HEARINGS

BEFORE THE

SU ITTEE ON RETIREMENT, INSURANCE, AND HEALTH BENEFITS

OF THE

COMMITTEE ON
OFFICE AND CIVIL SERVICE
USE OF REPRESENTATIVES

NINETIETH CONGRESS

SECOND SESSION

ON

H.R. 6351

A BILL TO AMEND THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF 1959 TO PROVIDE THAT THE ENTIRE COST OF HEALTH BENEFITS UNDER SUCH ACT SHALL BE PAID BY THE GOVERNMENT

JULY 9 AND 10, 1968

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[1] Deceased, July 14, 1968.

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HEALTH BENEFITS PROGRAM

TUESDAY, JULY 9, 1968

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON RETIREMENT,
INSURANCE, AND HEALTH BENEFITS OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:23 a.m., in room 311, Cannon House Office Building, Hon. Dominick V. Daniels (chairman of the subcommittee) presiding.

Mr. DANIELS. The subcommittee will come to order.

The Subcommittee on Retirement, Insurance, and Health Benefits is meeting this morning to take testimony with respect to the Federal employees' health benefits program; a fringe benefit program in which the Government, as the employer, helps to protect Federal employees and annuitants, and members of their families, against the cost of illness and injury.

The Government pays half of the premium charged under the low-option plans. However, the great majority of employees and annuitants select high-option coverage despite its much higher cost to the employee or annuitant with the result that, overall, the Government pays less than one-third of the cost of health insurance premiums.

As in the case of other health insurance plans, benefit payments under the Federal employees' health plans have steadily increased since the program's inception in 1960. The benefit cost per capita has continued to rise, and further premium increases are expected because of the rising costs of health services, increased utilization, and the fact that an increasing proportion of the covered group will consist of annuitants.

The view has been expressed that employees bear a disproportionately large share of the increased cost of benefits, and that consideration be given to changing the method of determining the division of costs between the employees and the Government.

It is the purpose of these hearings to make an objective appraisal of this vital program, with particular evaluation of the Government's participation in premium charges.

I would like to offer at this point in the record H.R. 6351, a bill which I introduced on March 1, 1967, to amend the Federal Employees Health Benefits Act of 1959 to provide that the entire cost of health benefits under such act shall be paid by the Government.

(The bill referred to follows:)

[H.R. 6351, 90th Cong., first sess.]

A BILL To amend the Federal Employees Health Benefits Act of 1959 to provide that the entire cost of health benefits under such Act shall be paid by the Government

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 7(a) of the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 3006(a)) is amended to read as follows:

"SEC. 7. (a) (1) The Government contribution for health benefits for employees or annuitants enrolled in health benefits plans under this Act, in addition to the Government contribution required by paragraph (2), shall be at a rate determined by the Commission as sufficient to cover the entire cost of such health benefits.

"(2) There shall be contributed by the Government amounts necessary for the administrative costs and the reserves provided for by section 8(b).".

(b) The last sentence of section 7(b) of such Act (5 U.S.C. 3006(b)) is amended by striking out "the employee and".

(c) Section 7(d) of such Act (5 U.S.C. 3006(d)) is hereby repealed.

(d) The last sentence of section 8(a) of such Act (5 U.S.C. 3007(a)) is amended to read as follows: "The contributions of the Government described in section 7 shall be paid into the fund.".

(e) (1) The first sentence of section 8(b) of such Act (5 U.S.C. 3007(b)) is amended by striking out "employees, annuitants, and".

(2) The last sentence of such section 8(b) (5 U.S.C. 3007(b)) is amended by striking out "employees and".

(f) Section 16 of such Act (73 Stat. 717; 5 U.S.C. 3001, note) is amended by striking out "withholding and".

SEC. 2. The amendments made by the first section of this Act shall become effective on the first day of the first pay period which begins more than thirty days after the date of enactment of this Act.

Mr. DANIELS. Our first witness this morning is Mr. David Silvergleid, president of the National Postal Union, who is accompanied by Mr. Robert Kephart, secretary-treasurer; Mr. John A. Morgen, executive vice president; and Mr. Edward L. Bowley, secretary treasurer of the NPU health benefits plan.

Welcome, Mr. Silvergleid. You look very, very well after your recent trip to Atlantic City to attend the State convention of your union.

TESTIMONY OF DAVID SILVERGLEID, PRESIDENT, NATIONAL POSTAL UNION, ACCOMPANIED BY ROBERT P. KEPHART, SECRETARY-TREASURER; JOHN A. MORGEN, EXECUTIVE VICE PRESIDENT; AND EDWARD L. BOWLEY, SECRETARY-TREASURER, NATIONAL POSTAL UNION HEALTH BENEFITS PLAN

Mr. SILVERGLEID. I'm glad you mentioned that, Mr. Chairman, because everyone here seems to be under the misapprehension that I have been on an extended vacation; and I haven't.

Mr. DANIELS. You are acquainted with the gentlemen on the left, my colleague from New York, Mr. Hanley.

Mr. HANLEY. I take this opportunity to extend my heartiest congratulations, Mr. Silvergleid, on your ascent to presidency of your great union.

Mr. SILVERGLEID. Thank you very much, Mr. Congressman.

For the record, Mr. Chairman, may I introduce my colleagues?

To our left is our executive vice president—and they are all newly elected—John A. Morgen. He is from St. Paul, Minn.

To my extreme right, our newly elected secretary-treasurer, Robert P. Kephart, of Philadelphia.

To my immediate right, our reelected secretary-treasurer of our health benefits plan, Edward L. Bowley.

Mr. DANIELS. I am well acquainted with the two gentlemen to your right and am glad to make the acquaintance of Mr. Morgen. I extend to each and all of you my sincere wishes for a very fruitful and productive administration.

Mr. SILVERGLEID. Thank you, Mr. Chairman.

Mr. DANIELS. I might also say that Mr. Silvergleid is a highly respected representative of the employees and a man that I know, from past experience when testifying before our committee, does his homework very well.

Mr. SILVERGLEID. Thank you, Mr. Chairman.

Mr. DANIELS. So with that introduction, you may proceed, Mr. Silvergleid.

Mr. SILVERGLEID. May I say, if it is not a matter of record, that inasmuch as I am now elected for the next 2 years, any nominating speech you care to make, Mr. Chairman, please make it a year and a half from now. [Laughter.]

At the outset, Mr. Chairman, we would like to express our appreciation to you for scheduling hearings on this vital legislation. Your foresight in recognizing the necessity and importance of such legislation is to be commended and has the gratitude of not only our membership, but of all Federal employees.

We are pleased to cite that numerous Congressmen have introduced similar legislation and that your counterpart in the U.S. Senate, Senator Daniel B. Brewster, chairman of the Subcommittee on Health Benefits, has also introduced a similar bill.

The subject of the Government's contribution to health insurance premiums is so important to our membership that our national executive board placed this at the top of our legislative goals for 1968.

Mr. Chairman, the continual rise in the cost of hospital and medical care in this country has become a national scandal, so much so that it prompted the President of the United States to appoint a committee to review the ever-rising costs to determine the reasons therefor and recommend solutions.

Unfortunately, however, the report of that committee does not appear to us to have the answers for the immediate problem; that is, to halt the spiraling cost and/or to reverse the trend.

We have attached hereto as part of this statement, statistical reports which cite the real problem, and we will refer to these throughout our statement.

But first, Mr. Chairman, permit me to provide the committee with some of the background on the Federal Employees Health Benefits Act, as I believe it will help provide a better understanding of the acuteness of the problem. We are grateful for the action taken by the 86th Congress, which provided for a health benefits program to take effect July 9, 1960.

Under the Health Benefits Act of 1959, Government contributions to health benefit premiums were limited to a maximum of 50 percent of the premium paid for the lowest cost of the two Government-wide low option plans, regardless of which plan or which option the employee selected. Our own experience at that time showed most of our members enrolled in the low option plan.

However, since that time, and during each subsequent enrollment period, the shift has been continually from the low option plans to

the high option plans. The reason: to provide more coverage for their families, particularly where greater allowances are needed, since low option plans have limitations on most benefits. This has been absolutely necessary to meet steadily increasing costs. The last official figures released show approximately 80 percent of all eligibles are in high option plans.

Maximum contribution by the Government was $3.12 for those enrolled for family coverage in a high option plan prior to Public Law 89–504 effective July 18, 1966, which increased slightly the Government contribution for the same type of coverage to a maximum of $4.10 biweekly.

The total inadequacy of the Government's contribution is pointed up in two major areas. First, the increase in the Government contributions referred to above failed to restore even the original percentage of premium paid by the Government, particularly in view of the overwhelming majority of enrollees compelled to enroll in the more expensive high option plans, and most carriers have been compelled to double their premiums since the inception of the program.

