countrywide. It cannot be explained entirely in terms of salary and wage increases and higher unit prices; there has been a tremendous advance in diagnosis and treatment requir-

ing more of everything: staff, laboratory tests, drugs. As medical care has improved and become more complex there has been unprecedented demand for new and better equipment and better designed facilities. There has been a tendency to use more specialists and more skills.

The bill, we believe, will be of great benefit to Federal employees generally, and we urge its enactment. Health service is a modern day necessity, and it is commendable that the Federal Government recognizes its responsibility as an employer to see that Federal employees are not denied this service because of financial limitations.

In conclusion, may I say that our association stands ready to assist to the full extent of our capacity in the Government health program.

Group Health Association, Inc., Washington, D.C., hospitalization, 1955-58

[Costs per patient-day, average length of stay, and cost per episode]

Year	Number of episodes	Number of days	Total cost ¹	Average per diem cost	Average days per episode	Average cost per episode
1955.....	1,688	10,321	\$326,764.30	\$31.66	6.1	\$193.58
1956.....	1,850	11,638	372,993.05	32.05	6.3	201.62
1957.....	1,844	11,540	404,342.69	35.04	6.3	219.27
1958.....	1,705	11,192	424,082.79	37.89	6.6	248.73

¹ Includes the following services: Anesthesiology, X-ray, physical therapy, special tests such as EKG, EEG, BMR.

STATEMENT OF MR. FRANK VAN DYKE, ASSISTANT PROFESSOR OF ADMINISTRATIVE MEDICINE, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE

I am very glad to have the opportunity to come here today to talk briefly about the Federal employees' health bill. First of all, let me say I endorse the general outline of the health plan proposed in Senate 94, and oppose the proposal of the Civil Service Commission as set forth in their statement to this committee. My views are my own. I do not represent either the State of New York or Columbia University. I want to make that clear, because most of my testimony will be a discussion of the health plan for New York State employees. This plan has been called "the most liberal and comprehensive program enacted by a governmental body to provide its employees with protection against medical care costs."

At the close of the year 1958, 83,000 State employees and retired employees had joined the plan. About 100,000 persons were eligible to join. The number of persons covered, including dependents, totaled about 200,000. It may be of interest to you to have a brief description of how the plan started, the principles embodied in it, administration of the program, and benefits and costs.

Late in 1955 the Joint Legislative Committee on Health Insurance Plans of New York State asked the Columbia University School of Public Health and Administrative Medicine, which was then acting as consultants to the committee, to prepare a set of principles which could be the basis for a health insurance plan for State employees. Several copies of a 17-page statement, drawn up by the university staff, have been given to your staff. You might want to include this statement in the record as part of this testimony as an example of how a university research group approaches the problem of how to devise a health plan. In brief, the staff suggested to the New York State Legislative Committee that a health plan for employees take advantage of the best existing health plans in the State and where possible give employees a choice of plan. We suggested that where service benefits were available for any type of coverage, the State purchase service benefits rather than indemnity coverage. The staff recommended that retired employees be covered in full at no increase in premium and that all health insurance be noncancellable and convertible.

Legislation to provide a health plan for employees passed both houses and was signed by the Governor. One of the features of the law which may be of particular interest to you is that it provided for a temporary health board of eight members. This board, four members of which were appointed by the Governor and four by the legislative leaders, was made responsible for preparing the health plan which was broadly outlined in the enabling legislation.

Whether by chance or design, this method of administration has proved to be extremely useful in working out a good health plan. The reason for this, I think, lies in the composition of the membership of the board. The director of the civil service commission is chairman. Other members are the State commissioner of health, the budget director, the comptroller, and four citizens at large. The citizen members are the Columbia University dean of the School of Public Health and Administrative Medicine, the director of the Endicott Johnson health plan for industrial workers, a plan which is one of the oldest and most complete in the State, the medical director of Cornell University Infirmary, now president-elect of the State medical society, and the officer of the General Electric Co. who was responsible for the administration of their insurance program.

A civil service commission staff is not apt to have the technical knowledge required to design a health plan. There is nothing extraordinary about this. The study of health services, like other branches of knowledge, is specialized. A knowledge of the various ways health services are provided, the strengths and weaknesses of different health plans, and ways in which insurance can improve the caliber of health services to people are needed if employees are to have the best available plan.

It seems to me that a Federal employees' health plan will be better if it is possible to find some administrative device which will put policy decisions in the hands of health-oriented persons. Otherwise you may find you will have an insurance program designed to meet the needs of the insurance companies and the people who administer the plan.

I respectfully suggest that you consider providing an administrative method so that the Federal employees' health plan will be guided by the disinterested advice of persons familiar with the provision of health services to people.

The report of the research staff to the Joint Legislative Committee on Health Insurance Plans of New York State advised the committee to provide service benefits wherever it was possible to do so.

A majority of the New York State Health Insurance Board accepted the service benefit principle in the plan design. Service benefits have at least two advantages. For low and moderate income people, it is important to have ready access to health services with as few financial barriers as possible. The second advantage is that it places an upper limit on the cost of medical care. This upper limit can be adjusted from time to time as needed, but it does tend to prevent inflationary charges. As an example of the inflationary aspects of some types of insurance, let me quote from the report of a consulting firm which specialized in health and welfare plans.

"Our company analyzed over 10,000 surgical claims where benefits were paid under a \$150 surgical schedule. We found that this surgical schedule paid only 55 percent of the surgeon's total charges. A similar analysis, for claims paid under a \$225 surgical schedule, showed that such a schedule paid 60 percent of the surgeon's total charges. And an analysis of claims paid under a \$300 surgical schedule showed that such a schedule paid only 69 percent of the surgeon's total charges. As you can see, a 100 percent increase in the surgical indemnity schedule served to reduce the patients' share of the bills by only 14 percent."¹

One of the first decisions made by the New York State Temporary Health Board was to think of the health plan as having three basic parts. Part I is a hospital plan, part II a medical plan, and part III is for coverage not included in the first two parts. The reason for dividing the health plan into three parts was to take advantage, as I said a little earlier, of the best available coverage.

The New York State Board decided to adopt a basic 120-day hospital plan including diagnostic admissions, coverage for infants, and mental coverage for 30 days. The specifications were written by the board and put out to bid. A number of insurance companies and Blue Cross bid on this part of the contract.

Medical-surgical benefits presented a special problem because the board wanted a service benefit contract with a \$6,000 income ceiling. There are seven different Blue Shield plans in New York State, two of which did not offer a service contract at that time. It was necessary to negotiate with these two plans, and they eventually agreed to participate in bidding on one statewide contract which provides that for families with incomes of less than \$6,000, the doctors will accept insurance payments as payments in full and will not render an additional bill to the patient. Insurance companies and Blue Shield bid on this part of the contract.

¹"The Consultant and Doctor-Sponsored Plans"; Martin E. Segal. Speech at New Washington Hotel, Seattle, Wash., Oct. 28, 1955.

Standard Blue Shield or insurance company contracts have a very important gap. They do not provide for home and office calls. To fill this gap, the Board decided to purchase a third program which would fill in some of the gaps of the two basic programs. A major medical program was devised and a number of insurance companies bid on it. An important part of this third step was to permit employees to substitute for parts II and III the two medical plans in the State which do offer home and office calls on a service benefit basis. Neither of these plans covers the entire State. The principle employed was to fix a contribution on the part of the State for the so-called statewide plan, i.e., parts I, II, and III. Those employees who elected to substitute one of the home and office call, service benefit, medical care plans for parts II and III would receive exactly the same employer contribution toward the costs of the plan as all other employees received.

In effect, the Board set the standard that employees were free to choose a nonprofit, comprehensive service benefit, home and office medical care plan. Freedom of choice was limited to those plans which could meet this standard.

Blue Cross was awarded part I of the plan, Blue Shield, part II, and the Metropolitan Life Insurance Co., part III.

Employees who had retired before the plan went into effect were offered parts I and II of the plan. Major medical insurance was not offered them, however. Only about half of the eligible prior retirees enrolled. The reasons for this low participation are not known.

The rates of the plan with its various options are appended to this testimony. The total monthly cost of the statewide program for a single employee is \$6.15, of which the State pays half. The monthly cost of the statewide program for a family is \$15.97, of which the State pays 35 percent. Total costs for the first year were \$10,702,000. For the statewide part of the plan, about 16 percent of the first year's premium was for part III of the plan. Parts I and II absorbed most of the costs because most of the services provided were through the two basic plans.

I said earlier that the New York State plan had 83,472 employees or retired employees enrolled. At the end of 1958, 66,844 of those were enrolled in the statewide plan; 14,381 chose to enroll in Group Health Insurance, Inc., as a substitute for parts II and III of the statewide plan. Group Health Insurance has arrangements with several thousand doctors who agree to accept the insurance payment as payment in full. The remainder, 2,247 employees, selected the health insurance plan of Greater New York, which is a medical group practice plan. This multiplicity of plans has not presented any insurmountable administrative problems. There is no doubt that one plan is easier to administer than several. This is particularly true during the first year of operation. Once employees are enrolled, however, the various routines necessary for payroll deductions and the like can be carried out without confusion.

An important aspect of any health plan is provision for continuous review of how it actually works. In New York State some thought was given to this, and a review committee of the board was established. This committee has begun to analyze the first year's experience to determine whether weaknesses exist which require correction. A Federal employee's health plan would benefit from continuous study. The Department of Health, Education, and Welfare is a center now for such research and you may want to consider whether that Department should be assigned the responsibility for technical review of a plan after it is established.

I would like to turn now to discuss a very important defect of the proposal made by the Civil Service Commission.

Total private expenditures for all forms of medical care in the United States amounted to under 4 percent of disposable personal income in 1950 but increased to 4.9 percent by 1957.²

This in itself is not alarming. Perhaps people should spend a somewhat larger percentage of their income on medical care. Much still needs to be done to improve the quantity and quality of medical care and this, of course, costs money. We need, however, to arrange things so that the cost of medical care is not unnecessarily increased. The Civil Service Commission in its testimony has proposed an insurance plan which may very well increase the cost of medical care for Federal employees and their dependents and, by setting a

² Source: Statistical Abstract of United States, 1958, p. 305, p. 76. Health Information Foundation, "Consumer Spending for Medical Care" ("Progress in Health Services," vol. VII, No. 10, December 1958).

pattern for charges by physicians, druggists, hospitals, nurses, and others, tend to increase the costs of medical care for everyone.

While this matter can be discussed for hours, the basic point I wish to make is simple. Major medical insurance, after an initial deductible of \$50 for example, pays a percentage of the total bill, for example 80 percent. This is a relatively new type of health insurance. There are two other general types of health insurance. There is the so-called service contract which pays the hospital and doctor in full for certain specified services, and an indemnity type which pays the purveyor of service or the patient a flat amount fixed in the contract. If a service contract is in effect, there is no possibility of the hospital or doctor increasing charges, except through change in the contractual arrangements. If an indemnity contract is in effect, the insurance will pay a fixed fee, and the remainder, if any, must be collected from the patient. The patient has an incentive to control the total fee because he must pay for everything in excess of the insurance indemnity. If the fee is excessive, he may refuse to pay. The patient has a pocketbook reason to control the fees he is charged.

Major medical insurance, in contrast to service benefit insurance or indemnity insurance, has no built-in incentives on the part of anybody to control costs. Let me give you an example. If you, a noninsured private patient, are charged \$500 for an operation, you of course pay the full \$500. If, however, you had a major medical policy for which you paid the first \$50 and 20 percent of the remainder of the bill, you would pay \$50 plus 20 percent of \$450, or a total of \$140. What if the doctor decided to charge \$600? Your share would be \$160 and the insurance company would pay the \$80 additional. This 20 percent increase in the total cost would of course be reflected in insurance company premiums for the next year, although your bill at the time of service would be only \$20 more. We must be realistic about such things. No studies are necessary to demonstrate that many people consider insurance companies as fair game.

The promise of "you send me the bill and we will send you the check" on the part of the insurance company is an open invitation to higher medical care bills. Nor is this fraud on the part of purveyors of service. It is only natural for people to place a high valuation on their own services. Therefore, if the buyer departs from his traditional role in our society of exercising caution, we can expect higher costs for health services without additional or better services. Ordinary prudence on the part of the Government would dictate that if the major medical approach to payment of medical bills is to be used at all, it should be used sparingly, as it is in the New York State program.

I want to tell you that these views I have expressed on the inflationary spiral which unlimited major medical insurance will bring about are not supported by very much scientific data. The reason for this is the insurance companies have never revealed scientific data on their payments to purveyors of service under major medical which is susceptible of comparison with payments for like services under other kinds of insurance. Having said that there is little available direct evidence to support a statement that major medical insurance may be inflationary, let me give you a clue, or straw in the wind, which tends to support this view. When the New York program was put out to bid, each of the three parts required a separate bid. The board found that one of the insurance companies explicitly stated that its bid would be higher if the two basic parts of the plan were not service benefit in nature. Unfortunately, the New York State experience data on the employees' health plan has not yet been published in a form which gives comparative costs for specific services.

I am sure the Government is not anxious to inflate the cost of medical care. If it is decided that major medical insurance should be considered, it seems to me the Government is entitled to know in advance what the likely effect of it will be. There is no need to take a leap in the dark. The insurance carriers could be asked to open their records to a Government research team which could determine, on the basis of a sample of a few thousand cases of major medical payment, stratified by income, place of residence, and type of procedure, the actual payments for certain specified services. These payments could then be compared with prevailing fee schedules and prevailing charges for persons with low and middle incomes.

If one of the large insurance companies would make all its records available to competent research technicians in the field who employed accepted methods of analysis, we would know whether their payments to the purveyors of service

are higher or lower than payments made by the same company on a generous fee schedule arrangement. If the cost were as little as 10 percent higher, we would be justified in questioning whether this method of payment is right to use for low and middle income employees. The people who are attempting to sell major medical insurance have an obligation to provide facts.

Until we can be sure that the purveyors of service do not charge more for the same thing under the major medical incentive to do so, we should be very careful of introducing such a scheme to cover several million people.

In preparing for today, I looked through the attachment to the letter dated April 14, 1959, to Senator Olin Johnston from the Civil Service Commission.

The various principles, beginning on page 2, seem designed to make it as simple as possible for the Civil Service Commission to administer a health plan. This is important, but undue weight seems to be given to administration. This statement of principles confirms my impression that people who have experience and training in health matters should be consulted.

In reading through the document, without attempting to analyze it, I noticed a few statements which seem to be in error. Page 24 states that "To require indemnification for the full cost of 120 days' hospitalization is not only unrealistic (the premium for such protection would be so high as to be prohibitive), but is contrary to the well-established practice of insurance carriers." This is not correct. A little later on page 33, it is stated that "withholding premiums from retirement annuities would be unprecedented—at least under the civil service retirement system." It may be unprecedented for the Federal Government, but ample precedent exists elsewhere.

The Civil Service proposal, with its principles and justifications, is almost identical to a plan considered by the New York State Temporary Health Board and rejected by it. If there is a single principle which the New York State Board used, a principle which they did not explicitly state, it is that established social devices which are in actual use and which provide for some control of the cost of medical care should be employed wherever they are available.

The Federal Government has many programs designed to improve or supplement the health care of all citizens. These programs over a period of years have developed standards which, in some fields of health at least, have resulted in marked improvement in the quantity and quality of health care for almost everyone. A health plan for Federal employees should not ignore the experience which the Government has attained in many years of work.

In summary, let me say that S. 94 can be the basis for a fine health plan for employees and at the same time be relatively simple to administer. You can secure a single, uniform, service benefit hospital contract for all employees everywhere from Blue Cross or an insurance company. Similarly, you can negotiate for a single medical-surgical service benefit in-hospital contract for all employees everywhere in the country. These may be a little more complicated to arrange, but it can be done either through an insurer or, if that fails, by the Government itself.

As a third part to the plan, a single extended benefit or a major medical contract can be written with as many safeguards as possible to supplement the hospital portions and the medical-surgical portion. It should be possible for the health experts of the Federal Government to develop an extended benefits program which will employ safeguards against runaway inflation. Such a program, if it supplements broad basic service benefits, should not be expensive.

As for employees who wish to choose some other service benefit plan, standards can be established which will limit the choice to those relatively few plans in the United States which offer comprehensive service benefit medical care. A few of these plans offer hospital care and medical care as a package. Most Government employees would join the nationwide plan. For those who choose one of the approved alternates, the Government could limit its liability as New York State has done, by making a uniform contribution for each employee.

The advantage to the Government in permitting employees to choose an alternate plan is that some of these plans are able to offer a high quality of medical care with controlled costs. The Federal Government, with its overriding concern for the health of all the people, should encourage sound efforts to improve the quality of care.

New York State health insurance program, schedule of employee-employer contributions for health insurance coverage, contract year Apr. 1, 1959, to Mar. 31, 1960

[Monthly rates]

	Blue Cross	Blue Shield	Metropolitan Life Insurance Co.	Total	Employees	Employer
Statewide plan:						
Individual.....	\$3.70	\$1.39	\$1.06	\$6.15	\$3.07	\$3.08
Individual and dependent.....	8.14	4.81	3.02	15.97	9.46	6.51
	Blue Cross	GHI				
Group Health Insurance Plan, Inc. option:						
Individual.....	\$3.70	\$3.85		\$7.55	\$4.47	\$3.08
Individual and dependent.....	8.14	11.33		19.47	12.96	6.51
	Blue Cross	HIP				
Health insurance plan option:						
Lower income:						
Individual.....	\$3.70	\$3.56		\$7.26	\$4.18	\$3.08
2 persons.....	8.14	7.12		15.26	9.38	5.88
3 or more persons.....	8.14	10.68		18.82	12.31	6.51
Upper income:						
Individual.....	3.70	4.32		8.02	4.94	3.08
2 persons.....	8.14	8.64		16.78	10.27	6.51
3 or more persons.....	8.14	12.96		21.10	14.59	6.51
	Blue Cross	Blue Shield				
Prior retirees:						
Individual.....	\$3.70	\$1.39		\$5.09	\$2.54	\$2.55
Individual and dependent.....	8.14	4.81		12.95	7.65	5.30

The CHAIRMAN. The meeting will stand adjourned until 10 a.m. tomorrow.

(Thereupon, at 12:05 p.m., the hearing was adjourned, to reconvene Wednesday, August 5, 1959, at 10 a.m.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

WEDNESDAY, AUGUST 5, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10:15 a.m., pursuant to notice, in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be continued on the various medical, hospital bills pending before the committee.

I wish that the members not here would come on time. I am not taking about those present. We have already lost 15 minutes this morning and we still do not quite have a quorum.

I am sure that nobody will make a point of no quorum, or I trust not. In order to proceed with this hearing just as fast as we can, the present arrangement is to complete the hearing of witnesses, outside the administration, by next Tuesday, August 11, and then on Wednesday August 12—1 week from today—we will hear from the witnesses of the Civil Service Commission and the Bureau of the Budget.

I would hope to wind up those hearings next week and then go into executive session.

I do wish the members would get here on time so that we can start promptly at 10 o'clock each morning.

The first witness this morning is Mr. Manton Eddy, vice president, Connecticut General Life Insurance Co., Hartford, Conn., representing the Health Insurance Association of America, the Life Insurance Association of America, and the American Life Convention.

Mr. MORRISON. Mr. Chairman, before the gentleman gets started, is it my understanding of what you said that all witnesses and all testimony will end a week from Thursday?

The CHAIRMAN. I said the administration would begin Thursday. I presume it will take a couple of days for the administration witnesses.

I hope to wind up the hearings next week.

Mr. MORRISON. I think we ought to be a little more definite on that. I think this. We have an understanding—I heard you talk to my distinguished colleague from Pennsylvania—I think if we could have an understanding on it as to when the hearings will end as far as all witnesses are concerned, why it would not be necessary to go into executive session. If we cannot have an understanding, I am going to move that we go into executive session.

The CHAIRMAN. We hope to finish the hearings next week.

Mr. MORRISON. It is not a question of hoping.

The CHAIRMAN. Nobody can tell definitely.

Mr. MORRISON. Mr. Chairman, then I—

The CHAIRMAN. We are pushing the hearings as vigorously as we can and if all members would be here on time, that would help.

I am glad that the gentleman from Louisiana is here.

Mr. MORRISON. The feeling is mutual.

I am going to move that the committee go into executive session to decide when the hearings will end. Is a referendum or motion—

Mr. FOLEY. I will second it.

The CHAIRMAN. I think we ought to take that up when the witnesses have completed their testimony this morning.

Mr. MORRISON. I am going to insist that that be done.

Mr. CORBETT. In view of conversations held this morning and in view of the exact times that had been scheduled, I think the chairman has misspoke himself,

You said the Government agencies would be heard starting Thursday, and earlier you said starting Wednesday. I think Wednesday was what you had in mind.

The CHAIRMAN. They are scheduled for Wednesday, August 12. That is right.

Mr. CORBETT. In view of that, I would like to say to the gentleman from Louisiana that if we can conclude Thursday or Friday, it is pretty well certain we would not do much at the end of the week anyhow. There is probably no important amount of time lost and I am satisfied that if we proceed without insisting on a quorum, or better still have a quorum present, we ought to be able to meet that schedule.

Mr. REES. I would like to have a quorum present from now on.

Mr. CORBETT. The House often—and we proceed under the rules of the House—in matters of this kind where we are not amending legislation, can proceed to take testimony so that it is available in the reports for the agencies and Members to peruse and if anyone wants to delay and fuss the thing around, then we are going to get into action that will just cause a lack of intelligent approach and perhaps an emotional one. This legislation is too important to get into a test of strength rather than the logic of the situation.

Therefore, Mr. Chairman, I am asking the gentleman from Louisiana if he perhaps cannot withhold that motion.

Mr. MORRISON. I would withhold it if we can have a definite understanding that all hearings will cease a week from this coming Friday.

Mr. LESINSKI. Do you think that we can conclude the hearings by that time?

The CHAIRMAN. I hope so. We can expedite them.

If the committee will come along with me, we will have sessions on Saturday and on Monday, if the committee will do it. I want witnesses to be heard and I do not want snap action or judgment taken by this committee.

Mr. LESINSKI. I concur with the chairman that this is important legislation.

The CHAIRMAN. How many people will be here Saturday?

Mr. OLIVER. I will be out of town, Mr. Chairman.

The CHAIRMAN. We will have three here Saturday.

Are you withholding the motion for the time being?

Mr. MORRISON. Provided we have an understanding that all witnesses and all hearings will end a week from Friday.

The CHAIRMAN. We will do the best that we can about it.

Mr. MORRISON. There is no question about doing the best that we can. I want a definite understanding.

You are entitled to your opinion and I am entitled to mine. I have a preferential motion before the committee and if there cannot be an agreement reached that all hearings and testimony end a week from Friday, then I am going to insist on my motion.

Mr. JOHANSEN. Mr. Chairman, I understand the statement made on the opening day of these hearings had to do with a willingness on the part of the gentleman from Louisiana—and I certainly respect his statement—to have sessions in the evening or on the weekend, or whenever necessary.

Mr. CORBETT. And he would be here.

Mr. JOHANSEN. And he would be here.

I think this is a matter of a two-way street and I unfortunately could not be here yesterday because I had to be in my district and was not able to return until after the morning session.

The CHAIRMAN. You must remember, Mr. Morrison, that the chairman of this committee has certain rights, responsibilities, and prerogatives.

After all, it is up to the chairman to go before the Rules Committee to present the request for a rule. If you take any step or action here this morning, I will not appreciate it and then you can go along with a discharge petition.

Mr. CORBETT. Mr. Chairman, I am going to move that the motion be deferred until Monday of next week.

Mr. JOHANSEN. I will support it.

The CHAIRMAN. Any discussion of the motion?

Mr. MORRISON. Is yours a substitute motion?

Mr. CORBETT. No, sir. I am, in effect, withholding action on the motion until Monday of next week for the purpose of determining how far along we are and determining the necessity and desirability a little better than we can do this morning.

Mr. MORRISON. The only way your motion can be recognized is for it to be a substitute motion to mine.

Mr. CORBETT. It is a motion to defer action.

The CHAIRMAN. A substitute?

Mr. CORBETT. It is a substitute or anything else. It is an action to table to a certain date. You can call it whatever you want.

The CHAIRMAN. Is there discussion on the motion?

If not, those in favor of the substitute motion of Mr. Corbett—

Mr. MORRISON. May I ask for the yeas and nays.

The CHAIRMAN. All right.

I think we will have to excuse these people and go into executive session.

You are all just wasting time here.

Mr. CORBETT. Mr. Chairman, I think we do not need to get into great technicalities. I could have moved that the previous question be set for next Monday and it would have been perfectly in order. Here with everybody gathered, I do not believe that the action of

postponement of the motion needs to be in executive session, postponement of a vote without a rollcall.

The CHAIRMAN. We can take a roll call but we cannot do that in open session.

Mr. CORBETT. Does the gentleman insist on a roll call?

Mr. MORRISON. Yes.

The CHAIRMAN. I ask that the room be cleared while the committee votes in executive session.

(The committee went into executive session.)

The CHAIRMAN (Open hearing being resumed following the executive session). The first witness this morning will be Mr. Manton Eddy, vice president of the Connecticut General Life Insurance Co.

Mr. Eddy, I hope you will make your statement as precise as possible and to the point.

STATEMENT OF MANTON EDDY, VICE PRESIDENT, CONNECTICUT GENERAL LIFE INSURANCE CO., HARTFORD, CONN., REPRESENTING THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE LIFE INSURANCE ASSOCIATION OF AMERICA, AND THE AMERICAN LIFE CONVENTION; ACCOMPANIED BY LAWRENCE CATHLES, VICE PRESIDENT OF THE AETNA LIFE INSURANCE CO. OF HARTFORD, CONN.

Mr. EDDY. Yes, Mr. Chairman, and with your permission I will attempt to brief it.

Might I have the full statement reproduced in the record? Would that be possible?

The CHAIRMAN. You will have such permission.

(The statement follows:)

STATEMENT OF MANTON EDDY ON BEHALF OF THE AMERICAN LIFE CONVENTION, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AND THE LIFE INSURANCE ASSOCIATION OF AMERICA

My name is Manton Eddy. I am vice president and secretary of the Connecticut General Life Insurance Co. of Hartford, Conn. With me is Mr. Lawrence Cathles, vice president of the Aetna Life Insurance Co., also of Hartford. We are appearing today on behalf of the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America, three associations having a combined membership of over 400 insurance companies. Collectively, these companies have more than 95 percent of the group accident and health insurance in force in the United States.

We wish to express our appreciation to the committee for the opportunity to appear today. We have had a deep and continuing interest in the matter of health care insurance for Federal employees and we wish to be of as much help as possible. We will freely make available our extensive experience in this field and in our testimony we will attempt to respond to the questions the chairman has raised in his letter of July 23.

It is a matter of record that there has been a tremendous growth in health insurance coverage in the last decade. Today in this country there are more than 121 million persons protected against the cost of hospital and doctor bills. Their protection may come through insurance company policies or through Blue Cross and Blue Shield or through other health care plans. However, of the 121 million persons with protection, 74 million of these are covered under insurance company policies. These policies are provided on both a group and an individual basis by the many hundreds of insurance companies handling health insurance in the United States.

Major medical expense insurance which helps people pay especially heavy bills resulting from a catastrophic or prolonged illness is a somewhat recent development but is having remarkable growth. At the end of 1956 the number of people protected was approximately 9 million. This number increased to more than 13 million by the end of 1957 and at the end of 1958 had reached 17 million.

Our member companies warmly endorse the proposal to make health care insurance available to the employees of the Federal Government and we sincerely hope that appropriate legislation can be enacted by this Congress.

We are of the opinion that S. 2162 and similar House bills provide a practicable basis for the development of a program of health care benefits for Federal Government employees, their families, and dependents. We do, however, urge careful consideration of the relationship of benefits and contributions under the proposed legislation, because even though almost all types of health care are indicated in the bill, the benefits received will necessarily depend upon the actual dollars available.

The chairman has suggested our giving a comparative discussion of paragraphs 1 and 2 of section 5(a) and our comments on the scope and meaning of subparagraph (D) of section 5(a)(1). Benefits under the service benefit plan are outlined in considerable detail in section 5(a)(1). However, the description of ambulatory patient benefits in subparagraph (D) is extremely broad and the scope of benefits could be almost unlimited. Earlier Blue Cross testimony has indicated that they would expect benefits under this subparagraph to be restricted to minor surgery and to services in case of accidental injuries. Such an interpretation would thereby exclude from subparagraph (D) a wide range of services for ambulatory patients such as all diagnostic and therapeutic X-rays, all pathology, and all home and office visits of physicians. Presumably benefits for such services would be expected to be covered under the supplemental benefits provided for in subparagraph (E) to the extent that funds were available.

On the basis of such a restricted interpretation of subparagraph (D) and of a reasonable interpretation of benefits in the other subparagraphs it is probable that service benefits can be provided in the first year for active employees within the maximum contributions specified in the bill. With retirees included, any possible margin seems to disappear. It is our conviction, however, that future increases in costs are to be expected and will inevitably necessitate either reduced benefits or increased contributions by Government and by employees.

These increases in cost will flow from two inexorable factors. These two factors are (1) the recognized annual upward trend in the cost of hospital-surgical-medical care, and (2) the greater average cost of benefits for annuitants who will increase in number each year.

With respect to the first, previous testimony before this committee has clearly indicated the continuing increase that has been taking place in the overall cost of hospital care. This increase has been attributable to the increased utilization of hospital facilities, the changing patterns of medical care, and in part to inflation. Abuse, we feel is an extremely minor factor.

Experts in this field appear to be in general agreement that hospital-surgical-medical costs can be expected to continue to increase for the immediate future at a rate of approximately 5 to 6 percent each year. It is pertinent to note that the Consumer Price Index of the Bureau of Labor Statistics for July 1959, shows that medical care has increased approximately 5 percent since July of last year, whereas other items in general have remained relatively constant.

The second factor of increasing cost concerns the number of annuitants under the program. Available statistics in connection with the Federal employees retirement plan indicate that in each of the next few years between 40,000 and 50,000 employees will retire. Contributions will be made at the same rate for annuitants as for active employees, but the facts are that the real costs of benefits for annuitants will be about 2½ to 3 times the costs of benefits for active employees. This is the experience of the insurance business and also that of Blue Cross as they have testified. In round figures the amounts paid out in benefits for annuitants will average \$140 more a year per annuitant than the contributions from Government and annuitants. If there are to be 40,000 new retirees each year, the total payments for benefits will increase substantially each year for that reason.

Table I, which is attached to this statement, makes a projection of benefit payments for active employees and new retirees over a 5-year period.

It is important that a soundly designed plan recognized at the outset that there are these factors which will bring about increased benefit payments year.

by year. If benefit levels are set initially equal to maximum contributions, it will follow that later benefits must be reduced unless additional contributions by Government and by employees are made in subsequent years. It would seem a prudent course to begin with benefits that are expected not to exhaust the Federal employees health benefits fund at the start. If a 20-percent margin between benefits and contributions is created in the first year, it should be possible to continue the level of contributions without a reduction in benefits for perhaps 5 years.

The chairman's letter asked that we suggest the nature of the benefits which could be offered by indemnity carriers under paragraph (2) of section 5(a) of S. 2162. It is not possible, of course, to predict at this time what would be the outcome of negotiations by the Civil Service Commission with indemnity carriers. We have, however, given thought to a program which would make wise use of the dollars available and concentrate on the important last dollars of catastrophic illness rather than on the first dollars of more frequent routine and minor illness.

One plan which might be considered could be described as a program of comprehensive medical expense benefits, as follows:

(a) For hospital room and board charges at the semiprivate level 100 percent of the first \$1,000 of such expense, and 80 percent of the excess over \$1,000;

(b) For other benefits (which would cover hospital fees other than room and board and would cover the complete range of diagnostic and therapeutic care and treatment, medical supplies, and services) 80 percent of charges subject to a \$50 deductible in a calendar year. There would be a lifetime maximum amount of \$15,000 and the first \$1,000 of benefits in any calendar year would not be counted in reaching the \$15,000 limit;

(c) The pregnancy benefit would be \$200 for normal pregnancies without a deductible or coinsurance;

(d) There would be certain exclusions but they would be the ones normally understood, such as occupational injuries, dental care other than oral surgery, most cosmetic surgery, and the cost of eyeglasses, hearing aids, and examinations for physical checkups.

Such a program would be very broad in scope and would provide substantial benefits for catastrophic illness within a reasonable budgetary cost. It would require the individual's participation in some of the costs of illness but at a moderate level which we believe is reasonable and proper and is on a basis which saves available dollars for their more important use when catastrophic illness strikes.

For such a program our estimate of benefit payments is \$216.4 million the first year for active employees and an added \$11.4 million for the newly retired.

Table II which is attached to this statement makes a projection of the benefit payments for active employees and new retirees over a 5-year period under such a program.

The figures do not include any estimate of administrative costs of the insurance carrier or any figure for State premium taxes.

We have assumed that the precise benefits under a governmentwide indemnity benefit plan would be determined through negotiations by the Civil Service Commission with potential indemnity carriers and that the choice of a particular carrier would result also from these negotiations. If the pattern of the Federal employees group life program is followed, the carrier selected as the principal underwriter of the program would be required to reinsure with all other qualified carriers desiring to participate in the program. If this committee feels that the group life pattern is desirable—and we urge that it reach such a conclusion—we suggest the following amendment to the bill so that there be no doubt about the intent of Congress:

After section 6(b) insert the following: "(c) Any contract or policy under this act shall provide that, under conditions approved by the Commission and a formula determined by it, portions of the total insurance under such contract or policy shall be reinsured with such other carriers as may elect to participate in such reinsurance."

Reletter the following subparagraphs of section 6 accordingly.

We have been asked to comment on the effect of extending the proposed legislation to Federal annuitants already on the retirement rolls and to their survivors. We are not in a position to offer recommendations as to whether this program should be extended to this group because, although obviously such an action on the part of the Federal Government would have very desirable and

perhaps far-reaching effects, the ultimate determination will most probably be based upon budgetary considerations.

It is quite evident that the average cost of benefits for annuitants is considerably greater than for the much younger group of active employees. As we have indicated in our previous statements with respect to future annuitants, we can expect benefits to be about 2½ to 3 times as great for annuitants as for active employees. Assuming that the 375,000 annuitants and survivors are composed of approximately 280,000 annuitants and approximately 95,000 survivors, we would estimate the first-year benefit payments under the program we have previously outlined, at about \$74 million.

In our earlier remarks we have pointed out the tendency of hospital-surgical-medical costs to increase in future years and these same forces will affect the benefits of annuitants. However, in the case of the present group of annuitants and survivors, there will be the offsetting forces of deaths, recoveries, and withdrawals. We would expect that these two opposing forces would largely offset each other for the next few years with the result that the cost would remain almost stable.

We trust, Mr. Chairman, that we have been responsive to the questions you have addressed to us and we wish to repeat our earlier assurance of desire to be of all possible assistance to this committee.

TABLE I.—*Projection of service benefit payments*

[In millions]

	Benefits for active employees	Benefits for future retirees	Total
1960.....	287.7	15.2	302.9
1961.....	302.1	28.2	330.3
1962.....	317.2	42.4	359.6
1963.....	333.1	58.7	391.8
1964.....	349.8	74.9	424.7

Assumptions:

- (1) 2,000,000 active employees are eligible.
- (2) 90 percent of active employees elect to join.
- (3) 40 percent of active employees enroll as individuals and 60 percent as families.
- (4) New retirees enter the program at an annual rate of 40,000.

TABLE II.—*Projection of comprehensive medical expense benefits payments*

[In millions]

	Benefits for active employees	Benefits for future retirees	Total
1960.....	216.4	11.4	227.8
1961.....	227.2	21.1	248.3
1962.....	238.6	31.7	270.3
1963.....	250.5	43.8	294.3
1964.....	263.0	56.3	319.3

Assumptions:

- (1) 2,000,000 active employees are eligible.
- (2) 90 percent of active employees elect to join.
- (3) 40 percent of active employees enroll as individuals and 60 percent as families.
- (4) New retirees enter the program at an annual rate of 40,000.

Mr. EDDY. The chairman has identified me and the three organizations for which I am appearing. With me is Mr. Lawrence Cathles, vice president of the Aetna Life Insurance Co., of Hartford, Conn.

The 3 associations we are representing have a combined membership of over 400 insurance companies.

I mentioned our interest in this field and our extensive experience and the fact that we have more than half the people covered who are covered by our insurance companies.

In connection with S. 2162, and similar House bills, the chairman has suggested our giving a comparative discussion of paragraphs 1 and 2 of section 5(a) and our comments on the scope and meaning of subparagraph (D) of section 5(a)(1).

Benefits under the service benefit plan are outlined in considerable detail in section 5(a)(1). However, the description of ambulatory patient benefits in subparagraph (D) is extremely broad and the scope of benefits could be almost unlimited. Earlier Blue Cross testimony has indicated that they would expect benefits under this subparagraph to be restricted to minor surgery and to services in case of accidental injuries. Such an interpretation would thereby exclude from subparagraph (D) a wide range of services for ambulatory patients, such as all diagnostic and therapeutic X-rays, all pathology, and all home and office visits of physicians.

Mr. PORTER. Mr. Chairman, at this point I would like to ask the gentleman if this is what the Commission finds to be reasonably desirable up to this time.

Mr. EDDY. No, sir. I am suggesting that a complete gamut of everything possible under that would cover these other services.

Mr. PORTER. Do you think that the legislation as written then is all right?

Mr. EDDY. I have no quarrel with it.

The CHAIRMAN. Proceed.

Mr. EDDY. On the basis of such a restricted interpretation of subparagraph (D) and of a reasonable interpretation of benefits in the other subparagraphs, it is probable that service benefits can be provided in the first year for active employees within the maximum contributions specified in the bill. The inclusion of retirees in the first year will bring the total benefits up just about to the maximum contribution specified. It is our conviction, however, that future increases in costs are to be expected and will inevitably necessitate either reduced benefits or increased contributions by Government and by employees. These increases in cost will flow from two factors. The first is the recognized annual upward trend in the cost of hospital-surgical-medical care, and the second is the greater average cost of benefits for annuitants who will increase in number each year.

I point out, as previous testimony has, that there can be expected an increase of approximately 5 percent a year in the cost of hospital-medical-surgical care.

At the end of this statement there is a table attached which makes a projection of the costs over a 5-year period and in our projection the benefits for active employees would total \$287 million and in 5 years' time would have increased to \$349 million.

The retirees would start at about \$15 million and in 5 years' time would have reached approximately \$75 million, or a total cost starting at approximately \$300 million and in 5 years' time reaching a figure of over \$400 million.

It is important that a soundly designed plan recognize at the outset that there are these factors which will bring about increased benefit payments year by year. If benefit levels are set initially equal to maximum contributions, it will follow that later benefits must be reduced unless additional contributions by Government and by employees are made in subsequent years. It would seem a prudent course

to begin with benefits that are expected not to exhaust the Federal employees health benefits fund at the start. If a 20-percent margin between benefits and contributions is created in the first year, it should be possible to continue the level of contributions without a reduction in benefits for perhaps 5 years.

The chairman's letter asked that we suggest the nature of the benefits which could be offered by indemnity carriers under paragraph 2 of section 5(a) of S. 2162. It is not possible, of course, to predict at this time what would be the outcome of negotiations by the Civil Service Commission with indemnity carriers, but we have given thought to a program which would make wise use of the dollars available and concentrate on the important last dollars of catastrophic illness rather than on the first dollars of more frequent minor illnesses.

Mr. JOHANSEN. Mr. Chairman?

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. May I interrupt? I want to go back a moment to what the gentleman said.

This differential, which I understand the gentleman suggested of 20 percent between the benefits and the payments, the gentleman may have stated it but it escaped me and I would like to know by what device should such a limitation, if there were one, be created?

Mr. EDDY. I think the bill creates a device of a fund into which the contributions are placed and out of which the premiums for the contracts, or the subscription rates, will be paid.

If the premiums and subscription rates are less coming out of the fund, are less than the amounts going into the fund, the fund would have this reserve margin for later years when the subscription rates and the cost of benefits are increased.

Mr. JOHANSEN. Would it be the self-restraint of the participants, or some provision of the program itself, which would provide this restraint and thereby provide the margin of 20 percent?

Mr. EDDY. I think, sir, it would be a conservative arrangement on the part of the Civil Service Commission that the program which they arranged, which under their contracts were arranged, were conservatively calculated so that it would not exhaust all the money coming into the fund.

Mr. JOHANSEN. In other words, the Civil Service Commission itself would police that by providing less than the maximum benefits during the earlier years?

Mr. EDDY. That is correct.

Mr. JOHANSEN. Thank you.

Mr. EDDY. We have outlined this program, which does place emphasis on catastrophic last dollars rather than on first dollars, and I will not read this in detail unless you wish.

The CHAIRMAN. Very well.

Mr. JOHANSEN. Mr. Chairman, I apologize for interrupting and I hope that I can avoid being repetitious, but I want to get at this point:

If the Commission so exercises restraint and if there are increased costs within the first 5 years, does not that, in effect, mean that the theoretical, potential benefits under this plan would, in all likelihood, not be achieved or attained at any time during the first 5 years?

I mean to say, if it is necessary to keep it down to meet the occurrence of increased costs during the 5 years, could not the effect be prac-

tically that the hypothetical, maximum benefits could never be achieved during that 5 years?

Mr. EDDY. That is correct.

At one time, we attempted to estimate the cost of the maximum, theoretical benefits which could be provided under section 5(a)(1), and our best estimate was a minimum of \$425 million, if the maximum benefits were included, which is complete coverage for all costs of hospital, surgical, medical, and health care.

Mr. JOHANSEN. Would there be any basis or justification for any feeling on the part of the Federal employees that the action subsequent to the enactment of this plan by the Civil Service Commission of restraining those benefits in order to provide this cushion would constitute in any way a deprivation or breach of faith with respect to what they had a right to expect from the program?

Mr. EDDY. It is possible that that could result. I would think that if this committee agreed with our thinking, that it is wise and prudent to start on a conservative cost, that the committee report would indicate that that is the intended program so that the individuals who were to benefit under the program would not feel that they had received less than had been intended.

Mr. JOHANSEN. Would the gentleman feel that there would be a normal and quite understandable pressure upon the Congress, or the Commission, or both, to increase those benefits in disregard of that principle of prudence?

Mr. EDDY. Let me speak broadly, if I may.

It has been our observation that human nature is the same everywhere and all of us are anxious to see more in the way of benefits year after year, if our employers will provide them.

Mr. JOHANSEN. The gentleman would agree that that rule with regard to human nature might conceivably apply to Members of Congress?

Mr. EDDY. I would say, yes, sir.

The CHAIRMAN. As I understand, you are convinced that the contributions that are made by the Government and by the employees who are covered will not be sufficient to take care of the benefits provided in this bill.

Mr. EDDY. We are convinced of that.

The CHAIRMAN. And, as I understand, under the bill if that situation becomes true there will have to be a reduction in the benefits; is that correct?

Mr. EDDY. That is correct.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. GROSS.

Mr. GROSS. To pay maximum benefits would cost more than \$400 million, I believe you said.

Mr. EDDY. I used the figure of \$425 million minimum.

Mr. GROSS. What would be the average contribution on the part of the Federal employees?

Mr. EDDY. This present bill provides a total of \$300 million, roughly, so that \$425 million would mean an increase of 40 percent more so that the \$1.75 would be about \$2.50 and the \$4.25 would be about \$5.75.

The CHAIRMAN. How many employees do you anticipate will seek coverage under this legislation?

Mr. EDDY. It would be difficult to predict, but all of us in the field of offering benefits have learned there is a point beyond which individuals cannot, and will not, contribute, and we are convinced from our experience that many people prefer to buy insurance that is reasonable and protects them against extreme hazards rather than attempt to buy protection for every possible dollar of payment.

The CHAIRMAN. Is it your opinion that if the contribution is not sufficient to provide the maximum benefits under this bill that it should be limited to major medical benefits?

Mr. EDDY. Under our proposal the first \$1,000 of hospital room and board on a semiprivate room basis would be covered in full. Beyond that there would be a \$50 deductible and a 20-percent coinsurance factor, so that the individual would be sharing in the cost of illness but not on a basis that is extreme or insupportable, and the maximum available would be a \$15,000 amount, which should take care of all catastrophic illnesses.

Our estimate of the cost of such a program is given in table II attached to my statement. You will find there the benefits for active employees at the outset is \$216.4 million and it grows in 5 years to \$263 million; and the benefits for future retirees start at \$11.4 million and grow in 5 years to \$56.3 million. The total at the outset is \$227.8 million and at the end of 5 years it is \$319.3 million.

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter.

Mr. PORTER. Mr. Eddy, are you against competition?

Mr. EDDY. I am very much in favor of competition. I say that sincerely. I think without competition businesses tend to become smug and self-satisfied.

Mr. PORTER. I do too.

I notice from your statement that you appear here representing companies that have more than 95 percent of the group accident and health insurance in force in the United States and that the three associations in whose behalf you are appearing have a combined membership of over 400 insurance companies. I do not see any competition here.

Mr. EDDY. I am sure the committee would not want to hear from 400 witnesses from 400 insurance companies. What we are speaking to is not the point of what we would like to sell. The committee has asked for our advice on what are good benefits, what we sell to businesses and industry generally, and we are glad to give that advice and those suggestions.

Mr. PORTER. Do you approve the principle of having one Government program?

Mr. EDDY. I think it would be difficult for the Government to undertake to have a great number of programs. Most businesses, when they decide to install benefits for their employees, review the programs and suggestions of a great many insurance companies and select the one they feel they would like to deal with. That decision is based on many factors. It includes the question of cost; it includes the question of services; if the business is a national concern doing business in 48 States it would not contract with a company doing business with only two States.

Mr. PORTER. As I understand, you are against having one Government program?

Mr. EDDY. No. I think the Government should have one.

Mr. PORTER. One plan but a lot of companies bidding?

Mr. EDDY. I think the Government should decide what are the exact benefits it wishes to purchase, and I think it should decide from whom it wishes to purchase those benefits.

Mr. PORTER. Do you think they should put it out on bid?

Mr. EDDY. I do not think this lends itself to competitive bidding on price basis because of the dollars paid for insurance, 95 percent of those dollars will go to doctors, hospitals, and nurses, and for the purchase of medical supplies and services. The administrative expense of the company handling the program will probably not be greater than 5 percent; it probably will be less.

Mr. PORTER. Mr. Massie testified the administrative expenses of his association were 10 percent 1 year and 8 percent 1 year. • Why should we not have the companies compete to lower those administrative costs to give a lower premium rate?

Mr. EDDY. I am sure before the Civil Service Commission will pick a company to administer the program, that company and other companies will have the matter of administrative expenses discussed. The group life program which the Government has purchased from one company started on the basis of administrative expenses of 1½ percent and the actual administration has been less than 1½ percent.

Mr. PORTER. As I understand, the plan here is to have the Government deal with a group of companies and they will divide the business. Is that correct?

Mr. EDDY. No. The Government will contract with one company if they follow the pattern of the group life program.

Mr. PORTER. I do not see any competition, then.

Mr. JOHANSEN. Will the gentleman yield?

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. Can the witness give any suggestion as to an administratively feasible program that would meet the criteria of competition? Will the gentleman tell us on what basis that would be administratively feasible?

Mr. EDDY. I think it would be very difficult to write the criteria in the bill. In my own eyes I can see the Civil Service Commission sitting down and talking to half a dozen of the national insurance companies, finding out what they can offer and at what price, what their administrative expense will be, and what their service facilities are, and the choice of company would be determined by the proposals that had been submitted from those different companies, and the Civil Service Commission would have selected the one that seems to offer the best price and the best service.

That is what we face in dealing with corporations in private business when we attempt to sell our product. The buyer will ask, "What will you do? How much will you charge? What are your service facilities?" And in the light of all the information that is elicited, the buyer will determine which company he will deal with.

Mr. PORTER. It seems to me it would be better to make up the specifications and let the companies bid and decide whether they can cut the administrative cost to give a lower premium.

Mr. EDDY. There is nothing in this bill, as I read it, that prevents the Civil Service Commission from going through that procedure, but

I do not think it would necessarily accomplish the result you have in mind.

Mr. PORTER. Why?

Mr. EDDY. This competitive bidding on price deals with dollars and the benefits provided under this bill will be dollars distributed among hospitals, doctors, health facilities, all over the country. Theoretically I can visualize I could make a lower bid if I were contemplating a delay in settling claims, for example. I could do it cheaper if I could do it with less service.

Mr. PORTER. That could be included in the specifications.

Mr. EDDY. I think it would be difficult to specify claims must be settled in 24 hours.

Mr. PORTER. You mentioned a 5 percent administrative cost and Mr. Massie, who preceded you, mentioned 8 percent and 10 percent, and I imagine in different companies that amount varies depending on the salaries paid their officials and many other things. I think the difference should go in lower premiums.

Mr. EDDY. I think the bill does not prevent it and I am sure the Civil Service Commission, in choosing an underwriter, will do so only after intensive discussions on all these matters with the companies.

The CHAIRMAN. The bill, under section 6(a), does not require competitive bidding.

Mr. EDDY. It does not require it, no.

The CHAIRMAN. Would you favor a provision in the bill requiring competitive bidding?

Mr. EDDY. I think it would restrict the Civil Service Commission in procuring the best results.

The CHAIRMAN. Do you think the various insurance companies will plan to pool their resources and share in this business and make one bid?

Mr. EDDY. No. We could not and would not make one bid. We would have to operate separately. While Mr. Cathles is with me today in speaking of our experience in the business, he would not be sitting with me if we were discussing a contract with the Civil Service Commission.

The CHAIRMAN. Would these private companies be able to provide benefits or coverage for employees overseas?

Mr. EDDY. Yes.

Mr. FOLEY. Mr. Chairman.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. I would like to point out there is this inherent competition between the mutual insurance companies and the stock insurance companies. Is that not correct?

Mr. EDDY. That is correct.

Mr. FOLEY. So that there is a guaranteed general competitive aspect between those two types of insurance companies.

Mr. EDDY. That is certainly a guarantee.

Mr. HOLIFIELD. Will the gentleman yield?

The CHAIRMAN. Mr. Holifield.

Mr. HOLIFIELD. While I would like to see competitive bidding where possible, I happen to know something about negotiated contracts and they frequently have the inherent competitive feature. I would assume if the Civil Service Commission sat down in good faith with 10

or 15 companies and asked each to make a proposal, that they would not be identical and the Commission would be in a position to exercise good business judgment and prudent judgment in selecting from that group the proposals which were in effect the competitive best among the proposals.

Mr. EDDY. That is true. You have said what I was attempting to say and you have said it clearly.

Mr. HOLIFIELD. In place of going through the regular prescribed competitive bidding procedures of the Government, this would be by negotiation?

Mr. EDDY. Yes, sir.

Mr. BROYHILL. Mr. Chairman.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. How does the program proposed in this bill compare with the average program of private employers in respect to the 50-50 employer-employee contribution and in respect to the benefits?

Mr. EDDY. There is such a wide range of programs and contributions in private business that it is difficult to speak of an average and be accurate. Programs can provide for no contributions by employees ranging up to full contribution by employees. But in general I think the 50-50 would be looked on as the middle of the road approach.

Mr. BROYHILL. Do you not have a standard policy that is a little more popular than others?

Mr. EDDY. In the field of group insurance where large businesses are buying benefits, a large business frequently has its own wishes and group programs for large employers are generally tailored to the wishes of that employer. Sometimes the choice is determined by the amount of dollars available to go into the program. Major medical expense insurance has been designed to take care of the long-term and catastrophic illnesses. It is the most recent form of benefits that we have and it is the most popular. If a person has the choice between dollars going for the first 10 days of hospital care or more dollars going for a long illness after his own dollars have been spent, it is our experience that the employee chooses the catastrophic type of benefits.

Mr. BROYHILL. The purpose of my question was to determine whether or not we are proposing in this legislation more benefits for Government employees than the average private employer provides for its employees. I understood your answer to be that in general the contribution is 50-50. Would you say the benefits were generally similar? In other words, we are not providing something a great deal better than the average provided by industry, or something a great deal less than the average in private industry?

Mr. EDDY. I would say roughly \$300 million provides benefits almost as liberal as any private employer provides today.

Mr. BROYHILL. Almost as liberal?

Mr. EDDY. As liberal as almost any. One may find an exception that proves the rule, but it would place the Government among the very best programs.

Mr. BROYHILL. As far as benefits?

Mr. EDDY. As far as benefits.

Mr. BROYHILL. But not as far as contributions?

Mr. EDDY. The 50-50 is the middle of the road approach.

Mr. BROYHILL. Mr. Eddy, I might say your company, the Connecticut General Life Insurance Co., underwrites insurance for a firm of which I am a stockholder.

Mr. EDDY. I am delighted, sir.

Mr. JOHANSEN. Mr. Chairman.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I am wondering if we cannot lay this bogeyman of no competition once and for all.

Do I understand in any type of insurance coverage there will be a definite competitive factor in the negotiations with the Civil Service Commission?

Mr. EDDY. I am convinced there will be.

Mr. JOHANSEN. Is it not also true that by reason of this program offering the Federal employees a choice between the Blue Cross-Blue Shield program and the type provided by your company and by other organizations, is it not true there is a factor of competition and a factor of choice for the Federal employee provided in this program not normally present in the programs of private employers?

Mr. EDDY. I think that is true.

Mr. JOHANSEN. I hope this will lay, once and for all, this bogeyman of no competition.

Mr. REES. Mr. Chairman.

The CHAIRMAN. Mr. Rees.

Mr. REES. We have been given to understand that the contributions under this bill would provide something over \$300 million?

Mr. EDDY. That is our judgment.

Mr. REES. And it is your estimate that it would cost \$400 million for the same benefits?

Mr. EDDY. The bill does not specify definite benefits. It speaks in paragraph (D), for example, of benefits for ambulatory patients, and it says those benefits shall be that which the Commission finds to be practicable, reasonable, and desirable. If the money is not available benefits will not be provided, and it is our judgment that the \$300 million will not provide a wide range of benefits for ambulatory patients except as they will come under paragraph (E), the supplemental benefits, where there is a coinsurance factor, and there may need to be a limitation of benefits there. You can only buy benefits to the extent you have money to buy benefits with.

There is a very important sentence at the beginning of section 5 which says "To the extent possible with the funds available" the benefits described will be provided. It is possible that the Federal employees will not identify the purpose and meaning of that sentence, but to me that sentence means, "We can only spend \$300 million and cannot provide benefits beyond that point."

The CHAIRMAN. I agree if the contributions are not sufficient to take care of all the benefits under this bill there is no alternative left to the Civil Service Commission under this bill than to reduce the benefits to match the contributions.

Mr. EDDY. Yes.

Mr. REES. Is it your opinion that it will take \$425 million to take care of the promises made under this bill?

Mr. EDDY. I do not think the bill makes those promises.

Mr. CORBETT. Did not the gentleman say, when he made the estimate of \$425 million, that that would be the cost of maximum benefits?

Mr. EDDY. Yes, sir.

Mr. BROYHILL. Will the gentleman yield?

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. The bill provides for specific amounts of contributions by the Government: \$1.75 biweekly for an individual employee; \$4.25 biweekly for a male employee and members of his family; and \$2.50 for a female employee and members of her family if a member of the family is a husband, other than a dependent husband.

How does that employer contribution for a health insurance program compare with employer contributions in other policies you sell?

Mr. EDDY. I think it is a liberal one.

Mr. BROYHILL. It is more than the average employer contributes?

Mr. EDDY. More than the average employer contributes.

The CHAIRMAN. There are several Government employee groups today that have health and hospitalization programs. For instance, the Federal Bureau of Investigation has its own program and so does the Central Intelligence Agency and the National Security Agency. Do you see any reason for not allowing those groups to continue their operations provided they have programs that meet Civil Service Commission specifications?

Mr. EDDY. There is no reason except the possible one of simplicity of operation. The more separate programs that are permitted to exist, the more administrative complexity will come about. That is not necessarily an important factor. I think it is important there not be a great number of separate programs because if we get too many small groups there can be additional costs that develop over the years. But if this committee or the Government felt it desirable to have more than one program, there is no reason for not having more than one.

The CHAIRMAN. I am concerned about the coverage of Government employees overseas. There are many of them. How would they be taken care of?

Mr. EDDY. Under an insurance company program they would be taken care of the same way that people are taken care of in this country. They are hospitalized, they have doctor bills, and those bills will be paid under the terms of the insurance contract the same as though the hospitalization or medical bills were incurred in the city of Washington.

Mr. IRWIN. Mr. Chairman.

The CHAIRMAN. Mr. Irwin.

Mr. IRWIN. I would like to commend the witness, who is from the State of Connecticut. You have been a very good witness.

Mr. EDDY. Thank you.

Mr. IRWIN. In your statement you make reference to two inexorable factors that will lead to increases in cost. The one with reference to the greater average cost of benefits for annuitants who will increase in number each year is clear, but could you help us in regard to the other factor, which you say is "the recognized annual upward trend in the cost of hospital-surgical-medical care"?

From the statistics that you quote from the Bureau of Labor Statistics, you point out medical care has increased 5 percent whereas

in general other items have remained constant. In effect that is partly contributing to inflation, it seems to me. You say it is generally recognized these costs will go up. How can that be stopped?

Mr. EDDY. I am not sure I can offer a solution, but I can give reasons for why that has happened.

The American people are getting better and better hospital care. The hospitals in great metropolitan centers are geared to provide almost the ultimate in hospital care. There are new drugs and new prostheses that have developed in the last couple of decades that contribute to greater cost for better care. The American public are more accustomed to going to hospitals. My generation were born at home. My children were born in hospitals. We use hospitals more.

Mr. IRWIN. Therefore, the increase in cost would really be an increase in cost for better benefits?

Mr. EDDY. Yes, sir. When we say the cost is mounting 5 percent a year, we are not pointing a finger of scorn at that. It is in fact evidence of better and better care. There is very little evidence of waste.

Mr. IRWIN. Is it due to the fact there is a lack of facilities and therefore more people are competing for those facilities?

Mr. EDDY. I do not think so. I could give you figures from the Consumer Price Index. All items in that Consumer Price Index from the base period of 1947, 1948, and 1949 to 1958 have increased to 123.5. Medical care has increased to 144.9. Of that 144.9 the hospital rates take the top billing. They have gone up to 198. Surgical fees have been increased to 122.7, and general practitioners' fees to 139.3. Not all have risen in the same degree but all have risen, and there is no reason why they should not have risen. They are contributing to better care of the American people.

Mr. IRWIN. Your analysis is that this increase reflects better service more than anything else?

Mr. EDDY. Yes.

Mr. IRWIN. Thank you.

The CHAIRMAN. Have not most of the companies raised their rates for these plans in the past 5 years?

Mr. EDDY. I cannot speak for all companies but my own company, we raised our rates about 15 percent in 1953 and 15 percent again in 1957 for hospital and medical care. Mr. Cathles tells me his company has done essentially the same. I suspect, competition being what it is in the insurance business, there is no great difference in rates among the major companies because one has to have a reasonable balance with his competitors to get any business.

The CHAIRMAN. If this legislation is enacted would you be willing to sign a 3-year or 5-year contract for a specified amount?

Mr. EDDY. I would prefer not to, sir.

The CHAIRMAN. Private insurance companies have to pay taxes?

Mr. EDDY. Yes.

The CHAIRMAN. Do they compete favorably with Blue Cross and Blue Shield in view of that situation?

Mr. EDDY. It does not make our competitive life easy. We are subject to State premium taxes of between 2 and 2½ percent. I imagine the average is 2¼ percent nationwide. I believe a half

dozen States require Blue Cross to pay premium taxes. That is a competitive factor that, as I say, makes life more difficult for us.

The CHAIRMAN. Blue Cross and Blue Shield have a certain advantage in that respect over private insurance companies?

Mr. EDDY. They have an advantage to that extent and it is something perhaps this committee would like to consider. I understand it would be within the prerogative of Congress to say in the legislation it would be free of State premium taxes.

Mr. GROSS. Will the gentleman yield?

The CHAIRMAN. Mr. GROSS.

Mr. GROSS. How do your benefits compare with those of Blue Shield and Blue Cross?

Mr. EDDY. Basically our benefits are sufficiently different so that there is no direct comparison possible, but we do have more than one half the hospital and medical insurance in this country, so I would think our rates and operations compare reasonably well.

Mr. GROSS. Despite the fact that in some States Blue Shield and Blue Cross are not taxed?

Mr. EDDY. That is right.

Mr. GROSS. That premium tax is between 2 and 2½ percent? Is that what you said?

Mr. EDDY. Yes, sir.

The CHAIRMAN. How many insurance companies do you represent here today? You represent the American Life Convention, the Health Insurance Association of America, and the Life Insurance Association of America.

Mr. EDDY. These three trade associations have a total membership of better than 400 insurance companies and those insurance companies have on their books better than 95 percent of the group accident and health insurance in force in the United States.

Mr. FOLEY. May I ask another question?

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. Going back to the matter of the purchase of these various categories of benefits for the dollars set forth in the bill, the insurance companies can provide benefits in every area for the fixed dollars set forth in this bill, is that right? In other words, in the plan you have submitted for the dollars set forth in this bill you provide benefits in every area?

Mr. EDDY. Yes, sir, and we suggested a program which is of the order of \$228 million. We could suggest a program of \$300 million. We are not inhibited from writing a very liberal program if the money is there to spend.

Mr. FOLEY. In other words, you can provide whatever benefits in whatever category of benefits the Civil Service Commission, in its judgment, feels are beneficial overall for the Government employees?

Mr. EDDY. Yes, sir.

Mr. FOLEY. So that for whatever amount of money, be it a dollar or \$10 a month, you can provide a certain percentage of hospital care, a certain percentage of surgical care, and so forth? In each category the benefit may be a smaller dollar benefit, but when the Civil Service Commission sits down with you gentlemen they can say, "We have decided we are going to spend 10 percent of these dollars for hospital care, 15 percent of these dollars for surgical care," and

on down the line, they can decide for themselves how much of this dollar they want to spend for each category, and you can provide those benefits to the extent of the money available in all categories; is that correct?

Mr. EDDY. Yes.

The CHAIRMAN. What kind of reserve does your company have, Mr. Eddy?

Mr. EDDY. Of course our company writes life insurance and pensions as well as health insurance. We have capital and surplus funds of \$160 million. Under our health program, which is term insurance, all of us carry reserves for known liabilities and for liabilities that we know will develop, but above that I think your question is directed to the contingency reserve, margin, and our goal is 50 percent of a year's premium, but none of us reach that goal. I think on an average if you looked at all group insurance it might be on the order of 15 percent of a year's term premium.

The CHAIRMAN. Under this bill do you think the Civil Service Commission should set up a reserve to take care of contingencies?

Mr. EDDY. I think it is always important to have a contingency reserve.

The CHAIRMAN. How much contingency reserve would you suggest?

Mr. EDDY. I think for that type of thing 2 or 3 percent a year is a good program, but that is intended to take care of the normal fluctuations that could come about from a mild flu epidemic or a mild polio epidemic. But the 20 percent margin I suggested at the start was to start the program less than maximum benefits so that it would not be necessary to raise the contribution or reduce the benefits over a 4-year or 5-year period. That was less of a contingency fund for fluctuations than a contingency fund for something that is almost certain to happen.

The CHAIRMAN. Would you suggest that the Civil Service Commission set up a contingency fund or contingency reserve? And if so, what would be a reasonable contingency reserve under this bill?

Mr. EDDY. I think they ought to start with a 20-percent margin.

The CHAIRMAN. 20 percent?

Mr. EDDY. Yes, sir.

Mr. JOHANSEN. To clear up that point, I am wondering if the 20-percent margin that the witness speaks of refers to the same thing the Senate minority views on S. 2162 referred to in saying that a reserve of 3 percent of 1 year's contributions plus other refunds was an inadequate reserve. I wonder whether the minority views of the Senate were talking about the same thing as the 20 percent the witness is talking about.

Mr. EDDY. They were addressing themselves to the same point.

Mr. JOHANSEN. Then you would agree that this 3 percent is totally inadequate?

Mr. EDDY. It would not serve the purpose.

The CHAIRMAN. You may proceed.

Mr. EDDY. We have assumed that the precise benefits under a governmentwide indemnity benefit plan would be determined through negotiations by the Civil Service Commission with potential indemnity carriers and that the choice of a particular carrier would result also from these negotiations. If the pattern of the Federal employees

group life program is followed, the carrier selected as the principal underwriter of the program would be required to reinsure with all other qualified carriers desiring to participate in the program. If this committee feels that the group life pattern is desirable—and we urge that it reach such a conclusion—we suggest the following amendment to the bill so that there be no doubt about the intent of Congress:

After section 6 (b) insert the following:

(c) Any contract or policy under this act shall provide that, under conditions approved by the Commission and a formula determined by it, portions of the total insurance under such contract or policy shall be reinsured with such other carriers as may elect to participate in such reinsurance.

Reletter the following subparagraphs of section 6 accordingly.

We have been asked to comment on the effect of extending the proposed legislation to Federal annuitants already on the retirement rolls and to their survivors. We are not in a position to offer recommendations as to whether this program should be extended to this group because, although obviously such an action on the part of the Federal Government would have very desirable and perhaps far-reaching effects, the ultimate determination will most probably be based upon budgetary considerations.

It is quite evident that the average cost of benefits for annuitants is considerably greater than for the much younger group of active employees. As we have indicated in our previous statements with respect to future annuitants, we can expect benefits to be about two and one-half to three times as great for annuitants as for active employees. Assuming that the 375,000 annuitants and survivors are composed of approximately 280,000 annuitants and approximately 95,000 survivors, we would estimate the first-year benefit payments under the program we have previously outlined, at about \$74 millions.

In our earlier remarks we have pointed out the tendency of hospital-surgical-medical costs to increase in future years and these same forces will affect the benefits of annuitants. However, in the case of the present group of annuitants and survivors, there will be the offsetting forces of deaths, recoveries, and withdrawals. We would expect that these two opposing forces would largely offset each other for the next few years with the result that the cost would remain almost stable.

We trust, Mr. Chairman, that we have been responsive to the questions you have addressed to us and we wish to repeat our earlier assurance of desire to be of all possible assistance to this committee.

The CHAIRMAN. Thank you very much.

Any questions?

Mr. REES. I have one question.

This bill has been submitted to us as having an approximate cost of \$304 million?

Mr. EDDY. Yes, sir.

Mr. REES. If benefits were given as provided in this legislation, is it your judgment that the cost of these benefits will be about \$425 million?

Mr. EDDY. The maximum contributions provided by the bill are estimated to be \$304 million. The benefits outlined in this bill are not specific in every category. They are not precise. There is a wide latitude. The dollars available are going to control the decision as to what the benefits will be. The benefits are not precise.

It was brought out that by starting with reduced benefits one can provide a program costing \$300 million. By reducing benefits still further one could provide a program costing \$200 million.

Mr. REES. Blue Shield and Blue Cross estimated the cost at \$304 million.

Mr. EDDY. I do not think they were estimating the maximum benefits provided by the bill.

Mr. REES. Is it your opinion that for the maximum benefits under this bill the cost would be about \$425 million?

Mr. EDDY. Yes.

The CHAIRMAN. If the bill were amended to include only major medical benefits what would be the cost?

Mr. EDDY. The cost would necessarily depend on where the major medical started, Mr. Murray. Would it pick up hospital bills after 70 days of hospital care or after 21 days of hospital care?

The CHAIRMAN. I am asking you as an expert. I know very little about it.

Mr. EDDY. A type of major medical could be provided for active employees for \$80 million.

The CHAIRMAN. Would that include hospitalization, too?

Mr. EDDY. That is based on the individual paying the first \$300 of cost.

The CHAIRMAN. Let us donate that \$300. What would be the cost of major medical and hospitalization under this bill, in your opinion?

Mr. EDDY. I think, sir, that is the type of plan we have suggested for a total cost at the outset of \$227 million.

Mr. JOHANSEN. Will the chairman yield?

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I would like to get very clear the testimony of the witness as to whether he deems it feasible or desirable or both to write into this bill any provision which would spell out for the first 5 years, or for an initial period, a mandate to the Civil Service Commission to make no commitment for a program which failed to provide this 20-percent margin.

Is it desirable and feasible to spell that out in the legislation?

Mr. EDDY. Yes, sir, and that very definitely would be our recommendation to you gentlemen.

The CHAIRMAN. To set up that much as a reserve in the beginning—20 percent?

Mr. EDDY. Well, the cost of the program, both from the trend of increased costs and from the addition of retirees, indicates that the cost at the outset will increase, say, 10 percent a year. If you start with a 20-percent margin, spending 80 cents of the dollar, the next year you will spend 90 cents, the third year \$1, the fourth year \$1.10, the fifth year \$1.20, and you would come out even. That is very crude arithmetic, but I think it explains what is behind our recommendation.

Mr. CORBETT. A 20-percent reserve would amount to approximately \$60 million a year?

Mr. EDDY. The first year.

Mr. CORBETT. And in 5 years it would be \$300 million?

Mr. EDDY. It would disappear. It would drop to zero at the end of the fifth year.

Mr. WALLHAUSER. You would be able to buy less benefits then?

Mr. EDDY. You would contract for less than maximum benefits. The alternative is to spend 20 percent more year by year or 10 percent more year by year.

Mr. WALLHAUSER. Unless you could arrange a longer term contract?

Mr. EDDY. If an insurance company were to contract for a 5-year period and had the certainty of these figures as I am giving them to you it would contract on essentially the basis I am suggesting. It would have to or it would go broke.

Mr. JOHANSEN. I think the gentleman is to be commended for a very sound, practical lesson in arithmetic, which this committee very badly needs.

The CHAIRMAN. Are there any further questions? If not, your full statement will be copied in the record.

Mr. REES. I would like to commend Mr. Eddy for his knowledge of the subject matter as shown in the testimony this morning.

Mr. EDDY. Thank you, sir.

The CHAIRMAN. The committee will next hear from Mr. Charles L. Massie, president, Federal Postal Hospital Association, of Kansas City, Mo., accompanied by Mr. Doyle D. Bonewits, vice president.

STATEMENT OF CHARLES L. MASSIE, PRESIDENT, FEDERAL POSTAL HOSPITAL ASSOCIATION, KANSAS CITY, MO.; ACCOMPANIED BY DOYLE B. BONEWITS, VICE PRESIDENT

Mr. MASSIE. Thank you, sir. I will endeavor to be brief.

The CHAIRMAN. You may highlight your statement, and the entire statement will be copied in full in the record.

Mr. MASSIE. Mr. Chairman, my name is Charles L. Massie. I am president of the Federal Postal Hospital Association. Accompanying me is Mr. Doyle D. Bonewits, vice president. This is a nonprofit organization incorporated under the laws of the State of Missouri governing benevolent corporations. We are furnishing service to all branches of the Federal postal service at cost.

Allow me, Mr. Chairman, to express our thanks to this committee for extending to us the opportunity of appearing at this hearing and to voice our views concerning the proposed legislation.

Our association started in 1937 with fewer than 100 members for the sole purpose of providing hospitalization to postal transportation clerks and their families at cost. It has so remained all these years. Today there are more than 14,250 members participating in hospitalization and 11,525 who have the surgical plan. We are national in scope, operating in 48 States, and have paid benefits of approximately \$2 million. Over a period of 22 years we have continuously raised old benefits and provided new ones as conditions warranted.

On January 1, 1959, because of service conditions instituted by the Post Office Department it became necessary to protect our membership and therefore we have expanded our organization to include all Federal postal employees.

Our purpose in appearing before this committee is threefold: (1) To state that we heartily endorse Federal health legislation; (2) to offer proposals and suggestions of our own based on 22 years of experience in this field; and (3) to make suggestions with reference to retired men not included in this bill.

The benefits proposed in H.R. 8210 usually referred to as fringe benefits, are benefits which employers in private industry all over the Nation have given to their employees in the last 10 years. Employees of the Government, lacking great means, have in the past provided this protection for themselves and their families through associations such as ours. For years postal clerks have initiated organizations such as credit unions, hospital associations, accident and fraternal companies and life insurance plans known as immediate relief associations. All of these things have been done with the idea only of furnishing as much family protection to these Federal employees as possible at a minimum cost. Therefore, we are very much pleased to see the interest of the Federal Government in providing such services and benefits under the Federal health plan and we are sure that after everyone has been heard this committee will submit a recommendation satisfactory to all Federal employees.

We are proud of the economic operation of the Federal Postal Hospital Association. Our administrative costs over the past 5 years have averaged only 10 percent, reaching an all-time low in 1958 of 8 percent.

Federal employees, having modest incomes, are interested in a basic plan of hospitalization furnishing the best coverage possible to obtain where costs are not excessive and service is the prime factor. By the Federal health plan of contribution, coverage will be much improved. In previous testimony we have stated "it does not seem unreasonable that a comprehensive medical, hospital and surgical plan including major medical could be evolved embracing these objectives at a moderate premium to the 2 million Federal employees, and that an all-inclusive standard plan covering all employees could be underwritten by eligible associations such as ours. It is obvious that the variance in hospital costs throughout the country strike an overall average and of course costs must be based on that average." If major medical is properly identified in a standard plan embracing full and comprehensive plans there need be no deductive features.

We are proud that virtually 100 percent of our members are postal clerks including many retired postal employees who have been members of our association for over 20 years, at the same rates as active employees.

Probably ours is the only hospital association, nonprofit or commercial, that employs a method of direct payment of the entire hospital bill for the member to the hospital. We find this is in accord with the recommendations as contained in U.S. Civil Service Commission report of April 8, 1959, page 3, paragraph 7. In conjunction with this we feel it is the only method of truly reflecting all administrative costs, since in most methods of handling claims the hospitals are required to perform various bookwork, breakdown of benefits paid for by insured or insurer, etc. Such service should be identified as part of the insurers operating expenses for a true picture of administrative costs. We have been highly commended by hospital administrators over the Nation for this method of benefit payments.

We are interested in making some suggestions to this distinguished committee which we think will be beneficial on some of the controversial points.

1. There could be duplication of benefits to members under this bill. There is no provision to exclude benefits involving third-party liability,

or for State and Federal hospitalization wherein the recipient receives free benefits.

2. There should be a clarification of benefits for mental disorders and psychiatric treatments.

3. Practically all Federal employees eligible to join the Federal plan already belong to some kind of an organization furnishing hospitalization and surgery benefits. Probably very few of them carry any form of major medical coverage. The history of our association discloses that over the past 5 years as a yearly average we would have had 1 case of major medical for every 2,200 members in hospital benefits, and 1 case for every 725 members carrying surgical coverage. We believe the rate structure could be provided and incorporated in a standard plan and would be at a much lower level than anticipated by the Civil Service Commission. In any event, the whole rate structure depends on what benefits are required of the carrier.

4. Every day 1,000 more Americans reach the age of 65, many of them Federal employees. The Civil Service Commission recognizes neither legal nor moral obligation to former employees now retired. Private interests do. New York State does. The Dominion of Canada recently adopted a hospitalization program and included those already retired. We believe the interest of these retired men is of vital concern not only to 500,000 senior citizens but to the whole Federal service. Whether this is done by amendment to H.R. 8210 or by separate legislation it is our belief that there is as much responsibility to the retired man as to those actively employed. We also believe the 30-percent additional cost for including retired men is grossly exaggerated.

Our organization considers these senior citizens as having built up a reserve sufficient to carry them and their families in their declining days. Therefore we have never discriminated against them in reduction of benefits or increase in rates. There is no justification for it. If New York State and the Dominion of Canada can afford to cover present retirees certainly our own Government should take a closer look at the humanitarian aspects of these senior citizens.

CONCLUSION

1. We believe this is a workable bill and that it presents much needed legislation and reflects great effort on the part of this committee to protect Government workers with a suitable health plan.

2. There should be formulated one standard plan for comprehensive health benefits composed of all the factors of coverage. Basic principles of this health plan should be in rendering services for the welfare of Government employees, which of course means the greatest possible benefits for the least amount of money.

3. The Federal Postal Hospital Association of Kansas City, Mo., is proud of the important role we have had in the past 22 years in the welfare of Federal employees, and it is our sincere belief that as a service organization we are fully qualified to continue in such service.

4. We believe that the term "National Employee Organization" in lines 3 and 4, page 5 of H.R. 8210 should be amended by the deletion of one word "labor."

5. Mr. Chairman, and members of this distinguished committee, please accept our sincere appreciation for the privilege of appearing before you in support of this legislation.

Mr. Chairman, I would like to give just a brief résumé of our organization in order to acquaint the committee with service organizations that do exist with the Federal employee structure at the present time. Our association, the Federal Postal Hospital Association, started in 1937 with fewer than 100 members for the sole purpose of providing hospitalization to Postal transportation clerks and their families at cost.

It has so remained all through the years. Today there are more than 14,250 members participating in hospitalization and 11,525 in the surgical plan. We are national in scope, operating in 48 States, and have paid benefits of approximately \$2 million over a period of 22 years. We have continuously raised old benefits and provided new ones as conditions warranted.

On January 1, 1959, because of service conditions instituted by the Post Office Department it became necessary to protect our membership and therefore we expanded our organization to include all Federal postal employees.

The CHAIRMAN. In what year?

Mr. MASSIE. January 1 of this year, sir.

Mr. JOHANSEN. I did not catch the import of that. You say because of service conditions instituted?

Mr. MASSIE. I will be happy to explain. The organization originally was founded for the railway mail service employees, which later became the postal transportation clerks. Due to service conditions within the Post Office Department—as an example myself, I was in one of the district offices of the Postal Transportation Service and those offices all over the country were closed and the employees were assimilated either in the other organizations or within local post offices such as I was. Under the previous restrictions those persons could not have continued their membership in our association, but by changing our constitution to expand it to all postal employees, we were able to retain and protect those persons. Does that answer it, sir?

Mr. JOHANSEN. It does.

Mr. MASSIE. Our purpose in appearing before this committee is threefold: to state that we heartily endorse Federal health legislation, to offer proposals and suggestions of our own based on 22 years of experience, and to make suggestions with reference to retired men not included in this bill.

The benefits proposed in H.R. 3210, usually referred to as fringe benefits, are benefits which employers in private industry all over the Nation have given their employees in the past 10 years. Employees of the Government, lacking great means, have in the past provided this protection for themselves and their families through associations such as ours. For years postal clerks have initiated organizations such as credit unions, hospital associations, accident and fraternal companies, and life insurance plans known as immediate relief. All of these have been done with the idea only of furnishing as much family protection to these Federal employees as possible at a minimum cost.

Therefore, we are very much pleased to see the interest of the Federal Government in providing such service and benefits under the Federal health plan. We are proud of the economic operation of the Federal Postal Hospital Association.

I at this time wish Mr. Porter were here. He made reference to part of our testimony in the previous hearing, and I would like to expand a bit on the problem of administrative costs.

As stated in our testimony, our administrative costs over the past 5 years have averaged only 10 percent, reaching an alltime low of 8 percent.

Please bear in mind, gentlemen, our organization is comparatively small as related to insurance companies or to Blue Cross.

Mr. REES. You are selective in your membership?

Mr. MASSIE. Yes; we are selective in our membership. In other words, our organization was created originally in 1937 for the very purpose that you gentlemen are contemplating today—gentlemen and ladies; pardon me, Mrs. Granahan and Mrs. St. George. For that reason, being restricted and being limited in our membership, we have endeavored to provide a service organization with the best possible benefits for the lowest possible cost, being controlled by postal clerks themselves.

It might interest you gentlemen to know that no officer in the Federal Postal Hospital Association has ever received one cent in salary. It is merely their desire to do the responsibilities of management of this organization as a service to their fellowmen.

The CHAIRMAN. Are you a Federal employee today?

Mr. MASSIE. I am a permanent employee in the Post Office Department. I am president of the hospital association; I have never received any salary for my work. Neither has Mr. Bonewits or any member of the board. We have four paid women employees in our office at the present time.

Federal employees, having modest incomes, are interested in a basic plan of hospitalization furnishing the best possible coverage to obtain where costs are not excessive and service is a prime factor. The Federal health plan of cocontribution coverage will be much improved.

In previous testimony we have stated that it does not seem unreasonable that a comprehensive medical, hospital, and surgical plan, including major medical, could be evolved embracing these objectives at a moderate premium to the 2 million Federal employees and that an all-inclusive standard plan covering all employees could be underwritten by eligible associations such as ours.

Mr. JOHANSEN. May I interrupt at this point to clarify my own understanding and the record? How is your program underwritten?

Mr. MASSIE. Our organization is incorporated under the eleemosynary laws of the State of Missouri, the same laws under which Blue Cross is operating. We determine a percentage of our reserve to be set aside. We have, fortunately, determined that on a very adequate basis by the fact that in the 22 years of existence we have adjusted our rates only twice.

Mr. JOHANSEN. In other words, it is completely self-insurance in the sense of being completely insured and handled by this organization.

Mr. MASSIE. That is right, sir.

Mr. JOHANSEN. Thank you.

Mr. MASSIE. Having made that statement, I would like to explain that in 1949, due to increased costs in hospitalization from 1937 to 1949, we made an adjustment in both benefits and rates and then last year, 9 years later, we made the second adjustment.

Mr. JOHANSEN. My point is, however, there are no outside underwriters.

Mr. MASSIE. No, sir. We are underwritten strictly by the postal employees themselves. Should conditions develop that would necessitate through depletion of our reserves an extra assessment could be imposed on our membership, but we have never as yet found that necessary.

The CHAIRMAN. Your program only covers hospitalization; is that right?

Mr. MASSIE. We have a hospitalization plan and a surgical plan. A little further in my testimony we will touch upon that, if it is agreeable with you.

Mr. HOLIFIELD. Could I ask how your rates compare with Blue Cross and Blue Shield, taking into consideration comparable benefits?

Mr. MASSIE. That is a difficult question to answer, sir, because Blue Cross particularly is a service organization. In other words, they endeavor to provide hospital service where it is possible.

In certain contracts with other hospital areas or Blue Cross areas they do have a cash indemnity provision, I understand. Of course, ours is more comparable to commercial insurance in that we provide a cash indemnity plan. We allow so much for the various services in the hospital and so much for the various types of operations.

Mr. HOLIFIELD. Give us, if you can, a comparison of your benefits and the costs or charges, rather, with what you could get commercially. Are they better, in your opinion? They must be, or you would not keep your organization together. If so, percentagewise how much better?

Mr. MASSIE. Of course, due to the variables in the Blue Cross plans throughout the country and also the variance in their rates in certain localities, I would estimate roughly that the rates we charge our membership for protection are between 20 and 30 percent lower than commercial insurance or Blue Cross. That, of course, is a rough estimate.

Mr. JOHANSEN. That is for comparable benefits?

Mr. MASSIE. Yes, sir.

Mr. HARMON. Mr. Chairman.

The CHAIRMAN. Mr. Harmon.

Mr. HARMON. Do you get from the hospitals a 5 percent discount for paying cash, as Blue Cross does?

Mr. MASSIE. Yes, sir; I have never heard of a hospital making a refund. If they do, we certainly have never received it.

Mr. HARMON. Are you aware of the fact that Blue Cross gets it?

Mr. MASSIE. No, sir; I am not.

Mr. HARMON. I am.

Mr. MASSIE. I would like to expand further, Mr. Harmon, with your permission, and say our organization, to the best of our knowledge, is the only hospital plan in the United States that advises the hospital to send the entire bill directly to our offices. We pay the entire bill, due to the fact that we have a membership which are considered as preferred credit risks, being postal or Federal employees,

we can take that chance. If there is a refund for services that are not included or excessive under the hospital stay, we collect that refund from the member ourselves. But the hospital has only one business transaction, that in sending the complete bill to our office and receiving the check for the entire amount to the hospital.

Mr. JOHANSEN. Will the gentleman yield?

Mr. HARMON. Yes.

Mr. JOHANSEN. In collecting that differential is it done on a single payment basis or is the employee able to work it out in time?

Mr. MASSIE. In the majority of cases there is no question at all. I remember that approximately 10 years ago we had one member in Baltimore, Md., who had a very tremendous bill, a lot of oxygen and the various services that were beyond the average hospital care facility. It was necessary for that member to make arrangements with the Railway Mail Credit Union in Baltimore for the payment. To my knowledge, that is the only one where there was a question of financial stress involved.

Mr. FOLEY. Mr. Chairman.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. In how many States do you have members who participate in this program?

Mr. MASSIE. We have members in all 48 States, Mr. Foley.

Mr. FOLEY. Of course, the hospital bills vary State to State, as you have already indicated; is that right?

Mr. MASSIE. Yes, sir.

Mr. FOLEY. For the same particular type of hospital service in one State you, out of your self-insured funds, would pay a little higher amount of money than in another State; is that correct?

Mr. MASSIE. No. We have two different plans under our organization designed for persons living in the more expensive areas such as here in Washington or New York or Los Angeles, and the people living in the Midwest or in smaller communities where hospital costs are not as high as they are in the larger cities.

The same rate, whichever plan they belong to, plan A or plan B, the same amount of money would be paid for the various services in any of the 48 States.

Mr. FOLEY. The cost of plan A is a little higher than the cost of plan B to the participating members; is that right?

Mr. MASSIE. The reverse. Our plan A is the less expensive.

Mr. FOLEY. Whichever is more expensive. In other words, plan B, the more expensive plan, in that case the cost nationally is the same in every location where plan B has participating members; is that correct?

Mr. MASSIE. Yes.

Mr. FOLEY. And likewise the same for plan A?

Mr. MASSIE. That is right.

Mr. FOLEY. Plan B, then, because the participating member pays more money into the fund, the bills which are higher in these areas are covered to a higher extent percentagewise and dollarwise; is that correct?

Mr. MASSIE. That is right.

Mr. FOLEY. Is your program to pay the full hospital bill either under plan A or plan B?

Mr. MASSIE. Eventually if the Federal health plan is enacted as written—of course, there will have to be clarifications, as Mr. Eddy pointed out—however, as the bill is now written the adjustment would have to be made for assuming the entire hospital bill.