The following schedule exemplifies necessary increases in National Postal Union's high option plan and reflects the proportionate decrease in the Government contributions since the inception of the health benefits program:

(The table referred to follows:)

FAMILY ENROLLMENT BIWEEKLY COST

Contract year	Enrollee's cost	Government contribution	Total cost	Government share proportionately, percent
1960–61	$5.88	$3.12	$9.00	34.67
1961–62	5.56	3.12	8.68	35.94
1962–63	5.56	3.12	8.68	35.94
1963–64	5.56	3.12	8.68	35.94
1964–65	8.75	3.12	11.87	26.29
1966	10.36	3.12	13.48	23.15
1967	12.05	4.10	16.15	25.38
1968	13.44	4.10	17.54	23.38

Mr. SILVERGLEID. I am not going through the schedule, Mr. Chairman, but you can note at a glance that the original Government share as far as NPU's health plan was concerned, which was 34.67 percent, has in 1968 dropped to a contribution of only 23.38 percent.

I would ask you to look at the first column, 1963–64, where NPU charged $5.56. The increase in the intervening years to 1968 is 119 percent as contrasted to the increase in the Government contribution in the same years of 33 percent.

So you can readily see what a wide disparity has now developed in the Government's contribution as contrasted to what it was when the law was enacted.

The other factor is that the average annual cost per person for health care services has been increasing steadily ever since the Health Benefits Act became effective, both because of increases in the cost of individual services and increased utilization of same.

In addition, since the inception of the program, there have been amendments to the Health Benefits Act which have been contributing cost factors to all carriers.

For example, when the act was amended in March 1964, carriers were compelled to provide benefits for additional eligibles such as foster children, and extended coverage for children from the ages of 19 years to 21 years, and later amended to 22 years of age, providing 3 years more coverage in cases where the children were unmarried and still dependent upon the member.

The late President John F. Kennedy presented a program requesting more coverage for the mentally ill in this country and the Civil Service Commission requested all carriers to cooperate in this regard. Public Law 88–282 liberalized eligibility to continue enrollment as an annuitant. By insurance standards this is an extremely high-risk group.

National Postal Union, however, was pleased to go along with all of these programs, but we must point out that these were all areas of cost to the carriers borne entirely by the enrollees, while there was no recommendation to increase the contributions by the Government.

More recently, alcoholism is becoming recognized as an illness, and the Civil Service Commission has once again asked all carriers to take cognizance of the situation and provide benefits in this area, beginning with the next contract year.

National Postal Union's actuaries are presently reviewing this request, determining to what extent we can afford coverage in this very vital area, affecting possibly millions of people in this country. But once again, we must point out that this, too, will add more cost to the plan.

Now, Mr. Chairman, let us really discuss cost. Rises in hospital costs are presently averaging 8 to 12 percent per year, and as a result, every single carrier has been compelled to increase premiums for essentially the same benefits over the past few years. The net practical effect has been pay cuts for postal employees forced to pay substantial increases in premiums in order to maintain essential coverage.

One source of data on trends in hospital costs is the series on hospital daily service charges developed by the Bureau of Labor Statistics, U.S. Department of Labor. In connection with the compilation of the Consumer Price Index, the hospital daily service charge is the charge to full-time adult inpatients for routine nursing care, room and board, and minor medical and surgical supplies. It usually excludes such additional charges in the hospital bill as laboratory work, X-rays, operating room, and special nursing.

As contrasted with hospital expense per patient-day, the daily service charge reflects additional charges to the consumer rather than the cost to the hospital of providing services.

Between 1946 and 1964, hospital daily service charges rose 292 percent—five times as much as the Consumer Price Index for all items. Throughout the intervening 18 years, hospital daily service charges also rose more rapidly than medical care prices, generally. Government calculations indicate medical costs have been rising faster than the total cost of living.

Attached hereto—and there is an exhibit at the back of the statement—taken from the Wall Street Journal for the first 6 months of this year are tables reflecting the monthly medical care cost rise, and the latest one released in June 1968 indicates medical care costs rose in April of this year to 143.5 percent of the 1957–59 average and from

142.9 percent a month earlier. These costs are components of the Consumer Price Index.

Worse, and there has been a rash of publicity in newspapers on this, are increases in hospital costs in the calendar year 1967, ranging from 10 percent to 25 percent of 1966 charges, and we are told by our actuaries to expect similar increases in 1968 and even greater increases in 1969.

All of the increases are compounded on the gross increases of previous years, of course, imposing a particularly severe hardship on employees for whom adequate health insurance is a must. There are additional exhibits attached hereto which point out the severity of the situation.

But if I may at this point, Mr. Chairman, rather coincidentally, I might say, in this past week on July 2, in the Wall Street Journal, an article appeared relating to a proposed or threatened strike by hospital employees which had been settled with the intervention of the New York City mayor.

It is interesting to note that the employees achieved what they were after in this instance, and that was a minimum wage of $100 a week. However, as a result of the minimum wage, if I may just read one statement:

> The New York hospital league estimates that the wage settlement will raise the average semiprivate hospital rate in New York by $18 to $20 a day. The average semiprivate rate in New York generally runs between $70 and $85 a day already, said William Abelaw, counsel for the league.

So that you can see that they can anticipate in the metropolitan area of New York a semiprivate rate of close to $100 a day beginning in 1969.

We had previously been told this might take place around 1970.

If I may, Mr. Chairman, I would like to submit this for the record.

Mr. DANIELS. Without objection, it is so ordered.

(The Wall Street Journal article referred to follows:)

[From the Wall Street Journal, July 2, 1968]

HOSPITAL UNION PLANS MAJOR EASTERN DRIVE AFTER NEW YORK WIN

ORGANIZATION SAYS MINIMUM WAGE OF $100 IS HIGHEST IN COUNTRY, PLANS TO USE AS 'SPRINGBOARD'

(By a Wall Street Journal Staff Reporter)

NEW YORK.—Bolstered by a settlement in which it won its primary wage demand, the New York Drug and Hospital Union said it is launching a major campaign to organize hospital employes in other major Eastern cities.

Negotiators for Local 1199 of the union and the New York League of Voluntary Hospitals and Homes reached a contract agreement at 7:20 a.m. yesterday shortly after pickets began to appear at at least six of the 17 voluntary hospitals involved. The union won a rise in the minimum weekly salary from between $72 and $78 to $100, with half the rise taking effect yesterday and the other half on July 1, 1969.

The pact also provides a night differential, a pension program and a job training program. The agreement, which is expected also to set a pattern for wage settlements at other New York hospitals not in the league, averted a strike by 12,500 union members. The strike would have severely hampered the care of some 8,000 patients at the hospitals.

The $100-a-week minimum wage is the highest such settlement for hospital workers in the nation, said a union spokesman. "We plan to use this as a springboard in our organizing drive in other Eastern cities," the spokesman said. "We've already made some progress in New Jersey and Connecticut."

There are about 2.1 million hospital workers in the U.S., and they are largely unorganized. New York has the largest hospital workers union.

The New York hospital league estimates that the wage settlement will raise the average semiprivate hospital rate in New York by $18 to $20 a day. The average semiprivate rate in New York generally runs between $70 and $85 a day already, said William Abelaw, counsel for the league.

A spokesman for the league said. "The union won a major concession on wages. But we believe we established the principle of arbitration and an end to strikes. For the first time in our negotiations with the union, there was give and take."

The league spokesman said that issues of seniority, hiring hall and the right to subcontract were being arbitrated.

The union membership includes nurse's aides, orderlies, housekeeping, laundry and clerical workers, X-ray and laboratory technicians and porters. The settlement will probably create "an increase in expectations" among elevator operators, porters and laundry workers in other industries, the union spokesman said.

Mayor John Lindsay took personal charge of the negotiations after talks between the union and bargainers for the league ran into difficulty Sunday afternoon. The 17 affected hospitals normally handle 10,000 patients, the league said, but about 2,000 were sent home over the weekend because of the strike threat.

Mr. SILVERGLEID. Another story appeared on July 3 in the Evening Bulletin of Philadelphia, Pa., and all I will read is the headline. I would like, if I may, Mr. Chairman, to submit this for the record also.

Hospitals here raising rates for room and board 12 to 30 percent. Total daily cost to hit $100 for some.

If I may, Mr. Chairman, I would like to submit that for the record.

Mr. DANIELS. It will be introduced in the record at this point, if there is no objection.

Mr. SILVERGLEID. Thank you.

(The Evening Bulletin article referred to follows:)

[From the Evening Bulletin, Philadelphia, Pa., July 3, 1968]

HOSPITALS HERE RAISING RATES FOR ROOM AND BOARD 12 TO 30 PERCENT

TOTAL DAILY COST TO HIT $100 FOR SOME

(By David M. Cleary, of the Bulletin staff)

Most general hospitals in Greater Philadelphia are raising sharply their daily room and board rates.

Increases range from 12 to 30 percent. Some became effective on Monday, as the hospitals began their new fiscal years on July 1. Others will rise next Monday.

A spot check yesterday produced these old and new room and board rates per person per day:

Hospital	Old rate	New rate
Children's	$41.00	$53.00
Delaware County	37.00	42.00
Einstein	42.00	47.00
Lankenau	31.00	40.00
Pennsylvania	42.50	52.50
University of Pennsylvania	55.00	58.00

The rate in each case is for the most commonly available accommodation. That's a room containing two beds, usually with lavatory and sometimes with toilet, in all the hospitals except Children's, where it's a room containing six to ten cribs.