Mr. FOLEY. I was thinking only of your present operation under your existing program. Do you today, either under plan A or plan B, pay the full cost?

Mr. MASSIE. No, sir; we have the cash indemnity allowance for the various services. However, our constitution is such that changes could be made to provide for the entire coverage of hospitalization in the basic plan and then reverting to the major medical.

Mr. FOLEY. Thank you very much.

Mr. HARMON. Getting back to this 5 percent, do you not think you should have the benefit of that as well as Blue Cross?

Mr. MASSIE. I most certainly do.

Mr. HARMON. Would that not be a great help in your plan to have this payment?

Mr. MASSIE. Because of the fact that we are taking the bookkeeping out of the hospital and putting it into our office, where we feel it should be, certainly if any organization is entitled to that 5 percent you refer to, we are.

Mr. HARMON. Perhaps you should look into it and see if you can make that kind of deal.

Mr. MASSIE. We also could provide even higher benefits if we received such allowance from the hospital for the discounting of their bills.

The CHAIRMAN. Mr. Davis.

Mr. DAVIS. Mr. Massie, what effect do you anticipate that the passing of this legislation would have, if any, on the continued operation of your group?

Mr. MASSIE. Mr. Davis, naturally that is of very serious concern to us. That is why we felt it was most important that we be privileged to appear before the committee to advise you in case you are not aware of the fact that there are numerous service organizations such as ours, nonprofit organizations. I am not speaking, of course, of employee groups where they have a health program that is underwritten by commercial insurance, but I am speaking only of organizations such as our which maintain their own protection. It maintains its own reserve and provides its own benefits.

Mr. REES. There must be quite a number.

Mr. MASSIE. Yes, sir; there are. It would be most interesting if I could even determine the total number. Just this morning I learned of the FBI having a similar group to ours. I know in the Kansas City area there is a plan for the employees of the Kansas City Post Office. There is one in St. Louis and I understand one in Chicago. There are probably many service organizations where the employees themselves have provided something to protect themselves. Certainly, they have successfully done so or they would not be continuing in existence today.

The CHAIRMAN. There is only one nationwide service plan under this bill, and with that you would not exist much longer, would you?

Mr. MASSIE. No, sir; on that basis we would not. However, I would like to suggest to this committee that in their investigations

they no doubt could determine the number of service organizations such as ours. If those organizations could be combined into one major service organization and set up on possibly a regional structure like the Post Office Department exists, it is not without possibility that they themselves, the employee organizations themselves, could manage and could operate most economically a Federal health plan.

Mr. JOHANSEN. I believe this is a fair question. I wonder if the witness would agree that the interests and the stake which your organization and the other organizations of the type you have described are of such a nature and such importance that this committee will be well advised to take the time, without any unnecessary delay, to consider that problem and attempt to deal in this legislation constructively with it and whether it is not advantageous in the terms of the end result that we take that necessary time rather than that we be crowded into a precipitate ending of these hearings.

Mr. MASSIE. Most certainly, sir, I sincerely hope that the committee does weigh the fact of the existence and the place these organizations have played in the many years in the things you are now contemplating.

Mr. JOHANSEN. In other words, while you are very much interested in and support the principle of this legislation, you nevertheless feel you and your fellow employees in this and similar plans have a very real stake in this legislation; is that right?

Mr. MASSIE. Most certainly, sir.

The CHAIRMAN. I sent a letter on August 1 to the Chairman of the Civil Service Commission which reads, in part, as follows:

Among these groups of employees of the Federal Bureau of Investigation—talking about these companies operating like yours—

approximately 9,200 members and 28,000 dependents; National Security Agency with 115,000 people affected; Central Intelligence Agency with a considerable number of employees participating in the program.

Most recently we have been informed of a similar situation in the Office of Civil and Defense Mobilization in Battle Creek, Mich., with approximately 2,100 persons participating in the program. All these plans vary and their continuance is a major issue of the employees concerned as well as the local agencies who are handling the insurance of these groups.

One of the main concerns of the employees is they have built up substantial reserves in their existing payments in which they as participants have an interest. I believe most important, before final decision is reached on this legislation, that the committee have information as to how many similar groups are in existence in the various Government agencies and just what will happen to the program under the terms of S. 2162.

We will get that information from the Chairman of the Civil Service Commission when he appears.

Mr. JOHANSEN. May I ask one further question, Mr. Chairman?

Do you feel that competitively, in terms of costs to your covered employees and in terms of benefits, that this program of yours might continue and might survive by reason of those advantages if there were some provision, of course, for Federal participation in such a program so that you would not be losing that gain but could continue the program with that added bonus?

Mr. MASSIE. Yes, sir; I do. I see no reason why organizations such as ours cannot continue, because economically, in spite of the fact of the statistics that have been given relative to administrative costs, I believe our organization's figures represent the only true figure.

As I pointed out, the hospitals themselves at the present time are performing administrative costs for both commercial insurance and for other organizations.

Mr. JOHANSEN. Is it your impression that law as now written would provide and include such arrangements whereby you could gain the benefit of Federal participation?

Mr. MASSIE. Sir, we will make a recommendation at the end of my statement that I feel confident will cover that justification for our being considered as a carrier.

The CHAIRMAN. I am interested in seeing what kind of plan you propose.

Mr. JOHANSEN. Can you not go directly to that recommendation?

Mr. MASSIE. I will, sir.

We believe under H.R. 8210 that the term "national employee organization" shown in lines 3 and 4 of page 5 should be amended by the deletion of the word "labor." The reason we make that recommendation for an amendment is that the words "national employee organization" will cover service organizations such as ours and such as the FBI and others.

This is meant with no reflection at all toward labor. Mr. Bonewits and I both belong to labor organizations within the Federal employee structure and we are proud of it. We feel the intent of this bill is relative to a health program for Federal employees. By the deletion of that word it specifically identifies these service organizations by use of the words "national employee organization."

The CHAIRMAN. Leaving out the word "labor?"

Mr. MASSIE. As not bona fide labor organizations; yes sir. If there are questions, I would be happy to answer them.

Mr. JOHANSEN. If it were amended to read "labor or other employee organizations," would it meet your requirements?

Mr. MASSIE. Yes, sir. I see no reason that that should not. It was merely the shortest way to arrive at the solution.

The CHAIRMAN. How many members do you have in your association now?

Mr. MASSIE. In our hospital association we have 14,250. It is better than that. Under our surgical plan we have 11,525.

The CHAIRMAN. Are there any further questions of the witness? If not, thank you very much, Mr. Massie.

Mr. Bonewits, do you desire to make any statement?

Mr. BONEWITS. No, sir.

Mr. MASSIE. Thank you for the privilege of appearing.

The CHAIRMAN. Mr. Bonewits is vice president of your association?

Mr. MASSIE. Yes, sir, and is a practicing attorney and retired railway mail clerk.

The CHAIRMAN. We have a statement, which will be placed in the record at this point, by Mr. Arthur Weissman, director of statistical information, Kaiser Foundation Health Plan, Inc., Oakland, Calif.

Also, our colleague, Mrs. Granahan, desires to present a statement from Hon. Francis R. Smith, insurance commissioner, Commonwealth of Pennsylvania.

Mrs. Granahan, the statement will be included in the record.

Mrs. GRANAHAN. Thank you, Mr. Chairman.

(The statements referred to follow:)

STATEMENT OF KAISER FOUNDATION HEALTH PLAN, INC.

On behalf of the Kaiser Foundation Health Plan, we wish to express our appreciation for this opportunity to present our comments on H.R. 8210 (companion bill to S. 2162).

The Kaiser Foundation Health Plan is a California nonprofit corporation which conducts a group practice prepayment medical care program. In June 1959, there were 350,000 Health Plan members in the San Francisco Bay area and 264,000 members in the Los Angeles and Fontana areas in southern California. In an associated program in Portland, Oreg., Vancouver, Wash., and vicinity, there were approximately 33,000 members. Recently our health plan began serving members on the Island of Oahu, Hawaii.

More than 10 percent of our members—some 70,000 persons—are Federal employees and their dependents. Our purpose in this statement is directly related to the Federal employees and their families who voluntarily selected our plan—who have chosen our approach to meeting their medical care needs.

HOW THE HEALTH PLAN OPERATES

To arrange comprehensive medical, hospital, and related services for health plan members, the Kaiser Foundation Health Plan contracts with groups of physicians organized as medical partnerships which provide all professional services to members. Hospital facilities and services are obtained by contract with Kaiser Foundation Hospitals, a California nonprofit and charitable corporation, which provides hospital and emergency facilities for the general community, furnishes charitable care, sponsors programs in medical education and research, and also meets the hospitalization requirements of health plan members.

Participating in this direct service prepayment program are 12 hospitals with a combined licensed capacity of more than 2,000 beds; some 40 outpatient medical centers; approximately 650 physicians (in the autonomous medical partnerships which contract with the health plan); and roughly 5,500 nonphysician personnel, including nurses, pharmacists, technicians, and other staff needed in hospitals and outpatient medical centers.

From experience dating back to 1933, our organization has developed a set of five principles governing the operation of the Kaiser Foundation Health Plan program. These principles are: (1) Group practice, (2) prepayment, (3) emphasis on preventive medical care, (4) use of integrated medical facilities for both inpatients and outpatients, and (5) voluntary enrollment in the health plan. These principles are briefly described in exhibit A, an excerpt from a statement recently presented by C. C. Cutting, M.D., executive director of the Permanente Medical Group—the medical group which contracts with the health plan in the San Francisco Bay area.

Federal employees in the Kaiser Foundation Health Plan comprise groups at the Alameda Naval Air Station, San Francisco Naval Shipyard, Mare Island Shipyard, and the Hamilton, Travis, Norton, and March Air Force Bases; post office employees, and groups in a wide variety of other Government agencies including the Atomic Energy Commission, U.S. Public Health Service, Internal Revenue Service, Veterans' Administration and Veterans' Administration Hospitals, Federal Bureau of Investigation, and the customs service.

These Federal employees and their families have all enrolled in the health plan voluntarily. From among many prepayment plans available to them, they have consciously and deliberately chosen our health plan, which—

- (a) arranges, on a direct service basis, for extensive day-to-day medical care services as well as services for catastrophic illness;
- (b) looks up services in the doctor's office as core services in prevention and early detection of disease, and in diagnosis and treatment;
- (c) considers broad scope, out-of-hospital medical care services to be at least equal in significance to a broad range of hospital services; and
- (d) regards comprehensive professional services, both in and out of the hospital, and comprehensive hospital care, as basic health care benefits.

Thus Federal employees in the Kaiser Foundation Health Plan have chosen, through the plan, to obtain medical care services to meet a broad spectrum of family health needs ranging from health maintenance services to services for catastrophic illness.

Our purpose in explaining the Health Plan's principles of operation and approach to the problem of providing hospital and medical coverage on a prepayment basis is not to urge the superiority of this approach or to argue the relative merits of this approach as compared with other types of plans or with the coverage offered by commercial insurance carriers. Rather, we wish to make it clear that a group practice prepayment plan, such as our Health Plan, represents an approach to meeting medical care needs which is significantly different from other types of available coverages and which is preferred by a substantial segment of those persons to whom it is available, including a considerable number of Federal employees.

FREE-CHOICE PROGRAMS ARE PRACTICAL

Numerous employers in commerce and industry, as well as local governments, contribute part or all of premiums or subscription charges toward hospital and medical care arrangements under which the employees have the opportunity to choose among two or more carriers. In April of this year a Senate subcommittee compiled a list of programs which offer choice of prepayment plans.¹

Our experience with many programs providing for choice of plan indicates a high degree of satisfaction with the free-choice arrangement by all parties concerned—the employees and their families, the employer, the providers of services, and the alternate plans or carriers. Mindful of this experience and of the basic fact that Federal employees, like other employees, differ in their preferences among prepaid medical care plans, we strongly endorse the choice of plan provisions of H.R. 8210.

In the hospital and medical-care field there is a place for several types of plans. This is demonstrated by all instances within our experience in which dual or multiple-choice programs are available to employees. Some families like our plan; other families prefer alternate plans or coverage offered by insurance companies. After the initial selection, an opportunity is afforded periodically for each family to transfer from one plan to another, thus furnishing all carriers with a competitive stimulus to maintain satisfaction among their subscribers. Our experience with the periodic transfer feature again demonstrates that there is a place and a need for different types of plans in a health benefit program for employees and their families.

We also note with favor that H.R. 8210 includes the language "informed choice," indicating that, prior to their selection of plan, Federal employees will be furnished information describing the benefits of the several plans; and that the bill provides for an affirmative choice by each Federal employee prior to enrollment in any of the alternate plans.

Neither we who work in prepaid medical-care programs, nor the purchasers of prepayment plan coverage have all the answers to the question of how best to meet the health-care needs of workers and their families. Some of these answers will not come from the experts; they will grow out of day-to-day comparisons made by employees and families who have different arrangements for obtaining medical care, as in programs permitting choice of plans.

HEALTH PLAN COSTS

H.R. 8210 specifies the maximum contribution for the health benefits program by an employee with no dependents (\$1.75 biweekly) and by an employee with dependents (\$4.25 biweekly). Matching contributions by the Government bring these biweekly totals to \$3.50 and \$8.50 respectively, which convert to a monthly total of \$7.58 for an employee with no dependents, and \$18.42 for an employee with dependents.

¹Pp. 207-210 of hearings before Subcommittee on Insurance of the Committee on Post Office and Civil Service, U.S. Senate, 88th Cong., 1st sess., on S. 94 (Health Insurance Program for Federal Employees), Apr. 15, 16, 21, 23, 28, and 30, 1959.

In the San Francisco Bay area where our health plan enrollment includes some 50,000 Federal employees and dependents, present subscription charges, on a payroll deduction basis, for the coverage now carried by Federal employees (as shown in exhibit B) would be:

	Kaiser Foundation health plan BC coverage	H.R. 8210 maximum
Employee with no dependents.....		
Employee with 1 dependent.....	\$6.55	\$7.58
Employee with 2 or more dependents.....	11.95 15.55	18.42

The present coverage for Federal employees provides broader benefits for the employee than for his dependents. We also offer a coverage in which benefits for dependents equal those for employees. The subscription charges for this plan (exhibit C) as compared with the H.R. 8210 maximum amounts, are as follows:

	Kaiser Foundation health plan BB coverage	H.R. 8210 maximum
Employee with no dependents.....		
Employee with 1 dependent.....	\$6.55	\$7.58
Employee with 2 or more dependents.....	13.10 18.10	18.42

Thus current rates for either of these health plan coverages are within the maximum amounts provided in H.R. 8210. The specific benefits under these coverages are described in exhibits B and C appended to this statement. Benefits and subscription charges differ in the several regions in which the health plan operates, reflecting differences in costs and other local conditions affecting direct service medical care programs. However, the above subscription charges, applicable in the San Francisco Bay area, are now somewhat higher than subscription charges in our other three regions.

As stated in the Senate committee report on the companion bill (S. 2162):

"The bill provides a broad framework within which the Civil Service Commission can develop specific contracts for benefits * * *. The committee considers it unwise to tie the Civil Service Commission's hands by specifying dollar maximums or to spell out in detail the specific benefit structures."

Accordingly, we have provided information on our subscription charges for certain of our benefit structures. Although modification of these benefits or future increases in costs of providing services would alter our subscription charges, there is at present some leeway within which benefits could be increased without exceeding the maximum amounts provided in the bill.

With respect to the adequacy of cost estimates for the total program contemplated by the bill, as presented in the Senate committee report, we feel that other witnesses are better able to evaluate the accuracy of the assumptions and computations involved in estimating costs.

In conclusion, we are gratified that H.R. 8210 provides for an informed choice of plans; and especially that, under the proposed program, Federal employees who so desire may join group practice prepayment plans.

EXHIBIT A

EXCERPT FROM A STATEMENT BY C. C. CUTTING, M.D., EXECUTIVE DIRECTOR OF THE PERMANENTE MEDICAL GROUP, PRESENTED TO THE COUNCIL OF MEDICAL SERVICES OF THE AMERICAN MEDICAL ASSOCIATION AT A MEETING IN CHICAGO, ILL., ON OCTOBER 17, 1958

The plan (Kaiser Foundation Health Plan) embodies five fundamental principles.

1. GROUP PRACTICE

With the greatly increased knowledge and technical developments taking place in medicine, we find it most desirable—from the standpoint of both the patient and the physician—to effect an integration of medical care through group practice. We further believe that physicians, working together, best know the type of care their associates give, and are anxious, under good leadership, to provide good care. Group practice brings into play one of the most potent controls of the quality of medical care—namely, the judgment, by physicians, of each others' work.

2. PREPAYMENT

It is well established that prepayment methods permit the individual family to budget expenditures for medical care. When prepayment is merged with group practice, it provides a relatively stable income to the providers of service. In this way members of the plan can afford to pay for modern medical care of high quality.

3. PREVENTIVE MEDICINE CARE

The fusing of group practice and prepayment with the prepaid funds going directly to the group (not as a fee for service) focuses attention on the importance of preventive medical care services. In such a plan it is both good medical care and good economics to keep the members as healthy as possible. Preventive medical care services, therefore, are an integral part of the basic services provided to members.

4. INTEGRATED MEDICAL SERVICES

When physicians in group practice use common facilities, both inpatient and outpatient, direct advantages accrue to the patients and to the physicians, and many economies in the costs of medical care are achieved.

5. VOLUNTARY ENROLLMENT

The Kaiser Foundation Health Plan adheres to the principle of voluntary enrollment. Each person who joins the plan does so as a result of his own individual choice. Since the bulk of the membership pays the subscription charges on a monthly or quarterly basis, each period they exercise their freedom of choice in determining whether to continue or discontinue their membership.

To insure this freedom of choice, when health and welfare fund groups apply for health plan coverage, it is a firm policy of the Kaiser Foundation Health Plan to urge the health and welfare fund to offer the employees a choice of plans—i.e., a choice of joining the direct service group-practice prepayment plan (Kaiser Foundation Health Plan) or joining a fee-for-service type of plan (e.g., Blue Cross, Blue Shield, commercial insurance company plan, etc.). Dual choice programs of this type provide the individual worker with prepaid medical care arrangements of his choice. The health plan does not accept the enrollment of a health and welfare fund unless such choice of plans is offered to the beneficiaries of the fund. Thus, the population served by Permanente Medical Group is composed exclusively of persons who voluntarily join and retain their membership in the Kaiser Foundation Health Plan.

EXHIBIT B

KAISER FOUNDATION HEALTH PLAN, INC., OAKLAND, CALIF.—GROUP MEMBERSHIP— BC COVERAGE

The Kaiser Foundation Health Plan is a nonprofit medical service plan. Affiliated with it are Kaiser Foundation hospitals and medical centers, and teams of doctors representing the major specialties in medicine.

The benefits of the plan are described in this pamphlet. Medical care is provided not only for serious illness, but for prevention of disease as well. Members of the plan are urged to have periodic checkups, seek medical advice, and get prompt attention at the first sign of illness.

You are encouraged to choose a personal physician from the large staff, and a doctor for your children from the pediatric department. The doctor who treats you directs your medical care. He orders X-rays and laboratory tests, prescribes

medicines and physical therapy, and arranges hospitalization when medically required.

To see a doctor, phone or visit the doctors' offices listed below for an appointment. If you cannot wait for an appointment, explain why your need is urgent and the doctor or his secretary will help you get prompt service.

To call a doctor to your home phone the house call department at the doctor's offices.

In case of emergency phone or report immediately to the emergency department at the nearest Kaiser Foundation Hospital. An ambulance will be sent if necessary.

WHO IS ELIGIBLE TO BE A MEMBER

The subscriber to the health plan may subscribe for himself alone, or for himself, his spouse, and unmarried dependent children under 19 years of age. If a spouse has reached the age of 60, his or her acceptance for membership is subject to medical review. Children upon reaching age 19 or upon becoming married must apply for separate membership if they wish to enjoy further benefits. Newborn children become eligible for membership at birth, provided application for membership is made.

CONVERSION PRIVILEGE

If membership through the group is terminated, a member may apply within 30 days for conversion membership under an individual account. Full details may be secured at any of the health plan offices.

TERMINATION OF MEMBERSHIP

If membership is terminated because of nonpayment of membership fees, all rights to service cease as of the date of termination.

Monthly membership fees

Subscriber alone.....	\$8.55
Subscriber and 1 dependent.....	11.95
Subscriber and 2 or more dependents.....	15.55
Subscriber, age 65 or over, additional.....	1.80
Dependent, age 65 or over, additional.....	1.20

A registration fee of \$2 is added to the first month's fee.

THE AREA OF SERVICE

Services are provided only by the doctors and hospitals associated with the plan. Ambulance service is provided within 30 miles of the nearest Kaiser Foundation medical facilities. Home calls are provided within the home call service area. A definition of the home call service area surrounding each Kaiser Foundation medical facility will be furnished on request to the facility.

CARE OUTSIDE THE AREA OF SERVICE

If a member requires emergency care more than 30 miles from the nearest Kaiser Foundation medical facility, the health plan will pay up to \$500 for the cost of such care. This allowance is for medical expenses incurred before the member's condition permits him to travel to the nearest Kaiser Foundation medical facility, and for special transportation arrangements, such as ambulance service, if such arrangements are necessary.

The allowance is made for accidental injury. In case of emergency illness, reimbursement is made only for direct medical expenses to the member and only when all of the following conditions are met: The member must be more than 30 miles from his home when he becomes ill; he must be a registered hospital bed patient; and the hospital in which he is treated must be more than 30 miles from the nearest Kaiser Foundation hospital or doctor's office. Reimbursement will be made only to the extent that the services would have been covered in a Kaiser Foundation hospital. The health plan should be notified within 48 hours of admission to the hospital in all cases of out-of-area illness.

EXCLUSIONS

The following conditions are excluded from coverage under the plan: Mental illness or disorder; attempts at suicide or other intentionally self-inflicted injuries or illnesses; tuberculosis; alcoholism; conditions covered by workmen's compensation; service-connected conditions; dental care; corrective appliances; conditions resulting from a major disaster or epidemic; contagious diseases and diseases requiring isolation.

Treatment and rehabilitation for polio is provided only after the acute and contagious state, and only at the California Rehabilitation Center in Vallejo, for a maximum period of 1 year or a maximum value of \$2,500, whichever is reached first.

If a member is paid for medical expenses for an injury by the party responsible for the injury, the member may be charged for medical care, at private rates, up to the amount paid for such care by the responsible party.

Medical and hospital services

	Type of service	For subscribers	For dependents
In the doctor's office: Diagnosis and treatment, specialists' care, continued care for chronic conditions, no limits on number of visits, physical checkups, pediatric checkups for children, eye examinations for glasses.	Doctor's office visits	\$1 charge per visit.	\$1 charge per visit.
In the hospital.	Laboratory tests, X-ray, X-ray therapy	No charge ¹ .	Half private rates.
	Casts and dressings	No charge.	No charge.
	Physical therapy	\$1 per treatment ¹ .	Half private rates.
	Drugs, medicines, injections, allergy tests.	No charge.	No charge.
	Physicians and surgeons' services, including operations.	No charge.	No charge.
	Room and board, general nursing, dressings, casts, use of operating room.	111 days for each illness each year at no charge. ¹	60 days for each illness each year at no charge. ¹ 51 additional days at half rate.
	Drugs and medicines, injections, special-duty nursing when prescribed, ambulance within service area on doctor's orders.	do ² .	60 days for each illness each year at no charge. ¹
	X-ray, X-ray therapy, laboratory tests, physical therapy.	No charge ¹ .	Half private rates.
	Blood transfusions, if blood is replaced.	No charge.	No charge.
	Doctors' home calls within home-call service area.	\$3.50, 9 a.m. to 5 p. m.	\$5, 5 p.m. to 9 a.m.
	Nurses' home calls within home-call service area.	No charge.	No charge.
	Maternity care: Full care starting early in pregnancy, all doctor and hospital services for mother and child during confinement, including transfusions if blood is replaced, Caesarean sections.	\$90 if confinement due after 10 months membership, \$140 before 10 months.	\$95 if confinement due after 10 months membership, \$140 before 10 months.
	Interrupted pregnancy	Private rates up to a maximum of 2/3 the fee for full maternity care.	Private rates up to a maximum of 2/3 the fee for full maternity care.
	Removal of tonsils and/or adenoids	\$15	\$35.

¹ Half private rates charged for pre-existing conditions (conditions present at the time the member joined the plan).
² Full private rates charged for pre-existing conditions.

EXHIBIT C

GROUP MEMBERSHIP BB COVERAGE

WHO IS ELIGIBLE TO BE A MEMBER

The subscriber to the health plan may subscribe for himself alone, or for himself, his spouse and unmarried dependent children under 19 years of age. If a spouse has reached the age of 60, his or her acceptance for membership is subject to medical review. Children upon reaching age 19 or upon becoming married must apply for separate membership if they wish to enjoy further benefits. Newborn children become eligible for membership at birth, provided application for membership is made.

CONVERSION PRIVILEGE

If membership through the group is terminated, a member may apply within 30 days for conversion membership under an individual account. Full details may be secured at any of the health plan offices.

TERMINATION OF MEMBERSHIP

If membership is terminated because of nonpayment of membership fees, all rights to service cease as of the date of termination.

MONTHLY MEMBERSHIP FEES

Subscriber alone.....	\$6.55
Subscriber and 1 dependent.....	13.10
Subscriber and 2 or more dependents.....	18.10
Members, age 65 and over, additional.....	1.80

A registration fee of \$2 is added to the first month's fee.

THE AREA OF SERVICE

Services are provided only by the doctors and hospitals associated with the plan. Ambulance service is provided within 30 miles of the nearest Kaiser Foundation medical facilities. Home calls are provided within the home call service area. A definition of the home call service area surrounding each Kaiser Foundation medical facility will be furnished on request to the facility.

CARE OUTSIDE THE AREA OF SERVICE

If a member requires emergency care more than 30 miles from the nearest Kaiser Foundation medical facility, the health plan will pay up to \$250 for the cost of such care. This allowance is for medical expenses incurred before the member's condition permits him to travel to the nearest Kaiser Foundation medical facility, and for special transportation arrangements, such as ambulance service, if such arrangements are necessary.

The allowance is made for accidental injury. In case of emergency illness reimbursement is made only for direct medical expenses to the member and only when all of the following conditions are met: The member must be more than 30 miles from his home when he becomes ill, he must be a registered hospital bed patient; and the hospital in which he is treated must be more than 30 miles from the nearest Kaiser Foundation hospital or doctors' office. Reimbursement will be made only to the extent that the services would have been covered in a Kaiser Foundation Hospital. The health plan should be notified within 48 hours of admission to the hospital in all cases of out-of-area illness.

EXCLUSIONS

The following conditions are excluded from coverage under the plan: mental illness or disorder; attempts at suicide or other intentionally self-inflicted injuries or illnesses; tuberculosis; alcoholism; conditions covered by workmen's compensation; service-connected conditions; dental care; corrective appliances; conditions resulting from a major disaster or epidemic; contagious diseases and diseases requiring isolation.

Treatment and rehabilitation for polio is provided only after the acute and contagious state, and only at the California Rehabilitation Center in Vallejo, for a maximum period of 1 year or a maximum value of \$2,500, whichever is reached first.

If a member is paid for medical expenses for an injury, by the party responsible for the injury, the member may be charged for medical care, at private rates, up to the amount paid for such care by the responsible party.

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

Medical and hospital services

	Type of service	For subscribers and dependents
<p>In the doctor's office: Diagnosis and treatment, specialists' care, continued care for chronic conditions, no limits on number of visits, physical checkups, pediatric checkups for children, eye examinations for glasses.</p>	<p>Doctor's office visits Laboratory tests, X-ray, X-ray therapy Casts and dressings Physical therapy</p>	<p>\$1 charge per visit. No charge.¹ Do.</p>
<p>In the hospital</p>	<p>Drugs, medicines, injections, allergy tests Physicians and surgeons' services, including operations Room and board, general nursing, dressings, casts, use of operating room. Drugs and medicines, injections, special duty nursing when prescribed, ambulance within service area on doctor's orders. X-ray, X-ray therapy, laboratory tests physical therapy Blood transfusions, if blood is replaced. Doctors' home calls within home call service area.</p>	<p>Provided at reasonable rates. No charge. 111 days for each illness each year at no charge.¹ Do.²</p>
<p>In your home</p>	<p>Nurses' home calls within home call service area. Maternity care: Full care starting early in pregnancy, all doctor and hospital services for mother and child during confinement, including transfusions if blood is replaced, cesarean sections. Interrupted pregnancy Removal of tonsils and/or adenoids.</p>	<p>No charge.¹ Do. \$2.50, 9 a.m. to 5 p.m.; \$5, 5 p.m. to 9 a.m. No charge. \$60 if confinement due after 10 months' membership, \$140 before 10 months. Private rates up to a maximum of 3/4 the fee for full maternity care. \$15.</p>
<p>Flat fee services: No charges except for fees listed.</p>		

¹ Half private rates charged for pre-existing conditions (conditions present at the time the member joined the plan).
² Full private rates charged for pre-existing conditions.

COMMONWEALTH OF PENNSYLVANIA,
INSURANCE DEPARTMENT,
Harrisburg, July 29, 1959.

HON. KATHRYN E. GRANAHAN,
Member, House of Representatives,
Congress of the United States,
Washington, D.C.

DEAR KATHRYN: I understand that the Senate of the United States passed Senate bill 2162 last week by a vote of 81 to 4. The bill, which creates a contributory health insurance program for Government workers is, I believe, now before the House Civil Service Committee where hearings are being held. I am directing this communication to you as a member of that committee.

As you know, I, too, once served in the Congress of the United States and, as the insurance commissioner of the Commonwealth of Pennsylvania, I have personally presided over many public hearings dealing with prepaid medical programs, both from the indemnity and from the service contract standpoints. I am sure that you will agree with me that, as a former legislator and as the insurance commissioner, I am, and should be, well qualified to speak on this extremely important problem which all of the people of the United States do and must face.

You also know that I am a past president of the Federal Business Association of the Philadelphia area. This organization is comprised of the heads and supervisory personnel of all of the Federal agencies, including the military establishments in the Philadelphia area. There are, I believe, some 70,000 Federal employees in the Philadelphia region. My comments, therefore, are of great importance not only to the 70,000 Government employees but, more important, are of equal significance to all of the people of the Philadelphia area because of the financial impact this bill will have on all of us.

At the beginning I must say to you that I am very definitely in favor of the enactment of Senate bill 2162 into law. It should be done as quickly as possible.

As the insurance commissioner I wrote an adjudication on filings made by the five Blue Cross plans in Pennsylvania and I am forwarding herewith six copies of my adjudication on the Philadelphia filing which explains in detail the problems involved therein and my views thereon. I am also forwarding you six copies of a speech which I delivered before the joint Blue Cross-Blue Shield annual conference in Florida which elaborates on this all-important problem.

I will endeavor, as a Pennsylvanian, to set forth very briefly some of the very important reasons why Senate bill 2162 should be approved.

There are close to 6 million people enrolled under the Blue Cross plans in Pennsylvania with 2¼ million of them being enrolled under the Philadelphia plan. That demonstrates the extent to which Pennsylvanians depend upon non-profit service associations (Blue Cross) for their hospital care. The financing of hospital care through Blue Cross plans has become a part of the social fabric of our State. The value of Blue Cross plans is directly dependent upon the ability of the plans to provide hospital care to the whole community at fair and reasonable costs which the members of the community can afford to pay.

It is unthinkable to me that employees of the U.S. Government should be denied every assistance from their Government to actively and vigorously participate in what has been accepted to be the public policy of the Commonwealth.

The failure of Government employees, substantial in number, to engage as subscribers in a community endeavor certainly does not help to proportionately distribute among all of the people of the community the cost of sustaining a voluntary prepaid medical service program. They, therefore, become, in my opinion, second-class citizens. That is not, and should not be the desire or the intent of Congress. These people, through their Government and through a payroll withholding plan, should actively participate and subscribe to Blue Cross as does other large numbers of employees through their group contracts.

If Government can partially defray the cost of such a contract for its employees, it will contribute much to their health and welfare and to the financial stability of Blue Cross and, therefore, make an overall contribution to all of the people of this great State.

You are at perfect liberty, and I so request that you incorporate my adjudication and my address to the joint conference of Blue Cross and Blue Shield and

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

this communication into the records of the hearings being conducted by your subcommittee.¹

With kindest personal regards and best wishes to my favorite lady Congressman, I am,

Very truly yours,

FRANCIS R. SMITH,
Insurance Commissioner.

Mr. JOHANSEN. I wish to say for the record I regret I cannot be here tomorrow. I have hearings with another committee in New York City with witnesses who are not eager to testify.

The CHAIRMAN. I realize the importance of that meeting and we will miss your presence here.

The committee will stand adjourned until 10 a.m. tomorrow, when the hearing will be resumed on this legislation.

(Whereupon, at 12 noon, the committee recessed, to reconvene at 10 a.m., Thursday, August 6, 1959.)

¹ The two documents referred to, "Common Sense and Blue Cross-Blue Shield Issues," an address by Francis R. Smith, Pennsylvania insurance commissioner, at the Blue Cross-Blue Shield Annual Conference, April 12, 1959, and Adjudication of Francis R. Smith, Insurance Commissioner, Commonwealth of Pennsylvania, April 15, 1958, in the matter of the filing of the Associated Hospital Service of Philadelphia (Blue Cross), were received by the committee and are retained in the official files of the committee.

**HEALTH BENEFITS PROGRAM FOR FEDERAL
EMPLOYEES**

THURSDAY, AUGUST 6, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

We will have to continue the hearings without the full representation of the committee. I wish the members of the committee would get here on time so that we could expedite the hearings. But since the majority is represented by two members, Mr. Harmon and myself, and the minority is represented by Mr. Wallhauser we will proceed.

The first witness is Mr. Edward W. McCabe, chairman, Committee on Legislation, National Association of Internal Revenue Employees, Nashville, Tenn.

We will be glad to hear from you at this time, Mr. McCabe.

Mr. McCABE. Mr. Chairman, I have with me our national secretary-treasurer, Mr. George Bursach. I would like to have him sit with me.

The CHAIRMAN. We are glad to welcome him.

You may proceed, Mr. McCabe.

**STATEMENT OF EDWARD W. McCABE, CHAIRMAN, COMMITTEE ON
LEGISLATION, NATIONAL ASSOCIATION OF INTERNAL REVENUE
EMPLOYEES, NASHVILLE, TENN.; ACCOMPANIED BY GEORGE
BURSACH, NATIONAL ASSOCIATION OF INTERNAL REVENUE
EMPLOYEES**

Mr. McCABE. Mr. Chairman and members of the committee, I am Edward W. McCabe, chairman of the committee on legislation. Our office is located 711 14th Street NW. I am on annual leave from my position in Nashville, Tenn.

Speaking for our association of 23,000 members, I strongly urge and recommend the enactment of a fair and equitable bill that would provide medical and hospital insurance for Federal employees and their families.

At each of our annual conventions for the last 5 years, we have unanimously favored the enactment of a basic health plan for all Federal employees.

The Senate recently passed S. 2162, the Johnston-Neuberger bill. We testified in favor of this bill. We likewise favor your bill, H.R. 7712.

Hospital, medical, and physician expenses are increasing rapidly. Many employees have at least two health insurance plans and still lack adequate coverage. I have three health plans, and they just covered a situation I had in Nashville recently.

Some Federal employees are not financially able to carry any health insurance or if they do it is grossly inadequate. Consequently, when illness strikes they are mired deep in the throes of economic bankruptcy.

The Federal Government has a responsibility to attend the welfare of its employees. It is most important to get a program started to provide protection for Federal employees and their families. Your bill H.R. 7712 will do this.

In the field of providing health insurance for its employees, the Federal Government has not kept pace with private industry. Many railroads and other corporations have given health insurance to their employees without cost to the employee.

While we do not advocate this, we do believe that the Federal Government should bear its fair and equitable share of the cost.

The proposed legislation will not entirely fill the gap that now lags between the Federal Government and progressive business and industry; nevertheless, it is a step forward and one that should be approved without further delay.

The time to act is now, not next year. While we debate our position, there are hundreds of Federal employees who are tasting the bitter roots of economic destruction because the Federal Government does not have a health insurance program.

You gentlemen have always manifested a kind, considerate, and helpful attitude to the Federal employee. I realize you have a dual duty, one to keep the cost of operating the Federal Government as low as possible, the other to enhance the welfare of the Federal employees. It is not easy to do both.

I have every confidence that this committee will reach an agreement for a fair and equitable health insurance bill.

We, the members of the National Association of Internal Revenue Employees, earnestly beg your support in this humanitarian cause. We would further ask that the effective date of this legislation be January 1, 1960.

I appreciate the opportunity to present this statement and urge your consideration.

The CHAIRMAN. How in the world could the Civil Service Commission get its machinery set up by January 1, 1960?

Mr. McCABE. I do not know, sir. I think we could do it, though, sir.

The CHAIRMAN. It will take considerable time to set up the proper machinery for carrying out this legislation, and I think the effective date of July 1, 1960, is very reasonable.

Mr. Harmon, do you have some questions?

Mr. HARMON. You said your association has 2,300 members.

Mr. McCABE. 23,000 members.

Mr. HARMON. I understood you to say you have three health plans. Does that mean you, personally?

Mr. McCABE. Yes.

Mr. HARMON. Is one of them in Blue Cross?

Mr. McCABE. Yes, one is Blue Cross.

Mr. HARMON. Are you aware of the fact that if you have another plan and Blue Cross finds out about it they will not pay you anything?

Mr. McCABE. You mean now?

Mr. HARMON. Yes. That is true in my State of Indiana.

Mr. McCABE. In Tennessee it is not that way.

Mr. HARMON. You are lucky, because in my State if they have an idea even that you have another plan they will not pay.

Mr. McCABE. We have supplemental plans. Blue Cross takes care of an amount and the other plans take care of additional amounts. My wife was in the hospital 25 days and it cost \$21.50 a day. Blue Cross paid \$8 and the other hospital plans took care of the balance.

Mr. HARMON. You are lucky. In Indiana, Blue Cross would not pay if you have other plans. Blue Cross is supposed to pay ambulance charges, but one night my wife needed to be taken to the hospital and the ambulance driver wanted to be paid right away, so I took out a \$10 bill and paid him and got a receipt. Do you think Blue Cross would reimburse me for that? No, they would not pay. The ambulance driver would not wait. He said he had dealt with them before and they would not pay.

The CHAIRMAN. How long have you dealt with Blue Cross?

Mr. McCABE. Since 1946.

The CHAIRMAN. You have both Blue Cross and Blue Shield?

Mr. McCABE. Blue Cross, Blue Shield, catastrophic, and even medical where they pay \$4 for a medical doctor. I pay roughly \$30 a month for my hospitalization insurance.

The CHAIRMAN. For the three different plans?

Mr. McCABE. For the three different plans.

The CHAIRMAN. What are the other organizations?

Mr. McCABE. Businessmens Assurance of Kansas City and Sovereignty.

The CHAIRMAN. Do you understand that this bill will provide for just one hospital plan?

Mr. McCABE. This one hospital plan might do it. I do not know that it would. If it precludes having supplemental policies it should be amended to allow you to take supplementary insurance if necessary.

This bill would provide for payments up to \$1,500, I believe, and 80 percent—I am not quite familiar with that—but over that I think it provides payment up to 120 days. My Blue Cross now only pays up to 70 days. I think this bill would be a great step forward. It would not help me as much as many others, because I do not know of many people that have three plans.

The CHAIRMAN. As I understand, the different plans vary.

Mr. McCABE. Yes. In Tennessee there are 10 different plans.

The CHAIRMAN. Mr. Wallhauser.

Mr. WALLHAUSER. As I understand, the bill does not spell out the benefits. It spells out the money that would be charged, but the bene-

fits would be arranged by the Civil Service Commission.

Mr. McCABE. That is correct as I understand it.

The CHAIRMAN. That is correct.

Mr. McCABE. I think it provides for semiprivate accommodations, something to that effect. I was using that as part payment.

Mr. WALLHAUSER. How many of your 23,000 members now have health plans? Would you have any idea?

Mr. BURSACH. I do not know. That is handled independently by each unit.

Mr. McCABE. It is handled independently by each unit, but I would say more than half of them, conservatively speaking, from my own knowledge, in Tennessee. We would have more than half there. That is the three different plans.

Mr. WALLHAUSER. You said the proposed legislation will not entirely fill the gap that now lags between the Federal Government and progressive business and industry.

Mr. McCABE. I know the L. & N. Railroad in Nashville pays the entire cost of the program, and that is the reference I had to the gap.

Mr. WALLHAUSER. I believe we had testimony that if this bill was adopted with 50-50 sharing it would be as good as the average.

Mr. McCABE. It probably would, but I say a progressive industry, and I say a progressive industry is one that pays all.

The CHAIRMAN. There seems to be considerable doubt that the contributions made by employees would be sufficient to cover the benefits provided under this bill, and in that case, as I understand, the benefits would have to be reduced.

Mr. McCABE. The cost for a family will run roughly \$9 a month, \$4.25 per pay period, and figuring a little over two times that would be \$9, and the Government matching it would be \$18.

I am only paying Blue Cross now \$9 a month and getting good protection. For instance, my hospital bill for my wife was over \$1,000 and they paid all but about \$300. If they can do that at \$9 a month, doubling that it seems they could provide the benefits you want.

The CHAIRMAN. Of course, you do not know how many employees will elect to come under this program.

Mr. McCABE. Most of them elected to come under the life insurance program. In our area, where the average grade is 6 point something I think most of them would come under it. I would say 90 percent of the Internal Revenue employees will come under it after the plan gets into operation.

The CHAIRMAN. You have no separate plan for Internal Revenue employees?

Mr. McCABE. No, sir; we have a life insurance program for our organization but we do not have a health plan, and we are running against hundreds of different plans and could never get a standard plan for all the States.

Mr. WALLHAUSER. Mr. Chairman.

The CHAIRMAN. Mr. Wallhauser.

Mr. WALLHAUSER. Is your life insurance plan with one company?

Mr. McCABE. Yes, Columbia National Life of Boston.

Mr. WALLHAUSER. Was that done under competitive bidding?

Mr. McCABE. Yes.

The CHAIRMAN. You are under the plan where the Government pays one-third and the employee two-thirds?

Mr. McCABE. Yes.

The CHAIRMAN. Any other questions?

We would be glad to hear from your Secretary if he wishes to add anything.

Mr. BURSACH. Perhaps I might say one thing. I do not have any statistics organizationwise to show how many people in the Internal Revenue Service do not carry any plan at all, basically due to the fact that the premiums involved are something that they cannot meet, and they are going year after year without any health insurance at all. Those folks, because of their economic situation, perhaps would suffer the most if someone, including themselves, should be hospitalized. I am sure the committee has considered that too. There may be a big segment in our Service and other services that do not have any coverage at all. I have not seen anything in that respect and I think that might be a good guideline to show the need.

As Mr. McCabe mentioned in respect to life insurance, we were a little apprehensive when the life insurance program was put out for their choice that perhaps they would drop the policies they carried under the group plan. We found they did not. So the tendency is to have more insurance because of the increasing cost of burials and hospitalization and so on, and I think that is getting to be one of the things we will all have to live with and develop as time goes on.

The CHAIRMAN. Any further questions?

Mr. REES. Mr. McCabe, I suppose you have given this matter considerable study?

Mr. McCABE. Yes, sir.

Mr. REESE. Could you envision all these present groups merging into one big group, or how will you work that out?

Mr. McCABE. It will be a problem, as Mr. Murray said, and I do know how the Civil Service Commission can do it by January 1, 1960. We might make it retroactive. I do not know. We have a beneficial society with the Treasury and the Civil Service Commission has gradually taken it over. I am now paying the Civil Service Commission what I used to pay to the Treasury Beneficial Society. I really do not have any idea of the amount of work that will be involved because I do not know how many different plans will be concerned.

Mr. REES. That is the thing that concerns me.

Mr. McCABE. Well, it will be a big job, sir.

Mr. REES. We might need your help.

Mr. McCABE. Thank you, sir.

The CHAIRMAN. I see our colleague, Mr. Wier of Minnesota, is in the room. Does the gentleman have a statement he would like to make?

**STATEMENT OF HON. ROY W. WIER, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MINNESOTA**

Mr. WIER. If you will permit me, I received a letter yesterday which concerns me greatly on this health insurance plan, and I would trust some representative of Blue Cross or Blue Shield would be present.

The CHAIRMAN. Is Mr. Colman or Dr. Stubbs present?

(No response.)

Mr. WIER. It will only take me a minute, but I do want to get this before the committee.

I understand the legislation before the full committee here is a matter of choice of coverage, but this letter comes to me from a printer that I know very well, I have known him over the years and have worked with him in the printing trades. He works for one of the Minneapolis papers.

This is the letter. It is under date of August 3, 1959, and it deals with Blue Cross and Blue Shield:

DEAR FRIEND ROY: I am hoping that the U.S. Government might be able to do something in the way of regulating the conduct of the Blue Cross and Blue Shield in the way of controlling the rates charged, especially those of us who have only social security as an income. It seems to me that they are continually raising rates so as to force us old folks to give up our contracts.

The following increases have occurred in the past 2 years—

This is Minneapolis, Minn. [Continuing quoting:]

Previous to August 1, 1957, I was paying \$34.50. August 1, 1957, they increased the rate to \$39.45. August 1, 1958, the increase was to \$46.05. I just received notice that my rate from August 1, 1959, will be \$60.30 per quarter—

The CHAIRMAN. Is that for Blue Cross and Blue Shield combined, Mr. Wier?

Mr. WIER. That is right. [Continuing quoting:]

This makes it \$240.20 per year for hospitalization and doctors' fees while in hospital. We get nothing for sickness at home.

According to the Readers Digest of a little more than a year ago, it was related that couples wishing to take a week or two vacation would have their doctors assign their children to a hospital under pretense they had some kind of ailment.

It would seem if some kind of penalty could be established by law by Congress or Senate, it would eliminate much illegitimate expense for the Blue Cross and Blue Shield. As I understand, the Blue Cross-Blue Shield is a national organization or institute and therefore would come under Government supervision.

Some time back I wrote our State insurance commissioner because of cancellation without my request. This took several months and some time and trouble to be reinstated. I stated above I took this matter up with the insurance commissioner. I was told they were not under control of the State's insurance laws.

When you are at the age of 76—

and that apparently is the age—

you cannot afford to drop this protection, and to pay what seems to be annual increase in rates becomes a real burden; further, for one to drop this protection would eventually become a great burden to the State in the event of a mass dropping by the older citizens.

I do hope that you can find a way to present a bill to Congress that would regulate the conduct of these health and hospital organizations in order to prevent many of the abuses that these institutes are unable to correct by themselves.

Mr. Chairman, this comes to my attention particularly because about a year ago here in the District we had the same complaint about an increase that seemed to be unreasonable. I present this to the committee with a bit of concern, because I would hate to see this kind of a situation develop among the hundreds of thousands of Government

employees if they chose this plan. Somewhere along the line there ought to be regulation of these organizations to control this kind of rate increases.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. The \$34.50 was when?

Mr. WIER. Prior to August 1, 1957, he was paying \$34.50.

Mr. GROSS. 1957?

Mr. WIER. Yes. On August 1, 1957, they increased the rate to \$39.45; August 1, 1958, the increase was to \$46.05; and he has received notice that the rate from August 1, 1959, will be \$60.30.

Mr. GROSS. So that now he is confronted with almost a 100-percent increase in the rate in 3 years' time, approximately.

Mr. WIER. This letter is available if the committee would like to have it. I did not read the name because it might get back.

The CHAIRMAN. Mr. Harmon.

Mr. HARMON. That bears out what I said before: that they have many different plans; they have fine print, and they sell you one deal and they will not deliver on another deal.

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter.

Mr. PORTER. On page 19 of the bill it says:

The Commission shall make a continuing study of the operation and administration of this Act, including surveys and reports on health benefits plans available to employees and annuitants and on the experience of such plans, with respect to such matters as gross and net costs, administrative costs, benefits claimed and provided—

and so on. In other words, it is contemplated that the Commission will study such matters. I am glad you brought this point up.

The CHAIRMAN. I understand there are 78 Blue Cross plans and 54 Blue Shield plans and they all have their own separate operations and fix their own contributions. Is that correct?

Mr. WIER. I am not too familiar with the number of them, but even in this one case I am only relating the case I have the information on. But we had the same situation in the District last year when the District people wanted an investigation of the increase that was being levied on them here. I believe that was last fall.

The CHAIRMAN. Any further questions? Mr. Harmon?

Mr. HARMON. I might have something to say, as usual.

I was at a little party last night and the first thing somebody called my attention to was something in the paper that I had not seen. Immediately this man told me that he and his wife had the Blue Cross-Blue Shield plan. He said there was a \$175 hospital bill, which he paid himself, thinking he would be reimbursed, and all he got was \$17. That is pretty good reimbursement for Blue Cross.

The CHAIRMAN. How much was the bill?

Mr. HARMON. \$175.

The CHAIRMAN. And how much did he get?

Mr. HARMON. Seventeen dollars from Blue Cross. He said he had proof of it and would like to bring it before the committee.

The CHAIRMAN. The next witness is Dr. Abe Rubin, secretary and editor of the American Podiatry Association.

Dr. Rubin, we will be glad to hear from you at this time.

**STATEMENT OF DR. ABE RUBIN, SECRETARY AND EDITOR,
AMERICAN PODIATRY ASSOCIATION**

Dr. RUBIN. Honorable Chairman and members of the committee, I am Dr. Abe Rubin, secretary and editor of the American Podiatry Association—known from 1912 until January 1958 as the National Association of Chiropodists. In the interests of those Federal employees who are patients of members of our profession, I should like to present some information to assist you in your consideration of legislation being proposed to provide health benefits for Federal employees and their dependents.

While our association has not considered whether Government contribution to health service plans for Federal employees is advisable or inadvisable, I am confident that the large majority of our membership believe that employees of the Federal Government are entitled to similar consideration for this type of benefit as are employees in private industry. As a profession, we are concerned that legislation providing for health service benefits permit the employee or dependent to elect the doctor of his choice. We are happy to note that this legislation does not deny the Federal employee this privilege. We mention this because, in the past, some legislation and/or resulting administrative regulations have denied some patients the opportunity to elect their podiatrist-chiropodist to perform a provided service or procedure. This is because we have failed to inform appropriate peoples and agencies.

Twenty years ago in a report—Journal of American Medical Association, page 1384, April 8, 1939—accepted by the American Medical Association, its judicial council stated in part that our profession “fairly well satisfies a gap in medical care that the [medical] profession has failed to fill.” Our schools are accredited institutions listed in the Education Directory, part III, higher education, published by the Office of Education, Department of Health, Education, and Welfare.

Members of our profession are legally qualified by licensure and by education and training to diagnose and treat the human foot by medical, surgical and other means in all the States, Territories, and the District of Columbia. It is, therefore, likely that a Federal employee, or his dependents, eligible for personal health service benefits would elect a podiatrist-chiropodist to perform a provided health service.

Most insurance companies honor claims for contractual health service benefits when a podiatrist-chiropodist renders the service he is legally qualified to perform. Approximately half of our members practice in States in which Blue Shield-Blue Cross plans honor claims for services performed by podiatrists-chiropodists. In some States, insurance regulatory agencies will not allow contracts to be written which restrict the patient's free choice of our practitioners for scheduled service.

As we are able to inform more and more responsible authorities and individuals, this right of the patient is being extended very rapidly. This represents a fundamental philosophy in that the individual is insured for health service benefits to be provided, and not for who shall perform the service.

Of more than passing interest is the fact that permitting the Federal employee (or dependent) to elect a podiatrist-chiropodist will not

in any way increase the costs of providing health service benefits, since the specific service or procedure must be one that is provided in any contract or agreement.

Much effort has been expended to correct inequities, and sometimes to reduce hardship, at both Federal and State levels, in this field of health service benefits. We believe you will recognize the wisdom in preventing this at its source. We bring this to your attention so that those so charged will recognize the intent of Congress not to abridge by administrative regulation or contractual agreement with an insurance carrier the prerogative of a patient to choose the doctor he prefers for a provided health service.

I thank you for this opportunity to present this information, and it would please me to be of service to you by attempting to answer any question you might raise. If I cannot answer your question, I will make a note of it and endeavor to provide a satisfactory reply by letter to your committee.

The CHAIRMAN. You do not think your professional services are covered under this bill?

Dr. RUBIN. They are covered under the bill but we are concerned that administrative regulations will eliminate it. That occurred in medical care for servicemen. The bill did not eliminate us but the administrative regulations did.

Mr. PORTER. Mr. Chairman.

The CHAIRMAN. Mr. Porter.

Mr. PORTER. This is a matter really for the Civil Service Commission, is it not?

Dr. RUBIN. We wanted to make certain that those who read the record would understand that this is understood in the congressional intent.

Mr. PORTER. Are you suggesting that we put it in our report?

Dr. RUBIN. No, sir. I am suggesting that those who make the regulations will undoubtedly read the record of the hearings.

Mr. PORTER. That I doubt.

Dr. RUBIN. We hope they will.

There is another matter we hope will not occur. One group of Federal employees had Blue Shield-Blue Cross and switched to a private company. While they were under the Blue Shield-Blue Cross plan the patients were able to choose a member of our profession for services and when they switched they found the plan of the private company only covered services by someone licensed to treat the body as a whole.

The CHAIRMAN. Mr. Harmon.

Mr. HARMON. Dr. Rubin, do you practice in this profession?

Dr. RUBIN. No; I am the chief executive officer of the American Podiatry Association.

Mr. HARMON. Let me ask you if you know whether there is a stipulation in the Blue Shield-Blue Cross plan that the services covered by the plan may be either in an office or in a hospital?

Dr. RUBIN. In some contracts the services must be performed in a hospital; in other contracts the services may be performed in an office. It varies from State to State and contract to contract.

Mr. HARMON. The little practitioner that people get out of bed at 2 or 3 o'clock in the morning, very few of them get anything under the Blue Shield plan; it is only specialists that get \$500 an hour.

Dr. RUBIN. There are only a few services that are covered. This gets to be a problem to the doctor to explain to the patient that if somebody else had performed the service he would get paid, but if the service is performed by another he is not paid.

Mr. WALLHAUSER. Mr. Chairman.

The CHAIRMAN. Mr. Wallhauser.

Mr. WALLHAUSER. What ailments would be included under a health policy that your profession could treat now under most plans?

Dr. RUBIN. Any surgical procedure performed on the foot, and that is the only thing that would be included.

Mr. WALLHAUSER. Such as an ingrown toenail?

Dr. RUBIN. Yes; or a surgical procedure to straighten a malformed toe, something like that.

Mr. WALLHAUSER. It would not cover removing a corn?

Dr. RUBIN. Only if a surgical procedure is involved, such as straightening a malformed toe underneath the corn.

Mr. WALLHAUSER. Is that covered now?

Dr. RUBIN. That depends on the State. In some States it is covered only if the service is performed in a hospital, such as the State of Michigan. In the District of Columbia it is payable if the service is performed in the office under certain circumstances.

Mr. WALLHAUSER. Are you desirous of having the Civil Service Commission try to arrange a plan so that it would be paid if performed in the office as well as in the hospital?

Dr. RUBIN. We have not considered that. We want to be treated in the same fashion as any other profession. We are not asking a special privilege. Personally, I believe it would reduce the total overall cost if the procedure was paid for if performed in the office. Many procedures can be performed in the office, but because the policy specifies it is not payable unless performed in the hospital, it is performed in the hospital, and this results in an added cost that is not necessary.

Mr. WALLHAUSER. So you believe it would be desirable if the Civil Service Commission broadened it to include services in the office?

Dr. RUBIN. I believe so. It would reduce the overall cost.

The CHAIRMAN. Any further questions?

Thank you very much.

The committee will next hear from Dr. Robin C. Buerki, chairman, Council of Government Relations, American Hospital Association, and director of the Henry Ford Hospital in Detroit, Mich.; accompanied by Mr. Kenneth Williamson, associate director, American Hospital Association.

You may proceed.

STATEMENT OF DR. ROBIN C. BUERKI, CHAIRMAN, COUNCIL OF GOVERNMENT RELATIONS, AMERICAN HOSPITAL ASSOCIATION, AND DIRECTOR OF THE HENRY FORD HOSPITAL IN DETROIT, MICH.; ACCOMPANIED BY KENNETH WILLIAMSON, ASSOCIATE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Dr. BUERKI. Mr. Chairman, I am Robin C. Buerki, M.D. I am a physician and the executive director of the Henry Ford Hospital in Detroit, Mich. I appear before this committee today in support of S. 2162, in my capacity as chairman of the Council of Government

Relations of the American Hospital Association, and I am accompanied by Mr. Kenneth Williamson, its associate director. On behalf of the association, I wish to thank you for this opportunity to appear before the committee and present to you our reasons for supporting this legislation.

The American Hospital Association is a voluntary nonprofit membership organization with about 7,000 members, including the great majority of all types of hospitals. Represented in this membership are 90 percent of the Nation's general hospital beds. The Nation's hospitals last year admitted more than 23,500,000 patients. A large segment of these patients had their care paid for at least in part by voluntary health insurance organizations.

Hospitals have been the prime movers in the provision of hospital benefits through voluntary health insurance. Hospitals were the sponsors of the Blue Cross movement. It was the success of Blue Cross which not only encouraged others to develop prepaid medical care programs but also encouraged the insurance industry to develop health insurance programs.

For more than a dozen years, we have urged upon the administration and congressional committees, as we have upon private employers, the need to bring to employees and their dependents the benefits of prepaid health service protection.

The Federal Government, the Nation's largest employer, has major responsibilities for the health and welfare of its employees. These responsibilities transcend those of private employers. Aside from the number of people directly affected, the action of the Federal Government in this matter will exert considerable influence upon other employers by the example it provides. We therefore welcome legislation which would make available a program sufficiently broad and comprehensive to meet substantially the health needs of those employees and their families.

Our support of S. 2162 is based on the fact that it not only recognizes the Government's responsibility as an employer, but also because it includes provisions which, in light of our long experience and studies of hospital insurance, we believe are desirable and in the public interest: (1) The bill recognizes the fact that voluntary prepaid insurance is the most economical means by which employees and their families can budget for their health needs, in keeping with basic concepts of the freedom of choice of both physician and hospital; (2) the benefits to be provided are reasonably comprehensive in scope; (3) all employees have the opportunity to select a service benefit plan for their basic hospital benefits; (4) the Government now recognizes the commonly accepted need for both payroll deductions and employer contribution; (5) the bill provides a Government contribution sufficient to enable the employees to obtain reasonably comprehensive protection for themselves and their families; (6) care has been taken to relate supplementary benefits to the basic service benefit program so as to meet the needs of the recipients in an advantageous manner; (7) with respect to future retirees, the bill takes cognizance of the particular problems retired employees have in maintaining health insurance; and (8) recognition is given to the benefits to be derived from an advisory council in the continued administration of the program.

There are a few other matters about which I should like to comment briefly.

With respect to the participation of the non-Government representatives on the advisory council, we believe that representation of the hospital field should provide for an individual who is an active hospital administrator.

In the letter of July 20 which we received from the chairman of this committee, particular interest was shown in the matter of costs. We understood that this committee was desirous of our commenting on the matter of hospital costs, with an indication as to the trends of such costs, past and future.

This is a subject which is of serious concern to hospital administrators, boards of trustees, and everyone associated with the provision of hospital services. It is a matter which has so many aspects that I shall not attempt to cover them in great detail here. I wish, however, to submit for the record of these hearings two statements published in the official journal of the association. The first of these, entitled "The Nature of Hospital Costs," appeared in April 1956.

The CHAIRMAN. What does that article cover? Give the committee a brief summary of what it says about increasing costs of hospitalization.

Dr. BUERKI. If you would care, I was going, in the next paragraph or two, to touch on one or two of the high points, and then we can go through this if you wish.

The CHAIRMAN. All right.

Dr. BUERKI. And the second one, entitled "Forces Affecting the Community's Hospital Bill," appeared in September-October 1958. The author of both of these statements is Ray E. Brown, superintendent of the University of Chicago clinics and director of the graduate program in hospital administration at the University of Chicago. Mr. Brown is a past president of the American Hospital Association. These statements are generally accepted in the hospital field as the most current and authoritative statements on the subject.

The first of these papers is an examination of hospital operating costs. The second article is an examination of the forces that set the total hospital bill of a given community, defining "forces" to mean causes that are beyond the control of the hospital itself, cultural, economic, and medical.

The statement on the nature of hospital costs says:

The average cost per patient day for all short-term general hospitals in the United States during 1946 was \$9.39. By 1954 this cost had risen to \$21.76, an increase of 132 percent.

The CHAIRMAN. Do you have any recent figures showing the hospital cost increases since 1954 up to the present time?

Dr. BUERKI. Yes, sir. [Continuing quoting:]

During the same period the Consumer's Price Index (which utilizes 1947-49 base for 100) for the Nation advanced only 37.6 percent; rising from 83.4 at the end of 1946 to 114.8 at the end of 1954. Even though the Consumer's Price Index has remained almost stable since 1951, rising less than a half point per year, the costs per patient day for the Nation's general hospitals have increased by 7 percent per year during that same period. Unless there is a very significant decrease in the general economic situation, we must expect hospital costs to continue to increase at about 5 percent annually for many years.

The CHAIRMAN. Doctor, how do you account for this tremendous increase in the cost of hospitalization during the last 10 or 15 years?

Dr. BUERKI. Fifteen years ago the average hospital employees earned less than half the amount earned by an equivalent employee in industry. I think in one of the large cities of the country hospital employees were earning, at the beginning of World War II, \$28 to \$30 a month and receiving a rather meager lunch in addition.

Mr. Williamson is pointing out these wages, which averaged \$1,330 in 1946 for a 48-hour week had reached \$2,873 by 1957 for less than a 42-hour week, an increase of 116 percent in pay and a decrease of about 13 percent in hours.

In other words, hospitals still are not paying salaries comparable to industry for the same type of individual. And at the beginning of the war many hospitals were working their people 52 hours a week, and almost none under 48 hours a week. Now, we are just above 40 hours a week.

The CHAIRMAN. This increasing cost of hospital care and medical care is a very bad situation.

Dr. BUERKI. This is the reason why, I believe, sir, insurance has taken hold, because to meet the problem out of pocket today is very difficult.

The CHAIRMAN. Do you expect those costs to continue to increase?

Dr. BUERKI. Yes, for two reasons. I am not an expert in this field, but as I see the trend, labor salaries and income will continue to increase and hospitals cannot stop, so there is still a possibility of increase to keep reasonably abreast; and even today hospitals are not paying salaries equal to those paid by industry; plus the fact that in hospitals almost every month we are developing new methods of clarifying diagnoses, making them more effective. Yesterday morning one of my associates came in and said we should be making new tests of gases in the lungs. He said it would not cost much, that to put in the new machinery with accessories would be just a little over \$6,000. This is entirely new, and while we are one of the large hospitals in the country, within 2 or 3 years this will be adopted by other hospitals in the country.

The public has the right to have applied to it all the advances that modern medicine has to offer, and, unfortunately, a lot of this costs money.

On the question of rehabilitation, we probably could get people back to work much earlier if we gave the average person 2 hours of rehabilitation in the hospital while he is there, but that would add \$5 or \$10 to the cost. Some of us do some of it, but I am afraid we do not do as much as we should.

The equipment to do mass spectrophotometry to find out the minerals in blood would run to \$40,000 or \$50,000.

Mr. HARMON. Is it not true that a lot of this equipment is donated?

Dr. BUERKI. A lot is, there is no question about it. Unfortunately, not enough.

Mr. HARMON. In our one and only hospital in Muncie, Ind., the good people of Muncie donated so much a month.

Dr. BUERKI. I happen to know your hospital. I have been there several times and it is one of the finest in the country. I think you

have as much public backing as almost any hospital in the country has.

Mr. HARMON. It is a very fine hospital. I notice the people who are specialists in the hospital get mighty fine salaries. I am not saying they are not worth it, but it has contributed to the cost.

Is it hard to find someone who can manage a hospital, a hospital manager?

Dr. BUERKI. Yes, sir.

Mr. HARMON. Well, I have seen some mighty poor managers, too.

Dr. BUERKI. Good management can account for a swing plus or minus 10 or 15 percent in cost.

Mr. HARMON. For a hospital such as we have in Muncie, on an average, would you say \$25,000 a year plus expenses for that manager is a good salary?

Dr. BUERKI. Yes.

Mr. HARMON. Do you think he should have it?

Dr. BUERKI. It is a good salary, sir.

Mr. HARMON. That is all.

The CHAIRMAN. In view of the trend of continuing enormous increases in hospitalization and medical care, if that trend continues I am afraid you will come to socialized medicine, to which I am bitterly opposed.

Dr. BUERKI. So am I.

The CHAIRMAN. But what can be done about these rising costs of hospitalization and medical services?

Dr. BUERKI. I go back to the fact that a big fraction of the cost is because we have been trying to catch up in salaries to hospital employees. Before World War II relatively few women could find employment in industry so that hospitals could get women for much less salary than industry would pay, but now the opportunities for women in industry have increased tremendously and hospitals have to continue to raise salaries or they are being totally unfair to their employees. It is all right to say to the employee, "Take some of your salary in satisfaction of doing good for the sick and injured," but this does not put bread and butter on their table at home.

The CHAIRMAN. Mr. Davis.

Mr. DAVIS. The highest per patient-day hospital cost mentioned in your statement for 1958 is \$29.24.

Dr. BUERKI. Yes, sir.

Mr. DAVIS. Does that figure allow a profit for a hospital?

Dr. BUERKI. The voluntary nonprofit hospitals cannot make a profit. If you run over this year you put it in a fund and probably balance out or run short the next year. If you operate below cost, finally the hospital closes.

Mr. WILLIAMSON. The figures that came out the other day indicated that the difference between the average cost per day, this \$29.24, and the income received from patients was \$4. So \$4 a day is having to be made up.

Mr. DAVIS. You mean \$29.24 still does not cover the total cost?

Mr. WILLIAMSON. It covers the cost but the income received from patients does not equal the cost yet.

Dr. BUERKI. This is what we get from the public.

Mr. DAVIS. Does the public make up the difference?

Dr. BUERKI. Finally one hand has to wash the other or the hospital closes.

Mr. DAVIS. What does this \$29.24 cover? How much nursing is involved in that?

Dr. BUERKI. All general duty nursing in the hospital is covered. It does not cover special nursing services.

The CHAIRMAN. You are not including the costs of private nurses?

Dr. BUERKI. No.

Mr. DAVIS. That covers the floor nurse, then?

Dr. BUERKI. That is right.

Mr. DAVIS. And it covers the cost of hospital facilities?

Dr. BUERKI. The operating room, laboratories, X-ray.

Mr. DAVIS. And food?

Dr. BUERKI. And food.

Mr. DAVIS. And all of that totals up to \$4 more than \$29.24?

Dr. BUERKI. No. It totals \$29.24 but the patient pays approximately \$25 or \$26.

Mr. DAVIS. You did not understand my question.

Dr. BUERKI. I am sorry.

Mr. DAVIS. All these services you mentioned amount to \$3 or \$4 plus this \$29.24?

Dr. BUERKI. No. They amount to \$29.24.

Mr. DAVIS. But a part of that \$29.24 comes from public contributions?

Dr. BUERKI. That is right.

The CHAIRMAN. Mr. Wallhauser.

Mr. WALLHAUSER. On this question of cost, do you include in the cost figures the depreciation on the building and so forth?

Dr. BUERKI. Yes.

Mr. WILLIAMSON. That is only in some cases, not nationally.

Dr. BUERKI. We do. Mr. Williamson says that is not included in the costs of all hospitals.

Mr. WALLHAUSER. But you say, generally speaking, it does include depreciation on the building?

Mr. WILLIAMSON. I think in the last 10 years many more hospitals include depreciation than used to but not all of them do yet.

Mr. WALLHAUSER. Do you see any stabilization in the method of running a hospital because of the fact you are now using many more practical nurses than registered nurses and other less skilled personnel?

Dr. BUERKI. Stabilization of costs in this field, yes. But again I was going to comment in our own institution we thought we had enough laboratory and X-ray space for 20 years. That was 4 years ago. We are now looking for additional space for new procedures, new diagnostic techniques, to the extent that the units we thought would last and that we could expand in for 20 years, we are now looking for extra space because it just is not fair to the patient not to offer some of these new tests and techniques.

Mr. WALLHAUSER. I am interested in your statement that we will continue to have rising costs because I, like the chairman, am opposed to socialized medicine. Are you taking into consideration the contributions you get from United Givers and other funds?

Dr. BUERKI. Those make up that extra \$4. The private individuals' contributions are not keeping pace with costs. In fact, the people

do not have quite as much money left to give to hospitals as they used to have.

Mr. WALLHAUSER. Going back to the question of depreciation, that is a figure that can be juggled. Sometimes a building that is 25 years old has just as much usability as a new building.

Dr. BUERKI. A few cents one way or the other I would not debate.

Mrs. ST. GEORGE. I am holding in my hand here a hospital bill. I would like to ask you, Doctor, how many of these items would be included in the \$29 that you have mentioned?

This is the bill: There is a room.

Dr. BUERKI. Generally, it would be a semiprivate room. That would be included.

Mrs. ST. GEORGE. That is correct. Then there is pharmacy. Would that be included?

Dr. BUERKI. It would.

Mrs. ST. GEORGE. Then there is miscellaneous, and I would not know what that is.

Dr. BUERKI. I would not either. I think that that would be included.

Mrs. ST. GEORGE. You would think so. It is a very small amount.

Dr. BUERKI. Telephone calls would not be, or a meal served to the patient's relative in the room.

Mrs. ST. GEORGE. No. Then there is clinical laboratory.

Dr. BUERKI. That would be included.

Mrs. ST. GEORGE. That would be X-rays.

Dr. BUERKI. That would be included.

Mrs. ST. GEORGE. Surgical supplies.

Dr. BUERKI. That would be included.

Mrs. ST. GEORGE. And again pharmacy, and this, I understand, was for some penicillin shots and it goes quite high. All of that would be included in your \$29?

Dr. BUERKI. Yes.

Mrs. ST. GEORGE. That comes to a good deal less than what the bill shows.

Mr. DAVIS. What was the second item that you mentioned?

Mrs. ST. GEORGE. Pharmacy.

Mr. DAVIS. You mentioned that twice.

Mrs. ST. GEORGE. In the second instance it is quite a considerable amount for penicillin shots. The first item is \$1 and the second is \$16.10, and the total bill, I might add, because I think it might be interesting to you, for this 12-hour accident case is \$68.45.

Dr. BUERKI. The first day's costs are always high just to get over the hurdle. When you average then your average in the one at the end at which time the cost is much less.

Mrs. ST. GEORGE. The patient in this instance was only in for 12 hours.

Mr. GROSS. How many X-rays would be included in the \$29.24?

Dr. BUERKI. The number needed to make the diagnosis normally, whether 1 or 100.

Mr. GROSS. Is that true in all hospitals, that there is no extra charge for X-rays?

Dr. BUERKI. We are talking about costs, the average hospital cost in the United States at this time.

The CHAIRMAN. I have been in a hospital several times, and all of these X-rays are extra charges on the hospital bill.

Dr. BUERKI. Yes, but you were then paying less for your room. These are over and above the room charge.

The CHAIRMAN. There is a fixed charge per day for the room.

Dr. BUERKI. And that room may have been \$15 as semiprivate, and for the X-rays those you are charged extra for, but in the cost it is the \$29 for the total overall.

The CHAIRMAN. It costs the patient with the average private room with special nurses around the clock \$80 to \$90 a day to stay in the hospital; is that correct?

Dr. BUERKI. I would think that is high for the average—way high.

The CHAIRMAN. For three special nurses around the clock?

Dr. BUERKI. Depending upon where you are, \$15 to \$18 a nurse for three nurses around the clock, then you are in for \$50 before you start.

The CHAIRMAN. And it runs about \$80 or \$90 a day, I know from experience.

Mr. DAVIS. What would be the cost to a patient in a hospital for his room, his meals, and the floor nursing?

Dr. BUERKI. About \$29, sir. That includes the X-ray that he may need.

Mr. DAVIS. I am just talking about those three items.

Dr. BUERKI. \$18 or \$20. I am just pulling those figures out of the air. We think that they are pretty reasonable.

Mr. DAVIS. How much has that figure gone up since 1947?

Mr. WILLIAMSON. It depends upon how they figure their costs. In some hospitals their cost structure is to have a high room rate and low charges on laboratory, drugs, and dressings and the rest of it, the use of the operating room, and others have their financial structure with low room rates and higher charges on the other services.

Mr. DAVIS. In one with a low room rate what would those three items amount to that I have mentioned?

Mr. WILLIAMSON. I do not know of any around the country for less than \$12 for the room, which would include the meals and private duty nursing care.

Mr. DAVIS. \$12 would cover those three things that I mentioned—room, meals, and private nursing care?

Mr. WILLIAMSON. General nursing care, not private nursing care.

Mr. LESINSKI. Dr. Buerki, you had a new addition put on the hospital recently. Who paid for that addition?

Dr. BUERKI. The Ford Foundation gave us the money for the clinic building.

Mr. LESINSKI. The Ford Motor Co. and the Ford Foundation are two separate entities?

Dr. BUERKI. Entirely.

Mr. LESINSKI. There is a connection between the directors and so forth. I asked that question to find out if you know what the Ford Motor Co. contributes for the employees.

Dr. BUERKI. The same as anyone else, not more and no less.

Mr. LESINSKI. What percentage? Is their contribution 15 percent?

Dr. BUERKI. The Michigan Blue Cross is one of the more complete coverages. I think that the Blue Cross will pay on the average for an employee 80 percent or better of the cost, or 90 percent.

Mr. LESINSKI. The Ford Motor Co. contributes how much toward the amount?

Dr. BUERKI. I think that it is 50 percent. I would not want to say definitely.

Mr. LESINSKI. You are not sure?

Dr. BUERKI. No.

Mr. LESINSKI. General Motors contributes 50 percent.

Dr. BUERKI. Then I am right. They would be the same.

The CHAIRMAN. Yesterday I presented a letter for the record from the Tennessee State Medical Association which says in part:

This letter is one primarily of information to advise you of a recent action of the Tennessee State Medical Association to try and solve some of the abuses that are involved in health insurance. This association has established a consultative committee on the administration of voluntary prepaid medical care plan to study and recommend steps be taken where abuses of health insurance occur, whether they be on the part of physicians, hospitals, the general public, or others.

What steps are the medical associations taking, and hospital associations, to try to see what can be done about the tremendous expense of medical care in hospitals?

Dr. BUERKI. There is a growing tendency on the part of hospitals to establish their own committees to review all admissions to see whether they are justifiable admissions, or whether they are not, and any possible abuse they find to curb.

Mr. WALLHAUSER. Would the mortgage interest be included in this cost figure?

Mr. WILLIAMSON. In some cases, yes.

Mr. WALLHAUSER. So maybe some part of this figure would depend upon the amount of mortgage on the hospital.

Dr. BUERKI. 2 or 3 percent, or something of that nature.

Mr. WILLIAMSON. The interest rate for those hospitals which have commercial loans, and that is what most have, are 4½ percent to 5 percent and 6 percent, and it may cost as much as 75 cents to \$1 per patient per day of their overall costs in some instances.

Mr. WALLHAUSER. Can you remove from the figure of \$29.24 the fixed charges and give me a net figure for each patient? Take out the insurance, the interest on the mortgage, depreciation, and the other fixed charges so that we can get at an accurate cost of actually servicing the patient.

Mr. WILLIAMSON. We can do that in some areas and for some hospitals. On a nationwide basis I am not sure that we can. We can give it to you for some areas.

Mr. WALLHAUSER. Can you approximate it?

Mr. WILLIAMSON. 2 percent, Dr. Buerki says.

Dr. BUERKI. Of the \$29, 2 percent I would say.

The CHAIRMAN. You paint a rather gloomy picture about the future of hospital care expenses. You seem to think there will be an increase for the next several years.

Dr. BUERKI. I am afraid so. In terms of lifesaving I want this kind of care and you want this kind of care. The costs are continuing to increase, and as the salaries for other people go up I do not see how

we can hold salaries down. Even more, it is the constantly developing of new techniques. There is the new work in cancer. A few years ago when they had the X-ray and deep therapy you sent them home to die, but now we are keeping them and doing things positively for them. Tomorrow we may have one of the answers. We are constantly trying. Whereas before when a patient was bedridden, now by cutting nerves the patient goes back home and does her homework.

Mr. DAVIS. Cutting nerves is not a hospital cost.

Dr. BUERKI. The patient has to be in the hospital to have it done.

Mr. DAVIS. I understand, but the doctor charges for that.

Dr. BUERKI. We did not use to do this. Now, they come to the hospital. We have the operating room. These are not short operations. We have the operating room cost and the cost of the patient in the bed, and it is not a 2- or 3-day procedure. We use to not do this at all.

Mr. DAVIS. I certainly appreciate everything the hospitals are doing and I do not want to criticize you, but it seems to me the costs for just living expenses in a hospital are so much greater than they are for living expenses in a hotel. It looks to me like they are out of line.

Dr. BUERKI. Not if you had the meals brought to your bedside in the hotel and if you had the nurse in every hour, or two, to do something for you.

The CHAIRMAN. How many patients does a floor nurse have on the average around the country? Is the number getting smaller or larger?

Dr. BUERKI. More, because there are more things positive to do. Twenty-five years ago you did an operation and you put the patient back into bed and the patient went through the valley of the shadow, and if he came through, fine. Now we can do so many things that we could not do formerly to keep him alive. Forty years ago a man or a woman in their late sixties or seventies hated to undergo surgery because they could not stand being in bed. Now, with the many things you can do they go through just like a breeze.

Mr. GROSS. I do not know about the breeze.

The CHAIRMAN. How about the cost?

Dr. BUERKI. It all depends upon whom the work is being done.

The CHAIRMAN. You may proceed with your statement.

Dr. BUERKI. Unless there is a very significant decrease in the general economic situation, we must expect hospital costs to continue to increase about 5 percent annually for many years.

The CHAIRMAN. You say "for many years." Could you be a little more specific in your prediction about how many years?

Dr. BUERKI. I would hope that it would not be forever.

Again, if I could find out what salaries for the average employee in this country in industry is going to be, we could be more accurate. And again there is this terrific intangible of new techniques coming in. Some of them cut costs.

Now, with regard to a thyroid operation. We did basic metabolism tests for 2 years. Now certain protein-bound iodine tests are much more accurate and cost much more and require more skilled people and more instruments. It is this type of thing that it is awfully hard to predict.

Mr. WALLHAUSER. Relating this statement to a consideration of the bill, would you say that the employees, and the Government should, in order to be realistic, realize their costs will go up in the years to come on this health insurance program?

Dr. BUERKI. I would think so, yes.

Mr. GROSS. Reading further in the gentleman's statement, he says, "We believe that Mr. Brown's estimate of a 5-percent annual increase in hospital costs is conservative."

Dr. BUERKI. That is right.

Mr. GROSS. It can be more than 5 percent?

Dr. BUERKI. Relating it to the bill, I think that there is a section in there whereby you can determine how complete the coverage shall be.

The CHAIRMAN. You are familiar with this bill, are you not?

Dr. BUERKI. Yes.

The CHAIRMAN. As it passed the Senate.

Dr. BUERKI. Yes.

The CHAIRMAN. How in the world can the Civil Service Commission provide for all of these benefits which are enumerated in the bill based on the present contributions if your story is correct about the increasing costs over the next several years? How can they do it?

Dr. BUERKI. To estimate what it is going to be several years from now is again a difficult thing, though we think a 5 percent increase is conservative. I would think this is a question for the actuaries working with the Commission to determine.

Mr. Brown's figures up through 1954 utilize an average cost for all short-term general hospitals. From the Guide published annually by the American Hospital Association, it is indicated that the per patient pay costs in voluntary short-term, general and other special hospitals in 1954 was \$22.78 and rose to \$26.81 in 1957, which is an average increase of slightly under 6 percent per year. In 1958 patients in voluntary short-term hospitals paid an average of \$1.28 a day less than the cost to care for them.

Mr. DULSKI. I cannot buy this when you say that the major costs are wages and salaries. We have a very particular incident in Buffalo at the present time where some of the people are getting only 60 cents an hour. Where do you separate the wages and salaries?

Dr. BUERKI. Almost 70 percent of all hospital costs are in salaries and wages.

Mr. DULSKI. Salaries are for people paid by the year, technicians, and so forth.

Dr. BUERKI. Yes.

Mr. DULSKI. Those are usually skilled laborers, but 70 percent of your hospital costs are in the lower brackets.

Dr. BUERKI. The overall is 70 percent, the total personnel cost, and even in the skilled fields people are being taken away from us by industry. Take a doctor of chemistry—repeatedly we lose him to industry at twice the salary the hospital pays. With regard to nursing, which if you will, is put in a salary bracket, industry employs that nurse at salary considerably higher than the hospital pays her and they take them away from us. In fact, for the fact that she works 40 hours a week and takes night shifts and evening shifts and

Saturdays and Sundays and holiday shifts, her salary is not comparable to an individual with an equal educational background. We are not paying the salaries at the expense of wages.

Mr. DULSKI. A few years ago you started raising the salaries of nurses because you were losing them.

Dr. BUERKI. We are still losing them.

Mr. DULSKI. To what field?

Dr. BUERKI. To industry.

Mr. DULSKI. Industry can only absorb a few nurses. They cannot absorb all the graduating nurses.

Dr. BUERKI. Some to doctor's offices. Then there is the fact that they do not get the number of girls coming into nursing that used to come in because they can go to a secretarial school for 6 months and come out and get almost the salary that we pay the graduate nurse who spent all of that time getting her education.

We have more than doubled the number of hospital days' care in the last 15 years. We are shortening the hours of work from 48 and 52 to 40 and 42. And then during the 1930's and early forties and during the war when men were scarce, girls worked after they finished their training in nursing. Now in the last year of school in nursing a large percentage of them are engaged and do not continue in the profession. So the number of years of professional life has been shortened by the very prosperity of the country. The husband now earns enough to support the woman and his children. These are all problems that we are up to our necks in.

Mr. DULSKI. Thank you.

The CHAIRMAN. Hospitals do not pay much to orderlies and nurses' assistants and charwomen.

Dr. BUERKI. And that is one of the reasons that I think we are going to have to continue to keep with industry's increase of salaries percentage-wise and actually catch up in salaries.

The CHAIRMAN. As to this big increase that you have been talking about, that has taken place over the past several years, I do not think that the orderlies and the nurses' assistants have been getting the increases that you are talking about. It might be true of the trained nurses, but it seems to me the hospitals are requiring the trained nurses on the floor to take care of more and more patients each year.

Dr. BUERKI. In the early forties they paid \$30 a month for orderlies. Now they are paying about \$100. Well, \$100 is still pretty thin.

The CHAIRMAN. That is not true of hospitals generally now, is it?

Dr. BUERKI. It is true of a lot of them. The \$30 figure I know about, but still many hospitals are not paying as low as \$100 a month.

The CHAIRMAN. What are you paying for your kitchen help generally?

Dr. BUERKI. 75 cents to a dollar an hour. It happens in my own hospital that we pay better than that.

The CHAIRMAN. What about these tremendous increases in hospital costs and expenses? Do you have more trained nurses?

Dr. BUERKI. We do not have enough.

The CHAIRMAN. Do you have as many internes as you used to have? They do not get much, do they?

Dr. BUERKI. Some hospitals are paying them as high as \$500 a month.

The CHAIRMAN. I did not know that. I am getting an education here. Are you talking about an interne who has just finished medical school?

Dr. BUERKI. Yes. That is not the average. I said "some." I happen to know of a couple.

The CHAIRMAN. Do not the hospitals use some internes who are still in medical school?

Dr. BUERKI. Teaching hospitals, sir, but of the 7,000 hospitals now only about 100 or 120 like that.

Mrs. GRANAHAN. May I inquire what is the average salary of a supervisor on a floor who is really responsible for all those who cannot have private nursing?

Dr. BUERKI. About \$350 a month. That is pretty low.

Mrs. GRANAHAN. That is very low considering what is expected of her.

Dr. BUERKI. Yes.

The CHAIRMAN. You may proceed.

Dr. BUERKI. The figures for the period 1958, which have just become available, indicate that the per patient day costs in this group of hospitals rose to \$29.24 per patient a day which is approximately a 9 percent increase over 1957.

The major factor in hospital costs is wages and salaries. There is every indication that such costs will continue to rise appreciably in the foreseeable future. We believe that Mr. Brown's estimate of a 5 percent annual increase in hospital costs is conservative.

Mr. Brown's second article discusses forces which come from outside the hospital and determine the demand which the community makes upon hospitals. In large measure these deal with the patterns of utilization of health facilities. Though this poses an important question with respect to determining costs of care for any group in the population, we are not in a position to suggest the effect of these forces upon the premium rates to provide voluntary insurance for Federal employees and their families.

With respect to the amount of Government contribution, we would merely reiterate our belief that it should be adequate to enable employees to secure necessary health protection. As I have stated, we believe that S. 2162 satisfies this requirement.

We appreciate the opportunity of bringing these views to this committee.

In these articles Mr. Brown—and I know this is my personal feeling and the feeling of many people in hospital administration—has set down the various problems and factors in the finest detail that we have ever had presented to any group. Frankly, I have appreciated the interest you have in our problems in the hospital field. These two articles go a long way in answering the questions asked this morning, and they answer them in a much more complete fashion than I have done.

The CHAIRMAN. The articles will be included in the record at this point.

(The articles referred to follow:)

[Reprinted from Hospitals, Journal of the American Hospital Association, Apr. 1, 1956]

THE NATURE OF HOSPITAL COSTS

(By Ray E. Brown¹)

Since the ending of World War II and the relaxing of price and wage controls, constantly mounting hospital costs have engaged the very serious attention of the hospital administrator, and have caused considerable concern on the part of doctors and the general public. Figures show just how real this problem is.