TWO HOLD THEIR RATES

Among the hospitals checked, two were not raising room rates at this time. They were:

—St. Luke's and Children's, where Administrator Thomas J. Donnelly said the rates were increased to an average $30 per day in December, "and we usually lag behind other hospitals in rate adjustments."

—Wills Eye, which also set a new rate (average $36) last December, but is raising charges for X-ray and other ancillary services by about 25 percent this month.

At University of Pennsylvania Hospital, the average rate was raised from $45 to $55 only a month ago, and is now going up by another $3 a day.

MORE THAN $100 A DAY

In some cases, the rate increases bring the total cost of a day's hospital care to more than $100, since the basic charge is only for room, food (including special diets) and the attention of nurses, nurses' aides, and doctors employed by the hospital as interns and resident physicians.

Other charges—operating room fees, drugs, oxygen, electrocardiograms, etc.—are additional, often as large as the room and board bill for a hospital stay of ten days or less.

The tendency of a basic charge to double is illustrated in the 1967 financial report of Lankenau Hospital.

Last year, Lankenau charged an average of $31 for room and board after July 1, and less during earlier months.

UP TO $60 DAILY

But when total income from patients and their insurance companies is divided by total number of patient-days for the year, the cost is revealed as $60 per day.

Harry R. Neilson, Jr., president of the board of trustees at Lankenau, explains, in a letter distributed to patients, that costs keep climbing because a hospital is "a seven-day-a-week, 24-hour-a-day, 365-day-a-year operation."

This requires a sizable work force, Neilson writes, representing 70 percent of the hospital's operating budget, and "for decades, hospital workers have been involuntary philanthropists. They are no longer willing to accept this role."

Neilson points to higher salaries for all employes. Minimum pay went up Monday from $1.50 to $1.60 per hour for the most menial worker, "with proportionate adjustments in all other salary grades."

PAY INCREASES MAJOR FACTOR

Hospital administrators throughout Greater Philadelphia echo Neilson's comment that salary increases are the major factor dictating rate increases.

Jerome Baron, financial assistant to Dr. Pascal F. Lucchesi, executive vice president at Einstein, also points to the $4 limit set by the state for providing a clinic service under Pennsycare.

"It costs a great deal more than that, and we have to make up those losses," said Baron.

The effect on Blue Cross payments to hospitals will be immediate in some cases, and felt over a period of several months in others, depending on the reimbursement contract each hospital has with Blue Cross.

BLUE CROSS TO PAY MORE

Lankenau, for example, is reimbursed by Blue Cross on the basis of costs, without regard to what the hospital charges patients who are not Blue Cross subscribers.

"We'll be paying more because of the increased salaries," said a Blue Cross spokesman, "but not because the hospital has adopted a new rate schedule."

Other hospitals operate on contracts which call for Blue Cross to pay a basic rate, set in 1958, plus a percentage of the difference between that rate and what the hospital charges its non-Blue Cross patients. Blue Cross payments to those hospitals will rise immediately.

WAITING FOR MAXWELL

At least one hospital—Hahnemann—is holding rate increases in abeyance for at least a few days, waiting to see how Pennsylvania Insurance Commissioner David O. Maxwell rules on a new "uniform" contract between Blue Cross and all the hospitals.

"We plan to raise the basic rate from $31 to $40 next Monday," said Hahnemann's administrator, Charles S. Paxson, Jr., "unless the new contract goes into effect before that."

Maxwell rejected a first draft of the uniform contract in March, because it contained no incentive for hospitals to control costs and made Blue Cross subscribers involuntarily subsidize hospitals for their losses in treating other patients, among other reasons.

DECISION EXPECTED SOON

A new version of the contract, said to include some incentives for economy, is now before the commissioner. He is expected to announce his decision on it some time this week.

Meanwhile, Maxwell on May 29 allowed Blue Cross to increase its subscription rates by an average of 13.5 percent, stating that "the alternative is bankruptcy."

Whether that increase in Blue Cross subscription rates—to go into effect as each group negotiates its new contract during the coming year—will be sufficient to pay for the latest round of hospital charge increases is not clear.

Mr. SILVERGLEID. The Brookings Institution, a nonprofit organization which engages in research and education, economics, government, and the social sciences, forecast that, "Average hospital costs of $100 a day are not far off." Many experts in this field anticipate such costs by 1970.

As I just pointed out, apparently the experts are just a little off, because we can anticipate the $100 a day cost by 1969.

The American Hospital Association estimated that the average cost per day of care for a patient including all special fees and drugs would jump to around $58 in 1967 from $48 in 1966. In large metropolitan areas, however, the rate was far higher than the average. For example, the New York Cornell Medical Center reported a per day cost of $78.67 in 1967. This pattern is being repeated all across the Nation. It adds up to a staggering increase in medical costs that far exceeds rises in other living costs.

Because the higher costs are reflected in higher medical insurance premiums and higher taxes to cover expenses for such Government-sponsored programs as medicare, they will be felt by practically all Americans, whether or not they utilize hospital and/or medical services themselves. We believe the problem is so acute it demands the immediate attention and action of Congress. Vigorous and determined action by our National Government is needed to control the skyrocketing cost if the consumer is not to be priced right out of the medical marketplace.

Other exhibits attached hereto reflect the breakdown of the medical dollar in 1964 compared with the same dollar 10 years previously. The exhibit points out that the hospitals are consuming more and more of the medical care dollar. But hospital costs are not increasing alone. Medical costs are also increasing rapidly. American people buy more health services today, and prices of such are much higher.

The American Medical Association has pointed out that one of the reasons is that the demand for services is much greater than the supply, and that long periods of training for health professionals is one of the reasons the demands cannot be met. Other factors of increasing medical costs are cited as being higher incomes, greater purchasing power, older population, and utilization of services.

Our experience has been that doctors charge more when they know an individual has a health plan, that six office visits are required when four would suffice, that extra days are added to hospital stays because the individual has health insurance.

We welcome the high quality of complex technology though we note oftenttimes there is a duplication of services because of the desire

of many physicians to specialize in a certain field. Even though they are quite capable of caring for an individual, it is our experience that doctors will refer patients to still another specialist, and as a result specialists' fees come much higher.

As a labor union, we believe that all workers', including physicians', incomes need to be commensurate with their high level of training, skill and responsibility, but it is obvious that many doctors have carried this too far. They do not appear to be satisfied with just an office, but must be in a high rent district and in the best part of town. They are not satisfied with just an automobile; it must be a Cadillac. The general practitioner is nearly extinct and the doctor who will get out of bed in the middle of the night and come to your home is a thing of the past.

We believe something can be done and something must be done in this area, if the administration and the Congress will find the time and make the effort to do something about it. But the immediate relief needed is an increase in the Government's contribution toward health insurance premiums, and the ultimate answer is that the full cost of such premium must be borne by the Government.

This is not unique, Mr. Chairman, nor is it a revolutionary approach. As a matter of fact, we find the Government lagging far behind private industry in this area. Nearly every major industry in this country provides a health insurance program for its employees, and in many instances underwrites the full cost. As a matter of fact, in this regard National Postal Union practices what it preaches. We have slightly more than 50 employees in our organization, and all of them are provided with life insurance and a health benefits program, paid entirely by the union.

A better example, however, are the employees of New York City, including firemen and policemen, who since April 1, 1967, have been receiving a health insurance program providing full coverage, for which the local government pays the entire cost. These employees have their choice of three major companies in the New York area providing health insurance.

We believe the time is long overdue for the Government to begin catching up with private industry in the area of providing fringe benefits to its employees. We have long felt that the Government should be a leader in all areas including pay, fringe benefits, et cetera, rather than constantly lagging behind.

As we have cited in previous testimony, Mr. Chairman, the turnover in the Federal Government and in the postal service in particular, attributable a great deal to the vast difference in salaries and fringe benefits offered in the private sector, in our opinion, costs this Government as much or more than the benefits we are seeking.

We have not submitted a table of the various private industries involved, Mr. Chairman, although I understand there will be such tables submitted by other witnesses.

But a recent study by the Department of Health, Education, and Welfare, of which we are aware, demonstrates very clearly that in the larger industries in this country, in the vast majority of cases, contracts have been negotiated by the employee unions which provide for the employer to pick up the full tab for life insurance, health insurance premiums, and so on.

Mr. Chairman, there are two other sections of the law which we feel should be amended. We call these to your attention very briefly. The first deals with enrollment period and the other with distribution of brochures.

Presently, the law provides for an "open season" enrollment period once in 3 years. The Civil Service Commission has already announced the next one will be November 14 to 28, 1969, which is 3 years after the last open season was held. In our judgment, this is entirely too long. The medical needs of a family can change greatly in a single year, and all plans do not provide the same benefits. We strongly urge consideration of an open season on an annual basis.