The average cost per patient day for all short-term, general hospitals in the United States during 1946 was \$9.39. By 1954 this cost had risen to \$21.76, an increase of 132 percent. During the same period the consumer price index (which utilizes 1947-49 base for 100) for the Nation advanced only 37.6 percent; rising from 83.4 at the end of 1946 to 114.8 at the end of 1954. Even though the consumer price index has remained almost stable since 1951, rising less than a half point per year, the costs per patient-day of the Nation's general hospitals have increased by 7 percent per year during that same period. Unless there is a very significant decrease in the general economic situation, we must expect hospital costs to continue to increase at about 5 percent annually for many years. Only by the best efforts of hospital boards, administrators, medical staffs and all members of the hospital team can costs be held within that level of increase.

The factors supporting such a forecast are built into the nature of hospital operation. The chief factor, and one around which the other factors revolve, has to do with the fact that hospitals are personal service institutions. Personal service spells people instead of machines. Much of the work of the hospital requires on-the-spot presence of individuals and the utilization of judgment as well as hard work. The opportunities for alternative use of machines when the cost of labor exceeds the cost of a machine are not too abundant in the hospital. The same is true of opportunities for increasing the productivity of hospital workers by the introduction of the rapidly developing science of automation. The major potential in this direction was found in the related connection of substituting less skilled personnel to take over the lesser-skill duties from the professional personnel in the hospital. Most of the gains to be obtained in this direction have been made and it may well be for the welfare of the patient that in some instances hospitals have already gone too far. The major criticism heard from patients regarding hospital care is concerned with the lack of warmth and the emphasis on efficiency rather than tender, loving care.

Data taken from the 1955 administrators guide issue, hospitals, Journal of the American Hospital Association, August, part II, published by the American Hospital Association, strongly illustrate the importance of personnel factor on hospital costs. Of the \$5.2 billion expended by all hospitals in 1954, 64 percent was for payroll. For the 9-year period, 1946 through 1954, total costs of short-term, general hospitals increased \$12.37 per patient day. Of this increase \$8.23 was in payroll alone. While the total costs per patient day were thus rising by a factor of 132 percent, the payroll costs per patient day were rising at the rate of 165 percent.

Most all economists agree that total U.S. productivity has increased per man-hour at an annual rate of over 2 percent for the past 85 years. Since 1956 this increase has averaged 2.9 percent per year for the Nation as a whole. In a carefully detailed story the November 1955 issue of Fortune magazine predicts an average annual increase of 3 percent, compounded, for the next 25 years. This increased productivity has been the cushion by which much of the increased wages of labor have been absorbed. Because of this phenomenon of increasing productivity per man-hour in industry, made possible largely through constant improvement in the machines and supplies provided the worker, industry has been able to grant sharp wage increases without equal increases in costs of productivity.

As pointed out earlier, the nature of the hospital's work provides little opportunity for such productivity gains. Nonetheless, hospital salary levels are af-

¹ Ray E. Brown is superintendent of the University of Chicago Clinics and director of the graduate program in hospital administration, University of Chicago.

ected directly by general salary levels. Under such circumstances every round of salary increases constitutes a direct increase in hospital costs. Over the years ahead, as the general labor force continues to receive its rightful share of proceeds from increased productivity, hospitals will be compelled to give equal increases in salary without comparable benefits from increased productivity. This has nothing to do with inflation, a factor to which hospital costs are also extraordinarily allergic, but is concerned with the number of bushels of wheat and the number of pounds of bacon that can be secured for a day's work. This is what the economists call real wages. It is inescapable that the costs of hospital care will follow very closely the constantly increasing real wage level of industry. As paradoxical as it sounds to say it, any improvement in the productivity of labor in general will adversely effect hospital costs. This means that while a day's work will each year buy an increasingly larger amount of most things it will buy a decreased amount of hospital care.

WAGE LEVELS RAISED

Actually, the cost of hospital care has considerably outstripped the real wage level. Since World War II one factor has played a very strong role in this regard. Hospitals rely primarily on female help and women make up approximately 80 percent of the average hospital's work force. It was not until the necessities of war production demonstrated the equal ability, and even the superiority, of women in many types of industrial work that women found a substantial place in industry. Hospitals benefited until that time from the lack of competition for female personnel and the low wage scale that went with limited employment opportunities. Since that time hospitals have been forced to do a double step in order to keep pace with general wage increases while at the same time upgrading their entire salary levels to meet the going wage rates of industry. By and large this problem of paying competitive rates has been met and its further influence on hospital costs will be decreasingly significant.

GROWTH OF HOSPITAL SERVICES

This is not true, however, with a second factor. The quality and quantity of hospital services per patient-day has shown dramatic and accelerating growth in recent years. This is a result of the cascading technical and scientific progress medicine is making. Both the medical profession and the American public demand that every discovery and improved procedure be made immediately available within the hospital. As medical science progresses there is no alternative but for hospitals keeping pace by providing the necessary facilities. Every medical advance can, however, be measured in terms of added hospital costs and added hospital personnel. Some indication of this fact is found in a comparison of the average number of hospital personnel per patient-day in short-term, general hospitals for 1946 and 1954. In 1946 those hospitals required 1.48 employees per patient. By 1954 this ratio has grown to 1.98 employees per patient. The personnel required to provide one patient-day of care thus has grown 34 percent in only 9 years.

It is true a separate factor has also contributed to this increased number of personnel. Most hospitals have moved toward a 40-hour week during this same period. It is estimated that an average of 4 hours has been deducted from the workweek of hospital employees since the end of World War II because of the big push hospitals have made to compete for personnel on an equal basis with industry. This would, however, account for only about 10 percent of the total increase of 34 percent in number of employees per patient-day. The largest increase in personnel is attributable to new services and this has an accumulative influence. The provision of new services and new procedures which permit the physician to diagnose and treat more varied and more complex conditions requires a more exacting control and an increased use of already existing procedures. cursory studies made on this question indicate that the number of routine nursing procedures per patient-day has increased more than 30 percent in the past 9 years.

The increasing intensity and complexity of hospital service is to some extent reflected in the comparative figures for hospital capital assets. The total capital value of all short-term, general hospitals was approximately \$3,100 million in 1946. The total beds in those hospitals numbered 473,059. In 1954, beds totaled 553,068 and the total capital value was \$6,177,500,000. In 9 years the capital

assets required per bed have thus increased from \$6,512 to \$11,170. It is true that some portion of the increased investment per bed reflects the inflation that has occurred in construction costs. The fact that a net addition of only 80,009 beds was made during the 9-year span is evidence enough, however, that most of the huge increase in capital assets went into improved and added services rather than beds. This point can be demonstrated in another way.

In 1946 there were 504,961 employees in short-term, general hospitals and the capital investment represented \$6,139 per employee. Despite the fact that the number of employees in those hospitals increased to 777,215 by 1954, the investment per employee grew to \$8,077. There is another interesting fact to be found in the above figures, which spell out the need for the wisest sort of study before new hospital construction is undertaken within a given community. The total operating expenses of short-term, general hospitals in 1954 were \$3,120,598,000, or equal to more than half their total capital assets. The problem of providing hospital care is an annual problem and the problem really only starts after the capital funds are raised.

The impact of a constantly increasing hospital cost per patient-day has been softened over the years by improved efficiency of medical care, in large part made possible by those same increased hospital costs. This efficiency served to reduce the average length of stay per patient from approximately 40 days in 1900 to 9.1 days in 1946. Over that period the constant decrease in length of stay actually served to reduce the average cost per hospitalized patient and consequently little concern was shown by the public over increased costs per patient day. In other words, if the units of care yielded quicker results, a higher price per unit was an economic advantage since a smaller number of units (patient-days) would be required. The gains in this direction, however, have been exhausted. The reasons are obvious. The closer the average stay per patient approaches zero days the more rapidly does it meet the point of diminishing effect from reduced length of stay. A quick calculation will demonstrate the diminished effect of early discharge on the patient's total hospital bill. In 1946 the average length of stay in general hospitals was 9.1 days. In 1954 the average was 7.8, a reduction of 1.3 days or 16.6 percent. During the same period the average patient's hospital bill per hospital admission increased from \$85.45 to \$169.73, an increase of \$84.28, or 99 percent. While decreased length of stay took some of the bite off the average patient's bill, it still left the patient paying double the number of dollars per hospital stay when compared with 1946.

REDUCED STAY UPS COST PER DAY

As a matter of fact, it can be argued that a further decrease in the length of stay will increase the net cost to the patient. An indication of this point was found in a study of 1,400 general hospitals made by the Commission on Financing of Hospital Care. The commission report, published in 1954 states, "In each of the various groups of hospitals, the average length of stay tended to be 1 to 2 days shorter in hospitals with per diem expenses of \$20 or more than in hospitals with per diem expenses of \$12 or less." One obvious explanation is the fact that the shorter the patient's stay the more intensive the treatment and the greater the number of procedures per patient-day. Such expensive items of cost as operating room, anesthesia, X-rays, etc., will be spread over fewer and hence more costly patient-days. But more important and more obscure is the increased loss of bed-days that occurs because of the problem of synchronizing patient admissions with patient discharges. The effect of shorter length of stay on bed utilization is clearly indicated by the following comparisons: In 1946 there was an average of 30 admissions annually for each general hospital bed in this country. In 1954 this had increased to 33.3 admissions annually per bed. But even though admissions per bed had increased by a margin of 11 percent, the average occupancy rate for those hospitals decreased during the 9-year period from 72 percent to 71 percent. The picture is more vividly illustrated when hospitals are grouped by average length of stay. During 1954 hospitals with a length of stay per patient averaging between 5 and 6 days, as a group, had an average percentage of occupancy of 55. But hospitals falling into the group with an average length of stay of between 8 and 9 days had a percentage of occupancy of 77.3. In other words, a reduction in length of stay on the average of 3 days reduced the utilization of the beds by an average of 40 percent.

The tremendous impact of low utilization on hospital costs is illustrated by a study of the statistics provided by the Duke endowment on operations of general

hospitals in the two Carolinas. The following figures are computed from the statistics for 1954 and cover the operations of a group of 39 hospitals providing approximately the same services and paying approximately the same wage scales. When the total annual cost of the 39 hospitals is divided by the total number of beds available in those hospitals, an average annual operating cost per available bed of \$3,269 is found. But if those same total annual costs are divided by the total number of occupied beds (derived by dividing the total days of care rendered during the year by the number of days in the year), the dramatically higher average annual operating cost per occupied bed of \$5,651 is found.

When we remember that "available" bed is defined as a bed fully staffed and ready for occupancy by a patient, and that payroll makes up 64 percent of the hospital's total operating costs, we can safely assign the major portion of the difference in cost per available bed and cost per occupied bed to unutilized payroll. The effect of costs of the unoccupied bed is more profoundly observed if the data from the 39 hospitals are broken into two groups—one consisting of those hospitals whose percentage of occupancy is less than the 1954 national average of 70 percent and another consisting of those hospitals whose percentage of occupancy is above the 1954 national average. The first group shows a difference of \$2,586 between the cost per available bed and the cost per occupied bed, while the second group has a difference of only \$1,366 between its available bed costs and its occupied bed costs. The plight of the average hospital administrator is seen when one observes that the differences in ability of the two groups to utilize nonavoidable overhead costs represent a factor of 2 to 1 in favor of those hospitals in the group fortunate enough to exceed the national occupancy rate.

The above computations support the generalization often repeated by hospital administrators to the effect that avoidable costs represent considerably less than half of a hospital's total costs. It also supports the axiom that "the empty bed is the costly bed." The effect of empty beds on operating costs being so significant, the question immediately arises as to why hospitals have not done a better planning job so as to minimize unutilized beds. In a few instances the fault doubtless is due to faulty planning, but in general, however, the problem is inherent in the nature of hospital service and the manner in which the public uses its hospitals. The problem is complex but some of the major factors can be demonstrated and these factors again point up the overpowering influence of hospital personnel on hospital costs. Hospitals are community agencies and are committed to meeting community needs for hospital care. This means hospitals must be staffed to meet the peak requirements anticipated at any given time. These requirements fluctuate widely and are in part predictable and in part unpredictable. The predictable fluctuations occur over short periods and are largely concerned with the public's unwillingness to remain in, or enter, the hospital over weekends and on holidays except under the most necessary circumstances. The fact that these predictable fluctuations in demand occur over very short-time intervals prevents the hospital from obtaining significant savings by staffing adjustments. Hospital personnel must have regular and full employment if they are to remain with the hospital. In any event, the readiness-to-serve requirements in order to meet the unpredictable fluctuations would seriously handicap any substantial staffing adjustments. The nature of these unpredictable fluctuations is well illustrated in a report of a study of the maternity bed facilities in Cook County, Ill., issued in May 1954 by the Chicago Metropolitan Welfare Council. Information obtained from 61 hospitals in Cook County during this survey shows that over the course of a year the total maternity beds of all the hospitals had a 69 percent occupancy. However, the occupancy on day of lowest census during the year for each maternity unit averaged 37 percent for the group. The occupancy on day of highest census during the year averaged 101 percent, or an average difference of 173 percent between the peak and bottom utilization. As the above figures demonstrate, the costs of standby service make up an extremely large portion of the hospital's operating costs and are largely beyond the control of the hospital administration.

A SYSTEM OF SMALL HOSPITALS

Hospital occupancy and, therefore, hospital costs are affected by still another feature that is directly related to the personal service nature of hospitals. Because hospital service is personal service, the hospital must be located rea-

sonably close to the population it attempts to serve. By and large, the United States is a Nation of small towns and this means its hospitals must be a system of small hospitals. Out of its total of 5,212 general hospitals open in 1954 there were over 18 percent with fewer than 25 beds. There were 3,492 hospitals, or 67 percent of the total, with less than 100-bed capacity. The effects of these facts on the occupancy rate of hospitals are very evident. During 1954 those hospitals with less than 25 beds averaged 51.6 percent occupancy while those with over 300 beds averaged 78.1 percent occupancy. The factor of size meant a difference of 51 percent in the respective abilities of the two groups of hospitals to utilize their personnel and facilities. Unfortunately for the sake of occupancy the picture as regards size is not improving. In 1946 all general hospitals of the Nation averaged 106.5 beds per hospital. In 1954 the average was slightly less, having decreased to 106.3 beds. Certain forces, such as the flight of the population from the center of large cities to small suburban towns and the emphasis given to construction of hospitals in rural areas by the Hill-Burton grants-in-aid of the Federal Government, will probably work against any increase in average number of beds per hospital during at least the next decade. The implications of size on hospital costs has been obscured because of the lack of correlation between small size and high per diem costs. In general the correlation is the other way and the higher costs are found in the larger hospitals. This fact must be interpreted in the context of two other facts. Small hospitals are most often located in small towns and to this extent have the advantage of the lower wage rates paid in smaller communities.

The report of the Commission on Financing of Hospital Care offers considerable evidence on another fact. In examining the question of variation of costs between individual hospitals, it demonstrated close correlation between the size of hospital and the number of special diagnostic and therapeutic services provided. The same correlation was demonstrated between the per diem costs and the number of those services provided. The following statement is from that report: "The relationship between the level of per diem expense and the scope of hospital service was apparent when per diem expense was determined for groups of hospitals classified according to the number of selected services they offered. * * * In all sections of the country, expense per patient day was directly related to the number of services. * * * In fact, the increased per diem expense in larger hospitals appears to be almost entirely a reflection of the more comprehensive service programs usually offered by these institutions."

Another of the major problems constantly testing the disposition of hospital administrators is also rooted in the fact that hospital care is a personal service. This is the problem of personnel recruitment and its effect on hospital costs. Some idea of the underlying causes of this problem can be gained from an examination of the personnel requirements of hospitals. In 1946 all hospitals, both general and long term, employed 829,571 full-time employees. In 1954 this number had grown to 1,245,669, an increase of approximately 50 percent. During the same period the total number of employed civilians for the entire Nation increased from 55,250,000 to 61,238,000, an increase of only slightly over 10 percent. Actually, during this period hospitals had to recruit five times the average for all other employers. It will be demonstrated later in this paper that this rapid recruitment was accomplished in large part by rapidly increasing the rate of pay. It is interesting to note that during 1954, 1 out of every 50 of the Nation's civilian workers was a hospital employee.

The problem of adequate personnel, and the cost of personnel for hospitals, is compounded because of the high percentage of professional and technical personnel required. Approximately one out of every three hospital employees meets the definition of a skilled employee. The burden of this requirement is demonstrated by a comparison with the automobile industry. A recent news item stated that only 200,000 out of the total of 1,251,000 members of the United Auto Workers Union were classified as skilled. As of May 1954, hospitals were employing 231,000 graduate nurses alone.

The problem of hospital personnel supply and personnel costs are further complicated because of professionalization and legal licensure of most skilled personnel in the hospital. Even though the hospital is the major user and in some instances the only user of these skills, the hospital has less and less to say about the qualifications and training that is required. These standards are set by national organizations which represent each of these groups of hospital personnel. The desire on the part of these national organizations to develop status for their membership causes them to work toward upgrading the individual as a person as well as a worker.

State licensing bodies have supported this movement to upgrade the quality of training offered in hospital schools and at hospital expense, while State legislatures, as well as private philanthropy, have shown a studied reluctance to pick up the tabs for any part of these educational expenses.

Without entering into the debate as to the social necessity for professionalization and legal control of a large segment of the hospital's personnel structure, it is pertinent to point out the implications these practices have on hospital staffing and hospital costs. Any standard that is extraneous to the job to be done is an inhibiting influence in that it decreases the number eligible and increases both the length and cost of preparation for entry into the job. All of these elements must be recognized in the salary offered after entry on the job, if the particular career is to compete successfully with alternative careers.

The inevitable tendency of professional associations and State licensure bodies to insist on lengthening the period of preprofessional training represents a double burden to hospital costs. It not only increases the salary requirements of the professional when she, or he, is finally ready to enter the field but also increases the time lag between demand and the preparation of the supply. The effect of the time lag has been an almost unrestrained bidding by hospitals for the services of the existing supply of trained personnel.

A rough indication of results of this bidding over the past 9 years can be seen from the following. Between 1946 and the end of 1954 total civilian employment increased from 55,250,000 to 61,238,000. The total yearly compensation paid all civilian employees in the United States in each of those years increased from \$117.7 billion to \$207.9 billion, an increase from \$2,130 to \$3,395 in average annual compensation per employee, or 59.1 percent.

Over the same period, total employees in all U.S. hospitals increased from 829,571 to 1,245,669 while their total compensation was increasing from \$1.10 billion to \$3.35 billion, an increase from \$1,338 to \$2,689 in average annual compensation per employee, or 101.5 percent. Hospital employees have gained salary increases at fairly close to twice the average rate for the rest of the Nation's work force during the 9-year period. To the extent that these increases were required to bring the traditionally lower hospital salaries into competitive alignment with salaries offered by all other employers, it can be expected that the tide is pretty well turned. To the extent that future increases are given to maintain stride with salary increases offered by those same employers, it appears from the nature of hospital costs that the only result must be a continuing increase in hospital costs.

Whatever answers there are to the problem of hospital costs must be found in the area of personnel budgets. From the evidence it looks as if gains in this direction will be slim in even the best administered hospitals unless new patterns can be developed for hospital service that permit more ambulatory care and which entail less personal service at the bedside for these patients admitted for inpatient care. Ultimately, it might also be that the hospitals will secure a higher degree of cooperation from the public as regards the problem of fluctuating occupancy of hospital facilities.

Like most other problems requiring public cooperation, however, this one apparently must wait until the public's ability to secure adequate hospital care is endangered by the mounting costs of that care. This one last set of statistics is given as evidence that this time has apparently not arrived and to the contrary, that the public's ability to utilize hospital care seems to have more than kept pace with hospital costs. In 1946 there were 10.3 persons out of each 100 of the country's population admitted to a hospital. In 1954 this had increased to 12.6 out of each 100 of our population. Whatever they may have thought about hospital costs, during 1954 one out of every eight persons in our population had a reason to think about them. Computed another way, 1 out of each 120 individuals in the Nation was in a hospital bed on an average day throughout the entire year. However you figure it, hospitals are an important and intimate part of the average American's life. They perform an essential community service and their boards and administrators must accept a responsibility for producing that service in the most efficient manner possible. At the same time the community must accept the reciprocal responsibility of understanding the nature of hospital costs and the necessity for judicious use of the hospital's services. Even with the best efforts on the part of all concerned hospital care is inevitably going to become increasingly expensive.

FORCES AFFECTING THE COMMUNITY'S HOSPITAL BILL

(By Ray E. Brown)

This paper is concerned only indirectly with hospital operating costs. It is rather an effort to examine the forces that set the total hospital bill of the community. By forces, we mean causes that are beyond the control of the hospital itself, causes that grow out of the changing environment in which the hospital exists. These forces are cultural, economic and medical. They determine the demands the community makes upon its hospitals. Most of them are cumulative in their impact, and in the long run will more significantly affect the community's total expenditures for hospital care than will the predicted increase in costs per patient-day of care.

One indication of their combined effect is the fact that in the 10-year period, 1948 through 1957, the number of inpatient admissions per 1,000 Blue Cross members increased from 117 to 136, or 16.2 percent. During this period the average length of stay for admission decreased slightly from 7.6 days to 7.5 days. But nevertheless, the average number of days of care utilized per 1,000 Blue Cross members in this country increased from 883 to 1,021. Even if hospital operating costs had remained completely static, Blue Cross subscribers would have had to pay almost 16 percent more in 1957 than 10 years earlier.

THE WELL NOW PAY THE BILL

The manner in which most hospital care is now being financed makes it important that everyone understand these forces. The spread of hospital prepayment coverage to more than two-thirds of the population means that the hospital bill is becoming largely a community bill, and that it is increasingly being underwritten by the well rather than by the sick.

It means that the public will increasingly visualize hospital costs in terms of the monthly cost of prepayment rather than as charges for services received. Under such circumstances, what they are getting will not be related to what they are paying.

It also means that the hospitals of the Nation are becoming increasingly dependent upon the community understanding that these forces are beyond the control of prepayment plans and hospitals and that they evolve out of the community itself. Voluntary hospitals are community agencies and must be responsive to the forces which the community exerts upon them. Voluntary prepayment plans are community mechanisms utilized by the community to collect from the community and disburse to the hospitals those funds necessary to underwrite the obligations imposed by the community on its hospitals.

Neither the voluntary hospitals nor the voluntary prepayment plans can significantly alter these forces, generated by the community, which promise to continue to rapidly push the community's hospital bill upward. This writer is not at all certain that most of these forces could or should be altered, nor that the community would want to alter them. It is urgent, however, that the community understand the source of these forces and their effect on the community's hospital bill before irreparable harm is done to the prepayment movement and to the voluntary hospital system through public misconceptions and misdirected intervention by state regulatory bodies.

One set of forces that will importantly influence the community's hospital bill are those involved with the rapid population growth anticipated for this country. It is estimated by the Bureau of the Census that the total population of the Nation will exceed 220 million by 1975. Using 1956 as a base, this will represent an increase of 50 million, or approximately 29 percent during the 18-year period.

As great as this expected growth is, however, it is not the size of the increase that is most significant. If the characteristics of the population remained the same, it could be presumed that the hospital costs per thousand of the population, and the monthly prepayment per subscriber, would not be affected. Under such circumstances the capital expenditures necessary to provide the additional facilities would be the chief complicating feature of a large population increase. Parenthetically, it must be said that those capital expenditures will represent a considerable item. Using current hospital construction costs of at least \$20,000 per bed, and ignoring the inevitable inflation that will occur in these costs, it

will require approximately \$4½ billion to provide the 225,000 new general hospital beds required just for this added population. Defined in terms of the local community, and at the risk of chilling the enthusiasm of local chambers of commerce, this means that almost \$100 for new hospital construction must be found for each new entrant into the community.

A CHANGING POPULATION

It is the changing characteristics of this population growth that will importantly complicate the community's hospital bill. The slowest growing group of population will be the age range 25-64 years—the segment which bears the major responsibility for the maintenance of families and the payment of Blue Cross. Compared with about 81 million in 1956, their number will rise to 96 million by 1975, or by somewhat less than 20 percent. At the same time the dependent child population, those under age 18, will increase some 20 million or about 35 percent. (The above estimates are taken from a report of the Bureau of the Census.)

This one aspect of the population change means that the number of dependents covered under prepayment family certificates will be increasing by 35 percent, while the number of family prepayment certificates will be increasing by only 20 percent.

This increasing expense per prepayment certificate can be stated another way. We will soon reach a point where the average family will have three children as compared with an average of 2.4 children per family in 1958. In other words, the monthly charge to the subscriber with family coverage will have to reflect the fact that he has 25 percent more children covered under his prepayment certificate than he did 10 years before.

The increased size of the family means also that there will be more births per prepayment subscriber. And the record shows an increasing percentage of these will be born in the hospital. In 1957, 95 percent of all births in this country occurred in hospitals as compared with 85 percent in 1947. This trend means that almost all births will be hospital births and the community will have increased its hospital expenditures for this one particular hospital service by one-tenth since 1947.

It can be argued with some logic that the increased percentage of the population in the younger aged group will tend to reduce the number of hospital admissions because of the lower incidence of hospitalized illness in that group. This advantage will be many times offset, however, by the changing characteristics of the population at the other end of the age scale. The experts say there will be 22 million people at ages 65 and over by 1975, compared with less than 14.5 million in 1956; an increase of 7.5 million or 52 percent. This compares with the previously mentioned increase in the total population of 29 percent for the same period. At present 1 out of every 12 persons is over age 65. This ratio will increase to 1 out of every 10 by 1975.

Without going into all the complex problems that the aging present to the community, one can determine pretty quickly the implications of the rapid growth of this group on the community's hospital bill. There have been several studies to examine the hospital usage of persons over age 65. One of the most recent and perhaps best documented was that reported by the national Blue Cross Commission in 1957.

This report states "the excess cost for ages 65 and over measured in days of hospitalization would be most probably somewhere between 2.5 and 3 days per year per person. This is equivalent to saying that the cost of hospitalization of persons 65 and over is from three to four times that for those under age 65."

Another study was reported recently by the Health Council of North Carolina. It covered all hospitals in that State. This study found that "hospital usage by persons over 65 year of age is over three times greater than for persons under 65 because of both the higher admission rate and the longer length of stay."

Approximately the same findings were made on a national basis in a survey conducted in 1953 by the American Medical Association. This was a special 1-day survey of the age and sex of all patients in the hospitals of the Nation on that day. The survey disclosed that on the survey day persons over age 65 made up more than 20 percent of all hospitalized patients. In 1953, persons over age 65 made up less than 8 percent of the total population.

If one accepts the findings of these two studies, which are in general agreement with other studies of this problem, it is apparent that those over age 65 on

the average require more than three times the hospital care of the population under age 65. Relating this fact of dramatically higher usage to the increasing ratio of the over 65 age group to the general population, we have no alternative but to expect an increasing cost for prepayment over the years ahead from this one factor alone.

Increasing life expectancy will also increase hospital usage for those in the age bracket immediately below age 65. A study reported by the Metropolitan Life Insurance Co. in 1956, covering insured male personnel of that company, shows the close correlation between increased hospital utilization and age once the individual reaches middle age.

The study showed that the age group 35 to 44 had an admission rate of 7.3 per 100 individuals and a length of stay of 8.8 days. The age group 55 to 64 had an admission rate of 13.8 per 100 individuals and a length of stay of 14 days. This means that, in terms of hospital days used, the age group 55 to 64 used 193 days per 100 individuals as compared with a usage of 64 days by the 35 to 44 age group—or a ratio of 3 to 1.

FAR-REACHING IMPLICATIONS

This finding has far-reaching implications for hospital usage. It means that the rate of hospital usage for the upper middle aged apparently is not very much less than that of the aged. This fact has not been given sufficient recognition in the planning we have done up until now to meet the health problems resulting from increased life expectancy. Our attention and statistics have been riveted on the mounting number of those over age 65 rather than at the major breaking point, medically speaking, of those reaching age 55. More importantly, it has seemingly been ignored in the free-swinging charges of overuse of hospitalization leveled at members of prepayment plans. There might be some connection between the increased utilization year by year and the increased number of individuals in the medically critical age group of those over 55.

It is interesting to reflect on the fact that average life expectancy in the United States was about 55 years when the first prepayment plan was founded in 1929. Ever since that date a larger and larger number of individuals have occupied the age group 55 to 65 and consequently a larger and larger utilization has been made of hospitals by the same individuals. In those intervening years average life expectancy has increased steadily year by year and is now at the Biblical promise of threescore and 10.

The population has been changing in many other ways than in age. These changes have affected, and will further affect, the utilization of hospitals and consequently the amount of the community's expenditures for hospital care. The movement of the population from the farm to the cities has been a natural result of the mechanism of farmwork and the improvement of farm technology. In 1940, approximately 20 percent of the total labor force of the Nation was employed on farms. Currently, only about 10 percent of the total labor force is thus employed.

Population experts predict that by 1975 the proportion will have been reduced to as low as 6 percent of the total labor force. The labor released from the farm, and their families, have little alternative other than moving to the urban centers where jobs are to be found. The fact that they do move is shown in the following statement by the U.S. Bureau of the Census; "Of the 14.7 million increase in the civilian population between 1950 and 1956, 85 percent was accounted for by the increase in the population living in the metropolitan areas." That this further urbanization will be an influence for further utilization of hospital care is evidenced by the significantly higher rate of usage of hospital care by urban dwellers over the farm population.

Some idea of the comparative usage of hospital care can be developed by taking the 10 States with the highest percentage of urban population in 1956, and comparing the average number of days of general hospital care used per 100 persons in that year with the same figure for the 10 States with the lowest percentage of urban population in that year. It will be found that the more urban States used 31 percent more general hospital care. The comparable usage was 121.3 days and 93.3 days.

How much the increasing urbanization and industrialization of the population is influencing the growing accident rate of the country is not computable from available data. How much the accident rate is affecting hospital usage, however, was demonstrated in a survey by Frank G. Dickinson, Ph.D., of the Ameri-

can Medical Association. For November 1955, Mr. Dickinson secured from the hospitals of the United States information on all accident patients discharged from the hospitals during that month.

This survey disclosed that accident cases represented 6.9 percent of the total patients discharged and 8.1 percent of the total inpatient days of care for the survey month. It showed that in addition to the 1,370,000 days of care provided during November to the 127,800 inpatients admitted because of accidents, the emergency rooms of those hospitals also examined and treated 390,000 accident cases. These are significant percentages of the general hospital's total load and it would be difficult to blame their admission on the doctor or the hospital.

WORKING WIVES

Who does the working is also changing rapidly. A survey in 1956 by the Bureau of the Census showed that the number of working wives had increased by 5 million, or about two-thirds in the last 10 years. All women made up 31.2 percent of the Nation's total civilian labor force, and married women, living with their husbands, totaled 13½ million, or more than 60 percent of this group. Two million of these working wives also had small children at home. The impact of the working wife on the utilization of hospital care can be easily imagined. It means most often that there is now no one at home to take care of the sick husband or child in over 25 percent of the 50 million families in this country.

The fact that the working wife chooses to send the sick individual to the hospital isn't altogether concerned with her possible loss of wages when absent. She also realizes the hesitation of employers to employ individuals who have family responsibilities that cause absenteeism. The increasing number of positions open to women in industry has a further effect on the availability of help to care for the sick at home. Female servants are disappearing rapidly as higher salaries paid by industry beckon.

Even wealthy families find it impossible to match these salaries. The percentage of families with full-time help in the home, has decreased an estimated 60 to 80 percent since the start of World War II.

THE VANISHING EXTRA BEDROOM

The high price of household help, plus the high cost of construction, has brought about another cultural change that works against the individual being sick at home. We are now in the era of the one-bedroom home and the utility apartment. An increasingly large segment of our population has no extra bedroom at home in which to be sick. Before we talk too much of overuse of our hospital facilities, we should seriously examine the economies involved in this one factor. The purpose of the hospital is to centralize those facilities under one roof that the individual cannot afford to provide for himself, or that can be more economically provided for the individual if he shares their use with other members of the community when they become ill.

From a dollars and cents standpoint it would seem that the community is much better off if one hospital room is constructed for the use of the 30-odd different individuals who can use the same hospital bed each year and who represent only one out of eight of the population annually. A little bit of arithmetic shows the tremendous savings to the community of pooling the sickrooms in the hospital rather than constructing dwellings that provide that sickroom.

SIGNIFICANCE OF EDUCATION

The level of education of the individual apparently has a good bit to do with the readiness with which people enter the hospital. The extent to which this is true is difficult to measure from available published data. In an effort to get an idea as to the effects of educational levels on hospital utilization, the author secured from the Blue Cross plan of one of the Nation's largest cities the payout ratios over a period of 4 years on two sets of the population having identical Blue Cross contracts. One set was made up of the personnel of the several universities and secondary school system of that city, and the other was made up of personnel employed in the electronics industry. The sets had about an equal number of individuals covered and the distribution as to sex is estimated as being approximately the same. Average annual income per individual is estimated to be fairly similar with the school group being the higher.

The only major difference between the two sets is believed to be the difference in educational level. One set can be described as composed primarily of college

graduates and the other as composed of individuals primarily not college graduates. The payout ratios for the 4-year period are dramatically higher for the primarily college graduates group.

Most any allowance can be made for other factors, and still usage by the group with higher education will be significantly higher. The payout ratio was 98.8 percent for the group with higher education as compared with 68.8 percent for the electronics industry group. This variance must be attributed to differences in educational levels between the groups.

Whatever significance educational levels have to hospital usage will be increasingly felt in the next several years. We seem to like to criticize our educational institutions in this country but the facts show that more and more of us are using them for longer and longer periods of study. The average schooling of all adults in the Nation has risen from an average of 9 years in 1950 to an average of 10½ years in 1957. During that time the number of high school graduates in the population has increased by 31 percent and the number of college graduates in our population has increased by a resounding 32 percent. In 1957 there were 7.6 million people with at least a college education as compared with only 5.7 million people in 1950. In 1957 some 2,269,000 of the population had done 1 or more years of graduate work. Some idea of the pressures on the population to improve its level of education is given in an article in the May 1958 issue of Fortune. This article states, "Since 1947 the number of professional and technical personnel in industry has increased an additional 43 percent, or two and a half times as fast as the labor force as a whole." To meet the demands of industry and society for a better educated level of personnel, the colleges and universities of the Nation are gearing up to handle more than double the present number of students by 1970. Prepayment plans may as well begin gearing their budgets to the increase in hospital utilization that will follow.

NEW KIND OF SOPHISTICATION

Another sort of education is having perhaps a stronger influence on the public's use of its hospitals. This is perhaps better described as medical and hospital sophistication. Through the press, radio, and television, the public learns quickly of each of the medical discoveries that have been pouring out in an amazing stream for the past two decades. They also learn to know that their hospital is a necessary element in the doctor's use of his new tools and knowledge. The more they learn of medical progress, the more likely they are to go to the hospital. After they go to the hospital for the first time, they are more likely to go again. There is evidence to support this tendency toward the increased use that comes with familiarity. Through the cooperation of the division of hospitals of the Illinois State Health Department, the author did a study of nine hospitals constructed in Illinois, with Hill-Burton support, in counties that had previously had no hospitals. These hospitals had been open for an average period of 5 years at the end of 1957. The percentage of occupancy experienced by each hospital during its first year of operation was compared with the percentage of occupancy during 1957. After correction for population changes, the percentage of occupancy of the nine hospitals showed a growth from an average of 39.9 for the group during the first year of operation to an average of 63 percent for the group during 1957. Another study covering the experience of the Saskatchewan Hospital service plan, illustrates the effect of the factor of repetitive admissions upon hospital utilization. The study covered 27,764 male patients who were admitted to Saskatchewan hospitals during 1954, and reviewed their hospital experiences. It was found that 11,009 of the patients had not had a previous hospital admission. The remaining group, those who had been to a hospital before, of 16,737 patients was found to have had 61,187 admissions during the 5-year period—an average of almost 4 admissions each during the period.

Full and adequate hospital care is becoming an accepted component in the average American's standard of living. It is an economic axiom that as national income rises increased demands are made for personal service. This simply reflects the fact that people have a great proportion of their income left for discretionary spending after the purchase of food, clothes, and shelter.

All of us are aware of the dramatic increases in national personal income during the last 20 years. Consumer income, after taxes, appears to have hit a new peak of almost \$300 billion.

The dramatic change in income has not been so much in the total, however, as in the manner in which this total has been distributed. This country is ap-

parently undergoing the greatest economic and social revolution of all time. Figures released recently by the U.S. Census Bureau show that 48 percent, or almost half, of the country's families had total incomes last year of between \$5,000 and \$15,000. Fifteen years ago only 5 percent of a smaller number of families had an income of more than \$5,000. The median income per family (half the families earned more; half less) in 1957 was \$4,971 as compared to a median of \$3,890 in 1952, just 5 years earlier.

In the meantime, the portion going to those at the top of the income ladder slipped again. Only 1.9 percent of the Nation's families had an income of more than \$15,000 in 1957. The correlation of income level of the general population with hospital usage can be demonstrated in a general way.

A comparison of average days of general hospital care for the 10 States with the highest per capita income in 1956 and the 10 States with the lowest per capita income in 1956 shows that the first group of States used an average of 123 days of care per 100 members of the population as compared with only 89 days for the second group.

This represents a difference of over 38 percent in hospital usage by the population in those States with the highest per capita income. It is the author's opinion that this comparison is not so much a measure of the difference in ability to pay for hospital care as it is the increased demand for hospital care that goes along with higher income and a consequent improved standard of living.

The rising standard of living of the American public has not only incorporated adequate hospital care as a usual and expected part of living, but it has also caused a demand for a nicer and more attractive sort of hospital service. Hospitals have been asked by their patients to match the niceties of the motels the motorist finds along the highways. This calls for air conditioning, piped-in radio, perhaps television, and certainly drapes at the window. It also calls for a telephone at the bedside and some choice as to the entree served at mealtime.

Hospitals have been forced to add these and other niceties as they became commonplace in motels, shops, restaurants, and other establishments serving the general public. Their effect on the patient's recovery is debatable and certainly not highly significant. Their effect on the hospital's unit cost, however, is significant.

Their provision has resulted from the demand of the community that hospital service be at least as attractive and convenient as the standard of living to which the community has otherwise become accustomed.

The community has added perceptibly to the operating costs of the hospital from another direction. During the early years of the hospital's development in this country, its service was largely confined to the poor who lacked the means to provide in their homes the minimum needs of the sick in the way of food, linens, and a sanitary environment. Because hospitals were serving the poor, at no charge or at most a nominal charge, the hospitals were granted immunity from public liability and malpractice claims. The idea was that the hospital was a charity and any recovery against the hospital was actually a recovery against a charity.

The attitude of the community toward hospital immunity started undergoing a change when the advances of medicine made it necessary that everyone use the hospital. The doctrine of immunity became a barrier against the claims of the citizens who were paying as well as the claims of those who were not. In recent years this change in attitude on the part of the community has caused a rapid erosion of the immunity doctrine.

This erosion is aptly described by the following comment from a recent opinion handed down by the Supreme Court of Ohio when it reversed that State's former rule of immunity: "The immunity of charities is clearly in full retreat in this country. And it may be predicted with some confidence that the end of another decade will find a majority of the American jurisdictions holding that it does not exist."

A few months later, New York's highest court decided, "Hospitals should shoulder the responsibilities borne by everyone else—liability is the rule, immunity the exception."

The New York court is probably correct, and hospitals should shoulder the same responsibilities borne by everyone else. What everyone else must realize, however, is that they are paying the cost of this new burden placed upon the hospital. It is not a small burden. Because of the nature of hospital

service, the hospital's exposure to liability claims is much greater than that of other types of enterprise. Also, perhaps because of the mystery surrounding medical and hospital activities, juries have shown a strong sympathy for those who bring reasonably plausible claims against the hospital.

This set of circumstances forces liability underwriters to charge almost prohibitive rates for hospital liability coverage. Many liability underwriters will not even accept hospital business. The added cost to hospitals represented in liability insurance, or court awards, in these States where immunity has been removed is sizable. Inevitably, this added cost becomes a part of the prepayment subscriber's monthly premium.

Community attitudes will affect prepayment rates in another connection. Traditionally, the community has forced the hospital to pass a part—and in many communities all—of the cost of the medically indigent on to the hospital's pay patients. For some reason it has been left up to the hospital to recover the cost of care of those who could not pay by "taxing" the sick through their hospital bills rather than by a tax on the whole community. Prepayment plans have not as yet permitted hospitals to include this cost as part of the reimbursement the prepayment plans make to the hospital for service to members. Further spread of prepayment coverage over a large segment of the population will make this burden so intolerable to the few remaining pay patients that hospitals will be forced to compel the prepayment plans to cover the cost of service rendered to the medically indigent.

Much has been said about the effect of medical advances on the daily operating costs of hospitals. Indeed, much can be said in that regard, and the full story of the effects of those medical advances would still be only half-told. The mushrooming discoveries of medicine are the reason the modern hospital has developed. The effects of these discoveries on the operating costs of the hospital, however, tell only half the story so far as their influence on the community's total hospital expenditures are concerned.

The effect on the utilization of hospitals is increasingly as important. In the first place these medical advances now permit doctors to offer treatment to patients whose condition was classified as hopeless and incurable a few years ago. These patients represented no expense to the prepayment plans because there was no treatment for them. If one reviews the average hospital's census today it is likely that a goodly percent of the patients will be undergoing therapy that was unknown just a few years ago. Much of this new therapy is difficult and of long duration. The effort on behalf of these patients consumes an increased number of more costly hospital days that represent a net addition to the pay-out total of the community's prepayment plan.

Hospitals and prepayment plans think it very doubtful that the community would want this work stopped. They hope that the community is equally willing to understand the financial consequences.

The rapid advances of medicine have been necessarily accompanied by a rapid increase in specialization by the doctors. They have been forced to restrict their study and work to smaller areas of medical science in order to keep abreast of the rapid developments in that science. Specialists are in general the largest users of hospital facilities for the same reason they are specialists. The rate of increase in medical specialists can therefore serve as a sort of index to the rate of increase in the utilization of hospital facilities.

THE ERA OF SPECIALISTS

Training for a medical specialty is secured through hospital residences approved by the American Medical Association. As late as 1951 there were a total of 15,851 residents in training. In 1956 their number had increased to 23,012. The number of different medical specialties recognized by the AMA in 1951 was 27. In 1956 these specialized branches of medicine had increased to 30. Some idea of the magnitude of this need for specialized knowledge by doctors, and the extent to which they are seeking it, can be gained from the fact that the number of doctors in residencies in 1956 equaled more than three times the number of medical school graduates for that year.

Medical advances will increase the burden of prepayment plans in another and somewhat paradoxical way. Prepayment plans are chiefly concerned with general hospitals. Two major diseases, tuberculosis and mental disease, have been an accepted responsibility of government and special hospitals for these diseases have traditionally been operated at government expense and without charge to the patient. Important medical advances in both those diseases, how-

ever, are causing a shift of many tuberculous and mentally ill patients into community general hospitals. This consequently shifts the expense of their care to the prepayment plan.

Developments in chemotherapy for the treatment of tuberculosis have reduced the death rate in that disease no less than 70 percent between 1949 and 1956. The decrease was from 25.5 to 7.6 per 100,000 population. This has meant the closing of many governmentally operated tuberculosis hospitals because of greatly reduced censuses.

In each community, however, there remains, and will remain for many years, a number of tuberculous patients. Such cases will require intensive chemotherapy treatment and followup care in their private physicians' offices. The doctor and each patient's family will quite properly insist that the local community hospital provide hospital care for these patients and that their repayment plan finance such care. The result will be an increase in the number of days of care utilized in the general hospital and a consequent increase in the cost to the prepayment plans.

Already an increasing number of general hospitals and prepayment plans are taking over such patients in their communities. A similar development is occurring in mental disease. The discovery of the tranquilizing drugs has not provided a cure for mental disease, but it has provided a means for safely hospitalizing most of those patients in the open floors of the general hospital.

R. A. Chittick, M.D., superintendent of the Vermont State Mental Hospital, stated recently that due to the use of tranquilizing drugs, "physical restraint and seclusion have been practically eliminated" in the treatment of mental patients. Families of those patients will rightfully insist that they now be treated, as the other sick of the community, by private physicians in local community hospitals. They will likewise insist that the cost of such hospitalization be paid by prepayment plans. To the extent this happens the taxpayer's burden will be decreased, but the prepayment subscriber will discover monthly prepayment rates have taken up the slack in his taxes.

EFFECT OF PREPAYMENT

One of the most important forces affecting the use of hospital care is the prepayment movement itself. The spectacular growth of this movement is well known. Over two-thirds of our population now have some form of hospital coverage. The effects of prepayment coverage on hospital utilization are, in my opinion, clear.

In the report of a nationwide survey made in 1953, the Health Information Foundation states "the admission rate to hospitals for all persons was 12 per 100 of the population. For persons with (hospital) insurance the rate was 14; for those without insurance the rate was 9. The number of hospital days per 100 persons for all persons per year was 90. For those with insurance there was 100 days per 100 persons, and for those without insurance, 70 days per 100 persons."

Somewhat similar findings can be demonstrated by comparing the 10 States with the highest percentage of population enrolled in Blue Cross in 1956 with the 10 States with the lowest percentage enrolled in that year. The 10 highest enrollment States in 1956 used an average of 128.2 days of general hospital care per 100 of population as compared with 101.1 days for the lowest enrollment States.

Because those with prepayment coverage utilize more hospital service than those without such coverage there has been a tendency to criticize the prepayment movement. The terms "abuse" and "overuse" have been used and somehow the hospitals and the doctors have been associated in a conspiracy to foster this supposed misuse of prepayment.

The question as to whether certain individuals may have gone to the hospital too often and stayed too long has no easy answer. There are no concrete standards by which to determine appropriateness of hospital usage. The question involves a complex of medical, economic, and cultural factors as related to the well-being and convenience of the individual patient. The essential question in this connection is not concerned with whether those with prepayment coverage used more hospital care. If prepayment is serving any social purpose at all it would be expected that its members would have had better financial access to hospital care.

The more practical question is: Do patients utilize hospitals' and doctors' services because they have prepayment, or, on the contrary, do patients have prepayment because they want to use hospitals' and doctors' services?

There is some evidence that the latter is the case and that prepayment coverage is a characteristic of those individuals who have built adequate medical and hospital care into their standard of living. In the study by the Health Information Foundation referred to previously it was found that "on the basis of the median, families with insurance incur charges exceeding twice that of uninsured families. If the amount paid by insurance is deleted, leaving out-of-pocket expenses of \$117, this is still twice the (total) charges incurred by uninsured families."

The uninsured themselves present strong evidence that demand for hospital care is increasingly a part of the way of life in the United States and coincidental to prepayment. This past year the uninsured segment of the population had an admission rate to the hospital more than twice that of all the population 25 years ago.

Another way to demonstrate that the public is not after a free ride at the expense of prepayment plans is to examine public usage of medical items which are not covered by prepayment. One such item is prescription sales in drugstores. Such prescriptions give a good index since they can be obtained only from a doctor, are almost never a benefit of prepayment, and occur outside the hospital. The American Druggist magazine reports that in 1957 prescription sales by drugstores totaled \$1.7 billion, nearly four times the total for 1947. Such a fantastic increase in the out-of-pocket expenditures for one aspect of medical care should offer some proof that the American people are primarily concerned with health care for its own sake and not as a means of beating the prepayment game.

Prepayment is only one of several forces motivating, and making possible, the public's increased utilization of hospital facilities. As mentioned earlier, for example, the average number of days of care used per 100 population was 128.2 in those 10 States with highest Blue Cross enrollment, 121.3 in those 10 States with most urban population, and 122.9 in those 10 States with highest per capita income.

Four States fell into all three categories mentioned above. The average number of days of care per 100 population used in these four States was 132.2. The three forces together exert a combined influence of dramatic proportions.

THE PREPAYMENT ORBIT

The percentage of the population covered by prepayment continues to increase and apparently will continue to do so. Currently, the number with prepayment coverage is increasing about three times as rapidly as the population growth. The increasing urbanization and industrialization of the population will bring a larger percentage of the Nation's population into the natural orbit of prepayment.

The effects of these changes can be seen in a statement in the report of the Health Information Foundation referred to earlier: "In urban areas 70 percent of the families have some sort of insurance, and on farms, 45 percent. Seventy-seven percent of the families with health insurance obtained it through their place of work, or through another employer." Prepayment plans are employee-group oriented, but are working toward developing means and experience in providing coverage for the self-employed and other nongroup individuals.

The influence will be further increased in another way. The quality and scope of benefits continues to grow. Today's prepayment contract is no more comparable to that of 10 years ago than today's automobile is comparable to one of that vintage. Neither is its cost and no one ought to expect it to be. The number of days of coverage per year has had a rather dramatic increase in those years. Many Blue Cross plans have increased the days of coverage provided annually from 30 to 120 in this period. The restrictions as to diseases covered, as well as the items of service covered, has decreased each year.

There is still much room for improvement of scope of coverage, however. This is especially true of commercial insurance coverage which is often tailored to meet competition rather than health needs. Currently, it is estimated that those with prepayment coverage, on the average nationally, have less than 70 percent of their basic hospital bills covered.

There is a strong feeling on the part of many persons and organizations that prepayment should become fully comprehensive and provide hospital services to ambulatory patients. Some responsible individuals believe that providing prepayment plans for hospital service on an ambulatory basis would remove any

financial incentive to enter the hospital as an inpatient in order to have prepayment cover the services.

Support for such thinking was provided recently in a study made under the direction of Paul M. Densen of the Health Insurance Plan of Greater New York and published by the American Hospital Association. This study covered the usage of hospital days of care by two large groups in New York City that were comparable in most all respects. One group, however, had Health Insurance Plan coverage providing full hospital and doctor service on an ambulatory basis. The other group had Blue Shield for inpatient doctor service only. Both groups had the same Blue Cross coverage. During 1955 the group with full hospital coverage on an ambulatory basis utilized 17 percent fewer hospital days than did the group without such coverage. This study does not cover dollar costs and comparisons of total expenditures under the two schemes are not given. The findings are such, however, as to argue for further study of the extension of prepayment benefits to include hospital services for ambulatory patients.

The cost of the prepayment mechanism itself does, of course, add to the total of the community's expenditures for hospital care. The overhead expenses of prepayment plans run from a minimum of slightly over 6 percent of the subscribers' payments for the Blue Cross plans to as much as 30 percent for a good many of the commercial insurance plans. This is not to say that the opportunity to budget for the costs of hospital care is not worth the overhead. Prepayment plans have more than demonstrated their social worth through placing adequate hospital care within the economic reach of the majority of our population. It is to say, however, that care must be taken by the community in the sort of prepayment mechanism it desires and the sorts of things it asks its prepayment mechanism to do.

This study has attempted to point out some of the forces that are affecting the total expenditures of the community for hospital care. These forces are generated within the community and are not within the control of hospitals nor prepayment plans. The precise influence of each of the forces cannot be determined. Doubtlessly these forces are interdependent and interacting.

The measurements in this paper probably are also reflections of still other factors in addition to the particular ones examined. This is not consequential so long as the existence of such forces is recognized and their influence is appreciated. The important issue is that recognition be given to the fact that hospitals and prepayment plans must be responsive to the changing characteristics of the community and to those demands which the community itself makes.

Increasing hospital costs and hospital utilization can be rationally explained. There are quite likely some inefficiencies in hospital operations and some inefficient utilization of hospital services. It would be quite surprising if an industry spending over \$36 annually for every member of the population and providing a half billion days of care per year did not have some of both occur. Hospital and prepayment plans must of course continue their efforts to minimize any inefficiencies that do exist.

Inefficiency is not, however, an important factor in the increasing total of the community's expenditures for hospital care. Increasing quality and increasing demand are the two really important influences.

The basic question confronting the American people is what sort and amount of hospital care they want. There are no objective standards as to what they should have. How much hospital care is largely a question of how much hospital care the public wants and is willing to pay for.

The amount of care the public is using does not presently represent any sizable allocation of annual income. During 1956 the total expenditures of all general hospitals of the Nation represented only 1.8 percent of the national disposable personal income, after taxes. The manner in which the Nation's income is being increasingly spread across the population, and the increasing use of the prepayment mechanism for averaging the cost of hospital care among the total population, means that there are increasingly fewer individuals for whom hospital care represents in any way a financial problem.

The important thing is that the American people themselves understand the issues and make the decision for themselves. The quality and quantity of hospital care should not be determined by political debate nor through arbitrary rate setting by State regulatory agencies. Such intervention can only lead to deterioration of quality since the public is pretty well demonstrating that it will not decrease the quantity.

The CHAIRMAN. As I understand it, the American Hospital Association owns Blue Shield; is that correct?

Dr. BUERKI. No.

The CHAIRMAN. Blue Cross then?

Dr. BUERKI. They do not own Blue Cross. The group you would be dealing with in buying this insurance is National Blue Cross. They have set up a special organization that the hospitals accept—

The CHAIRMAN. I am talking of the American Hospital Association and I thought they controlled the operations.

Dr. BUERKI. We control standards and in Michigan the costs of operation of Blue Cross are less than 4 percent of the dollar taken in.

The CHAIRMAN. Did your association set up these various Blue Cross plans over the country?

Dr. BUERKI. Our association did not set them up. They sponsored them.

The CHAIRMAN. Who did?

Dr. BUERKI. The hospitals did in the various communities.

The CHAIRMAN. I thought that the American Hospital Association had charge of the sponsorship of the entire program. Is that not correct?

Dr. BUERKI. Sponsorship, yes, but not direction and control of setting them up, sir. If they had done so, there probably would not be as many variations in the plans as you mentioned earlier, where there are some 87 plans and with varying benefits.

Mr. WILLIAMSON. When the idea of prepayment started down in Texas in the first Blue Cross plan, the association studied that, and various committees did over a period of time and felt this was something, looking into the future, that was an essential element for the purpose, and therefore they stimulated and urged hospitals nationwide to get busy and study it in every community and State and develop these plans. It is that kind of sponsorship that the association undertook.

Mr. GROSS. Are there any other national hospital associations in addition to yours?

Dr. BUERKI. There is a Catholic Hospital Association and a Protestant Hospital Association, but their hospitals as individuals, almost without exception, belong to the American Hospital Association. This is the association.

Mr. GROSS. You were not fooling at all when you said that hospital costs are likely to go up 5 percent.

Dr. BUERKI. No.

Mr. GROSS. Because you say in your statement that they went up 9 percent in 1957 and 1958.

Dr. BUERKI. But over the years it has been an average of about 5 percent.

Mr. GROSS. Up to this point.

Dr. BUERKI. Yes.

Mr. GROSS. You have not said anything about inflation this morning. I will not go into that.

Dr. BUERKI. It scares us too.

Mrs. ST. GEORGE. Doctor, in looking over the report from the other body on S. 2162, I notice in one of the minority reports they say something that I would like your opinion on. They say:

To stave off frequent increases in contribution rates S. 2162 should explicitly provide for setting aside an adequate reserve. The reserve of 3 percent of 1 year's contribution, plus income derived from any dividend, premium rate credit,

or other refunds which S. 2162 relies on to provide necessary reserve is totally inadequate for the purpose.

Dr. BUERKI. I do not see how I can comment on that because that is primarily in the field of actuarial ability and experience. In that I am very naive. I fight with the actuaries at times, but I am naive.

Mr. CUNNINGHAM. Do you set up a reserve in your own hospital?

Dr. BUERKI. Yes.

Mr. CUNNINGHAM. How much does that run as a percentage?

Dr. BUERKI. Two and a half percent of the cost of the building. I am setting up a reserve for replacement of buildings, sir, and a reserve for the replacement of equipment. It will average out about 3 percent for the total equipment on which the average life will run from 5 to 15 years and the building life from 40 to 60 years.

Mr. CUNNINGHAM. Do you set up any reserve for future contingencies?

Dr. BUERKI. Only for bad debts, and during the last year that has had to be increased because people have not had quite the money to pay.

Mr. GROSS. I thought you said this is a period of prosperity.

Dr. BUERKI. You were talking about today. People still came to the hospital and we had to write off a few more bills than we did prior.

Mr. GROSS. It has been borrowed prosperity on the part of the Government and on the part of an awful lot of people. That is what it has been, so when you say "prosperity," you do not mean prosperity in the true sense of the word, do you?

Dr. BUERKI. A willingness to spend and a desire to spend.

Mr. GROSS. Go into debt.

Dr. BUERKI. And we carry some of that.

The CHAIRMAN. Do you have any figures comparing the ratio of patients in the hospital 65 years of age and over and those under 65?

Mr. WILLIAMSON. Yes, there have been studies made on a day. The percentage of people 65 years and over, in relation to the number of aged of the total population, is very much higher. We have exact figures that we can give you on that.

The CHAIRMAN. I wish that you would supply those figures for the record. You do not have them available right now?

Mr. WILLIAMSON. No. As I remember the figures, it is almost three times. I think that is a fair figure of aged people in hospitals, if you take a day and see what the census is on that day.

Dr. BUERKI. Sixty-five is a pretty arbitrary line to draw. The people from 55 to 65 use the hospital much more than people from 20 to 30. It is not a sudden step-up. It is a growing line. That is another reason we are using more hospitals today, because of the aging population and this again is reflected in Blue Cross costs.

Mr. CUNNINGHAM. The witness referred to the advisory council.

Dr. BUERKI. That is called for in the bill. There are three people, one medicine, one public health, and one hospital. Our suggestion is that this man should be an active hospital administrator chosen from the field who could bring—and I do not think this is quite clearly spelled out—to the advisory council his day-to-day background in the hospital field.

Mr. CUNNINGHAM. The language is, "Who shall be representative of hospital administration?"

Dr. BUERKI. We would like for him to be an active administrator chosen from the total field, wherever you can get the best man, but a man who is an active administrator.

Mr. CUNNINGHAM. In your study of this advisory council, since you have been so specific about it, what do you envision as the duty of the advisory council, or what benefits does the proposed plan derive from the advisory council, and have you studied the makeup of the rest of the council other than just the one?

Dr. BUERKI. Yes. Their primary interest, of course, is in the Federal Government point of view, and it brings to the committee three different points of view that will be of value in finally determining policy.

Mr. CUNNINGHAM. They have no authority. The council has no authority.

Dr. BUERKI. I know.

Mr. CUNNINGHAM. It seems that the Civil Service Commission has full authority.

Dr. BUERKI. But the Civil Service Commission could ignore them, but I wonder if they would.

Mr. CUNNINGHAM. It is not a question of ignoring them. I think the Civil Service Commission has full authority to make the plans, and your authority that this Advisory Council would be beneficial to give advice to the Civil Service Commission?

Dr. BUERKI. That is right.

Mr. CUNNINGHAM. Do you think it is an important part of the bill?

Dr. BUERKI. Yes.

Mr. WILLIAMSON. If I may comment: we have at various times in the association in terms of legislation recommended Advisory Councils and suggested that they be given authority except for an instance we have always found the Congress to be reluctant to tie the administration's hands. They are willing to set up a body to give advice, but to tie administration's hands by giving an advisory committee authority they have been reluctant to do. The only time that they have done this was in the Hill-Burton grant-in-aid program, where they did give the Advisory Council authority.

The CHAIRMAN. How many hospitals belong to the American Hospital Association?

Dr. BUERKI. About 6,200 of the 7,000 hospitals.

The CHAIRMAN. What percentage of the hospitals are privately owned?

Dr. BUERKI. Five percent, and that may be high.

The CHAIRMAN. That is what I was thinking. Do you see many new private hospitals being built today?

Mr. WILLIAMSON. In some areas. In California, Florida, and one or two other States. Primarily in California there is a development of proprietary hospitals. For many years in those areas where there was a high percentage they bowed out of business, but in recent years there has been a change in that direction.

The CHAIRMAN. I thought they were getting fewer.

Mr. WILLIAMSON. In most places they are.

The CHAIRMAN. In the last 25 or 30 years.

Mr. WILLIAMSON. You are right. Nationwide, historically, they are getting fewer and fewer.

The CHAIRMAN. And they are in the metropolitan areas mostly.

Mr. WILLIAMSON. Generally speaking, you are correct.

Dr. BUERKI. They are very small, 15 to 25 beds.

Mr. WILLIAMSON. In some communities they perform a very important service because they are the only hospitals—especially in small communities.

Dr. BUERKI. But they are very small in number.

Mr. BARRY. Could you shed any light on that recent hospital strike in New York? You will recall several large hospitals struck and the public was aghast.

Dr. BUERKI. Yes.

Mr. BARRY. But later on when the facts came out the reasons for it were quite evident.

Dr. BUERKI. \$33 a week salaries for a lot of their employees, yes. This is one of the problems that we have been talking about, the need to increase salaries. The hospitals in New York knew this, but they tried to push the city government to pay more for the charity patients. They were pushing Blue Cross to get higher rates and were not winning, and to keep in business they washed one hand with the other and took it out on the employees, and this we deplore.

Mr. BARRY. What was the average salary rate paid those who struck in New York?

Dr. BUERKI. I do not know. I only know the figure of \$33.

Mr. BARRY. That is a dramatic incident of what you have been talking about.

Dr. BUERKI. Of what I have been talking about.

Mr. BARRY. And what you have been trying to describe to the committee.

Dr. BUERKI. Yes.

Mr. BARRY. How many hospitals struck?

Dr. BUERKI. Sixty-seven.

Mr. BARRY. How many beds did that come to?

Mr. WILLIAMSON. They would average 700 beds or more.

Mr. BARRY. You know what settlement was reached? Do you know what they got out of the strike?

Mr. WILLIAMSON. They agreed upon a salary increase for the workers. They agreed upon the establishment of an arbitration group made up of six citizens appointed. I believe the chairman is to be one of the presiding judges in one of the courts, and six chairmen of the hospital boards of trustees, and that group is to continue. I think that they will have to have a staff. Somebody will have to finance it. They will have to continue to study costs and salaries in relation to costs and the needs of the workers and recommend changes in the future, and they are also, I understand, a body to which the workers can bring complaints, or questions they have for arbitration.

Dr. BUERKI. I am correct, am I not, that in agreeing to increase the salaries, first the city had to agree to raise the rates they were going to pay in hospitals, and Blue Cross agreed to arrange the increase in rates to pay the hospitals.

Mr. WILLIAMSON. That is right.

Mr. BARRY. Would you say that a strike is an indication of what could be expected in other communities?

Dr. BUERKI. Provided that we do not continue to raise salaries, yes, more nearly equivalent with what industry is paying.

The CHAIRMAN. Thank you very much for your statement.

We will insert in the record at this point a letter from Mr. John S. Warner, Legislative Counsel, Central Intelligence Agency, addressed to me as chairman.

(The letter referred to follows:)

CENTRAL INTELLIGENCE AGENCY,
Washington, D.C., August 5, 1959.

Hon. TOM MURRAY,
Chairman, House Post Office and Civil Service Committee,
Washington, D.C.

DEAR MR. MURRAY: On July 29, 1959, Mr. Dulles indicated that as suggested in your letter of July 23 I would contact Mr. Frederick C. Belen, chief counsel of the committee, regarding the committee's hearings on S. 2162 and similar House bill to provide a health insurance program for Federal employees. I have discussed briefly with Mr. Belen the Agency's health insurance program as it relates to the proposed legislation. I believe this letter will provide further information as well as several suggestions for the committee's consideration.

As you know, our Agency faces certain security problems in conforming to general legislation providing employee benefits. We are, for instance, precluded from adhering to any procedures which require the disclosure of the names, number, or location of our employees. This prohibition arises out of the mandate to the Director of Central Intelligence under section 102(d)(3) of the National Security Act to protect intelligence sources and methods and the exemption in section 6 of the Central Intelligence Agency Act from any provision of law requiring such disclosures. To avoid security breaches in remitting premiums and settling claims, this Agency established a hospitalization insurance program which could be administered within the Agency in conformity with Agency security requirements. This program has operated successfully in various forms through an organization of Agency employees since 1948. Over \$600,000 was paid in health insurance claims last year under this program.

It is important to the operation of this Agency that, in any health insurance legislation which may be enacted, provisions be included which would permit the Central Intelligence Agency to make appropriate arrangements with the Civil Service Commission concerning the administration of the Agency's health insurance program. While we do not wish to obtain an exemption from this legislation, it is imperative that the Agency have sufficient latitude to resolve its security problems within the general framework of the bill.

We have discussed the Agency's security requirements with representatives of the Civil Service Commission who feel that S. 2162 and the similar House bills do not provide such latitude. They have suggested that section 4 of S. 2162 or similar House bills be amended to add a subsection (5) which would read:

"(5) Central Intelligence Agency plans—Group plans for employees of the Central Intelligence Agency."

Similarly, section 5 should also be amended to add a subsection (5) to read: "(5) Central Intelligence Agency plans—Benefits of the type specified in this subsection under paragraph (1) or (2)."

This Agency is in agreement with the Commission's recommendation or any similar amendment and we shall be pleased to make appropriate representations to the committee to this effect. Accordingly, it is requested that the committee give favorable consideration to this recommendation based on the above.

Sincerely,

JOHN S. WARNER, *Legislative Counsel.*

The CHAIRMAN. Subsequent to the hearing of August 6, 1959, the following letter was received from Dr. Buerki.

(The letter referred to follows:)

HENRY FORD HOSPITAL,
Detroit, Mich., August 12, 1959.

HON. TOM MURRAY,
Chairman, House of Representatives,
Committee on Post Office and Civil Service,
House of Representatives, Washington D.C.

DEAR MR. MURRAY. Thank you for your letter of August 8, 1959. It was a privilege to have an opportunity to testify before the Post Office and Civil Service Committee.

Your question regarding the possible acceptance by the hospital of identification of a Federal employee under an indemnity health insurance plan in lieu of payment at the time of discharge is not an easy one to answer. You would probably get a different answer from each hospital administrator to whom you put the question. Basically the problem is as between the service benefit plan (Blue Cross) approach and the indemnity (insurance company) approach.

The nonprofit Blue Cross plans have been developed as community organizations with hospital sponsorship. Their approach, in the main, has been to provide whatever hospital services the patient requires to get well through a direct contractual relationship with the voluntary hospitals in the area served by that Blue Cross plan. Blue Cross does not customarily limit the amount of service in terms of dollars and since no "assignments" are necessary and payment is made directly to the hospitals and not to the individual patient, the hospitals have traditionally accepted the Blue Cross identification card in lieu of either cash deposit or payment at the time of admission or discharge.

Indemnity insurance, on the other hand, if of a different nature. Instead of dealing with one local Blue Cross plan, a hospital finds itself dealing with literally dozens of different insurance carriers, each with a variety of benefit programs. These insurance benefit schedules run the gamut from inadequate dollar allowances to good coverage. There is a wide variety of claims handling procedures among various insurance carriers.

The result is, therefore, that the great majority of hospitals know the Blue Cross benefits and procedures and because the Blue Cross settlement is made directly with the hospital, the hospital is usually able to compute the Blue Cross payment at the time of discharge. In the case of the insurance carriers, the hospitals will usually accept identification in lieu of payment only after there has been sufficient experience with a particular company and a particular set of benefits to justify the hospital's faith that the bill will be promptly paid.

My answer to your question, therefore, is that the extent of acceptance by the hospitals of identification of Federal employees under an indemnity plan will doubtless be determined only after such a plan is put into operation. If the established dollar allowances cover comprehensive services, if the insurance company is prepared to honor such assignments, and if rejections are minimal and if payment is prompt, I believe that most hospitals will go along with such a program. It would be difficult to make arrangements in advance for such acceptance by all or even by any substantial number of hospitals.

To the extent that deductibles, coinsurance or other limitations might be imposed in an indemnity policy for Federal employees, the patients would of course have to make payments in cash. If the amounts were substantial it is likely that hospitals, which commonly have none too much working capital, might insist upon some deposit at the time of admission.

Again, thanks.

Sincerely,

ROBIN C. BUERKI, M.D.,
Executive Director.

The CHAIRMAN. The committee will stand adjourned and the hearings will be resumed tomorrow morning at 10 o'clock.

(Whereupon, at 11:45 a.m., the committee adjourned, to reconvene Friday, August 7, 1959, at 10 a.m.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

FRIDAY, AUGUST 7, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order, please.

The hearings will be resumed on S. 2162 and similar House bills on health insurance for Federal employees.

I will call first on Mr. Dan Jaspán, legislative representative of the National Association of Postal Supervisors.

Mr. PORTER. I have been looking over some of the statements here and some do contain new material, but there is also a good deal of the testimony that is repetitive. I wonder if the witnesses would confine their testimony to that which is new in the interest of expediting the hearings.

The CHAIRMAN. They can highlight their statements. It will not be necessary for them to read them line for line, but their whole statements will be included in the record.

STATEMENT OF DANIEL JASPAN, LEGISLATIVE REPRESENTATIVE, NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

Mr. JASPAN. Mr. Chairman and members of the committee, I appreciate the fact that I am called first. I do have to go out of town.

My name is Daniel Jaspán. I am the legislative representative of the National Association of Postal Supervisors, composed of more than 23,000 supervisors in the postal field service.

We are deeply grateful to the members of this committee and other Members of Congress who have sponsored various bills providing for health insurance for Federal employees. We appreciate the interest of the chairman in this subject and take this opportunity to thank him for scheduling these hearings. This proposed legislation is extremely important to our members, most of whom have had more than 25 years in the postal service and many of whom are approaching the time of life when the necessity of medical treatment and hospitalization is continually increasing. On the other hand, the salaries received do not permit a liberal budget for medical treatment and hospitalization. The costs of hospital and medical insurance have increased to such an extent that they impose a financial burden on our members and they cannot afford any prolonged hospital and medical services.

The Federal Government, which had long been the leader in fringe benefits, is gradually surrendering that leadership to private industry. Most of our members can well remember that, when they entered the postal service, the Government fringe benefits were far ahead of those in industry and that was one item that made Federal service more attractive, even though actual salaries were often less than in industry. According to the U.S. Chamber of Commerce survey "Fringe Benefits 1957" the following industries at that time practically equaled or surpassed the Government in the percentage of payroll spent for fringe benefits: banks, finance and trust companies, 31.7 percent of its payroll for fringe benefits; petroleum industry, 27.3 percent; insurance companies, 26.7 percent; miscellaneous nonmanufacturing (including coal mining, warehousing, and laundries), 25.5 percent; chemicals and allied products, 24 percent; public utilities, 23.5 percent. The average for all industries at that time (1957) was 21.8 percent of the payroll for fringe benefits. Undoubtedly those averages have increased and others have moved into the upper ranks in the intervening years. The passage of health insurance legislation will once more place the Government among the leaders, even through it won't be the leader.

The "Digest of One Hundred Selected Health and Insurance Plans Under Collective Bargaining, Early 1958," published by the Bureau of Labor Statistics in October 1958, illustrates very well how much progress has been made in health and insurance plans in private industry. Here, for example, is what the American Sugar Co. offers its employees, according to its April 1958 contract. It must be remembered that the company assumes the full cost, with the employee contributing nothing, either for himself or his dependents. The employee is given life insurance coverage ranging from \$500 to \$2,000 according to his length of service; he receives free insurance covering accidental death and dismemberment; accident and sickness benefits begin the first day and he is entitled to 365 days of hospitalization in a semiprivate room and the full cost of specified services is covered. Required outpatient care is provided, as is surgery according to a specified table. The contract covers medical bills of \$3 per day for home or office visits and up to \$10 the first day of hospitalization, with 21 home visits or 365 daily office visits per year. Seventy days of hospitalization are covered per illness or disability. For maternity benefits there is coverage for 7 days in the hospital, plus \$75 for delivery. This plan also covers diagnostic X-rays and laboratory allowance for nonhospitalized cases up to \$100 per year. This plan grants practically the same benefits to the employee and his family after retirement. It cannot be emphasized too strongly that the company assumes the total cost of the whole program.

Another company listed in the same publication is the American Can Co., according to its contract of February 1958. This company, too, assumes the full cost of life insurance, as well as health insurance for its employees. The life insurance ranges from \$7,900 for an employee with a salary of less than \$76 per week to \$13,200 for an employee with earnings of more than \$115 per week. It is interesting to note that, after retirement or age 65, the face value of this insurance is reduced only 50 percent for employees with 25 or more years of service, as compared with a reduction of 75 percent in our own Federal in-

insurance, and the company finances the policy; there is no employee contribution either while the employee is active or after he retires, or reaches age 65. The American Can Co. insurance plan also provides for 120 days of hospitalization in a semiprivate room and pays the full cost of specified services per disability or illness. It provides required outpatient care for emergencies. There is a specified schedule, with a maximum of \$300, for surgery, plus a medical allowance of \$4 for each day of hospitalization, both for the employee and dependents. The maternity benefits provide up to \$90 for normal delivery and 6 days in a semiprivate room. Other benefits include anesthesia (out of the hospital) diagnostic X-rays up to \$75 per year (in or out of the hospital); diagnostic examination (in or out of hospital) up to \$75 per year; and radiation therapy treatment of \$7.50 per treatment, with a maximum of \$200, in or out of the hospital.

The Firestone Rubber Co. also signed a progressive contract with its employees in February 1958. They also provide free insurance ranging from \$2,000 to \$4,500, and this insurance, too, reduces to only 50 percent of face value after retirement or age 65. There is an equal amount of insurance for accidental death or dismemberment. Hospitalization of 120 days in a semiprivate room is provided, with the full cost of specified services per illness or disability. There is a surgical schedule, covering cases in the home, office, or hospital, with medical payments beginning with \$5 and then reduced to \$3 per day, with a maximum of \$364 and 120 days per disability. This same schedule applies to dependents. Maternity benefits are included as are diagnostic X-rays for employees and dependents for nonhospitalized cases. Provision is made for the same benefits for retired employees, with the company assuming the whole cost. The United States Rubber Co. is operating under practically the same contract and assumes the full cost of the plan.

There are many other plans covered in the publication. Some are less liberal than the above; some are even more liberal, such as the plan for which the Sperry Gyroscope Co. pays the full cost. This liberal contract even provides for electro-shock treatment as well as radiation therapy. The majority of the companies listed pay the full cost for the employee, and a very high percentage pay the full cost for dependents.

We realize that examples of plans in private industry should not be the sole basis in our request for similar treatment. But we also feel that, if these companies can grant such liberal plans, including insurance and hospitalization, with little or no cost to the employee, the Government should not expect the employee to assume the major cost, as he has done in the case of the life insurance plan.

We appreciate the introduction of so many bills on the subject. At this late date, inasmuch as the Senate has passed a bill covering the subject, and generally an excellent bill, acceptable to various insurance carriers and plans, as well to employee groups, we feel that consideration should be given to S. 2162 which has been referred to this committee after passing the Senate, and H.R. 8210, introduced by Mr. Morrison; H.R. 8211, by Mr. Porter; and H.R. 8222, by Mr. Davis; since they are in agreement with the Senate bill and would enhance our chances of having health insurance legislation enacted during this session. We would like to offer one amendment and that is, on page 2,

line 22, to strike the word "involuntary." There are employees who have reached the optional retirement age, many of whom will need the provisions of these bills. They will retire as soon as they can be assured of coverage after retirement. Some of them are not in the best of health and are unable to perform their duties at maximum efficiency. Unless this change is made in the bill as reported out by this committee, they will probably try to stay on the rolls until after July 1, 1960—and no one can blame them when we realize that their annuities will not permit the payment of large medical and hospitalization bills.

Since the cost of medical care and hospitalization is increasing so rapidly—much more rapidly than our salaries and the general cost of living—and since all forecasts point to an increased cost of living, it is essential that a health insurance plan be enacted into law as soon as possible. Although we were disappointed when the effective date of this proposed legislation was changed from January 1, 1960, to July 1, 1960, we realize that it takes time to put such a plan into operation. For the same reason, we urge immediate action by this committee in agreeing on a bill and reporting it out and the full support of each member so that enactment will come in time so that everything will be in readiness on July 1, 1960. Any delays will mean that more Federal employees will find themselves in insurmountable debt on account of prolonged illness and hospitalization, and we hear of more and more such cases all the time.

The enactment of health insurance legislation is long overdue. There have been a number of unfortunate delays in previous years. We are glad that this committee recognizes the necessity of bringing Federal employees and their dependents the benefits of health insurance, as has been expressed by the chairman and most members of the committee at various times. Benefits will be reaped not only in improved morale, but in the improved health of the employees who are unable to afford such essential medical and hospital care due to prohibitive costs. This is an item that is difficult to measure in the overall picture of the cost to the Government. It is difficult to measure health, morale, and peace of mind in dollars and cents. We honestly believe that the dollar cost to the Government—which will be matched by the employee—although it is a significant amount, will result in much better productivity and will be money well spent.

We believe, too, that the Government should lead, and not follow, private industry in fringe benefits. In these times, health insurance is fast becoming one of the most important, and one of the most essential, fringe benefits.

We would like to see legislation enacted providing for similar coverage for employees who, after many years of faithful service, have already retired and are finding it most difficult to assume the greatly increased costs of medical, surgical, and hospital bills.

We are very appreciative of the opportunity of appearing before this committee and are hopeful that the pleas of our members for adequate coverage at the lowest possible cost to the employee—and we do not even ask that the Government assume the total cost as is being done in much of industry—will be answered by the quick enactment

of health insurance into law. We thank the members of this committee for permitting us to state our views.

The CHAIRMAN. In the fourth paragraph of your statement you say:

The contract covers medical bills of \$3 per day for home or office visits and up to \$10 the first day of hospitalization.

Is that the limitation on the hospital costs?

Mr. JASPAN. That is \$10 for the doctor's visit in the hospital.

The CHAIRMAN. You say for the first day of hospitalization.

Mr. JASPAN. I mention that the payment is the doctor's. That is either at his office, home, or in the hospital. In the hospital they pay \$10 for the doctor's visit.

The CHAIRMAN. You mentioned the American Can Co. and the American Sugar Co. I am sure that both the American Can Co. and the American Sugar Co. are in much better financial position than the Government today. The Government is very much in debt and there is this ever-increasing deficit that we are piling up here all the time. I guess that future generations will have to pay for it. I am worried about what is going to take place in this country in the future.

Mr. JOHANSEN. I may have missed it, but going back to the early part of your statement where you list the percentage of payroll spent for fringe benefits, what do you show as the percentage for Federal employees?

Mr. JASPAN. Mr. Johansen, that seems to be a figure that is hard to get. I remember when we were having a hearings on pay about 3 years ago one of the members of the Cordiner Committee testified then and he said it would be about 27 percent if the Government made the total contribution they were supposed to for the retirement plan. But the Government has not made the total contribution and I believe he said that it would be about 23 percent or 24 percent, taking that contribution off.

Mr. JOHANSEN. Of course, the presumption is that the Government stands back of its guarantee whether it actually votes the contribution or not.

Mr. JASPAN. We certainly hope so.

Mr. JOHANSEN. We hope so, too. That is one of the reasons, associating myself with the chairman, I hope we do not get in the habit of making commitments down here that we are not prepared to perform on because in that manner, just as in the debt, it goes to the question of the good faith and credit of the U.S. Government.

Mr. JASPAN. We are certainly concerned with the cost of this, too, and we are also concerned about the cost to our members who are hit hard and cannot afford to carry full coverage under their own plan.

The CHAIRMAN. I think that the Government has been very fair and liberal to its employees, generally speaking.

Mr. JOHANSEN. You say on page 2:

We realize that examples of the plans of private industry should not be the full basis in our request for similar treatment. But we also feel that, if these companies can grant such liberal plans, including insurance and hospitalization, with little or no cost to the employee, the Government should not expect the employee to assume the major cost, as he has done in the case of the life insurance plan.

These statements seem to be balancing opposing views. Would you care to elaborate just a moment on that first statement where you say:

We realize that examples of plans of private industry should not be the sole basis in our request for similar treatment.

Would you care to elaborate?

Mr. JASPAN. The important point there is that word "sole." I do not think we should be treated in a manner that is completely different from people in private industry. Usually we can get benefits much later than people in private industry. Everything came later. The 40-hour week work log came later, time and a half for overtime came later, hospitalization is coming much later. Practically everything, every benefit, came much later than to private industry. We certainly feel that for many reasons we should be entitled to some of the benefits that those people have, if not the complete benefits.

Mr. JOHANSEN. Do you anticipate within a very short time, if this program is adopted, there will be a move to make the Government's share of the group hospitalization and medical coverage 100 percent?

Mr. JASPAN. That is a pretty difficult question to answer, Mr. Johansen. Of course, if the trend in industry is for all to pay 100 percent, we would want 50 percent at some future date.

Mr. JOHANSEN. I respect your position and I realize the light that I place myself in by asking that question. Some people are very eager to give the impression that I am against progress, the employees, and humane treatment. I am not against any of those.

Mr. JASPAN. Your past actions have shown that.

Mr. JOHANSEN. I share the chairman's very great concern that we are going to have to start facing up to the fiscal situation of the country. If I said that only with respect to employees' legislation, I could be properly criticized, but I do not. My voting record shows that.

Mr. JASPAN. We realize that. You voted for many of our benefits.

Mr. JOHANSEN. And I voted against a lot of squandering and other activities of the Government.

Mr. JASPAN. Of course, this is a relatively small amount.

Mr. JOHANSEN. Most of them are.

Mr. JASPAN. We really believe there are other ways of cutting down some of the waste.

Mr. JOHANSEN. So do I. But I do not see my colleagues doing it. I do not want to punish the Federal employees because my colleagues do not have the wisdom to do what I think they ought to do, but I have to deal with the net result of that folly.

Mr. PORTER. Mr. Jaspán, I notice that your statement is very much in favor of the enactment of the bill, but you do propose an amendment. I suppose that you are talking about page 2, line 21, of the bill.

Mr. JASPAN. That is right.

Mr. PORTER. Actually you are in favor of the bill. You think that it ought to be enacted this year. You think it is fair in terms of private industry. I would like to understand your proposal a little better.

Mr. JASPAN. Here is the amendment that we propose in S. 2162, as passed by the Senate, on page 2, line 22: Strike the word "involuntary." As it now reads, the employee who is now on the rolls and

who would retire before the effective date, would only be included if he were separated involuntarily between the enactment of the bill and the effective date. There are a lot of people who would like to retire or leave the service voluntarily. Some of them who may have illnesses would like to leave, but they feel they should be here until there is some hospitalization. I feel many of those people would leave if the bill were passed. I believe that it would be better for the service and those people.

Mr. PORTER. Do you have any figures on the number of people that retire? I realize that you do not know how many are thinking about retiring, but how many are eligible to retire and have that choice?

Mr. JASPAN. I have the figures at the office, but I do not have them with me.

Mr. PORTER. I do not suppose that you have figured out what the additional cost would be, if any?

Mr. JASPAN. No; I do not have the figures on that.

Mr. PORTER. If we had the basic figures we might be able to figure it out; that is, how big a chunk this would mean.

Mr. JASPAN. I believe that there would be relatively few people because it would affect mostly those who are ill to a certain degree, but not enough to retire on disability.

Mr. JOHANSEN. I wonder if the witness heard the testimony on Wednesday regarding some of these voluntary health medical and hospital plans within the postal service. I wonder if the witness would care to comment on the possible effects of this legislation on those and whether he feels there should be some provision to protect the interests of such voluntary plans.

Mr. JASPAN. I had to miss Wednesday's session. If possible, I believe that there should be some provision made for those people. I have heard of the testimony, though I have not read it. It seems as if some of those companies would be pretty hard hit if they were not included in this plan.

Mr. JOHANSEN. These are private employee groups, self-insured. They do not involve an outside underwriter. Some of us feel it is rather important that the initiative that they have shown and the stake that they have in those plans should be recognized. Would you agree to a suggestion made by the witness that either the word "labor" be stricken from the bill, or the words, "labor and other organizations" be inserted?

Mr. JASPAN. To me, that latter suggestion seems as if it would cover those people. I know when the insurance bill was passed there were some of the organizations caught in the squeeze similar to that. There was provision made for them later. Such coverage would seem to be in the best interests of those groups.

The CHAIRMAN. Under the life insurance program the Government only contributes one-third of the cost; is that correct?

Mr. JASPAN. That is right.

Mr. PORTER. I am not quite sure that I understand the effect of the amendment. As it is now, between the date of enactment of this act and the effective date next June 30, if someone retired, not because he had to retire—

Mr. JASPAN. For optional retirement, without reaching the mandatory age. People of 55 and up.

Mr. PORTER. Under the present provision of involuntary that would not apply?

Mr. JASPAN. No. That would be an optional retirement.

Mr. PORTER. It would have to be someone mandatorily retired?

Mr. JASPAN. Either by reaching the age limit, or for some other reason.

Mr. PORTER. What you want to do is to take out the "involuntary" so that an optional separation would not disqualify an employee?

Mr. JASPAN. Yes.

The CHAIRMAN. After how many years of service?

Mr. JASPAN. Of course, they would have to have 30 years and be age 55 under the present conditions, with a reduction in their annuity, of course, at age 55.

Mr. PORTER. What is the effect of the phrase "after 12 or more years of service?"

Mr. JASPAN. That is in the bill. They must have been in the service 12 or more years before they can come under the benefits of this plan.

Mr. PORTER. Actually they would not be able to retire by option unless they had considerably more?

Mr. JASPAN. Under the present conditions they need 30 years of service to retire optionally except under certain circumstances—disability separation, and some involuntary separations. And you probably realize our group, the supervisory group, are mostly in the upper grade brackets because most of our people have 25 years of service or more.

The CHAIRMAN. On the last page of your statement you say:

We would like to see legislation enacted providing for similar coverage for employees who, after many years of faithful service, have already retired and are finding it most difficult to assume the greatly increased cost of medical, surgical, and hospital bills.

How much would that coverage cost?

Mr. JASPAN. Apparently no one has any figures on that. That is why we would like it explored, and if anything could be done we would appreciate it.

The CHAIRMAN. Where do you think the money is coming from for the Government to provide all these benefits?

Mr. JASPAN. As I suggested to Mr. Johansen, one of the ways, I believe, and I think most of you people will agree with me, would be lopping off some of the spending, and particularly the wasteful spending. There is quite a bit of that. I believe that it would amount to much more than the amount that would cover these benefits.