May I say here very briefly, Mr. Chairman, that the Commission has always taken the point of view that there is a rather moderate turnover when they do have an open season of about 2 percent, and therefore it doesn't appear to be worthwhile. But there is absolutely no doubt in our mind—and this is the opinion of our actuaries—that practically every union plan and the Government-wide plans will have to request or submit a program for a further increase in premiums for 1969.

Now, the Commission has sent a statement to all the carriers saying in effect, "We are not declaring an open season, so we are going to ask you to use a certain amount of restraint in raising or considering raising your premiums."

On the other hand, if you don't raise your premiums sufficiently in their opinion, they will call you in and say, "You've got to have it a certain percentage whether you like it or not, because we want you to be financially stable."

So that I am emphasizing at this point that having an open season as they have been having them on a 2- or 3-year basis really makes captives of all our union members who belong to union plans and want to remain in union plans because they cannot move from one to another until such an open season is held.

We would suggest the members of the committee consider this for at least some future legislation.

With respect to the distribution of brochures, only the two Government-wide plans are distributed to all employees. This is the way the Civil Service Commission has applied the law. We feel that this is not in keeping with the law's intent of providing all eligibles with an informed choice.

We respectfully request that employees be given all brochures of plans for which they are eligible and for which they can qualify so that they will truly have an informed choice.

In conclusion, Mr. Chairman, we again want to thank you and the members of this subcommittee for scheduling these hearings and for providing us with this opportunity to present our views, enabling us to make known to you and to the American public the problems that exist.

We are hopeful, of course, that while there probably will not be any action during the 90th Congress, that the entire issue will be aired at the present time as it is being done by this subcommittee, and that early in the 91st Congress perhaps the members, the new chairman—and I am hopeful the new chairman will be the present chairman—the members of this subcommittee will be able to take early action on

an issue that we consider not only a true bread-and-butter issue but one that is vital, vital to our people.

As we pointed out, every time there is a raise in premiums—and there is going to be one every year under present conditions—it represents a cut in take-home pay which the employee can do nothing about.

Mr. Chairman, I sincerely appreciate your attention, and if there are any questions we will be glad to answer them.

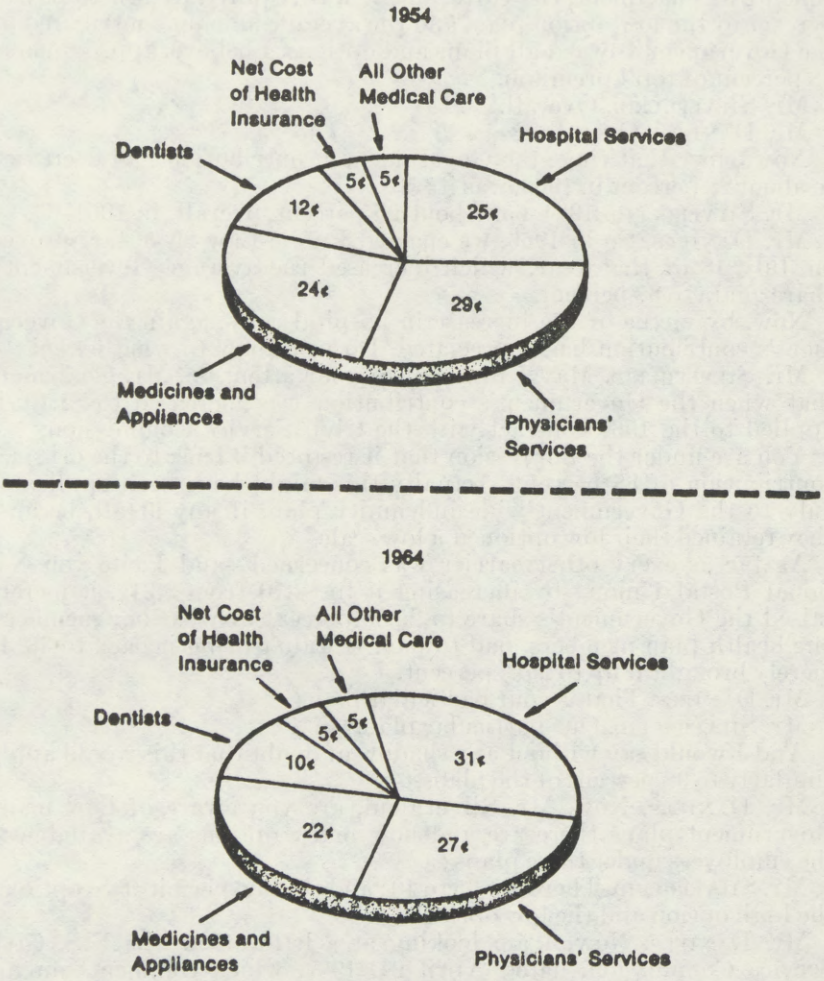
(The attachments to the statement of Mr. Silvergleid follow:)

INCREASES IN ROOM AND BOARD RATES

Hospital	Date	Private	Semiprivate	Ward
Memorial Hospital, Long Beach, Calif	5-67	$47 to $49	$42	$40.
	4-68	$50 to $52	$45	$43.
Mercy Hospital, San Diego, Calif	3-67	$50 to $52	$44	
	5-68	$55 to $70	$48	
St. Joseph Mercy Hospital, Pontiac, Mich	11-67	$50	$45	$40.
	1-68	$52	$47	$42.
Archbishop Bergan Mercy Hospital, Omaha, Nebr.	6-67	$45	$35	$28.
	5-68	$48	$37	$30.
St. Barnabas Medical Center, Livingston, N.J.	7-67	$55	$35	
	1-68	$60	$40	
Underwood-Memorial Hospital, Woodbury, N.J.	1-67	$35 to $46	$28 to $30	$24.
	2-68	$38 to $51	$30 to $33	$26 to $29.
Presbyterian Hospital, Charlotte, N.C	10-67	$31.50 to $36	$28.50 to $30	$26 to $26.50.
	3-68	$33 to $38	$30.50 to $32	$28 to $28.50.
Elyria Memorial Hospital, Elyria, Ohio	12-67	$41.50 to $46	$38 to $39	$36.50.
	6-68	$45.50 to $50	$42 to $43	$40.50.
St. Francis General Hospital, Pittsubrgh, Pa.	2-67	$37 to $50	$33 to $39	$29.
	7-68	$65 to $78 [1]	$55 to $65 [1]	$49.[1]
Le Bonheur's Children's Hospital, Memphis, Tenn.	1-68	$36.50 to $39	$32.50	$26.
	6-68	$40 to $43	$35	$29.
Butterworth Hospital, Grand Rapids, Mich	7-67	$35 to $38	$31 to $32	$28.
	11-67	$38 to $41	$34 to $35	$31.
Children's Hospital of the District of Columbia.	7-67	$50 to $52	$45	$38.
	1-68	$60 to $62	$55	$48.
Doctor's Hospital, Phoenix, Ariz	7-67	$45 to $60	$33 to $39	
	1-68	$50 to $70	$45 to $60	
Elyria Memorial Hospital, Elyria, Ohio	1-67	$36.50	$33 to $34	$31.50.
	12-67	$41.50 to $46	$38 to $39	$36.50.
Immanuel Hospital, Mankato, Minn	5-67	$21.95 to $30.75	$19.95 to $20.75	$20.75 to $21.75.
	11-67	$22.95 to $33.95	$20.95 to $22.75	$22 to $23.75.
Maine Medical Center, Portland, Maine	3-67	$45	$40	$37.
	4-68	$50 to $55	$48 to $50	$45.
Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.	67		$46	
	68		$64	
Mercy Hospital, San Diego, Calif	8-66	$45 to $47	$39	
	3-67	$50 to $52	$44	
Peoples Community Hospital, Authority, Mich. (Includes 4 hospitals.)	2-67	$37	$32	$30.
	7-67	$40	$35	$33.
Redlands Community Hospital, Redlands, Calif.	4-67	$45 to $51	$41 to $45	$39.50.
	4-68	$46 to $52	$42 to $46	$40.50.
Santa Monica Hospital, Santa Monica, Calif.	4-67	$51	$49	$45.
	4-68	$55	$53	$49.
Sibley Memorial Hospital, Washington, D.C	3-67	$44 to $46	$34.50	
	1-68	$49 to $51	$39.50	
Sierra Hospital, Fresno, Calif	8-66	$39 to $41	$35	$32.
	1-68	$41 to $43	$37	$34.

[1] All inclusive rate.

Distribution of the Medical Care Dollar



Source: United States Department of Commerce and Health Insurance Association of America.

97-232—68——3

Mr. DANIELS. Mr. Silvergleid, I want to thank you for a very fine statement made here this morning, and I wholeheartedly agree with you that when the premiums are increased it does affect the employee's salary. It does mean a cut in his salary.

Now, I would like to go back and review the history of the Federal Employees Health Benefits Act, which was adopted in 1959. At the time of its enactment, the Government was required by law to pay 50 percent of the low option plan, and the average amount contributed by the Government toward all plans and options, I believe, approximated 38 percent of total premium.

Mr. SILVERGLEID. Overall.

Mr. DANIELS. Overall.