The CHAIRMAN. Perhaps you should confer with Mr. Stans of the Bureau of the Budget and give him the benefit of your sound fiscal advice.

Mr. JASPAN. I do not believe that he controls the actions of the Congress.

Mr. JOHANSEN. Would the gentleman favor an increase in taxes to meet the additional cost?

Mr. JASPAN. Yes, I would be opposed to it, but I believe before taxes are increased there should be some examination of the present spending with a view to reducing what I call waste.

Mr. PORTER. Not to get into a time-consuming self-serving declaration about the budget, but if you will look at the appropriation bill for the first session you will see this year we are something over \$166 million under the budget estimate, and also there are reports that we are going to have a very substantial surplus because of more money from taxes. That is a little on the optimistic side. I want to balance the budget and pay off the national debt. I am for taxes necessary to do these things we should do, and I think this is one of them. So much for my self-serving declaration.

Mr. JOHANSEN. I am happy to hear the testimony—

Mr. PORTER. I thought that we were through with self-serving declarations.

Mr. JOHANSEN. We have had testimony that the prosperity is such that the Federal revenues might be increased.

Mr. JASPAN. We certainly do appreciate the opportunity of expressing our opinion here and we hope there will be adequate coverage at the lowest possible cost to the employees. We do not ask the Government to assume the total cost as is being done in much of industry today. We are willing to pay what is considered a fair share, and apparently most of the witnesses have considered 50 percent a fair share.

Thank you very much, Mr. Chairman, for this opportunity, and especially for letting me appear earlier.

Mr. REES. Do you have any insurance plan of your own in your organization?

Mr. JASPAN. No, sir, we do not have any. All of our people have to provide their own plan.

Mr. REES. Do nearly all of them belong to the Blue Cross?

Mr. JASPAN. From what I understand, a very large percentage of our members do belong to the Blue Cross plan because that is about the only thing open nationwide. Some of them belong to the Kaiser Foundation on the west coast and some to the HIP in New York, but, generally speaking, most of them belong to the Blue Cross.

Mr. REES. Is it your opinion that these other plans, the Blue Cross and others, will merge into one big insurance plan?

Mr. JASPAN. I doubt it very much. I think that they are all very jealous of their own plans.

Mr. REES. You think that they will continue to carry on as they are?

Mr. JASPAN. Except to cover these provisions.

Now, Mr. Chairman, in regard to the cost, we were discussing the cost of the bill. Of course, I am not an actuary by any sense of the imagination, but I was wondering when they figured the cost of this, and each employee would contribute half and the Government contribute half or a total of \$221 each year, most of the Blue Cross plans and the service plans, I understand, could be covered for about \$100 a year. I have asked some people that I know that are in the insurance business to get some figures about what major medical costs for groups would be, and it seems that about \$40 a year would cover much smaller groups than ours which means that a hospital plan like Blue Cross, or the service plan, or an indemnity plan for \$100, plus \$40 for major coverage, would be plenty of money, and it may be much less to cover the cost than anticipated.

Mr. JOHANSEN. Pursuing the question of the gentleman from Kansas, you say that quite a few of the members of your organization are under the Blue Cross plan. You mean under a group basis?

Mr. JASPAN. Yes.

Mr. JOHANSEN. Are they local groups?

Mr. JASPAN. Yes.

Mr. JOHANSEN. So they do get a group rate?

Mr. JASPAN. Yes.

Mr. JOHANSEN. It is not individual participation?

Mr. JASPAN. For Blue Cross generally they are under the group rate. I carry Blue Cross and Blue Shield. The Blue Shield I had to get in as an individual because we do not have enough for a group, but for Blue Cross we have the group coverage.

The CHAIRMAN. Thank you, Mr. Jaspán.

The committee will hear next Mr. James Riddell, counsel for the underwriter of several Government employees' plans.

STATEMENT OF JAMES W. RIDDELL, COUNSEL FOR THE UNDERWRITER OF SEVERAL GOVERNMENT EMPLOYEES' PLANS; ACCOMPANIED BY FRANK CARBO, ASSOCIATE MANAGER OF THE JOSEPH E. JONES AGENCY OF WASHINGTON, D.C.

Mr. RIDDELL. My name is Dick Riddell, I am a partner in the firm of Dawson, Griffin, Pickens & Riddell, of this city. I appear today as counsel for Joseph E. Jones, an underwriter of this city who, since 1942, has been instrumental in negotiating with, and establishing for Government employee associations, programs for hospital, surgical and medical insurance.

The number of Federal employees and dependents currently insured under health insurance programs pioneered by Mr. Jones now numbers approximately 100,000. Specifically, the associations having plans in force negotiated by Mr. Jones include the American Foreign Service Protective Association (foreign service offices of the Department of State and other agencies), the Government Employees Benefit Association (employees of the National Security Agency), the Government Employees Health Association (the employees of the Central Intelligence Agency), and the American Federation of Government Employees.

Because of the unique requirements and challenging problems presented by the health insurance needs of the employee members of these associations, coverage normally available to them in the insurance market would be inadequate to fulfill their needs. It is my understanding that, in fact, the failure of these employee groups to secure adequate protection and administrative convenience with the standard coverages provided by carriers who were unwilling to experiment and pioneer in the field of insurance led them to negotiate with Mr. Jones and his carrier.

The unique health insurance problems referred to above, which I will spell out later, also presented a major challenge to the carrier represented by Mr. Jones because of the pioneering nature of the coverage required and the major challenges presented together with the lack of actuarial and morbidity data available at that time.

Before a satisfactory solution from the point of view of the employees involved could be reached, each of these cases required pioneering in the field of health insurance and a willingness on the part of the carrier to depart from the then normal and accepted underwriting practices of the health insurance industry. In each case, experience has proven that a willingness to approach a challenging problem with a flexible point of view and a desire to achieve a successful result can provide liberal benefits for employees at a premium rate that is practical for the employee and for the carrier. These plans have been successful from the date that they were first negotiated.

In referring to the past, I do not intend to imply that the fruit of experimentation has been static, for the original plans have been continually improved until today the original concepts with which we began have been so expanded and so liberalized that the employees who enjoy their benefits have some of the finest insurance now available anywhere in the world in these plans.

The benefits now enjoyed by the employees of the associations to which I have referred would not be possible had not attention been given to the equally important facet in health insurance of planned administration. These plans have been premised on the assumption that an employee who is able to present a claim for benefits with a minimum of inconvenience to himself is a happier employee. With this in mind, Mr. Jones has developed an administrative staff that processes claims originating all over the world in such countries as Argentina, Canada, Australia, Ireland, Finland, France, Israel, Italy, Japan, Switzerland, England, India, Ceylon, Republic of Philippines, Mexico, the Netherlands, South Africa, Norway, Chile, Peru, Germany, Lebanon, Turkey, and many others.

Both he and his carrier have every reason to be proud of the efficiency and dispatch with which claims for benefits are handled. The Government employee associations who enjoy the benefit of these plans appear to be equally proud and most satisfied with the results achieved. In discussions concerning this bill, each of these associations have indicated a strong desire to continue with their present insurance carrier.

For security reasons, it is not possible for me to know of or to discuss many of the problems presented by some of the plans to which I have referred. However, all of them involve some employees who are without the United States in the various countries of the world. This fact alone creates many problems. For example, the overseas aspect of these insurance programs have made it necessary to develop techniques of administration which are not normally confronted in the administration of the ordinary health insurance program. Claims which are filed from overseas areas involve the conversion of foreign currency, the translation of foreign languages, and require an understanding of the variety of hospital licensing requirements found throughout the world. Hospital accounting and other peculiarities of hospital administration in the various areas of the world also differ widely and present their problems. To cope with these problems it has been necessary—as I have stated above—to create a staff of administrative personnel to administer these programs. This staff is qualified to translate the languages of the world and otherwise able to cope with

the problems presented in a manner which renders a maximum of service to the employees who enjoy their services.

Additionally, efficient handling of these insurance programs requires flexibility in administration and policy interpretation. Since the insured employees are often in transit or residing in overseas areas, it is not convenient, practical, or even possible for them to repeatedly contact the insurer for clarification of claims material or to gain an understanding of their rights and benefits under their policy. This fact alone requires highly trained and competent personnel who, given a policy of insurance providing an unusual degree of flexibility and freedom of interpretation necessary to comply with the special needs of the employee, must often lean over backward to construe any doubt against the carrier and in favor of the employee.

Unless these programs can be continued under the provisions of the bill, the employees involved will no longer have available to them this quality of service, flexibility of administration, and liberality of interpretation. This follows because no carrier will have an incentive to provide service which caters to their needs. The bill in its present terms permits but one carrier who, having acquired the business, may be tempted to rest secure in its position and who, free from all competition, will have no incentive to attempt to continue to improve service or even to continue those now in effect.

In many respects our plans are more liberal from the point of view of coverage than is the plan envisioned under the bill. For example, the bill fails to recognize that tuberculosis, nervous, and mental conditions can require as prolonged and expensive treatment as many other types of illnesses. As a matter of fact, recovery from these dreaded diseases is oftentimes more expensive and time consuming than other diseases. Under our plans, the same coverage is provided for these diseases as for any other. The employee is not limited to an aggregate of 30 days of protection.

In the same class with the plans to which I have already alluded is the plan provided by the Panama Canal Company and the Canal Zone Government for both Panamanian and U.S. citizens who are employees of the Canal Company. This plan which was first contracted in December of 1956 and which has been renewed on an annual basis since that time, covers approximately 28,000 employees and their dependents. It is designed to dovetail with the official tariff of the Panama Canal Company and is keyed to the seven salary classifications of the various groups of employees. Today we maintain in Panama an office staffed by eight employees trained to meet the health insurance problems of the employees of the Panama Canal Company. These employees are, of course, required to speak both Spanish and English in order to provide adequate service. If this plan is not continued, a new carrier will have to be qualified to underwrite it in Panama and the expenses of enrolling employees, together with the initial start-up expenses of a service office in Panama will have to be incurred again.

If we read S. 2162 correctly, it would appear that the 100,000 Government employees currently insured and enjoying benefits under our individually negotiated and administered insured programs would be deprived of their free choice of insurance coverage. Let me assure you as members of this committee that were it not for the free choice

of insurance coverage available up to now to employee associations the plans which we now underwrite would not have become available. We have the business and 100,000 Government employees have the benefits because—and only because—of competition.

It provided the incentive to Mr. Jones and his carrier to depart from the then generally accepted practices and standards of the health insurance industry in a pioneering endeavor which has redounded to the benefit of the employees involved and Mr. Jones and his carrier.

Without the prod of competition our plans would not have reached their high state of development and service. It is our sincere hope that the committee will give serious consideration to amending the bill to provide that the Government employee association plans now in effect may continue under the bill on a competitive basis. We do not ask that we be given a patent to continue as the underwriter and the carrier with respect to these plans. We only ask—and in this we think we are joined by the employees involved—that we may continue to compete for the business and that the employees may continue to enjoy the fruits of their negotiation. Attached to this statement are copies of the two amendments which would achieve this purpose.

(The two amendments referred to follow :)

On page 8, line 11¹ strike out "organizations," and insert in lieu thereof "organizations, or agency employee associations".

On page 5, insert at the end of section 2, the following new subsection:

"(1) The term "Agency Employees Association" means an association of two thousand or more employees of any department, agency, or instrumentality of the United States which, on July 1, 1959, had in force a plan providing benefits for health services to members of the association, contracted for by the association."

On page 8, add at the end of section 4 the following new subparagraph:

"(5) CITIZEN EMPLOYEES OF THE PANAMA CANAL COMPANY.—A plan contracted for by the Panama Canal Company and the Canal Zone Government providing benefits for health services to employees of the Panama Canal Company who are United States citizens."

Mr. PORTER. The first part of your statement is somewhat repetitious, and then you get to the matter of competition.

Mr. RIDDELL. I have not had the privilege of attending the hearings, Mr. Porter, but if I understand correctly, we are the first witnesses who have been here to advocate specifically that employees have gone out and had the initiative to negotiate their own plans and to be allowed to continue under this bill to keep the fruits and benefits of those plans.

I will simply state that long before 1942 Mr. Jones began to negotiate with the employee associations named on the first page of my statement. He was aware at that time these people were not receiving the services that they wanted; that they had some unique and particular problems confronting them, and he thought that he could persuade his carrier to help the employees solve them. Now, as you noticed, one of the associations is the Government Employees' Health Association representing the Central Intelligence Agency and another represents the employees of the NSA. I cannot discuss with you the unique problems of these people because of the security implications involved. I will say this, that each and every one of the plans

¹ Page and line references refer to July 20, 1959, version of S. 2162.

that Mr. Jones has set up involves overseas employees. Just this fact alone, gentlemen of the committee, creates some severe problems.

On the very day a claim arrives from overseas, Mr. Jones' agency pays the claim. He has to convert the payment into foreign currencies. He has to translate foreign languages. He has to be familiar with all the various hospital licensing practices of the world. He has established a staff that is capable of doing that and coping with all the other problems, including the security problems, of the groups that we have here.

Now, on a competitive basis, he has gone out and satisfied these employees that he can take care of their needs. He has been doing so, and what he is asking for on behalf of himself and his carrier is that this bill be amended to save whole to these groups of employees their continued free choice of a plan of health insurance.

Now, in many respects the benefits offered by Mr. Jones' plans are more liberal than those contemplated under the bill.

Mr. JOHANSEN. I notice in your statement that you refer to American Federation of Government Employees.

Mr. RIDDELL. They are taken care of under the bill. Our remarks here with respect to the amendments are not applicable with respect to them. Under section 4(3) of the bill, employee organizations, nationwide in scope, are taken care of.

Mr. JOHANSEN. I was referring specifically to page 1 of the associations having plans in force negotiated by Mr. Jones, and the last of those you list is the American Federation of Government Employees. In other words, you have plans that relate, outside of these other agencies, to members of the American Federation of Government Employees; is that correct?

Mr. RIDDELL. Yes.

Mr. JOHANSEN. About how many of those do you have?

Mr. RIDDELL. Are you asking for the number of employees?

Mr. JOHANSEN. What I am trying to clarify is whether your reference to the American Federation of Government Employees is a category apart from those other federations or Federal agencies.

Mr. RIDDELL. Yes.

Mr. JOHANSEN. How many Federal employees are in that category?

Mr. RIDDELL. Well, in total for all the associations that we list here, including the American Federation of Government Employees, we have about 100,000 governmental employees and their dependents.

The CHAIRMAN. How many Government employees without dependents?

Mr. RIDDELL. I am informed there are about 10,000 employees and dependents under the American Federation of Government Employees.

Mr. JOHANSEN. Not included in these other categories?

Mr. RIDDELL. That is correct.

Mr. JOHANSEN. That is the point. You have been able to enlist that much interest by the American Federation of Government Employees in the program.

Mr. RIDDELL. Yes.

Mr. JOHANSEN. I want to say to the witness that I am very sympathetic with the problems he is presenting, and I am sure that I will do all in my power to see that he is considered very carefully.

Mr. RIDDELL. Thank you, sir.

Mr. PORTER. I do not see in the Senate hearings that this information was presented. Did you appear?

Mr. RIDDELL. No, sir. We had no opportunity to appear at that time. We were under the distinct impression the bill would extend to, and permit, our associations, or our agency associations of employees, to procure the benefits of their plans for the future.

Now it is true we were laboring under a misapprehension, but we do not want to pass up this opportunity to make our point.

Mr. PORTER. Do you anticipate opposition to this proposal?

Mr. RIDDELL. No, sir. Taking into account the questions here this morning, I can see no reason why the bill would not be amended to cover our point. You gentlemen are concerned about the costs. We have a proven record of handling extremely difficult cases at very, very low administrative costs. We have a proven record of granting a unique and unusually good service to a large block of Government employees, and we are convinced that they want to continue with us. They would like to have the privilege of having their own plans continued.

When I say "with us", we would hope we would get their business, but we are not here asking this bill be amended to give us a patent on the business for the future. The only thing that we are asking for is that it be amended to give us a chance to bid on it. We are very much in favor of competition under this bill. We got our business, Mr. Porter, because we are competitive; because in a headon fight with other companies for the business we were able at the lowest cost to provide the most service and to meet these problems when nobody else really wanted to solve them.

Mr. PORTER. I am sure that this committee wants to get the most service for the least cost. I do want to inquire about your amendment. I notice it is limited to employees and associations in existence and having 2,000 or more. You would not want the field to be so open to competition that new agencies could be formed?

Mr. RIDDELL. Well, sir, I will have to answer you in this way. We are not unaware of the fact that the Civil Service Commission has stated that for administrative reasons they want the number of plans limited. Now, I admit this amendment was drafted taking into account the point of view expressed by the Civil Service Commission's representative. We would like to have the bill as competitive as possible, but if there is validity to the point that the availability of too many plans would cause administrative inconvenience, we would like to have it cut out this way.

Mr. PORTER. To afford competition we might as well leave out your second suggestion.

Mr. RIDDELL. I quite agree.

Mr. PORTER. And just strike out organizations and insert in lieu thereof organizations or agency employee organizations and not limit it to those already in existence.

Mr. RIDDELL. I agree with you 100 percent.

We think that we have been able to do a good job up to now. We would like to be in a position where we can continue to do a good job for those employees who today have the benefits provided by our services. I think the two amendments here do the job.

I have not mentioned the Panama Canal Company case, and I would like to take just a second to cover that.

Today there is in existence a plan negotiated by the Panama Canal Company and the Canal Zone Government on behalf of its employees. It presently covers both citizens and noncitizen employees. We are aware of the fact that the decision has been made within the bill to cover only citizen nonresidents of the United States, and we do not quarrel with that premise at all. However, today in Panama we have established a branch office, staffed by people who speak both Spanish and English, who are intimately familiar with the health problems confronted in the Panama Canal Zone who are prepared as a practical matter to give service, and we would like to be in a position to continue to bid on and operate that plan for citizen employees under this bill.

The amendment simply serves the purpose of adding a new category to the number of plans that may be authorized by the Civil Service Commission.

Mr. GROSS. Under the American Foreign Service Protective Association you insure aliens as well as Americans; is that correct?

Mr. RIDDELL. No, sir, only under the Canal Zone plan. That is a separate plan from the American Foreign Service Protective Association.

Mr. GROSS. You spoke of the classified nature of some of these plans you have, or something to that effect. I do not recall your words. What is so secretive about the hospital and medical care plans from that standpoint?

Mr. RIDDELL. I hope you will appreciate that I am not in a position to answer that question.

Mr. GROSS. Give me a hypothetical case.

Mr. RIDDELL. Let us take a hypothetical case.

Mr. GROSS. I do not want to mention individuals.

Mr. RIDDELL. For example, sir, we could not identify individuals by name, and the only thing we know about some of our insured is their numbers. We may not even know their age or their sex, or their medical history.

Mr. GROSS. In the Foreign Service, do you mean?

Mr. PORTER. The CIA.

Mr. GROSS. I am talking about the Foreign Service.

Mr. RIDDELL. The chief problem with respect to the Foreign Service, and one of the reasons we have had unique problems with them, is that about 90 percent of their personnel are overseas.

Mr. GROSS. I am talking about this classified angle, this super-secrecy that attends so many things around here.

Mr. RIDDELL. It is principally with respect to the employee associations for the Central Intelligence Agency and the National Security Agency.

Mr. JOHANSEN. In other words, this problem of secrecy does not relate to the Foreign Service?

Mr. RIDDELL. No, sir.

Mr. JOHANSEN. But to these other agencies, who, by the very nature of their operations, must be secret?

Mr. RIDDELL. Yes.

Mr. JOHANSEN. Even to the identity of the employees involved?

Mr. RIDDELL. Yes. I am sorry that I confused you.

Mr. PORTER. I would think that the gentleman from Iowa would join me in open admiration for any company that insures CIA employees overseas against their health problems.

Mr. GROSS. Why?

Mr. RIDDELL. We found that we could do it when other people were not willing to try.

Mr. GROSS. I can remember when the CIA came before the Manpower Utilization Subcommittee and said that they could not even give us the number of supergrades in that Agency. I am sure that the chairman of the subcommittee will substantiate what I am saying. We had to go after them in order to get merely the number of supergrades. I am a little fed up with all this supersecrecy.

Mr. JOHANSEN. I am perfectly willing to be critical of the CIA, but I do not think the criticism of the CIA justifiedly extends to the restrictions of the insuring agency who has been subjected to those restrictions.

Mr. GROSS. I did not mean to imply in any way criticism of your operations, Mr. Riddell.

Mr. RIDDELL. I understand that.

Mr. DAVIS. Unfortunately, I could not be here at the beginning of your statement, but I have read it through. I gather that the employees to whom you refer in your statement are practically all overseas employees?

Mr. RIDDELL. Many of them are.

Mr. DAVIS. Are there any here in the United States?

Mr. RIDDELL. Yes.

Mr. DAVIS. How many in the United States?

Mr. RIDDELL. I cannot give you the breakdown, sir. I do not know it now.

Mr. DAVIS. Can you say approximately how many?

Mr. RIDDELL. With respect to one agency, the Foreign Service group, 90 percent, I am informed, would be overseas.

Mr. DAVIS. Do you have approximately 100,000 employees covered under this system?

Mr. RIDDELL. And dependents, yes.

Mr. DAVIS. And dependents?

Mr. RIDDELL. Yes.

Mr. DAVIS. Now, with regard to those who are overseas, do you merely provide an indemnity for them, a cash payment, or do you provide hospital and medical services?

Mr. RIDDELL. We provide indemnity, sir.

Mr. DAVIS. You do not undertake to provide the hospital and medical services, though?

Mr. RIDDELL. No, sir.

The CHAIRMAN. I have received a letter from the Central Intelligence Agency and also one from J. Edgar Hoover, of the Federal Bureau of Investigation, concerning their health insurance plans. The letters have been previously inserted in the record.¹

A portion of Mr. Hoover's letter reads as follows:

SAMBA provides a comprehensive hospital, surgical and major medical expense policy underwritten by the Prudential Insurance Co. of America. The

¹ See pp. 289 and 106.

association has enjoyed a history of improved benefits each year since it was organized in 1948. There are approximately 9,200 members, and including dependents about 28,000 people come under the protection provided through SAMBA. During the last fiscal year claims paid totaled approximately \$830,000.

In reviewing the Federal Employee Health Benefit Act of 1959, S. 2162, it appears that SAMBA satisfies the language therein as an employee organization except for the restrictive definition of such an organization as a "bona fide labor organization" in section 2(h). I am taking the liberty to bring this to your attention with the hope that if amendments are made in the bill it may be possible to include such wording as would make it possible for SAMBA to qualify as an employee organization under the bill.

Mr. RIDDELL. The amendment I propose would cover that case as well as our case.

The CHAIRMAN. As well as the Central Intelligence Agency?

Mr. RIDDELL. And the Foreign Service case, the NSA case and any other case of a similar nature.

The CHAIRMAN. Judge Davis?

Mr. DAVIS. As to these employees who are here in the United States, do you furnish any hospital and medical services for them?

Mr. RIDDELL. Indemnity, sir.

Mr. DAVIS. I notice that you gave a list of those employees you have insured and you also include in that list the American Federation of Government Employees.

Mr. RIDDELL. Yes, sir. They are not apropos of our present discussion. They are already covered by the provisions of the bill.

Mr. DAVIS. How many AFGFE employees did you say you have?

Mr. RIDDELL. Including their dependents, sir, around 10,000.

The CHAIRMAN. You say that this bill as passed by the Senate would put you out of business?

Mr. RIDDELL. No, sir; the carrier and the agent will continue in business. We are right scrappy people and we have always managed to do business, but it would preclude us from continuing to provide services to these associations in the manner we have in the past, and since there will be only one indemnity carrier allowed under the bill, who will then reinsure with the other companies, it would preclude us from handling them as an individual case.

We have the machinery all set up and the experience, the operating advantages that these people have need for and think to be desirable.

We simply like to be in a position to continue to bid for their cases.

Mr. JOHANSEN. Would the chairman yield?

The CHAIRMAN. Yes.

Mr. JOHANSEN. I think the import of the chairman's question was whether this legislation, without the amendment proposed, would put you out of business with respect to these Federal employees?

Mr. RIDDELL. Yes, sir. It would put them out of business as employee associations for the purposes of taking care of their own health problems.

Mr. JOHANSEN. So this would put you out of business so far as they are concerned?

Mr. RIDDELL. Yes, sir.

Mr. REES. Mr. Chairman?

The CHAIRMAN. Mr. Rees?

Mr. REES. I understand that you want to amend the bill on page 8, line 11, by adding the words "or agency employee associations"?

Mr. RIDDELL. Yes, sir; plus the addition of a defined term which would define agency employee associations to mean an association of 2,000 or more employees of any department, agency, or instrumentality of the United States which, on July 1, 1959, had in force a plan providing benefits for health services to members of the association, or contracted for by the association.

As I pointed out to Mr. Porter, the limiting factors of date and the number of employees were added for the purpose of attempting to meet the statements in the Senate report or those made heretofore by members or representatives of the Civil Service Commission to the effect that they wanted to narrow administrative problems as much as possible.

Mr. GROSS. Mr. Chairman?

The CHAIRMAN. Mr. Gross?

Mr. GROSS. This is very interesting. You provide medical and hospital plans for the CIA or the Foreign Service, take any of them, on the basis of numbers? You just have numbers? You do not have names? You just deal in numbers?

Mr. RIDDELL. We do not have any of that information.

Mr. GROSS. That is very interesting. I do not quite understand how it is done, that you can get by with a plan of this kind on the basis of numbers, period.

Mr. PORTER. Do you make money on this?

Mr. GROSS. Why, sure they make money on it.

Mr. RIDDELL. Initially, I do not know that that was the case, Mr. Gross. It is simply that, confronted with the problem, we were willing to take the case on. Standard underwriting practices of the industry would have caused us to throw up our hands and say, "Goodness, we cannot do this business."

Mr. GROSS. If that is the way we are operating this Government on a blind check basis—

The CHAIRMAN. That is what happened in the Central Intelligence Agency, is it not?

Mr. GROSS. The Foreign Service is listed here, too.

Mr. RIDDELL. Mr. Gross, may I add an addenda to my answer?

Mr. GROSS. Sure.

Mr. RIDDELL. The plan today is paid for by the employees.

Mr. GROSS. I understand that.

Mr. RIDDELL. They evidently have found it possible for us to handle their cases—

Mr. GROSS. But under this bill a Federal contribution is to be made, is it not?

Mr. RIDDELL. Yes, sir.

Mr. GROSS. We are going to be picking up some of the check from here on out if we pass the bill with the amendment that you suggest?

Mr. RIDDELL. Yes, sir.

Mr. GROSS. Still we are going to be dealing only in numbers, are we not?

Mr. RIDDELL. From our point of view we are the people taking the risk with the lack of information.

Mr. GROSS. I do not know how it is done.

Mr. RIDDELL. On the basis of the integrity of the association we are dealing with. We know from experience that when they send in a

claim to us it is a valid claim. We have never had any reason whatsoever to doubt the integrity of the association.

Mr. GROSS. It would be interesting to know how you issue a check. How do you pay a claim? That is a new one on me.

Mr. CHAIRMAN. Is Mr. Jones present? Maybe he can explain the modus operandi of this organization.

Mr. RIDDELL. Mr. Chairman, may I state that it would be most embarrassing to Mr. Jones to have to go into the details of this operation here. It would possibly impinge upon security considerations and we would prefer, if possible, not to have to give this information in a public hearing.

Mr. PORTER. I do not see how it is relevant.

The CHAIRMAN. How about the Federal Bureau of Investigation?

Mr. RIDDELL. We do not have that case.

The CHAIRMAN. You do not have the FBI?

Mr. RIDDELL. No, sir.

Mr. GROSS. You have the same thing in the Foreign Service?

Mr. RIDDELL. No, sir.

Mr. JOHANSEN. Mr. Chairman, in view of the fact that the witness has been asked a question, whether the firm makes money—and I understood the witness to answer in the affirmative—I assume, and I hope, that the record will show that neither the company nor the witness is apologizing for that fact.

Mr. RIDDELL. No, sir.

Mr. JOHANSEN. I do not think we have reached the point in this country yet where we apologize for making a profit. If we have, we are further down the drain even than I fear we are.

The CHAIRMAN. How long have you been underwriting the CIA employees?

Mr. RIDDELL. Since 1948, sir.

The CHAIRMAN. Any other questions?

Mr. PORTER. I take it that there is no proposal that you underwrite 2 million Government employees on the same basis?

Mr. RIDDELL. No, sir.

Mr. JOHANSEN. Mr. Chairman, just one further question.

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I realize that from the standpoint of the problems of administration there has to be a minimum cutoff.

Do you have any knowledge as to whether the 2,000 minimum proposed in your amendment would still preclude any similar arrangements?

Mr. RIDDELL. None to our knowledge, sir.

There may be, somewhere in the United States, one that we have not heard about, but not to our knowledge; none.

Mr. JOHANSEN. I do want to say one further word, the fact that there have been employee groups that have had the initiative—and this applies to the testimony we had the other day, as well as to yours—to develop programs of these types on a private initiative and private enterprise basis, is most commendable and I shall do everything I can to see that there is a reasonable safeguarding of their interests in this matter.

Mr. RIDDELL. Thank you.

The CHAIRMAN. Mr. Davis?

Mr. DAVIS. Mr. Riddell, how many similar organizations to yours do you know of that are in business today and would be covered under this amendment?

Mr. RIDDELL. The FBI is the only one we know of that is on the same basis that we are, sir.

The CHAIRMAN. That will be referred to the Civil Service Commission when their representative appears here.

Any other questions?

Do you wish to make any comment, Mr. Carbo?

Mr. RIDDELL. He is the associate manager of the agents.

The CHAIRMAN. He is with Mr. Jones?

Mr. RIDDELL. Yes, sir.

The CHAIRMAN. That is an individual business, is it not? Is it incorporated?

Mr. RIDDELL. It is an underwriting agency, sir; yes, sir.

The CHAIRMAN. It is not an incorporated insurance agency in the District of Columbia?

Mr. RIDDELL. It is an incorporated general agency of an insurance company.

The CHAIRMAN. All right.

Thank you, sir.

We will next hear from Mr. John D. Bremsteller, independent insurance broker, Association Group Insurance Agency.

**STATEMENT OF JOHN D. BREMSTELLER, INDEPENDENT INSURANCE
BROKER, ASSOCIATION GROUP INSURANCE AGENCY, ACCOMPANIED BY JOHN P. MILLER**

Mr. BREMSTELLER. Mr. Chairman, this is my father-in-law, Mr. Miller.

My statement takes 6 minutes, Mr. Chairman. Thank you for allowing me to testify.

My name is John D. Bremsteller, 500 Walker Building, Washington, D.C. I am an independent insurance broker licensed under the laws of the District of Columbia. My chief source of income is derived from selling "association" health and accident coverage to Federal employees. If Senate bill 2162, before your committee, is enacted, its effect will essentially wipe out my present source of livelihood. I therefore feel that I have a valid right to testify before your forum. My chief objection to the bill, as now written, is section 4, provisions 1, 2, 3, and 4. This section will distribute the business to a select few insurance carriers; completely ignoring the fact that there are programs now existent in Government agencies and associations which are not only lower in cost, but which are more definitive and comprehensive in benefits than those standards set forth in S. 2162. I have one such program now in effect in the Geological Survey of the Interior Department which after 6 months of active solicitation has reached a participation rate of better than 65 percent. I believe that if you and the members of your committee are sincerely interested in adding employee fringe benefits and at the same time holding Government expenditures to a minimum, it is incumbent upon the committee to hear testimony that purports to do both.

I request that section 4, provisions 1, 2, 3, and 4, be amended to include those programs now available to Government agencies and associations which meet the standards to be set down by the Civil Service Commission.

The program attached to this statement is the health plan—there have been some revisions made since the printed brochure—now in effect in the Geological Society of Washington. This society is more than 50 years old; over 80 percent of its members are Federal employees in one or more departments of the Government.

(The program referred to follows:)

GEOLOGICAL SOCIETY OF WASHINGTON PRESENTS YOUR GROUP INSURANCE PROGRAM INCOME REPLACEMENT AND MAJOR HOSPITAL INSURANCE—DESIGNED EXCLUSIVELY FOR MEMBERS AND THEIR DEPENDENTS

HIGHLIGHTS

You gain these advantages after your coverage is validly in force:
 Your insurance cannot be terminated or restricted by the company so long as the group plan remains in force, you remain a member of the society or until you retire.
 Full policy benefits payable for successive periods of sickness disability when such periods are at least 90 days apart.
 Every active member in good standing under 70 and who is not disabled, is eligible to apply for the insurance.
 Coverage is worldwide. There is a free choice of physician or hospital.
 Each member can tailor the monthly indemnity to meet his needs.
 The cost is low because of being purchased on a group basis.
 Premium waived if total disability exceeds 6 months.
 The only exclusions are pregnancy, intentionally self-inflicted injury, war, military service and flying other than commercial scheduled.
 House confinement is never required to obtain your benefits.
 When your insurance is validly in force, the benefits are payable regardless of any other insurance you may carry.
 31 days of grace are allowed for payment of premiums.
 Administered by John D. Bremsteller, Silver Spring, Md. Underwritten by American Casualty Co., of Reading, Pa.

	Plan AAA	Plan AA	Plan A	Plan B	Plan C
Monthly indemnity, accident:					
A monthly indemnity for total disability beginning with the 1st day and payable for life, if disabled for so long a period.....	\$500	\$400	\$300	\$200	\$100
A monthly indemnity for partial disability beginning with the 1st day and payable for 3 months.....	250	200	150	100	50
Actual medical expense up to the amount of ¼ month's indemnity in case of nondisabling injuries.....	125	100	75	50	25
Monthly indemnity, sickness: A monthly indemnity beginning with the 1st day of hospital confinement or the 8th day of total disability (whichever occurs first) and payable up to 24 months. (House confinement not required).....	500	400	300	200	100
Accidental death, dismemberment and loss of sight indemnity:					
Loss of life.....	5,000	5,000	5,000	5,000	5,000
Loss of any 2 of the following: Hands, feet, or eyes.....	5,000	5,000	5,000	5,000	5,000
Loss of 1 hand or 1 foot.....	2,500	2,500	2,500	2,500	2,500
Loss of entire sight of 1 eye.....	1,625	1,625	1,625	1,625	1,625
Thumb or index finger of either hand.....	1,250	1,250	1,250	1,250	1,250

NOTE.—Loss must occur within 180 days after the accident. The above amounts are payable in addition to any other indemnity, if any, up to the time of loss of limb or sight. In the event of more than 1 loss, only 1, the greater, is payable.

Premiums

	Plan AAA	Plan AA	Plan A	Plan B	Plan C
PLAN 1—1ST DAY ACCIDENT—8TH DAY SICKNESS					
Age of member:					
18 to 39	\$142.00	\$115.00	\$88.00	\$61.00	\$34.00
40 to 49	164.50	133.00	101.50	70.00	38.50
50 to 59	202.00	163.00	124.00	85.00	46.00
60 to 69	223.00	184.00	145.00	99.00	53.00
PLAN 2—91ST DAY ACCIDENT—91ST DAY SICKNESS					
Age of member:					
18 to 39	79.50	65.00	50.50	36.00	21.50
40 to 49	92.00	75.00	58.00	41.00	24.00
50 to 59	109.50	89.50	68.50	48.00	27.50
60 to 69	124.50	101.00	77.50	54.00	30.50

Note.—Premiums apply at age of entry and at attained age upon renewal date. Semiannual premiums are ½ above amounts.

MAJOR HOSPITAL SPECIFICS

Coverage

The benefits to be gained are many. The plan provides payment of hospital and nurse expenses incurred as a result of any one accident up to 2 years from occurrence or any one period of sickness up to 2 years from first day of hospital confinement which are in excess of the deductible, up to a maximum of \$10,000 for each covered person.

1. One-hundred percent of hospital room and board.
2. One-hundred percent of charges made during hospital confinement for necessary miscellaneous hospital care and treatment.
3. Seventy-five percent of the expenses incurred for the services of a registered nurse while hospital confined.
4. Doctor's visits or treatments while hospitalized up to \$5 per call not to exceed two calls per day for the first 3 days and one call per day thereafter. (Excludes surgical procedure and post operative care).
5. Up to \$1,500 for confinement or treatment within an institution operated especially for mental or senile patients.

Surgical benefits

Pays in addition to the above amounts and not as part of the \$10,000 limit of payment and not subject to the deductible. Benefits from \$5 to \$500 according to a comprehensive schedule.

Recurrent sickness

After you have incurred no expense for a period of at least 12 months from a condition for which benefits were paid under this policy, a recurrence of such condition shall be deemed a new sickness, subject to a new deductible and a new \$10,000 limit of payment.

Renewability

Major hospital is renewable each year and cannot be terminated by the company so long as the program remains in force, unless you cease to be a member of the society, retire from your profession, fail to pay premium when due, or until the premium due date following your 70th birthday.

Tax deductibility

Major hospital premiums qualify under the Internal Revenue Code as Medical expense.

Dependency coverage

Major hospital can cover spouse and dependent unmarried children between ages of 14 days and 20 years.

Exclusions

Pregnancy, childbirth or miscarriage, except complications other than surgical procedure, military service, war, confinement or treatment in a U.S. Government institution or agency thereof; intentionally self-inflicted injury.

Eligibility

All active members under age 70 in the full time practice of their profession are eligible to apply. They may also include their spouse if under age 70 and all dependent unmarried children 14 days to age 20 for coverage. If a participation of 50 percent of the eligible members is attained during the charter enrollment period, all applicants will be insured regardless of medical history. After the charter enrollment period the company reserves the right to accept applications on the basis of applicants' insurability.

Premiums

Age of member	Member	Member and spouse	Member, spouse and all children
Plan A (\$100 deductible, \$10,000 maximum):			
18 to 39.....	\$28	\$62	\$91
40 to 49.....	44	91	121
50 to 59.....	64	141	183
60 to 69.....	92	202	229
Plan B (\$500 deductible, \$10,000 maximum):			
18 to 39.....	11	24	35
40 to 49.....	16	36	47
50 to 59.....	25	55	66
60 to 69.....	43	93	104
Surgical benefits (optional):			
18 to 39.....	9	24	36
40 to 49.....	12	32	43
50 to 59.....	15	40	60
60 to 69.....	18	48	72

Note.—Premiums apply at age of entry and at attained age upon renewal date. Semiannual premiums are ½ of above amounts.

Mr. BREMSTELLER. With statistical data available to me as of July 1, 1959, I have made the following survey relevant to the program: (1) 433 members are covered under the major hospitalization portion of the program; (2) average age of these 433 members, 40.9; and (3) average yearly premium of these 433 members, 83.52 and a fraction per member; or a total yearly premium of \$36,073.

Assuming that the maximum premium was charged under S. 2162, the total premium for the 433 members above mentioned could be \$83,083 broken down as follows:

97 single members at \$1.75 biweekly.....	<i>Per year</i> \$8, 827
336 family members at \$4.25 biweekly.....	74, 256
Total cost.....	83, 083

With these same 433 members in my program—and assuming each member took the maximum program, i.e., the \$100 deductible with surgery—the total premium would be \$53,824 per year. It is extremely unlikely however, that all members would select the maximum coverage, even if the Government would subsidize one-half of the cost; therefore, the \$53,824 is an unrealistic figure—but it is my intent to spell out maximum as well as minimum costs.

Though my actual program is before you, I would like to make a brief synopsis of its coverage in this statement. Each member—meaning everyone in his family—is entitled to a hospital expense

account of \$10,000 for each separate accident or sickness, with only the following significant limitations:

- (1) The first \$100 or \$500 of hospital expense must be borne by the member.
- (2) Only 75 percent of the expenses incurred for the services of a private nurse will be reimbursed.
- (3) Doctor's visits or treatments while hospitalized, up to \$5 per call not to exceed two calls per day for the first 3 days and one call per day thereafter (excludes surgical procedure and post-operative care).
- (4) Up to \$1,500 for confinement or treatment within an institution operated especially for mental or senile patients.
- (5) Benefits from \$5 to \$500 for surgeon's fee (this is not a part of the \$10,000 limit of payment and therefore not subject to the deductible).
- (6) No benefits for maternity.

I am not opposed to the Government paying 50 percent of the health insurance premium for Federal employees. I am not opposed to Federal unions. But I am opposed to the Government legislating out of business the agent and independent broker; when he can compete successfully with the big insurance carriers. In my judgment, the evil in erasing this small businessman from participating in Government distribution of business far outweighs the argument that his inclusion in it would add to the workload of a Government agency.

If the committee sees the merit of my position, I request that section 4, provision (3), be amended to include those associations consisting predominantly of Government employees which already have in practice a program of health insurance which meets or will meet the requirements of the Civil Service Commission; further, that section 2, paragraph H, be revised to include the type of association mentioned herein.

I now am ready to answer your questions.

The CHAIRMAN. Any questions?

Mr. PORTER. You are supporting the amendment offered by your predecessor?

Mr. BREMSTELLER. With one exception, the 2,000 minimum.

Mr. PORTER. You want to take that out? That would mean more plans and more competition?

Mr. BREMSTELLER. Yes, sir; but the bill has a cutoff date of July 1, 1959.

In other words, an association could not be formed now to have an insurance program. It would only include those in effect as of July 1.

Mr. PORTER. My own opinion is that as of now it is just the first amendment; namely, changing that language and leaving out the second amendment completely unless the Civil Service Commission deals with all people who want to compete, whatever their source and whatever the date of their formation.

Mr. BREMSTELLER. I would say that they would save quite a bit of money if they did that, sir.

My statistical data points out a difference of almost \$50,000 between the Government cost and what the cost is on our program.

Mr. DAVIS. How do the benefits compare?

Mr. BREMSTELLER. We think they are wider.

Mr. DAVIS. Your plan is more beneficial?

Mr. BREMSTELLER. Yes, sir.

A person who plans his insurance well will insure for those big things. One of the evils of high premiums and high hospital costs today is the fact that everybody gets a carte blanche when they go to the hospital for the first few hundred dollars. We discourage unnecessary hospital care by saying, "You pay the first \$100," or "You pay the first \$500."

We say, "We will take care of the big things and you take care of the small things."

The most you would spend under our program is \$100 or \$500, whichever program you select.

Where we take it off the front, other programs take it off the back. You know what we are going to charge you; you know what you are going to pay.

I heard the testimony of the American Hospital Association witness the other day that Blue Cross pays about 80 to 90 percent of the total bill. I would rather pay the first \$100 than pay 10 or 20 percent of the balance. That is the principle of our program and our benefits go to \$10,000.

In other words, we do not care what hospital you go to, anywhere in the world. We do not care whether you take a private or semi-private room. We do not care how much you spend for X-rays, oxygen, and so forth. We pay up to \$10,000 for each hospital stay or sickness.

Mr. PORTER. After a deduction of the first \$500?

Mr. BREMSTELLER. Yes, except for surgery. We do not deduct for surgery.

For example, if your hospital bill were \$50 and your surgical bill \$300, we would not pay any of the \$50 but we pay, if it meets our surgical schedule, all of the \$300.

The CHAIRMAN. You have a surgical schedule for different types of operations?

Mr. BREMSTELLER. Yes, sir. We have one here if you would like to have it.

The CHAIRMAN. Do you have any Government employees with you? How many Government employees are covered by your plan?

Mr. BREMSTELLER. Better than 500, sir. Probably close to 600.

Mr. REES. All in one agency?

Mr. BREMSTELLER. I would say that 95 percent of them are in the Geological Survey at the Interior Department.

Mr. REES. Do you have a proposed amendment?

Mr. BREMSTELLER. Yes, sir. I have proposed one.

Mr. REES. It is attached to your statement?

Mr. BREMSTELLER. It is incorporated in the statement, Mr. Rees.

The CHAIRMAN. You recommend that section 4, paragraph 3, be amended to include those associations consisting predominantly of Government employees which already have in practice a program of health insurance which meets, or will meet, the requirements of the Civil Service Commission?

Mr. BREMSTELLER. Yes, sir.

The CHAIRMAN. You also suggest that section 2, paragraph H, be revised to include the type of association mentioned here?

Mr. BREMSTELLER. Yes, sir. That latter paragraph defines what an employee association is and that definition would have to be changed as well as the first, section 4.

The CHAIRMAN. Do you have the two amendments drafted?

Mr. BREMSTELLER. No, sir; but I can draft it for you, sir.

The CHAIRMAN. How long have you been in the insurance business?

Mr. BREMSTELLER. 5 years.

The CHAIRMAN. You represent various insurance companies?

Mr. BREMSTELLER. Yes, sir.

The CHAIRMAN. You are a broker, are you not?

Mr. BREMSTELLER. Yes, sir.

The mechanics would be simply this: The Geological Survey appoints me as their broker and I go to Continental Casualty, the Mutual of Omaha, or American Casualty, and other companies, and submit their bids. That is where your competition comes in. That is why we can do it cheaper than one carrier. We get the benefit of competition each time, and we also have the benefit of being closer to the case.

With all due respect to Mr. Jones, we do not identify people by numbers. We go after people personally.

The CHAIRMAN. But you do not cover any CIA employees, do you?

Mr. BREMSTELLER. No, sir. We do not.

Mr. JOHANSEN. That is the reason they do identify them in that way?

Mr. BREMSTELLER. Yes, sir. They must do so under the security code. We have a personal touch with our association members and in that respect we feel that our premiums will never rise for the reason that if our claim ratio gets out of proportion to premium income, we will go out and get fresh people to offset that—meaning, in the way of new members.

The CHAIRMAN. Has your coverage of Federal employees been increasing or decreasing over the last several years?

Mr. BREMSTELLER. Have the benefits been increased?

The CHAIRMAN. No; the coverage of those Federal employees. Has the number been increasing or decreasing?

Mr. BREMSTELLER. You mean the number participating in the program?

The CHAIRMAN. Yes, sir. You say that you deal principally with the Geological Survey in the Department of Interior and no other agency except the Geological Survey of the Interior Department is included in your contract?

Mr. BREMSTELLER. No, it could be a geologist in the Agriculture Department or in the Army, or in the Bureau of Mines, if they are eligible for the association. If they are eligible for the association, they are eligible for our coverage.

The CHAIRMAN. Geologists, principally?

Mr. BREMSTELLER. Yes, sir. It might be a geologist at Johns Hopkins University would be eligible for the program; as long as he belongs to the society.

Mr. JOHANSEN. Mr. Chairman?

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. I am a little disturbed about this. I wonder whether there is a potential problem posed by this proposed language in the

amendment to include those associations consisting of predominantly Government employees.

I am wondering what constitutes "predominantly Government employees" and whether the fact that it involves a commingling in coverage of non-Government and Government employees might pose a problem.

Mr. BREMSTELLER. No, sir.

To answer your second question first, the benefits under the Government program would only inure to those who are Federal employees as far as the subsidy is concerned. In this case, for example, we had better than 80 percent of Federal employees in the society and I say that falls within the definition of predominant. I could not pick an arbitrary—

Mr. JOHANSEN. Is it my understanding that you are now proposing that the cutoff date that was referred to earlier be eliminated and that hereafter new organizations and associations of this type would be formed? Is that what you are proposing?

Mr. BREMSTELLER. I would not say one way or the other, but I would say that if it is removed that the Government will save a good bit of money. With more people competing in this program it may throw a workload on the Civil Service Commission but it will save money and it will more than offset the added administrative costs.

Mr. DAVIS. That cutoff date was not proposed by him. It is already in the bill.

Mr. JOHANSEN. I realize that, but I say to the gentleman that, off-hand, I am not absolutely sure whether we may not be creating very serious problems if this is going to be open in the future to a large crop of these associations or private brokers who spring up because of the availability of Federal funds.

Mr. BREMSTELLER. If that is a fear, that cutoff date could be kept in the bill. In overall philosophy, I still believe there is a greater evil in legislating a bill, or enacting a bill, which says to four or five companies, "Here are 2,400,000 customers for you," and cutting out every agent and broker who makes his living selling to those people.

I think it is a greater evil in the latter case than in the former.

Mr. JOHANSEN. I think the gentleman heard my remarks earlier.

Mr. BREMSTELLER. Yes, sir; and I appreciate that.

Mr. JOHANSEN. Established associations, and so on?

Mr. BREMSTELLER. Yes.

Mr. JOHANSEN. I want to be sure we strike a balance here that is, as far as possible, fair and yet recognizes practical problems that the Government has in the matter.

Mr. BREMSTELLER. If the cutoff date is kept there, I do not think you will find many associations—

Mr. JOHANSEN. You would not object to the retention of that?

Mr. BREMSTELLER. No, sir; I would not, sir.

The CHAIRMAN. Any other questions?

If not, thank you very much, Mr. Bremsteller.

The committee will next hear from Mr. Vaux Owen, president, National Federation of Federal Employees.

You may proceed, Mr. Owen.

**STATEMENT OF VAUX OWEN, PRESIDENT, NATIONAL FEDERATION
OF FEDERAL EMPLOYEES; ACCOMPANIED BY LELAND M.
WALKER, SECRETARY-TREASURER**

Mr. OWEN. Mr. Chairman and members of the committee, my name is Vaux Owen and I am the president of the National Federation of Federal Employees. I am accompanied by the national secretary-treasurer, Mr. Leland M. Walker.

The National Federation of Federal Employees is an independent organization and is the largest and oldest in its field. It has members in all departments and agencies and in virtually all categories of employment and in all grades. Its members serve the Federal Government in all of the States, the District of Columbia, the Territories and possessions, and at many stations and installations throughout the world.

I wish to express the strong support of the National Federation of Federal Employees for the medical and health legislation now under consideration by this committee.

The objectives of this legislation long have been sought by our organization.

Successive national conventions of the NFFE have gone on record unanimously in favor of such legislation.

The need for this kind of a program has been increasingly apparent and with a mounting degree of urgency.

Costs of medical care have been growing rapidly. Extended illnesses have had catastrophic economic effects upon the individuals and families concerned.

In progressive business and industry, the need for the kind of medical and hospital insurance protection contemplated in the pending legislation has been recognized for many years. That recognition has had tangible results in the establishment of health benefit programs for employees at an accelerated rate.

Progressive employers have not only recognized the imperative need for this kind of protection for their employees but they have found by experience that it is the soundest kind of personal policy to provide it. In other words, it is good business practice that returns dividends in both tangible and intangible ways.

It is the considered view of the National Federation of Federal Employees that the enactment of a medical and hospital insurance program not only would benefit the employees but would be highly useful to the Government in the more efficient conduct of the public business.

The enactment of such a program would have positive and constructive effects in helping the Government both to recruit and to retain qualified personnel. It would tend to reduce the costly turnover rate. And it would have highly beneficial effects moralewise, since an employee who is not beset by constant worries over the costs of illness is a better and more effective employee on the job.

Mr. Chairman, we have extensive statistical and other evidence, much of it on the record, with respect to the imperative and growing need for this kind of legislation. I shall not at this time further burden the record with that evidence, although we are prepared to

provide it if desired. Moreover, there is no lack of evidence to prove conclusively that in this area of personnel administration progressive private employers have long since taken the lead, and that action by the Federal Government is not only appropriate but long overdue.

We appreciate the fact that the members of this committee are cognizant of the need for action. They have evidenced in the past, and they evidence now, a keen understanding of the urgency of the problem. We know that they have shared our disappointment that differences of approach, and conflicting interests, have thus far delayed final action.

At this time I wish to emphasize as strongly as possible the position of the NFFE on this matter. It is simply that we have consistently and persistently urged a reconciliation of those differences so that a program can be started. That is the primary need—getting the program started.

The pending legislation is, in our opinion, a sound compromise upon which all concerned can and should agree so that a beginning can be made toward providing the protection so seriously needed and so long delayed.

This does not mean, of course, that we do not have some reservations with respect to detailed provisions of the present proposal. For example, we believe that a strong case can be made, and indeed has been made, for a contribution of two-thirds by the Government and one-third by the employee, as compared with the 50-50 contribution plan provided in the bill. But we recognize, as a practical matter, that the present proposal is a compromise between the two-thirds employee contribution proposal and one-third Government contribution proposal which the administration has been strongly advocating. It is the considered opinion of the sponsors of this legislation in both the Senate and House that the 50-50 contribution plan presents a reasonable compromise and above all is one which stands a good chance of winning final approval. And that, in the final analysis, is what the NFFE is seeking: A bill that can make a good start on the kind of a program the employees and the Government both need—and the kind of a bill that can get on the statute books. In this connection I may say that the overwhelming bipartisan support given to S. 2162 in the Senate, where it passed by a vote of 81 to 4 on July 16, 1959, is a clear indication that the measure is one upon which there can be very general agreement.

We have reservations also, among others, with respect to the so-called Advisory Council set up under this legislation, although the bill as reported by the Senate Post Office and Civil Service Committee and passed by the Senate provided for some changes in the makeup of the Council as urged by the NFFE. We believe that there is reason to question the advisability of the Advisory Council plan as a whole, but we would not make an issue of it at this time.

I want to emphasize again that the reservations which we have with respect to some aspects of this bill do not in any way lessen the strength of our support for it. We would not wish to see further delays result from questions which, while important, may not be fundamental. In its main outlines and in its major provisions this is a good bill. It takes a long step forward in giving protection to Federal employees and their families and in bringing the Government at

least partially into line with progressive practices in business and industry in the area of health and hospital insurance.

Mr. Chairman, the Congress has been considering this problem for a long time. It has gone into the matter, at successive sessions, in the fullest detail. I know of no question in the field of Federal personnel administration which has been subjected to more searching scrutiny and has had brought to bear upon it more thought, more discussion, more statistical and other evidence.

The consensus of all of this concentrated thought and attention is unmistakably clear, namely, that the Federal Government should enact a medical and hospital insurance program now, and that the enactment of such a program unquestionably will benefit the Government no less than it will benefit the employees who will participate in the program.

The legislation which now is before this committee represents the result of the many years of consideration given to this subject, tempered and qualified with the end in view of the practical situation with which we are confronted, namely, the need for a bill which, while it may not be perfect in every respect, nevertheless is progressive, beneficial, and should win final approval.

I wish again to express the appreciation of the National Federation of Federal Employees to the chairman and members of this committee for their continuing interest, and to urge an early and favorable report on this highly important piece of legislation.

I have no further comments to make unless there are some questions by the committee.

The CHAIRMAN. I would like to know precisely what your position is. Do you endorse this legislation?

Mr. OWEN. Mr. Chairman, we endorse the legislation. We do not mean by that that we are entirely satisfied with every feature of it. There are some reservations we have about it.

Mr. REES. Are you for it?

Mr. OWEN. I do not suppose that this bill or any other bill on this subject that might come up would satisfy everybody.

Mr. REES. Are you for the bill as written?

Mr. OWEN. We are for the bill as written.

We have no specific amendment to make, but I think there could be some improvements made in it.

Mr. PORTER. You say in your statement you have some doubts about the Advisory Council?

Mr. OWEN. Yes, sir.

Mr. PORTER. What particular change did you have in mind, if any?

Mr. OWEN. Mr. Porter, the Advisory Council includes three representatives from the employee organizations.

I would like to say that if this provision is retained in the bill, the National Federation of Federal Employees would want to be on that Advisory Council, but, as a general proposition, we see no reason to have the Advisory Council, particularly an Advisory Council which is charged with the many duties specified in the bill for it, and we think it adulterates the authority and responsibility of the Civil Service Commission.

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If you have a job you want to give to an agency of the Government our thought is that this ought to be given to them. I do think that there would be some merit in an Advisory Council, or a council that the Civil Service Commission itself might select seeking new information.

Mr. REES. Would you advise striking it out of the bill?

Mr. OWEN. I would favor striking it out.

Mr. PORTER. Or having the Civil Service Commission select it?

Mr. OWEN. Yes, sir.

Mr. JOHANSEN. That would be with the understanding that there would be no delegation to this commission of the administrative authority or responsibilities of the Civil Service Commission?

Mr. OWEN. That is, if it is kept in the bill?

Mr. JOHANSEN. Yes. That is, if it is appointed or selected by the Civil Service Commission, you would still want no delegation to it?

Mr. OWEN. Certainly, the Commission should be responsible for doing the job.

Mr. JOHANSEN. I agree with the gentleman completely.

The CHAIRMAN. You go along with the views of the Civil Service Commission on this bill?

Mr. OWEN. On that feature of it.

The CHAIRMAN. I am talking about the Advisory Council.

Mr. OWEN. On that part of it.

The CHAIRMAN. It says here that the function of the membership is now designed to aid in sound administration and the Council's assigned function is to make investigations of the program and receive reports directly from the carriers and employees.

Such assignment would confuse Commission authority in its provision for the carriers. The Civil Service Commission should unmistakably be responsible for the success of this program and then they go on to say that the Council's function should be advisory only.

That is the position of the Bureau of the Budget on the Advisory Council section.

Mr. OWEN. That would represent our view on it.

The CHAIRMAN. That is your position?

Mr. OWEN. Yes, sir.

The CHAIRMAN. Any other questions?

Mr. OWEN. There is one other point I might mention since we have gone into the field of the employee organizations.

The definition given for employee organizations, which has been referred to here this morning on page 5 of the bill, beginning at line 3, the term "national employee organization" means a bona fide labor organization, national in scope, which represents only employees of one or more departments or agencies of the Government.

Mr. Chairman, we are an independent organization and we do not know how the term "bona fide labor organization" is going to be interpreted. If it should be interpreted that it applies only to those labor organizations that are affiliated with the AFL-CIO, that would rule our organization out and would rule us out if the Advisory Council provision is retained.

We would lose out on any representation on the Advisory Council.

We have no objection whatsoever to organizations being included in the bill that are affiliated with the AFL-CIO, but we do object to

being ruled out if this interpretation should be given to the term used.

The CHAIRMAN. Any further questions?

Mr. JOHANSEN. Mr. Chairman, just to clarify this Advisory Council matter, I am wondering if the record is clear as to what is the witness' preference—whether it be abolished completely or that it be by selection of the Civil Service Commission, without assuming or requiring any of the administrative responsibilities vested in the Civil Service Commission?

Mr. OWEN. I believe it would work better with the latter provision. That is, that the Civil Service Commission select their Council. The disadvantage about this Council is that they are to meet once every 3 months and I anticipate that there are going to be a great many questions in connection with the operation of this program. I do not think that a council that is going to meet every 3 months will be on the job to give the assistance that they would need. I think the Civil Service Commission ought to have a freer hand in seeking advice and I do not think they should be prohibited from seeking advice. I think they should be encouraged to do it, and they know what their problem is and probably would know where to go for advice. Certainly, they are going to be under the supervision of this committee and the eyes of the Congress and their work is going to be watched also by employee organizations of all kinds.

Mr. JOHANSEN. Does the gentleman feel that in the wording on page 22 of the bill, line 8, where it says:

No contracts shall be awarded, renewed, or terminated, and no regulation shall be promulgated, for the purpose of carrying out this Act, unless copies of proposed drafts thereof shall have been furnished to the Advisory Council—

does the gentleman feel that there is any danger of that becoming the first crack in the opening of the door to delegating to the Advisory Council some authority to develop what regulations shall be issued?

Mr. OWEN. I could have such a fear and I think that the mere request for all of this detailed information to be given to the Advisory Council contemplates that there must be intended they do something about it besides just giving advice.

It will grow into a super-supervision agency if you write that sort of a thing into this bill.

Mr. JOHANSEN. This becomes one more effort, to put it coldly and bluntly, to intervene in the responsibilities of management; namely, the Government itself?

Mr. OWEN. It could have that effect, I think.

Mr. JOHANSEN. That is why I oppose the section entirely.

Mr. PORTER. Mr. Chairman?

The CHAIRMAN. Mr. Porter.

Mr. PORTER. As to the matter of discussion, I was looking over your testimony and was not this matter before the Senate committee—the matter of abolition?

Mr. OWEN. I wrote a letter to the chairman of the committee stating that we had reservations about the Advisory Council.

Mr. PORTER. Did you get a response from them?

Mr. OWEN. I do not believe I have had a response.

The CHAIRMAN. I wish that you would turn to the last section of the bill as approved by the Senate, section 16, which provides that the

Commission shall transmit to the Committee on Post Office and Civil Service of the Senate and the Committee on Post Office and Civil Service of the House of Representatives, not later than May 1, 1960, copies of any contracts proposed to be entered into, policies proposed to be purchased, and regulations proposed to be promulgated, for the purpose of placing into operation health benefits under this act.

What do you think of that section?

We are busy enough, it seems to me, without taking on that responsibility.

Mr. OWEN. I would not want to state for either this committee or the Senate committee what they should do about it. I should think they have ample means of obtaining any information they desire without writing this into the law.

The CHAIRMAN. We do not have time to go into proposed contracts, policies, and regulations.

Mr. OWEN. I cannot see that it would serve a very useful purpose.

Mr. JOHANSEN. Will the chairman yield?

The CHAIRMAN. Yes.

Mr. JOHANSEN. I wonder if the gentleman does not actually feel there might be implied a constitutional issue of separation of powers between the executive and legislative branches with respect to this provision? This is an administrative function and once it is set by statute, I question very seriously—for once taking the side of the executive branch—whether this is a legitimate role of the Congress.

Mr. PORTER. Would the gentleman yield?

Mr. JOHANSEN. Yes.

Mr. PORTER. It only applies to transmission.

I agree with the chairman that it is a futile gesture to transmit them here. If we want to see them and raise some objection, we can do that, but to have them transmitted here would be a burden.

The CHAIRMAN. We are overburdened now with files and records in this committee.

Thank you very much, Mr. Owen.

Mr. OWEN. Thank you, Mr. Chairman.

The CHAIRMAN. The committee will next hear from Mr. George Riley, legislative representative, AFL-CIO.

**STATEMENT OF GEORGE RILEY, LEGISLATIVE REPRESENTATIVE,
AFL-CIO**

Mr. RILEY. Mr. Chairman, I believe you have copies of my statement, but in addition to that, I would appreciate having an appendix attached to it made a part of the record. I will give a copy to the reporter.

The CHAIRMAN. That will be included in the record.
(Mr. Riley's prepared statement follows:)

PREPARED STATEMENT OF GEORGE D. RILEY, AFL-CIO LEGISLATIVE REPRESENTATIVE

The AFL-CIO supports H.R. 8210 and its companion bills. There is a real hope among Government employees that they will, at last, be able to obtain substantial health protection through shared contributions with Government. We congratulate the sponsors of such bills, and look to you to expedite this legislation through the House so that Federal Government will assume a position of leadership in its role of employer.

The provisions of H.R. 8210 meet, to a great extent, the principles set forth by the AFL-CIO executive council for health coverage for persons employed in the Federal civilian Government service. The council suggested the following as guiding principles for this legislation :

- (1) A choice by employees from among various types of plans.
- (2) Government contribution of at least half the cost of comprehensive medical care for employees and their families.
- (3) An advisory council providing employee representatives with an effective role in guiding the program.
- (4) Full disclosure of financial operations of participating plans and continuing studies of costs and benefit adequacy.
- (5) Continued coverage for retired employees.

We consider the following to be crucial provisions in the legislation :

(1) There is an effective choice among various types of health plans. In those areas where comprehensive direct service plans are available, the employee is free to choose that type of coverage which provides for the greatest financial protection and which goes much further than any of the other plans in assuring high quality of care.

Those employees who do not desire to have this kind of health coverage or who live in areas where it is not available can choose from among approved Blue Cross-Blue Shield, commercial insurance, or employee association sponsored plans. The competition that will undoubtedly be encouraged among these plans due to this free choice provision will most assuredly accrue to the benefit of all.

(2) The bill provides for substantial Government contribution toward cost of coverage for both employees and dependents. This is in accord with the practices prevalent in private industry and will make possible widespread coverage among Government employees at all earnings levels

(3) The bill provides for representation of Federal employees through their elected spokesmen, on the Advisory Council, and gives the Council an active and responsible role in the program.

(4) The Civil Service Commission and the Advisory Council are charged with the responsibility of making continuing studies, surveys, comparative analyses and reports on the various health insurance plans and organizations participating in the program, including detailed financial reports and cost studies and analyses of the utilization and adequacy of benefits.

This provision is in complete accord with the AFL-CIO's longstanding position on the beneficial effects that full study and disclosure will have on operation of any welfare plan. Adequate evaluations and analyses are a crucial element in programs utilizing public funds.

(5) Further, the bill provides for coverage for future retired employees at the same cost and with the same benefits as apply to active employees. This is an essential provision since people are faced at the time of retirement with both lower income and higher medical care costs. Unless these costs are shared by a group which includes active employees, health insurance for retired persons entails a cost burden which is insupportable by the retired individual.

We regret that the bill now before you does not provide coverage for those persons already retired from Government service, and urge that you give consideration to this matter as soon as time can be found for adequate study of the problem.

There is one further basic point. We of organized labor are concerned with what a health plan can do to protect the health of Federal employees and their families as well as with the extent of financial protection against the costs of illness to be provided to these employees. We can no more underestimate the importance of removing the dollar barrier to needed care than we can dismiss the contention that financial protection against infrequent but costly major illness is desirable.

The tragedy of a family whose resources are wiped out by a catastrophic illness is no greater than the tragedy suffered by the family of a man whose illness is fatal because he postponed a visit to the doctor for months while he weighed the discomfort of his minor pain against the \$50 he would be charged for a physical examination. We are therefore extremely gratified to note that H.R. 8210 makes possible adequate basic health benefits as well as protection against extended illness.

For all of the reasons outlined above, we urge most strongly that this legislation be passed in substantially its present form. Under no circumstances should there be any reduction in the benefits or Government contribution pro-

vided for. The bill, as now written, represents the minimum adequate program. This program cannot be cut back without severe damage to the protection that Government employees will receive against ill health and against the financial disasters which accompany illness.

The cost to the Government of the bill before you is estimated by the staff of the Senate committee as \$145,300,000. That sum is \$1,030,000 more than we spend in this country on ballpoint pens and refills each year. It is \$1,380,000 less than we spend on shampoos. Can that be said to be too much to pay for health protection for the employees of the Federal Government? The higher levels of income and the growing gross national product that will accompany returning prosperity in the years immediately ahead will produce, in increased revenue, far, far more than the amounts needed to make possible a Government expenditure of \$145 million for the health of its employees.

(The appendix to Mr. Riley's statement follows:)

APPENDIX

The subject of fringe benefits in Government service has been mentioned several times during the current hearings. On this subject, attention of your committee is suggested for reference value to the report of the Cordiner committee of some 2 years ago. That committee included this statement in its report:

"The Federal Government has lost the advantage it once enjoyed in the area of fringe benefits."

That committee reported that expenditures for fringe benefits in Government service were estimated at 27.2 percent of Government salaries, if retirement benefits are valued at normal cost plus interest on the unfunded liability.

The same Cordiner report pointed out that Government employees are required to contribute somewhat in excess of 7.2 percent of their pay for these benefits. The net cost to the Federal Government is, not 27.2 percent, but 20 percent.

An analysis of "Benefits 1957," published by the U.S. Chamber of Commerce proves the statement made by the Cordiner committee. The study was made of 1,020 employers. The total cost of all fringe benefits received by the employees of these 1,020 employers was 25.6 percent of payroll. The employers paid 21.8 percent and the employees 3.8 percent. The employer paid 1.8 percent more than the Federal Government does for its employees and the employees of private industry paid 3.4 percent less for their benefits than Government employees.

I have not heard reference to productivity in the Government service, the result of which savings are useful to the Government itself. At the same time, such savings rightfully should be yielded in part and in the form of benefits to the employee.

On July 26 this year, the New York Times published an item titled, "Productivity Rise Found in U.S. Jobs." The news item was in reference to an analysis prepared by Henry D. Lytton, an economic consultant. The analysis according to the Times has "aroused interest among Government economists because of the light it sheds on a little-explored, but significant segment of the national economy." Said the Times story:

"For want of reliable information on the productivity of these workers, current calculations of improvements in the Nation's overall productivity assume the civil servants improvement to be zero, or neutral.

"A worker's productivity is generally defined as his output in an hour. "Mr. Lytton's analysis is based on output by the person, rather than by the hour. It uses a combination of methods to calculate the work put into a job and the product that comes out—the relationship being productivity.

"Mr. Lytton uses recent estimates by the National Bureau of Economic Research to compare Government with private industry. The Bureau's estimate, as reported by Mr. Lytton, found productivity rose in the private domestic economy at an average of 3.1 percent a year for the 12 years through 1958—the years covered by Mr. Lytton's study.

"Mr. Lytton's analysis was based on computations already prepared by 5 Government agencies that employed 793,000 civilians as of last October 31. The total was roughly two-thirds of the civilian Federal workers outside of Congress, the judiciary, and the Defense Department.

"The sample was composed of almost 539,000 postal workers, 171,000 in the Veterans' Administration, 51,000 in the Internal Revenue Service, 24,000 in the Social Security Administration, and 7,000 in the Agriculture Department's Commodity Stabilization Service.

"With the exception of approximately 115,000 VA employees in hospital work, Mr. Lytton describes his sample as essentially homogeneous—in service and finance. The Bureau's estimate, in the domestic economy, covers everything from service (laundries) and finance (banks) to such highly mechanized activities as coal mining and automobile production.

"The five agencies showed average annual improvement ranging from 1¼ percent in the Post Office to 8 percent in the Commodity Stabilization Service. The hospital segment of the Veterans' Administration showed an annual decline of 1 percent. Four of the agencies showed a slowdown in the rate of improvement in the more recent years.

"Mr. Lytton's overall figure showed a decline for 1953 and 1958, but an advance of 17 percent for the full 12-year period. He omitted the 12th year (1958), to give a 'more normal' 11-year period, and omitted the VA hospital workers, whose work does not fit with general service-and-finance character of the sample. Mr. Lytton then came up with an average annual rate of improvement of 2.15 percent.

"In any event, the Lytton analysis indicates improvement, where none could be calculated heretofore. The difficulties of calculation stem in part from the fact that the constant change of Government programs resists year-to-year comparison, and in part from the difficulty of measuring productivity in the service field.

"What, for instance, is the output of a fireman? It is easier perhaps to measure the output of a stenographer, except that when she gets an electric typewriter her job may be expanded to more than the simple letter typing she was doing before."

It seems only fair that the savings to the Federal Government from such sources as have been cited in the above and savings which can be derived from the potential lessening of claims for early disability and disability compensation can well be considered as factors. In the long run, it is apparent that the presently proposed legislation rightfully need not be considered a cost item to the Government even though the bookkeeping factor will continue to show the Government will be matching funds with the employee in the fair cause of a material contribution to an important segment in the national health.

Mr. RILEY. I will try to uphold my reputation for brevity and quote briefly from my prepared statement starting with the five points which appear in the middle of the first page.

First of all, we are in support of the proposed legislation and the main points which we wish to accept are, that the legislation contain a choice by employees from among various types of plans; (2) Government contribution be at least half the cost of comprehensive medical care for employees and their families; (3) that there be an advisory council providing employee representatives with an effective role in guiding the program.

Mr. JOHANSEN. Mr. Chairman, would the gentleman yield?

I appreciate his elaboration on the phrase "an effective role in guiding the program," but does that mean sharing in the administrative decisions?

Mr. RILEY. That only means what it says, Mr. Johansen. I do not think I want to go beyond what those words say. I think any reasonably minded man could come to the same conclusion, that it is not open to wide interpretation.

Mr. PORTER. Mr. Chairman, I gather that the gentleman supports the provisions of the bill as written?

Mr. RILEY. That is true. I am just giving five points on why we support it.

(4) Full discharge of financial operations of participating plans and continuing studies of costs and benefit adequacy; (5) continued coverage for retired employees.

In regard to the appendix which I mentioned—and I have copies here I would be glad to submit to the committee—that appendix

refers to two items: (1) To fringe benefits on which there has been some discussion; (2) on productivity of Government employees.

May I mention that the U.S. Chamber of Commerce supports the general statement of the Cordiner report of some 2 years ago, in which it is quite clear that the Federal Government no longer holds the advantage it once enjoyed in the area of fringe benefits and that, instead of the net cost to the Federal Government today of 27.2 percent for fringe benefits, the actual cost, according to the Cordiner report, is but 20 percent.

In regard to the productivity of Government employees, I refer you to a statement in the New York Times of July 26 of this year in which it was stated—and I only want to quote one paragraph—

that the study which a Mr. Linton, an industrial engineer, has made of a considerable sample of Government employees, shows that there has been an advance of 17 percent in a 12-year period of productivity among Government employees.

He omitted the 12th year, 1958, to give a more normal 11-year period and omitted the veterans' hospital workers whose work does not fit the general service and finance character of the sample.

Mr. Linton then came up with an average annual rate for those 11 years in improvement in productivity of 2.15 percent.

I mention that because I have heard discussion from time to time here on the question of, where are you going to get the money and do you want special taxes for this and that, and so forth.

The CHAIRMAN. Where do we get the money? I would like you to solve that problem.

Mr. RILEY. All right. I have been waiting for that one, Mr. Chairman.

Our economic policy committee is on record, and I suppose will continue to be so until there is some action by the Congress in closing tax loopholes. Tax loopholes do not come under your committee and therefore I think we can reasonably say that you are not responsible one way or the other for doing something about it, but we estimate that tax loopholes are costing the persons who are not beneficiaries of it in this country some \$9.1 billion a year. Nine billion dollars divided by the cost of this bill would, in a single year, pay the Government's share 67 times.

The CHAIRMAN. Have you presented that to the House Ways and Means Committee?

Mr. RILEY. The subject has not been up before the Ways and Means Committee that I know of, but the subject of cost and where you are going to get the money is before this committee.

The CHAIRMAN. Will you appear before them?

Mr. RILEY. We will at the proper time. We have given statements in the past on closing loopholes.

The CHAIRMAN. All right.

Mr. RILEY. So there is your chance to get the money any time the opportunity comes up.

The CHAIRMAN. Any questions?

Mr. JOHANSEN. Mr. Chairman, I have one question.

Does the gentleman feel that there is a need which reasonable-minded people would recognize for taking care of existing employee associations, health, and hospitalization or medical and hospitalization programs, such as has been testified to here the day before yesterday and today?

Mr. RILEY. I have only come here intermittently, Mr. Johansen, and you must realize that I have made it a point to be here. I wanted to accent our emphasis of support on this matter and I am very glad to have the opportunity to appear today. I have not been here, or was not here at the time the discussion such as you mentioned took place.

Mr. JOHANSON. Basically, it was a question, when testified to on Wednesday, of existing hospitalization and medical programs among postal employees which was self-insured and not underwritten. The testimony was that, under this program, this legislation as written, they would simply be put out of business.

Mr. RILEY. We are not for putting anybody out of business. The testimony I heard this morning was, the more the merrier, and the higher the competition, the less the cost will be.

Mr. JOHANSEN. There would be no objection to a word or two added which would recognize the status of those gentlemen?

Mr. RILEY. I am sure you would want to make it inclusive rather than exclusive.

I did hear the testimony presented at the outset on this statement when the seven representatives of our affiliated unions were present. I am pretty sure that if they did not lock it up on that discussion, that they would be glad to fill it in for you. I see many of those representatives present right now.

Mr. JOHANSEN. I appreciate that.

The CHAIRMAN. Any other questions?

If not, thank you very much.

Mr. RILEY. Thank you.

The CHAIRMAN. We will next hear from Mr. John W. MacKay, president, National Postal Clerks Union, accompanied by Mr. Philip Seligman, treasurer, New York.

STATEMENTS OF JOHN MacKAY, PRESIDENT, NATIONAL POSTAL CLERKS UNION, AND PHILIP SELIGMAN, TREASURER, FAMILY HOSPITAL PLAN, NEW YORK POST OFFICE CLERKS, NEW YORK, N.Y.

Mr. MacKAY. Mr. Chairman and members of the committee. We have prepared statements we would like to request be inserted in the record, and in order to conserve time, Mr. Chairman, we would like merely to emphasize two recommendations we wish to make to the committee with respect to the legislation under consideration.

The CHAIRMAN. Your request will be granted, and you may highlight your statement for the record.

(The two statements follow:)

STATEMENT OF JOHN W. MacKAY, PRESIDENT, NATIONAL POSTAL CLERKS UNION

My name is John W. MacKay and I am serving as president of the National Postal Clerks Union located at 918 F Street NW., Washington, D.C. We represent approximately 25,000 post office clerks throughout the Nation.

I am accompanied by Mr. Philip Seligman, treasurer, family hospital plan of the Postal Union of Manhattan-Bronx Clerks, New York City, the largest local union of post office clerks in the world and an affiliate of the National Postal Clerks Union. Mr. Seligman has a brief statement to submit concerning a situation on hospital plan coverage now prevailing in the cities of New York and Brooklyn.

At the outset, Mr. Chairman, permit me to express our appreciation for this privilege of appearing before your committee on this vital legislation. We would also like to express our gratitude to the various Congressmen on this committee that have introduced and supported measures to provide Federal and postal employees with medical and health benefits.

Mr. Chairman, we desire to express our approval and endorsement of the principles generally enunciated in S. 2162 as approved by the Senate July 16, 1959.

HISTORY OF MEDICAL INSURANCE

We feel it is important to go into the history of health insurance very briefly to establish a reasonable basis for the two amendments which we propose to offer for your consideration. That this legislation is long delayed and would redound to the benefit of the Federal employee and his employer, the U.S. Government, as well, is now axiomatic and no longer to be questioned.

A review of events and statements relating to employee health demonstrates the extent to which management, labor, the medical profession and both public and voluntary health agencies have increased their understanding of, and interest in, employee health problems. Healthy workers are not only industry's greatest asset, they are equally important as a national resource. As far back as 10 years ago, Dr. Robert B. O'Connor of Harvard University suggested the old adage "Production comes from people" be changed to "Maximum production comes from healthy people."

MEDICAL INSURANCE IN GOVERNMENT

Government participation in employee health plans has been proposed over a long period. Among the reasons given by proponents for advocating these proposals have been: (1) The example of the Federal Government as an employer and the incentive of such fringe benefits; (2) generally improved health standards resulting from the enrollment of as large a group as the Federal and postal employees; (3) the advantages to the employee of payroll deduction plus employer contributions for health insurance premiums.

Concrete proposals for providing health insurance protection to Federal civilian employees and for payroll deductions for the cost of the premiums have taken a variety of forms over the past 10 or 12 years. The Wagner-Murray-Dingell proposals for compulsory health insurance in 1945 contained separate provisions for recruiting Federal employees under the program, the separate provisions being necessary because civil servants were not subject to other social security tax deductions. One of the early omnibus health bills, sponsored by Senator Taft, contained a section applicable to Federal employees.

In 1952 the President's Commission on the Health Needs of the Nation recommended that payroll deductions and health insurance premiums of Federal employees should be allowed.

In 1953 Senator Carlson introduced a bill authorizing payroll deductions. No contributions from the Federal Government were contemplated in this bill other than the expense incurred in making these deductions.

Subsequent bills, including the 1957 proposals, have called for a Federal contribution to the cost of the health insurance. Those providing only major health expense benefits placed the entire cost of a proposal of insurance on the Federal Government.

MEDICAL INSURANCE IN INDUSTRY

It is now an indisputable fact that as many as probably 100 million American workers and their dependents are protected under one form or another of medical and hospital insurance. Rare is the collective bargaining agreement negotiated these days that does not contain some provision for medical insurance. As to the method of financing these plans, an evident trend was described in a booklet issued June 1953 by the U.S. Department of Health, Education, and Welfare, entitled "Management and Union Health and Medical Programs."

Under the heading of "Extent of Financing," we read the following:

"The degree to which an employer should carry the responsibility for financing health and welfare programs recently has become a major issue in collective bargaining, and at present there is a growing tendency for benefits to be financed entirely by employers. Although the phrases 'employer financing' and 'employer contributions' are commonly used, the employees regard contributions as money which is theirs since it is provided in lieu of wages. It should

be recalled that the amounts reported as payments by the employers represent both the amount paid under the collective bargaining agreements and contributions to other prepayment plans financed by employers alone or jointly by employers and employees. The method of financing health and welfare benefits paid under collective bargaining agreements is known for programs covering nearly 6.5 million workers in mid-1950. Of these, nearly 60 percent were covered by plans financed entirely by the employers. Of the unions for which data are available, about half had from 80 to 100 percent of their workers covered by health and welfare plans which were entirely financed by the employer. In mid-1950, about 30 percent of the workers covered by any type of health and welfare program had protection against all or part of their hospital bills and almost 65 percent of these workers were covered by programs financed entirely by the employer, and 35 percent of these were covered by programs jointly financed by employers and employees."

A subsequent study completed in November 1957 by the Department of Labor showed continuing progress, not only in the increase in number of workers covered by some form of medical insurance plan, but also a continuing trend toward complete financing of such plans by the employers.

We recognize the difficulties confronting this committee, particularly with respect to the cost element. We also recognize and appreciate the efforts on the part of the chairman and members of the committee to arrive at a bill which will be generally acceptable. However, we believe the questions of principle and cost must be met and solved forthrightly and honestly. Government should set the pace for private industry in the treatment of its employees. This it has thus far failed to do in the field of medical insurance. All available statistics indicate a preponderant trend toward employer financing of medical insurance plans. We request this committee give serious consideration to an amendment to S. 2162 which would provide the Government fully underwrite the cost of the proposed legislation.

LOCAL UNIONS

We would like to call to the attention of this committee the fact that there are local unions of Federal and/or postal employees in certain metropolitan areas which have for many years maintained medical insurance plans of their own. Provision is made in S. 2162 for "health insurance plans duly sponsored or underwritten by a national employee organization." We believe the sponsors of this bill would have included a provision for such local unions had the matter been called to their attention. For the protection of such existing local plans, we suggest the following amendment to S. 2162, to wit:

On line 19 of page 25 change period after the word "organization" to comma and add the following words: "or subdivision thereof." Also, on line 3, page 29, insert after the word "organizations" the words "or subdivision thereof".

CONCLUSION

In closing, Mr. Chairman and members of the committee, may we again emphasize we strongly support and endorse the basic principles of S. 2162. We are hopeful you will give serious consideration to the two amendments we have suggested. May we assure you, Mr. Chairman, there is urgent and abundant need for this legislation by our membership as well as all other employees of the Federal Government. We sincerely appreciate your very evident interest, and are grateful for this opportunity to express our sentiments on this bill.

PREPARED STATEMENT OF PHILIP SELIGMAN, TREASURER OF THE FAMILY HOSPITAL PLAN OF NEW YORK POST OFFICE CLERKS

Mr. Chairman and members of the committee, my name is Philip Selgman, and I am treasurer of the Family Hospital Plan of New York Post Office Clerks. The Family Hospital Plan of New York Post Office Clerks was organized in 1946 to provide hospital coverage for the clerks and families in the New York Post Office. Its field of membership includes the New York Federation of Post Office Clerks and the Postal Union of Manhattan-Bronx Clerks. We were one of the first groups to establish an employee hospital plan along the lines being considered by the House Post Office and Civil Service Committee.

HEALTH BENEFITS FOR FEDERAL EMPLOYEES

Our plan has a membership of 4,500 families with an enrollment of 12,000 individuals. There are many plans operating in the New York area. A membership of this size indicates a decided preference for this plan among the clerks eligible to join. We have developed a program of considerable coverage in harmony with the aims of the health benefits program of H.R. 8210 and H.R. 8211. We therefore seek to be included as a participating group in the Federal Employees Health Benefits Act of 1959.

The Family Hospital Plan of New York Post Office Clerks is recognized by the 300 hospitals in the New York area; hospital assignments are received at our office daily so that members are not required to make a large payment to the hospital in advance. Verbal commitments over the phone are readily accepted as authentic thereby enormously facilitating the admittance of the patient into the hospital. Our office is centrally located and easily accessible. Many members avail themselves of this and present their claims directly at the office where they are given immediate and personal attention. This is unique and consistent with the local background of our plan.

Operating over a period of 13 years, our fund has always been and continues to be solvent as shown in the following brief summary :

Year ending July 31	Enrollment	Number of claims	Receipts	Benefits	Assets
1947	2,879	87	\$10,361.75	\$3,879.00	\$5,776.06
1950	9,153	468	53,568.53	39,314.44	25,641.36
1954	11,770	1,205	157,970.31	126,628.37	73,211.75
1958	11,310	1,481	217,431.95	197,593.91	117,967.08

During the past year benefit payments ranged in amounts from \$5 to \$1,850. Our administrative costs are 9.3 percent which includes a 2-percent collection cost.

We have expanded the scope of our plan over the years to meet the needs of our members. In 1946, when the family hospital plan began, hospital benefits of \$8 per day were sufficient to pay 70 percent of the average hospital bill. As the charges for hospitalization rose, our plan instituted higher coverage sections to meet increasing needs. In 1949, surgical benefits for surgery in the hospital were added as well as maternity benefits. The length of coverage was increased from 30 days to 60 days placing it in the forefront among hospital benefit plans. In 1951, the scope of the plan was expanded to include surgery in the doctor's office as a compensable item. This was in conjunction with a panel of medical specialists so that surgery is on a service basis. The allowance for first aid was increased. In 1953, an other stride forward was accomplished by the extension of the plan to 90 days' hospitalization coverage, a higher coverage rate, reimbursement of doctors' fees for in-hospital treatment of nonsurgical cases. We were one of the first hospital plans to provide coverage for outpatient diagnostic laboratory and X-ray services which are of ever-increasing importance in the field of preventive medicine.

Our utilization of the concept of "major hospital expense benefits" dates back to 1953. A provision was included at that time granting 75 percent reimbursement of the hospital bill over \$1,000 and not covered by the hospital benefits of the plan. At present, we provide a choice of three basic plans to fit the budget of the postal clerk: Plan B at \$49 per year for a family group, plan A at \$74 and plan AA at \$94 per year. Plan A provides up to—

- \$1,350 for room and board care in a hospital for 90 days.
- \$300 in special services in a hospital (operating room, drugs, X-rays, etc.).
- \$250 for surgery (in hospital or doctor's office).
- \$270 for doctors' fees in hospital medical cases.
- \$150 for obstetrical benefits in normal deliveries.
- First-aid benefits. Specialist consultation in hospital medical cases.
- Outpatient diagnostic laboratory and X-ray services.
- Major hospital expense benefits of \$1,000 in addition to all of above coverage.

A fuller description of our plan is attached.

There has never been an age limit in our plan nor a higher premium on account of age. There is no cancellation provision in our plan except for nonpayment of dues and premiums. Nor is there a good health requirement in our plan.

Members upon retirement retain coverage in the plan for themselves and their families. Wives and children of deceased members are also retained. Their continued protection is of deep concern to the plan.

The family hospital plan of New York post office clerks is a local plan. It has been lawfully engaged for 13 years in reimbursing to members the cost of hospital, surgical, and medical care. In the course of performing an invaluable service to the community of postal clerks in this area, we have acquired an identification with high standards in this field. Our plan has always featured good coverage at most economical cost, service to the member, constant development and growth. This is possible because we have direct personal contact with the member and are responsive to his health needs. The inclusion of the family hospital plan under the Federal Employees Health Benefits Act is both deserving and necessary.

I appreciate this opportunity of presenting our views on the subject.

FAMILY HOSPITAL PLAN
New York Post Office Clerks, New York, N.Y.
PLAN AA

Premiums (quarterly)

First adult, \$10. Each additional adult, \$8.
All children under 18 years (as a group), \$5.50.
Family group (for additional maternity benefits), \$23.50.
Family group, member, spouse, and children or member and spouse.

Hospital benefits—Bed, board and general nursing care

Adult nonmaternity schedule: Ward or semiprivate, up to \$15 per day from 1st to 30th day; up to \$10 per day from 31st to 90th day. Private, up to \$10 per day from 1st to 90th day.

All children under 18 years (as a group): Ward or semiprivate, up to \$13 per day from 1st to 30th day; up to \$8 per day from 31st to 90th day. Private, up to \$8 per day from 1st to 90th day.

Special services

During period of hospitalization, reimbursement up to \$300 for special services including X-rays, laboratory, operating room, and medication.

Allowance up to \$25 for anesthetist included.

Doctors fees for surgery

Reimbursement of surgeon's fees for surgery in hospital, home, or office according to fees listed in the specialist plan booklet.

Up to \$250 for one operation consisting of single procedure or multiple operative procedures.

Maximum benefits in any 12-month period

For each adult, \$1,350 in hospitalization and \$500 in surgery.

For all children (as a group), \$1,170 in hospitalization and \$500 in surgery.

Maternity benefits

Allowance up to \$100. Caesarian delivery, up to \$150 for hospitalization and \$25 for doctor. Family group, \$50 additional for doctor.

Tonsillectomy benefits

In doctor's office, up to \$40. In hospital, full schedule of plan AA benefits.

First-aid benefits

Up to \$15 for outpatient emergency treatment in hospital or doctor's office within 24 hours after accidental injury.

Operating room facilities

When beneficiary is not registered bed patient and cost is incurred for operating room, reimbursement up to \$15.

Doctor's fees for medical care in hospital (other than surgical or maternity hospitalization)

Reimbursement of doctor's fees for medical care in hospital up to \$3 per visit for 90 days. Benefits paid for not more than one visit in any day. Limit in 12-month period \$270 for each adult or for all children.

Specialist fee for consultation in hospital-medical case

Reimbursement of cost up to \$15 for one consultation by accredited specialist during a hospital admission when attending physician certifies need for such consultation. Limit in 12-month period for each adult or for all children, \$30.

Outpatient laboratory and X-ray services

Reimbursement of fees in accordance with specialist plan fee schedule. Limit in 12-month period for each adult or for all children, 130. Benefits for these services are payable only for bona fide diagnostic services rendered at the direction of a physician following development of symptoms. These benefits are not payable for routine health examinations.

Laboratory and X-rays benefits are not paid for dental work, maternity cases or for accidental injury for which first-aid benefits are paid.

Major hospital expense benefits

When hospital bill costs alone for an adult or for all children are over \$1,000 in a 12-month period, 75 percent of the amount over \$1,000 and not covered by hospital benefits of the plan to be reimbursed the member. Limit under this clause in any 12 months for each adult or for all children (as a group) is \$1,000 and is in addition to all other benefits.

PLAN A

Premiums (quarterly)

First adult, \$8. Each additional adult, \$6.50.

All children under 18 years (as a group), \$4.

Family group (for additional maternity benefits), \$18.50.

Family group, member, spouse, and children or member and spouse.

Hospital benefits—bed, board, and general nursing care

Adult nonmaternity schedule: Ward or semiprivate, up to \$14 per day from 1st to 30th day; up to \$10 per day from 31st to 90th day.

All children under 18 years (as a group): Ward or semiprivate, up to \$12 per day from 1st to 30th day; up to \$8 per day from 31st to 90th day.

Special services

During period of hospitalization: reimbursement up to \$1.50 for special services including X-rays, laboratory, operating room, and medication. Allowance up to \$25 for anesthetist included.

Doctor's fees for surgery

Reimbursement of surgeon's fees for surgery in hospital, home, or office according to fees listed in specialist plan booklet. Up to \$250 for one operation consisting of single procedure or multiple operative procedures.

Maximum benefits in any 12-month period

For each adult, \$1,170 in hospitalization and \$500 in surgery.

For all children (as a group), \$990 in hospitalization and \$500 in surgery.

Maternity benefits

Allowance up to \$75. Caesarian delivery, up to \$125 and \$25 for doctor. Family group, additional allowance of \$50 for doctor.

Tonsillectomy benefits

In doctor's office, up to \$40. In hospital, full schedule of plan A benefits.

First aid benefits

Up to \$15 for outpatient emergency treatment in hospital or doctor's office within 24 hours after accidental injury.

Major hospital expense benefits

When hospital bill costs alone are over \$1,000 in 12-month period, 75 percent of amount over \$1,000 and not covered by hospital benefits of plan to be reimbursed the member. Limit under this clause in any 12 months for an adult or all children is \$750 and is in addition to all other benefits.

PLAN B

Premiums (quarterly)

First adult, \$5.50. Each additional adult, \$4.25.

All children under 18 years (as a group), \$2.50.

Hospital benefits

Adult nonmaturity schedule: 1st to 4th day, up to \$25 each day; 5th to 30th day, up to \$10 per day, 31st to 90th day, up to \$5 per day.

All children under 18 years (except for tonsils): 1st day up to \$20; 2d to 4th day, up to \$15 per day; 5th to 30th day, up to \$7 per day; 31st to 90th day, up to \$3.50 per day.

Maximum hospital benefits in 12-month period

\$660 for adult, \$457 for children.

Doctor's fees for hospital surgery

Reimbursement up to fee listed in specialist plan booklet less \$15. Limit of \$135 for operations on genital system.

Limit for other operations, single or multiple procedures, \$200. Maximum in any 12-month period for an adult or for all children, \$400.

Maternity benefits

Allowance up to \$50. Caesarian delivery, up to \$100 and \$25 for doctor.

Tonsillectomy benefits

In hospital or doctor's office, up to \$25 in child cases.

First aid benefits

Up to \$10 for outpatient emergency treatment in hospital or doctor's office within 24 hours after accidental injury.

Supplementary benefits

In certain cases as described in bylaws and based upon schedule of benefits.

Major hospital expense benefits

When hospital bill costs alone are over \$1,000 in 12 months' period, 50 percent of amount over \$1,000 and not covered by hospital benefits of plan to be reimbursed the member. Limit under this clause in any 12 months for an adult or for all children is \$500 and is in addition to all other benefits.

This is an outline. Complete information is contained in the constitution and bylaws of the family hospital plan pertaining to other benefits, waiting periods, exclusions, limitations, etc.

Mr. MACKAY. Thank you, sir.

We take the position, Mr. Chairman, which is referred to on pages 4 and 5 of our statement, and at the conclusion of page 5 we wind up with a request that this committee give serious consideration to an amendment to S. 2162 which would provide the Government fully underwrite the cost of the proposed legislation.

The CHAIRMAN. Pay for all of it?

Mr. MACKAY. Yes, sir.

Continuing with our statement, we have drawn attention to a situation that prevails with respect to local unions.

In our union we have an insurance where two of our affiliates have had, for approximately 10 or more years in operation, their own family hospital plans. They have been very successfully operated and we believe, as has been pointed out here previously by other witnesses, that an amendment should be made in section 4 of the bill. I refer particularly to line 19 of page 25 of S. 2162 as passed by the Senate, to change the period after the word "organization" to a comma, and add the following words: "or subdivision thereof".

The CHAIRMAN. What page of the bill?

Mr. MACKAY. That is on line 19 of page 25.

Mr. GROSS. S. 2162?

Mr. MACKAY. Yes, sir.

The CHAIRMAN. There are just 24 pages in the bill.

Are you referring to the Senate-passed bill, S. 2162?

Mr. MacKAY. There has been a change there. On S. 2162, it would be on page 5.

The CHAIRMAN. Is that the Senate-passed bill?

Mr. MacKAY. Yes, sir.

The CHAIRMAN. What pages?

Mr. MacKAY. It would be under section 4, Mr. Chairman.

The CHAIRMAN. All right.

Mr. MacKAY. To add the words, "or subdivision thereof" after the word "organization".

It would make provision for the inclusion of these local plans.

The CHAIRMAN. Where would you add that?

Mr. MacKAY. Section 4, page 7.

Mr. Gross. Page 8.

The CHAIRMAN. Paragraph 3, is that where you would amend it? Do you have a copy of the Senate-passed bill?

Mr. MacKAY. I have a copy of S. 2162.

The CHAIRMAN. Are you referring to paragraph 3, employee organization plans? Or are you referring to paragraph 1 of section 4?

Mr. MacKAY. That would be on page 8, Mr. Chairman.

I regret that I do not have a copy of S. 2162 as reprinted. It would be on page 8, under employee organization plans, and after the words "employee organizations" on line 11, we propose to add the words, "or subdivision thereof".

The CHAIRMAN. Exactly what do those words cover?

Mr. MacKAY. Under the proposal as it is now, employee organization plans which are sponsored, contracted for, or administered in whole or substantial part by national employee organizations, we would add the words, "or subdivision thereof" in order to take care of these local affiliates that have organized for many years their own individual hospital plans.

The CHAIRMAN. Your organization does not yet have a comprehensive plan for all your locals; is that it?

Mr. MacKAY. Yes, we do. We organized such a plan on May 1 of this year and we have approximately a thousand members signed up. Prior to that time, and for many years past, it happened that two of our local affiliates had organized independent plans of their own. They started back in 1945, as I recall.

Mr. Seligman, the treasurer of the plan in New York, is here to explain more in detail if you desire information on the operation of that local plan in New York City.

The CHAIRMAN. I do not care for it unless the members of this committee want it.

Mr. MacKAY. He has a statement ready he would like to file for the record.

The CHAIRMAN. It has been made a part of the record. Do you have any further observations?

Mr. MacKAY. No, sir. We would like to say that we are in favor of the legislation and we feel it is long overdue. We feel that the record of private industry in providing for health benefits is one that should be followed and emulated by the Federal Government. Our people are greatly in need of relief of this kind and we take the position that the cost of the program should be underwritten by the Govern-

ment because we feel that our people at this time are just not financially able to met the additional costs.

The CHAIRMAN. You think the Government should pay the entire cost?

Mr. MACKAY. Yes, sir; we do.

The CHAIRMAN. Any questions?

If not, thank you very much.

Mr. JOHANSEN. I do have a question which occurs to me which I would like to direct to either, or both, of the gentlemen.

If the proposed amendment mentioned by Mr. MacKay, calling for the total underwriting by the Government, were adopted, would it not involve a radical revision of the entire legislation with respect to setting fixed benefits and fixed standards of coverage for each and all categories of employees?

I am referring now to such things as marital status, sex, and so on. There would be a flat, blanket program of fixed benefits since the element of choice to the employee would be eliminated, as to how much he wanted to bear.

Mr. MACKAY. As we understand the bill, it will not take effect for approximately 1 year during which time the Civil Service Commission is charged with the responsibility for determining a scale of benefits. There are many other things that are left unwritten and unprovided for in the bill, and which are assigned to determination by the Commission.

We feel that there is ample opportunity and ample time for the provision for things that you have mentioned.

Mr. JOHANSEN. I am not arguing whether there is opportunity or time. I am just saying that is the approach that will have to be made. There would have to be a single standard program. There would be no degree of choice on the part of the employees.

Mr. MACKAY. Not necessarily. We think the bill could be written in such a way that there would be an opportunity, but after all, I think the majority of our people at least are interested in obtaining as much coverage as they possibly can. I think it is possible to write a bill that will give them an adequate amount of coverage to take care of their needs, particularly for the more serious illnesses they encounter.

Mr. GROSS. How could there be any selectivity?

Mr. MACKAY. You have those that are single. Naturally they would fall under one plan. Those that are married and with families would fall under another.

Mr. JOHANSEN. They would all be standard plans.

Mr. MACKAY. We believe that it could be worked out. I think the mere fact that the Government would be underwriting the cost of the legislation would certainly not jeopardize the writing of such programs. I know that better than 50 percent of the industrial firms in private industry provide total coverage for their employees.

The CHAIRMAN. Do they have various plans written by different companies?

Mr. MACKAY. I would say that approximately 60 percent of industrial firms take care of the total cost of hospitalization and medical services for their employees. I believe if such an objective can be reached in private industry that the Government could well emulate it.

The CHAIRMAN. I am referring to the local organizations of these various employee groups. There may be hundreds of them, and there would be all kinds of plans that the Civil Service Commission would have to enter into, it seems to me.

Mr. JOHANSEN. Certainly the plan that was most generous would be the plan that every employee would want, is that not so?

Mr. MACKAY. That stands to reason, but under the present income schedule of the people we represent they just are not in a position to afford additional payment at this time.

Mr. JOHANSEN. We are not arguing that point. The point that I am making is, I see no basis for continuing all of these various and sundry plans which by their very character represent different types of coverage and different types of opportunity for choice of the employees. Certainly you would not have that great variety so that the Federal Government would be paying in on one scale of benefits to one group of employees and another scale to another group.

Mr. MACKAY. Mr. Johansen, I might cite for your consideration the example we experienced in the establishment of the life insurance program. I think that that program was accomplished. There were many private organizations prior to that time among Federal and postal employee groups and they had their own plans, and yet they have been able to handle it in such a way there is no serious damage.

Mr. JOHANSEN. Does the Government pay all the costs of the insurance?

Mr. MACKAY. No, sir.

The CHAIRMAN. Just one-third.

Mr. JOHANSEN. That is my point.

Mr. MACKAY. I think that it could be worked out.

Mr. JOHANSEN. I certainly want to respectfully disagree with the gentleman. You are not going to want your organization to have a lesser plan than some other group of employees. The law of gravitation is going to work opposite to nature. You will gravitate upward to the best program the Government offers; that is obvious.

Mr. MACKAY. I personally feel that there is no reason why there should be a differentiation between Federal employees on the one hand and those in the military service on the other. I do not think that there is any problem involved in providing full coverage for those people in the military service, and I think the people that are employed in the Government should have equal consideration. We do not feel that there is any necessity to draw any lines in that respect.

Mr. JOHANSEN. Again the witness misses my point. I am simply saying that it would seem to be pointless to attempt to preserve the validity of programs and plans to which your other amendment regarding subsidization thereof seems to address itself since whatever the Government programs are, the most generous program is the one that will apply to all the employees.

Mr. MACKAY. That might well be the result.

Mr. GROSS. You are not putting an employee in the Post Office Department on the same grounds as a private in the Army in terms of medical care and hospitalization, are you?

Mr. MACKAY. No, we are not putting them on the same basis as a private in the Army, but we do feel that as long as they are working for the Federal Government, as long as they are Federal employees,

and as long as they devote their lives, their careers, to Federal employment, that there is no justifiable reason why the Government could not underwrite the cost of providing them with adequate medical care.

The CHAIRMAN. And you would give them the same free care as is given to the military?

Mr. MACKEY. I think a comparable program could ultimately be worked out. I think there would be sufficient funds to do it.

The CHAIRMAN. I cannot agree with you at all. Are you a veteran?

Mr. MACKEY. Yes.

The CHAIRMAN. You expected medical coverage while you were in the Army, did you not?

Mr. MACKEY. Yes, I did; and I cannot help but feel that other Federal employees are entitled to equal consideration.

The CHAIRMAN. I cannot agree with you at all on that. I am a veteran just like you are, but I think there should be some distinction made between the two categories, those in the active military service and the civilian employees of our Government.

Mr. MACKEY. How many plans are there like yours among Federal employees?

Mr. SELIGMAN. I do not know exactly, but from our experience and knoweldge I do not think there are more than half a dozen; local plans that are exclusively run by the unions that have organized these plans.

Mr. JOHANSEN. Are you suggesting this plan might be the model for the Federal plan to be totally financed by the Federal Government.

Mr. SELIGMAN. No, sir. There is a problem that President MacKay has indicated here that is different from the facts that present themselves. The bill S. 2162 and the accompanying bills of the House call for a different type of plan than that called for a 100-percent benefit plan. This has passed the Senate. The House is considering this bill and we wish to come under the provisions of the bill now presented to this committee.

The CHAIRMAN. If there are no other questions, we thank you very much.

The next witness is Mr. Frank Wilson, representing the National Association of Retired Civil Employees.

STATEMENT OF FRANK J. WILSON, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

Mr. WILSON. Mr. Chairman and members of the committee. My name is Frank J. Wilson. I am president of the National Association of Retired Civil Employees. I am accompanied by John A. Overholt, legislative representative of our association, Joseph L. Spilman, first vice president, and John J. Madigan, secretary. Our association has been functioning for more than 38 years. It has over 99,000 members and 730 local chapters. A principal objective of our association is to provide the welfare of all retired civilian employees of the Federal Government and of the District of Columbia.

The National Association of Retired Civil Employees wholeheartedly endorses Senate-approved S. 2162, and also H.R. 8210, H.R. 8222, and H.R. 8211. We consider this legislation one of the most important

forward steps ever taken by the Government in order to promote the efficiency of its employees and thus to promote the welfare of all our citizens through the improved efficiency of all Government agencies. We congratulate and thank the Members of Congress who demonstrated their interest in this outstanding matter by introducing appropriate legislation. We urge the members of this committee to give the legislation their serious consideration and to give it very prompt and favorable action. Prompt action is necessary in order that the time required for extensive negotiations and administrative action will be sufficient to have the program made effective July 1, 1960.

Our retired civil service employees in the 49 States were disappointed when they were excluded from this proposed legislation. However, they are encouraged by the strong sentiment which appears to exist among the Members of the Senate and the Members of the House for their coverage in a separate bill. They respectfully petition the members of this committee to also give prompt consideration to legislation to provide a health plan for them. They urge you to follow the fine example of the State of New York, the Dominion of Canada, and many large industrial corporations which have recognized their obligations to their retired employees and provided health plans for them.

In the event a separate bill is not passed, many thousands of present retired employees will be severely penalized because they are now covered by various health plans which they started and which will eventually be forced out of business. This will happen because, as a result of the passage of S. 2162 or one of the House bills before you, their health plans will be unable to recruit future retired employees as new members. One of the health plans referred to above is sponsored by the National Association of Retired Civil Employees and over 51,000 retired employees and spouses are covered by it. Their future health protection will be jeopardized and they may lose it because the participants in the policy will quickly reduce to such an extent that the policy may have to be abandoned or it may be necessary to increase premium rates to such an extent that the aged retired employees cannot afford to carry the insurance. As a result they will be without protection when they most need it. As individuals, at their advanced age, they will be unable to purchase health insurance on their modest annuities. We do not believe that the members of this committee or other Members of Congress wish to be partly responsible for such a serious situation. The situation will not develop if the already retired employees are provided health coverage through a separate bill.

I wish to state once again that we endorse S. 2162 and the comparable bills that have been introduced in the House.

The CHAIRMAN. You are not included in the Senate-passed bill?

Mr. WILSON. That is right.

The CHAIRMAN. And you are seeking to be covered in other legislation?

Mr. WILSON. We are hoping to be covered in other legislation. We might state that our members in 49 States were disappointed that we were not included in this bill.

The CHAIRMAN. This is a very difficult field, coverage for retired employees.

Mr. WILSON. We do not believe it is a real difficult field. We have had experience in our own association. We have an insurance plan. We have 52,000 people that are covered by this and it was not a difficult proposition to initiate, nor to operate.

During the last couple of years we paid approximately \$4 million in benefits to our retirees, and they are extremely happy with it.

The CHAIRMAN. How old is your plan?

Mr. WILSON. Two years.

Mr. PORTER. Is it your plan that the retirees be included on the same basis as Government employees actively serving?

Mr. WILSON. The present bill would not include them.

Mr. PORTER. I know that it does not. But if it were amended.

The CHAIRMAN. If they were covered would you not expect them to pay the same premium?

Mr. WILSON. We would expect to pay the same premium, but would not expect the same live benefits that the current employees and the other folks obtain.

Mr. PORTER. In other words, the same amount of contribution from the Government as for the active employees. That is all that you are asking in terms of an amendment, not any additional amount representing assumed additional need for service on the part of the retired employee?

Mr. WILSON. That is correct. We ask for an equal financial contribution, the same contribution that the present bill will make toward people who retire in the future.

Mr. PORTER. Do you have any estimate of the cost of that?

Mr. WILSON. We estimate the cost of that would be about \$13 million.

Mr. PORTER. A year?

Mr. WILSON. For the first year, and then it would progressively reduce.

The CHAIRMAN. Who gave you that estimate?

Mr. WILSON. That is an estimate that we figured in our office. It is not difficult to figure it because you have a fixed rate of contribution, and what you must do is figure how many participants there will be and you practically have the cost.

The CHAIRMAN. What is the average age of the retired employees?

Mr. WILSON. The average age is around 70.

The CHAIRMAN. I believe that there has been testimony presented here that persons over 65 are hospitalized three times as much as persons under 65; is that correct?

Mr. WILSON. We do not know that. We have not seen any substantial or reliable figures. We have heard statements with respect to that.

The CHAIRMAN. We have had testimony in the hearings to that effect.

Mr. WILSON. Yes, but we have never seen any substantial statistics to establish that, unfortunately. I do not believe that there are many substantial statistics to substantiate that.

Mr. PORTER. The Government would make the same contribution but you would be getting fewer services; is that correct?

Mr. WILSON. We would be getting fewer benefits.

Mr. PORTER. So it would not be a burden?

Mr. WILSON. Not to the slightest extent.

Mr. PORTER. Have you drawn up an amendment to this bill?

Mr. WILSON. No, Mr. Porter, we have not. We realize this is a very important bill and a complicated bill and rather than complicate the bill through an amendment we are in hopes there will be a separate bill that will provide this coverage for us, and we have encouragement from Members in the House and in the Senate that they feel we should be covered and they are considering drawing up a separate bill.

Mr. REES. You are not asking that it be included under this bill?

Mr. WILSON. No, sir.

The CHAIRMAN. Are there any other questions? If not, we thank you very much.

The committee will next hear from Mr. Dillard Lasseter, executive officer, Organization of Professional Employees of the Department of Agriculture.

Mr. Lasseter.

**STATEMENT OF DILLARD B. LASSETER, EXECUTIVE OFFICER,
ORGANIZATION OF PROFESSIONAL EMPLOYEES, DEPARTMENT
OF AGRICULTURE**

Mr. LASSETER. Mr. Chairman and members of the committee, the Organization of Professional Employees of the U.S. Department of Agriculture is this year observing its 30th anniversary. OPEDA, as it is generally called, has something over 5,000 members who are engaged in professional, scientific, technical, and administrative work. The members are located in the 50 States and in various other places throughout the world.

OPEDA strongly endorses S. 2162 and respectfully recommends favorable consideration by your committee and enactment of the bill by the present Congress.

To the extent that your committee deem it prudent and desirable to do so, we would call your attention to possible changes in the bill which our organization would endorse.

1. In section 5(a)(1)(B) and (C), strike the last part of each sentence which reads as follows: "* * * to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes." These provisions would deprive employees in the upper salary levels of much of the economic protection otherwise afforded by the bill. We believe the same treatment should be accorded all employees with respect to these benefits.

2. The rigid limitations in section 7 on the amounts that may be withheld from the salaries of employees and those that may be contributed by the Government would make it necessary, in the event of continued rising medical costs and/or of increased services to members, to reduce benefits under the act. We believe that frequent renegotiation of contracts and curtailment of benefits would be an administrative burden and a source of confusion to employees and would partially defeat the primary purpose of the bill. If practicable, greater flexibility should be provided in the cost structure.

3. We would question the desirability, from the standpoint of efficient administration, of giving statutory status and powers to the

Advisory Council provided by section 12 and to the Bureau of Retirement and Insurance provided by section 13. Likewise, we question the need for or desirability of section 16(a). OPEDA has confidence in the Civil Service Commission's desire and ability to administer the program competently and in the effectiveness of the House and Senate Committees on Post Office and Civil Service to oversee such administration.

4. We suggest the desirability of prefunding the costs of the program for future retirees.

Thank you.

The CHAIRMAN. Thank you, Mr. Lasseter.

We will now hear from Mr. Perry Stevenson, president, Commerce Branch, National Federation of Federal Employees.

**STATEMENT OF PERRY J. STEVENSON, PRESIDENT, COMMERCE
BRANCH, NATIONAL FEDERATION OF FEDERAL EMPLOYEES**

Mr. STEVENSON. I want to say that when I asked for permission to appear as president of the Commerce Branch, I had no intention of infringing upon the prerogatives or the testimony of our national president, Mr. Owen. It happens that this legislation has been of particular interest to the Department of Commerce, and I think we can safely say that we have spark-plugged it in the national federation.

(Mr. Stevenson's prepared statement follows:)

**PREPARED STATEMENT OF PERRY J. STEVENSON, PRESIDENT, COMMERCE BRANCH,
NATIONAL FEDERATION OF FEDERAL EMPLOYEES**

I am Perry J. Stevenson, a retired civil servant. We want to express our appreciation of your concern with the legislation before you and to emphasize our belief that it will have a valuable byproduct for our people as a whole. Such a large insured group will furnish increased experience tables which should result in lower rates and increased coverage, which is the democratic operation of our free enterprise, capitalistic system.

At this late date it may be difficult to alter the provisions of the bill, especially as the goal of all concerned is the enactment at this session of medical insurance legislation. At the same time, we desire to set forth certain viewpoints for your consideration.

We find it difficult to understand a strange contradiction. All authorities are agreed that this type of insurance would benefit most of all our senior citizens, the retirees. Yet, in spite of pious gestures and some crocodile tears, the only retirees covered are those who will retire after July 1, 1960, and who will continue to pay the same rates and with the same governmental assistance as those on the active rolls. It would seem simple justice to extend this provision to all retirees. If this is not possible, could not the retirees be permitted to pay the entire cost without any Government contribution? Even granting the validity of higher rates for this group, we would point out that the experience of the past 5 years with the ordinary group life insurance has been that the civil servants are living longer than the general public and even longer than the medically screened risks of the insurance companies. In part this seems to be due to careful selectivity, to a level of intelligence, to good use of a higher average income, to better housing, and living conditions, factors which may also lessen the incidence of sickness.

We have another criticism of the current proposal. The uniform costs would fall with very unequal weight on the lower grades as would the deductible feature. We would like to see the rates adjusted so that the payments of the insured rise with their incomes and the Government's share increases conversely.

If the testimony given on August 5 by Mr. Manton Eddy is interpreted correctly, the insurance companies are proposing a built-in escalator system on the assumption that the recent inflationary trend will continue indefinitely. At

the end of 3 years, there would be reserves equal to 1 year's costs less 18 percent, not taking interest earned on the reserve into account. Such surrender in advance to inflation seems unnecessary and the distribution of this reserve, comparable to the so-called dividends of the life insurance companies, would be difficult, costly, and inequitable. Markedly absent in any assumption that there will be any breakthrough in the conquest of any of the major diseases, as with polio.

In closing, we want to express our gratitude for the medical insurance program as one of the finest proposals ever advanced for those in civil service and of vastly greater significance than a pay increase. The general aim of our suggestions is lessened cost to the Government to insure its acceptability without a veto.

Mr. REES. Your membership is within the Department of Commerce?

Mr. STEVENSON. Yes, the Department of Commerce.

The CHAIRMAN. How many members are in your group?

Mr. STEVENSON. We are just in the midst of so much reorganization of our organization, it would be difficult to say, but I would assume around 250 or 300.

The CHAIRMAN. How old is your group?

Mr. STEVENSON. They are members of the National Federation of Federal Employees.

The CHAIRMAN. You do not have a separate plan?

Mr. STEVENSON. Oh, no. We are just making certain general comments that we feel the committee might be glad to hear.

Mr. REES. You have your own hospitalization plan; do you not?

Mr. STEVENSON. No, except within the national federation. We have no separate plan.

The CHAIRMAN. Does your national organization have a plan?

Mr. STEVENSON. You have heard Mr. Owen, and there is a hospital plan in local No. 2, but we are not trying to complicate that issue at this time, sir.

Mr. PORTER. In your statement you say:

We would like to see the rates adjusted so that the payments of the insured rise with their incomes and the Government's share increases conversely.

Is that not a matter for insurance companies and the health plans to decide?

Mr. STEVENSON. I am speaking now of life insurance companies as being indicative of the better grade of risk involved in the Government employees.

Mr. PORTER. Could they not decide that also? Is it not their decision to make, what to charge?

Mr. STEVENSON. I cannot quite hear you.

Mr. PORTER. The Government gives a stipulated amount in each case, does it not, under the bill?

Mr. STEVENSON. Yes.

Mr. PORTER. Then the employee has to pay the rest. And is not the amount of the balance up to the carrier in every case?

Mr. STEVENSON. Is that not what is wrong—the highest priced people pay so little and the lower grades pay so much?

Mr. PORTER. Should not that be addressed to the company? Is not that up to the company, or have we made that a stipulation in the bill?

The CHAIRMAN. As I understand it, they have fixed the rates in this bill for coverage according to age. In other words, you would charge an employee 21 years old more than an employee 65.

Mr. STEVENSON. Not according to the bill, as I understand it.

The CHAIRMAN. What is your contention?

Mr. STEVENSON. Our contention is the rate should be raised according to the income, the salary.

The CHAIRMAN. Income rather than age?

Mr. STEVENSON. Income.

The CHAIRMAN. I see. How many brackets would you have on an income basis?

Mr. STEVENSON. You would presumably get a greater contribution from the employee than less contribution from the Government.

The CHAIRMAN. How many different brackets of pay would you have? Start out with \$2,500. You would charge that group so much and then the group at \$3,000 so much, and then the group for \$3,500 so much. You would keep raising it; is that it?

Mr. STEVENSON. I would raise the rate as the salary went up.

Mr. REES. A man making \$5,000 a year would have to pay more than a man making \$2,000?

Mr. STEVENSON. That is right. The relative weight of the take-home pay of the lower grades as compared to the top grades is about 500 percent.

Mr. REES. Would you amend this bill that we have before us?

Mr. STEVENSON. I am not sure that it needs to be amended. It seems to me that could be a practical way of operation. The Civil Service Commission could use its own judgment in connection with such a scheme.

Mr. REES. You think that the Civil Service Commission under this bill could do that without an amendment?

Mr. STEVENSON. I am not a lawyer, sir. I am just trying to set forth a principle which seems to us to be valid and of value both to the Government and the civil servant and to retirees.

Mr. REES. I think that you would have to amend the bill to do the things that you are talking about, to some degree, at least.

Mr. STEVENSON. If you desired to do it, that would be a part of your decision, sir.

Mr. REES. I said what I did because I thought perhaps you might have a proposed amendment.

Mr. STEVENSON. I am not an actuary, though I have delved into the mystery of this for the past several years.

Mr. GROSS. You make out an awfully good case for Government employees. You say that they are of high intelligence, they make better use of higher average income, they have better housing, and better living conditions. All of this adds up, you say, to lessening the incidence of sickness. I wonder if we ought to pass this bill at all.

Mr. STEVENSON. I do not think there is any question, sir, that the committee and Congress have been fair and very liberal with the civil servants as a group.

Mr. GROSS. I am glad to hear you say that.

The CHAIRMAN. How much more would the employee who makes \$15,000 be paying compared to the one making \$5,000? Let us follow your philosophy through here.

Mr. STEVENSON. I am not sure whether it should be a percentage of the take-home pay, or just an equal gradation of stepping up. That is a matter for those who will have to work out the financial details to decide. That is beyond my scope, sir.

The CHAIRMAN. You would base the contribution on the salary that the employee is receiving?

Mr. STEVENSON. That is right.

The CHAIRMAN. What would you do about basing it on age? A young man gets much cheaper insurance than a man who is 50 or 60 years old.

Mr. STEVENSON. That might well be considered, sir.

The CHAIRMAN. On age and income?

Mr. JOHANSEN. Do I understand your suggestion is that the Government's share of the participation be less for the higher paid employee?

Mr. STEVENSON. Absolutely. Perhaps there should be none at the very top.

Mr. JOHANSEN. I would like to say, while I am not sure it is practicable to work this out, there have been a couple of very pleasant shocks in the gentleman's testimony.

Mr. PORTER. As I read this contribution section, the Government gives the same amount to the employee that the employee has to give, and for that he gets a package, depending upon what he selects. That package is going to be determined by what the carrier can give in each case. If the man wants more than that he will have to pay more. To that extent it is open end, or he can get it outside someplace if he wants more than that. I do not understand why it is necessary to adjust this amount in terms of benefits, because it seems to me the benefits in that package will be determined by contributions existing at the time they are purchased.

Mr. STEVENSON. I am going on the assumption that the maximum rates set forth in the bill have been fairly and carefully studied by experts and they represent a fair target, recognizing of course they are on the topside as they must be in any such proposal.

Mr. PORTER. Your thought is that, as with the progressive income tax, this ought not to be harder on the people in the lower brackets by being the same for everyone. It ought to be less for the people in the lower brackets?

Mr. STEVENSON. It should be more equitable relatively with these lower brackets people.

Mr. PORTER. They are the ones who perhaps would require the most care in terms of having children and all the problems of new families. That is an actuarial matter, is it not?

Mr. STEVENSON. That may be true. But this is a social welfare group that can hardly be entirely placed in a financial framework, as I see it, sir.

Mr. REES. So you are saying the person who gets the higher salary, or more income, ought to pay the biggest share of the cost of this legislation?

Mr. STEVENSON. Yes.

Mr. GROSS. He is going to pay more for it, is he not, because he will pay more in taxes and therefore he makes a larger contribution to the Government.

Mr. STEVENSON. This is getting down to the rarified refinements of this, sir.

Mr. GROSS. A lot of us are in space already.

The CHAIRMAN. How long have you been with the Department of Commerce?

Mr. STEVENSON. This is a 40-year service. I missed the first 4 months of the Department of Commerce.

The CHAIRMAN. Are you still an employee of the Department of Commerce?

Mr. STEVENSON. No; I retired in January 1958.

The CHAIRMAN. I thought you were in the high bracket down there.

Mr. STEVENSON. I was in such a bracket that I can afford to do work for the National Federation of Federal Employees without compensation or pay.

Mr. GROSS. I note in your statement you have some doubt as to whether there is going to be some more inflation?

Mr. STEVENSON. I just do not believe it is good psychology to build it into the system or to provide for it.

Mr. GROSS. All right.

I might agree with you but I think we are going to have some more inflation with interest on Government securities going up and so on and so forth.

Mr. REES. I would say you are submitting a very interesting proposal.

Mr. STEVENSON. Thank you.

The CHAIRMAN. What differential would you make in the rates for the higher income bracket as compared to the low-income employees? Let us say an employer making \$15,000 and another employee making \$4,000, what differential would you establish between those two?

Mr. STEVENSON. I would start with the take-home pay level after taxes.

The CHAIRMAN. Let us say one man earns \$4,000 and the other \$15,000.

Mr. STEVENSON. Possibly the difference should be graded so it has some degree of equity as it moves up. That would be my basic principle.

I have not attempted to do this and I am not an actuary.

The CHAIRMAN. Could you give us some examples of employees whose take-home pay is \$4,000, another \$6,000, and another \$10,000? I want to see your plan. How concrete is it?

Mr. STEVENSON. All I am setting forth is a principle. The implementation of it is a matter I would assume is for people who are skilled in the techniques of this sort of thing.

I have been in the international relations commercial side, my friend, and I would not attempt to lay down anything more than this principle and I may say these principles have been approved at the last two meetings of our branch.

The CHAIRMAN. That is the National Federation of Federal Employees?

Mr. STEVENSON. That is right, the Commerce Branch.

The CHAIRMAN. We will next hear from Mr. Joseph F. Thomas, president of the United National Association of Post Office Craftsmen.

Mr. Thomas.

**STATEMENT OF JOSEPH F. THOMAS, PRESIDENT OF THE UNITED
NATIONAL ASSOCIATION OF POST OFFICE CRAFTSMEN**

Mr. THOMAS. Mr. Chairman and members of the committee, it is a privilege to be allowed to present my views before this distinguished committee today.

I appear in support of hospitalization bills introduced by Congressmen Morrison, Davis, and Porter, all of whom have introduced bills identical to S. 2162, which has already been passed by the Senate by a substantial vote.

Hospitalization is a fringe benefit long sought by postal employees and postal unions. It is a benefit which, according to statistics, has already been granted to about 90 million American workers and their families, as well as to the members of the Armed Forces. Actually, it seems as though the U.S. Government employees are the only sizable group not participating in such a benefit.

The bill S. 2162 has been the subject of much study by the Senate Post Office and Civil Service Committee and in my opinion is a valuable and reasonable bill, which would go a long way toward easing postal employees' hospitalization problems at this time. The 50-50 premium payment proposed in S. 2162 is in line with the thinking of our members and would be consistent with the policy used in the granting of other fringe benefits, such as retirement, which recognizes the equal payment policy.

On the other hand, the plan suggested by the Civil Service Commission some time ago is inadequate in most respects. The Commission plan does not provide sufficient coverage, it is too costly for most employees and it is in no sense an insurance bargain. I am not an actuary and have no experience in the insurance field. However, by making a few simple comparisons of Blue Cross and privately sponsored contracts, it is very evident that the Commission plan is not the answer to our problem.

Under the Commission plan even the simplest of surgical operations would result in considerable expense to the individual postal employee and in many cases would surely result in postponement of needed medical care.

It may be of interest to the committee to know that our association conducted a poll of its membership at the time of the last pay raise hearings and we found that 55 percent of our members had no bank account at all, but rather owed money to either finance companies or credit unions. What these people need is low-cost hospitalization, something they can afford to pay for.

Hospitalization has now been the subject of study for a period of about 10 years. There is little need for further study. Postal employees want and need hospitalization. Those in power favor it, as do the Members of Congress. The Senate has presented us with what seems to be a workable and useful bill. I, therefore, request that this committee give prompt and favorable consideration to S. 2162, so that at long last our Government employees may be granted the hospitalization benefits now received by most other workers.

The CHAIRMAN. Thank you, Mr. Thomas.

The committee will now hear from Mr. Ross A. Messer, legislative representative, National Association of Post Office & General Services Maintenance Employees.

Mr. Messer.

**STATEMENT OF ROSS A. MESSER, LEGISLATIVE REPRESENTATIVE,
NATIONAL ASSOCIATION OF POST OFFICE & GENERAL SERVICES
MAINTENANCE EMPLOYEES**

Mr. MESSER. Thank you, Mr. Chairman and members of the committee, for the opportunity to appear before you today. I am Ross A. Messer, legislative representative of the National Association of Post Office & General Services Maintenance Employees, representing the custodial employees of the postal field service and General Services Administration in the 49 States, Hawaii, Puerto Rico, the Virgin Islands, and the District of Columbia.

I wish to thank you, Mr. Chairman and members of the committee, for the interest you have shown in legislation to provide health insurance for the employees of the Government. Especially do we wish to express our appreciation to you, Mr. Chairman, for scheduling hearings on health insurance the same date the Senate approved S. 2162. Bills which are identical to S. 2162 have been introduced by Congressmen Morrison, of Louisiana, H.R. 8210; Porter, of Oregon, H.R. 8211; and Davis, of Georgia, H.R. 8222. We wish to express our sincere thanks to these members of your committee, as well as to the other Members of Congress who have introduced bills on health insurance.

For a number of years bills have been introduced on this subject and hearings have been held. However, this is the first year that it has been possible to get any type of agreement between all parties concerned. This year, for the first time, all groups are presenting a united front.

Our association wholeheartedly endorses the proposals for health insurance as set forth in S. 2162, H.R. 8210, H.R. 8211, and H.R. 8222 in preference to the plan submitted to the Senate Post Office and Civil Service Committee by the Civil Service Commission.

It is our belief that the employees should have an opportunity to select the plan best suited to their individual needs, instead of being blanketed under the general plan as has been proposed by the Civil Service Commission. Facilities in the various parts of the country differ considerably and the providing of benefits which are not available in a particular area would be of little service to the employees concerned if they cannot secure the benefits. It is for this reason that we are of the opinion that the employee should be allowed to select the type of coverage best suited to his immediate needs and available in his particular locality. It is our opinion that the provisions of S. 2162 allow sufficient latitude for the necessary coverages.

We are greatly interested in securing adequate coverage, including major medical. However, the item of cost is foremost in our mind. According to the 1958 annual report of the Postmaster General, the average salary of the 13,919 full-time post office custodial employees was \$3,807 as of June 30, 1958, and the average salary of the 2,344 part-time employees was \$3,317 on the same date.

The Post Office is not the only agency with low average salaries. The average salary of GSA maintenance employees is \$4,051. In 27 States, Hawaii, and the District of Columbia, General Services Administration has full-time employees who are receiving an annual salary of \$3,000 or less.

S. 2162 provides a maximum cost of \$1.75 per pay period for an individual and \$4.25 per pay period for family coverage. As these cost figures are maximum cost figures, it is believed that the Civil Service Commission will be able to work out a plan which will furnish coverage for the lower paid employees without too much financial strain on the employee and his dependents.

In our opinion, the cost of any plan should be divided 50-50, with the Government and the employee paying equal shares. If the cost is not on a 50-50 basis, many of the employees in the lower salary levels will be unable to secure the coverage offered.

Regardless of how good the health insurance program may be, it will be of no value to the employee if it is priced above his ability to meet the cost.

I wish to again thank you, Mr. Chairman and members of the committee, for this opportunity to appear before you today.

The CHAIRMAN. Thank you, Mr. Messer.

We will now hear from Mr. Charles R. Larson, president, National Rural Letter Carriers' Association.

Mr. Larson.

STATEMENT OF CHARLES R. LARSON, PRESIDENT, NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

Mr. LARSON. Mr. Chairman, I am Charles R. Larson, president of the National Rural Letter Carriers' Association, representing 36,725 regular, substitute, and retired rural carriers. This association sponsors health insurance plans for our membership and presently is covering approximately 27,000 persons—members and dependents under those plans.

We are pleased to appear before this committee and express our views relative to the bills under consideration, and in general to comment on the legislative proposal to provide for Government participation in a program designed to assure a sound plan of health benefits for the employees.

The desirability of such legislation is already well-established and adequately substantiated. The Bureau of Labor Statistics show that the majority of workers in the Nation do enjoy such protection financed either in whole or in part by their employers. The U.S. Government should do no less for its employees.

We all recognize that this legislation deals with what at best is a complex problem. We believe, however, that the bills now before the committee provide a program for Federal employee group health insurance which is sound, workable, reasonable in cost, and which provides a fair sharing of the cost. Therefore, we endorse H.R. 8210, H.R. 8222, and H.R. 8211. We want to take this opportunity to commend Congressman James H. Morrison, Congressman James C. Davis, Congressman Charles O. Porter, and other Members of the House for sponsoring the legislation to provide this important and needed benefit for Federal employees. We also want to thank you, Mr. Chairman, and your fellow committee members for holding hearings on this important legislation.

We are strongly in favor of the provisions of these bills which would give the employee a choice of several plans. Employees should not be

blanketed into one type of protection. The opportunity to select will, in our opinion, maintain a healthy and needed area of competition and will likely work to the advantage of the program.

Under such an arrangement, the approval of plans sponsored or underwritten by national associations has considerable merit. First of all, it is giving a recognition which surely is due in that associations ventured in this field and have served well in providing insurance protection to date. In addition, many employees like the identity afforded under such plans, and they appreciate the liaison between the insurance program and themselves which is provided by their association.

Prepaid health insurance is no longer an experiment. It is a necessary protection which can only be adequately provided through the participation of large groups. The group method of insuring has proven its worth. It has helped control costs to the individual and frequently made the difference between proper medical care or the lack of it due to high, sometimes impossible costs.

This legislation is feasible costwise both for the Government and the employee. The enactment of this legislation will be an important day for all employees of the Government. This accomplishment will rank with any other benefits of employment. It will provide an inducement for Government service comparable to that presently provided in many private industries and businesses and will be a great forward step in maintaining a well-rounded personnel program within the Federal Government.

Employees are cognizant that this is not a gift but a joint venture. This is an employer-employee program of a scope which permits maximum protection consistent with reasonable premium costs. Enactment of this program will boost morale and will contribute considerably to the efficiency of the employee. Adequate medical care will be assured, health standards will be improved, and the protection for catastrophic illnesses will stand as a symbol which most private industry may well, for a change, attempt to match with Government instead of the reverse.

Experience with our own insurance program has amply demonstrated the need and value of this type of health protection. In the operation of our program we have learned of the benefits which were made available in many areas where adequate health insurance protection could not otherwise be secured. Our program has also demonstrated the value of group enrollment and shown the financial savings which come through group participation which would be provided in the legislation before you.

Beyond general endorsement of these bills, there are some pertinent comments and recommendations we would like to submit for the committee:

(1) The cost of the program must be kept within the financial means of the employee, otherwise the program will be but an empty gesture. For this reason we strongly support payment of one-half of the cost by the Government.

(2) We strongly favor the establishment of an advisory council with adequate Federal employee representation and urge that such a council be provided for in any legislation reported by your committee.

(3) We would strongly urge that the effective date of the health insurance program be not later than July 1, 1960. In this connection we also urge this committee to expedite hearings and to report the measure to the House as soon as possible. All of us are aware of the need for early action in order that we may have a Federal employees' health insurance law enacted during this session of Congress. Health needs don't wait and every day of delay is, in effect, denying protection which could otherwise be an important part of the personal package of benefits for each and every employee. We feel the need for speed is urgent, particularly in the area of major medical benefits. While these hearings are being conducted there are those who are being subjected to financial costs which will wipe out life savings, or make charity cases out of our fellow employees. Each day's delay is at the cost of personal misery, suffering, and staggering financial burdens on some employees. Admittedly the number who will need the benefits of major medical are small, but, in our opinion, that makes prompt action even more important.

(4) The National Rural Letter Carriers' Association regrets that annuitants under civil service retirement are not included under the provisions of the bills now before the committee. We recommend the fullest possible exploration of a method to extend coverage to our retired employees. We do not believe that our retired employees would object to paying a fair cost for the protection they would receive. Our older citizens today are not complaining about paying for insurance protection. Their objections are to unreasonable costs in relation to the protection provided and, in many cases, the fact that insurance cannot be secured.

Mr. Chairman, we appreciate this opportunity to express our views and present recommendations to the committee. We trust that early favorable action may be taken in reporting the bill to the House.

The CHAIRMAN. Thank you, Mr. Larson.

That will conclude the hearing this morning. The committee will stand adjourned until 10 o'clock Tuesday morning.

(Whereupon, at 12:34 p.m., Friday, August 7, 1959, the committee adjourned to reconvene Tuesday, August 11, at 10 a.m.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

TUESDAY, AUGUST 11, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order. The hearings will be resumed on the various health insurance bills now pending before the committee.

The first witness this morning is one of our colleagues whom we are glad to welcome, Hon. James M. Quigley of Pennsylvania.

STATEMENT OF HON. JAMES M. QUIGLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. QUIGLEY. Thank you.

Mr. Chairman, members of the committee, I appreciate this opportunity to appear before you to add my voice to the many that have testified in favor of H.R. 8210 to provide a health benefits program for Government employees.

For a great deal longer than my time in Congress there have been attempts to provide Federal employees health insurance programs. I am told that they go back a dozen years to 1947 and that these efforts have repeatedly failed because of the deep-rooted disagreements among everybody involved; the employee groups, the insuring groups, the servicing groups, and the members of the administration, and the Congress.

Now, as we all know, that bickering and buffeting has all but disappeared and this measure has the support and endorsement of the American Medical Association, the American Hospital Association, the insurance industry, Blue Cross and Blue Shield, group medical practice plans, and all the Federal employees union. A score of Members of Congress have come before you to urge the adoption of H.R. 8210, and I daresay if there were time enough you might even muster a majority of Members as witnesses in favor of the legislation.

Certainly no one needs to be reminded that the Members of the other body saw fit to pass this legislation by an 81 to 4 majority. I believe that majority speaks as eloquently as any words ever could for the almost universal acceptance of the merits of this legislation. Thus I will keep my own thoughts brief in the interest of time. And I ask you, too, to consider the interest of time.

I stand before you because there is always a danger in the closing days of a legislative session that some measures that are strongly supported and truly worthwhile will fail of passage, even of consideration. That should not happen to this bill. It should be passed this session because it will take time to set up the machinery for the operation of a health insurance program. If we act now, it is possible to have a health benefits program ready for operation by July 1, 1960.

So far as I can see, the only serious objections to this legislation come from 17th Street and Pennsylvania Avenue. There, in the financially myopic eyes of the Bureau of the Budget the cost to the Government of H.R. 8210 seems too high. That one agency, and I might add it seems to be just that one agency in Government, feels that the Government, as employer, should contribute only half as much as the employee rather than its equal share toward this program.

It used to be that Government personnel policies led the way to the future and that it was industry's task to catch up with the enlightened policies of Government in this field. But in health insurance private industry has been the leader for many years.

In passing, I might point out that the Dupont and General Electric companies, to cite just two, pay half the cost of their employee health programs. There are others who pay even a greater share, some who pay the whole cost. Thus, 50-50 cost sharing is hardly a radical departure in such programs. It is, in fact, a compromise designed to meet the Budget Bureau objections.

This legislation is, indeed, long overdue. The time to act on it is now. The end of the session is in sight. I ask you to report favorably on H.R. 8210.

The CHAIRMAN. Thank you, Mr. Quigley. Are there any questions?

Mr. FOLEY. I just want to commend our colleague for his very forthright statement setting forth the value of this program.

Mr. CORBETT. I would just like to ask. Mr. Quigley a question regarding his statement about opposition, that the only opposition that he knew came from, I assume, the White House.

Mr. QUIGLEY. Actually, I meant specifically the Bureau of the Budget. The White House may or may not relay that attitude. As far as I am concerned, the villain in the piece is basically and fundamentally the Bureau of the Budget.

Mr. CORBETT. If you were referring to the White House, I was going to point out that the opposition would be coming from the gentleman's district at the present time.

Mr. QUIGLEY. The gentleman is very much in order in pointing that out. If I am not representing adequately and well my distinguished constituent at the moment, I am afraid I am not.

Mr. CORBETT. More seriously, I think that it ought to be noted that the administration has favored this legislation and it has been under consideration by them for a number of years. It was simply set aside because of the costs of the measure plus the pay raise that was recommended at that time.

I think that we ought to keep the record straight on the facts. The administration is friendly to this bill. There might be some disagreement as to how much the administration feels the Government should pay and how much they feel the employees should pay. Other than that, I would rather have it be we were all pretty much for this legislation.

Mr. QUIGLEY. I would rather have it that way too. As I indicated in my general statement, it was my understanding it was only the Bureau of the Budget, of all of the agencies of the Federal Government, that raised serious objection and their objection was based upon the question of cost.

Mr. FOLEY. I was just going to observe, Mr. Corbett, our colleague mentioned 17th Street and Pennsylvania Avenue rather than 1600 Pennsylvania Avenue.

Mr. QUIGLEY. 17th Street and Pennsylvania Avenue was an oblique reference which may have confused you. I intended to refer to the Bureau of the Budget and not the White House. If that is an important distinction I think that it should be made.

The CHAIRMAN. I think everyone favors the general objectives of this legislation and the purposes of it. There is some disagreement about the contribution on the part of the Federal Government. The Civil Service Commission has a number of amendments which they think should be made which would improve the bill in their opinion. You certainly would not object to any timely amendment to the bill, would you, Mr. Quigley?

Mr. QUIGLEY. Not at all. As I say, I think my basic point in being here today is to urge this committee to do what it thinks it can do, and to do it with dispatch so that there would be a possibility the House could work its will on this in the 3 or 4 weeks we still have remaining in this session of the Congress.

The CHAIRMAN. Thank you very much.

We will next hear from Mr. E. S. Willis, consultant, employee benefits, General Electric Co., New York, N.Y.

**STATEMENT OF E. S. WILLIS, CONSULTANT, EMPLOYEE BENEFITS,
GENERAL ELECTRIC CO., NEW YORK, N.Y.**

Mr. WILLIS. To identify myself, I am E. S. Willis. I am employed by the General Electric Co., where I have responsibility for the overall development and administration of the company's employee benefits plan. I might also say that since its inception I have also served on the temporary health insurance board of the New York State plan for its government employees. I heartily endorse the objective of making health insurance available to Federal Government employees, and the purpose of my appearance here is simply to be of whatever assistance I can to the committee in its most difficult problem of trying to provide a sound insurance program.

My company has had a long history of experience in the health insurance field dating back to the 1930's. The first major medical insurance, which is now the fastest growing group of insurance, was developed in General Electric, and offered to an executive group by the executives themselves in 1949.

In 1951 we were the first, I believe—there may have been others—but I think we were the first company where major medical was also made available to all employees at all levels of the company. This was done in three different plants having about 45,000 employees.

Again, in 1955 we pioneered in developing the comprehensive type of insurance which has now been put into effect in the succeeding 3 years in some 16,000 other plants. This plan is much like the program suggested to this committee by the insurance industry recently.

Our plan was also negotiated with over 90 unions that we have in the company.

In addition to certain general principles that we followed in the company in putting our insurance into effect, there are three or four that I believe may be of some help to the committee to bring to your attention for use in the Government insurance.

The first is we feel that a plan should really help people with their medical bills across the board and not limit protection to just a few areas, such as only hospital and surgical expenses which represent only about two-thirds of the individual's normal medical costs.

We have found that this is helpful in the case of our employees who are now learning that they do not have to go to the hospital to have their medical expenses paid, and the number of 1-day stays in the hospital which can be expensive on a cumulative basis has dropped very radically since we first put this new type plan in in 1955.

Secondly, we believe insurance protection should be applied when and where it is needed and not on the useless payment of the small bills which becomes just a swapping operation in the lower levels.

For example, in our own plan, where we have a \$25 deductible on the hospital and surgical costs, I multiplied the \$25 by the number of claimants we had in 1958—and this, of course, excludes the people who did not turn in any bills because they had not reached the \$25 deductible—and this gave me a total of about \$2,200,000 which was equal to all of the major claims we had over \$2,000 in 1958. That to me indicated these little dribbles can really be helpful when they are applied where the employee really needs them.

The third principle that I thought important was that the insurance plan should solve abuses without putting on more restrictions. We believe that people have an inherent sound judgment and that the insurance plan should encourage this responsibility on the part of the individual and his medical adviser to decide what is needed and what is right and what is best for the individual.

I might say that based upon these principles and others, plus the regular and continuing work we have done with the medical profession and others, we feel that the comprehensive insurance in our company has been quite successful. Obviously, we have had some increases in costs annually, but these increases have always been less than the rise in the Consumer Price Index of medical care, or in any of its component parts, which indicates that the principles are operating successfully.

Based upon this experience on our plan, and based on the experience I have now had in the New York Temporary Health Insurance Board, I have a few suggestions that I would like to make in connection with the bills that are before this committee, especially S. 2162, which went through the Senate, and its companion, H.R. 8210.

These are offered, I might say, entirely in a constructive vein in the hopes of helping the committee in this difficult problem.

First, it seems to me that in the light of existing conditions it is obvious that a decision to give employees a choice is appropriate. There is no question about that. There is also no question it will provide a wealth of administrative complexities, and I present my sympathy to the Government agencies that will have to administer it. But I think as long as the choice is kept within feasible limits this is a sound procedure.

We gave our employees a choice between two plans in 1955. We gave them the choice between the comprehensive plan and a plan that is sort of old-fashioned now—a basic insurance plan with major medical superimposed. At that time, only 4 percent chose the basic plan with major medical superimposed; 96 percent chose the comprehensive type plan. Since then most of these people have shifted over so that at the present time we have less than 2,000 employees, which is about 0.8 percent of our employees, in the basic plan with major medical. The 99.2 percent of employees all have the comprehensive plan. That just shows the good judgment of the employees.

Second, I think that there are many combinations of coverage which are practical and which are sound, but I do believe it is a mistake for the law to specify the detailed benefits as the present bills do in the so-called service plan area. I believe that this will handicap the Government agency that is responsible for developing and administering the law and restricts it to certain benefits which may in time, and probably not too far in the future, become outmoded. As they are now described in the bill, I think they are unbalanced even to start with. Therefore, I would suggest that the description of the section relating to so-called service benefits be as broad as the descriptions that now exist for the other alternatives in the bill.

I believe that a more practical basis of control is simply to set a maximum amount of Government participation in dollars per employee and in percentage of cost. I will discuss that next.

Third, as in the New York program, I believe there should be certain predetermined figures as to the cost of the basic plan, and that this figure is paid—and by “figure” I am referring to a percentage of cost and dollars both—for any employee even if he chooses other alternatives. No more would be paid than for this primary plan regardless of what the other alternative costs.

For example, in the New York State plan the employee coverage in the basic State plan is shared on a 50-50 basis, and the dependent coverage is paid for 35 percent by the State. The dollar equivalents of these amounts in the basic State plan are established and they are used then to reimburse employees who participate in other plans such as the GHI plan and the HIP plan, even though both of these others are more expensive plans.

It seems to me that to pay 50 percent, or 35 percent as appropriate, of the coverage of varying cost plans and more expensive plans in some cases, is unfair to those employees who select a more moderate plan. I suggest that the cost limitations then be based on a sound conservative plan. I think that the so-called service plan, as I have indicated, is now described in the bill, is perhaps unbalanced and seems to me to be unnecessarily costly for the results it produces. The comprehensive type plan with moderate deductible and coinsurance, but broad protection—much as described by the insurance industry recently—costs about 25 percent less as indicated both in the testimony of the insurance people and as compared with the cost of our own plan. Therefore, I suggest the costs of this type of plan be used as a primary plan in evaluating the amounts that are paid for alternate selections by employees.

I feel also that the costs of an insurance plan should be well below the top limit of the bill—whatever limits are established by the Congress—so as to allow room for increases which will occur. While

the GE plan during its first 3 years was within its original premium estimates, the New York State plan as the end of its first year had to have an increase in cost.

The next point I would like to make is that there seems to be some question as to whether the proposed plan would also pay in addition to any workmen's compensation medical benefits. Since this duplication would obviously be unsound, I would recommend the bill be clarified on that point.

The final point that I would like to make is that it seems to me that the Government agency which is designated to do the job of development and administration should be given freedom to do that job and held fully accountable for it.

I recommend that section 12 requiring an advisory council be omitted. In my opinion, it will only handicap the development and operation of the plan, and it could be an unnecessary screen between Congress and the administrative Government agency. This recommendation is based upon experience not only in my own company's plan, but as a member of the New York Temporary Health Insurance Board. The responsibility for the plan, for its future development, for studies of it, and all the other duties described in the bill can be done more efficiently and more effectively by the organization to which responsibility for the plan is assigned—the Civil Service Commission in this case. It will certainly be much easier and more expeditious and more certain for Congress if the full responsibility is assigned to the Government agency and not disseminated in any way to others who are not as conversant with the plan, nor who have the responsibilities with respect to that plan that the agency would have. Those who have lesser responsibilities usually exercise less responsibility.

However, if the Congress feels that there is some advisory group that is necessary, I would urge that this be left up to the Government agency itself to select the kind of council that it needs to help it supervise and administer this program. The makeup of such a council probably would even change between the time of development and the time of operation of the plan.

I am sure that the Government agency involved, whichever one it may be, can easily obtain the technical competence that exists in industry without the hampering effect of a mixed board made up of persons each of whom might have a different purpose and which he is hopeful of attaining.

These purposes in a board, it seems to me, are not always in the best interests of the employees. Sometimes the individuals are rather self-serving. In my considered opinion the council proposed in the bill now is definitely unbalanced and unwieldy, and I am sure that it would not provide the aid desirable and would simply be a happy hunting ground for university statisticians and others.

The Government agency, if it were free to establish its own council, could bring in experts from the carriers, from other sources in industry and elsewhere, and even competent medical advisers if it felt they were necessary, and then it would consult with the employees, but the emphasis in this type of council would be considerably different than in the type of council which is forced onto the agency from the outside.

In conclusion, Mr. Chairman, I would like to say that I appreciate the opportunity of appearing before this committee. I hope that my comments will be helpful in the program ahead of the committee in providing sound legislation so that employees of the Federal Government may have health insurance in the near future and health insurance which is designed and applied along lines that will be of most aid to the employees, and that will also provide a sound example in the field.

Thank you, sir.

The CHAIRMAN. I wish to thank you for the valuable contribution and assistance you have given the committee in considering this legislation.

What kind of plan does your company have for your retired employees?

Mr. WILLIS. We have been experimenting in this area because there is so little known about the cost of insurance in the area of retired employees.

The CHAIRMAN. I am referring to employees who have been covered under your plan and later retired.

Mr. WILLIS. We have had a plan for about 10 years now which provides not only for those who retire, but those already retired, and so far as we have provided benefits for those who retired in the future, we likewise have provided benefits for those already retired.

We have been feeling our way along in this area. I think some people might be critical of the restrictions that we place upon our retired plan. We provide \$1,500 of benefits for the lifetime of the pensioner who has requisite service of 15 years. I do not think that any of us would say that \$1,500 is necessarily an adequate amount, but it is an experiment trying to find out what is the right amount and how we can properly finance it.

As the committee knows, the retired people are somewhere in the neighborhood of two to three times as expensive as the active employees, and of course they have less to pay for insurance. I might say that the amount we pay or provide is provided free of charge.

The CHAIRMAN. The employee makes no contribution?

Mr. WILLIS. No contribution; no, sir. This gives him some freedom to use his money for the purchase of any other coverage.

The CHAIRMAN. How old is your plan?

Mr. WILLIS. Do you mean the pensioners' plan?

The CHAIRMAN. Yes.

Mr. WILLIS. We first initiated that in 1948. We started off with \$250 worth of benefits at that time. That bought more 10 years ago. We have expanded it until it now provides up to \$1,500 of benefits.

The CHAIRMAN. When was your first plan originally adopted—the first medical plan?

Mr. WILLIS. We first had health insurance back in the 1930's in our company and gradually improved that. We put in the first major medical plan in 1949. We put in a company health insurance plan for all employees—not major medical, but just a standard plan—in 1950. Then we provided major medical for employees and at all levels in certain plans in 1951, and in 1955 we developed and pioneered this comprehensive type insurance that we now have in effect. It was negotiated with the unions on a 5-year contract so this is still in effect

where on a union contract, and for all others where we do not have a contract.

The CHAIRMAN. What kind of reserves does your company set up?

Mr. WILLIS. In the health insurance area, since this is carried by the insurance companies for active employees, the only reserves are the standard reserves that the insurance company requires, which are contingency reserves, and reserves for claims and processing, and that sort of thing.

The CHAIRMAN. How much does that amount to?

Mr. WILLIS. Well, the contingency reserve is about 2 percent of the premium. The reserve for claims in process and unreported is a stupendous amount because these are claims that have not yet gotten in. It is almost, in our plan, equal to a half year's claims under the normal procedure because there is always a lag. Then in the retired area we have handled the benefits for retired employees in a trust plan, a trustee plan, if you will, which was originally qualified with the Bureau of Internal Revenue as a plan for this purpose. The Internal Revenue people had qualified it in 1948 and 1950 but since 1955 they are taking another look at it to see if we should continue to use a trust for this purpose. We have not heard from them. If it does not qualify we could probably carry this under an insured plan. This trust has substantial reserves in it. We were accruing those as each person retired. We set aside an amount we estimated would pay for his benefits for the rest of his life. Currently we are not doing that because we cannot use the trust, so our practice is temporarily stopped and we are paying benefits on a current basis, but our intention would normally be to reserve for the retired people.

The CHAIRMAN. Under this legislation what kind of reserve do you think the Civil Service Commission should set up in the beginning?

Mr. WILLIS. Well, in view of the fact that naturally the Government plan cannot be on quite as elastic basis as an industry plan, I think that it would be desirable to have a reserve carried which would provide two things, as I see it. One would be for probable increases in the cost of the plan. Normal plans are going up all the time at the rate of 5 or 6 percent a year. Hospital rates, of course, have gone up much faster than that, but the others are not going up that fast, so there should be enough in the reserve so that these increases for several years should be taken care of. I think if the plan is soundly designed 5 percent would be enough. Our General Electric plan incidentally runs about 4 percent, so we are running behind the normal trend, thanks to the good judgment of the people.

The second type of reserve, I think is undoubtedly a reserve which would build up during the lifetime of employees leading toward the payment of benefits after they are retired. So there are these two types. Of course, there are other reserves that come along. The reserve for epidemics, or an explosion of some kind, or something of that sort—a minor contingency reserve—but I think the carriers usually provide for this so that the reserve that I am talking about I believe would be in the fund that is provided in the bill.

The CHAIRMAN. You do not think that the establishment of the Advisory Council is desirable?

Mr. WILLIS. No, sir, I do not. I have found in serving on the New York Temporary Health Insurance Board this is really a handicap to the operations.

The CHAIRMAN. Does New York State have an advisory council?

Mr. WILLIS. Yes. It is called a Temporary Health Insurance Board. The word "temporary" may be open to doubt. It has been in existence for 3 years now, but it is provided by the Legislature in New York, and of course subject to their determination as to whether it continues or not.

The CHAIRMAN. How is that board or council constituted?

Mr. WILLIS. Four of the members are appointed by the Governor. Those four have been the comptroller of the State, the budget director, the president of the civil service commission, and the commissioner of health.

The other four members are appointed, two by the speaker of the house and two by the president of the senate. I was appointed by the president of the senate.

In my statement about the handicaps the New York Board has been under, I am not referring to any individuals on the board. I mean nothing personal. It is just the way that the board operates. They have to get the eight of us together or a majority, and we have to come to a meeting and each of us, of course, has an ax to grind. As I mentioned in my testimony, I do not think the ax of a board member is always in the best interest of employees. He may feel that it is, but I do not think it always is.

I have found in our own case that we could move much faster, and much more effectively—and I think New York could have moved much more effectively in the development of a plan and its administration—without a board.

I think if you feel a board is desirable it should be one that is appointed by the government agency responsible and is brought in to advise it on its problems. It may have a board of technicians and experts from the carriers, or from industry, or from whomever it wants, to help it on the technical part. It can have a board, much as they do now in life insurance for Government employees, of employees who would advise us as to the feelings of the employees. I think the Government agency should be assigned the responsibility to bring in the experts that it needs.

I also have grave fears that when you have a group who are not fully responsible for anything—and obviously a board cannot be fully responsible because they have other duties—they may serve as a sort of screen, and I think the Congress should be free to go in directly to the Government agency and find out how the plan is operating and what it is doing rather than having to be involved with two different forces, a Government agency and a board.

The CHAIRMAN. What contribution do the employees of the New York government make under the New York State plan and what part does the State contribute?

Mr. WILLIS. For employee coverage the costs in New York State are split on a 50-50 basis, the State paying half of this basic plan. For the dependent coverage, the State pays 35 percent and the employees pay 65 percent. Then the employees who select other alternatives such as the HIP and the GHI, are given the same amount as the State pays for the basic plan. That does not represent the same percentages of the total cost in those alternate plans because they are more expensive than the basic plan. But this is the employees' option—to determine that they want the more expensive

plan even though they get less help from the State than otherwise. I think that is about the sort of split that should be used in the Government employees' plan. I suggest a 60 percent split on the employees' coverage because then you treat all employees the same, whether married or not.

The CHAIRMAN. How does the General Electric plan compare in contributions to benefits with the plans under this bill?

Mr. WILLIS. Well, on contributions, we pay about two-thirds of the employee coverage and we pay about 10 percent of the dependent coverage. The net result is 50-50 overall. It has not quite come out to 50-50. At the moment it is about 48½ to 51½. The employees have to pay more. For 1959 I think it will be on a 50-50 basis. It is a little difficult to compare these in dollars with the Government plan because our plan is a package plan, it has in it life insurance, dismemberment insurance, and it has weekly disability benefits in addition to health insurance, so it is a little hard to compare. But taking just the health insurance I did some arithmetic. I would say that the composite rate, that is taking the employees' coverage and the dependents' coverage, and assuming 60 percent of the employees have dependents, our rates would be somewhere in the neighborhood—the cost of our plan—of \$10.25. The composite cost indicated in the bill for the Government plan is something like \$14 on this same arithmetical basis. So the Government plan at the present time is about 25 percent more than our plan in cost.

The Federal plan as proposed in S. 2162 costs more than the New York State plan at the moment, but I do not understand why because the New York State plan is a little richer than the Government plan in some respects. I think they should, in the long run, come out to be about the same figure. The New York plan is about 17 percent higher than the General Electric plan. I think the State plan and the service plan area in the Government are unduly rich for the benefits they provide. I think that they are not entirely sound. I think a sounder plan would provide lower costs, as indicated by the General Electric plan which costs less than is estimated in either of these cases.

Mr. REES. Could your plan be used under this proposed legislation?

Mr. WILLIS. It could. It is not much different from the plan proposed to this committee by the insurance industry when Mr. Eddy testified recently.

Mr. REES. In other words, we could apply the same program to the Government employees that you apply?

Mr. WILLIS. Yes.

Mr. REES. In your plan?

Mr. WILLIS. Yes. I would be happy to see it done.

Mr. REES. I want to commend you for your splendid presentation.

Mr. WILLIS. Thank you.

Mr. REES. You have done exceptionally well. Your statement is most helpful.

Mr. WILLIS. Thank you.

The CHAIRMAN. Judge Davis.

Mr. DAVIS. You mentioned, I believe—as I recall your testimony—that you had a maximum benefit of \$1,500.

Mr. WILLIS. For the retired employees.

Mr. DAVIS. If a retired person has received a benefit of \$750 while employed, would that be deducted from the maximum of \$1,000 or \$1,500?

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Mr. WILLIS. No. That \$1,500 is all applicable after he retires. Whatever he builds up during his lifetime as an active employee is stopped at the time that he retires. As a matter of fact, if he were totally disabled at the time he retires, the active plan that he had as an employee carries forward until that disability ceases, or 2 years, and then he goes over under the other plan.

Mr. CORBETT. I want to commend the gentleman on a very helpful statement. I wonder if I am summarizing the burden of his testimony correctly in saying that it is your recommendation that the least restrictions that we write into the legislation the better?

Mr. WILLIS. Yes.

Mr. CORBETT. And by eliminating the advisory council, or utilizing an advisory group appointed by the commission, we would then leave the commission free to bargain for the best program possible?

Mr. WILLIS. Yes.

Mr. CORBETT. We would have faith and confidence in them, and then the appropriate committees of the House and Senate from time to time could review?

Mr. WILLIS. That is correct.

Mr. CORBETT. Review what they have accomplished?

Mr. WILLIS. Yes.

Mr. CORBETT. This appeals to me very much because as technical as these things are, if we had a small responsible group with the right to negotiate with the carriers, then certainly we would have less delay and confusion and probably come out with a better program.

Mr. WILLIS. I can say, based on our New York program, you would have much less delay and I think you would have better results.

Mr. CORBETT. We have found already with the advisory council—and perhaps we can understand their motive—that various groups will want someone on there so that a particular type of benefit will be included in the program.

Mr. WILLIS. That is certainly one of the reasons. Another may be to find out about the experience. I do not know that this is it, but in theory the university groups may want to get the figures that are available from such a large group as 2 million employees. Now they may, as a result of the figures, develop some helpful figures, and I am sure they would, but without saying anything against universities I think that there might be some question in that case about their ability to advise in a sound health insurance plan or its administration.

Mr. CORBETT. It is the general idea that if we set up maximum payments, maximum expenditures and draw broad outlines we would do better to let some responsible agency negotiate on behalf of the Government?

Mr. WILLIS. Yes.

Mr. CORBETT. Thank you.

Mr. PORTER. You have a life insurance program too?

Mr. WILLIS. Yes.

Mr. PORTER. Do you deduct from the face value of the life insurance the amount paid out for hospitalization?

Mr. WILLIS. What we have in the pension area is this—back in 1955, when we improved our plan in the medical area we also improved it very considerably in the life insurance area. We went from benefits of about 1½ times annual earnings to about 2 times annual earnings,

and we determined at that time that the increase resulted in better than \$500 more of life insurance for future retired employees. Therefore, in order to give employees in the retired area as much benefit as possible, we decided to start a program as part of this pensioner system under which the \$1,500 that is available to the employee retired benefits would consist of two parts, \$1,000 from the trust fund that I mentioned and the other \$500 would come out of this increase in life insurance. These are future retired people that we use the life insurance for. To quote one of the advertisements it becomes a "living insurance." He can use a part of it while he is alive. His net life insurance, even after using up \$500, if he does, is still equal to what he had before any adjustment from 1955.

Now with respect to the people who retired prior to 1955, who did not have the advantage of this increased life insurance, this full \$1,500 amount is charged to the trust fund and there is no effect on their life insurance.

Mr. PORTER. As for the others, to the extent that there has been an increase, that also might be balanced out against hospitalization charges? In other words, if they have a hospital bill, that would come out of that additional insurance?

Mr. WILLIS. After they went over the \$1,000 then that extra \$500 for the future retirees would come out of the increased life insurance they had, yes. I think that is a sound way to take care of a part of the hospital expenses, leaving a minimum amount available for the employee in case of death, but helping him while he is still alive.

Mr. PORTER. The matter of doctors' fees is something that this committee has inquired about before, and we cannot do anything about it. Your workers, I understand, in Schenectady make about 72 percent of the labor force?

Mr. WILLIS. I am not sure of the percentage. We are a major company in Schenectady.

Mr. PORTER. I understand in Erie and in Bridgeport you also have a good percentage of the workers.

Mr. WILLIS. Yes, with the lowest percentage of the workforce in Bridgeport.

Mr. PORTER. Where you are such a vital factor in a community's life you can exercise a certain amount of influence on the doctors, can you not?

Mr. WILLIS. We possibly can in those communities, but I should point out that we have plants in 135 communities in the United States and of course offices I think in 48 of the 49 States. I think in one of the Dakotas we do not have an office, so our plan is pretty well spread around.

Now, there are certain large plants in some of these older communities where we are an important community influence—in Schenectady predominant; in others, declining, so in the other communities we are frequently a small frog in a great big pond.

Mr. PORTER. What I am trying to get at, though, is you do exercise influence with regard to the reasonableness of fees where you do have a lot of employees.

Mr. WILLIS. I am glad you brought this up because this happens to be one of my pet projects. We have done an awful lot of work with doctors.

Mr. PORTER. With, or on?

Mr. WILLIS. We just cannot do anything on a doctor. They are more independent than anyone else, but we have worked with them and I would like to describe this program.

In some 60 communities where we have plants we have had meetings with the doctors. We have either invited them into our plant or we have met with them when they have had their monthly meetings. It depends on however they wish to handle it. At those times we have explained to them the philosophy, the principles of our plan, so they would understand what we are trying to do and that we are trying to be reasonable, we are trying to help employees on a sound basis, and ask doctors not to take advantage of this plan. Our plan has no limits, we have no surgical schedule, for example, we do not say that an appendectomy is worth \$125, we say that it should only be the reasonable customary fee—

Mr. PORTER. You do not have that established?

Mr. WILLIS. We do not have a schedule.

Mr. PORTER. Whatever the doctor charges you, you pay?

Mr. WILLIS. No. If we think the amount is unreasonable then we will go back and talk it over with them.

Mr. PORTER. In Schenectady you might do better than you would in Eugene, Oreg.

Mr. WILLIS. The anesthetist fees in Schenectady are 8 percent higher than the anesthetist fees of any city that we have tabulated in the United States.

Mr. PORTER. Is that your fault?

Mr. WILLIS. No. It is the anesthetist's fault.

Mr. PORTER. Do you condone it?

Mr. WILLIS. No, sir. We have gone to the medical society and to the anesthetists and pointed out these facts and said we think that they are being unreasonable. We are not going to tell them what are reasonable fees. We will tell them what the percentage is of surgical operations, and what the average fees for some typical operations are elsewhere in the country. This work with the anesthetists in Schenectady is still proceeding. We have not gotten their cooperation, and I am not sure whether we are going to get it or not. We are still working with them and hope they will become more reasonable.

Now, I think elsewhere in the country we have received excellent cooperation from the doctors. We have been very pleased with the cooperation, and it has been entirely voluntary cooperation. We have tried different methods.

For example, in Los Angeles County, which has some 7,000 doctors in it, and that is twice as many doctors as we have employees in the county, we could not obviously have a meeting of the doctors, but what we have done out there is to have an article published in the Los Angeles County Medical Journal. It happens to be an article that I wrote based on a talk out there, just to explain the principles, and since all the doctors in the county receive it they will have a chance to read it. At the same time, the doctors who are working with the General Electric Co. employees, have been sent a letter locally from our manager just calling their attention to this article and suggesting they read it and understand the General Electric plan. This has been done so recently I do not know what the results are in Los Angeles County, but we are trying to extend the same thing to San Francisco where we also have very few employees.

Mr. PORTER. You would suppose that the Civil Service Commission would want to do the same thing—

Mr. WILLIS. Yes.

Mr. PORTER. With respect to a Government plan in order to keep the fees down.

Mr. WILLIS. Definitely.

Mr. PORTER. Would this not be a little beyond the scope of their ability and would not this be something that an advisory council might well do?

Mr. WILLIS. No, I do not think so at all. There are only six of us in New York and we have pensions and insurance, saving plans and everything else. We have used our local people. We have provided our local people with talks in describing the philosophy and the sort of thing they could use in talking to doctor groups. In a very few cases I have gone out, or one of my colleagues has gone out, and talked to the doctors, and then in addition we have endeavored to have the local medical societies, the county medical societies and the State medical societies publish articles in their journals describing the basic principles, and this has been quite effective.

I might say that Dr. Hess, who is a former president of the American Medical Association attended one of our meetings in Erie, where he is a resident physician, and was intrigued with our particular plan, so he wrote an article for the American Medical Journal which went to all of the doctors in the country. It is this sort of thing that gets across. I think the minute the Government takes up a sound type of plan this will be recognized, and that, plus working with the doctors and explaining this to the doctors, is very helpful.

I might say that we have had very few cases where we have had to go to the doctor and tell him that we think his charges are exorbitant. In practically all those cases they have agreed they were, after discussion.

Mr. PORTER. I am sure it should be done. I am sure the Civil Service Commission does not have time to do it.

Mr. WILLIS. They would have to use the Government groups.

Mr. PORTER. I do not think G.E. has a half million employees. I know you have a lot.

Mr. WILLIS. Only 250,000.

Mr. PORTER. I have one other request. You have appeared before the Senate?

Mr. WILLIS. Yes, sir.

Mr. PORTER. And you have appeared here, too. I thought your testimony was very good. You had some excellent suggestions to make.

We will be considering the bill, we hope, in a week within the committee.

If it would not be too much trouble, could you make a list of the particular amendments that you think should be considered in relation to this bill and as close to the exact wording as possible in accordance with your statement?

Mr. WILLIS. I have been busy, so I have only a rough outline statement here.

Mr. PORTER. You mention proposed coverages, and so on. I would be interested in your precise recommendations as to language. I think it would help us a good deal.

Mr. WILLIS. I will endeavor to do so. I am not a lawyer.

Mr. PORTER. But you are an expert in the field.

Mr. WILLIS. I would be glad to be of any help I can in listing these things that I think might be changed. I would be more than happy because I am anxious to see it go through.

The CHAIRMAN. I am sure that will be helpful. If we can prevail on you I am sure it would be of considerable help. Give us the benefit of your advise as to what improvements might be made in the pending legislation, in the Senate passed bill we are considering.

Mr. WILLIS. Yes, sir.

Mr. GROSS. I want to commend you for an excellent statement, Mr. Willis.

Mr. WILLIS. Thank you, sir.

Mr. GROSS. I want to say that I thoroughly agree with you with respect to an advisory council. That is not the only suggestion you made that I agree with, but I particularly agree with that.

This Government is overrun with advisory boards and advisory councils. Some of them might have some merit. In my opinion about 98 percent of them are screens and hurdles which the Congress has had to overcome in order to deal properly with their problems.

The Civil Service Commission can very well be given full responsibility to set up the machinery to properly handle this program, the screening of fees, and so on.

Mr. WILLIS. I think this can pretty much be a local problem with the local medical societies in most cases. We found them generally cooperative.

Mr. GROSS. Are you acquainted with the life insurance program operated by the Government?

Mr. WILLIS. Somewhat; yes, sir.

Mr. GROSS. Do you think there could be a reasonable coordination of these programs?

Mr. WILLIS. You mean put them into one package?

Mr. GROSS. Yes.

Mr. WILLIS. I think there could be; yes.

Speaking somewhat off the cuff here, perhaps the contributions of the Government and the employees to that program might well be taken into account in considering the contributions in this health insurance program, and putting the two together.

I do not think there is a necessity for packaging them but just to take them into account.

There is a lot of feeling, even in industry, about packaging life and health insurance. A lot of people think it is a mistake because there are a lot of girls who do not want life insurance but want health insurance, and this sort of thing.

Mr. GROSS. I am not advocating it at this time. I am simply fishing for information.

If in the suggestions you are going to give to this committee you have further thought on that matter I would appreciate it.

Mr. WILLIS. I think they should be taken into general consideration, certainly, sir.

Mr. FOLEY. How many different insurance plans does G.E. have?

Mr. WILLIS. One plan companywide for all employees at all levels of the company in the comprehensive insurance.

This other plan which I mentioned, which was the standard basic plan, major medical, is available all up and down the company, too. It is the one where we have less than 2,000 employees, however.

Mr. FOLEY. I was curious about which plans were jointly administered under the Taft-Hartley law, between yourselves and the union representatives.

Mr. WILLIS. Neither are really jointly administered. We are operating on a level of benefits program under which we provide a level of benefits at a set employee contribution, a set rate of contribution, and the company pays the difference.

However, we did negotiate both of these plans I mentioned with the unions, the more than 90 unions.

Mr. FOLEY. With the 90 unions?

Mr. WILLIS. Yes.

Mr. FOLEY. Would you say this is a self-administered program by the company?

Mr. WILLIS. That is right.

Mr. FOLEY. It is not jointly administered with trustees from the unions?

Mr. WILLIS. No. It is administered by the company. It is open to the grievance procedure in the unions but not arbitration.

Mr. FOLEY. Are you the administrator for the program?

Mr. WILLIS. I guess you would call me that; yes.

Mr. FOLEY. I can see you have definite experience in this particular field.

You made one comment regarding various principles, one having to do with the proposition that the Federal Government, under this proposed bill, is paying too high a figure, and that there should be a lower figure with some formula written in providing for costs.

I know Mr. Porter requested you give us specific details on these proposals.

I wish you would explain a little more what you have in mind on that particular point.

Mr. WILLIS. What I would suggest is that rather than using the plan that is now in the bill, a service type plan which is rather unsound in my opinion, I would take a sounder type of plan much as the insurance industry has suggested, and I am not saying this because it is the insurance industry. Blue Cross or Blue Shield can provide the same thing.

Mr. FOLEY. Are these plans of yours fully insured other than the one that is self-insured?

Mr. WILLIS. Yes.

I would suggest developing a sound plan which meets certain principles of broad coverage and which is most helpful to employees across the board, and so forth, determining the cost of that plan and using that as the primary plan.

Let us say this plan is a \$15 plan, just to pick a figure.

If you want to pay a certain percentage, you would base it on this \$15 figure.

Mr. FOLEY. Fifty-fifty, 50 percent by the employee and 50 percent by the Government?

Mr. WILLIS. I just use this as an example. We should discriminate between employee coverage and dependent coverage. Suppose we use a 50-50 plan as an example. \$7.50 would be the employee cost and \$7.50 for the Government. This is the maximum.

Then, if the other alternative plans are available to employees, let us say the X plan costs \$20, you would still pay toward that plan only \$7.50, and the employee in his turn would pay \$12.50.

Mr. FOLEY. Pick up the difference?

Mr. WILLIS. Yes. He has the choice of taking the standard plan or taking the more expensive plan, and if he wants to pay for it that is fine.

Does that answer the question?

Mr. FOLEY. I don't know, because it is your idea.

I have been very much impressed by your emphasis on the fact that the Advisory Committee and everyone else, apparently, and I share this view, should be employee conscious, because this a program for employees.

However, in light of that position, I am interested in a statement you made here in your letter of July 23 to our distinguished chairman in the last paragraph.

I suggest that the proposed cost seems excessive because of the undue richness apparently built in.

Would you explain the choice of that language?

Mr. WILLIS. I think the program which has been used as a basis for cost in this bill, as I understand it, which is the service plan and which in the bill provides for hospital, surgical, medical in the hospital, some outpatient benefits which apparently are not quite clearly defined yet, is unduly rich in my opinion.

Mr. FOLEY. I am turning to page 11. Indemnity benefit plan refers to hospital care, surgical care and treatment, medical care and treatment, obstetrical benefits, drugs, prescribed drugs, medicines and prosthetic devices, and other medical supplies and services.

Is that what you had in mind, Mr. Willis, on page 11 of the bill?

Mr. WILLIS. I have only the Senate bill here. Which item is that?

Mr. FOLEY. It itemizes the plan.

Mr. WILLIS. Yes.

Mr. FOLEY. Is that what you were thinking of?