Now, since that time, the Government's contribution had decreased to about 28 percent in 1966, was it?

Mr. SILVERGLEID. 1964–65. About 25 percent, overall, in 1964–65.

Mr. DANIELS. So in 1966, we enacted Public Law 89–504, approved on July 18 of that year, which increased the average Government's share again to 38 percent.

Now, by virtue of the increase in hospital costs, again the Government's contribution has depreciated. Do you know to what extent?

Mr. SILVERGLEID. May I first call to your attention, Mr. Chairman, that when the Government's contribution was increased to $4.10, it applied to the 1967 contract with the Civil Service Commission.

You are under the impression that it restored it back to the original contribution of 38 percent. Actually this might have been applicable only to the Government-wide indemnity plan, if any at all, because they retained their low option at a low scale.

As far as every other carrier was concerned—and I cite you National Postal Union—by increasing it to $4.10 from $3.12, it merely raised the Government's share to 25.38 percent of what our members, our health plan members, had to pay. It didn't bring it back to 38. It merely brought it up to 25½ percent.

Mr. DANIELS. That is your particular plan?

Mr. SILVERGLEID. Our particular plan.

And I would say without any shadow of doubt that this would apply similarly to 98 percent of the plans.

Mr. DANIELS. Now, Mr. Silvergleid, are you aware of how many Government plans there are and how many options are available to the employees under these plans?

Mr. SILVERGLEID. There are 35 to 40; and the law permits two options, the high option and the low option.

Mr. DANIELS. Now, I am looking at a letter from the U.S. Civil Service Commission, dated April 24, 1968, which comments on my bill, H.R. 6351. On page 2 of this letter it states that there are 36 plans offering 54 options.

Now, apparently there is a wide variance between one plan and another by virtue of the options which are offered to the members. Is that not correct?

Mr. SILVERGLEID. Well, the 54 options they refer to, Mr. Chairman, are the high and low. Each carrier has the option of offering two. Some of them offer only one. So, as a result, you have 36 plans with 54 options in the aggregate. This is what they mean.

Mr. DANIELS. Now, do these various plans—that is, the 36 that have been alluded to—vary from one organization to another?

Mr. SILVERGLEID. They do.

Mr. DANIELS. Some offer greater benefits than other plans?

Mr. SILVERGLEID. Some offer much more comprehensive coverage, such as ours does, and necessarily have to charge a higher premium. Some are underwriten by insurance companies. Some are underwritten by the unions themselves. We underwrite our own plan. Most of the big unions do. Some of them don't.

So that you have a vast variety of operations. But in the aggregate, the overall picture, obviously I think it would indicate that constantly we are falling behind that original percentage.

I might point this out, Mr. Chairman, for clarification. When the bill was enacted, when it was being considered in 1959, the apparent intent—and this was expressed in the reports—was that the Government contribute 50 percent. It finally evolved with that 50 percent being attributed only to the low option.

So that, as more and more of the Federal employees, Federal and postal workers, were compelled to go into the high option field to get the necessary coverage, they began to pick up more and more of the entire cost of premiums.

The net result is now the Government contributes only 23½ percent to the premiums charged by National Postal Union. I don't know what it will be in our particular instance; but again I say, Mr. Chairman, that practically every carrier, if not all of them, in view of what we have just seen—the increase in hospital costs and the rise in medical costs—will have to submit an additional increase in premiums for 1969 and 1970, and so on.

Mr. DANIELS. How does your high option plan compare to the other high option plans that are offered the employees? And what is the ratio of the Government's contribution toward the premium of those other plans?

Mr. SILVERGLEID. I would say, based on what we know of the benefits they offer, that the Government contribution would range from as low as ours. Our plan is undoubtedly one of the richest offered to postal and Federal workers. We have a program of benefit, Mr. Chairman, that is unequaled by any other plan. So I would say the range would probably run from the 23½-percent contribution the Government makes now to our premiums to perhaps 27 or 28 or perhaps even 30 percent for some of the plans that do not offer as many benefits as we do.

Mr. DANIELS. I note that you recommend, instead of having an open season at least every three years, it be on an annual basis. Would this not cause a possible runout on some plans, and a high percentage of increase of enrollment in other plans?

Mr. SILVERGLEID. This could be the result, but this would provide the Federal worker with the opportunity to move into a plan that might fill his needs at a time when he was captive in a plan that no longer took care of his needs.

Mr. DANIELS. Well, if we put it on an annual basis, and should such a runout on some plans occur with a great infusion into another plan—which offered, say, better or higher benefits—might not this jeopardize the former plan?

Mr. SILVERGLEID. Well, it might, although we haven't as yet had any liquidations among the bigger carriers.

Mr. DANIELS. I am trying to find out the reason why the law contemplated an open season every 3 years. Now, perhaps that is the reason for it—not to jeopardize any particular plan by an immediate abandonment of one plan and a great enrollment in a different plan which offered greater benefits.

We certainly don't want to endanger any particular plan by a fast runout; like a run on a bank.

Mr. SILVERGLEID. Mr. Bowley.

Mr. BOWLEY. Mr. Chairman, first of all, the law doesn't provide for an open season every 3 years. It provides for one within the 3-year period. There has never been a period of time that we have exceeded even 2 years. This is the first time that we have gone the full 3 years.

This is what we are objecting to—the fact that it is too long a period of time to keep people a captive group in a plan when their medical needs of their family can change.

Mr. DANIELS. Well, would you endorse a requirement that an open season be provided by law not less often than every 2 years?

Mr. SILVERGLEID. It would be preferable to the 3-year period that they have the option to declare now.

Mr. DANIELS. I would like to get your thinking on that, because while we are reviewing this legislation, as you indicated earlier in your testimony, the possibility of getting this legislation through this year is going to be rather difficult. I hear rumors around here that the Congress is trying to adjourn sine die on or about August 3 before the national conventions take place in the month of August.

If that is so, there is not sufficient time remaining for this legislation to be duly considered in both bodies.

We would like to give everybody who is interested in this legislation an opportunity to be heard. We would like to get all of the various views, get the benefit of your thinking and the benefit of the thinking of the other people who have indicated a desire to testify on this legislation.

So I don't think time will permit us to actually adopt legislation on this subject in the time remaining in this session.

Now, Mr. Silvergleid, in your experience, what primarily has contributed to the steady rise in hospital operating costs?

You have made some reference to it in your testimony, but I want you to expand upon it.

Mr. SILVERGLEID. Well, we have been given various reasons by so-called experts in the field—the actuaries. In the first place, they refer to the increased labor costs as being one of the reasons. Frankly, we do not believe that that is a paramount or main reason.

Needless to say, Mr. Chairman, hospital employees have been so far behind the rest of the parade that what they have been getting in increased wages has been something that is long overdue. But, this must be a factor in what the hospitals are charging.

Beyond that we really don't know. We feel that the medical profession—and this is not in criticism of a profession, by the way, on which my son is now embarking, my youngest son—but we feel that they are taking advantage of overall insurance. They recognize that the necessity for health insurance is such combined with medicare that it is a wide open field. People must have services, and somebody is going to pay for it.

It is no longer a matter of billing people or dunning them. They can get their money. They are taking advantage of the situation.

We find that medical costs rise continually. Some of the bills submitted for surgical procedures, Mr. Chairman, would astound the members of this committee. They astound us.

Mr. DANIELS. Well, what you are saying, then, is that doctors are making an unjustifiable or an unreasonable charge for their services?

Then, if that be so, do you recommend in your plans, whether it be low option or high option plans, that there be a schedule of fees to which the doctor would be entitled?

Mr. SILVERGLEID. Well, there are such schedules. But let me point something out. We don't abide by a schedule as such, because we recognize that if we set a limit the doctor would merely go to the member who can't afford it and say, "I want the difference."

NPU happens to have a unique approach to this situation. We will pay any amount required for surgery provided it's reasonable and customary in the particular area. So that we pay more for surgery than the normal carrier does. But we don't want our members to get stuck with the difference.

I would say this, Mr. Chairman, and we have asserted it in this prepared statement. The situation, in our opinion, has become so crucial that it is time that the Congress of the United States took a good hard look at it, and ascertained whether it is necessary to impose certain regulations and restrictions on hospitals, on the medical profession.

I have no doubt the AMA would rear up in its wrath and fight any such attempt. They would scream socialized medicine and everything else. But I think it has reached the point now where we can no longer ignore it.

Mr. DANIELS. Well, I am of the opinion that every person has a right to determine for himself what his hire shall be. Now, if a particular doctor feels that he has the expertise, the knowledge, the experience, and has taken the necessary followup courses after having been admitted to practice, he may feel that his services are worthier of a higher compensation than another doctor.

Where do we draw the line as to who shall make this determination?

Mr. SILVERGLEID. Well, I think what we have in mind isn't in conflict, Mr. Chairman. We merely say that there ought to be some program, some regulations developed, some guidelines—and I hate to use that term.

Under those guidelines, presumably particular specialists would be in a class by themselves.

But at the same time we would have some element of control over what has become a runaway medical inflation.