Mr. WILLIS. With the appropriate deductibles and coinsurance that is what I have in mind. It could be an across-the-board plan if it is properly set up so there is individual responsibility by the employee and by his medical people.

Mr. FOLEY. I understand your recommendation to be that the specified benefits set out on page 11 should not be included in the statute. I understand you say there should be no statutory restriction placed on the administering agency as to the benefits to be provided. Is that it?

Mr. WILLIS. What I have in mind are the descriptions on pages 9 and 10 of the bill. I now have it before me.

Mr. WALLHAUSER. You refer to page 9.

The CHAIRMAN. It appears to me you mean that on page 9, where hospital benefits are stated, that the rest of that language should be omitted?

Mr. WILLIS. Yes.

The CHAIRMAN. And also surgical benefits should be omitted?

Mr. WILLIS. Yes.

The CHAIRMAN. In-hospital medical benefits should be omitted?

Mr. WILLIS. Yes.

The CHAIRMAN. And also ambulatory patient benefits and the description there should be eliminated?

Mr. WILLIS. Yes.

Mr. CORBETT. There could be a great deal of wisdom in this. The gentleman feels that if we commission someone to go out and make the best contract they can for the Government employees that they can be trusted to do that and not be hampered by having so much of this, so much of that, and so much of the other.

Mr. WILLIS. That is my feeling on it, that we should not have to be tied down.

It may be, for example, that these in-hospital medical benefits are, in my opinion, already becoming outmoded because we certainly have physician charges that come outside the hospital, so you may not want to tie them down with this kind of a restriction.

I would give the agency a freer hand in developing a well rounded and a sounder plan.

I think this description also would result in a plan that is not entirely sound because it pays right from the first dollar.

Mr. FOLEY. I wanted to crystallize your position. I am happy that my colleagues corrected me. Would you also leave in the statute or would you recommend there be taken out of the statute these specified benefits under that indemnity benefit plan which normally is the type of plan the insurance industry provides? Is that correct?

Mr. WILLIS. Yes, this is one they provide. I think probably the bill could specify that these items, A through F, which are under the indemnity benefit plan, could be placed at the beginning, and you can say these are the general types of benefits which will be provided, A, by service benefit plan; B, by an indemnity benefit plan, and then leaving items 3 and 4, which should be on a comparable basis, I think.

Mr. FOLEY. Does the experience which you have had and which health administrators have had in this field indicate that a health and hospitalization plan accomplishes generally these types of benefits set forth?

Mr. WILLIS. Yes.

Mr. FOLEY. And your suggestion is that reference should be made to these benefits in a disjunctive sort of way, saying these are not all inclusive nor are they specified as mandatory, but they are the types of benefits Congress has in mind in setting up this program.

Mr. WILLIS. That is right.

Mr. FOLEY. Then you would leave to the agency the negotiating for the various types of benefits?

Mr. WILLIS. That is right.

Mr. FOLEY. The way the bill presently is written you are saying the Congress is tying the hands of the agency and requiring this type of plan to be purchased.

Mr. WILLIS. That is right.

If you put a top dollar limit and a top percentage, then you have put the restriction on how far they can go and you should give them freedom to develop the soundest type of plan.

I am sure working with the employees and experts they can do this.

Mr. FOLEY. Let us assume that the present bill goes through as written. The benefits provided for are good benefits, are they not?

Mr. WILLIS. They are too good, yes.

Mr. FOLEY. Would you explain that point, too good? How can they be too good?

Mr. WILLIS. I think they are too rich. They are too expensive. They would result in undue payments by the employee and tying up unnecessary amounts of his money in regular monthly contributions to the plan because it is putting too much into the plan, and correspondingly too much of the Government's money.

Mr. FOLEY. I conclude from what you say that this is a matter of growth. You have indicated in your own program you have increased the types of benefits and perhaps the amounts of the benefits.

Mr. WILLIS. Over the years, yes.

Mr. FOLEY. Based upon your own experience, and the advice that the drafters of the bill have had, this is a full-blown program, is that right?

Mr. WILLIS. It is full blown in some areas but not entirely broad coverage. For example, this plan provides hospital-surgical, in-hospital benefits, and omits physician's services without the hospital.

Mr. FOLEY. Then additional benefits should be set forth, and you are not recommending to the committee that any of these benefits be deleted, restricted, or eliminated?

Mr. WILLIS. I would think the area of A and B, hospital and surgical under the service benefit plan, might be restricted by providing some coinsurance and some deductible, a very modest deductible, which then provides the money available for these other types of benefits. In other words, you have to work on a balanced basis.

Mr. FOLEY. I think your testimony is that under the \$25 deductible program, multiplying all the claims up to that, you came up with a \$2 million figure one year, and comparing that with what you spent for major medical it came out to \$2 million?

Mr. WILLIS. Approximately the same, yes.

Mr. FOLEY. What is the reasoning behind this deductible feature?

Mr. WILLIS. There are at least two reasons. One is that any individual who is employed can pay the small bills up to a minimum limit. There are no problems there. Anyone can afford \$25 in a year's time.

When they begin to get excessive and he gets more than \$25 and it begins to build up, then the plan should come in and help him.

As long as they are in the \$5 category, \$7, \$10 category, for a single bill, or even two or three of these bills, he can afford it.

The second thing is that if we waste money in the insurance plan by just paying these bills, where he hands in a bill for \$5 for X-ray or something, and we hand him a \$5 payment, we are just swapping money. We are not really helping him out.

Mr. FOLEY. Would you explain that further? That does not register with me. Whose money is being swapped?

Mr. WILLIS. He is swapping his own money for it. We are just paying the little things that he can afford to pay. If we wait until this grows into a size that becomes difficult—and I am not sure that \$25 is really difficult—but this is where we have to put it, after it once exceeds \$25 then the plan steps in and helps him out.

Mr. FOLEY. Is your thinking oriented along the line of catastrophic insurance, major—

Mr. WILLIS. No, even modest payments. As a matter of fact, Mr. Congressman, the average benefit in the GE plan is somewhere in the neighborhood of \$175, so we are not talking catastrophic.

Mr. ALFORD. Like all the other Congressmen here, I wish to congratulate the gentleman on his fine statement.

I wish also to make an observation and ask if we are not in agreement with the experience that you have had?

First of all, what we are trying to do is to achieve the greatest benefit for the employees, and the greatest benefit that all Americans need today is catastrophic insurance.

The average Federal employee makes \$5,000 a year and his great trouble is trying to insure himself and his family against this illness that may take him away as the breadwinner of the family for a great period of time and at a great financial loss, so I think we are making a serious mistake in taking his money and purchasing insurance that he is able to pay, and would probably prefer to pay, in small medical bills, just as he would be in the same position relative to his grocery bill or his television set, or servicing things of that sort. I would observe that the greatest need is insurance that will protect the employee and his family against a catastrophe.

Would the gentleman agree to that?

Mr. WILLIS. Yes, sir. I think you are sound and I certainly would agree with you. Unfortunately I believe the trends around have been in somewhat the other direction.

Mr. ALFORD. I think it is unfortunate.

Mr. WILLIS. As frequently happens we sort of compromise. Following the principles you have enunciated, that is why we put in a \$25 deductible in the hospital and surgical and for all the rest we put in \$50, so we have said the most an employee pays out of his pocket as deductible is \$50 in a year.

As you have indicated, an employee can pay this in a year's time on himself and it is much better to be free to pay that when it arises rather than have it tied up in a plan so he is always stuck with this \$50 and somebody else is spending it for him.

Mr. ALFORD. That is my point. Also would the gentleman agree that insurance of that type, which would insure him and his family against catastrophe, would be infinitely less expensive?

Mr. WILLIS. Yes.

Mr. ALFORD. Less expensive than some of these plans dealing with just minutiae?

Mr. WILLIS. We found 28 percent of the costs of the original plan which we had, which was a standard plan paid right from the first dollar, went for the first \$25.

Mr. JOHANSEN. The gentleman from Arkansas and the gentleman from Maryland both have touched on a point which both interests and concerns me.

As written in S. 2162, what discretion and what option does the Government agency administrator have with respect to providing to the employee options in the field of a larger degree of coverage for the catastrophic type insurance?

What flexibility does the Civil Service Commission have with respect to offering options to the employee, and if it is not in the witness' opinion adequate how can we modify the language to increase that option?

Mr. WILLIS. I think in the bill as written, the first part of it, the service benefit plan, provides catastrophic coverage but it is also burn-

ing the other end of the candle by paying from the first dollar, so you get both of them added up and it is high.

Mr. JOHANSEN. How high will catastrophic go?

Mr. WILLIS. Section E, called supplemental benefits, is the major medical. This provides \$1,500 or an additional maximum, as would be determined by the Commission. I believe this is correct. There is, therefore, a catastrophic provision and the Commission could set this figure. In our alternate plan, this is \$5,000 for this type of a major medical plan in a year.

The CHAIRMAN. Do you believe the contributions by the employee provided for in this bill will in any way take care of the benefits of this bill?

Mr. WILLIS. I think they might take care of it the first year. Please understand, I am not an expert on costs. I would prefer to leave this up to the Blue Cross-Blue Shield and the insurance people. This is a sort of half-baked opinion. It would be my opinion, based on the testimony I have seen, which you have received, that the costs specified in the bill would apparently provide the service benefit plan with a small margin, but I am afraid an inadequate margin. But I may be wrong in this. I think the Blue Cross people could speak more adequately to this.

In the indemnity benefit plan, if it is of the type such as General Electric has, there would be a wide margin, because our costs are about 25 percent now below the costs which are shown in the bill here for insurance. So there would be a much wider margin.

I do not know about these other areas.

Mr. JOHANSEN. Is it my understanding that you are suggesting that there be a flexibility given the Civil Service Commission which would enable them to do either of two things—either to increase the insurance coverage of the catastrophic type or the heavier burden type by possibly increasing the amount of the deductible, or to leave the maximum of the catastrophic type where they are but by increasing the deductible reduce the cost to the employee? Which of the two, or is there an element of both?

Mr. WILLIS. I think it is more the latter, Mr. Congressman, if you provide a modest deductible and coinsurance. I would like to mention that. By coinsurance I refer to the 20 percent the employee pays of the bills, where he has a direct interest in the bills, too.

Mr. JOHANSEN. Will you explain that just a little further?

Mr. WILLIS. Yes. The plan provides that the supplemental benefits will be 80 percent of the additional charges. This means that the employee pays 20 percent of the additional charges. So he has a direct interest in those charges. He tells the doctor, "I have a direct interest in how this money is being spent, and if your bill is excessive it just comes out of my pocket, too." The doctor will have an interest and the employee has an interest in it.

So this is a coinsurance. He shares in these areas by a 20 percent corridor, if you will. That is what I mean by coinsurance.

There are many variations which can be made in the coinsurance areas. There are some which have a straight 20 percent up and down, and there is one which is coming in now—I mention this because it is a new thought—which, instead of the flat 20 percent, gradually begins to come over so the coinsurance reduces when you get

up into the very high-cost areas of \$3,000 or \$4,000. This, I think, could be a flexibility item that might be worked in.

In any event, for a sound plan, a plan which does not use excessive costs, with these two items of deductibility and coinsurance you can provide the catastrophic coverage which has been mentioned, and still not have an excessive cost plan. You apply the money where it really is needed, and when the employee is in a tough position, money comes in to help him. When he has only a \$25 bill or a \$5 bill, he does not need that kind of help.

Mr. JOHANSEN. Is not the problem, then, basically one of providing options to the employee so he will not be overinsured in areas where his need is actually least, and whereby he will have the maximum of insurance at reasonable cost where that need may prove to be the greatest?

Mr. WILLIS. Yes, sir.

Mr. JOHANSEN. That is the basic principle.

Mr. WILLIS. Yes, sir. That is a principle I would certainly agree with.

Mr. JOHANSEN. It is your recommendation, then, that there be modification of the legislation to permit greater discretion on the part of the Civil Service Commission in order to provide against that very contingency?

Mr. WILLIS. Yes, sir, to give the most for the right expenditure of money.

Mr. WALLHAUSER. Mr. Chairman.

Mr. FOLEY. Mr. Chairman, I have a couple of questions.

The CHAIRMAN. We shall get Mr. Wallhauser first.

Mr. WALLHAUSER. Mr. Chairman, I, too, have had some doubts about the Advisory Council. I wonder if we shall hear any testimony which will allow the proponents of the Advisory Council to tell us why that section of the bill is desirable. I agree with the gentleman about the Advisory Council problem, and I have been concerned about it. Do you suppose anyone we are about to hear or will hear will be able to tell us?

The CHAIRMAN. Some of the employee organizations' representatives have touched on the Advisory Council.

Mr. WALLHAUSER. I suppose we shall be able to inquire of the Civil Service Commission.

The CHAIRMAN. Yes.

Mr. Foley.

Mr. FOLEY. I do not want to pursue this too much, but I am a little concerned about the characterization of these benefits as "undue richness." I want to get your precise thinking on this. You do not take any issue as to the value or merit of these particular benefits set out here.

Mr. WILLIS. Yes, I do.

Mr. FOLEY. I want to find out which ones you feel are of lesser or greater value.

Mr. WILLIS. Let me say that I think the payment of the first dollar—it may be the first \$25 or the first \$50, somewhere in there—in the hospital area, in the surgical area, and in inhospital medical, lumping them together, is unduly rich and unnecessary.

Mr. FOLEY. Following up the statement which was made by our colleague from Michigan, do you think there is overinsurance in this area?

Mr. WILLIS. Yes, sir.

Mr. FOLEY. Overinsurance for what reason?

Mr. WILLIS. For the first dollar benefits.

Mr. FOLEY. Because it is economically feasible for the individual to pay these himself up to a certain limit?

Mr. WILLIS. Yes, and use the money where he really needs it, when he gets in catastrophic or not even a fully catastrophic, but a difficult situation.

Mr. FOLEY. That is your definition of "undue richness"?

Mr. WILLIS. Yes. In other words, they are using the money for these and are omitting some of the other areas where I think an employee should be insured. For example, take the heart case. A man who does not have to go to the hospital but can be in bed at home and has oxygen and has medical care, who may have to have full-time nursing for a while, is not protected under the first part of the bill here. I think this can be a really severe medical cost. I would prefer to take out the bottom dollars in these other areas and apply them to this kind of case. That is what I have in mind.

Mr. FOLEY. Thank you, Mr. Chairman.

Mr. JOHANSEN. I wonder if what you are actually talking about is not undue richness, but mislocated richness in the sense that it is not insurance where it is most needed.

Mr. WILLIS. I think that is right, yes. I think these are unduly rich because they are misdirected.

The CHAIRMAN. Thank you very much.

Mr. LESINSKI. I am sorry I was called out of the hearing room, Mr. Willis. Is your plan a total of \$25 per year, or for each illness?

Mr. WILLIS. Per year.

Mr. LESINSKI. Is there not a parallel in the auto insurance, the first \$50 or \$100 being deductible?

Mr. WILLIS. It is the same sort of idea.

Mr. LESINSKI. If you have full coverage in auto insurance, it would cost a lot of money.

Mr. WILLIS. It is the same idea, yes, sir.

The CHAIRMAN. Thank you very much, Mr. Willis. You made a very valuable contribution. I hope you will give us the benefit of your suggestions for revisions which can be made in this bill before we go into executive session next week.

Mr. WILLIS. I shall go right after it as soon as I leave here.

The CHAIRMAN. It would be appreciated if you can do that.

Mr. WILLIS. I want to be of help in anything I can do.

Mr. REES. I would make the same observation and hope when we get the legislation going you will cooperate with the Civil Service Commission.

Mr. WILLIS. I have met with them once before, and I shall be glad to continue to help in any way I can.

STATEMENT OF E. A. SHELLEY, DIRECTOR OF PERSONNEL, TENNESSEE VALLEY AUTHORITY, KNOXVILLE, TENN.; ACCOMPANIED BY RUDOLPH F. BERTRAM, CHIEF, LABOR RELATIONS BRANCH, AND LLOYD L. HUNTINGTON, PERSONNEL STAFF OFFICER

The CHAIRMAN. The next witness is Mr. E. A. Shelley, Director of Personnel of the Tennessee Valley Authority; Mr. Rudolph F. Bertram, Chief, Labor Relations Branch; and Mr. Lloyd L. Huntington, Personnel Staff Officer, of the TVA.

How long is your statement, Mr. Shelley?

Mr. SHELLEY. Mr. Chairman, I have a statement which presents in some detail the way in which the two health plans we have in TVA were evolved and the benefits that are provided. If the committee desires that this statement be made a part of the record, I can confine my remarks to a few highlights.

The CHAIRMAN. I wish you would do that because it is now 25 minutes to 12 and we shall have to adjourn when the House is in session. Your statement will be printed in full in the record at this point. I would appreciate your highlighting it for the sake of saving time.

(Mr. Shelley's prepared statement follows:)

STATEMENT OF E. A. SHELLEY, DIRECTOR OF PERSONNEL, TENNESSEE VALLEY AUTHORITY

TVA's interest in a health insurance program for employees dates back to 1946, 13 years ago, when a joint committee of employee and management representatives was established to explore the desirability and feasibility of a broader health insurance program for TVA employees. Protection against unanticipated hospital and medical care costs was recognized as one of the most urgent needs of employees. Group health insurance plans were being developed and industries in the areas were becoming more and more interested in this form of employee protection.

As this committee may know, TVA has long followed the policy of negotiating matters affecting the compensation of its employees and related fringe benefits with its employee organizations on the basis of practices found to be prevailing in private industry and public agencies in the area. This policy is authorized under section 3 of the TVA Act. This section gives the TVA Board broad powers to fix the compensation of TVA employees and to provide a system of organization to fix responsibility and promote efficiency.

In all negotiations with TVA the salary policy (white collar) employees are represented by the Salary Policy Employee Panel, which is composed of the five white-collar employee unions. Similarly, the Tennessee Valley Trades and Labor Council, which is composed of 16 craft unions, negotiates for all trades and labor employees.

On the basis of the joint committee's recommendations in 1946, voluntary enrollment under the statewide Blue Cross-Blue Shield plans was encouraged because these plans seemed to offer the most desirable type of coverage at the lowest cost. At that time membership was limited to groups of employees in established administrative units who could arrange among themselves for the collection of membership premiums. Even so, by the end of 1948, some 75 Blue Cross groups had been formed throughout TVA. Under this system of enrollment, however, it was difficult for employees in small work units and the more isolated work locations to arrange for participation. This difficulty could be removed, the joint committee pointed out, if payroll deductions could be authorized and all TVA employees considered as one group.

In reaching this conclusion the committee was aware that payroll deductions for this purpose had not been authorized generally in the Federal service. Although Blue Cross was by then well established in units of Federal departments and agencies located throughout the country, the collection of membership pre-

miums was handled in each enrolled group by a designated member of that group. The cost of collecting the premiums did not appear, therefore, as a direct administrative expense to TVA, even though collections were usually handled during work hours. Our Joint Committee believed also that when the hidden costs of a voluntary collection system were considered, payroll deductions would not increase but rather decrease the administrative cost of this service. It therefore recommended that payroll deductions be approved.

In February 1949 the TVA Board of Directors authorized the establishment of payroll deductions on a voluntary basis for the collection of Blue Cross and Blue Shield premiums. This payroll deduction plan became effective on May 1, 1949, over 10 years ago.

During the next few years enrollments in the Blue Cross plans increased throughout TVA. By 1955 about 75 percent of our employees had enrolled under the various State Blue Cross plans. TVA did not share in the premium costs of these plans; employees paid the entire amount. By 1955, however, it became clear from our annual wage and salary surveys that a majority of the industries surveyed were contributing to the costs of health insurance plans for their permanent employees. TVA therefore agreed in negotiations with its employee organizations to follow this practice for nontemporary employees. Separate medical insurance plans were negotiated with the Salary Policy Employee Panel and the Tennessee Valley Trades and Labor Council for the two groups of employees. The basic features of these two plans which were developed by joint committees of employee and management representatives are shown in the charts which we have prepared for this committee's information. The detailed provisions of each plan are set out in informational booklets distributed to all employees. Copies of these booklets are available for the use of this committee.

Medical insurance plan for annual salary policy employees

The joint committee which developed the plan for our salary policy employees first made a careful study of the kinds of medical care plans that would be best suited to the insurance needs of salary policy employees and the methods of establishing and administering such plans.

The committee concluded that the most effective means of obtaining the information needed for this study was to prepare specifications detailing the type of benefits desired and to invite bids from insurance companies on these specifications. It sought the advice of qualified consultants in the field of health insurance for this task.

Assistance was obtained from Mrs. Agnes W. Brewster, of the Social Security Administration, and Mr. George B. Buck, Actuary of the TV Retirement System. Specifications were prepared for four hospital-surgical-medical plans:

1. A service-type plan, as normally written by Blue Cross, which provides certain defined services regardless of cost; and
2. Three alternative indemnity-type plans, as normally written by insurance companies, which provide reimbursement within defined dollar limits for each kind of benefit provided. Each of these specifications was designed to give uniform benefits for all employees regardless of geographic location.

Recognizing the need for additional protection against the excessive costs of major illnesses, quotations were also requested on a major medical plan which would be available to employees on a voluntary basis. It was understood, however, that the entire premium for this major medical coverage would be borne by the employees.

The invitations to bid were sent to 34 insurance firms and Blue Cross. The list included most of the large insurance companies in the country that offered group hospital and surgical policies. Fourteen companies submitted bids, eight of which contained proposals on the service-type specifications. The committee decided that the indemnity-type plans were not sufficiently attractive to warrant undertaking the difficult adjustments that would be involved in changing from the service type to this form of insurance coverage. Primary consideration was given, therefore, to the comparative merits of the bids received on the service-type hospital and surgical plans. Evaluation of the bids narrowed the field of consideration to four companies, one of which was Blue Cross. Representatives of these firms were interviewed by the committee to clarify provisions of their particular quotations and to discuss possible variations in benefits to keep the costs within the negotiated limits. As a result of these discussions and further analyses, the committee unanimously concurred in the following recommendations:

1. The basic coverage for hospital, surgical, and medical care as then provided under the Blue Cross-Blue Shield of Tennessee, Alabama, and

Kentucky should be continued, with TVA and the enrolled annual salary policy employee sharing the costs of the monthly premiums on a 50-50 basis for either individual or family coverage.

2. A major medical plan, which would be underwritten by Blue Cross, should be made available; the entire cost to be borne by the employees.

3. All employees retiring after age 60 or for disability should be eligible for continued coverage under both the basic and major medical plans at the same group rates as for active employees; the retiring employees to pay the entire costs.

The major medical plan recommended was designed to protect the employee and his dependents against the excessive costs of major illnesses. It would be available only as a supplement to the basic coverage provided in the Blue Cross-Blue Shield plans. It would provide coverage for any one illness up to a maximum of \$10,000. A deductible amount of \$200 over and above the benefits paid by the basic plan would be paid by the employee. Eighty percent of all additional costs up to \$10,000 (but not more than \$5,000 in any one year) would be paid by Blue Cross and the remaining 20 percent by the employee. No diseases were excluded from the illnesses covered.

The committee's recommendation for the continued coverage of retired employees under both the basic and major medical plans recognized the urgent need of retired employees for the same protection against medical care costs as they had while active employees. Although reliable statistics on the possible cost of these extended benefits were not available, both the committee and Blue Cross believed that the anticipated higher costs of medical care for our retired employees could be absorbed within the established premium rates.

The three recommendations were approved by the salary policy employee panel and adopted by the TVA board of directors on December 5, 1955. The new insurance program went into effect as planned on January 1, 1956.

For the first 3½ years TVA paid 50 percent of the basic Blue Cross-Blue Shield premiums either for individual or family coverage. The employees paid the other half of these premiums plus the entire cost of the major medical plan. The major medical premium is \$1.21 a month for individual coverage and \$2.94 a month for family coverage. No changes in the premium rates for the major medical plan have been necessary during the past 3½ years. Because the costs of the major medical plan have been less than anticipated, the benefit pattern of this plan has been substantially liberalized during the past 3½ years. The \$200 corridor between the basic and major medical plans which was in effect during the first 2 years has now been reduced to \$100. For overlapping or continuous benefit periods this corridor has been further reduced to \$50 to provide assistance to families in greatest need. In addition, the hospital room allowance under the major medical plan has been increased from \$15 to \$20 a day. It is anticipated that the added costs of these new benefits will approximately equalize the income and outgo of the major medical plan in the next few years.

On July 1, 1959, TVA began paying a fixed dollar amount toward the cost of basic Blue Cross-Blue Shield coverage rather than a percentage of these costs in order to reflect more precisely prevailing practices in private employer contributions toward health insurance cost for white-collar employees in the TVA area. TVA now pays \$2.50 a month toward the cost of individual coverage and \$6.50 a month toward the cost of family coverage. This amounts to \$30 a year for individual and \$78 a year for family coverage. This is more than 50 percent of the basic Blue Cross-Blue Shield premium, but is about 50 percent of the total cost of a combined Blue Cross-Blue Shield and major medical premium. At the present time 5,578 out of a total of 6,015 annual salary policy employees (92.6 percent) are enrolled in this plan. Ninety-one percent of the enrolled employees have both basic and major medical coverage while the remaining 9 percent are enrolled under only the basic plan.

Medical insurance plan for annual trades and labor employees

Up to 1956 our trades and labor employees, like our salary policy employees, had insured themselves under the available State Blue Cross-Blue Shield plans. From 1949 to 1956 their premiums were collected through payroll deductions.

In the fall of 1955 the council requested that TVA set up and pay for a comprehensive health insurance plan for all employees represented by the council. A joint committee studied the proposal and reviewed the supporting data collected in the 1955 wage survey. These data showed substantial precedent in prevailing practice for TVA's contribution to the cost of medical insurance for

annual trades and labor employees. Accordingly, the committee set out to develop a plan which would best meet the needs of these employees.

The committee engaged the services of the firm of Marsh and McLennan to help prepare the plan and get it into operation. That firm has continued to serve as consultant to the committee.

Although the representatives of the trades and labor council were aware of the plan adopted for salary policy employees a few months earlier, they were more familiar with experience-rated plans and believed that the employees they represented would more readily understand this type of plan and consequently find it more acceptable. The committee accordingly prepared specifications for a comprehensive experience-rated service-type plan. It invited bids on these specifications from 18 companies. Blue Cross was not included because it had previously indicated to the committee that it would not be interested in bidding on the type of plan the committee had under consideration. Seven of the eighteen companies submitted bids. After a careful analysis of these bids the committee recommended that Provident Life and Accident Insurance Co., Chattanooga, Tenn., be selected as the insurer and administrator of the plan. The recommendation was approved by the TVA board and the plan became effective on October 1, 1956.

The initial premium per month under this plan was \$3.48 for individual coverage and \$10.45 for family coverage. These premiums had to be increased on January 1, 1958, by 20 percent on the basis of the first year's experience under the plan. These rates—\$4.18 per month for individual coverage and \$12.45 per month for family coverage—are still in effect.

In exploring the proportion of the premium cost that TVA should bear, the committee carefully examined the various health and welfare plans in effect in the vicinity. It found so many variations between these plans that a comparison of the benefit patterns was of little help. It also found that most of the plans provided for additional benefits such as life insurance, which are supplementary to hospital and medical insurance. It was agreed, therefore, that TVA and the council would negotiate a flat rate payment which TVA would make toward the premium cost. This payment would be based on the amount which private employers included in the TVA wage survey paid toward the cost of hospital and medical insurance coverage under their plans. On this basis TVA and its employees presently contribute to the cost of the trades and labor plan as follows:

	Coverage for employee only	Coverage for employee and dependent
Employee pays per month.....	\$2.38	\$7.14
TVA pays per month.....	1.80	5.40

The TVA contribution is subject to renegotiation once a year. The negotiations are based on prevailing data secured in the TVA wage survey. In our negotiations which resulted in the change in rates effective January 1, 1958, we made comparisons with 67 firms covered by 56 plans. Our records show that the total amounts spent for medical insurance are increasing and that the contributions of employers toward this insurance are on the upgrade. Our employees have indicated, even in the year in which their premium had to be increased, that they preferred continuing the comprehensive coverage rather than reducing the benefits to cut the cost.

Participation in the plan is open to all annual trades and labor employees. This includes all full-time operating and maintenance employees. It excludes all hourly employees who are engaged on construction and related work and whose appointments are temporary or intermittent. At present about 4,717 employees are eligible. Of these, 4,509 or about 96 percent participate.

The plan provides for the payment of four types of expenses:

Class I expenses are charges made by a legally constituted hospital. Of these expenses the plan pays the first \$500. Of expenses in excess of \$500, employees pay 20 percent, and the plan pays 80 percent.

Class II expenses are charges made by physicians or surgeons for surgical operations. The plan pays 80 percent of these expenses.

Class III expenses are other covered medical expenses. Of these expenses the insured pays the first \$50. Of expenses in excess of \$50 the plan pays 80 percent.

Not included in the above three classes of expenses are maternity benefits. Maternity benefits are provided for in lump sum as follows:

Normal delivery.....	\$150
Caesarean delivery.....	200
Miscarriage.....	75

These benefits are subject to a lifetime maximum benefit of \$10,000 for each insured employee and dependent. This maximum, however, can be reinstated upon recovery and presentation of evidence of insurability.

We have included in the plan a provision which permits employees of age 60 or over to continue a more limited coverage after retirement for the same premium they paid as employees. TVA makes no contribution to the retired employee's premium. It is collected and remitted by the TVA retirement system.

General conclusions

We have worked out satisfactory arrangements with the carriers of the two plans to cover any employee who is transferred from a trades and labor position to a salary policy position or vice versa. Therefore, there is no loss of coverage through waiting periods or exclusion of preexisting conditions for employees who are transferred and must change insurance plans.

With some 3 years of experience under these two health insurance plans, we have found them quite satisfactory. We have had very few complaints from employees and these have usually involved technical questions of coverage. The two committees that were instrumental in developing these plans continue to function as general advisory bodies to TVA and their respective employee organizations. Each year they study the experience data under each plan and recommend such changes in benefits or costs as may be deemed advisable. In addition, they act as liaison agents between TVA and the insurers and review claims of employees whenever satisfactory settlement of disputed claims cannot be secured between the employee and the insurer.

The evidences of the value of our insurance plans to employees continue to multiply as time goes on. We are convinced that health insurance has been a most needed and helpful program to all employees.

We have requested to be exempted from S. 2162, as provided in section 2(a), so that we can continue to handle our health insurance program as an integral part of the total package of pay and fringe benefits which is negotiated annually with our employee organizations. Since substantial precedents for medical-care programs exist in private industries and public agencies in the area, we believe that the continued development of our health insurance program can best be achieved through our annual surveys of prevailing practices and the continued study of experience data under our own plans. The Tennessee Valley Trades and Labor Council and the Salary Policy Employee Panel concur with TVA in seeking this exemption.

Mr. SHELLEY. The first developments in the health insurance program for TVA employees dates back to 1946, some 13 years ago. At that time TVA employees were encouraged to enroll under the state-wide Blue Cross-Blue Shield plans. By the end of 1948, some 75 groups of employees had been established throughout TVA.

In 1949, because of the widespread interest in obtaining coverage for employees in remote locations who could not become a member of a group, the Board of Directors authorized payroll deductions on a voluntary basis for the collection of Blue Cross premiums. By 1955, over 75 percent of our employees had enrolled through payroll deductions.

Mr. GROSS. What is your total employment?

Mr. SHELLEY. About 15,000 now.

TVA was not sharing in the cost of these plans. The employees paid the entire amount. But by 1955, it became clear from our annual wage and salary surveys that a majority of the industries and agencies in the area which we surveyed were contributing to the cost of health insurance plans for their employees. We therefore agreed in negotiations with our employee organizations to follow this practice.

Separate medical insurance plans were negotiated with the Salary Policy Employee Panel, which represents the white-collar employees in TVA, and the Tennessee Valley Trades and Labor Council, which represents the trades and labor or blue-collar employees in TVA.

The basic features of these two plans are shown in a couple of charts which we have for the committee's information. The detailed provisions of each plan are set out in informational booklets which have been made available to the staff of the committee.

This chart shows generally what benefits are provided in the plan for our white-collar workers. The block at the bottom shows the service type coverage of hospital costs under the Blue Cross plan and the schedule of payments for surgical care under the Blue Shield plan.

Above these basic benefits there is a deductible corridor of \$100 which the employee pays. When the employee's expenses exceed this corridor, the major medical plan takes over and pays 80 percent of all remaining costs up to \$10,000 for any one illness, with a limit of \$5,000 in any benefit year. No diseases are excluded from the illnesses covered under the major medical plan.

This plan became effective on January 1, 1956, and for the first 3½ years TVA paid 50 percent of the basic Blue Cross-Blue Shield premiums, the part covered by the lower block, and the employees paid the other half. The employees paid the entire cost of the major medical premiums. The major medical premium is \$1.21 a month for individual coverage, and \$2.94 a month for family coverage.

On July 1, 1959, we began paying a fixed amount toward the cost of basic Blue Cross-Blue Shield rather than a percentage of these costs in order to reflect more accurately the prevailing practices of private employer contributions toward health insurance costs for white-collar employees. We now pay \$2.50 a month toward the cost of individual coverage and \$6.50 a month toward the cost of family coverage.

The CHAIRMAN. What does the employee pay, then?

Mr. SHELLEY. The total cost of the plan varies, because we are covered by three States in Blue Cross. I cannot keep all those State figures in my head. For individual coverage the employee pays 50 cents a month in Alabama, \$1.25 a month in Kentucky, and \$1.45 a month in Tennessee. For family coverage the employee pays \$2.10 a month in Alabama, \$2.80 a month in Kentucky, and \$4.10 a month in Tennessee. In addition, he pays the total cost of the major medical premium. The employee's contribution approximates 50 percent of the overall cost.

At present we have about 5,500 employees out of a total of about 6,000 who are enrolled in this plan. Ninety-one percent of them have both the basic coverage and the major medical coverage.

The other chart we shall show you is our plan for our trades and labor employees. This is a different type insurance plan. It provides payment for three classes of expenses. Class I expenses are charges made by legally constituted hospitals. Of these expenses, the plan pays the first \$500. Of the expenses in excess of \$500, the employee pays 20 percent and the plan pays 80 percent.

Mr. PORTER. If I might interrupt the gentleman, because I shall have to leave in a moment, I see from your statement you want an exemption for your plan. You want the exemption because you have a plan which is working well. Could you not phrase that that you

want to be included but allowed to have your own plan? In other words, an amendment to the present bill.

I understand plans like yours are eligible to be certified and included under our general plan. Have you drafted any language which would either exempt you or include you?

Mr. SHELLEY. Of course, the proposed legislation, both H.R. 8210 and S. 2162, provide for exemption of TVA.

Mr. PORTER. For TVA and others, too.

Mr. SHELLEY. Yes; not only TVA.

Mr. PORTER. Other groups are exempt under the present legislation.

Mr. SHELLEY. Yes.

Mr. PORTER. Then you are happy with the bill as it is written now.

Mr. SHELLEY. That is correct.

Mr. PORTER. In other words, you are just trying to inform us.

Mr. SHELLEY. We were asked to tell you of our experience. Our major reason for asking exemption is so we can continue to handle them as a total part of our package of pay and fringe items which are negotiated with employees.

Mr. PORTER. On what page is that shown?

Mr. GROSS. Page 11, paragraph 3. That is one place.

Mr. SHELLEY. In the Senate bill it is on page 2 at the end of the first paragraph.

The CHAIRMAN. The Tennessee Valley Authority's exemption appears on page 2 of the Senate-approved bill.

Mr. PORTER. You are the only governmental corporation exempt, then, are you not?

Mr. SHELLEY. I suppose that is right.

Mr. PORTER. To your knowledge, are there any other governmental corporations which are in a similar situation?

Mr. SHELLEY. I do not know of any others which have developed plans such as we have or which have them as a part of their total pay and fringe benefit package.

Mr. PORTER. You do not see any advantage to your being sort of autonomous under this act, being allowed to run your own show the way TVA does generally, being autonomous but under the general jurisdiction of the Civil Service Commission with regard to this plan?

Mr. SHELLEY. The way the exemption is provided in the two bills at present would be preferable.

Mr. PORTER. You are perfectly satisfied with the present language?

Mr. SHELLEY. Yes.

Mr. PORTER. That is all.

The CHAIRMAN. You may proceed. Have you anything further?

Mr. SHELLEY. I might mention where I was on this chart. I believe I had gotten to the class II expenses, which are charges made by physicians and surgeons for surgical operations. That is co-insurance, 80 percent paid by the plan and 20 percent by the employees.

Class III expenses are other covered medical expenses, of which the insured pays the first \$50 and then it is on an 80 percent-20 percent basis.

The cost of this plan for individual coverage is \$4.18 a month, of which the employee pays \$2.38 and TVA pays \$1.80. The cost of

the family coverage is \$12.54 a month, of which the employee pays \$7.14 and TVA \$5.40.

We have now about 4,500 out of 4,700 blue collar employees who are enrolled in this plan.

Both plans provide for continued coverage of retired employees, but with somewhat different provisions and with the retired employee paying the total cost.

Mr. GROSS. May ask the gentleman a question. Why is there a difference of \$4.10 in Tennessee and \$2.10 in Alabama?

Mr. SHELLEY. The Blue Cross has basic State plans in each State, and our employees are located in the three States. The employees located in Alabama, for example, are under that plan.

Mr. GROSS. What makes the rate vary so greatly? Is it the setup they have in the particular State which makes the rate so much higher?

Mr. SHELLEY. That is correct. They have adjusted their premiums at different times. Tennessee just this year made an increase in premium, and Alabama has not had one for a couple of years.

Mr. REES. All of your employees are under either Blue Cross or Blue Shield or both, is that correct?

Mr. SHELLEY. No. There is one group of employees, our temporary employees, who are not covered by these two plans on joint participation or contributions. They are eligible for the basic Blue Cross-Blue Shield by paying the total premium, but they are temporary employees.

Mr. REES. All of your employees are protected under Blue Cross or Blue Shield?

Mr. SHELLEY. That is correct.

Mr. REES. You want to continue them under Blue Cross-Blue Shield as they are, is that it?

Mr. SHELLEY. Yes. This trades and labor plan is not Blue Cross-Blue Shield. It is written by the Provident Life & Accident Insurance Co. in Chattanooga.

The CHAIRMAN. The TVA is interested in being exempted from the present legislation.

Mr. SHELLEY. That is correct, sir.

The CHAIRMAN. The Senate-passed bill does it definitely.

Mr. SHELLEY. That is correct.

The CHAIRMAN. You ask for the same exemption over here before the House committee.

Mr. SHELLEY. That is right.

The CHAIRMAN. I do not understand that wide variance of cost among the States—Tennessee, Alabama, and Kentucky. Do the plans provide for additional benefits in Tennessee than in Kentucky or Alabama?

Mr. SHELLEY. The basic costs vary somewhat between Tennessee and Alabama. I think the major reason for the wide variation now is that the Tennessee plan has just raised its rate. We think Alabama probably will.

The CHAIRMAN. I was referring to the benefits.

Mr. SHELLEY. The benefits are essentially the same.

The CHAIRMAN. There is quite a wide disparity between the charges in Tennessee and the other States.

Mr. GROSS. If they have to raise from \$2.10, they have a long way to go to catch up with Tennessee at \$4-and-something a month. I still am in the dark on the reason for that.

SOE HEALTH BENEFITS FOR FEDERAL EMPLOYEES

The CHAIRMAN. I do not understand that down in my own State.

Mr. SHELLEY. I think the Tennessee Blue Cross recently raised their rates, and they had not raised their rates for several years.

The CHAIRMAN. Did they extend further benefits?

Mr. SHELLEY. They extended further benefits also, increasing the number of days of hospitalization provided, for example.

The CHAIRMAN. They have more liberal benefits than Alabama and Kentucky have?

Mr. SHELLEY. In some respects, yes.

The CHAIRMAN. Do you think that largely accounts for the larger cost in Tennessee?

Mr. SHELLEY. It is a combination of difference in benefits and the fact that Alabama has not yet raised its rate. I think also the Tennessee plan hoped that by making the increase they have made this time, it would not be necessary to make another increase for several years.

The CHAIRMAN. You want your entire statement in the record, do you?

Mr. SHELLEY. If the committee so desires.

The CHAIRMAN. That will be permitted.

Do the gentlemen accompanying you desire to make any statement?

Mr. SHELLEY. Not unless someone has a question.

The CHAIRMAN. Have you any observations to make, Mr. Bertram?

Mr. BERTRAM. No, sir.

The CHAIRMAN. Mr. Huntington?

Mr. HUNTINGTON. No, sir.

The CHAIRMAN. Are there further questions?

Mr. JOHANSEN. Mr. Chairman, I had to be absent from the room. Was there an indication of the amount of the increase in rates for Tennessee?

The CHAIRMAN. He said there had been an increase this year, he understood.

Mr. SHELLEY. It was about 20 percent.

Mr. JOHANSEN. In other words, even before the rate increase there was a considerable differential between Tennessee and Alabama.

Mr. SHELLEY. There was some differential, yes, sir.

Mr. LESINSKI. How are the employees of the Tennessee Valley Authority paid?

Mr. SHELLEY. I am not sure I understand the question.

Mr. LESINSKI. Do the funds for the employees come from the profits from power, or from public funds?

Mr. SHELLEY. They come both from appropriated funds and from corporate funds. Some of our programs are appropriation financed. Our power program and our chemical program are largely financed from revenues.

Mr. LESINSKI. What percentage of employees receive salaries from appropriations?

Mr. SHELLEY. It would be purely a guess, but I would guess 10 to 20 percent.

The CHAIRMAN. I thank the gentleman very much.

The CHAIRMAN. The last witness this morning is Mr. Marvin J. Cetron, engineering assistant to the Technical Director of Material Laboratory, New York Naval Shipyard, Brooklyn, accompanied by Mr. Albert R. Allison, head of the Chemistry Branch of the same laboratory.

These gentlemen have been scheduled at the request of our colleague, Representative Francis E. Dorn, of New York.

We shall have to quit in a few minutes.

Mr. LUTZER. Mr. Chairman, one correction. My name is Lutzer. I am here in place of Mr. Allison, who unfortunately could not make it.

STATEMENT OF M. J. CETRON, CHAIRMAN, LEGISLATIVE COMMITTEE, NEW YORK CHAPTER, AND I. LUTZER, MEMBER, NATIONAL LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF NAVAL TECHNICAL SUPERVISORS

Mr. CETRON. My name is Cetron. I should like to read into the record our very brief statement, and of course will be available for comments on it. I am the chairman of the legislative committee of the National Association of Naval Technical Supervisors, New York chapter. The statement, however, will be from both ourselves and from Mr. Allison, the chairman of the national legislative committee.

The National Association of Naval Technical Supervisors advocates enactment of H.R. 7712. The National Association of Naval Technical Supervisors is made up of the managerial level of civilian technical employees GS-12 and above. In all of the 11 naval shipyards and in one of the major laboratories of the Bureau of Ships and the field service of the Department of the Navy, the association itself has 800 members in these higher grades, but we are responsible for the efforts of a total of more than 4,000 scientific, technical, and engineering personnel in various naval establishments across the Nation and in Hawaii. These technical people are engaged in the design of nuclear propulsion systems, antisubmarine warfare systems and guided missilery and they constitute a substantial portion of the entire technical personnel employed by the Navy. It is in the interest of both the members of the association and of the employees that are supervised by us that we are testifying here today. As members of this association we view this matter as a management problem. We find it difficult to attract and retain qualified people who are to carry out the scientific and technical missions of the Navy Department.

The Government has traditionally been the leader in providing fringe benefits and employment advantages which industry has consistently followed in due time, but today the situation is reversed. The Government has been surpassed by industry in the field of progressive employment policies, especially so in the area of fringe benefits. If H.R. 7712 is passed, even though the Government would not pay the same proportionate share of the total bill as most private companies do, it would still be a step in the right direction to adjust the present situation.

The Government should regain the lead now held by industry and accept its responsibility by enacting legislation to help defray the expense of a good medical and health insurance program. The passage of this legislation would afford the following advantages to the Government:

- (a) Will aid in the recruitment of technical and scientific personnel.
- (b) Will aid in the retention of technical and scientific personnel.
- (c) Will improve the morale of career personnel.

It is a well-known fact that fringe benefits constitute a significant part of the overall remuneration of employees of both Government and industry. In the New York area 9 out of 10 of our major competitors in recruitment of engineers and scientists have health or catastrophe insurance benefits fully paid for by the employer.

During recruitment interviews the major medical area is painfully avoided. The applicant, however, well aware of the fringe benefits commonly offered by outside industries, invariably raises this issue. Such remarks as, "You mean the Government doesn't have this coverage?" or "Why doesn't the Government have medical coverage? The other two companies I was interviewed by did," are common during any recruitment college session. Comments like these point to an obvious weakness in our recruitment program. Couple this with the statements contained in the "Engineers Joint Council Report on Professional Income of Engineers, 1958" and "The 1958 Survey of Professional and Scientific Salaries" released by the Los Alamos Scientific Laboratory of the University of California and you can see clearly that the Government's scientific and professional salaries lag by at least 15 percent below the average.

It is our observation that remuneration, a natural consideration in the engineering or scientific graduate's mind, is not the sole factor in choosing a position. However, we are of the opinion that a candidate sets a minimum limit on salary and fringe benefits below which he will not go. It seems obvious to us as Government recruiters that a salary differential of 19 to 36 percent is appreciable enough to be below that limit without having fewer fringe benefits. Table 1 gives a comparison of the salaries offered recent graduates by industry and Government in the New York area. The differentials shown are not substantially different from those of the national averages. The disadvantageous position of the Government would definitely tend to be overcome by the availability of a health benefits program.

As far as the retention of engineers is concerned, generally, those who stand in greatest need of this medical provision will be our older and more technically qualified engineers and scientists representing a large percentage of the key personnel of the naval technical force. In addition, the newer or more recently hired employees who have spent a shorter time in Government service have been disillusioned by lack of remuneration and opportunity are more susceptible to the lures of industry principally because of the offers of greater fringe benefits and prospective greater overall remuneration.

As an illustration in the problem of retention, the material laboratory's Polaris program effort was to be increased by 18 employees to bring it up to full complement. From the period of February 1 to November 31, 1958, the attrition rate was so high that even though 30 people were hired to fill these 18 positions, only 14 remained on board. It can be readily seen in table 2, the overriding reason for most of these individuals leaving was unequivocally the economic factor (salary and fringe benefits). As was brought out before, fringe benefits are very close to salary and since each of the fringe benefits has a tangible dollar value, passage of this bill will afford some relief in the retention situation.

From the standpoint of improved morale and performance, there is a third class of individuals who are dedicated, career employees with no intention of seeking employment in private industry. These men

and women constitute the backbone of the productive and creative effort in the technical force of the Federal Government. In order to maintain this segment at maximum effectiveness, it is not only desirable but necessary to remove from them the burden of the potential expense which major illness and disability may bring, in order that they may be better able to concentrate their full potential in accomplishing the Navy's mission.

Security has always been a basic factor in the employment of many of our technical and professional staff, but of late faith in this security has been shaken by program retrenchment. While patriotism and dedication must of necessity be primary considerations, the obligation and security a man owes to his family cannot be ignored. Enactment of this bill will tend to hold some of our better technical personnel in the face of offers from competitive industries who have this medical fringe benefit. For the average Government employee, a serious illness could drop him into an economic abyss that might take him years to climb out of, if at all. This threat looms menacingly before him in the light of the actuarial claims that one member out of every family will undergo some form of surgery every 3 years. The Government cannot expect full and effective performance from its employees under these conditions.

In summation, one of the major reasons the Government is having trouble recruiting and retaining qualified technical personnel is directly traceable to higher salaries and fringe benefits offered by private industry. There are, of course, other reasons why people leave or will not assume Government technical positions but these are secondary and almost always overshadowed by or indirectly related to economic factors such as salary or fringe benefits. The National Association of Naval Technical Supervisors believes that enactment of this bill is directly alleviative of this problem and, therefore, recommends immediate passage of H.R. 7712.

TABLE 1.—Survey of starting salary levels of recent engineering graduates in the New York area

	Number in sample	Average salary per month			Upper decile average salary	
		All branches of engineering	Electrical engineers	Mechanical engineers	Electrical engineers	Mechanical engineers
City College.....	225	484	491	478	607	567
Columbia University.....	65	489	500	500	543	519
Cooper Union.....	56	479	497	488	560	546
Manhattan College.....	250	480	480	-----	600	600
New York University.....	82	494	500	487	-----	-----
Polytechnical Institute.....	377	487	503	493	600	625
Pratt Institute.....	08	489	499	467	600	540
Stevens Institute.....	110	472	-----	472	-----	550
Total.....	1,213	484	496	484	585	564
Civil service salary (GS-5) lower 3d quarter.....		374	374	374	-----	-----
Upper quarter of class (GS-7).....		-----	-----	-----	452	452

NOTE.—
 \$1,320 per annum more paid by private industry to average, all branches of engineering or 29 percent higher.
 \$1,464 per annum more paid by private industry to average, electrical engineering or 33 percent higher.
 \$1,320 per annum more paid by private industry to average, mechanical engineer or 29 percent higher.
 \$1,536 per annum more paid by private industry to average, top electrical engineers or 36 percent higher.
 \$1,324 per annum more paid by private industry to average, top mechanical engineers or 19 percent higher.

TABLE 2.—Summary of material laboratory Polaris resignations from Feb. 1 to Nov. 31, 1958

Name	Grade	Duty dates	Reason	Salary increase
1. Mr. F.....	GS-7..	Oct. 21, 1957, to Oct. 10, 1958.....	Better remuneration.....	\$1,200
2. Mr. S.....	GS-5..	Jan. 28, 1958, to Aug. 29, 1958.....	do.....	1,500
3. Mr. H.....	GS-5..	Feb. 10, 1958, to May 16, 1958.....	do.....	2,000
4. Mr. S.....	GS-5..	Mar. 10, 1958, to Sept. 2, 1958.....	do.....	(?)
5. Mr. R.....	GS-5..	June 23, 1958, to Aug. 22, 1958.....	do.....	(?)
6. Mr. C.....	GS-5..	June 16, 1958, to Oct. 29, 1958.....	do.....	1,250
7. Mr. A.....	GS-7..	Jan. 23, 1958, to Oct. 16, 1958.....	Sea trips interfere with graduate study.	1,500
8. Mr. S.....	GS-5..	Oct. 12, 1958, to Nov. 19, 1958.....	do.....	2,000
9. Mr. H.....	GS-5..	Feb. 10, 1958.....	do.....	(?)
10. Mr. W.....	GS-7..	Feb. 24, 1958, to Oct. 31, 1958.....	Health and pressing school studies.	(?)
11. Mr. D.....	GS-7..	Aug. 14, 1957, to May 6, 1958.....	Military service.....	-----
12. Mr. B.....	GS-5..	June 25, 1958, to Oct. 5, 1958.....	Reassigned.....	-----
13. Mr. S.....	GS-9..	June 17, 1955, to Nov. 21, 1958.....	Better remuneration.....	2,500
14. Mr. H.....	GS-5..	Did not report.....	do.....	1,000
15. Mr. D.....	GS-7..	Sept. 16, 1957, to Apr. 18, 1958.....	do.....	(?)
16. Mr. S.....	GS-5..	Feb. 24, 1958, to Mar. 4, 1958.....	do.....	(?)

Summary: 10 better remuneration; 4 school; 1 military service; 1 reassigned (could not work Saturdays); average increases, \$1,620.

NOTE.—The laboratory in trying to keep up to a ceiling of 18 additional men in this project has hired a total of 30 men with only 14 remaining on board.

The CHAIRMAN. The time is growing short. The House will soon be in session. Will you tell us whether you are for or against this legislation, and why?

Mr. CETRON. We are absolutely for it, and the reason we are for it is that we need this legislation. We are actually behind private industry, and especially so in our area.

I was commenting to my colleague on the rates in Tennessee and Alabama being \$2.10 and \$4.10. We are paying for Blue Cross and Blue Shield right now, and it is costing me, as a family man, \$8.74 per month.

The CHAIRMAN. Where is that?

Mr. CETRON. New York City. So, if there is a big discrepancy, I do not know why the larger discrepancy should be in New York.

Mr. LESINSKI. I am paying \$12 a month.

Mr. CETRON. Any help in this area would be greatly appreciated, and it would give us a talking point—something which we do not have at the present time—when we go to colleges and universities trying to recruit engineers.

Mr. REES. Are you a member of a group at the New York Naval Shipyard?

Mr. CETRON. We have a group, that is correct. We have a group insurance policy at the yard.

The CHAIRMAN. You do not have a medical plan?

Mr. CETRON. We have Blue Cross and Blue Shield.

Mr. REES. You want to be included in the program?

Mr. CETRON. We definitely would like to be included.

Mr. REES. You represent a group of salaried people of about how many?

Mr. CETRON. We represent 4,000 scientific and technical people throughout the country, as I mentioned before, in the 11 shipyards and in the laboratory and the New York shipyard. We definitely believe this is necessary. We believe it is long overdue, and the sooner we get it the better off we will all be.

Mr. REES. Has your colleague any statement to make?

Mr. LUTZER. Yes, Mr. Chairman. I would like to make a statement as the representative of the design division. We, too, are for this bill, and of course our greatest concern is in recruitment. I feel, if the bill is passed, it will give us a chance to keep the people we are recruiting. It takes years of experience; and once they are trained, if they find benefits outside which are far greater than we can offer, of course they leave. If this bill is passed and we can offer them something on a par with private industry, I feel we can keep them. Based on that, of course we are all for it.

Mr. REES. You have no amendments to offer?

Mr. LUTZER. No, sir.

Mr. CETRON. I do not believe so.

The CHAIRMAN. Thank you very much, gentlemen.

Mr. CETRON. Thank you.

The CHAIRMAN. The committee will now stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12 noon, the committee adjourned, to reconvene at 10 a.m., Wednesday, August 12, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

WEDNESDAY, AUGUST 12, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m. in room 215, House Office Building,
Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be continued on the various health insurance
bills for Federal employees.

I have received a statement from our colleague, Representative
Thomas B. Curtis, which will be inserted in the record at this point.
(The statement follows:)

STATEMENT OF THOMAS B. CURTIS, A REPRESENTATIVE IN CONGRESS FROM THE
STATE OF MISSOURI

Mr. Chairman and members of the committee, I wanted to go on record as
expressing my interest in the hospital and health legislation for Federal workers.
Certainly personnel practices for Federal employees must be sufficiently good
that competent persons will be willing to remain in Federal service instead of
going to more attractive jobs in private enterprise.

As a matter of fact, our personnel practices should be sufficiently good that we
can recruit the competent employees necessary in order to carry on the function
of the Federal Government. This is just a matter of commonsense and good
economics. I have always felt that the Federal Government should be somewhat
ahead of private enterprise in its employment practices, which includes adequate
salaries, retirement, fringe benefits, and working conditions, in order to set an
example to private enterprise.

It is my understanding that many private employers have hospital and health
insurance for their employees. Certainly the Federal Government as an em-
ployer should have been doing more in this area than they have. I do not know
the pros and cons of the particular measures and I am merely lending emphasis
to the fact that I think the Federal Government as an employer should be
moving ahead in this area.

The CHAIRMAN. We have with us this morning, Dr. Sterling
Mead, one of the outstanding oral surgeons of the Nation. I have
had the pleasure of knowing him for several years. We are very glad
to have him here this morning. He was formerly the president of the
American Dental Association. I recall meeting Dr. Mead several
years ago when he relieved me of intense pain and misery. I was
suffering from extreme jaw trouble, and in a few minutes he relieved
me of my pain.

Mr. REES. Mr. Chairman.

The CHAIRMAN. Mr. Rees.

Mr. REES. I, too, want to recommend Dr. Mead this morning.
I had an experience similar to that of the chairman. But I want to
introduce him also as being a Kansan.

The CHAIRMAN. That adds to his stature also.

STATEMENT OF DR. STERLING G. MEAD, WASHINGTON, D.C.

Dr. MEAD. Thank you.

Mr. Chairman and members of the committee, I am particularly interested in the legislation before your committee. I am past president of the American Dental Association and past president of the District Dental Association, and have practiced dentistry in the District for over 45 years.

It is impossible to separate dentistry and medicine in any health measure. Oral surgery is an integral part of surgery in any part of the body. You cannot separate many of those different types of surgery from surgery in any part of the body, and I trust that this bill which you are now considering will take recognition of surgery in the mouth by the dentist.

The CHAIRMAN. Doctor, exactly what does oral surgery include?

Dr. MEAD. Of course that is a thing for this committee to determine. Quite often in many of the insurance plans it includes such things as tumors, cysts, fractures, and simple extractions are not always included but impactions are usually included. Impacted teeth are as difficult or more difficult than any other surgical procedure.

The CHAIRMAN. I believe you have a hospital in the District of Columbia?

Dr. MEAD. Yes. I have had a hospital about 40 years. I have a hospital licensed by the District and approved by the American Medical Association, and it will be approved by the American Dental Association.

The CHAIRMAN. Any questions? Mr. Rees?

Mr. REES. No questions.

The CHAIRMAN. Mr. Porter?

Mr. PORTER. Doctor, are you familiar with this bill?

Dr. MEAD. Yes, I think I am fairly familiar with it.

Mr. PORTER. Do you think this bill should be changed?

Dr. MEAD. No, not necessarily. I am only interested in putting in the minds of the framers of this bill the recognition of oral surgery done by the dentists. I have been assured, I think, by the comments in the Senate, that it is intended that oral surgery is to be included in the bill. That is the intent, and the intent over there too was that it should be done by the dentist. I wanted to be sure in the House there would be the same intent as in the Senate. If the dentist was not specifically brought into the bill, somebody without the training of oral surgery could do the surgery without the dentist, and the dentist is more efficient in doing surgery in the mouth than those who do not have the training of the dentist.

Mr. PORTER. You are a surgeon yourself?

Dr. MEAD. Yes. I only do oral surgery.

Mr. PORTER. Do you believe other services by dentists should be included in this bill too?

Dr. MEAD. Of course, it would be nice to have all services included, but I know there are many factors you are considering, and I think we have to be reasonable. But I think that surgery is the thing that is the most important consideration of this bill.

Mr. PORTER. We want to be reasonable, and we want to take testimony from people like you as to whether the bill should include other services by dentists.

Dr. MEAD. I am sure the Dental Association would like to have other services included. When you get into other services I think the question of cost always enters into it.

Mr. PORTER. You do not think prepayment plans for dental services have proved themselves yet?

Dr. MEAD. I think it is coming to that, but it is in the experimental stage now. The American Dental Association is working on experimental plans now.

Mr. PORTER. And eventually you think they should be included?

Dr. MEAD. That is correct, eventually.

Mr. PORTER. Thank you.

The CHAIRMAN. Any further questions?

Mr. FOLEY. Mr. Chairman.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. Along the line of Mr. Porter's questioning, Doctor, there are programs that are in effect throughout the country where—under, through various health and welfare programs, dental clinics have been established, are there not?

Dr. MEAD. Yes; that is correct.

Mr. FOLEY. And of course those dental clinics are a little different from the various types of health and welfare insured benefit programs that deal with the payment of hospitalization cost and medical services costs; is that right?

Dr. MEAD. That is right.

Mr. FOLEY. For the benefit of the committee, could you describe how the dental needs of various members of unions and groups are being met through dental programs rather than through prepayment insurance programs?

Dr. MEAD. Various organizations who have provision for care of that kind give the patient the choice of dentist. Some of them have clinics that do a certain amount of work but in most instances I think the work goes to his own dentist with payment from the organization. What clinics there are are small clinics, they are not extensive, and I think they are more or less experimental with groups.

Mr. FOLEY. You are familiar with the fact that in Washington there are being provided—and I know they are being provided in other parts of the country as well—separate clinics manned by leading dentists in the country who provide all services short of oral surgery. Is that not true?

Dr. MEAD. You mean they perform services such as—

Mr. FOLEY. They X-ray the teeth, they fill, they extract, they provide dental hygiene instruction, but when it comes to the serious problem of oral surgery some of the clinics do not provide those services.

Dr. MEAD. That is correct. They provide minimum benefits because they do not provide prosthetics and bridgework and things of that kind.

Mr. FOLEY. They provide partial plates and full plates.

Dr. MEAD. If they do, it is limited. I am not familiar with that.

Mr. FOLEY. Could you tell us some of the problems these health and welfare prepayment plans run into so far as providing comprehensive dental service?

Dr. MEAD. I think any plan is better that provides a choice of an operator or an office where they go. When you have any organiza-

tion that is set up permanently, in a question of time those are not as efficient as when you have competition. Competition is the lifeblood of everything whether it is dentistry or medicine or anything else, and I think you have better dentistry and better medical service where there is competition.

Mr. FOLEY. Then you are against a prepayment plan providing comprehensive dental service?

Dr. MEAD. No. I know the American Dental Association has plans for prepayment of those services in the experimental stage.

Mr. FOLEY. What are the problems you have encountered in the American Dental Association in this comprehensive dental program?

Dr. MEAD. So far it has been working out a plan of cost. When you consider this bill, if it is too comprehensive, I think there will be objection on the part of the companies and others that it is too expensive.

Mr. FOLEY. Is it a problem because of the fact no insurance company can insure against dental difficulties or conditions because actuaries cannot estimate the cost?

Dr. MEAD. I would not say that. The American Dental Association has plans. I am not familiar with all the plans they have because I have been out of their organization so far as work of this kind, but I know they have experimental plans now and are trying to perfect them.

Mr. FOLEY. Thank you very much.

The CHAIRMAN. Any further questions?

Thank you very much, Dr. Mead.

Dr. MEAD. Thank you.

The CHAIRMAN. The next witness will be the Chairman of the Civil Service Commission, Mr. Roger W. Jones, accompanied by members of his staff, whom he will introduce.

STATEMENT OF ROGER W. JONES, CHAIRMAN, CIVIL SERVICE COMMISSION; ACCOMPANIED BY WARREN B. IRONS, EXECUTIVE DIRECTOR, AND DAVID F. LAWTON, ASSISTANT DIRECTOR, BUREAU OF DEPARTMENTAL OPERATIONS

Mr. JONES. Thank you very much.

I will ask Mr. Warren Irons, our Executive Director, and Mr. David Lawton, the Assistant Director of our Bureau of Departmental Operations, who have worked extensively on this legislation, to accompany me here at the table, if I may.

The CHAIRMAN. Certainly.

Mr. JONES. A few days ago the Civil Service Commission filed its formal report on S. 2162, the major bill which is before the committee. The views in that report are also applicable to H.R. 8210 and H.R. 8211. If that report has not already been placed in the record, I will ask your permission to have it placed in the record at this point.

The CHAIRMAN. Without objection, the report referred to will be made a part of the record at this point.

(The report referred to follows:)

AUGUST 5, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. MURRAY: In response to your letter of July 8, 1959, I am forwarding the Commission's views on the bill S. 2162, to provide a health benefits program for Government employees, as the bill has been amended by the Senate Post Office and Civil Service Committee and reported to the Senate. These views would also apply to H.R. 8210 and H.R. 8211, which are identical to S. 2162.

In the interest of brevity we are not here including a section analysis of S. 2162. The Senate committee's report of July 2, 1959 (No. 468) contains an explanation of the bill by sections. Except as noted hereinafter, the Commission construes the bill as stated in that explanation.

As the central personnel agency of the executive branch, the Commission considers enactment of a health insurance program for Federal employees highly desirable. Such a program would fill the one remaining major gap in employee fringe benefits and be of incalculable value in attracting and retaining Federal personnel.

We are in incomplete agreement with the fundamental concepts underlying S. 2162. Very briefly, these would—

- (1) Permit employees a free choice among a Government-wide service benefit plan, a Government-wide indemnity benefit plan, a local group practice prepayment plan, and an employee organization plan.
- (2) Require contributions from the employee and from the Government.
- (3) Make the Commission responsible for the overall administration of the program while sharing the day-to-day operating responsibilities with the employing agencies and the insurance carriers.
- (4) Create a central fund into which all receipts would be deposited and out of which all disbursements would be paid.

The soundness of these same concepts (except for the first, which is pertinent only to health insurance) has been solidly established by the efficient operation of the Federal employees' group life insurance program.

The Commission does not, however, altogether favor the manner in which S. 2162 applies these four general principles. We also have serious reservations about several other provisions of the bill. Under the circumstances, we find S. 2162 sufficiently objectionable to compel us to report unfavorably. If the objectionable features were corrected, we would find the bill acceptable and a good basis for a successful, enduring health benefits program.

There follows a discussion of what we consider to be the objectionable features of the bill, together with suggestions for rectifying them.

RETROACTIVITY

Regardless of how long before July 1, 1960, S. 2162 were enacted, it would become generally effective no earlier than that date. Section 2(b)(2), however, contains a proviso which would extend the benefits of the bill to certain employees and certain survivors who qualify for annuity between the time the bill is enacted and the time it becomes generally effective.

We appreciate and are not unsympathetic with the purpose of this proviso which is to protect those people who would otherwise be denied the benefits of the bill because, owing to circumstances beyond their control, they are separated before its effective date.

The situation which the proviso in section 2(b)(2) seeks to cure is not new. It occurs each time beneficial legislation is enacted and on each such occasion it appears that numbers of people have been denied benefits because they were prematurely separated. Depending largely on the value of the benefit, the group which considers itself aggrieved by having been denied the benefits ranges all the way from those who were separated as little as 1 day too early to those who were separated as much as 5 or even 10 years too early.

It is unfortunate that any person has to be denied a benefit because he has been prematurely separated, but we know from long experience that the proviso in section 2(b)(2), although it may slightly lessen the number of persons who will feel aggrieved, will not appreciably remedy the situation. The proviso in section 2(b)(2) would extend health benefits to certain employees who retire involuntarily

or for disability during the interval between the enactment and effective date of the bill and to survivors of certain employees who die during this interval. The number of people whom the proviso will affect will depend on how long this interval may be, but in any event the proviso will not affect the large number of employees who, for example, will voluntarily retire during the interval and later claim they had no knowledge of the fact that, had they waited, they could have qualified. Nor, for another example, will it affect the even larger number of employees who retired (or died) 1 day, 1 week, 1 year before the enactment date.

A line of demarcation must be drawn somewhere. The fairest and firmest place to draw the line is at the date the enacted bill becomes effective. Any retroactivity, unless it were complete, would be discriminatory and would intensify the aggrievement the excluded groups would feel and the representations they would make for having the benefits extended to them. The Commission, therefore, recommends that the following text be deleted from the bill:

- (1) Subsection 2(b)(2) on page 23, beginning in line 13 and ending in line 18.
- (2) Subsection 3(b)(2) beginning on page 26, line 25, and ending on page 27, line 11.

BENEFITS AND CONTRIBUTIONS

There are at least two aspects of the bill's benefit-contribution structure which, in the Commission's view, are so objectionable as to make S. 2162 unsatisfactory. These aspects are as follows:

(1) *Government contributions*

At the maximum rates specified in section 7(a), the total contribution required of the Government has been estimated by the Senate committee at \$145.3 million annually. We would make two observations concerning this estimate: First, it does not include the sums which the Government would have to contribute annually toward insuring annuitants; second, the administration's frequently stated position is that it cannot at this time acquiesce in spending more than \$80 million a year on this program.

(2) *Contributions versus benefits*

It can be contended that under section 7(a) contributions of employees and Government may be kept low by setting the rate at a figure less than the maximum authorized amount. But, we are not aware that any carrier has submitted a firm offer to underwrite, at a price less than the maximum contribution rates, the ultrarich benefits which are described in section 5 (a)(1) and which are further implied in the Senate committee's report on S. 2162.

In the absence of such firm offer, we have reservations as to whether the implied benefits can be contracted for even at the maximum contribution rates. To the extent that they cannot, or to the extent that Government fiscal policy requires the contribution rates to be set lower than the maximum, the implied ultrarich benefits will have to be curtailed. Any such curtailment in benefits will, like the too-high contribution rates, result in employee disaffection with the program.

We discern other weaknesses in the benefit-contribution structure of S. 2162 but those mentioned above are considered sufficient to justify our recommendation against enactment.

In the absence of a written commitment from a reputable carrier containing detailed specifications of benefits and subscription charges, we believe it wiser not to mislead employees into believing that they will receive ultrarich benefits. It would be infinitely better to delete section 5 of the bill in its entirety and rely on the Commission to negotiate contracts which will provide employees with generally better benefits than they now can get, at a cost to them which, depending on the geographic area, may be less than or about the same as they now pay.

We believe that, to assure enactment of a program, section 7(a) should limit the Government's total contribution to an amount which is acceptable to the administration. And, further, to permit employees who may be so inclined to enroll in plans offering very rich benefits (e.g., some existing group-practice plans) at a subscription charge greater than the maximum contribution rate stipulated in section 7(a), no limit on the employee's contribution rate should be specified. Suggested language to accomplish both these points follows:

1 "Sec. 7. (a)(1) The Government's contribution to the subscription charge for each enrolled employee or annuitant shall be 33 $\frac{1}{3}$ per centum of the subscription charge but may not exceed (i) 95 cents biweekly if he is enrolled for himself alone, or (ii) \$2.30 biweekly if he is enrolled for himself and members of his family, or (iii) \$1.35 biweekly in the case of a female employee or annuitant who is enrolled for herself and members of her family, including a nondependent husband.

"(2) There shall be withheld from the salary of each employee or annuity of each annuitant enrolled in a health benefits plan under this Act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment."

CONTRACTING AUTHORITY

Section 6 authorizes the Commission to negotiate contracts with qualified carriers. It enumerates some of the items to be specified in the contracts but offers no guidance—nor does the Senate committee's report on S. 2162—on what we regard as a critical issue: Should each carrier of a Government-wide plan assume the total risk under his contract or should he be required to share his rights and obligations with other insurers?

For several reasons, but primarily to simplify negotiations with prospective carriers, the Commission considers it highly desirable that the prime carriers' rights and obligations under the two Government-wide plans be shared in much the same manner as the Congress has provided under the Federal Employees' Group Life Insurance Act. While the Commission, in contract negotiations, would probably insist on such sharing even if section 6 were enacted in its present form, it would be preferable to have the Congress express its intent in this regard by including language along the following lines in section 6, perhaps as a new subsection (b):

"(b)(1) The contract for the Government-wide service benefit plan shall require the carrier to allocate its rights and obligations under the contract among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates and approved by the Commission.

"(2) To be eligible as the carrier for the Government-wide indemnity benefit plan, a company must be licensed to issue group health insurance in all the States and the District of Columbia. The policy for such plan shall require the carrier to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission."

The Commission assumes, of course, that the national Blue Cross-Blue Shield organization will be the prime carrier for the Government-wide service benefit plan. To eliminate all but a dozen or so of the largest, most responsible insurance companies from consideration as prime carrier of the indemnity benefit plan, and to avoid diversity of citizenship difficulties in the event of a court action by an employee, the suggested language requires the prime carrier to be licensed in all the States and the District of Columbia. All other companies which write group health insurance would, of course, be eligible to acquire their fair share of reinsurance from the prime carrier.

HEALTH BENEFITS FUND

I am sure your committee is aware that increasing use of hospital and other health services and the continuing rise in the cost of these services has required many insuring organizations to raise their subscription or premium rates. Some organizations have had to raise their rates several times within the last few years. The current situation in New York City, where the Blue Cross has very recently announced a substantial increase in its rates for the second time in less than 2 years, is characteristic of the trend toward higher insurance costs. Also characteristic is the reported widespread dissatisfaction with the rate increases among subscribers.

Informed opinion is to the effect that steady increases in the cost of providing health services are inevitable. To avoid the necessity of having to increase contribution rates under the Government-sponsored program with unnecessary frequency and, incidentally, to avoid the employee dissatisfaction and the administrative difficulties entailed in each such rate increase, the Commission believes that an adequate contingency reserve should be set aside which could be drawn upon to stave off frequent contribution rate increases. Section 8 of S. 2162 makes no provision for setting aside funds for this purpose other than those derived from "dividends, premium rate credits, or other refunds." These refunds (and there is nothing to guarantee that any will be made by the carriers) are completely inadequate for use as a contingency reserve.

The Senate committee, in page 18 of its report on S. 2162, seems to have recognized the need to stabilize contributions by setting aside a portion of contributions

as a reserve. It indicates that the reserve shall "not * * * exceed approximately 3 percent of any 1 year's contributions or [exceed] an accumulative total of approximately 10 percent." However there is no language in section 8 which would authorize retention of any portion of the contributions as a reserve, much less the specific percentages indicated in the Senate committee's report. In view of the explicit authorization in section 8 to set aside a 1 percent reserve for administrative expenses, we question the propriety of setting aside a larger contingency reserve without explicit authorization.

Increases in the cost of health services cannot, of course, be forecast with precision over a long period of years. The Commission feels rather strongly, however, that a contingency reserve should be accumulated which will be adequate to stave off increases in contribution rates for at least the first 5 years of the program's existence and, if possible, longer. To the best of our ability, we have estimated that to do this, it will be necessary to set aside moneys up to a maximum of 10 percent of all contributions paid into the fund. Suggested language for amending section 8 to permit the setting aside of an adequate reserve follows:

"SEC. 8. (a) There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the 'Fund,' which is hereby made available without fiscal year limitation for the payment of all subscription charges or premiums, under contracts or policies entered into or purchased under section 6. The contributions of employees, annuitants, and the Government toward the subscription charges shall be paid into the Fund.

"(b) Portions of the subscription charges contributed by employees, annuitants, and the Government shall regularly be set aside as follows: (1) a percentage not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made available in section 9; (2) for each plan, a percentage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

"(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund."

ADVISORY COUNCIL

The Commission believes that an advisory council can be a valuable adjunct to the health insurance program. Conversely, a council could operate to hamper administration of the program.

In our considered opinion, two features of section 12 will seriously impair efficient operation of the program.

(1) Composition

The 11-member Council called for by S. 2162 is so large as to inhibit unified and timely action which may be required of it.

Of the members mentioned in clauses (1) through (7) of section 12 (a) only the Director of the Bureau of the Budget, because he is concerned with Government fiscal policy, and the three representatives of employee organizations have a continuing intrinsic interest in the program. We do not see that the other members mentioned (the Secretary of Labor, the Surgeon General, the Chief of the Bureau of Medicine and Surgery, a representative of the public, and three representatives of universities) have more than a casual interest in or concern with the program nor what long-range purpose would be served by their permanent membership on the Council. In any event, the services and advice of any or all these persons could be readily obtained when, in a particular situation, it was considered desirable.

We would suggest that section 12 be amended to create a smaller, more efficient Council whose membership would be representative of the vital interests affected by the program. This membership should, in our opinion, consist of the Director of the Bureau of the Budget, the Secretary of the Treasury, because he is charged by S. 2162 with the management of the health benefits fund, the Secretary of

Health, Education, and Welfare, because he is officially concerned with public health and health benefits and, finally, to represent employees' interests, two elected officers of employee organizations and two insured employees at large.

(2) *Duties*

Three of the Council's duties prescribed by section 12(b) are sufficiently inappropriate for an advisory council to repeat and comment on here:

(a) "to make studies from time to time of the operation and administration of this Act."

This prescribed duty is sheer duplication of what the Commission is required to do by section 11(a)—"[to] make a continuing study of the operation and administration of this Act."

(b) "to receive reports and information with respect [to this Act] from the Commission, carriers, and employees and their representatives."

This duty will (1) interpose the Council between the Commission and the carriers and impair the carriers' accountability to the Commission, and (2) make the Council a forum for airing employee grievances. Even if S. 2162 did not require it, the Commission would, as a matter of course, furnish reports and information to the Council and otherwise keep it current with developments so that it would have a basis on which to furnish advice and make recommendations.

(c) "to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances and reserves."

The Commission, as trustee of the Fund, would do just this on a continuing basis and its efforts in this regard would automatically be audited by the General Accounting Office.

We cannot help but feel that, especially at the outset of the program, the Advisory Council as constituted by section 12 would have to be in virtually continuous session, would divert the energies and resources of the Commission, and, in general, would impede efficient administration. We urge that section 12 be amended so that it provides for a council whose function will be to advise and to recommend rather than to monitor the Commission. Language which would do this follows:

"SEC. 12. (a) There is hereby established a Federal Employees Health Benefits Advisory Council which shall consist of the following:

"(1) The Director of the Bureau of the Budget or his representative;

"(2) The Secretary of the Treasury or his representative;

"(3) The Secretary of Health, Education, and Welfare or his representative;

"(4) Four members, to be appointed by the Chairman of the Commission, of whom two shall be elected officers of national employee organizations and two shall be employees enrolled under this Act.

"(b) It shall be the duty of the Advisory Council (1) to consult with and advise the Commission in regard to the administration of this Act, and (2) to make recommendations to the Commission with respect to the amendment of this Act or improvements in its administration.

"(c) Members of the Council who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at a rate to be fixed by the Commission, but not exceeding \$50 per diem, while away from their homes or regular places of business.

"(d) The Advisory Council shall be convened once yearly or oftener on the call of the Chairman of the Commission or on request of any three members of the Advisory Council."

STATUTORY BUREAU OF RETIREMENT AND INSURANCE

The only reasons we know of for the inclusion of section 13 in S. 2162 are the ones advanced in page 19 of the Senate committee's report on the bill. To put it briefly, the Commission does not find these reasons persuasive.

It is quite possible that the Commission may find it advisable to organize a bureau to handle its retirement and insurance functions. This possibility exists whether S. 2162 is enacted or not. The Chairman of the Commission is already empowered by law to reorganize the Commission and if considerations of economy and efficiency should in the future so dictate, he would do this. But his right, among other things, to choose a propitious time for the reorganization, to assign a name to a newly created bureau, to delegate responsibility, and to determine,

in accordance with position classification standards, the grade of a bureau director should not be invaded by a statute which is not germane to these matters.

We most strongly urge that section 13 be deleted entirely from S. 2162.

CONTRACTS AND REGULATIONS

The last feature to which the Commission feels obliged to object is the directive in section 16(a) which would require the Commission to transmit by May 1, 1960, to the House and Senate Committees on Post Office and Civil Service, copies of the contracts it proposes to enter into and the regulations it proposes to promulgate.

We cannot perceive nor have we been able to ascertain the purpose of this directive unless it is to assure that the Commission takes timely action to implement the enacted bill. If this is its purpose, its inclusion in the bill is superfluous since section 16(b) directs that the enacted bill become effective July 1, 1960. If the bill is enacted, we will of course deploy all our resources to have implementation completed by that date. We feel, in this connection, that it is necessary only to call attention to the very prompt action the Commission took in August of 1954 to make the Group Life Insurance Act effective—and this with no effective date specified in the statute.

In addition to being superfluous, section 16(a) would leave the Commission in a quandary in at least two respects.

(1) Prudence would seem to dictate that the Commission, having transmitted copies of the contracts and the regulations, postpone their signing and promulgation while it awaited some formal acknowledgment from both the Senate and House committees that they had objections to or that they approved of the proposed contracts and regulations. The wait could of course result in significant delay but any action, either negative or affirmative, on the part of either committee could be construed as an infringement upon the Executive's powers.

(2) If, between the time copies of the contracts and the regulations were transmitted and the time they were signed and promulgated, changes were made in either or both, the Commission would presumably have to notify the committees of the changes and again await acknowledgments. Such last-minute changes could easily occur after May 1, 1960, in which case the Commission could, involuntarily, be in violation of section 16(a).

Viewed in the most favorable light, section 16(a) is superfluous and enigmatic. It should be deleted from the bill.

We are not, in this statement of our views, suggesting language to perfect a number of relatively minor items in S. 2162 which we think can (and should) be easily improved. Mostly, these improvements would facilitate administration of the program.

I would be glad to have a representative of my office meet with your staff to work out these perfecting changes and, if you wish, to provide such other technical assistance as your committee may want.

The Bureau of the Budget advises that there is no objection to the submission of this statement to your committee.

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

Mr. JONES. Mr. Chairman, I am particularly glad of this opportunity to meet with the committee to discuss orally with you the bill S. 2162 and other identical bills. I have already indicated the two other members of the Commission staff accompanying me. Mr. Irons has worked on this problem over the last 4 or 5 years, and this year, particularly, Mr. Lawton has done yeoman service all the way on health insurance legislation.

First let me say that the thoroughness with which your committee has gone into this legislation has made a great contribution in clarifying many issues inherent in any new insurance plan. The testimony offered by earlier witnesses and the questions asked by the members have brought into focus most of the major points which this committee will have to resolve.

This legislation represents a pioneering effort in a complex field. We should not expect or seek to enact a perfect piece of legislation.

Primarily we need a flexible bill, but definite enough in enunciated policies to permit discretion in handling problems which could not possibly have been anticipated despite the thoroughness of these hearings. It is certain that such problems will occur when it is remembered that the health insurance program contemplated by this legislation will be the largest employer program in the world. No one should expect that it will go altogether smoothly. We will make mistakes and we shall need leeway to correct them as rapidly as possible.

Since we at the Commission are the ones who, day in and day out, will have to live with this program, I should like to bring to the committee's attention some of the problems we do anticipate. The fact that I shall here do little more than touch on the provisions of the bill involved should not imply that we take them lightly. I strongly urge the committee to correct the problem areas we do recognize now.

I will take these subjects up, if I may, Mr. Chairman, by major categories, and will deal first with the question of the contracting authority authorized in the bill.

CONTRACTING AUTHORITY

The bill as now drafted offers the Commission no guidance on the question whether each carrier of a governmentwide plan should assume the total risk under his contract or whether he should be required to share his rights and obligations with other insurers.

In drafting the Federal Employees' Group Life Insurance Act, this committee insisted—and properly so in my judgment—that the prime carrier cede reinsurance to all other qualified and interested carriers according to an equitable formula.

Partly because this will be the largest health insurance program of its kind in the world, and partly to insure fair treatment of all eligible carriers large and small, prudence and equity both dictate that a similar prescription be written into S. 2162.

Mr. JOHANSEN. Mr. Chairman, may I interrupt at this point?

The CHAIRMAN. Mr. Johansen.

Mr. JOHANSEN. Is this statement applicable to the so-called service-type carrier, the Blue Shield and Blue Cross? In other words, is this element of reinsurance applicable to that particular group?

Mr. JONES. Mr. Johansen, I do not know enough about the interrelationships of the Blue Shield-Blue Cross plans to be able to say categorically, but I would say no for this reason—and I believe Mr. Coleman is here and can answer it better than I can—the service type thing is not strictly an insurance type contract, and while there is a federation, as I understand it, of the Blue Cross-Blue Shield effort, it would not be so much a matter of reinsurance as having all the particular parts of that overall organization come into it together.

Mr. JOHANSEN. Perhaps I am anticipating some other testimony, but in your testimony will you make reference to the type of existing employee self-insurance program which already exists?

Mr. JONES. That I will do because we have been getting some special information for the committee on that and I will come to it later on. If it gets away from me, Mr. Johansen, call me back on it a little later, will you?

Mr. JOHANSEN. Sure.

STATUTORY BUREAU AND ADVANCE SUBMISSION OF CONTRACTS

Mr. JONES. The next question is the statutory bureau and advance submission of contracts to the Congress. These provisions are included in section 13 and section 16(a) of the bill.

The one would require the Commission to establish a Bureau of Retirement and Insurance and the other would require the Commission submit copies of the proposed insurance contracts and regulations to this committee and to the Senate committee on Post Office and Civil Service.

I group these sections together because both are objectionable for similar reasons. They will freeze the organization and tie the hands of the Commission in administering the program. The latter will also complicate contract negotiations with the carriers. In our judgment, neither section will contribute to the success of this program. Both are unnecessary, potentially harmful, and should be stricken from the bill.

Next, also an organizational issue, is the Advisory Council.

THE ADVISORY COUNCIL

Like the statutory bureau and the advance submission of contracts, the composition and duties of the advisory council created by section 12 are objectionable because they would hamper administration.

The Commission is quite willing to assume undivided responsibility for the administration of this program. We are not willing to be held accountable for a program in which responsibility is divided as this bill would divide it. We do not need or want, as a partner in administering this health insurance program, an advisory council accountable to no one, and with duties which inevitably will put the Council directly into administration.

We do not believe that a statutory Council is necessary. If the committee agrees that such a Council need not be prescribed in the bill, the Commission will seek competent outside advice whenever it becomes necessary to do so, and will include representation of employee organizations in whatever advisory body we set up. And when I say "whenever it becomes necessary to do so," it very definitely will be necessary. There are many paths that will have to be charted as we go along; and we will need the best brains we can get from a lot of people to accomplish our purposes.

CONTRIBUTION STRUCTURE

I foresee another serious trouble spot; section 7 puts a limitation on the amount an employee may contribute. This limitation will preclude an employee from enrolling in some of the existing group practice prepayment plans. Subscription charges of at least one of these plans already exceed the maximum contribution permitted by S. 2162; rising costs may soon price other plans beyond the contribution limits of the bill.

The language of the bill promises the employee he may join an approved group practice prepayment plan. Section 7, as it is now written, may well operate to deny many employees enrollment in such a plan.

The CHAIRMAN. What suggestion do you make for improving section 7 of the bill?

Mr. JONES. If I may, I would like to take that up when I come to a set of suggested amendments to the bill, if that is agreeable to you, sir.

The CHAIRMAN. Very well.

Mr. JONES. The next subject is contingency reserves.

CONTINGENCY RESERVES

I have no wish to belabor the matter of setting aside a reserve to absorb contribution increases. If there is anything that has been well demonstrated at these hearings, it is that adequate reserves are necessary. You have heard expert testimony urging that 20 percent be set aside initially as a reserve. I believe we need a clear expression in the bill of congressional intent that the Commission set aside a portion of the contributions paid into the fund. Prudence demands that it be sufficient to forestall an increase in contribution rates or a reduction in benefits for the first few years of the program. No good experience data can be compiled if rates and benefits have to be changed each year.

HOW TO REMEDY THESE DEFICIENCIES

Mr. Chairman, in our report to you of August 5 we have made suggestions for necessary language changes to correct each of the points just mentioned.

We suggest, in addition, a number of perfecting, technical changes which will facilitate administration of the program. I do not wish to take the time of the committee to describe all these small minor language changes, but staff of the Commission is available at any time to work with your committee staff to tie up these loose ends. And I have brought with me this morning a marked-up copy of S. 2162, which I would like to come back to later.

The CHAIRMAN. That will be fine.

Mr. REES. Does the marked-up copy contain the suggested changes?

Mr. JONES. Yes. That has not been done in multiple copies. We could leave the copy we brought with the staff.

The CHAIRMAN. The staff can make copies.

Mr. JONES. What we thought was that if the committee thought well of it, it might well be the basis for a committee print.

The CHAIRMAN. Very well.

Mr. JONES. The next question is cost.

COST

The Senate hearings on S. 94 have convinced us that employees should have a free choice between a plan involving deductibles and coinsurance, and a so-called service benefit plan which insures against the first-dollar cost of hospital and surgical expenses.

To our surprise and consternation, however, S. 2162, as it came to the House from the Senate, emphasizes the richest, most expensive kind of benefits—benefits which are considerably greater than are provided by private employers except in the most unusual cases. As far as the administration is concerned, the cost of providing these ex-

tremely rich benefits, plus the supplemental or major medical coverage mentioned in section 5 of the bill, is prohibitive.

In this connection, I am sure that the large majority of employees are more interested in how much they will have to pay for this insurance out of their pay checks than in exactly what benefits they will receive. Most employees will expect better benefits from a Government-sponsored plan than those they now have, and quite naturally will expect to pay somewhat less than they now do—especially since the Government will match their contributions.

The maximum contribution which a married employee could now be required to make under the bill is \$9.20 a month. Yet this is more than the average employee now pays. This committee has heard prominent employee spokesmen say that a figure of around \$7 a month is what the rank and file of employees can afford, and that \$9 a month would price most of them out of the market. Perhaps I should say many of them, but I believe there was some testimony that said "most." If the plan is to accomplish its purposes it must have the broadest possible coverage, the largest possible number of participants, and costs commensurate with both coverage and participation. We cannot leave out the lower paid employees and we must remember that the average salary of all civilian employees is about \$5,000. The take-home pay of these employees is already considerably less than \$100 a week.

In contracting with the carriers, the Civil Service Commission will be strongly influenced not only by considerations of administration fiscal policy but also by the impact of its negotiations upon the employee's pocketbook.

These factors make it necessary for me to record that if this bill is passed by the Congress and signed by the President, the Civil Service Commission proposes to negotiate and contract for the maximum benefits that it can obtain for a cost which will be in accord with the administration's fiscal policy and within the financial reach of most employees. This will be a cost substantially lower than that which would be permitted by the maximum contributions now set forth in the bill. We construe the language of the bill as clearly permitting this, and the Commission will exercise the discretion given us in the way I have described. We urge that there be no misunderstanding on this point and that it be clearly stated in the committee's report on the bill, if the legislation is favorably reported.

In connection with cost discussions, I wish to make it clear that the administration does not favor the 50-50 cost-sharing features of the bill as it passed the Senate. We believe that the cost sharing should be in the one-third Government two-thirds individual ratio of the Federal Employees Life Insurance Act. This point will be developed further by the Bureau of the Budget when their representatives are before you.

RETIRED EMPLOYEES

I cannot leave the discussion of cost without calling to the committee's attention one matter which everyone should understand.

The Commission is on record as favoring free coverage for annuitants without the necessity for direct annual appropriations by the Congress. Our arguments for this have apparently not been convincing. In

the interest of speedy enactment we have receded from our original free coverage recommendation. But I would point out a little-noticed fact if the committee will follow me while I do some simple arithmetic.

A retired employee will contribute at the same rate as an active employee and the Government will match his contribution. But the cost of insuring a retiree is about three times that of insuring an active employee. This means that the sum of a retiree's contribution and the matching Government contribution will pay only one-third of the ultimate cost of benefits provided. So that it will be a matter of record, I want to point out that there is no specific provision in the bill for paying the remaining two-thirds excess cost for a retiree. As the bill now stands, this two-thirds excess cost must come from the contributions for active employees, another reason for building adequate reserves.

DESCRIPTION OF BENEFITS

Another point in the bill on which I should like to comment has to do with the benefits as they are described in section 5(a).

On the day after the Senate passed S. 2162 the Washington Evening Star ran a front page article itemizing in detail the benefits described in section 5 and stating further that these benefits were guaranteed. They are not guaranteed at all. The benefits will be whatever the Commission contracts for—not those maximum benefits which are implied in the bill.

My point is that if section 5 misled the usually accurate Evening Star it will similarly mislead Federal employees throughout the country into believing they will get all the benefits mentioned in section 5(a).

I urge the committee to change the preamble to section 5(a) to say that what follows are the types of benefits which may be provided; that the detailed description of benefits, such as the one on full cost of 120 days in the hospital, be eliminated; and that section 5(b) also be stricken because it would then be superfluous.

RETROACTIVITY

Another troublesome area is the matter of retroactivity. The provisions in the bill which extend benefits to certain employees who retire between the date of enactment of the bill and its effective date should be deleted.

As in all beneficial legislation of this kind, a line must be drawn somewhere between employees who are eligible and those who are not. Hard-won experience in the fields of retirement, life insurance, and pay convinces us that this line should be drawn at that point in time on which the enacted bill becomes effective generally. In this instance, moreover, a commitment has been made that health insurance for already retired employees will be introduced in the near future. If legislation of this kind should be enacted, employees who retire between the date of enactment and the effective date of the present bill will be accorded the same treatment as other employees who have retired too soon to qualify for the benefits of S. 2162.

ASSOCIATION PLANS

The committee has heard several pleas for including in the program nonlabor employee associations which provide health insurance to their members. These associations consist mainly of numerous local plans which serve small numbers of employees in limited areas.

We know of the existence of more than 200 of them. I am sure there are at least as many more that we have not yet heard about. To allow them all to participate in the program would result in an administrative nightmare. If they are included, the Commission will, year after year, have to check into their corporate structures, their bookkeeping arrangements, their reserves, their methods of operation, their membership requirements, and the relationship between the benefits they offer and the subscription charges they require.

There are a few associations in addition to the labor organizations already mentioned in the bill which operate on a nationwide basis or serve an entire agency. These should be allowed to participate and can be by changing the language in section 2(h) so that it does not limit participation to employee labor organizations.

I reach this conclusion not for reasons of administrative feasibility alone, although this is a most compelling reason. Most of these associations originally served a useful purpose by providing benefits of a type which employees could not otherwise obtain. Under this program employees will be able to obtain benefits as good as and in most instances better than those the associations now provide. It is clear to me that their usefulness and the purpose they originally served are at an end. Even if they are allowed to participate in this program, we believe that new employees will preponderantly choose to enroll in Government-sponsored plans. The associations will not attract new, good-risk enrollments and eventually will have to close their doors.

I would, therefore, recommend to the committee that S. 2162 be changed to allow only associations of the types (nationwide or entire agency) I have previously mentioned to participate. If more than these are allowed to participate, I am convinced, based on our experience with similar associations under the life insurance program, that administration would be almost impossible and very costly. If a bill which permits all of these 200 and more associations to participate is sent to the White House, the Commission will have to give serious thought to recommending disapproval.

Mr. Chairman, I conclude by saying that we at the Commission have worked diligently for 5 years to obtain a health insurance program for Federal employees. The Civil Service Commission wants to see a health insurance program on the books and I sincerely trust that your committee will favorably report out a bill in which all of the trouble spots I have mentioned have been corrected or eliminated.

That, Mr. Chairman, concludes the formal statement. I would like to go on for just a moment, if I may, to indicate that I have made every effort to write this statement in as simple and in as concrete prose as we are capable of in the Commission. I felt at this point in the hearings it would be of far more value to the committee if you could have short, simple statements of what we see is wrong and what can be corrected than for me to qualify and make a good many parenthetical suggestions.

I realize there are points of view in this statement with which members of the committee may disagree, and certainly there will be disagreements from certain member organizations. I do this not in the interest of creating controversy, but in the interest of clarifying issues as the administrative agency sees it.

I am sure members of the committee will agree that if this legislation goes into effect there will be a period of negotiations when great care will have to be taken to see that the Government and the Government employees are dealt with fairly, and that the arrangements ultimately reached either with indemnity type contractors or with the Blue Cross-Blue Shield plan will be such that we will not have bitten off more than we can chew and that the plan will not result in disillusionment or failure on either side. This is a program we should not go into until we are sure we can make a success of it. The most tragic thing we could contemplate would be to undertake a plan under a Federal statute that failed of its own weight either because the employees could not afford to pay the subscription charges under it or the organization could not pay the benefits under it. We urge with all the sincerity at our command that when and if we move into this plan we do so slowly, carefully, and on a modest basis.

The CHAIRMAN. You are convinced that the benefits are too rich in respect to the contributions and that the contributions will in no way match the benefits proposed in the bill?

Mr. JONES. That is our judgment, recognizing we too can make many, many errors, but on the basis of all the cost estimating we have been able to make up to this point we do not believe we could write contracts either of the indemnity kind or of the service kind to meet the maximum benefits in the Senate bill.

Mr. REES. Was that explained to the other body?

Mr. JONES. It was explained informally to the other body. It was not explained formally to them because the other body moved rapidly and the Commission was not recalled for further testimony after S. 2162 was put in shape for executive consideration by the committee.

The CHAIRMAN. I read your report of August 5, 1959, in which you suggest amendments. Did you make this same report to the Senate Post Office and Civil Service Committee?

Mr. JONES. Yes, sir.

The CHAIRMAN. Judge Davis.

Mr. DAVIS. Mr. Jones, you say you object to the setting up of a Bureau of Retirement and Insurance as provided in section 13. Just how do you propose for these matters to be handled if we do not have such a Bureau?

Mr. JONES. Well, as you know, Judge Davis, we now have in the Civil Service Commission a Bureau of Departmental Operations. Within that Bureau the retirement work is one of the subunits. This retirement system will have a growing workload all the time. We have separated it so that we know what it is doing and can keep our fingers on it. It is manned by a group of valuable people, and we believe nothing could be gained by picking it up bodily and moving it into another organization, the head of which will inevitably have to give a substantial part of this time to the handling of this new insurance program.

Mr. DAVIS. You think these matters can be handled in this same department over there?

Mr. JONES. Temporarily we would place the organizational responsibility in our Bureau of Departmental Operations. Whether we would leave it there, I do not know. We would have to work that out in consultation with you people on the Hill, both your committee and the Appropriations Committee. The bill contemplates we would be allowed to get our first administrative funds from the reserve funds of the employees' life insurance fund, so that we would not immediately have to come for appropriations.

I cannot tell you now exactly what the best form of organization for this would be.

Mr. DAVIS. What I was interested in was knowing how you intend to take hold of it and put it in operation, and as I understand you think you can do that smoothly in this department you have in the Commission without hamstringing your work you are doing now?

Mr. JONES. I am sure we can if we can do this job as the exclusive job of the group of people that is there. This is probably the biggest job of negotiating and ironing out of problems the Civil Service Commission has ever had to undertake. The life insurance program is a breeze compared to what this will be.

Mr. DAVIS. And you think you can move it into that bureau and do it smoothly?

Mr. JONES. I think so.

The CHAIRMAN. On page 4 of your report to the committee you suggest the deletion of section 5 of S. 2162, which specifies the benefits to be received under the bill.

Mr. JONES. Yes. Mr. Chairman, I do not have enough copies of this to go around, but the committee can see what we have done. We would take out of section 5 almost all the detailed description of the benefits and leave a catalog of types of services to be provided. If the members of the committee have copies of S. 2162 I could read what we propose to do in this section in the revised form.

The CHAIRMAN. Does each member have a copy of the bill, S. 2162?

Mr. JONES. Section 5 would then read this way:

The CHAIRMAN. What is the first revision? Is the first revision in section 5?

Mr. JONES. The first revision would be in the preamble of section 5, (a). We would take out the words "To the extent possible with the funds available under this Act." That is section 5(a) on page 9.

The CHAIRMAN. Let us start at the beginning of the bill.

Mr. JONES. Yes, I will be glad to.

One minor amendment we would recommend is that instead of calling this a health benefits program, we think it ought to be called a health insurance program, because we think it has more the characteristics of insurance. Health benefits has a special connotation with us, thinking of Blue Cross and Blue Shield.

On the second page of the bill there are only technical changes which I do not believe we need to go into.

On page 3 of the bill, again, the changes are purely word changes to straighten out some little things about the language we do not think are quite as clear as they should be. I do not believe that it would be necessary to read those to the committee.

On page 4 there is one change which is slight in substance but nevertheless important, where we talk about "dependent husband"

in line 6, subparagraph (d). We say, "The term 'dependent husband' means a husband incapable of self-support by means of mental or physical disability," and then we strike out the words "and who receives more than one-half his support from the employee or annuitant." We substitute in lieu of that, "and which can be expected to continue for more than 1 year," "and who is in fact dependent on the employee, or annuitant for support."

This kind of minor change we would recommend for your consideration all the way through the bill to make it perfectly clear what we are talking about, to cut down the area of administrative argument about who is in and who is out.

I will not mention all these, but I just wanted to pick this one to illustrate.

Mr. PORTER. Is that the Bureau of Internal Revenue's definition of a "dependent"? Do you have to be entirely dependent?

Mr. JONES. We believe the language "who in fact is dependent" is better in this category than one-half or more, which is the Internal Revenue type of thing. Where you have a husband or a wife relationship this is determinable, in our judgment, on a medical basis.

Mr. PORTER. Does this mean wholly dependent? What if he has a small income, but it does not come up to half?

Mr. JONES. We do not mean wholly dependent in that sense.

Mr. PORTER. It would seem to me that you would be more precise.

Mr. JONES. We still would not want to impose the one-half criterion of the Internal Revenue Code.

Mr. PORTER. It ought to be precise, I would think.

The CHAIRMAN. Let us go back to subsection (c), and the language there about the natural child and the adopted child and those regardless of age who are incapable of self-support because of a mental or physical incapacity that existed prior to reaching age 19 and who are in fact dependent on the employee or annuitant for over one-half of their support.

How are you going to determine whether he is dependent for over one-half his support?

Mr. JONES. We recommend that you take out this Internal Revenue standard of one-half because that implies a kind of specific measurement you have to back up with figures that we do not think we could well do. What we would prefer to do is get the general evidence of the status of the individual.

The idea of "incapable of self-support," we think, is a much more meaningful phrase in a medical insurance sense than one-half of his support. "Incapable of self-support," Mr. Porter, we think could be defined—someone who cannot go out and work and earn enough money to keep himself.

Mr. PORTER. I just wondered about wholly dependent or partly dependent. There are always stages of dependency.

Mr. JONES. It is a good question. I have to say, touché, because we were attempting to get a little leeway here and get away from the strict arithmetic of the Bureau of Internal Revenue. We were carrying the concept of incapable of support. I would hate at the moment to put a percentage figure on that.

Mr. PORTER. I think perhaps you might be able to improve on that.

Mr. JONES. On page 5, Mr. Chairman, there is another important small change beginning in line 3 in subparagraph (h). That now reads:

The term "national employee organization" means a bona fide labor organization, national in scope, which represents only employees of one or more departments or agencies of the Government.

This, consistent with the statement I made, we would change to read:

The term "employee organization"—
leaving out the word "national"—

means an association, or other organizations of Federal employees which is (1), national in scope, or (2), in which membership is open to all employees of a department or agency who are eligible to enroll in a health benefit plan under this act, and which applies to the Commission to participate in the program on, or before, December 31,

and then you would put in whatever the year would be, 1959 or 1960.

The next major change would be on page 6, beginning at line 6, subsection (2), where there is a long description of the act applying to an annuitant not enrolled in health insurance plans, going on down through line 21. We would strike all of that language beginning at line 6 and ending with the period at the end of line 21 and substitute for it the following:

may continue his enrollment under such conditions of eligibility as may be prescribed by regulations of the Commission for the purposes of this subsection. A member of the family includes a child born after the employee, or annuitant dies or retires.

Here again I think we would be opening ourselves up to 1,001 administrative determinations and arguments if the language is too precise. I think we can do more by working our way through it with regulations than we can by having too tight a statutory standard.

On page 7 there are some changes in the service benefit plan language to be consistent with what we have suggested later on. We would suggest that read in lieu of what is there:

(1) SERVICE BENEFIT PLAN.—One Governmentwide service benefit plan under which the carrier agrees to provide in whole, or in substantial part, covered health services through contracts with hospitals, physicians, or other providers of such services, or to make reimbursement of the cost of such covered health services as may be procured in localities where the carrier has no contractual arrangements with hospitals, physicians, or other providers of such services.

That, I think, would clarify considerably the relationships that now exist under the standard Blue Cross-Blue Shield plan.

We would make an insert on page 8 at the bottom of the page, after line 22. We have talked there about group practice prepayment plans. We would make that (a), and then we would make a new (b) which we would call "individual practice prepayment plan," as contrasted with group practice prepayment plans.

The language of this insert would read as follows:

(b) INDIVIDUAL PRACTICE PREPAYMENT PLAN.—Individual practice prepayment plan which offer health services in whole or in substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree under certain conditions to accept the payments provided by the plan as full payment for covered services rendered by them, including in addition to in-hospital services general care rendered in their offices and the patients' homes, out of hospital diagnostic procedures and preventive care, and which plan shall have been in operation at least 5 years.

Mr. DAVIS. What group would that cover, and what services would that cover that are not provided for in the other plans mentioned? Who are you aiming at with that language?

Mr. JONES. Well, the big one that we are aiming at is the organization which has already testified before the committee, the so-called Group Hospitalization, Inc., of New York, which is a very large plan and includes, I think, something over 6,000 civil service employees of one sort or another.

We are informed that there are other individual practice plans of this type. There is the medical mutual plan in Cleveland, which is a very well known plan and has received quite a bit of attention. There is a plan in Oregon, Mr. Porter, the Oregon Hospital and Health Service Association, with which I am sure you are familiar, and there is one in Michigan. There is a Cumberland Valley plan in the State of Kentucky.

Mr. DAVIS. These groups would not fit in in any one of the others?

Mr. JONES. They would not, in terms of their charters, I guess that is the word. It is the way that they are set up.

Mr. DAVIS. Thank you.

Mr. JONES. On page 9, coming back to this question of section 5, as I indicated earlier, essentially what we would do would be to remove from the bill the specifics of this collection of benefits and leave only the key words so that section 5 would be very short and would read as follows:

SEC. 5. The benefits to be provided under plans described in section 4 may be of the following types—

The CHAIRMAN. Would you leave out "to the extent possible"?

Mr. JONES. We would take out the words "to the extent possible with the funds available under this act."

Then, after the words, "following types" first we would have category (A) which would be service benefit plan, and under that the following numbers: 1, hospital benefits—with no description at all; 2, surgical benefits—again with no description; 3, in-hospital medical benefits—taking out the description; 4, ambulatory patient benefits; 5, supplemental benefits, which, under this kind of thing, picks up most of the rest of the kinds of things that are there; 6, obstetrical benefits for normal delivery, and then having made that catalog, we would come to (B) which would be the indemnity benefit plan, and here again we would have a little catalog of 1, 2, 3, 4, 5, and 6 which would be essentially the a, b, c, d, and e and f that are included in lines 10 through 16 on page 11 of the bill.

Mr. BROYHILL. It is my understanding that the Civil Service Commission would have the option to reduce the cost of this insurance to the employees of the Federal Government?

Mr. JONES. Well, I do not want to seem to be splitting hairs with you, but I do not think we would put it in quite those terms. We would have the option of writing the best contract we could for the amount of money that would be available on both sides.

Mr. BROYHILL. Let me put it this way. It would be your objective here to make all costs uniform, whether they be in the indemnity plan or the service type plan?

Mr. JONES. I do not think we could do quite that.

Mr. BROYHILL. I am talking about the cost to the employee and the Federal Government.

Mr. JONES. Well, if you mean there would be just one amount paid for every individual in the Federal Government, with the same amount contributed under this bill by the Government, the answer is "No." There will be inevitably, as we work into this, some variations in the cost of individual plans which are covered by the act.

Now, uniformity will come, perhaps—and hopefully—over a period of time, but the purpose of asking for these changes is not so much to reduce the cost as it is to be sure that the statute gives us enough leeway to contract with either Blue Cross-Blue Shield or the insurance companies, for a plan that both the Government and the employees can afford.

Mr. BROYHILL. You would have the authority, would you not, to reduce the cost to the employee?

Mr. JONES. Yes. Naturally, as we now see it, that is definitely contemplated because if the costing figures are correct in the bill—the figures that are now given here as the employee figures—they would be maximums, and we do not believe that we could come up to that because we do not think we could write the kind of contract that would give what would be accepted under those maximums.

Mr. BROYHILL. Is there a possibility, however, you might, since you have the authority, say that you are not going to contract on a service type plan for \$1.50 each for the individual employee and require lesser services?

Mr. JONES. No. I do not think that I would put it quite that way. We are dealing with very difficult intangibles here, but once again what we will have to do is this, if I may illustrate: assuming this legislation passes with the amendments recommended by the Civil Service Commission, then in effect what we will have to do is to sit down and talk out with the insurance companies and their principal representatives, and with the Blue Cross-Blue Shield people, with representatives of all of them, exactly what kind of contract are they prepared to offer for what price. As has been pointed out, there are considerable difficulties in figuring this on the same kind of actuarial basis that you can figure life insurance. You have different areas of the country. They already have substantially different scales of cost of in-hospital care. There are substantially different scales of charges that are made by the physician and surgeons. There are all kinds of things of that sort that have just got to be woven into this.

At first, we are going to have frankly almost a kaleidoscopic picture. Every time we turn the button there will be a new arrangement of the little figures in the view. But as we work our way through this thing—and we have had the fullest assurance from all sides everyone will work together with us—I think that we are going to be able to develop a reasonably consistent picture in a relatively short time. But without leeway we are just going to be in trouble because I do not think the companies—

Mr. BROYHILL. In answer to my question the other day, Mr. Eddy of the Connecticut General stated that the benefits provided in this measure were much greater than the average private industry plan.

Mr. JONES. That is correct. I believe I made that point earlier.

Mr. BROYHILL. Is there a possibility in working out the indemnity plan you may find here it is a full program which can be provided for, let us say, \$1.50 per pay period instead of \$1.75, and that gives him

a full program under the indemnity plan? Would you be in a position then, or do you feel that you would be compelled to reduce the service-type plan to \$1.50 each, also, when that might not provide the full type service program?

Mr. JONES. I do not know whether the word "compel" is quite right, but we would move in that direction. We have to talk to both sides. This is not an effort in any way, in my judgment, and should not be an effort to hold up either of the major contributors to the success of this plan. We are not going to try to hold a pistol at the Blues' heads by quoting what the indemnity people do or vice versa. We hope that we can all work together and move in the direction of pretty general agreement on types of services to be provided, what they will cost, what the terms of the contract should be, and so forth.

Mr. BROYHILL. You see no likelihood that an employee who wants the service-type program being denied a service-type program under this?

Mr. JONES. No; not at all. We have not in any way interfered with the option of the individual in the bill. The only way we interfere with his option is in terms of the rather staccato statements that I made about some of the small local plans.

I may say, because I do not believe this has been called to your attention, in response to the committee's request we have done a quick tabulation through our field offices as to how many of these local plans there are in existence, and the 200 figure that I gave you is before the committee at this time. In summary, there are 239 plans that we have so far dug up—I guess that is the correct word—and they have a membership of 102,359. There are many more. Some of these are very small and in some regions there are very few in a region. In the New England region there are only five such associations that we have so far discovered, and one of them has only 52 employees. There are some which are even smaller than that.

The CHAIRMAN. Does this membership consist entirely of Federal employees?

Mr. JONES. Of these it does. This one that I referred to in the first region is the National Association of Internal Revenue Employees, located in Portsmouth, N.H., 52 employees. The Arlington Postal Employees Plan in Carney, N.J., has only 15 people in its plan.

The CHAIRMAN. Would you deal with all of those local plans?

Mr. JONES. No, sir; under our proposal we would not.

The CHAIRMAN. What would happen to them?

Mr. JONES. What would happen to them, I think, would be this: We do not write down the service they have been performing, or the fact that it has been a very useful service, but we believe that the employees would, of their own volition, willingly come over into other plans. Please remember, sir, medical insurance is practically on a current cash basis. We are not dealing with the kind of problem we had with the small life insurance plans where you had large reserves that were scattered from cash to mortgages and back again. What you are dealing with is really a cash reserve for paying current bills. They are practically liquid, and we think in a relatively short time they can be persuaded, just because of the logic of the situation, to giving over these small plans, taking something that would provide better benefits for less cost and coming in under the larger tent. I say "I believe." We do not know. We may run into some trouble.

Some of these are fairly big. There was one called to our attention that you mentioned to me the other day, the one in Chicago that is fairly substantial, but I think that we could work out the problem in time.

Mr. JOHANSEN. I would like to go to the language of your statement appearing at the bottom of page 6 of your statement and the top of page 7, and develop the meaning of that just a little. I am not doing this critically, but with a view to clarifying the record.

You say:

These factors make it necessary for me to record that if this bill is passed by the Congress and signed by the President, the Civil Service Commission proposes to negotiate the contract for the maximum benefits it can obtain for a cost which will be in accord with the administration's fiscal policy and within the financial reach of most employees. This will be a cost substantially lower than that which would be permitted by the maximum contributions now set forth in the bill.

I would like to understand the practicalities of that. As I understand it, whatever legislation is enacted would provide a maximum of benefits?

Mr. JONES. Yes.

Mr. JOHANSEN. It would provide a set ratio of contributions, either 50-50 or some other ratio, between the Government and the employee?

Mr. JONES. Yes.

Mr. JOHANSEN. Now, those two limitations having been set, is it my understanding that the Commission feels that it would be its prerogative and its responsibility actually to set up benefits less than the maximum and involving less contribution by the employer and the employee?

Mr. DAVIS. If the gentleman will yield, I would like to point out there is language in the bill which gives you that description.

Mr. JONES. It is in our amendment, Judge Davis, not in the language as it now stands.

I think that you could argue as to whether that discretion is now there. If it is now there in the present language, it comes only in connection with the little qualification there is to the extent funds are available. That qualification is in there, but under our amendment we would have this discretion.

The CHAIRMAN. You have the discretion under section 5 where the language says "to the extent possible."

Mr. JONES. Within the funds available.

Mr. DAVIS. I was just referring there to the amount of contributions. This language says, "shall contribute a like amount." It says that the contribution of the employee shall be so much and the Government shall contribute a like amount.

Mr. JOHANSEN. My question goes to who determines where the authority resides for determining what the contribution shall be.

Mr. JONES. The Civil Service Commission will have that authority if our amendment is accepted.

Mr. JOHANSEN. Within a limit?

Mr. JONES. Yes.

Mr. JOHANSEN. Then would not the effect of the discretion you exercise be in part, at least, to provide something of this very reserve that we are talking about?

Mr. JONES. Definitely; yes.

Mr. JOHANSEN. And the cushion. Do you anticipate any serious criticism directed at the Commission from employees by reason of not receiving as substantial benefits, or coverage, as they might have envisioned or desired?

Mr. JONES. I think that that is inevitable. I do not believe we could possibly avoid it. This criticism will be given in good faith, that we are sure of.

Mr. JOHANSEN. Certainly.

Mr. JONES. We will work with it as much as we can, but on the other hand we also recognize that the spokesmen for the Federal employee organizations, after pretty careful canvass of the fiscal realities of their membership, recognize that in many cases people cannot go as high as this bill would appear to contemplate.

Mr. GROSS. The most fatal thing that could be done would be to hold out something that is false, hold out false hopes?

Mr. JONES. Exactly. If we hold out false hopes here, and if this thing falls on its face, we will set the cause back for years and years and years.

Mr. JOHANSEN. I associate myself completely with that viewpoint.

Would you anticipate that after the first 2 or 3 years, and after you have sized up the problem and sized up the willingness of the employees to pay their share of the load, there would then be moves—and again I do not say this critically—to increase participation, either by the Government or by the employee, or both, in order to step up the benefits?

Mr. JONES. I think that also is inevitable in any event, but if we do not succeed in stabilizing hospital and medical care costs it will be even more inevitable.

Mr. JOHANSEN. Do you anticipate as an inevitability the effort to increase the Government's share without increasing the employees' share?

Mr. JONES. I cannot speak to that, sir. I do not know. I know, of course, that the employee organizations strongly favor the Senate cost-sharing provisions of the bill. The administration equally strongly favors the one-third-two-thirds concept. I think we could probably say that if the benefits do not turn out to be what people hope they will be, and if they do not seem to be filling a need, then, as is always the case, the first effort will be to see whether Uncle Sam will agree to pick up any more of the costs, and perhaps some day he could. But I think under present fiscal conditions, which will be described by the Budget Director, this becomes quite impossible to do.

Mr. JOHANSEN. Thank you.

The CHAIRMAN. I am glad that you are stressing the fact that these benefits in the Senate-passed bill are not guaranteed to the employees. You say in your statement:

The Washington Evening Star ran a front-page article itemizing in detail the benefits described in section 5 and stating further that these benefits were guaranteed.

As you say, they are not guaranteed at all under this bill.

Mr. JONES. We want to be sure.

The CHAIRMAN. You do not want the employees to be misled?

Mr. JONES. We do not want the employees to be misled, and we do not want the members of the committee and the Members of the House to be misled.

The CHAIRMAN. In other words, the benefits will go just as far as the contributions permit; is that correct?

Mr. JONES. As far as the contributions will permit in the light of the combined judgment of the administrative agency of the Federal Government and of representatives of the people who will undertake to provide this, the Blue Cross-Blue Shield and the insurance companies.

The CHAIRMAN. What kind of reserve do you think would be set up?

Mr. JONES. I cannot put a figure on that, Mr. Murray. One of the responsible witnesses before the committee—and I do not remember now who it was—suggested in the first year those reserves should be as high as 20 percent. We earlier had suggested that in the initial stages—which I am afraid we did not define too concretely—there ought to be 10 percent. We ought to get experience here. It is our hope that we can get between 1,800,000 and 2 million employees coming into this kind of program. Assuming the passage of the legislation in due course, we can, with that large body of people over a relatively short time develop some experience data which, while they may not have all the actuarial certainty of life-insurance data, will, nevertheless, be good enough so both we and the companies, working together, can do a better job, frankly, of estimating what the costs are going to be and what you can provide within the amount of money available. This is big. We have never tried anything like this for so many people before.

Mr. GROSS. You had better leave yourselves ample elbowroom in the first few years.

Mr. JONES. I certainly hope so. I think here again one of the most irresponsible things which the Civil Service Commission can do today would be to come down here and say to the Congress that we live in the best of all possible worlds and nothing is going to happen here if you do not set up reserves. We feel very sure if we do not set up reserves something will happen. I, for one, do not want to take the responsibility of not having warned it was going to happen, and not having asked the Congress to do something about it. If we do not warn you and have to come back up here and bail out this program with new legislation, or with a very large appropriation, I think we will not have discharged our public trust properly.

The CHAIRMAN. I agree with you entirely, and I commend you for it.

Mr. FOLEY. On this point I would like to propose a hypothetical situation. Let us assume that 50 percent of the participating employees select a benefit under the service benefit program and 50 percent go up under the indemnity benefit program. The experience under the service benefit plan would be, say, in the neighborhood of a 20-percent loss ratio for the year; whereas under the indemnity plan there would be a 2-percent net.

Have you, in your studies, projected the consequences? And what action would you take under that type of program in rating the results of the program? Would you lump the net gain as a deduction against the 20-percent loss so that there would be a total 18-percent loss?

Mr. JONES. No, sir. What we want to do, Mr. Foley, would be to set up reserves by individual carrier categories. Now, actually, nothing in our experience data so far accumulated leads us to believe there would be anywhere near that kind of discrepancy. You cited us an example just to dramatize the possible differences.

Mr. FOLEY. That is right.

Mr. JONES. Conceivably, something could go wrong and you could get a large discrepancy. We do not anticipate it, but we just do not know. We would try to keep the reserves by plans so if we get into trouble on one we would not make the employees who had chosen the other plan suffer by a reduction in the benefits, or an increase in the cost.

Mr. FOLEY. You would not have plan used to bail out another plan?

Mr. JONES. We would not so visualize. The Congress might legislate otherwise, or there might be some alternate reason for coming back to you and asking for congressional ratification for doing that, but we frankly would consider it almost a breach of contract with the employees involved.

Mr. FOLEY. I will reserve my other questions for a more appropriate time.

Mr. REES. Your proposed amendment simplifies section 2. Do you really mean in your proposed amendment to get the best contract that you can from the insurers? Is that about it. Do you want to get the best balanced program you can get for hospital benefits and surgical benefits?

Mr. JONES. I think the answer is categorically "Yes." It does not mean that we would hold ourselves to an implied statutory standard of 120 days because we do not think we could get 120 days.

Mr. REES. We had testimony this morning that oral surgery should be included.

Mr. JONES. Yes. I heard Dr. Mead's testimony, and we would certainly hope, and contemplate, that under a reasonable definition of oral surgery we could go along with that kind of thing. We certainly do not believe that we could go into it on the basis of saying we are going to take care of all dental costs, or all of the costs of what was called, when I was a kid, pulling teeth. This gets you into an area where there are a great many intangibles, but again the overall figures throw out a warning flag. The committee knows the total medical expenditures in the United States are somewhere between \$14.3 billion and \$14.5 billion a year; and of this, according to the best figures we have, about \$1.6 billion is paid for dental care—and that is better than 10 percent. This has not come into the figuring of the insurance companies, as I understand it, or the Blue Cross or the Blue Shield. You simply could not absorb it.

Oral surgery, as Dr. Mead referred to it this morning, is a different kind of thing. It is no different from surgery on your elbow, or hand.

The CHAIRMAN. Would that not be included in the Senate-passed bill?

Mr. JONES. We think that it could be worked out. We have had no detailed discussions about what should go into contracts because I do not think that it would be fair to the insurance companies to ask them, or to ask the Blue Shield organization, to give us a, b, c, d, exactly what you will do.

Mr. JOHANSEN. Would you amend your answer to Mr. Rees' question to read, you would not only endeavor to get the best possible coverage with the rate of contributions by both parties determined upon, but you would also endeavor to provide a maximum opportunity of choice as between the total first dollar type of coverage, which some employees might want, and the type of coverage which

provides for the deductibles, and for a higher coverage for the so-called catastrophic type. Would it not be the aim of the Commission to make available those choices and to be sure that they were available?

Mr. JONES. Yes.

Mr. JOHANSEN. I think that is tremendously important.

Mr. JONES. To the limit we can.

Mr. JOHANSEN. Yes, of course.

Mr. JONES. I want to point out again we are awfully humble people about just how successful we are going to be in the first instance on this. We do not have any doubt about the capacity to bring something out of this in a relatively short time, but we are going to make mistakes, gentlemen, and they are going to be mistakes about which people are going to be very critical. I do not doubt that for a moment.

Mr. JOHANSEN. So long as you provide the maximum that you can within what is available, and so long as you provide a maximum opportunity of choice in the area that I mentioned, it seems to me that you meet the two most fundamental responsibilities.

Mr. JONES. I think that is correct, yes.

Mr. DAVIS. With reference to the answer you have given to Mr. Johansen, and come under this bill, there would be a maximum of \$1.75 for one person and a maximum of \$4.25 for the family. As I gathered from your discussion you feel that the Commission would have authority to cut that down to half of the \$1.75, or half of the \$4.25 if you thought it was best to do so; is that correct?

Mr. JONES. Maybe I have been just a little elliptical, Judge Davis, and misled you perhaps as to the way we would change the language.

The language that Congressman Johansen referred to appears on page 14, beginning at line 8, section 7(a) (1), (2), and (3).

Mr. DAVIS. First let me understand what your construction of it is as it is written in the bill. I understand that you say now that the Commission could reduce those figures.

Mr. JONES. Yes.

Mr. DAVIS. To anything they saw fit.

Mr. JONES. Yes. We would like to make that a little more certain so that there would be no argument. We would propose to strike out all of page 14 beginning at line 8 and the first three lines on page 15 and substitute in lieu thereof this language:

The Government's contribution to the subscription charge for each enrolled employee, or annuitant, shall be 33½ percent of the subscription charge, but may not exceed amounts that the Commission may by regulation from time to time prescribe. The amounts so prescribed shall not exceed (1), \$1.75 biweekly if the employee, or annuitant is enrolled for himself alone, or (2), \$4.25 biweekly if he is enrolled for himself and members of his family, or (3), \$2.50 biweekly in the case of a female employee, or annuitant who is enrolled for herself, and members of her family, including a nondependent husband. There shall be withheld from the salary of each employee, or annuitant, of each annuitant enrolled in a health benefit plan under this act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment.

Mr. PORTER. I want to say this because I am going to have to go in a few minutes, I have certainly appreciated your testimony. It is exactly what I needed and I think the committee needed, and I certainly want to have the benefit of this print after it is printed. There are a number of other opinions that we are going to need from you on suggested amendments that I trust we will get in due course.

Setting this up would take some time, would it not?

Mr. JONES. Yes. I cannot tell you how much, but it would take some time.

Mr. PORTER. As things are now the effective date of the bill is June 30, I believe, next year.

Mr. JONES. Or July 1. It is a fiscal year proposition.

Mr. PORTER. Most of us on the committee would like to see it enacted this year. I would like to have your comment on the importance of enacting the legislation this year in terms of the work that you would have to do.

Mr. JONES. Do you mean in terms of whether we could meet a July 1 deadline date next year?

Mr. PORTER. Yes.

Mr. JONES. That is difficult to answer. I do not know how rapidly these things will fall into focus. If the legislation should be enacted this year I think there certainly is plenty of leeway. On the other hand, Mr. Porter, we would rather have a bill that everyone understands than to have something whipped through now which will create more problems and take more time than we would save by waiting and getting the kind of legislation that we are sure that we can administer to the best of our ability.

I want to stress again we are not going to try to indicate to the committee we think we have all the answers. We do not. We will trade time for better language with great pleasure and conviction that we are doing the right thing.

Mr. PORTER. I think there is no disposition on the part of the committee to hurry through. We appreciate the way that you have presented this. I know that we will consider at all times the suggestions that you have made. I have a number of questions that will have to await my turn. I assume that the gentleman will be back tomorrow.

Mr. JONES. I will be available whenever the committee wants me.

The CHAIRMAN. Let us continue with the other provisions.

Mr. JONES. We left off with section 5, and I had just read what we would do with the indemnity benefits plan.

Mr. GROSS. What page?

Mr. JONES. Page 11. Before we took the other questions I had just read the new (b) plan, which would have under it 1, 2, 3, 4, 5, running from line 10 through 16 with the present a, b, c, d, e, and f.

INDEMNITY CARE

1. Hospital care.
2. Surgical Care and Treatment.
3. Medical Care and Treatment.
4. Obstetrical Benefits.
5. Prescribed Drugs, Medicines and Prosthetic Devices.
6. Other Medical Supplies and Services.

So we would have directly parallel construction in this section, listing under the indemnity benefits plan the list of things to go into the contract, just as we would under the service benefit plan.

Mr. FOLEY. As I understand your testimony, this listing would be suggestive rather than mandatory?

Mr. JONES. That is correct. It would be introduced by the language:

The benefits to be provided under plans described in section 4 may be of the following types:

Mr. JOHANSEN. In that connection, is there anything you care to comment on as to the cost factor in the overall picture of obstetrical benefits and the extent to which the commission would feel free to exercise discretion as to their inclusion or noninclusion, or their degree of inclusion?

Mr. JONES. I do not think that I am really qualified to speak on a basis worth anything. I have a certain amount of personal feeling about it; namely, that I think the present insurance and Blue Cross and Blue Shield plans are about right. I think on an overall basis you are running on obstetrical, including prenatal and immediate postpartum care, in the \$150 to \$300 range, assuming a normal delivery. I think that it has been contemplated that we would split the middle there and come out at about \$200, as most of them do.

The CHAIRMAN. Would you keep the language under (F) on page 11?

Mr. JONES. We would simply say, "obstetrical benefits."

The CHAIRMAN. Like the suggested revision under section 5 at the beginning?

Mr. JONES. Yes.

The CHAIRMAN. And enumerate all the possible benefits?

Mr. JONES. You would have to work it out.

Mr. JOHANSEN. This is the reason that I asked the question. I have been given to understand this is one of the major cost factors in the service type program, and there was the question as to whether that proportion of the cost should be included in the program where it might be used for the catastrophic type of situation.

Mr. JONES. I do not think that I am competent to comment. This involves many professional judgments that I, as a layman, cannot give. I do think that we have to carry in mind the things that are going to make the plan popular, and certainly with as many young people as we have working in the Government today, and certainly with their tendency to have rather substantial families, I think that obstetrical benefits will be a most attractive element.

The CHAIRMAN. I certainly agree with your observations that the Senate-passed bill represents the most expensive kind of benefits. We do not want to mislead the employees by saying that they are going to receive all of these various benefits listed in the Senate-passed bill because if the money is not there from contributions the benefits just cannot be provided. Is that not so?

Mr. JONES. If I may hazard a guess, Mr. Chairman, on the basis of my own rather elementary arithmetic, I do not believe that you can provide what is in the bill with the amount of money in this bill even if you reversed the administration's position on the ratio and raised the Government's contribution. I think that it would just plain cost more money than that.

The CHAIRMAN. You may proceed with the other suggestions as to revisions of the Senate-passed bill. You are through page 11, are you?

Mr. JONES. We are at the bottom of page 11.

We would have as subsection (c), employee organizations' plans, with some changes in language, and we would have a substantial section (d), comprehensive medical plan.

The top of page 12 we would strike out lines through 9. They would not be needed if we changed and have just the catalogues.

Moving on down to the "Contracting Authority," there are some slight changes there which are just language changes. Where it says, "renewable from year to year," in line 19, we would say, "renewable from term to term," because it may not be on a yearly basis.

At the end of section 6(a) we would insert a new subsection, beginning between lines 20 and 21, which would be subsection (b) which would read something as follows:

(1) The contractor governmentwide service benefit plan shall require the carrier to allocate its rights and obligations under the contract among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates, and approved by the Commission.

(2) To be eligible as the carrier for a governmentwide indemnity benefit plan a company must be licensed to issue group health insurance in all States and the District of Columbia. The policy for such plans shall require the carrier to reinsure with such other companies as may elect to participate in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available and to be determined by the carrier and approved by the Commission.

Both of these are to spread coverage and also to make it possible to set up a formula for additional participation. This was done quite successfully under the life insurance program and I think we now have 160 companies participating in the life insurance plan.

This is also, may I say, Mr. Chairman, the answer to some people who insist the Government is never interested in doing anything that involves the little fellow, that it always wants to do something for the big fellow. This would give all the insurance companies who write this kind of business an opportunity to come on the basis of an equitable formula.

The CHAIRMAN. Did the Civil Service Commission collaborate and assist in the preparation of the provisions of S. 2162?

Mr. JONES. Do you mean as it now stands?

The CHAIRMAN. Yes.

Mr. JONES. That is a hard question to answer without splitting hairs. I think that the answer must be "No," we did not. We knew of some of the things being done, but we did not play a very active part in the actual development of the language. We made some suggestions to the committee, a number of which were adopted, and we, of course, worked with them on the specific language, but in terms of doing it from the first page through to the last page, sitting down around a table, no, we did not, nor in terms of preparing the kind of text that I have been suggesting to you here today and which I would again recommend be made a committee print. We did not do that.

The CHAIRMAN. I suggest after we adjourn, or some time before we meet tomorrow, that you and other officials of the Commission get together with our committee staff and assist in the preparation of a tentative committee print for consideration.

Mr. JONES. If that can be done it would be a considerable favor to us and I think of considerable assistance to the committee. I would like to suggest, if we do this, though, we do it the old way by showing both the present language stricken out and the new language inserted. Then the committee will have less difficulty in following me, because they are now pretty well acquainted with the language of S. 2162, and it would save having two pieces of paper in front of you.

The CHAIRMAN. I agree that it should be done and I will ask the committee staff to follow that procedure.

Mr. BROYHILL. I have a question, and I will preface it with the remark that it is not for personal reasons that I ask the question—is it your understanding the term “employee” on page 1 includes Members of Congress?

Mr. JONES. Yes, it does. It must.

Mr. BROYHILL. Similar to the language in the Life Insurance Act?

Mr. JONES. Yes. It is “officer,” but you are an officer; you are not an employee.

Mr. BROYHILL. The other question is, is it your understanding that retired employees who come back to work for the Federal Government would be included under this act?

Mr. JONES. People already retired, or subsequently retired?

Mr. BROYHILL. Well, previously retired and now are back to work for the Federal Government.

Mr. JONES. Yes.

Mr. BROYHILL. They would be entitled to the benefits of this act?

Mr. JONES. Yes, under certain conditions.

Mr. BROYHILL. The annuity they are receiving provides a portion of their salary.

Mr. JONES. That is right.

Mr. BROYHILL. They are on the retirement rolls, but that would not preclude them or deny them the benefits of this act?

Mr. JONES. No. This is the kind of thing you certainly would nail down in regulations.

The CHAIRMAN. It is now 5 minutes to 12. The committee will stand adjourned until tomorrow morning at 10 o'clock, when the hearings on this legislation will be resumed.

I hope in the meantime you will get together with the staff of the committee and prepare this committee print by the time we meet tomorrow morning.

Mr. REES. Do you have any more amendments that you want to offer?

Mr. JONES. There are a dozen more amendments, some very substantial and many of them just word changes.

The CHAIRMAN. They will all be shown in the committee print?

Mr. JONES. They will all be shown in the committee print.

The CHAIRMAN. The committee will stand adjourned.

(Whereupon, at 11:55 a.m., the committee adjourned to reconvene at 10 a.m., Thursday, August 13, 1959.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

THURSDAY, AUGUST 13, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m., in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be resumed on S. 2162 and other bills introduced by various Members of the House on the health insurance program for Government employees.

Since adjournment yesterday a committee print has been made with the assistance of Mr. Jones, Chairman, and Mr. Irons, Executive Director, of the Civil Service Commission, and members of the committee staff, which I understand embodies the various suggestions made by the Chairman of the Commission.

Now, Mr. Jones, how far along did you get with these suggestions as to revisions yesterday?

STATEMENT OF ROGER W. JONES, CHAIRMAN, CIVIL SERVICE COMMISSION, ACCOMPANIED BY MR. WARREN B. IRONS, EXECUTIVE DIRECTOR, AND DAVID F. LAWTON, ASSISTANT DIRECTOR, BUREAU OF DEPARTMENTAL OPERATIONS—Resumed

Mr. JONES. I think more or less in detail we have finished section 5, which in the committee print ends on page 14.

Mr. LESINSKI. I am sorry that I had another committee meeting yesterday morning and could not be here and hear all the testimony.

There is a question that I would like to ask you.

You are opposed to including retired civil service employees from the time of the enactment of the law. Would you allow these people to pick it up on July 1, 1960?

Mr. JONES. Would you mean to have them pick up the entire cost of the period between the date of their retirement and the date that bill becomes effective? Is that what you have in mind?

Mr. LESINSKI. What about the contributions?

Mr. JONES. These things are relative. We believe quite strongly the fairest and most equitable thing to do is to start this program at a given date and not have any retroactive activity in the program at all. If you make it retroactive for one group perhaps you should for other groups.

Mr. LESINSKI. Your argument is that you do not have the program set up yet?

Mr. JONES. That is part of it; yes. There is also the general problem of what do you establish as a cutoff date if you move backward. Is there any more justice and equity in establishing the date the bill passes both Houses of Congress than today or the 1st of July? Some people will miss entitlement by a few hours regardless of what date we establish.

The CHAIRMAN. You may proceed.

Mr. JONES. I think perhaps I should ask if the members have any questions up to page 14 that were not asked yesterday. It makes no difference whether they ask them now or go back to them. Perhaps the members will want to review these pages, and if they have questions we can go back and pick them up.

Beginning in the middle of page 14 and section 6, there are some minor language changes that I do not believe need to be discussed, and then, as I indicated yesterday toward the end of the session, we would add a new section (b) with subparagraphs (1) and (2), which would bring into the bill two features we think are quite necessary.

The first is to permit the benefit plan people to allocate their rights and obligations among all their affiliates. These are the affiliates of Blue Cross and Blue Shield, and that would be done in accordance with an equitable formula.

The second subsection refers to the carriers of the indemnity plan, or insurance companies, in which we would adopt a proposal exactly parallel with that under the Government Life Insurance Act, which permits reinsurance so you can spread the risk among all of the insurance companies.

The language, I think, is self-explanatory.

Mr. PORTER. My question goes back to pages 8 and 9, where you refer to a "one governmentwide service benefit plan" for the service benefit plan, and one governmentwide indemnity benefit plan under the indemnity benefit plan. I recognize the difficulties of administering many plans, 200 or 300, but I wonder if there is not some happy medium here, some middle road, between just 1 plan and 200 or 300. I am thinking more of service benefit plans than insurance plans which are a little different in this respect. I am thinking of competition and the portion of this that seems to say that you do not have to take bids.

I would like to have your opinion of why we must use the term "governmentwide." Why not leave it to the Civil Service Commission? Why tie down to "governmentwide," or why not keep you bound by regulations and laws which have to do with competition?

Mr. JONES. I think there are basically three reasons, and perhaps a fourth.

The first is that so far as we now know—and we do not pretend to know everything about this—there are something over 200 plans and they are not of a nature, either in terms of their coverage or in terms of their enrollment, as to suggest that their inclusion would be particularly helpful or attractive either to the employees or to the people who manage the plans themselves.

Mr. PORTER. May I comment at this point? You are taking the other extreme. I am not proposing that you would have to recognize all of these. In New York there may be a plan big enough for you to

deal with in terms of more than just the employees of one department. Why not be able to deal with such a group and take their competitive bid against Blue Cross and Blue Shield?

Mr. JONES. I will give you my second answer. I am not sure there is any effective competition in the service benefit plan area. It is my understanding—and I cannot say it is more than that because I do not have definitive information—almost as rapidly as the service benefit plan idea becomes active in a community, or in a company, the net result is to end up with a plan which becomes an affiliate of the Blue Cross-Blue Shield type of insurance.

Mr. PORTER. Did you hear the testimony of the gentleman from New York that there was an alternative?

Mr. JONES. We have allowed in here for some of the kinds of things you may be referring to. The Group Health Insurance plan in New York is definitely contemplated for coverage.

Mr. PORTER. How is that contemplated in view of "government-wide"?

Mr. JONES. If you will look at page 10 you will see what comes under our new language under our individual practice prepayment plan. This is language which I read yesterday, but which, of course, the members of the committee did not have in front of them. It reads as follows:

Individual-practice prepayment plans which offer health services in whole or in substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions, approved by the Commission, to accept the payments provided for the plan as full payment for covered service rendered by them including, in addition to in-hospital services, general care rendered in their offices and in the patients' homes, out of hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have operated such plans for at least 5 years.

These are the kinds of things I referred to yesterday, including the one that you know, the Oregon hospital plan.

Mr. PORTER. I would call that a group plan. What is the difference?

Mr. JONES. May I ask Mr. Irons to answer further on this?

Mr. IRONS. Basically, under the group practice prepayment plans the doctors under contract operate in a group in a building, whereas in the other type they will have other contracts with many more doctors throughout a city, and the individual goes to that doctor in his office for service. It is a question of physical location and whether he actually has to go to the building to get the service or not.

Mr. PORTER. In Blue Shield you go to an individual doctor.

Mr. IRONS. To an individual doctor for that kind of thing.

Mr. PORTER. And you call that an individual practice prepayment plan?

Mr. IRONS. Would you like to expand on that, Mr. Lawton?

Mr. LAWTON. I would add just this: as far as the individual practice prepayment plan is concerned, as Mr. Irons has said, the plan offering this kind of insurance would have contracts with many doctors in the city, but the plan would be offered on a service basis, not as in the case of Blue Shield, which is part service and part indemnity.

Mr. PORTER. Does this group practice prepayment plan always have its own headquarters and its own place, if I understand Mr. Irons correctly?

Mr. LAWTON. That is correct. It may have more than one center as HIP in New York City does.

Mr. PORTER. But actually an operational headquarters?

Mr. IRONS. Operational headquarters at centers throughout the city.

Mr. PORTER. If you were an individual you could just go to a particular physician?

Mr. IRONS. That is right.

Mr. PORTER. The one in New York, is it group or individual?

Mr. IRONS. It is GHI. That would be individual.

Mr. PORTER. You feel that this bill allows you not to have competition where there are plans that may compete?

Mr. JONES. No. That was the third of my three reasons.

I believe that the element of competition which you stress there is very adequately provided for by the language of the bill as it now stands.

Mr. PORTER. Why do you want that provision in there saying you do not have to obey that section of the law which provides for bids?

Mr. JONES. Do you mean section 3709, competitive bidding?

Mr. PORTER. Yes, appearing on page 14.

Mr. JONES. For the simple reason we do not know enough about this business to get competitive bids. We are going to have to work with the insurance people, the medical people, the hospital people straight across the board in order to find out what we can and cannot do. In other words, I do not think that we today can write specifications which are specific enough to permit what you might call competitive bidding.

Mr. PORTER. Why not?

Mr. JONES. Because you do not have any experience data to start from.

Mr. PORTER. You say for so much you want so many days in the hospital.

Mr. JONES. There are not common definitions of what that means. There may be on such a thing as how many days in a hospital, but the other things have great variances in them—the amount allowed for prosthetic devices, the amount allowed for anesthetics, the supplemental services within the hospital, such as the use of recovery rooms and a great many other things of that kind. I think that it would be far wiser and far more satisfactory to give us an opportunity to work our way into this to see if eventually we can come up with standard concepts and standard specifications.

Mr. PORTER. But eventually, even if you just have one contract with one group, you are going to have to have specifications because you are going to be paying them so much for services. I would think that you could write the amount and offer them to all the companies who qualify financially and then let them bid.

Mr. JONES. I think there is an important additional difference, Congressman, and that is this—in the case of the Blue Cross-Blue Shield organization you are dealing primarily with nonprofit organizations. In the case of the insurance companies you are dealing with a large variety of different approaches which have restrictions in part that are imposed by 47 different States' insurance laws. I just do not say that we are going to get as good results.

Mr. PORTER. We have evidence here that the administrative costs would vary from 5 to 10 percent and presumably the ones who made the administrative costs lower could bid lower and pass that saving on to the Government worker.

Mr. JONES. I do not think that that necessarily follows.

Mr. PORTER. They could pass it on. They would bid lower.

Mr. JONES. I do not think that administrative costs are the swing feature in this at all.

Mr. PORTER. We have had testimony showing what a hospital would charge in a particular community, and what the hospital would charge is pretty well set overall, and those costs are not hard to control. Now, administrative costs can vary from 5 to 10 percent and that can be an awful lot of money in a situation like this. It would seem very good if we could pass that on to the Government workers by having competition.

Mr. JONES. I think Mr. Irons will answer this further in a minute. I think we need not worry about the capacity to pass on any savings that there are going to be in this program. All the incentives on both the indemnity type of carrier and the service type of carrier are going to be in the direction of coming up with the best program they can devise as cheaply as they can. I would like to ask Mr. Irons to add one more word.

Mr. IRONS. I wonder if I could add a couple of points here.

If you will turn to page 17 I think that it is important to read lines 6 to 19. This is on S. 2162, the committee print. The language which the Commission proposes be put in the bill is consistent with the way that we operated under the group life insurance act so successfully. The purpose, as you know, of section 3079 of the Revised Statutes is to produce low bids. We feel that this language will perform that task and do it more effectively. We say here:

Subscription charges and premiums under health benefit plans described in sections 4 (1) and (2) shall be determined on a basis which, in the judgment of the Commission, is consistent with the lowest schedule of basic rates generally charged for new group health insurance issued to large employers. Subscription charge and premium rates determined for the first contract term shall be continued for subsequent contract terms, except that they may be readjusted for any subsequent terms, based on the experience under the contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health insurance to large employers.

Now, let me elaborate a bit on that language which I said is based on how it was handled in the group life insurance plan. The way that we did this group life insurance I think would be the same way we would do it here. We found out in advance from both large employers and the insurance carriers the rates that the large employers were paying to make certain that the rate quoted to us, proposed to us in negotiation, was not as high. Also, it is highly desirable in this business, of course, to select the carrier initially because to change from year to year from one contract to another will present real problems because of the fact that when the contract runs out perhaps one of the employee's wife is 6 months pregnant and you have to argue who pays, the carrier of the contract in the initial year or the carrier of the contract at the time of renewal.

Mr. PORTER. What is the answer to that? Let me say, I think this is good to have in here. I do not have any doubt of the good faith and the ability of the Civil Service Commission to try to get the best deal possible for the Government employees, but the large employers referred to, do they not ask for competitive bids when they set up their plans?

Mr. IRONS. Some do and some don't. General Electric did not.

Mr. PORTER. If somebody is in it because they want to get the money and they can cut administrative expenses and other expenses and still give services they should be able to bid lower. I cannot understand why the Civil Service Commission cannot decide on some specifications. These contracts have been made for years and years now, and it would seem to me that you could have specifications written, many of them with standard clauses that have been well worked out, and you could put them up for bids. Why leave "governmentwide" in there? It seems to me that that restricts the Civil Service Commission. Would you have any objection to taking "governmentwide" out?

Mr. JONES. Very definite objections.

Mr. PORTER. It ties your hands?

Mr. JONES. It does not tie our hands at all. I think that our hands would be very badly tied by having it otherwise, except insofar as these special plans are concerned, because you are going to have to deal with a number of companies who basically cannot give you anything you want.

Mr. PORTER. You do not have to deal with them, do you? What in the bill makes you deal with people you do not want to deal with?

Mr. JONES. If you are going into section 3709—

Mr. PORTER. If you put the specifications out and some company could provide you with the service you wanted, do you think that that would be bad?

Mr. JONES. No. If you are saying this is something that could be negotiated, I would not object to it. But if you are saying take out "governmentwide" and restore the requirement for competitive bidding, I object very strenuously to it.

Mr. PORTER. You would be willing to take our "governmentwide" as long as you could negotiate. Of course—

Mr. JONES. I do not know how you term "governmentwide."

Mr. PORTER. I want to know.

Mr. JONES. If you are getting back to the kind of plan that we are talking about, such as the Oregon Hospital Association has, this is not governmentwide; no. But we are providing for that kind of organization to come under the tent here.

Mr. PORTER. What I am getting at is, is the Blue Cross, for example, the only organization that can provide it as you seem to think? Are there other organizations that ought to be given a chance to compete because they are big enough and will not bog you fellows down in your administrative work? I am not saying all the 200, but where there are those big enough that you could deal with them and they would agree to meet the specifications that you set out, which are being met by Blue Cross, why not let them bid on it?

Mr. JONES. On the basis of the information we have at hand, the answer is "no; there is no such organization."

Mr. PORTER. No one else could give that interchangeability factor that you think is important?

Mr. JONES. It is highly important.

Mr. PORTER. I think it is, too.

Mr. JONES. It would be important for the Members of Congress. You are here now and 3 weeks from now perhaps you will be at home.

Mr. PORTER. Is it your impression that the bill covers Members of Congress?

Mr. JONES. It does, indeed.

Mr. PORTER. That is interesting. We have not had any testimony on that and many of us were concerned.

Mr. JOHANSEN. Is not there, first of all, a very fundamental type of competition as between the four or five types of categories and insurance plans?

Mr. JONES. In my judgment, yes. This is competition that will appeal to the individual and to the Government.

Mr. JOHANSEN. And it is competition in terms of choices for the individual?

Mr. JONES. That is right.

Mr. JOHANSEN. And competition in terms of the various participants trying to win the interest and the participation of the individuals; is that not correct?

Mr. JONES. Yes.

Mr. JOHANSEN. And is there not also within the category of commercial insurance companies enough element of competition so that the best possible plan is going to be devised by the various participants in that category of coverage?

Mr. JONES. In my judgment that is inherent when you talk about insurance. The insurance companies operate on that principle.

Mr. JOHANSEN. Can you tell me what alternative there is that would add to the competition?

Mr. JONES. No; I cannot. That is why I had some difficulty answering Congressman Porter. I do not think there is.

Mr. JOHANSEN. I have not heard anybody who has been able to offer any description as to how there would be greater competition.

Mr. JONES. Congressman Porter suggested perhaps we could write specifications which would enable the various companies in bidding to use, among other things, the difference in their administrative costs as an element for reducing the amount of the bid to the Government. I do not think that it would work that way.

Mr. JOHANSEN. Are you talking about administrative costs or profits?

Mr. JONES. I am talking about the Congressman's term.

Mr. JOHANSEN. How would it be possible to write such specifications for competition between these types of insurance? How would it be possible to write uniform specifications if one of the purposes of this competition is to provide a variety of choices?

Mr. JONES. I do not believe you can, sir.

Mr. WALLHAUSER. Mr. Jones, there is no competition under No. 1 really, is there?

Mr. JONES. Which page are you now referring to?

Mr. WALLHAUSER. Page 8.

Mr. JONES. No, sir.

Mr. JOHANSEN. It is not available.

Mr. JONES. That is correct. Congressman Porter raised the very definite question whether in my judgment there was any other organization which was capable of competing in this field, and my answer is "No, I do not think there is. I do not think there will be for a long, long time, if ever."

Mr. JOHANSEN. You would know if there were, would you not?

Mr. JONES. I am sure we would, but I cannot be sure there might not be organized overnight some kind of service plan just under the stimulus of this bill.

Mr. JOHANSEN. And if there were, you would certainly give them an opportunity to be heard on the matter?

Mr. JONES. We would, sir.

Mr. JOHANSEN. And there would be competition to that extent?

Mr. JONES. I believe so, yes.

Mr. WALLHAUSER. May I continue?

The CHAIRMAN. Mr. Wallhauser.

Mr. WALLHAUSER. Is it not a fact that of the 200 insurance companies that you have mentioned there would be only a very, very few of them that would be willing to undertake to write this risk to begin with?

Mr. JONES. I cannot say that for sure. I do not know how many of the insurance companies will be willing to come in under an indemnity plan. It is our hope that quite a substantial number of them will be willing to carry a part of this.

Mr. WALLHAUSER. But each has a different idea as to coverage and so on?

Mr. JONES. Yes.

Mr. WALLHAUSER. And therefore it will require negotiation?

Mr. JONES. Yes.

Mr. WALLHAUSER. And someone has said there would be a reinsurance pool?

Mr. JONES. Yes; that is provided for.

Mr. WALLHAUSER. So eventually they would all have to agree to this one plan anyway?

Mr. JONES. That is correct.

Mr. WALLHAUSER. So I believe by giving you the power to negotiate you can produce a better contract for the Government than by putting out specifications and having them bid.

Mr. JONES. That is our belief.

Mr. JOHANSEN. Let us get this thing out in the open. If the concern is that these insurance companies will have excessive administrative costs—and if it is, let us say so—is there any protection for the Government and for the employee against that type of abuse, assuming—and I do not necessarily assume—the insurance companies are on the make to shake down the Government and the Government employees?

Mr. JONES. I think the protection is of two kinds, one direct, which Mr. Irons read on page 17 as to the policy of the Government on subscription charges, and the other is the protection of responsible administration by the Federal Government. This is the kind of thing you will do literally in a goldfish bowl and you cannot afford to operate on any other basis.

Mr. GROSS. And with the Congress looking over your shoulder at all times.

Mr. JONES. I hope so; yes.

Mr. JOHANSEN. And if there are abuses, Congress will not only look over your shoulder but will expose it?

Mr. JONES. That is correct.

Mr. JOHANSEN. I hope I do not have to ask any more questions about this matter of competition, but I will if it persists in being raised.

Mr. LESINSKI. Mr. Chairman.

The CHAIRMAN. Mr. Lesinski.

Mr. LESINSKI. On page 10, the last line, you say "which plans are offered by organizations which have operated such plans for at least 5 years." What is the purpose of that?

Mr. JONES. To get adequate experience.

Mr. LESINSKI. You said there might be a new plan brought up under the stimulus of this legislation?

Mr. JONES. I said it is conceivable that there could be the establishment of a new nationwide competitor of the Blue Shield-Blue Cross type organization. I do not believe there would be, but it is not something that is prohibited from happening. The purpose of the 5-year requirement is that we do not pick up something completely untested.

Mr. LESINSKI. This problem has been touched on before, but in view of the various health plans that might be considered, how does it affect employees who may transfer, say, from Detroit to some other State?

Mr. JONES. I believe that will not be as much of a problem as it seems at first instance. There will be to some extent, perhaps, a problem if the person is covered by the service benefits plan in Washington and is transferred to another post of duty in the field where there is no arrangement at all for a continuing insurance of that kind. But I think it is pretty much standard practice across the board to make arrangements so that you can go even in a nonparticipating hospital and be covered for the time being. Eventually the employee may have to shift his type of coverage.

Mr. LESINSKI. Say he has the Blue Cross-Blue Shield type of coverage?

Mr. JONES. They have provisions in their standard contracts which enable you, if you are taken suddenly ill, to go in a hospital and they take care of that on an emergency basis.

Mr. LESINSKI. Getting back to competitive bids, would you say that roughly at 3, 4, or 5 years it should be provided in the bill that you shall seek the lowest bid?

Mr. JONES. I cannot answer that now with certainty. I do not think so, for this reason. What we are trying to do here is to provide service. There will always have to be reasonable judgments, both lay and administrative and medical, as to whether any type of service is best just because A is willing to provide it for a little less than B. There are many intangibles that have to be brought into the picture.

Mr. LESINSKI. Suppose we say the best for the money?

Mr. JONES. I do not think we can answer that now.

Mr. LESINSKI. I said after 5 years.

Mr. JONES. I am not sure 5 years will be enough. This is the kind of thing I would expect the Congress, looking to the Civil Service Commission for stewardship, to ask us about maybe before the 5 years.

Mr. LESINSKI. These things drag out sometimes many years before anything is done. That is why I am asking these questions now.

Mr. WALLHAUSER. Will the gentleman yield?

Mr. LESINSKI. Yes.

Mr. WALLHAUSER. On page 13 of my copy of the committee print the words "The plan may include deductible and coinsurance provisions applicable to some or all of the benefits" are crossed out.

Mr. JONES. That is right.

Mr. WALLHAUSER. Does that mean as the bill now stands you cannot have deductible and coinsurance provisions?

Mr. JONES. Yes, you can, because it is permissible under the general language.

Mr. WALLHAUSER. It is permissible?

Mr. JONES. Yes.

Mr. WALLHAUSER. Could you show me where it is permissible?

Mr. JONES. The fact it is not prohibited means that it is permissible. I do not think we need this specific language to permit us to do it when you are dealing with this type of thing. It is a standard part of the business unless it is prohibited.

Mr. LESINSKI. One other question. I can see the cost of this insurance going up. Are you contemplating a deductible clause?

Mr. JONES. I cannot answer that definitely. Expressing purely a personal opinion, I think for certain kinds of things we may have to go to a deductible clause early in the game.

The CHAIRMAN. What percentage of Federal employees do you think would come under this program?

Mr. JONES. We are making a guess under the experience we have had with the life insurance plan, where we had over 90 percent or between 1.8 million and 2 million.

The CHAIRMAN. What about temporary employees?

Mr. JONES. Temporary employees are not covered under the bill as it now stands.

The CHAIRMAN. There are quite a few of them, are there not?

Mr. JONES. Yes.

Mr. REES. What percentage?

Mr. JONES. I do not remember the exact figures, but I think there are about 200,000 temporaries all the time. Some of these people, you might say, in the Post Office, for example, present some kind of problem because they are almost the same as regular employees. But the fellow working in a national park in the summertime or the fellow who is just carrying the mail at Christmas time is not.

Mr. REES. Will you not be faced with somewhat of a problem to discern between the permanent and temporary employees?

Mr. JONES. I think we can discern by definition. I am sure we can.

Mr. LESINSKI. Would the terminology "temporary indefinite" be better?

Mr. JONES. Temporary indefinite? You mean as an inclusion rather than an exclusion?

Mr. LESINSKI. Be excluded?

Mr. JONES. Mr. Irons would recommend that we would use the same kind of definition that we have used for the group life insurance. The exclusions under the group life insurance are the following:

Noncitizen employees whose permanent duty station is located outside of the United States or the District of Columbia; members of the uniformed services, who, as you know, have their own medical care arrangements; employees serving under appointments limited to 1 year or less except employees so appointed for full-time employment without break in service or after a separation of 3 days or less following service in which they were insured, and acting postmasters; seasonal or emergency employees whose employment is uncertain or are purely temporary employees; part-time or intermittent employees having no regular tour of duty; etc.

Mr. LESINSKI. So the regular temporary employees of the Post Office Department could be included?

Mr. JONES. They could be and are, I believe; yes.

Mr. JOHANSEN. What about acting postmasters? Are they in or out?

Mr. JONES. In.

Mr. IRONS. They are not usually temporary.

Mr. JOHANSEN. They certainly are not now.

Mr. LESINSKI. I am sorry the gentleman interrupted, but I can assure the gentleman that the acting postmasters of Michigan would have been confirmed if a certain person had kept his mouth shut.

The CHAIRMAN. Let us get back on the bill.

Mr. JONES. We were talking on page 15 about the two additions that were made in section 6(b) (1) and (2).

I am not sure whether Mr. Porter had one additional question on that or did not have?

Mr. PORTER. It was just a question of why it was necessary; why do you not leave it with the Civil Service Commission to determine whether it might not serve the best interests of the employees?

Mr. JONES. I hope I have been able to clarify that by indicating that where we use the term "governmentwide" we are speaking of the service plan and indemnity plan, and that does not mean there are not other plans in the picture, but it is only the governmentwide people who must provide for reinsurance under the indemnity plan or for participation of affiliates under the service-type plan.

Mr. PORTER. As I see it, this would mean you would have only one service plan and only one indemnity plan and therefore only one insurance company would have this contract?

Mr. JONES. I think that is correct, but that does not mean we are excluding people who do not operate on a governmentwide basis.

Mr. PORTER. But there is only one organization involved?

Mr. JONES. Yes.

Mr. PORTER. And in each case no other company would put in a bid?

Mr. JONES. On the service-type benefit we are sure of that as things now stand. On the indemnity type we believe the insurance provision is necessary to obtain necessary participation by all companies who wish and are able to come in.

Mr. PORTER. On that point, there are many insurance companies that would qualify in terms of the indemnity plan, is that not true?

Mr. JONES. I think that is true, yes.

Mr. PORTER. Then unless they get together and violate some anti-trust act and have a collusive arrangement, why would there not be a difference in their bids for the indemnity plan if you put it up to bid?

They make different profits, they have different administrative costs, and why should we not have competition under those circumstances? Maybe you have been over that before, and maybe you are being patient with me.

Mr. JONES. I do not think a witness ever has to be patient with a Member of Congress. I think the obligation of a witness is to be able to explain his position. That I have tried to do. I am trying to say it in another way but I cannot find the necessary words.

Mr. PORTER. You say you will select one and they will spread it out among the others for reinsurance so that everybody will be happy. I am saying, why not have some competition among these companies since more than one would qualify to take the governmentwide indemnity contract?

Mr. JONES. I believe there will be competition in that we will be talking with companies A through X or Y or whatever it happens to be. In our efforts to establish the dimensions of the plan, and in our talking back and forth of the services they can provide with x dollars for so many people, and so on, in the course of doing that you are getting the same competitive element the Congressman is looking for.

Mr. PORTER. And the contract would go to the one with the best price?

Mr. JONES. I am not sure the best price is the only criterion here.

Mr. PORTER. But this is just an indemnity plan?

Mr. JONES. There are all sorts of things involved—promptness of service, promptness in settling claims, the amount of redtape you have to go through to get the money promptly, and other factors.

Mr. PORTER. You would look into that with each company?

Mr. JONES. Very definitely. I do not say this as criticism of any insurance company at all, but there are vast differences in the way in which insurance companies settle their claims.

Mr. PORTER. But you could provide in your specifications that they must provide 24-hour service, and so on; you could put that in the specifications and you could set up the money you have to spend and say, "We will give this contract to the company that agrees to give this service and to the company that can give more benefits in terms of these specifications," and let them bid on that.

Mr. JONES. May I say again, Mr. Porter, I do not say it could not be done this way; I say it is our judgment it should not be done this way.

Mr. PORTER. And the reason is the matter is too complex and you cannot draw specifications and you want to look at each company's proposal to see which is the best?

Mr. JONES. That is part of my reason, yes.

Mr. PORTER. What is the other part?

Mr. JONES. That the kind of thing Mr. Irons referred to in partial answer to one of your questions earlier which automatically gives the protection you are seeking. I should not say automatically, but by congressional intent and policy.

Mr. PORTER. I would say competition would insure it more by allowing insurance companies to bid instead of negotiating. I think when you have standard services bidding is the best way to get the lowest price, and I would think the lowest price could be had by bidding.

Mr. JONES. That is something I cannot buy, sir.

Mr. PORTER. You mean in regard to the indemnity plan?

Mr. JONES. That is right.

Mr. PORTER. Let us assume Blue Shield is not bidding for the indemnity plan—I am assuming that—but under the insurance plans various carriers could do the job. In your judgment that could not be done by writing specifications?

Mr. JONES. Let me say I do not want to write specifications at this stage of the game.

Mr. PORTER. But when you have a contract you will write the terms?

Mr. JONES. Perhaps I can make it clearer by saying it this way. I am speaking as an individual. I am only one member of the Commission. It is a tripartite body. But I do not want to put myself in a box by going out on one set of specifications and then deciding those specifications are no good and going out again with other specifications. Whether some day we will come to the point where we can proceed with reasonable assurance on a competitive basis plan, I do not know. As Mr. Irons has said, while some companies have put out their plans for straight competitive bidding, there are none of them that are dealing with as many employees, and I doubt that any of them are dealing with people in 50 States.

Mr. PORTER. I think you have a unique problem, but the alternative is that you talk to each insurance company. How many are there?

Mr. JONES. The large companies which are licensed in all 48 States and which would be willing to come in here, I would say up to a dozen or maybe not that many.

Mr. PORTER. You will have to talk with up to a dozen companies and make up your mind which would be the best primary carrier?

Mr. JONES. That is an oversimplification, but essentially that is it.

Mr. PORTER. You will have to talk to 12 of them?

Mr. JONES. If 12 want to talk. Maybe some will not. I do not think it is without the realm of possibility that there may be a decision by a number of the large companies not to come in this thing at this time.

Mr. PORTER. You mean they do not want the business of 1.8 million Federal employees?

Mr. JONES. They automatically will get it under the provisions on page 17.

Mr. PORTER. They will get it under reinsurance?

Mr. JOHANSEN. Mr. Chairman, of course, I foresee the possibility of an amendment either in executive session or on the floor compelling competitive bidding, so let me ask this:

In this process, let us assume there are 12 companies in this category you will be discussing this problem with or negotiating with—are you not going to have among the subjects of your discussion the type of things that will be agreed upon, what the benefits will be under the indemnity plan, and what the costs will be, with each of the companies you will deal with?

Mr. JONES. Yes, and the language includes the flat requirement that there be reinsurance. All the companies who are the least bit interested are going to have to talk basically against the same specifications and the same concepts.

Mr. JOHANSEN. And in the final analysis, after getting the judgment of each as to what the price tag is going to be, then are you not going to get that figure as low as you can in relation to the service you want to buy, and then, if that figure is not right, you will not accept it, will you?

Mr. JONES. We could not in good conscience do anything else.

Mr. PORTER. Will the gentleman yield?

Mr. JOHANSEN. I shall be happy to yield.

Mr. PORTER. I would like to ask about this reinsurance. Just what is it?

Mr. JONES. It is spreading the risk and pulling your rates down.

Mr. PORTER. And even though someone won the contract as such, he would do that normally?

Mr. JONES. It can generally be done and is frequently done. Sometimes it is prohibited.

Mr. PORTER. The company who makes the deal as to the particular things indemnified—are the other companies committed to that?

Mr. JONES. Yes.

Mr. PORTER. Can you describe how it is done?

Mr. JONES. Let me ask Mr. Irons to describe how it was done under the life insurance program.

The CHAIRMAN. All right, Mr. Irons.

Mr. IRONS. Under the life insurance program the same kind of language was included in the act. We determined by reference to appropriate sources that there were, I believe, eight life insurance companies that fit the description outlined in the law. The Commission decided on one of the eight to be the primary carrier. The law itself provided that there should be reinsurance based on the amount of group life insurance that each company had.

Mr. PORTER. So you just divided it up the way it was?

Mr. IRONS. Of course, there were a number of life insurance companies involved, and each company got its proportionate share of the life insurance risk.

Mr. PORTER. That is the system here?

Mr. IRONS. That is the system here. Actually, the formula worked out in this committee was weighted in favor of the small life insurance companies so that they got more than their proportionate share of the business.

Mr. PORTER. That would not happen here?

Mr. IRONS. Here it is suggested it be on a basis "consistent with," so it would be the same formula.

Mr. PORTER. In other words, you cut the pie the same way it was cut, and actually these companies probably act pretty closely together? There actually is not much competition?

Mr. IRONS. There is bitter competition; bitter. This is real competition. It just does not happen to be competition under section 3709 of our Revised Statutes. It is based on their ability to give service and the way they handle the claims—promptly and with fairness and equity.

Mr. JOHANSEN. Mr. Irons, if I may be deliberately nasty for a while, how do you know and how does Congress know we got the best possible deal on life insurance?

Mr. IRONS. I do not know how you know whether you got the best possible deal or not. The Congress placed the responsibility for deter-

mining whether it was the best deal with the Civil Service Commission. The Civil Service Commission made its judgment. I am sure, if we had made a seriously erroneous judgment, there are enough Congressmen who have constituents who have insurance companies that we would have heard from them long ago.

Mr. JOHANSEN. And the Congressmen would have heard from the insurance companies that could have underbid or negotiated a lower priced contract for that life insurance. So, there was competition?

Mr. IRONS. I consider it competition, yes.

The CHAIRMAN. I have never received a complaint on the life insurance program for Federal employees—not a single complaint.

Mr. IRONS. It has been one of the most successful programs Congress ever established.

Mr. JOHANSEN. And you do not feel there was collusion on the part of the life insurance companies to the extent there would be one erring brother who would have come in with a lower bid?

Mr. IRONS. I have never done business with people who were more scared of collusion.

The CHAIRMAN. Proceed.

Mr. JONES. Moving to page 16—the changes there are all technical language changes.

We have discussed the language on page 17 beginning with line 6 and running through line 19. This was read earlier by Mr. Irons in connection with a question by Congressman Porter.

On page 18 we have one of the most important of all the changes. It goes back to my testimony of yesterday and covers two points. The first is with respect to the administration's belief that this bill should not be enacted on a 50-50 sharing of cost basis, but should be handled on the basis of one-third paid by the Government and two-thirds by the employees.

The other change is to get the language in such shape that it makes it very clear that the amounts given here are statutory maximums and not statutory minimums.

Mr. PORTER. Is this the open-end provision, this provision (2)?

Mr. JONES. You have to take both subsections (2) and (3).

Mr. PORTER. In other words, if charges go up, as they are likely to do, and if you want to keep the same benefits, you would have to readjust your plan and all future increases would go completely on the employees, as I read this. Is that correct?

Mr. JONES. No. If you look at the language in subsection (3), it states:

The Government's contribution as determined by the Commission for the first contract term shall be continued for subsequent contract terms, except that the Government's contribution, subject to the maximum amounts of—

I will not repeat them—

and the employee's contribution may be readjusted for any subsequent contract term, based on the experience and benefit adjustments under the subsequent contract, such readjustment to be in the same ratio as the Government's contribution bears to the employee's contribution during the first contract term.

Mr. PORTER. In other words, as these prices go up the Government's share would go up, too?

Mr. JONES. On a proportionate basis; yes, sir.

Mr. JOHANSEN. That means that the Government's dollar share would go up, but the percentage would remain the same?

Mr. JONES. That is correct.

Mr. PORTER. You had some statements at the end of your report saying that unless these changes were made you might change your report and make it an adverse report. If the bill is left at 50-50 cost sharing, is that sufficient to make your report adverse?

Mr. JONES. I would rather you ask that of the Bureau of the Budget.

Mr. PORTER. You have no opinion on it?

Mr. JONES. I have the opinion which I expressed to the Senate and which I have not changed, that the provision of equal sharing is not an unreasonable one if it is announced as congressional policy that they want to do it. The President has the responsibility of either approving or disapproving legislation under the Constitution, and I cannot say what the President's attitude would be. But if all the other changes are made I think it would greatly lessen the objections we have to the bill.

I am not backing up. I am saying we are in favor of one-third to two-thirds. We think it is fair and equitable and much more within the Government's fiscal resources. But I am not saying anything as important as this would fall on this one point.

Mr. PORTER. But on the basis of your experience you are prepared to testify that most of the large companies are on a 50-50 basis with their employees?

Mr. JONES. Yes. I am also prepared to say that the fringe benefits—I dislike that term—but the fringe benefits for Government employees tend to be at least equal to those of private employees, and since they are and in some respects more, we do not think it is unreasonable to ask the Government employees to pay two-thirds of the cost.

Mr. PORTER. Is it your contention that the pay scale of Government employees is as good or better than that of private employees?

Mr. JONES. In some cases they are and in some cases they are not. In the middle and lower scales they tend to be equal, but not in the higher.

The CHAIRMAN. I am sure you are concerned about the present fiscal condition of the Government?

Mr. JONES. Yes, indeed. I could not have spent the years I did in the Bureau of the Budget if I were not concerned.

Mr. JOHANSEN. Is it clear there is nothing in your testimony with regard to the one-third as against one-half Government contribution which implies a threat of a Presidential veto?

Mr. JONES. No, sir. I am not free to make a threat of a Presidential veto.

Mr. JOHANSEN. I know you are not, but I want it clearly in the record.

Mr. JONES. What I said with respect to the Commission's attitude on disapproval related only to the question of the large number of small local plans.

Mr. JOHANSEN. And that is because of the impossible administrative position in which you would be placed?

Mr. JONES. Yes.

Mr. JOHANSEN. And that is a valid objection.

Mr. GROSS. That was also true as to S. 2162 as it came over here?

Mr. JONES. As it came over from the Senate; that is right, Mr. Gross.

The CHAIRMAN. You may proceed.

Mr. JONES. I think we have covered the change at the top of page 18 and subparagraphs (2) and (3) which have to do with the question of increases in premium costs.

Moving to page 20, there are simply language changes there.

On page 21, beginning in line 13, there are a number of lines stricken, and substituted for that there are on page 22 new lines beginning at line 4 and going through line 20, which language I think I should read:

Portions of the subscription charges contributed by employees, annuitants, and the Government shall be regularly set aside as follows:

(1) A percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made available in section 9;

(2) For each plan, a percentage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

This relates to the very strong point I made yesterday that the bill, in our judgment, if it is to be a success, must have adequate provisions for reserves.

It also relates to the statement I made yesterday that these reserves should not be pooled but separately kept in different accounts in order that we may not penalize one plan to get the experience in another plan.

Mr. JOHANSEN. Is there any possibility that we are creating here an escape hatch for the Congress to duck its duty by failing in its appropriation to provide the maximum amount requisite for the one-third or one-half; in other words, reducing the amount of the Government's share of this contingency fund?

Mr. JONES. In my judgment that would not happen without again having substantive legislation by the Congress. In other words, the Congress, in an appropriation bill or elsewhere, would have to say something like this: "Provided that in a given year x proportion shall come out of a given reserve."

Mr. JOHANSEN. Which would be legislation in an appropriation bill.

Mr. JONES. If it were in an appropriation bill it would be subject to a point of order. If it came before this legislative committee we would have a run at it to say whether we thought it was good or bad.

Mr. JOHANSEN. I do not want Congress to default on this as I think I can say we have on others. I do not want you to lead us into temptation, because I think we succumb easily sometimes.

Mr. GROSS. I want to join my colleague in his statement about the use of the reserve.

The CHAIRMAN. You may proceed.

Mr. JONES. This provides the necessary money, we believe and we hope, for administrative expenses. The initial administrative expenses would, of course, be provided by an advance from the life insurance fund, which I mentioned yesterday.

There is nothing on page 23 of importance, nor on page 24.

On page 25 there is a provision for studies and reports which the Commission would have to make and would be held to by statutory standards.

On page 26, beginning in line 17, there is the long strikeout to carry out the recommendation which I made yesterday for the removal from this bill of a statutory advisory council.

Mr. GROSS. Mr. Chairman.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. I am glad that the Commission has joined in suggesting the striking out of this provision. Let me ask this question:

You are here setting up the world's biggest health insurance program. What, within the Civil Service Commission, do you contemplate as an administrative setup?

Mr. JONES. Well, here again I will have to speak for myself, because this has not been discussed with my colleagues in any detail, and we have certainly never taken a vote on it. My own idea is we would establish an advisory group which would have in it representation of employee organizations.

Mr. GROSS. I am not speaking now of a replacement for this, but for your setup within the Civil Service Commission.

Mr. JONES. You mean, how we would administer this?

Mr. GROSS. Yes.

Mr. JONES. I would speak to that in connection with the next substantial strikeout which appears on page 29 in which we recommend that the committee remove the language which would require the Civil Service Commission to establish a Bureau of Retirement and Insurance.

The plan of organization and operation within the Commission has not yet been established, but we would contemplate, I think, roughly this: Within our Bureau of Departmental Operations, which is answerable to one of our senior career people, we would establish an organizational unit probably of divisional nomenclature which would have the job of organizing the initial work under this program.

We would not want to make that a part of the retirement work or a part of the life insurance work, although the skill and expertise of both of those other parts of the Commission's organization would be available upon request.

We think that a continuing administrative job already established within fixed proportions should not be mixed up with a new effort to get this thing off the ground. Where we would go once it was established, I cannot at this time tell you, but my own belief is that it would probably become an independent division within the Commission setup.

The administrative job here will be rather large. This is a matter, however, on which we, in all probability, will want to have further consultation with the Congress, both in terms of the substantive committee here and the Appropriations Committee.