Mr. DANIELS. What is your opinion about hospital costs? Do you deem that hospitals, on the average, make fair and reasonable charges?

Mr. SILVERGLEID. Well, hospitals are in a unique position, as I understand it, Mr. Chairman. They have to depend to a considerable extent on private philanthropy, on donations. But at the same time you can readily see what is developing when we approach—and we have now approached—$100 a day for semiprivate care. There isn't a worker in this country who can afford it unless he is insured.

Mr. DANIELS. As to a fee charge of $75 to $100 a day for a semiprivate room, how does that compare to what the charge was in 1959 when this law was enacted?

Mr. BOWLEY. In many instances the rates have doubled.

Mr. DANIELS. So, today hospital charges are approximately double what they were when this law was enacted?

Mr. SILVERGLEID. Well, I can give you a good example, Mr. Chairman, because we started the first postal worker health plan in Brooklyn back in 1944. We had an unwritten agreement with the New York City hospitals—$4 a day for a ward. That was equivalent to semiprivate in those days; $4 a day. What is it today?

Mr. BOWLEY. Well, we had a contract with the department of hospitals in the city of New York in 1960, just about the time this program went into effect, where we paid $20 a day as an all-inclusive rate. The same inclusive rate today is $54—about two and a half times.

Mr. DANIELS. That is a 150-percent increase.

Mr. SILVERGLEID. That is a pretty good illustration.

Mr. DANIELS. The gentleman from New York, Mr. Hanley.

Mr. HANLEY. Thank you, Mr. Chairman.

I want to commend the gentleman on his excellent statement. I am delighted to note that enactment of H.R. 6351 would provide your union with its No. 1 legislative objective.

The bill itself is again rather conclusive evidence of the desire of the chairman to see to it that fringe benefits allowed the private sector become those of the Federal family.

I further want to commend you on your very excellent analysis of hospital costs. I don't want to elaborate on it. You have engaged in a dialog with the chairman on it. I think you have a very straightforward statement relative to this national problem. Certainly in my judgment it is one that requires looking into.

I think when you compare the private hospital operation with that of the Veterans' Administration, you will find that there is a substantial difference in the per diem cost of hospitalization, and there are reasons for this, and I think that you have pretty well put your finger on the basic cause in your statement here. How we go about correcting it is a horse of another color.

Just one question, and that is relevant to the brochures. There are only two provided. I can only assume this is for reasons of administrative expediency, and I can only further assume that brochures of other plans are available. Is this true?

Mr. SILVERGLEID. Well, in a sense, Mr. Hanley. You see, we must admit this is a competitive area. Every group, every carrier, is vying for members to join the health plan. I can talk about post offices only.

Now, in most post offices they will give the Government-wide plans to the employee, with a local plan if there is one in the area, like GHI or HIP in New York. Beyond that, the others are available only if you request them.

Now, with a new employee coming in to the job, he isn't going to know that National Postal Union exists or the NALC or any other group. So it might be difficult for him to know what he is getting.

Mr. HANLEY. Wouldn't it be rather cumbersome and awkward and difficult, administratively speaking, to provide brochures for all of the plans just automatically?

Mr. SILVERGLEID. Well, not all of them, but we suggest those for which the particular employee would be eligible.

If he went into a post office, for instance, he could have the various union plans in addition to the Government-wide. He wouldn't get the ones outside because they wouldn't serve his purpose.

Mr. HANLEY. Just one further comment. You make an interesting analysis with respect to the Government share or proportionate percentage there, and it is interesting to me to note that it has declined actually better than 11 percent in an 8-year period. I think that you have provided the committee a great service with respect to your testimony.

Mr. SILVERGLEID. Thank you very much, Congressman.

Mr. HANLEY. Thank you.

Mr. DANIELS. The gentleman from Georgia, Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

I, too, would like to thank Mr. Silvergleid for his presentation.

It is pretty apparent that the cost of medical care and hospital costs are reaching such staggering proportions that something is going to have to be done. The average American simply can't afford even $50 a day for hospital.

I was interested in the fact that I believe you said in 1944 in New York City you had an arrangement for a ward or a semiprivate room at $4 a day.

Mr. SILVERGLEID. $4 a day.

Mr. THOMPSON. In 1960 this was $20. Is that correct?

Mr. BOWLEY. Yes.

Mr. THOMPSON. And in 1968 it was $54. So it is apparent there has been a tremendous increase in the cost of hospital facilities.

I note that in the information you provide you have shown the distribution of the medical care dollar and that in 1954 hospital services took 25 cents of the medical dollar, physicians' services took 29 cents, and in 1964 the hospital services increased 6 cents while physicians' services decreased 2 cents.

I had an experience over the Fourth of July with my daughter. She had a high fever, and I couldn't get a doctor to come to the house. We ended up taking her to a clinic. She had a 104° fever.

But the doctors there were completely overworked, and I think one of the problems is that we need more people like your son to go into the medical profession. The physicians whom I know are some of the hardest working people, and they work very long hours. A human being can only endure so much effort. So certainly part of the problem of medical services is going to be in training more people.

But, the thing that disturbs me the most is: Why have we had such a tremendous increase in hospital cost? Now, this seems out of proportion. It seems completely out of proportion.

I don't know specifically what this committee can do about that, but it is something that is disturbing me that from 1960 to 1968, in 8 years, we have had a 150-percent increase, as your figures indicate, in hospital cost.

I appreciate very much the fact that you have brought out that the basic concept on which we have entered into our hospitalization plans, of course, was on a basis of 50-50 sharing for certain minimum options. However, I think that a reasonable approach is that we need more than minimum options. I think we do need a family plan, and I think that this should be recognized, and we should have a 50-50 sharing basis on that.

Trying to be reasonable about this, sometimes you get into certain difficulties as to what your option should be.

I appreciate very much your bringing out the fact of brochures. I think every employee should be furnished with a brochure of all available plans available to him, not just plans in existence but plans that he could avail himself of when he becomes employed in a particular job. So I think you have given us a very knowledgeable and very interesting presentation. I appreciate it immensely.

I would be less than honest if I would say I knew what the answer was, but maybe with the information you have given us we can come up with an answer.

Mr. SILVERGLEID. Thank you very much.

Mr. THOMPSON. Thank you very much, Mr. Chairman.

Mr. DANIELS. Mr. Silvergleid, is enrollment in your plan open only to the members of the NPU or may any Federal employee enroll?

Mr. SILVERGLEID. The Civil Service Commission regulations provide that in order for a Federal employee, postal or otherwise, to enroll in a union plan, he must be or become a member of that union.

Now, our plan is available to all eligible postal workers and to classified Federal workers as associate members. We offer them an associate membership in our union in order to give them the opportunity to participate in our health benefit plan. We have approximately 10,000 career Federal workers.

Mr. DANIELS. May a letter carrier, for example, enroll in the NPU program?

Mr. SILVERGLEID. Yes. We are an industrial-type union, as you know, Mr. Chairman, and our membership consists of every postal craft below supervisory level regardless of their designation or title.

Mr. THOMPSON. Mr. Chairman, may I ask a question at this point?

Mr. DANIELS. Yes.

Mr. THOMPSON. Let me ask you this: If it is a requirement that an individual belong to your union in order to participate in your plan, would this not lead to a means of trying to capture union members from other unions, from the letter carriers or something, by your effort to offer a plan that is much more attractive to them?

Mr. SILVERGLEID. Mr. Thompson, I mentioned a while ago that this happens to be a competitive area, and there are no doubts about it. Whenever there is an open season, there are strong efforts made by all carriers to induce or attract people who have plans in other groups in order to take their plan.

Mr. THOMPSON. May I follow it up with this: Do you feel that the proper function of a union is to determine who can provide the best hospital care or who can do the best job in representing the employees' interest? In other words, would it be possible for an employee to be attracted to one union because they have an outstanding hospital plan, yet that union may not do as sufficient a job in representing their interest as another union would that does not have the frills of a particular plan?

Mr. SILVERGLEID. What you say, Congressman, is entirely possible. But let me emphasize this, and this is one of my pet theories that I developed many, many years ago. As a postal labor union, our basic and primary function is to represent the people who are members of our union and all postal workers in the legislative and organizational

field. But, as a labor union, we cannot forget their welfare and their social needs as well.

This is why we have developed these welfare programs. We give them a life-accident insurance policy if they are interested. We give them the health benefits program. In many local areas they give them fraud protection against counterfeits and that sort of thing.

Every local has a welfare group. If people go to hospitals, they get baskets of fruit. If they retire, they get gifts. This is all part of our makeup as a postal labor union. We believe strongly in that approach.

Mr. THOMPSON. Thank you very much.

Mr. SILVERGLEID. Thank you.

Mr. DANIELS. Just one further question. The Civil Service Commission, in their report on this legislation, makes this statement, and I would like your comment on it:

> If the Government were to pay the total premium, employees would naturally choose the more expensive plan and options that provided the richest benefits.

Mr. SILVERGLEID. Well, I think they come to a very logical conclusion, Mr. Chairman. I am not going to argue that point.

Mr. DANIELS. Thank you, that's all, Mr. Silvergleid.

Mr. SILVERGLEID. Thank you very much.

Mr. DANIELS. The next witness is Mr. John A. McCart, operations director, Government Employes' Council, AFL–CIO.

TESTIMONY OF JOHN A. McCART, OPERATIONS DIRECTOR, GOVERNMENT EMPLOYES' COUNCIL, AFL–CIO

Mr. MCCART. Mr. Chairman, if it meets with your approval, I would like to summarize the formal statement we have presented to the subcommittee.

Mr. DANIELS. Without objection, your formal statement will be introduced in the record immediately following your oral testimony.

Mr. MCCART. At the outset, Mr. Chairman, I want to express the appreciation of the 35 unions affiliated with the Government Employes' Council for your arranging this hearing and also to you and to more than 16 of your colleagues in the House who have introduced the bills authorizing the Federal Government to defray the entire cost of health benefits premiums.

Now, you have reviewed the history of the health benefits program from its inception in 1959 to the present time, and it isn't necessary for me to go into that in detail. There are just one or two statements I would like to make in that connection.

The first is, that when the plan was first undertaken in 1959, the contribution by the Federal Government to the high-option programs was approximately 38 percent. Because there was a fixed dollar ceiling—and still is—on the Government's share of the premium cost, by 1965 the employer's share had declined to 30 percent.

Then, Public Law 89–504 was enacted, and the result was that today the employer is contributing 32 percent.

So that, in effect, we have 85 percent of the Federal employees who are covered by the high-option plans contributing more than two-thirds of the cost of their health benefits coverage.

When we look at the private sector, we find an entirely different trend. The Bureau of Labor Statistics has undertaken studies in this

field since 1960. At that time they found that 38 percent of the workers in private industry were having the entire cost of their health benefits coverage defrayed by employers. In 1967, that figure had risen to 53 percent.

So that last year the Bureau of Labor Statistics found that of approximately 16 million workers, 53 percent had their health benefits coverage defrayed entirely by the firms for which they worked.

Now, the Health Insurance Institute, which is an organization of private insurance companies, undertakes studies in this field also, and they found in 1967 that in companies employing 25 to 499 workers, small companies, in 49 percent of the cases the employer defrayed the entire cost of health benefits coverage, and that during the 4-year period, 1963–67, that figure remained relatively constant.

In June of this year the Monthly Labor Review, published by the Department of Labor, included an examination of the changes in the supplementary benefits for private industry workers from 1963 to 1966. This study revealed—and I quote now from the Monthly Labor Review:

> Existing health and welfare plans have been liberalized for three-fifths to two-thirds of all workers affected by settlements each year. Most frequent change has consisted of employers assuming a higher proportion of the cost of such provisions.

These are the health benefits provisions.

So that what we find in summary, Mr. Chairman, is that while the trend in private industry toward the employer paying the entire cost of health benefits has increased very substantially in the last 7 years, we find that the Federal Government's rate of contribution has declined very substantially. Thus, the principle of comparability that Congress recognized in 1962 and has attempted to follow thereafter is simply not being observed in the health benefits field.

Mr. DANIELS. Mr. McCart, in regard to that last statement you made, how do the benefits in private industry plans compare to those provided for under the Government plans?

Mr. MCCART. Well, Mr. Chairman, as you are aware, there is a great variety in the Federal service, and there is even a greater variety in the private sector. There are studies that the Bureau of Labor Statistics has undertaken of specific private industry plans. I don't have them here, but they vary to a great extent.

I think it is difficult to make any general comparison between the two.

Mr. DANIELS. Would you say where the employer pays the entire cost that the benefits under those plans are comparable to those that are provided for in the Government plans?

Mr. MCCART. I can only say, Mr. Chairman—I am not trying to evade the question at all—I think we would have to examine the plans of the individual companies. We will find in some——

Mr. DANIELS. That is most important when you start talking costs.

Mr. MCCART. In some, you will find the benefits are superior to the Federal Government's. In others you will find they are less favorable. It is going to be very difficult to make a comparison because there is such a variety in the Federal service to begin with and such a variety in private industry.

Mr. DANIELS. When the Federal employees' health plan was adopted in 1959, it started out on the premise that the Government would pay

50 percent of the cost of the low option plan. The amount paid on the high option came to 38 percent, I think you said?

Mr. McCart. That is right.

Mr. Daniels. Is the reason why it came to 38 percent primarily due to the fact of the cost involved?

Mr. McCart. Well, I can recall the events that occurred at that time, and I can recollect the principal proponent of this legislation in the Senate making the assertion that while the objective was an equal sharing, the Government was embarking on the largest undertaking of this kind known in the world. So, the Senators felt that at the outset it was necessary to be conservative. While they desired to achieve the 50–50 objective, they preferred not to do it when the legislation was initiated. That is the reason it wasn't done in 1959. Clearly the House and Senate reports on this legislation indicate that the basic principle to be attained was an equal sharing. And not only has that not been achieved, but the proportion has actually declined.

Mr. Daniels. Well, wasn't it contemplated when the legislation was enacted that if you wanted additional benefits those benefits would cost more and would have to be paid for?

Mr. McCart. Yes.

Mr. Daniels. Do you have any recommendation to make as to the adoption of standards, as Mr. Silvergleid indicated in his testimony, on these various plans?

Mr. McCart. Well, Mr. Chairman, I think the question of spiraling medical, hospital, surgical costs is a national problem. It certainly isn't confined to Federal employees. As you gentlemen in the Congress are very well aware, committees of the Congress have examined and are examining this question very carefully now. The executive branch has done so.

As a matter of fact, this morning in the Senate the Government Operations Committee is conducting a hearing on various aspects of this subject.

It would be quite difficult for me to offer an immediate simple solution for the problem. Certainly the quality of medical care and hospital care has increased immensely in the last 10 or 15 years. There are some things that can be done to encourage stability in these cost factors, such as greater use of group practice, fuller cross-utilization of equipment and facilities, libraries, and things of that kind.

But I don't pretend to know the total answer, Mr. Chairman. We just can't view this problem in the perspective of the Federal employees alone. It is something that affects the entire Nation.

Mr. Daniels. Mr. McCart, do you think that the Government could in any way control the cost of health benefit plans if it paid the entire premium? Do you think that the only way it could control the cost would be, ultimately, to have only one plan and prescribe particularly what benefits it would provide, such as is now being done under medicare?

Mr. McCart. I think that there is need for diversity. There is need for competition. We have basically three types of health benefits coverage in the Federal field at the present time. We have the group health program, the commercial carrier program, and we have the union programs. It is necessary to maintain those three fundamental types of coverage.

But within that principle it should be possible to operate something like we have in the life insurance program where one carrier handles the administrative relationship between the industry and the Commission for the entire industry, and the other commercial carriers share in whatever reasonable profits accrue.

If there were one monolithic program, it would tend to discourage a very necessary element in this field, and that is the matter of competition.

I am not opposed to medicare, by the way. I think it is a very fine and necessary piece of legislation.

Mr. DANIELS. You say that today there are three plans. The Government provides one where it pays for services, that is generally known as Blue Cross. The second plan sponsored by the Government is indemnity insurance, provided by Aetna, which reimburses for costs. And then the third is the various plans provided by the unions and group practices.

Mr. MCCART. Yes.

Mr. DANIELS. Is that correct?

Mr. MCCART. Yes.

Mr. DANIELS. Now, most of the employees are enrolled in either the Blue Cross or the Aetna insurance plans; is that not correct?

Mr. MCCART. I think that's correct, Mr. Chairman.

Mr. DANIELS. About what percentage of all Federal employees are enrolled in those two programs; Blue Cross and Aetna?

Mr. MCCART. I don't have that figure readily available. I will be happy to supply it.

Mr. DANIELS. I am just told the figure is approximately 80 to 85 percent.

Mr. Hanley, any questions?

Mr. HANLEY. I want to commend the gentleman on his excellent presentation, which again is a contribution to the deliberations of this committee.

Just one question. I notice a disparity between the percentage figure in your testimony and that of the previous witness. It has to do with the Government's share or proportion in high option. You have it as 32 percent.

Mr. MCCART. This is an average.

Mr. HANLEY. The testimony of the previous witness indicated he had a 23.38 percent.

Mr. MCCART. Yes. Well, I gathered from that testimony that Mr. Silvergleid was referring to a particular plan.

In any case, the only thing I can tell you, Mr. Hanley, is that this figure was given to me by the Civil Service Commission when I made the inquiry as to the average contribution. I don't want to dispute Mr. Silvergleid's figure.

Mr. HANLEY. Thank you, Mr. McCart.

Thank you, Mr. Chairman.

Mr. DANIELS. The gentleman from Georgia, Mr. Thompson.

Mr. THOMPSON. Yes. Mr. McCart, going to the point Mr. Hanley was making, the 30 or 33 percent figure is an overall average figure that basically you are talking about, and Mr. Silvergleid's was on their specific plan.

Let me ask you do you feel that a health insurance plan is a legitimate means for a union to compete with other unions for membership?