Mr. GROSS. Would an individual confirmed by the Senate be acceptable? Do you think he would be acceptable or would that be practical?

Mr. JONES. As I see it now, it would not. I think it would sort of mess up organizational concepts if we did that.

This is a professional job of the kind we are quite certain we can do adequately within the limitation of appointment under the competitive civil service.

Mr. GROSS. I do not mean to create another bureau, but to designate some one person with plenty of know-how in this field.

Mr. JONES. I think we can obtain him, but I do not think we have to require Senate confirmation. I think it would create a rather strange anomaly to have a subordinate officer of the Commission in the same status as the Commissioners themselves.

Mr. GROSS. I understand that.

Mr. JONES. In other words, I think there is this distinction: A senatorially confirmed officer appointed by the President presumably has some direct line of responsibility to the President as an individual. I would doubt whether it would make very much sense to ask the President to take on the responsibility for this program at the present time. The Congress is delegating this job to the Civil Service Commission.

Mr. GROSS. That is a suggestion, and I am just looking for information.

Mr. JONES. I understand that.

Mr. GROSS. This is going to be a tremendous job for some individual and obviously the members of the Commission cannot devote their full time to this. This requires the full time of one individual to head up some kind of a division within the Civil Service Commission.

Mr. JONES. It will, sir; yes.

Mr. GROSS. You cannot do that and carry on the other work of the Commission, I do not believe.

Mr. JONES. I do not either.

Mr. GROSS. I just want to be sure of what we are getting into here.

Mr. JONES. My best judgment at the moment is that that is about the way we would handle it.

The CHAIRMAN. We would appoint someone to head this Division—call him a Director or whatever title you want to give him—who would be responsible to the Commission?

Mr. JONES. Yes, sir. In our regular way, through the Executive Director.

Mr. REES. You would consult with people who had some experience?

Mr. JONES. We will have to have extensive consultation on this, Mr. Rees, and we will probably have some formal arrangements for advisory consultation of the kind we, ourselves, would set up.

Mr. REES. We had Mr. Willis before us a few days ago of General Electric. He is the type of person, it seems to me, would be most helpful.

Mr. JONES. On the basis of his testimony, I would say he is one of the best witnesses the committee has had.

The CHAIRMAN. You would not favor the Bureau of Retirement or Insurance within the Commission?

Mr. JONES. I would not, sir.

This grows out of a fair amount of experience with Government organization over a pretty long period of time, and it has not generally been my experience that if you take a new operation and stick it into an old operation with definitely prescribed operations that you will get very far. Certainly, we have discovered that in connection with certain emergency organizations in periods of war or other emergency.

You do not get the right kind of a job done if you stick all the responsibility in an old-line agency which has another, and by its own

rights, probably a more important job to do. This job is important enough to stand on its own feet and be done from scratch.

The CHAIRMAN. You are opposed to the status of an Advisory Council as set forth in the Senate-passed bill?

Mr. JONES. Yes, sir; for the primary reason that the language of the bill, I must construe, gives this Advisory Council substantive responsibilities for the program.

In the first place, I do not believe that advisory councils can have substantive responsibilities properly and, in the second place, if you spell it out too much here, we are just destroying the flexibility we need to do the kind of a job that the Congress and employees want us to do.

The CHAIRMAN. I agree with your observation right there.

Mr. FOLEY. Could I ask a question, Mr. Chairman?

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. How is the present life insurance program operated, from the division or department standpoint?

Mr. JONES. Well, I again will ask Mr. Irons, as the man who directly bosses it, to tell you.

Mr. IRONS. The life insurance program is administered by the Director of Departmental Operations. He has certain responsibilities and I, as Executive Director, have certain responsibilities. When it comes to the signing or approval of contracts, and so on, is what I mean.

Much of the routine work under the life insurance program of determining facts with regard to the settlement of claims is done by personnel in the Retirement Division.

Mr. FOLEY. Then, as I understand this proposal, as it stands in section 13, the Retirement Division and the life insurance operation under the Operations Department and in this new program, would be lumped under one heading and one department, and you are opposed to that; is that correct?

Mr. JONES. No. May I say that we are opposed to a statutory bureau here which puts all of these things together.

The CHAIRMAN. He is asking about section 13 of the Senate-passed bill.

Mr. JONES. Yes, but in this connection, may I point out one thing that is centrally important. Administratively, this health insurance job, for as far as we can see in the future, is going to be a far bigger job than the life insurance job. Our life insurance administrative costs are infinitesimal. They are very small, because we are dealing with something in which most of the factors were known. The development of this job is going to be a much bigger administrative task and it is going to cost more money. It is probably going to require a larger organization for some time and we think that organization should be self-contained. It will be within the general lines of authority that flow from the Commission through the Executive Director to the Bureau of Departmental Operations.

It will be a subordinate unit within a bureau.

Mr. FOLEY. I am inclined to agree with you but I am just wondering if that is the only objection you have to section 13.

As you know, it does provide for the classification of Director and that provides that the Director shall be responsible only to the Chairman of the Commission.

Are you saying that all of these other provisions are defective or just the organizational structure?

Mr. JONES. They are definitely defective to this extent: That the Congress provided for the reorganization of the Civil Service Commission and established the position of the Executive Director. We see no reason at all that you should take one subordinate officer of the Commission and remove him from the normal chain of command within the Commission, which is to put things through the Executive Director.

Mr. FOLEY. Also, the placing of a grade 18, would you say that specifying that in the statute would be binding your hands a little bit?

Mr. JONES. I do not think it ties our hands. My only regret on that is that this would be one more grade GS-18 which is certainly badly needed, Mr. Foley. I have no doubt at all that there will be no difficulty in agreeing on what the proper classification level for this officer should be.

Mr. FOLEY. You prefer that should rest with the Commissioners rather than spell out—

Mr. JONES. I think it is inconsistent with our whole philosophy to do it otherwise.

Mr. FOLEY. Going on to this Advisory Council, as I understand your testimony—and we have had previous testimony on this—it is your anticipation that such an Advisory Council would impede or hamstring, or interfere to some extent with the normal administration of your program, your policy, and decisionmaking function?

Mr. JONES. Yes, sir. In a word, yes. They are given duties which put them directly in the management of the program and I do not think advisory committees can do that, or should do it.

Mr. FOLEY. Of course, you are not saying that you feel you do not need advice?

Mr. JONES. No; we do need advice.

Mr. FOLEY. You would like to have the privilege of selecting your advisers on particular subject matters you feel you need advice on; is that correct?

Mr. JONES. Yes.

This freezes the organization and gives them two specific jobs to do. For instance—

to make studies from time to time of the operation and administration of this act.

Goodness knows that is a job of the Civil Service Commission to do. Congress holds us responsible for that.

(2) To receive reports and information with respect thereto from the Commission, carriers, and employees, and their representatives.

Again, purely administration.

(3) To ascertain from time to time the status of the Federal Employees Health Benefits Fund * * *

They do not have to ascertain anything. That will be published regularly.

Then it goes on to say that—

* * * No contracts shall be awarded, renewed, or terminated, and no regulations shall be promulgated, for the purpose of carrying out this act unless copies of proposed drafts thereof shall have been furnished to the Advisory Council.

Mr. FOLEY. I understand the proposal gives them these duties but they do not have real authority?

Mr. JONES. That is correct. They have no responsibility. They get some authority, but no responsibility.

Mr. FOLEY. You could anticipate a pulling and hauling between the Commission and Council as to whether they have these duties and certainly Congress intended us to do something. Since we have not spelled out the authority nor defined the limits of the authority, if they have any authority that could, as you say, interfere with your own development of this program?

Mr. JONES. I think that is one of the innate natures of councils that are established.

Mr. FOLEY. What I also want to ask is your reaction to this: I believe Mr. Gross has characterized this equitably and properly as the world's largest health program, and you have further clarified that by saying it is going to far exceed the life insurance administration problem or program that you have. I am just asking this of you: Do you think, from your experience with the Commission and also with Congress, that it might be advisable for this committee, and maybe the Senate committee, to establish a joint subcommittee of some sort not to look over your shoulder, but as an existing facility that you know, that you could consult and bring your more frequent problems, primarily basic ones, for the education of the committee members?

Complexities of this type of activity and program would make it hard to inform fully all members of the committee, and it would take a great deal of time to have the Congress going into the various facets of your program.

I am just tossing this out for your thinking and reaction as to whether or not it might be advisable for some sort of a permanent subcommittee, solely as a liaison, to be informed and to be educated so that these members could be more fully acquainted with the very complex problems that we know exist in this particular field.

Mr. JONES. Well, I do not think it is appropriate for me to make suggestions on organization within the committee structure, Mr. Foley, but I think, again, to give you my own "druthers" on this, if you will, I would rather be in a position of knowing that I could deal anywhere across the entire membership of both committees than to be tied down to a subcommittee which might or might not be available at the time we most needed them.

Mr. PORTER. Would the gentleman yield?

Mr. FOLEY. Yes.

Mr. PORTER. Both Mr. Foley and Mr. Gross said something which I fear I must challenge. I do not think this is the largest health plan. The one in the United Kingdom is larger than this plan.

Mr. JONES. We said in the United States, Mr. Porter.

Mr. PORTER. I thought it was—

Mr. FOLEY. Mr. Gross said the largest.

Mr. GROSS. Will the gentleman yield?

Mr. FOLEY. Yes.

Mr. GROSS. If the British have the world's largest health plan, we are paying for it.

Mr. PORTER. If we are paying for it—I am not saying that it is not a good investment, too, and it may be—but if we are, is there any

plan to draw on the very considerable experience which they have had in administering plans very similar to this?

Mr. JONES. I think there is a very, very basic difference which, to me, would remove the basis of comparison. This is an employee plan and the health program of the British Government is not an employee program. It is a mass plan of one form of social insurance, if you will.

The CHAIRMAN. Socialized medicine is what it is.

Mr. JOHANSEN. The witness does not equate this plan with what they have in England and about which I understand there has been some grumbling even in England.

Mr. JONES. I do not equate it in any way, shape, or manner with that plan.

Mr. PORTER. It has been accepted by both parties, as I understand it.

Mr. CORBETT. Mr. Chairman, would it be in order to get back on the subject?

The CHAIRMAN. Yes, Mr. Corbett.

Mr. CORBETT. No questions.

Mr. FOLEY. I wanted to get your immediate reaction to this.

You feel that personally you would prefer to deal with the committee because it would be easier to communicate with the full committee than with a standing subcommittee charged with the responsibility?

Mr. JONES. Not necessarily easier, Mr. Foley, but I think it would certainly, in the initial stages, probably be a lot more satisfactory because even though subcommittees have specifically assigned jurisdiction, this certainly does not remove the right of the other members of the committee to remain interested, to remain concerned, and to remain responsible.

Mr. FOLEY. They are charged by their oath to be doing that and we know that the members of this committee do that and members of most committees do, but because of the complexities and technicalities involved—and I am just tossing this out—maybe in your interest it probably would serve the interests of the committee as a whole to have some fairly well acquainted and well educated members of the subcommittee keeping abreast of this particular problem so that when we get into the sacred precincts of the executive session we would be able to rely more, shall we say, confidently on—

Mr. JOHANSEN. Mr. Chairman, before the witness responds to that question, I think the witness answered adequately when he said with proper deference that he did not think it was appropriate for him to make recommendations on that. I subscribe to that answer.

Mr. FOLEY. That is all, Mr. Chairman.

Mr. CORBETT. Mr. Chairman?

The CHAIRMAN. Mr. Corbett.

Mr. CORBETT. Because of many, many factors, I am wondering if I can visualize this situation properly.

If we set up a program here with x dollars to finance it and we turn the Commission loose on the job of purchasing the best contracts possible and determining what groups shall be eligible to sell those contracts, the program gets into motion and then some time thereafter there would be a full review of it here with the committee as to what has happened, what could happen, and by eliminating the Advisory

Council and eliminating the restrictions in this bill, we could trust whomever the Commission selects to do the negotiating. We probably would come up with as good a contract as we can arrive at. Then, once having those contracts and having some experience with them, we could review them as to possible improvements?

Mr. JONES. I feel sure, Mr. Corbett, and I would hope very frankly that the Congress would see fit to have hearings perhaps each year for several years on the subject of the administration of this program. That is, not against this particular piece of legislation, if that gets off the track, but not an investigation either. Just an open hearing in which we can exchange views, exchange information, ideas, and make the kind of a public report I think you cannot reduce to the 24 pages of an annual document that gives a few figures and stops there.

Mr. CORBETT. That is all.

The CHAIRMAN. I see you have recommended that section 16 on the last page of the bill, page 30, be stricken.

I fully agree with your recommendation.

Certainly, the two committees of the Senate and the House do not have time to look over all of these proposed contracts and policies to be purchased, and regulations proposed to be promulgated, for the purpose of placing into operation health benefit plans under this act. I fully agree with you.

Mr. JONES. This, again, Mr. Chairman, implies a degree of assumption of responsibility by the committees that I do not believe the committees basically wish or that they could exercise very effectively.

Committee control of this program is the normal committee control of any executive agency in requiring it to report fully on its stewardship.

That concludes our amendments, Mr. Chairman.

Mr. WALLHAUSER. I must apologize for not having been able to be here all through the hearings and during Mr. Jones' testimony.

I wonder, Mr. Jones, if, in your testimony before the Senate, you did not cover the Advisory Council section?

Mr. JONES. If you have the record in front of you, you know better than I. I do not remember whether that question was raised with me in the Senate or not. It was raised subsequently in staff discussions, but I do not remember whether it came up then.

Mr. WALLHAUSER. I was thinking of a conference between the Senate and the House on the bill.

I wondered how firm the Senate would be on the Advisory Council or who suggested it, or whether it had been discussed with anyone.

Mr. JONES. The Senate is well aware of our opposition to the Advisory Council thing. I cannot say that I gave that information in testimony, because I do not remember.

Mr. WALLHAUSER. Does anybody know? Does anybody know how this Advisory Council concept got originally into the bill?

Mr. JONES. Do you know, Mr. Lawton?

Mr. LAWTON. I do not know.

Mr. JONES. I cannot answer your question. I do not know.

Mr. WALLHAUSER. I have not found anybody yet who can.

Mr. CORBETT. Traditional governmental procedure is to delay action.

Mr. WALLHAUSER. You have answered it. Thank you.

The CHAIRMAN. I am certainly opposed to the establishment of this Advisory Council as set forth in the Senate-passed bill.

Mr. REES. I am, too.

Mr. GROSS. I am opposed to it, period. Include me in.

Mr. WALLHAUSER. And me.

Mr. JOHANSEN. Mr. Chairman, I do not want to invade the prerogatives of either the distinguished minority leader or the chairman, but I do ask permission to say to this witness for myself that I think he has given us very distinguished testimony, remarkably clear, and I want to commend him and his associates for that.

I want to say that my confidence in the outcome of this legislation and in the administration of this program is enhanced by the expectation that you will be identified with it.

Mr. JONES. Thank you very much, Mr. Johansen.

The CHAIRMAN. I wish to join in the commendation of the Civil Service Commissioner.

He has made a very excellent witness and the committee appreciates the time he has given and the benefit of his timely views about this legislation.

Mr. JONES. May I say, Mr. Chairman—and I would like to put this definitely on the record—sometimes a team effort is pretty good and I think we have had a really remarkable team working on this in the Civil Service Commission, in the staff and among the Commissioners themselves. We appreciate the support, help, and advice we have had from the Members of Congress on both sides and their staffs who have worked on this problem up to date. That has really been a team effort.

I would not exclude from this list the very valuable advice we have had from the Blue Cross and the Blue Shield organizations and the work that has been done by the insurance companies both with us and here before the committees and the employee organizations.

Mr. REES. Mr. Chairman?

The CHAIRMAN. Mr. Rees.

Mr. REES. Mr. Jones, your testimony has been very helpful to the committee and has clarified a number of the problems in this legislation. I join the chairman and the other members in commending you on your fine statement. Your advice is most valuable.

I have one further question.

Does the committee print dated August 13, 1959, of S. 2162 contain all of the recommendations?

Mr. JONES. To the best of my knowledge and belief, it does, Mr. Rees. We did not have it until this morning but we read it pretty carefully and I think everything is here.

If there is anything else, I do not think it is of any consequence at all.

The CHAIRMAN. Mr. Irons, do you wish to make any observations? We will be glad to hear from you.

Mr. IRONS. My only observation is, quit when you are ahead.

The CHAIRMAN. All right, sir.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, the hearing was adjourned at 11:50 a.m.)

HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

FRIDAY, AUGUST 14, 1959

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The committee met at 10 a.m. in room 215, House Office Building, Hon. Tom Murray (chairman) presiding.

The CHAIRMAN. The committee will be in order.

The hearings will be resumed on the Senate-passed bill, S. 2162, on health benefits for Federal employees, and other related House bills.

I have received a report from Hon. Maurice H. Stans, Director of the Bureau of the Budget. Without objection, the report will be inserted in the record at this point.

(The report referred to follows:)

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., August 4, 1959.

HON. TOM MURRAY,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.*

MY DEAR MR. CHAIRMAN: Reference is made to your letter of July 8, 1959, requesting the views of the Bureau of the Budget on S. 2162 to provide a health-benefit program for Government employees, presently before your committee.

Since 1954 this administration has advocated, and now continues to advocate, the establishment of a voluntary health insurance program for Federal employees. Specific programs were proposed in 1954, 1955, 1956, and 1957, each proposal being an attempt to formulate a better program. In 1958 the administration gave priority to pay increase legislation and recommended that action on employee health insurance legislation be postponed. It should be noted that during these years Government annual expenditures for Federal employee pay and benefits have been increased by substantial amounts due to increases in pay rates under both the statutory and prevailing wage systems, increases in annuities under employee retirement systems, the liberalization of the premium pay benefits system, the liberalization of the civil service retirement system, and the establishment of such new benefits as the allowances for uniforms and the group life insurance and unemployment compensation systems.

Following this administration's basic policy that the Federal employee should be compensated for the services he renders to the Government under a pay and benefit system that is reasonably comparable in structure and level with the compensation provided by progressive private employers, the Bureau of the Budget favors legislation authorizing a Federal employee health insurance program with benefits providing financial protection against the cost of health care reasonably comparable with those benefits provided in private employment. Although the existing Federal employee fringe benefit system has been reported to be already more liberal than the typical private business fringe benefit system, it does not include a program of health insurance benefits. Adding these benefits to the existing system will further increase the total value of the Federal employee fringe benefit package. Under these circumstances it is essential that the value added by the new health insurance benefit program be kept in line with private industry health benefits.

The new health insurance benefits should be made available only to employees who earn them by rendering services to the Government under the new program after it becomes effective. Compensation in the form of pay and benefits is paid to employees for services rendered. Former employees who rendered service under a compensation system which did not include these health insurance benefits have already been paid in full for their services in the form of pay and benefits already received or in vested rights to payment of future benefits already earned. Whenever salary or benefits are adjusted, an effective date must be selected. It may be unfortunate that some former employees must miss eligibility by narrow margins, and a retroactive approach is often suggested. However, a retroactive approach actually creates an inequity where none would otherwise exist. For while prospective entitlement is firmly linked to services rendered under a compensation agreement, retroactive entitlement is pure gratuity. If any former employee is granted this special gift, then any other former employees who are excluded by the particular retroactive date selected will feel they merit equal consideration. The new health insurance benefits should therefore be provided only to employees who render service to the Government after a prospective effective date.

S. 2162, now before your committee, while including several desirable features, falls short of providing an acceptable employee health insurance program in two major respects: The cost to the Government is higher than justifiable in establishing a health insurance benefits program reasonably comparable with existing private business programs, and the organization and administrative system is defective.

The cost sharing feature of the bill would require the Government to pay one-half of the premiums rather than one-third, as established for the Federal employee group life insurance program in 1954. The first year cost of the bill to the Government is estimated in the Senate committee report to be \$145.3 million, which must be increased by \$2.5 million in the first year and \$25 million in the fifth year to include the Government share of the cost of annuitant coverage. This amount is substantially higher than the \$80 million figure which is actually needed as one-third of the cost, including the cost of annuitant coverage, of a sound program providing a benefit level in line with private industry plans, and providing a sound experience basis for accumulating the facts on which an appropriate Federal employee health benefits program can evolve for the future. It would be prudent for the Government to seek the patterns and level of health benefit protection best suited to the problems of the Federal employee, the benefits that will yield the most effective return for the premium dollar. Experience elsewhere strongly suggests that an effective program will evolve best from a conservative base. Sound development can occur as the genuine needs of the covered employees are clearly defined through experience, and a pattern of effective health care benefits grows up to meet these needs. The bill should be modified to clearly provide this sound, conservative beginning.

The organization and administrative provisions of S. 2162 should be modified. The Civil Service Commission will advise you in full detail concerning these modifications. This report will comment only on three organization provisions: the Advisory Council, the Civil Service Commission reorganization, and the submittal of proposed contracts and regulations.

The functions and membership of the proposed Advisory Council are not designed to aid sound administration. The Council's assigned functions include making investigations of the administration of the program, and receiving reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relations with carriers, employing agencies, and employees. The Civil Service Commission should be unmistakably responsible for the success of this program. The Council's functions should be advisory only. The Council's membership should reflect its character as an element of a Federal employee benefit program, and should include appropriate Government officials, ex officio, together with employees, or their representatives, who are contributing and participating in the health insurance system. There is no need to create a statutory organization based on an assumption that the Civil Service Commission will fail to give adequate consideration to all parties, including all qualified prospective carriers. The Government's lack of experience in administering a health insurance program for its employees and the asserted absence of facts upon which to base decisions does not argue for splitting responsibility in this program between the

Civil Service Commission and the Advisory Council. Rather, it requires placing a special responsibility on the Commission to proceed prudently, to develop factual experience as rapidly as feasible, and to build soundly, and it places a special responsibility on those who contribute to the design of the authorizing statute to provide the clearest authority and proper organization that will be so essential. Section 12 should be modified accordingly.

The proposed statutory reorganization of the Civil Service Commission would interfere, to no defined purpose, with the existing statutory power and responsibility of the Chairman of the Civil Service Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. It is especially important in this new program to avoid a rigid organization prescription that could hamper the proper adjustment of administration with experience. Section 13 should be deleted from the bill.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is unnecessary to assure energetic administration by the Commission and is clearly improper if it is intended to provide the committees with a power of prior review of executive action. Subsection (a) of section 16 should be deleted from the bill.

S. 2162, as passed by the Senate, includes several features which are desirable in a program of Federal employee health benefits, but it seeks to provide a level of benefits at an unnecessarily high cost, and it provides an unsound system and organization for administration. Unless S. 2162 is modified as to cost and administrative provisions, as above noted, the Bureau of the Budget would not favor enactment of the bill.

Sincerely yours,

MAURICE H. STANS, *Director.*

The CHAIRMAN. The first witness this morning is the Honorable Maurice H. Stans, the Director of the Bureau of the Budget, who was formerly Deputy Postmaster General.

Mr. Stans.

STATEMENT OF MAURICE H. STANS, DIRECTOR, BUREAU OF THE BUDGET; ACCOMPANIED BY PHILLIP S. HUGHES, ASSISTANT DIRECTOR, OFFICE OF LEGISLATIVE REFERENCE; AND WILLIAM P. LEHMAN, OFFICE OF MANAGEMENT AND ORGANIZATION

Mr. STANS. Mr. Chairman and members of the committee. I am pleased to appear before your committee to express the views of the Bureau of the Budget with respect to S. 2162. In this statement I will confine myself to the main features of the administration's position in this matter. The details of the bill and many of the specific technical adjustments necessary to make S. 2162 acceptable have been set forth in the report of the Civil Service Commission and in the testimony of the past few days.

In summary, we favor an employee health insurance plan but we do not like some of the provisions of this bill.

First of all, this administration favors the establishment of pay and benefits systems for Federal employees which are reasonably comparable in structure and level to the pay and benefits systems provided by progressive private employers. In a special statement on personnel legislation in February 1954, the President pointed out that the Federal employee compensation system failed to provide two types of benefits protections which were necessary elements in a well-rounded compensation system, and recommended the establishment of a program of employee group life insurance and a program of employee health insurance.

The life insurance program was enacted promptly, but agreement on a health insurance program turned out to be more difficult. Again in 1955, in 1956, and in 1957, specific programs were recommended by the administration—each program different from its predecessor, each seeking a formula that would be acceptable to all concerned. In 1958, it was recognized that pay adjustment legislation was needed, and the President recommended that consideration of the health insurance program be postponed. Now, in 1959, the administration again recommends the enactment of a sound and suitable employee health insurance program.

During these years the Federal employee compensation system of pay and benefits has been very substantially liberalized, both as to rates of salary and wages and as to fringe benefits. In 1957, the so-called Cordiner Committee, which was investigating the compensation of civilian scientific, professional, and managerial personnel of the Department of Defense, reported that the expenditures for fringe benefits made by the Government for its civilian employees exceeded the expenditures for fringe benefits by private employers, even though the Federal fringe benefits package did not include a program of health insurance.

Second, the Civil Service Commission has advised your committee that a sound program providing a level of health insurance benefits protection reasonably comparable with the more progressive private industry plans can be provided Federal employees at a total cost considerably less than the cost estimated for S. 2162. Such a plan would cover not only the active service employees but also those employees who retire in the future and their survivors. Health care needs of employees for themselves and their families can only be clearly defined through experience. The Civil Service Commission program provides the framework for an appropriate and continuing Federal employee health insurance program. We deem it essential that the program operate within this framework, particularly in its early years.

A more ambitious program going beyond the private employment standard, such as would be provided at the maximum expenditure rate provided in S. 2162, is either required in equity to the Federal employees nor fair to the Nation's taxpayers.

The third point I would like to make is that the system and organization established to administer the new health insurance benefit program should result in clearcut assignment of responsibility and unmistakable accountability for the effectiveness of the program. The provisions of S. 2162 do not set up a sound organization. I will mention three major modifications which we believe necessary. They pertain to the proposed Advisory Council, the proposed reorganization of the Civil Service Commission, and the proposed submittal of contracts and regulations to congressional committees. The Civil Service Commission, I understand, has advised you and offered to work with you to correct several other administrative features which require modification.

The functions and membership of the proposed Advisory Council are not designed to aid sound administration. The Civil Service Commission is designated as the administering agency, and properly so. However, the Council's assigned functions include making investigations of the administration of the program and receiving

reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relation with carriers, employing agencies, and employees. The Civil Service Commission should be held unmistakably accountable for the effectiveness of this new program. The Commission itself can and will seek the advice of responsible experts in the health insurance field. Accordingly, we recommend that section 12 of the bill be deleted.

The proposed reorganization of the Civil Service Commission would interfere with the existing statutory powers and responsibility of the Chairman, and we are unable to discover any purpose to be served by it. Since 1949, the Chairman properly has been authorized to determine internal organization of the Commission's business and to designate officers and employees to perform assigned functions. We recommend that no change be made in this regard.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is not only unnecessary but could bring about confused accountability for the program. The requirement is unnecessary to assure energetic administration by the Commission, since the July 1, 1960, effective date for beginning the program is stated in the bill. If the requirement is to be used as a kind of appeals procedure by prospective contractors or others seeking to overcome Commission administrative decisions, we consider it improper as well as unwise. The powers of the committees to investigate and to recommend legislation to the full Congress are unquestionable and they will in themselves constitute their usual positive influence toward equitable and effective administration. No power of prior review of executive action, such as is apparently proposed here, would be proper. We recommend that subsection (a) of section 16 be deleted from the bill.

Fourth—and this is really the principal point in which the Bureau of the Budget has an interest—the cost of the new health insurance benefits system should be shared between the employee and his employing agency on the same basis as was established in 1954 for the Federal employee group life insurance program. The sound cost-sharing basis established in that program has not been seriously questioned. Under that program the Federal employees pay two-thirds of the cost and the Government pays one-third. We see no basis for upsetting this arrangement, and we believe it should be incorporated in the new health insurance program. Applying this cost-sharing formula to the \$240 million total cost which has been found necessary to provide the Federal employees with health insurance protection reasonably comparable with that provided in progressive private industry, we have derived the proper Government's share of the annual cost as \$80 million. The Bureau of the Budget therefore takes the position that this is the maximum Government expenditure necessary to provide an acceptable health insurance program.

The CHAIRMAN. Thank you, Mr. Director.

How much do you estimate S. 2162, as passed by the Senate, all the benefits listed therein, would cost the Federal Government and employees?

Mr. STANS. Well, the total cost under the bill would be \$309 million, plus whatever requirements were necessary to provide an adequate reserve, and the bill provides that the Federal Government should

share half of that, so its share would be roughly \$155 million a year as a minimum.

Mr. REES. How much?

Mr. STANS. \$155 million a year as a minimum.

The CHAIRMAN. I know you are concerned with the fiscal condition of the Federal Government today, its tremendous debt and its deficit in the last fiscal year.

Mr. STANS. Mr. Chairman, I am not only concerned about it thus far, but also with the prognosis of the fiscal condition of the Government in the years ahead. I think we have built into our commitments of the Federal Government so many things that are on the increase in the years ahead that we should be cautious every time we take on a new program that we do it on a conservative basis and one that will reasonably take care of the needs, rather than in a luxurious or plush fashion.

The CHAIRMAN. Do you anticipate a balanced budget at the end of the present fiscal year?

Mr. STANS. It is a little too early to tell, Mr. Chairman. There are a number of uncertainties that remain. We are not yet able to be reasonably precise about the revenue estimate for this year. We think it will be somewhat higher than the original budget estimate of \$77 billion, and we have indicated to the Ways and Means Committee that we think the revenues will be up a half billion above the budget figure. On the expenditure side, however, we have already informed the country that it looks like our interest costs will be up half a billion dollars above the budget. We have not succeeded in getting the President's proposal for increased postal rates; costs of some of our agricultural programs are running heavier than expected; and it is too early to tell what the overall expenditures will be for the year. These factors all tend to make it difficult for me to say whether we will have a balance or not.

Finally, Mr. Chairman, there are a number of things still in the Congress for action in this session that could have a considerable effect on the fiscal 1960 and 1961 budget levels.

The CHAIRMAN. What do you estimate to be the cost of the various fringe benefits that employees of the Federal Government now receive?

Mr. STANS. I have no official figures on that, Mr. Chairman. I believe the Civil Service Commission is more up to date on that than we are. But the latest information I had was that it was just short of 30 percent.

The CHAIRMAN. How do fringe benefits for Federal employees compare with similar benefits for employees in private industry?

Mr. STANS. Again, the Bureau of the Budget does not make its own studies in matters like this, and I would rely on the Civil Service Commission's testimony, but I understand the Federal Government's fringe benefits, without a health insurance plan, are at least equal to or perhaps greater than those of private industry on the average.

The CHAIRMAN. Do you insist that the Government's share of this program should not exceed \$80 million a year?

Mr. STANS. I think in view of the precedent established in the life insurance program it is a fair provision, and I think in view of the need of the Government to conserve its resources to the fullest extent, it would be inappropriate to undertake the program, at the outset certainly, at a cost higher than this.

The CHAIRMAN. Do you think the benefits enumerated in the Senate-passed bill are too rich?

Mr. STANS. Yes, I do.

The CHAIRMAN. Mr. Rees?

Mr. REES. No questions.

The CHAIRMAN. Mr. Porter?

Mr. PORTER. I want to say Mr. Stans has always given us excellent testimony, and on this bill we need him again.

I want to ask the Budget Director if he believes that competition is a good thing as a rule?

Mr. STANS. I certainly do.

Mr. PORTER. And do you believe that it sometimes results in greater efficiency and lower costs?

Mr. STANS. I think very frequently it does.

Mr. PORTER. When we get down to this particular provision we have discussed many times before in these hearings, section 6(a), which is on page 12 of the copy of the bill which I have—I believe it is on another page in the revised copy—it says:

The Commission is authorized, without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding, to enter into, or authorize enrollment under, a contract or contracts with or to purchase a policy or policies from, qualified carriers—

and so forth. In other words, it releases them from the obligation to be under the statutory provision requiring competitive bidding.

I wondered if you had made a study of that section, and if so if you would care to comment on it?

Mr. STANS. Mr. Porter, I think the provisions of the bill, both the original Senate bill and the modifications that the Civil Service Commission has proposed, have built-in competition provided, principally in the opportunity of each individual employee of the Government to choose between a service plan and an indemnity plan.

Mr. PORTER. I understand that. I am not talking about that. I am talking about among insurance companies and among indemnity plans, particularly among insurance companies. There are up to nine insurance companies each of which could handle this program, yet they will not be able to make competitive bids.

Mr. STANS. I am not sure what the plans of the Commission are in administering this section, but I would be inclined to rely on the Commission to negotiate with all those willing to provide the coverage and to get the lowest cost to the Government.

Mr. PORTER. That is the point, they will negotiate rather than asking for bids. I was wondering what you thought about that?

Mr. STANS. I would be inclined to rely upon the Commission to get the lowest possible cost to the Government.

Mr. PORTER. I am sure they would act in good faith, just as the Defense Department acted in good faith to get the lowest cost, but as a general practice it would seem not to be the best way to achieve efficiency or economy.

Mr. STANS. I do not disagree with the basic principle that competition and competitive bidding are desirable. I am not enough of an expert—in fact I am not an expert at all—in the field of health insurance, and I do not know if another procedure would be more effective. I think the committee would have to make its determination based on the testimony of Mr. Jones yesterday.

Mr. PORTER. Then about the advisory council. Under the plan you recommend, and which Mr. Jones recommends, the employees would be paying in two-thirds of the money and one-third would come from the Government. I have doubts about the exact purpose of the advisory council too, but I imagine it is to look after the employees' share, and on that basis do you not think it was some justification?

Mr. STANS. I think we could assume that the Commission's primary objective will be to look after the employees' interests. The Congress also has a continuing right of inquiry and investigation as to how the program is going, and I think the Commission undoubtedly will secure all the technical advice it needs in the development of this program.

Our objection to the advisory council is twofold, first, that it introduces another entity in the structure of the U.S. Government; and second, the provisions applying to this particular advisory council would in effect give it almost administrative responsibility and encroach upon the administration that the Commission would be giving to the program.

Mr. PORTER. I am inclined to agree with you at this point, but I was wondering if the employee giving two-thirds to one-half, if that did not entitle him to direct representation?

Mr. STANS. I think we can be sure that the Commission will deal with employee groups any time they seek advice.

Mr. PORTER. Let us assume the legislation as finally enacted does include most of the recommendations of the Civil Service Commission but retains the 50-50 formula. Will that mean that the Budget Bureau will recommend it not be enacted as a law?

Mr. STANS. That is always a hard question because it is very hard to decide, except in the context of the bill as a whole and in the context of the condition of the Government as a whole. I would regret very much to see that happen. I think the members of this committee and the Members of Congress are as concerned as I am about the trend of expenditures in the Federal Government, or would be as concerned as I am if they had the facts I have, in my capacity, always before me.

I would not say at this time I would definitely recommend to the President that he sign a bill with such a provision, nor would I indicate that I would recommend that he veto it; but I do urge upon this committee's consideration that the present situation of the Government is such that it requires that we take a reasonable and conservative approach whenever we add any further expenditures on the Government.

Mr. PORTER. In the first part of your testimony you mentioned you do favor the establishment of a program providing a level of health insurance benefits protection reasonably comparable with the plans of the more progressive private employers, and I believe yesterday Mr. Jones did testify that 50-50 sharing was normal with many big progressive private employers. In other words, that is not something unusual that the Federal Government is seeking to confer on its employees. He went on to mention that the fringe benefits given to Federal employees are equal or perhaps somewhat above those given to private employees on the average. But this bill does not confer on Federal employees anything unusual?

Mr. STANS. I think what you say is entirely right. One reason I think the Government's contribution should be held to 33½ percent is that the aggregate of fringe benefits to Government employees, even without this bill, seems to equal or exceed the general level in private industry.

Mr. PORTER. Do you think the salaries paid Federal employees are comparable with the general level in private industry?

Mr. STANS. I think that is pretty much true except possibly in the upper levels; and certainly the Government's fringe benefits for annual leave and sick leave are more liberal than those in general in private industry.

Mr. PORTER. Thank you very much.

The CHAIRMAN. Mr. Gross.

Mr. GROSS. Mr. Stans, representing the Bureau of the Budget, you did not provide very much testimony before the Senate committee, did you?

Mr. STANS. My deputy, Mr. Elmer Staats, testified before the Senate committee.

Mr. GROSS. You submitted a letter for the record, but the testimony was not very extensive, as I understand it.

In other words, you reached a decision with respect to the Advisory Council after the Senate bill was passed; is that not true?

Mr. STANS. On that point, I will be perfectly honest with you, Mr. Gross. We changed our minds on it since the testimony before the Senate committee. After further study by our management people in the Bureau, we are strongly of the opinion that it should not be contained in the bill.

Mr. GROSS. You are supporting the taking out of the Advisory Council, and certain other recommendations have been made.

Since the subject of the fiscal condition of the Government has been brought up—I did not know that this was going to be introduced this morning—I wonder if the administration will support a good healthy cut in the foreign aid appropriation. We have got it down in the House to \$3.1 billion and I wonder if the administration will help us cut it some more in conference?

Mr. STANS. Mr. Gross, I am quite well aware of your feelings with respect to the mutual security program. It would take me an awful—

Mr. GROSS. I refer to it as "foreign giveaways."

Mr. STANS. It would take me an awful long time to explain it in the detail it would be necessary to assure you that the President's budget proposals are reasonable. I would rather not engage in that today, although I would be very happy to discuss it with you any time.

Mr. GROSS. I could not disagree with you more than that the Government's recommendations in that respect are reasonable. I think they are far out of line in view of the fiscal situation in this country.

You spoke of another entity in the Government. I recall only a couple of weeks ago the administration sent a bill to Congress to create the Inter-American Bank despite the fact that we have international lending agencies all over the map in this Government and despite the fact that the World Bank provides in its charter that it emphasize loans to South America.

I do not understand the approach to some of these things. As far as I am concerned, there was absolutely no valid reason for creating

another international lending agency. I do not understand why the administration comes in with bills of that kind.

Mr. STANS. I can give you a general view as to why the administration proposed the Inter-American Bank, Mr. Gross. One of the basic objectives of creating it is to encourage cooperation among all of the countries of South America toward resolving their own problems.

Mr. GROSS. What is wrong with the World Bank?

Mr. STANS. The World Bank has standards of lending which are somewhat higher than those which would be expected of the Inter-American Bank.

Mr. GROSS. What is wrong with the Development Loan Fund?

Mr. STANS. That is what I was coming to.

The objective of drawing capital of other nations into institutions like the Inter-American Bank and the International Development Association is to get other nations to take over some of the burden that this country has assumed through the years of helping the economic development of the underdeveloped countries.

I agree with you that we are getting to the point at which it is very difficult for us to finance so much of the needs of underdeveloped nations to improve themselves. We need help in this from the nations of Europe and the other countries that are in a position to be of assistance to the smaller countries.

Mr. GROSS. Let us put the cards on the table. The only reason for the creation of the Inter-American Bank was because the State Department wanted it as a matter of their dollar diplomacy in South America. So we load upon the taxpayers another expensive organization in Government.

I do not want to labor this thing, but let us not split hairs around here on some of this spending. Let us get at some of the things that are contributing to the real deficit in this country.

Mr. STANS. Mr. Gross, as you say, this is one of the matters that can better be discussed in another context than this bill.

Mr. GROSS. I agree with you but the subject was introduced here—deficits, interest rates, and so on and so forth.

This is all a part of it and a big part of it.

The CHAIRMAN. Any other questions on my left?

Mr. IRWIN. Mr. Chairman, I agree that maybe this is not the place, but needless to say many of Mr. Stans' objections to the legislation are based upon this very fact, and he cannot at this moment just cut out all of your other views and say that this is bad and forget about the rest that we are spending money on.

Is it not true that to a large extent Congress has cut the appropriations requested by the administration this year?

Mr. STANS. I would say that the Congress has reduced most of the appropriations by some amount. There is a substantial increase, as you know, in the appropriations for the Department of Health, Education, and Welfare, and an increase pending for Public Works.

Mr. IRWIN. Right.

Mr. STANS. The significant reductions by the Congress so far appear to be in defense construction and in the mutual security program. All the other reductions seem to be balanced by increases.

Mr. IRWIN. Do you know what the overall reduction is to date?

Mr. STANS. In the case of the appropriation bills that have actually passed Congress, the net so far is a small increase in the overall budget.

Mr. IRWIN. My question is, in the House of Representatives to date, do you know what the cut is?

Mr. STANS. A billion and a quarter dollars.

Mr. IRWIN. What was your response to Mr. Gross with regard to the Inter-American Bank?

What was the objective of that Bank?

Mr. STANS. The objective of that Bank is to draw the South American countries into a plan whereby they help to finance each other's problems.

Mr. IRWIN. What is this being done for? Why?

Mr. STANS. To improve their strength as countries and help us in our defense of the free world.

Mr. IRWIN. Do they need money of ours?

Mr. STANS. They certainly need to improve their living standards and the strength of their economies.

Mr. IRWIN. Are there any areas of our country that need this help?

Mr. STANS. I am sure that there are some.

Mr. IRWIN. Do you think the Federal Government should help in those cases?

Mr. STANS. I think we are doing a great deal.

Mr. IRWIN. Do you think we should do more?

Mr. STANS. I am not aware of any new proposals that I think I would support at this time beyond the budget.

Mr. IRWIN. You do not?

Mr. STANS. I am not.

The CHAIRMAN. Mr. Johansen?

Mr. JOHANSEN. I do not propose to engage in a foreign aid debate here today.

The CHAIRMAN. Let us get back to this bill.

Mr. JOHANSEN. However, I would like to talk about the bill.

I do want to make this one observation: The decreases in total spending would not be even what they are if there had not been decreases in some of the proposals that have been pushed pretty hard in this Congress and if they were enacted into law. I will drop the matter with that.

Mr. STANS. I would like to amplify that, if I may, Mr. Johansen, by pointing out that there are a great many matters in the Congress now that would tend to push up our expenditures beyond budget levels.

Mr. JOHANSEN. That is exactly what I am talking about, but I do not want to push the matter further. I think the record is clear. I would like to ask one question about the pending legislation.

Mr. STANS. Yes.

Mr. JOHANSEN. Would you give me again the estimate of the total cost that you cited for the Senate bill?

Mr. STANS. \$309 million plus an undetermined amount necessary to create a reserve.

Mr. JOHANSEN. One aspect of this matter that concerns me—because I want to be fair to all parties—would the employee share in the aggregate under the one-third to two-thirds split be equal to, or greater than, the employee share under the 50-50 formula applied by the Senate bill?

It seems to me there would be about \$5 million less, if my arithmetic is right. In other words, under the two-thirds formula, based

on the \$240 million figure, it would be \$160 million, and under the 50-50 formula, it would be \$155 million.

Mr. STANS. The figures are just about right, as you put them.

Mr. JOHANSEN. There would be just a slight difference for the employee.

Would you feel that under the \$240 million program there would be needed also an excess to take care of this matter of reserve or would that reserve be practicable within the \$240 million figure?

Mr. STANS. I think the Civil Service Commission is in a better position to answer that, and it would depend upon the negotiations with the carriers. I would hope that the \$240 million figure could include some reasonable provision for reserve.

Mr. JOHANSEN. It is true that whether it is \$240 million or \$309 million, that is a maximum. That is not the mandatory amount, but that is the maximum the cost would be?

Mr. STANS. Under either of those plans; yes.

Mr. JOHANSEN. Yes.

Mr. STANS. Excuse me one second.

I am told that the Senate bill under certain contingencies could run even higher than the \$309 million.

Mr. JOHANSEN. That is not necessarily the maximum under the authority given in the Senate bill?

Mr. STANS. That is right.

Mr. CORBETT. Will the gentleman yield?

Mr. JOHANSEN. Yes; if I may keep the floor.

Mr. CORBETT. Would it not be much more likely, if the Civil Service Commission comes up with contracts of various costs, that many of our employees would elect to buy the cheaper programs because the total amount in that bill which could be deducted from their payrolls, I think, in many instances, is more than they would like to have deducted?

Mr. STANS. I think it is quite clear that the amounts of the maximum deductions permissible under the bill may well be more than many of the employees would like to contribute.

Mr. JOHANSEN. That would be true whether on a one-third to two-thirds, or 50-50 split basis?

Mr. STANS. I think so.

Mr. LESINSKI. Would the gentleman yield for a question?

Mr. STANS. The matter of a reserve has disturbed me a little bit. The Government is not going to assume this if the program is to be insured through other insurers.

In other words, why is this necessary?

Mr. STANS. You have a situation in which the costs under these programs are continually advancing; medical costs and hospital costs are continually advancing, and unless there is some reserve the plan can get into trouble at the end of the first year, upon going into the second, before an opportunity to adjust the charges or rates involved.

There is an undetermined factor also in the bill, in its provisions for employees who retire. They are going to receive benefits which will be out of all proportion to the contributions they will be currently making and all of these are factors that the Civil Service Commission believes should require the provision of some kind of a reserve.

Beyond that, again, there are experts on this subject and I am not, but I merely point out that from a fiscal standpoint this is a matter to be seriously considered.

Mr. LESINSKI. I was given the impression by witnesses who testified here that it was up to the health insurance companies to take care of that reserve in their own plan. In other words, they would have the reserve.

Mr. JOHANSEN. Will the gentleman let me interrupt at that point and say that it was my understanding of the testimony of the witnesses from both the Service and the commercial type carriers that the reserve we are talking about is a reserve in the overall program designed to meet possible increases in costs on a basis that would make it unnecessary, for the first 2 or 3 years, to increase either the rates or decrease the benefits. So it is that kind of a reserve we are talking about rather than a normal operating reserve of an insurance company.

Mr. STANS. That is my understanding; yes.

Mr. JOHANSEN. I have one other question: I suppose it is something less than discretion to raise the point, but is there any question in your mind that if this program is adopted there will be in the years ahead—and I say this not critically at all but as a matter of realism—efforts to improve the plan or to increase Government participation in the program?

Mr. STANS. I think it is quite likely that as time evolves the Civil Service Commission, the administration, and the Congress will want to take a continuing look at a program of this type to see whether it satisfies reasonably the requirements and needs of Government employees. I am quite certain that there will be plenty of opportunity to make adjustments in it.

My basic point is that a program of this type has so many uncertainties in it as to cost and other factors that it ought to be started on a reasonably conservative basis.

There is plenty of time to improve it.

Mr. JOHANSEN. Is there any doubt—again, I am not speaking critically—that employee organizations may seek such increases from time to time? They are not going to be forestalled from doing that certainly, so that we are not legislating forever on a Medes and Persian basis.

Mr. STANS. I would say you are legislating something in the way of a rather novel type of thing for the Government, and it ought to be approached carefully and cautiously, and adjustments can be made as time goes on, if necessary.

Mr. JOHANSEN. Is it not a transcendently important thing that we get our feet on the path and get the program started?

Mr. STANS. That is exactly as I see it.

The CHAIRMAN. Are there any other questions?

Mr. Foley?

Mr. FOLEY. Mr. Stans, there is really no question about the cost of this program, is there? Is that not written right into the statute itself?

Mr. STANS. No; there is discretion—

Mr. FOLEY. Do you have any doubts about what the program would cost?

Mr. STANS. Yes, sir. There is discretion to the Commission to develop a plan within certain maximums.

Mr. FOLEY. That is right. In other words, the maximums are fixed and what benefits can be purchased within the maximum is fixed by statute.

That is one of the questions.

Another question is whether the employees are willing and should pay the costs that are represented by the maximum and, finally, what can the Government afford and should expend for its contribution.

As a practical matter you have already given the figures here today on what a 50 percent participation would cost the Government. The standards there are precisely set forth in the statute; is that correct?

The CHAIRMAN. You mean the bill, do you not?

Mr. FOLEY. You are right. I am anticipating a little bit, Mr. Chairman.

Mr. STANS. The standards mentioned in the bill could very well cost more than the maximum contributions provided in the bill.

Mr. FOLEY. If I understand you, I think I would share your view if I think you were saying that the benefit standards indicate that the maximum purchasable health and welfare benefits could be quite expensive.

You have mentioned that the cost figure is uncertain.

In my mind, the cost is fairly clear because it puts a maximum figure on dollar amounts; that is, the maximum participation by the Federal Government, the maximum participation by the employees, too.

The cost factor can be ascertained, but what you can buy with this money is the competitive item that Mr. Porter was referring to. Maybe I misconstrued that.

Mr. GROSS. Would the gentleman yield?

I think Mr. Stans gave his estimate on the basis of a one-third contribution; did you not, Mr. Stans?

Mr. STANS. I gave it both ways. I gave it on a basis of a 50-percent contribution in the Senate bill, which would be \$155 million. On a one-third contribution to what we think would be a satisfactory and adequate bill, it would be one-third of \$240 million, or \$80 million a year.

Mr. FOLEY. The difference between the \$80 million and a 50-percent contribution is \$75 million?

Mr. STANS. Yes.

Mr. WALLHAUSER. Would the gentleman allow me?

Does not the number of employees who will take the plan have some effect on the total cost to the Government?

Mr. STANS. Yes. That, of course—

Mr. WALLHAUSER. Is that not an uncertain factor at this time?

Mr. STANS. That is an uncertainty to the extent that the cost estimate is, I believe, based on something less than full participation by employees. There is a variable in that sense.

Mr. WALLHAUSER. It is not an accurately fixed total maximum?

Mr. STANS. No. I do not think the maximum is fixed. I understand, although I am not in a position to name them, that there are some other technical factors that can cause the maximum to change a bit, too.

Mr. FOLEY. The maximum to the Federal Government?

Mr. STANS. The maximum cost under the program.

Mr. FOLEY. I agree with Mr. Wallhauser that the extent of employee participation overall would determine how much the Federal Government is going to have to pay on this, but I was just thinking that there is also of this certainty written right into the bill as to the basic amount, the per capita cost the Government will pay.

The question now is, to what extent, the 33½ or 50 percent?

You recommend 33½ percent?

Mr. STANS. I do.

Mr. JOHANSEN. Will the gentleman yield?

Mr. FOLEY. Yes.

Mr. JOHANSEN. I think I agree with the gentleman from Maryland. Basically, the maximum cost to the Government and the employees is fixed in this legislation, but is it not a fact that the extent and adequacy of the benefits which can be provided under that maximum is certainly in some measure an unknown quantity and is it not true that if, under that maximum amount, events demonstrate that the benefits are not adequate, we are going to have a very natural pressure to increase the maximum costs, both to employees and to the Government in order to bring those benefits up to what are regarded as adequate?

Mr. STANS. I think that is certainly true. It is also true that if the Commission bought the benefits that could be purchased for the maximum amount under the first contract, experience under that might very well make it necessary under the same maximums to reduce the level of benefits in other years or make other adjustments in the plan.

Mr. JOHANSEN. Would it not be a regrettable development?

Mr. STANS. I think it would be regrettable and confusing. It would be much better to start on a more cautious basis and evolve experience on this kind of thing.

Mr. FOLEY. Mr. Johansen, I think you have clarified the point I was trying to make.

On this cost item, from the standpoint of the Bureau of the Budget, you recommend that the Government should defray one-third less and the employees one-third more than the Senate bill provides, as far as the fixed dollar amounts in the bill before us today?

Mr. JOHANSEN. No, the gentleman's fractions are in error, if I understand his statement. It is a reduction from 50.

Mr. FOLEY. You are absolutely right. The difference between 33½ and 50 percent. That is the difference?

Mr. STANS. Yes, sir.

Mr. FOLEY. From a cost standpoint, that is what your major concern is, that this 16½ should be borne by the employee and 16½ cost item should not be borne by the Government?

Mr. STANS. Yes, except that there is a further factor in our point of view. The size of the program should be less than the maximums, certainly in the early stages.

Mr. FOLEY. Those are the benefits that we buy with the money available?

Mr. STANS. The benefits and also the expenditures.

Mr. FOLEY. That is a matter we cannot fix by statute. That is something that the Civil Service Commission can decide within the policy limits we decide in the bill?

Mr. STANS. That is right.

The CHAIRMAN. Any other questions?

Mr. GROSS. Mr. Chairman?

The CHAIRMAN. Mr. Gross.

Mr. GROSS. Mr. Stans, in your statement you say, and I thoroughly agree with you, that the Civil Service Commission should be held unmistakably accountable for the effectiveness of this new program, and then you go on to say in the next paragraph that the proposed reorganization of the Civil Service Commission would interfere with the existing statutory powers and you are unable to discover any purpose to be served by it.

Were you referring to the advisory council or is there something else in this bill I have not seen that provides for a reorganization of the Civil Service Commission?

Mr. STANS. This is the provision in the bill to create a new bureau within the Civil Service Commission.

Mr. GROSS. An advisory council?

Mr. STANS. No.

Mr. GROSS. A new bureau?

The CHAIRMAN. That is another part of the bill.

Mr. CORBETT. That is section 13 on page 29. The Civil Service Commission also recommended that that part be deleted.

Mr. GROSS. Thank you.

I agree with both of your statements here then.

Mr. STANS. Thank you.

The CHAIRMAN. Thank you very much.

Mr. OLIVER. Mr. Chairman, may I ask a question?

The CHAIRMAN. Mr. Oliver.

Mr. OLIVER. I am the anchor man and I have been sitting here for some time listening to testimony from various witnesses and the testimony has been very instructive and very informational.

I am pleased to be here to get this information.

Great stress has been placed, however, upon only one phase of this situation so far as my understanding of it is concerned, and that is the cost to the Government. The stress seems to be placed upon that.

Have you any reactions as to what benefits might be derived, so far as the Government is concerned, by the enactment of this type of legislation? Does the Government itself benefit from this type of legislation?

Mr. STANS. Of course, it is always difficult to isolate benefits that come from any one piece of employee legislation. Inherent in it is the morale, the ability to do an effective job, and a great many other factors. I am sure that fringe benefits are an essential part of any compensation system and I think that this type of thing has become recognized as a part of compensation of employees.

Mr. OLIVER. Would you say that there are, then, no tangible benefits that you could put your finger on as a result of this type of legislation? Would it cut down on sick leave, for example?

Mr. STANS. I am not sure that it would. I am not sure that I am qualified to give an answer on that. I think the Civil Service Commission would be in a better position to know that than I would.

Mr. OLIVER. In other words, what you are saying is that you feel the only benefits that can be derived from this, or would be derived from it, would be more or less psychological?

Mr. STANS. I would think they would be more or less intangible, although there may be facts that would prove the contrary.

Mr. OLIVER. You do not know whether private industry has found such legislation to be beneficial so far as dollars and cents savings are concerned?

Mr. STANS. I do not.

Mr. OLIVER. Therefore, you take the position the Government would have no way of determining whether there was any tangible benefits to be derived?

Mr. STANS. I can only say that I know of none, and I would rely upon the Commission's knowledge as being far superior to mine in that field.

Mr. OLIVER. Thank you very much.

Mr. FOLEY. Mr. Chairman, just one question.

The CHAIRMAN. Mr. Foley.

Mr. FOLEY. I wanted to get my figures correct, if I may.

Is the estimated cost about \$310 million? Is that what it is?

Mr. STANS. Yes, sir; \$309 million.

Mr. FOLEY. One-third of that comes to approximately how much, according to your figuring?

Mr. STANS. One-third of that would be \$103 million.

Mr. FOLEY. The \$80 million you gave earlier, you want to have that corrected right now?

Mr. STANS. No, I do not. I urge that the program be held at a level of \$240 million and we pay one-third of that.

Mr. FOLEY. I get the picture.

Thank you very much.

The CHAIRMAN. Mr. Corbett?

Mr. CORBETT. It is a pleasure to see Mr. Stans again.

Mr. STANS. Thank you.

Mr. CORBETT. And equally a displeasure to find myself in disagreement with the gentleman once more.

Because of your extremely influential position in the Government, I am hoping that you and those associated with you might reconsider this to some degree. There are those of us who believe that out of our budget in the neighborhood of \$70 billion, there are very few items that recommend themselves so persuasively to us as does this item of \$80 to \$100 million.

I am sure that the gentleman can think of hundreds of activities and services rendered, of items bought, which are far less deserving than this program which should be very high on the priority list. Some of us feel, certainly, that this amount of money spent on the health of 2¼ million people, or 2 million people, is an extremely fine investment.

As a matter of fact, we are reasonably certain that some of the employees with their limited means to supply themselves with a livelihood presently will not be able to purchase the full maximums provided. I am just taking this time to urge as sincerely as I know how that the gentleman not consider \$100 million in this program per year very much of a luxury. I am not going to make comparisons with the farm program. We spend a million dollars a day to keep the worms out of the wheat and keep foodstuffs dry and all that sort of thing, but very little to keep our employees healthy. I think it is an item that the taxpayers of the country would not complain about. It is

an expenditure which private business, and which stockholders, greedy for funds, find a good program for them.

I just express the hope that as a good Director of the Budget, and those associated with him, he not be too firm in opposition to a reasonable expenditure here, knowing the word "reasonable" to be in disagreement.

Mr. STANS. Let me assure you, Mr. Corbett, that I am just as much concerned about our expenditures for wheat and other things as you are.

I think I work just as hard to try to find ways of reducing other expenditures as I can.

Mr. CORBETT. I am sure that is true.

Mr. STANS. My only concern here is that the Congress recognize that, sitting in my position, I see hundreds and thousands of programs that create demands on the Government. There is just not any way we can finance all of the things that the people of the country would like us to do. There is just not any way that we can keep our budget in balance as we need to do, unless we recognize and exercise extreme caution, particularly when we take on a new program.

I urge to this committee that it not overdo this in the first step and that we take a reasonably conservative approach, follow the Civil Service Commission's objectives, hold the costs to the Federal Government to one-third, which we can absorb, and then, on the basis of experience over a period of years, we can determine whether the benefits are adequate, whether the cost is reasonable, whether there is a better way of providing the health protection our employees should have, and just what other changes ought to be made.

Mr. GROSS. Mr. Chairman?

The CHAIRMAN. Mr. Gross.

Mr. GROSS. I thought before the session was over, farm subsidies would get into the picture.

The CHAIRMAN. Let us get back to the bill.

Mr. GROSS. All right, but the gentleman was addressing himself to the bill a moment ago.

The CHAIRMAN. Now we are getting on the farm program and the South American program.

Mr. GROSS. I notice the gentleman did not stop the gentleman from Pennsylvania when he injected the farm subsidy program into the discussion. The farmers of this country lost a billion dollars net in the first 6 months of this year underwriting the cost of living for the people in Pennsylvania and elsewhere over the country.

I might point out to him that the farmers have a long way to go in the matter of subsidy in trying to catch up with the corporations in Pennsylvania and other industrial areas with their fast tax writeoffs, and so on. We will drop farm subsidies when you drop your subsidies.

Mr. JOHANSEN. Mr. Chairman, pursuing the point raised by the gentleman from Pennsylvania, I would just like to develop for the record a matter of a little arithmetic here that I think is accurate, having in mind that successful legislation involves some process of compromise. If we were to accept the Senate version and the Senate cost of \$310 million, roughly, and were to pay half of that, the Government's share would be \$155 million.

If we accept the reduced total cost that is proposed here, and I am inclined to agree, of \$240 million, and we were to pay half of the cost,

the cost to the Government would be \$120 million, or a paper saving, at least, of \$35 million in terms of cost to the Government.

The increased cost to the Government under the \$240 million figure, as between 50 percent and 33½ percent, is an increase of \$45 million over what the witness has recommended.

Mr. STANS. \$40 million.

Mr. JOHANSEN. \$40 million. I beg your pardon.

In terms of cost to the Government, what you are doing is gaining \$35 million in reduction and taking \$40 million in increase. In other words, it is practically splitting the difference between the two by reason of lowering the total aggregate cost. I think that is something that can be considered and I am certain that we are going to be on the way to a 50 percent participation in the reasonable near future.

I am not nearly so concerned about the 50-50 proposition as I am about the aggregate cost which may be out of line and may be excessive as far as a starting point. I think maybe we are balancing discretion in terms of aggregate cost and reasonable regard for sharing the cost with the employees, if we were to consider—I am not committing myself to it—but if we were to consider a 50-50 deal on the lower aggregate cost when we just about split the differential in cost between the two programs.

Mr. STANS. That does not call for a reply by me, I guess, but I would hope that, nevertheless, the committee would give very serious consideration to holding the Government's share to one-third.

The CHAIRMAN. Thank you very much, Mr. Stans. We appreciate your testimony and I realize what a difficult and trying job you have as the Director of the Budget.

Mr. STANS. Thank you very much.

Mr. FOLEY. Trying or crying?

The CHAIRMAN. Trying.

You might cry some, too, at night.

Mr. STANS. I do, frequently.

Mr. DAVIS. Mr. Chairman, may I make a statement for the record?

The CHAIRMAN. Yes, sir.

**STATEMENT OF HON. JAMES C. DAVIS, OF GEORGIA, A
MEMBER OF THE COMMITTEE]**

Mr. DAVIS. Mr. Chairman and members of the committee, as author of two health insurance bills, H.R. 494, and H.R. 8222, before our committee, I am glad to testify in support of legislation before this committee which would establish a health insurance program for Federal employees.

The Federal employees, in my opinion, definitely need a program which will provide them with health insurance benefits during their active service with the Government and after their retirement. Such a program should also provide similar care for the dependents of these employees.

My bill, H.R. 494, which I introduced at the beginning of the present Congress, provided that the Government and the employees would share the cost of the benefits proposed for a health program, the Government to contribute two-thirds and the employees one-third.

I felt at that time that this division of cost was sound and that the Government should pay the larger share of the cost. I realize that

at times we must be guided by the practicalities of the legislative situation. Also, I recognize the fact that there is considerable difference of opinion as to the extent to which the Government should share the cost. Much of this opinion favors a smaller Government contribution than I proposed in H.R. 494.

Mr. Chairman, the big difference between H.R. 494 and H.R. 8222 is on the ratio of costs between the employee and the Government. H.R. 494 provided that employees pay one-third, the Government pay two-thirds, and covered those already retired. H.R. 8222 provides a 50-50 ratio for payment and covers only active employees and those who are involuntarily retired before the active date of this legislation. This bill is similar to the Senate-approved bill, S. 2162, and my purpose in introducing it was to expedite action on this legislation.

While the contribution of the Government has been reduced in my second bill, that portion which would have to be paid by the employee still is within the means of a person who has the limited income of many Federal employees. In my opinion, to have a program that is acceptable to our employees, we must provide sufficient contribution for a practical health program plus an adequate insurance plan against the catastrophic illnesses.

For some 12 years the legislation to provide health benefits to Federal employees has been before this committee and before the Senate Post Office and Civil Service Committee. I strongly feel that the time is right for consideration and approval of a health insurance program for our Federal employees. Today, the average employee in the Government makes only about \$100 per week. It is, therefore, not at all difficult to understand the need that these employees have for health protection to themselves and for their dependents. All of us recognize the costs involved for a catastrophic illness or extended illness such as TB, cancer, muscular dystrophy, and heart attacks.

This extended illness with the accompanying terrific expense, without some form of catastrophic sickness insurance, can hardly be borne financially by the Government employees in the top pay brackets, much less by the average Government employee. My bill, H.R. 8222, will provide this much needed protection to our Federal employees.

Of equal importance in this health insurance program is the opportunity which employees should have to choose one of several different types of coverage. This is also a feature of my bill. I feel very strongly that our employees should be able to choose the plan which best fits their needs. H.R. 8222 will allow the individual to choose between a benefit service plan, an indemnity-type plan, and in some instances, a group prepayment plan, or a program in his own employee organization. This choice of plans must certainly be in any piece of legislation our committee reports out.

There is one other aspect of this legislation which we should consider at this time. We are all most interested in maintaining the high quality of employees in the Federal Government. If the Federal Government in the future is to be able to attract able young people, it must be regarded by them as a progressive employer. It is well recognized that practically all of the progressive employers in this country today have health insurance programs for their employees. This legislation should prove, therefore, to be an effective means of

attracting and retaining the well-qualified career-type employees who are so necessary for an efficient and effective civil service.

Mr. Chairman and members of the committee, I am grateful for this opportunity to present my views, and I commend my colleagues for their hard work on this type of legislation. I commend our chairman for scheduling and holding these hearings, and I believe that the legislation which this committee finally reports will be a bill which will meet in large part the hospital and medical needs for our Federal employees.

The CHAIRMAN. The next witness is Mr. Leon L. Wheelless, Staff Director, Civilian Personnel Policy Division, Office of the Assistant Secretary of Defense (Manpower, Personnel and Reserve).

Proceed, Mr. Wheelless.

STATEMENT OF LEON L. WHEELLESS, STAFF DIRECTOR, CIVILIAN PERSONNEL POLICY DIVISION, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (MANPOWER, PERSONNEL AND RESERVE)

Mr. WHEELLESS. I appreciate the opportunity to appear before this committee on this important subject.

The Department of Defense, with more than a million civilian employees, has a vital interest in assuring that personnel management in the Federal service is conducted upon a sound and progressive basis and that a program of fringe benefits is provided for Federal employees which is reasonably comparable with that provided by progressive private employers. Where this is not the case, the Department is hampered in its ability to attract and retain the caliber of personnel required for the most effective and efficient accomplishment of its essential mission.

To date, the greatest gap in the Government's program of fringe benefits has been the absence of a health insurance program for its employees. The Department of Defense has consistently supported health insurance recommendations by this administration since 1954, and is pleased to see this matter receiving active consideration by the Congress at this time.

In its testimony on this subject before the subcommittee of the Senate Post Office and Civil Service Committee, the Department of Defense emphasized three points which, from the standpoint of its size and the dispersion of its activities throughout the world, were of especial importance to it. These points were:

1. That U.S. citizen employees serving in foreign areas should not be excluded by law from any coverage under the program, but that any necessary and appropriate exclusions or adjustments applicable to such employees should be left to determination by the agency responsible for the overall administration of the program;
2. That whatever program is established should be as simple of administration as possible; and
3. That the program should provide the maximum possible benefits at the most reasonable cost, both to the Government and the employee.

S. 2162 goes a long way toward meeting these requirements and, with some essential modifications, will provide a satisfactory basis for a needed health insurance program for Federal employees.

From the standpoint of assuring the most economical and efficient administration of the program, the Department of Defense is concerned with those provisions of S. 2162 which establish and prescribe the functions and duties of the Federal Employees Health Benefits Advisory Council.

The wording of section 12 makes this Council much more than an advisory body. It has monitoring and investigative functions, may make studies of the operation and administration of the act, may receive reports and information from the Commission, carriers, and employees and their representatives, and may recommend amendments to the act, presumably with or without concurrence of the Civil Service Commission which is the agency responsible for the program.

All these powers and duties of the Advisory Council will, in the opinion of the Department of Defense, tend to dilute and impair the position of the Commission as the administrator of the program, create confusion, and make more complicated the administration of a program which will be complicated enough even under the best of circumstances. It is the belief of the Department of Defense that the Advisory Council should be confined to those functions which the name implies—advising and making recommendations to the Civil Service Commission.

It would also seem unnecessary and undesirable to provide for a Council as large as that contemplated under section 12(a), or to provide for membership of representatives of university schools of medicine, hospital administration, and public health. While these are undoubtedly sources from which the Civil Service Commission would desire to seek information and advice from time to time, this can be done without providing membership and votes on a statutory Advisory Council.

Attention is also invited to the fact that no representation on this Council is provided for employees who are not members of national employee organizations, and who will undoubtedly constitute the bulk of employees participating in the program. Provision for such representation would be desirable.

The Department of Defense urges this committee to amend section 12 of S. 2162 in the interest of better and more effective administration of the health insurance program. The Department believes that the recommendations which the Civil Service Commission has made along this line are sound.

The Department of Defense is also concerned with the probable costs to the Government of this program, approximately one-half of which would have to be borne by this Department. As the committee is aware, the estimated cost to the Government, based upon the maximum rates specified in S. 2162, is far in excess of the maximum contribution which has been recommended by this administration. We believe that necessary amendments should be made in the bill to fix the Government cost at a more reasonable figure and at the same time to permit individual employees who desire to do so to enroll in approved plans which may exceed the total premiums now provided for in section 7(a).

There are undoubtedly other features of S. 2162 which can be improved from the standpoint of providing a better and a more sound health insurance program for Federal employees. On these points the Department of Defense defers to the views of the Civil

Service Commission. It is our hope that needed changes in this bill can be made, for we believe that it includes many desirable features and can form the basis for the kind of health insurance program which should be provided for Federal employees.

The CHAIRMAN. What kind of health insurance coverage do the Federal civilian employees have at the present time at the Department of Defense?

Mr. WHEELLESS. At the present time, Mr. Chairman, most overseas employees are provided health services in the Department of Defense's facilities overseas.

Our main concern with this bill as originally introduced in the Senate and which would have, by law, excluded all employees serving overseas, was that we do have many instances in which our civilian employees cannot take their dependents to foreign areas. We felt to deny them coverage under this type of program would mean they could not provide any protection for their dependents who would remain in this country.

The CHAIRMAN. How many employees does the Department have overseas?

Mr. WHEELLESS. U.S. civilians in foreign areas, approximately 20,000 at this time.

The CHAIRMAN. Do you know what proportion of the civilian employees of the Department of Defense now have some kind of health insurance coverage and protection?

Mr. WHEELLESS. I do not know exactly, Mr. Chairman. I would estimate at least 75 percent. I think the Civil Service Commission made an estimate at one time that about 90 percent of the people in the Washington area at least had such coverage. I think the Department of Defense would probably run about that same average.

The CHAIRMAN. I believe Chairman Hones of the Civil Service Commission testified there are more than 200 employee health programs now in the Government. Do you have any idea how many such programs may be in effect at this time in the Department of Defense?

Mr. WHEELLESS. I would not have any idea, Mr. Chairman. I would guess, though, that since we have some type of activity, or installation in at least every State, Territory, and possession, our employees would probably be affected by most of those that the Commission discovered.

Mr. DAVIS. Mr. Wheelless, at the top of page 4 of your statement you suggest an amendment to permit individual employees who desire to do so to enroll in approved plans which may exceed the total premiums provided for in section 7(a).

Do you have any suggestions as to what kind of an amendment should be adopted? I would like to have your views on that.

Mr. WHEELLESS. I think, Mr. Davis, the language which has been suggested by the Civil Service Commission in its committee print would take care of that point. The problem under the bill as passed by the Senate is that it fixes an absolute maximum that may be deducted, or withheld from an employee's salary. In other words, if that bill should pass, and an employee wished to enroll in a group health program at a cost of \$12 per biweekly pay period, he could have only \$4.25 withheld from his pay by the Government. Presumably

he would have to work out some kind of other arrangement to take care of the additional cost.

Mr. DAVIS. Your thought follows the thinking of the Civil Service Commission?

Mr. WHEELLESS. That is right.

The CHAIRMAN. Have you looked over this revised bill of the Civil Service Commission and the changes they have suggested that were given to the members of the committee yesterday?

Mr. WHEELLESS. I have reviewed it hurriedly. I did hear Mr. Jones analyze the bill. Certainly the major changes which the Commission recommends seem to be sound, and we would go along with them.

The CHAIRMAN. And they would take care of any objections you have to the measure?

Mr. WHEELLESS. They would, sir.

Mr. GROSS. Did you testify before the Senate committee?

Mr. WHEELLESS. Yes, I did.

Mr. GROSS. Why did the Senate committee exclude the Foreign Service?

Mr. WHEELLESS. The Senate, after our testimony, amended the bill to include them. The original bill before the Senate subcommittee which, as I recall, was S. 94, had a provision in it that excluded U.S. citizens employed outside the States and Territories.

Mr. GROSS. Do you have 20,000?

Mr. WHEELLESS. Approximately 20,000.

Mr. GROSS. Exclusive of dependents; is that correct?

Mr. WHEELLESS. That is true.

Mr. GROSS. Exclusive of dependents?

Mr. WHEELLESS. Correct.

Mr. GROSS. Is that number growing or decreasing?

Mr. WHEELLESS. Decreasing.

Mr. GROSS. By how much?

Mr. WHEELLESS. Rather slowly now, but it is decreasing.

Mr. GROSS. You do not foresee any increase?

Mr. WHEELLESS. We do not at this time; no, sir.

Mr. GROSS. Would you not anticipate some serious management difficulties if we insured dependents of those who are overseas?

Mr. WHEELLESS. I think not, Mr. Gross, because these would be the dependents who remained in the States.

Mr. GROSS. What about the principal, the head of the family?

Mr. WHEELLESS. The principal who went to a foreign area, as long as he happened to be in an area where we could provide medical facilities for him, probably would not need the protection of this program. But we are concerned about the fact he should be permitted to carry coverage for his dependents who remain in the States.

The CHAIRMAN. Does the Senate bill provide that?

Mr. WHEELLESS. It does, Mr. Chairman.

Mr. REES. You are familiar with the recommendations of the Civil Service Commission?

Mr. WHEELLESS. In general, yes, the major ones certainly.

Mr. REES. And you are in accord with their views?

Mr. WHEELLESS. We are.

Mr. REES. All the way along the line?

Mr. WHEELLESS. Yes.

Mr. JOHANSEN. With reference to your statement that we believe necessary amendments should be made in the bill to fix the Government costs at a more reasonable figure, do you have in mind both the reduction of the aggregate cost of the program and also the reduction of the portion of Government participation? Are you suggesting both, or one of the two?

Mr. WHEELLESS. What we have in mind, Mr. Johansen, is that we should like to see whatever bill passes the Congress not carry even the possibility of costs to the Government which exceed those that the administration states it is willing to assume. In other words, we believe, as an illustration, if the bill as passed by the Senate should become law and the Government, in the light of its present position, is unwilling to make a contribution which comes anywhere near meeting the maximum cost of that bill as estimated in the Senate report itself and as stated by Mr. Stans this morning, the result would be that employees would have considerably less benefits under whatever program is adopted. We think that in itself would create dissatisfaction and misunderstanding. So whether the Government contributed 50-50, or one-third as opposed to two-thirds, we think the bill should permit enough flexibility to establish a program within the framework of the stated willingness of the administration, in terms of money, to meet the costs.

Mr. JOHANSEN. Perhaps this is not a fair question to ask you, but would you be willing to consider any type of compromise as between the cost of the Senate bill on a 50-50 basis and the cost of the proposed bill, a \$240 million aggregate, but on a 50-50 basis?

Mr. WHEELLESS. The only way I know I could answer that would be to say that we would certainly be in favor of whatever position might be taken by the Bureau of the Budget on that point.

Mr. GROSS. You say that you do not know how many of these programs you have in the Department of Defense, or whether you have any?

Mr. WHEELLESS. Of these 200 that Mr. Murray referred to?

Mr. GROSS. Plans for medical and hospital care.

Mr. WHEELLESS. In the Department of Defense at the present time we have employees participating in Blue Cross-Blue Shield, of course—in considerable numbers—and on the west coast we have them participating in the programs out there, the Kaiser program, and in New York the programs which have been referred to previously in testimony here. We have considerable numbers in group prepractice plans such as Group Health in the Washington area.

Mr. GROSS. You have those in the Department of Defense that are in the same classified status as those in the CIA?

Mr. WHEELLESS. Do you mean personnel?

Mr. GROSS. In other words, the CIA is insured by an organization in Washington, I have forgotten the name of it, and the insuring company apparently deals in numbers.

Mr. WHEELLESS. I am not familiar with their program.

Mr. GROSS. I suppose that you have employees of that nature.

Mr. WHEELLESS. We do have some in highly classified work; yes, sir.

Mr. GROSS. I should have addressed the question to Mr. Jones yesterday with regard to how the Civil Service Commission proposes to handle the CIA if this bill is passed.

The CHAIRMAN. I see Mr. Irons here. He can supply the information.

**STATEMENT OF MR. WARREN B. IRONS, EXECUTIVE DIRECTOR,
CIVIL SERVICE COMMISSION—Resumed**

Mr. IRONS. We have the same problem with life insurance retirement right now. Employees of the CIA and similar agencies are covered by the Life Insurance Act at the present time. We have administratively worked out individual arrangements with the agencies to protect the identity of the individuals.

Mr. GROSS. Do you just deal in numbers?

Mr. IRONS. Numbers, and with people.

Mr. GROSS. How do you deal with people? The thing that puzzles me is how do the people in these agencies fill out a standard form?

Mr. IRONS. They fill out a standard form, and the form is retained in the agency.

Mr. GROSS. So you never see it?

Mr. IRONS. We are not concerned with it.

Mr. GROSS. My contention is that you ought to be concerned with it. If we set up this program, we will be making the Civil Service Commission accountable for the operation of the program. How can it be accountable in those cases where it deals strictly in numbers?

Mr. IRONS. Frankly, Mr. Gross, under this program, or the life insurance program, we have no interest in who is insured. We are interested in having paid into the trust fund the dollars contributed on the part of the employee and appropriated by the Government, and we audit to see that we get the proper amount of dollars for these people covered whether John Jones or Susie Jones.

Mr. GROSS. You cover anyone regardless of whether they are a diabetic, or have some other serious affliction?

Mr. IRONS. The legislation proposed here—properly, I think—covers all employees of the Federal Government who wish to participate regardless of their physical condition.

Mr. GROSS. That is the way Blue Cross and Blue Shield operate?

Mr. IRONS. Certainly. Our contractual requirements with any carrier would be at the initial time of contracting they assume the coverage of those employees who wish to be associated without regard to race, creed, color, or physical condition.

Mr. GROSS. Is that the way the private corporations operate their programs?

Mr. IRONS. Yes.

Mr. GROSS. They take them regardless of heart condition, or any other conditions?

Mr. IRONS. Yes. Those people who are ill are the ones who need protection.

The CHAIRMAN. Have you finished, Mr. Wheelless? We thank you very much.

Mr. LESINSKI. I would like to submit for the record the following resolution adopted by the Michigan Federation of Post Office Clerks at its convention on May 22-23, 1959, endorsing legislation to provide a medical health plan for Federal employees.

The CHAIRMAN. Without objection it will be inserted in the record at this point.

(The resolution referred to follows:)

A RESOLUTION FAVORING GOVERNMENT CONTRIBUTIONS TO MEDICAL HEALTH PLAN

Whereas according to a report published by the Foundation on Employee Health, Medical Care & Welfare, Inc., today there are more than 89 million American workers and dependents receiving some form of health insurance through worker's jobs and

Whereas another related figure released by the Bureau of Labor Statistics gives a clue to the wide acceptance of the value of protection against medical care costs by employers, while Bureau of Labor data suggest that more and more contracts negotiated by collective bargaining provide some type of health insurance, and

Whereas for the year 1957-58, 80 percent of office workers and 86 percent of plant workers were covered by hospitalization, an increase of 8.2 percent and 8.5 percent, respectively, over the previous 5-year period, and

Whereas U.S. Senator, Olin D. Johnston, South Carolina, chairman of the Senate Committee on the Post Office and Civil Service, has introduced S. 2162, in the U.S. Senate and Representative James H. Morrison, of Louisiana, has introduced H.R. 7712, and Representative John Lesinski of Michigan, has introduced H.R. 1141, to "provide for Government contribution toward personal health service benefits for civilian officers and employes in the U.S. service, and their dependents, to authorize payroll deductions for participants * * *" which when enacted into law will place government workers, including post office clerks on an equal footing with industrial employes in the health service field: Now therefore be it

Resolved, That we the delegates to the 41st Annual Convention of Michigan Federation of Post Office Clerks, assembled at Kalamazoo, Mich., May 22-23, 1959, do hereby go on record as earnestly supporting this proposed legislation, and do petition the Michigan delegation in the 86th Congress to exert its influence in behalf of the early enactment into law of same, and be it further

Resolved, That copies of these resolutions be dispatched to the two U.S. Senators and the Representatives in Congress from the State of Michigan.

Mr. LESINSKI. I would like also to insert in the record a letter from the United Auto Workers Social Security Department about its experience in collective bargaining in relation to health insurance.

The CHAIRMAN. Without objection the letter will be inserted in the record at this point.

(The letter referred to follows:)

AUGUST 11, 1959.

Hon. JOHN LESINSKI,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN LESINSKI: Since the proposed legislation to provide health insurance to Federal employes will have great significance for the whole development of health insurance in this country, and a vast impact on health plans negotiated in private industry, I thought that some comments growing out of our experience with collectively bargained programs might be of use to you and your committee. I recently wrote to the Senate Post Office and Civil Service Committee on this matter, but would also like to put these issues before you for your consideration.

The notion which has been advocated before your committee by some witnesses, that health insurance should not cover minor expenses gives only the side of the story. It is not true, as far as we can ascertain on the basis of all available experience, that when comprehensive medical services are offered without deductibles or other economic deterrents, there are excessive demands on service. It is clearly demonstrated by the documented experience of the Windsor medical plan, H.I.P. in New York, the Kaiser Foundation health plan and other medical service plans which cover practically all our experience with broad coverage for minor medical care items, that complete, free access to a full range of services does not bring abuse by patients. There is a very revealing survey, made by the Bureau of Public Health Economics, University of Michigan, of the Windsor medical service plan which does provide comprehensive benefits, including care for minor conditions and home and office physicians' care without extra charge over and above the premium. This experience tests what has often been called an inevitable tendency * * * to utilize the benefits for medically trivial reasons

and the assumption that for the subscriber this means unnecessarily high premiums and for the physician unnecessary demands on his time and temper * * * the data clearly show that this is not the case. First, about 33 percent of subscribers to the comprehensive plan did not avail themselves of any care during the year * * * as a matter of fact, the most interesting finding is that, despite the overall higher utilization of services by the plan's subscribers, the plan has about the same proportion of low, medium and high users as the rest of the population. In other words, there is no evidence of a serious volume of abuse under this comprehensive plan run by the medical society and covering the great majority of the population of Windsor, Ontario.

The argument that it costs more to administer a small claim than the benefit is worth, is true only when no efforts are made to pool the claim costs and reduce administrative cost. Again, in the Windsor medical plan study, the " * * * assumption that it is economically unfeasible to provide home and office benefits under prepayment because of the costs involved in processing small claims" is tested. "The statement is frequently heard that the expense of processing these low cost claims approaches the cost of the claim itself, so that the whole procedure is wasteful and self-defeating. The tenacity of this assumption is bewildering in view of the fact that its validity is subject to the relatively simple and accepted test of cost accounting methods. When this was done, it was quite apparent that the facts do not accord with the assumption. For the cost accounting month selected for study, there were 47,750 claim cards submitted for a total of 71,998 services or 1.51 services per claim card. Calculating the costs of processing these claims by standard accounting methods, the average processing cost per claim was 14 cents, or 2.3 percent of the claim. The processing cost per service was 9 cents."

There should also be an examination of the medical, rather than the economic aspects of the use of deductibles. To assume that economic deterrents would operate with any kind of medical sensitivity is to ask too much of such crude administrative instruments. Perhaps a large deductible would keep a person from making an unnecessary visit to the doctor, but it can just as well keep him from going promptly with early symptoms in a situation where early treatment could be lifesaving. The assumption that economic deterrents will inhibit only unnecessary care is completely unwarranted. These negative incentives do not operate with any medical discrimination. Their use, in effect, is like handing the practice of medicine over to the patient.

The public concern over health insurance is very clearly demonstrated by a study made by the Michigan Medical Society in 1957, which showed that people want health insurance to cover minor as well as major illness. Apparently, the concern of people to have minor expenses covered is influenced by their income and resources. Whereas executives and professional people are about equally divided about whether they want minor and major coverages, 80 percent of workers with lower earnings were found by this medical society survey to want minor as well as major expenses covered, and were ready to meet the cost.

A plan promulgated for civil servants has to meet the needs of a great variety of different income levels. A \$25 deductible may not be very serious in deterring care for a highly paid executive, but for the maintenance worker it may operate with medical deadliness.

The Government could offer a variety of basic programs, such as commercial insurance, Blue Cross-Blue Shield and, where available, comprehensive group practice plans like Group Health in Washington, H.I.P. in New York, and the Kaiser Foundation Health Plan in California. The less adequate coverages might be supplemented by major medical. It could keep a uniform level of Government contribution to the individual employee's coverage and, at the same time, let him choose the kind of insurance he prefers. This sort of choice is available in S. 2162, in the public programs of certain States, and in a good many collective bargaining plans.

I hope these comments may be helpful.

Sincerely yours,

JAMES BRINDLE,
Director, Social Security Department.

Mr. PORTER. I understand that this legislation has been considered in other years a number of times but that it has always run ashore because the carriers could not agree. Now I understand it may be that the plan proposed by the Civil Service Commission, and the various modifications they propose, might not be acceptable to the Blue Cross.

I would like very much to have the comments of the Blue Cross since they are supposed to be the ones——

The CHAIRMAN. I see Mr. Colman sitting in the back of the room. You may come around, Mr. Colman.

Mr. PORTER. Mr. Colman, have you had a chance to study the proposed changes?

**STATEMENT OF MR. J. DOUGLAS COLMAN, VICE PRESIDENT,
BLUE CROSS ASSOCIATION—Resumed**

Mr. COLMAN. Yes, I have.

Mr. PORTER. Do you find them acceptable to the Blue Cross?

Mr. COLMAN. I cannot speak for Blue Cross. I have not had an opportunity to consult with my colleagues. I have some reservations about them personally. Whether these will be upheld by my colleagues or not, I do not know. I would like permission, if I may, to give you our comments in writing just as fast as we can.

Mr. PORTER. Do you have a doubt that the Blue Cross would go along with the proposed changes?

Mr. COLMAN. I believe there are some about which we would have some serious reservations.

Mr. PORTER. When do you think we could have their views?

Mr. COLMAN. Certainly by Tuesday.

Mr. PORTER. Thank you very much.

The CHAIRMAN. If you can get a statement in by Tuesday, all right. (Mr. Colman submitted suggested changes to the committee which are retained in the official committee file on S. 2162.)

The CHAIRMAN. This concludes the hearing on all the health insurance bills and the committee will stand adjourned until next Tuesday morning at 10 o'clock for an executive session.

(Whereupon, at 11:45 a.m., Friday, August 14, 1959, the committee adjourned.)

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