Mr. McCart. I certainly think so, Mr. Thompson, because unions have traditionally operated in the field of social benefits. If you look at the older union organizations, the craft organizations that have been in existence for a hundred years, they had death benefit programs, and they had small sick benefit programs for their members. And so throughout the history of trade unionism, unions have participated in these kind of social benefits, especially in the early days, since they were not supplied by the employer to any extent. So, I think it is a very valid field for the unions.

Mr. Thompson. You also testified I believe that you would be opposed to one large monolithic plan for all Government employees, stating that you feel that the competitive factor is a very good factor that would work to the benefit of employees.

Mr. McCart. Yes.

Mr. Thompson. But at the same time how are we going to apportion fairly the Federal dollar to all of these plans if we do not set certain standards as to what is to be covered by the plans?

Mr. McCart. I may not have completely understood the chairman's question in that particular context. It could very well be that the Federal Government as an employer could devise certain standards, maximum standards, and certain minimum standards, and that the various carriers involved in the field could then compete within those limitations.

But I believe that it's most important that the Federal employee have an opportunity to make selections. This is good for the trade union movement. It is good for private industry. Because when you have yardsticks you have competition.

Thus, there is a good possibility that the committee could explore the establishment of maximum and minimum standards. But I would be reluctant to move beyond that.

Mr. Thompson. May I ask you one further question? Does the Government Employes' Council have a plan?

Mr. McCart. No, sir.

Mr. Thompson. You do not?

Mr. McCart. No, sir.

Mr. Thompson. Can you give me an answer to this question? Why is it that such a large proportion, percentage figure, as was evidenced by the figure which the chairman gave us, such a large percentage of the Government employees are insured in either the Blue Cross or the Aetna plan?

Mr. McCart. Well, I think there are several reasons, Mr. Thompson. The first is that Blue Cross was quite popular in the Federal service before the inauguration of the health benefits program in 1959, and, as it were, Blue Cross had a leg up on the total business.

I can't account for the number who are insured by the private carriers. My opinion is that that would be relatively small in relation to the Blue Cross coverage.

Now, the union programs for the most part are new. There were some that existed prior to 1959, but not to the degree that they do today. So the union programs have developed largely since that time. At that time also the union membership was not nearly so great as it is today. These factors contributed to the Federal employees securing Blue Cross coverage.

Mr. THOMPSON. In other words, as the union membership increases, there is a greater base on which you could base your plan and more possible people to enroll?

Mr. MCCART. These union plans have been growing ever since the inauguration of the program in 1959, and some of them were really begun at that time as a consequence of this legislation.

Mr. THOMPSON. Do you have any plans in the future to offer a comprehensive medical and hospitalization plan?

Mr. MCCART. The Government Employes' Council?

Mr. THOMPSON. Yes.

Mr. MCCART. No, sir.

Mr. THOMPSON. Thank you very, very much, sir.

Mr. DANIELS. Thank you, Mr. McCart.

Mr. MCCART. Thank you.

(The prepared statement of Mr. McCart follows.)

PREPARED STATEMENT OF JOHN A. MCCART, OPERATING DIRECTOR, GOVERNMENT EMPLOYES' COUNCIL, AFL-CIO

Mr. Chairman and members of the subcommittee the Government Employes' Council and its 35 affiliated unions are deeply grateful to you for providing this hearing on the Federal employees' health benefits program and the extent of the Federal Government's participation in financing the system.

We are conscious and appreciative of your introduction of H.R. 6351 authorizing the Federal Government to defray the entire premium cost of health benefits coverage for employees and their families. The fact that 16 of your colleagues in the House—five of whom are members of the Post Office and Civil Service Committee—have sponsored similar measures is an indication of the widespread interest in funding the largest program of its kind in the world.

When the general health plan was enacted in 1959, the principal underlying cost was that the employer and employees would share the expense equally. This assumption is found in Senate Report 468 and House Report 957, 86th Congress. However, the fact that the Federal Government was embarking on an overall program affecting the largest number of employees and dependents in the Nation resulted in language in the law limiting the 50–50 relationship to low option coverage.

Today, slightly more than 85 percent of Federal employees participate in high option plans. When the program was inaugurated, the Government's share of premium cost to this kind of coverage was approximately 38 percent. But as the total cost increased, the Government's contribution declined to a point in 1965 where it was less than 30 percent. The following year, Congress acted to restore the 38 percent Government contribution (Public Law 89–504).

In 1967 and 1968 many carriers underwriting various plans found it necessary to increase premiums. This action was caused by sharp advances in medical and surgical costs throughout the Nation. The result is that the Government at the present time is contributing approximately 32 percent of the total cost of the high option plans. Put another way, 85 percent of the employees are paying more than two-thirds of the cost of their health benefits coverage. Thus, the goal envisioned when the system was inaugurated has never been achieved.

Contrast these developments to the trend in private industry in financing employe health coverage. In 1960 employers defrayed the entire cost of health benefits for 38 percent of the workers in all industries. Seven years later, that figure had risen to 53 percent. The 1967 figure covered 15.5 million workers in plants and offices.

Table I appended to this statement depicts these changes in three categories of health benefits—hospitalization, surgical, and medical.

Another perspective is given the problem in a study of new health insurance policies written by private insurance companies in 1967 undertaken by the Health Insurance Institute. This review embraced only small enterprises employing 25 to 499 workers. It revealed that 49 percent of the employees had the total cost of their group health insurance paid for by the employer. Between 1963 and 1967, that figure remained relatively constant.

The June, 1968, issue of the Bureau of Labor Statistics' Monthly Labor Review contains an examination of changes in supplementary benefits incorporated in major collective bargaining agreements in the 4-year period 1963–66. This excerpt is pertinent to the subject under consideration: "Existing health and welfare plans have been liberalized for three-fifths to two-thirds of all workers affected by settlements each year. Most frequent change has consisted of employers assuming a higher proportion of the cost of such provisions."

It is clear, then, that private industry has made rapid advances in recent years in assuming the entire cost of employee health coverage. The Federal Government during the same period has reduced its share of health benefits payments.

At its biennial convention in December 1967, the American Federation of Labor-Congress of Industrial Organizations adopted a program for the Federal employees represented by its unions. Included was, "Legislation for the Federal Government to defray the entire cost of health benefits."

From the inception of the Health benefits program the Government Employes' Council has maintained that the Government should improve its contribution consistent with the practice of enlightened employers in private industry.

Mr. Chairman, we believe deeply that simple justice requires that the Government reverse the trend of declining employer contributions to the Federal program. We urge, therefore, that the subcommittee move promptly to correct this inequity by approving the legislation sponsored by you, Mr. Chairman, and your 16 associates in the House.

TABLE I.—PERCENT OF PLANT AND OFFICE WORKERS COVERED BY HEALTH PLANS FINANCED SOLELY BY EMPLOYERS [1]

	Plant workers		Office workers	
	1960	1967	1960	1967
Hospitalization	48	64	39	49
Surgical	47	63	37	48
Medical	34	53	27	43

[1] Source: Bureau of Labor Statistics, Department of Labor.

Mr. DANIELS. Our next witness is Mr. Patrick J. Nilan, legislative director, United Federation of Postal Clerks, AFL–CIO, who is accompanied by Mr. Jack Love, secretary-treasurer of the UFPC hospital plan.

Welcome, Mr. Nilan. It is always a pleasure to have you at our hearings, and to listen to your presentations.

TESTIMONY OF PATRICK J. NILAN, LEGISLATIVE DIRECTOR, UNITED FEDERATION OF POSTAL CLERKS, AFL–CIO, ACCOMPANIED BY JACK LOVE, SECRETARY-TREASURER, UFPC HOSPITAL PLAN

Mr. NILAN. Mr. Chairman, it is always a pleasure to appear before your committee, and I will try to go through this statement as quickly as possible in an effort to cooperate with both the committee and the other witnesses waiting to be heard.

For the record, I am Patrick J. Nilan, national legislative director of the United Federation of Postal Clerks, AFL–CIO, with headquarters at 817 14th Street NW., Washington, D.C. I am accompanied today by Mr. Jack Love, national secretary-treasurer of our union's health benefits plan.

We appear before this distinguished committee today as representatives of the exlusive bargaining union for the Nation's 306,000 postal

clerks with officials of the Post Office Department. Our union has membership in the 50 States, District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

We would like to express our appreciation to the distinguished committee chairman, Congressman Dominick V. Daniels, and the other members of this House Post Office and Civil Service Subcommittee on Retirement, Insurance, and Health Benefits for scheduling these important hearings on the Federal employees' health benefits program.

We wholeheartedly endorse and support H.R. 6351 introduced by Chairman Dominick Daniels which proposes that the entire cost of health benefits under the Federal Employees Health Benefits Act of 1959 shall be paid by the Government.

Any move to shift the heavy cost of Federal health benefits to the Government and thus to ease the ever-growing burden on individuals and family breadwinners is certain to have widespread rank-and-file support throughout our AFL–CIO Postal Clerks Union.

In fact, the delegates to our last national convention in Louisville, Ky., in August 1966 unanimously listed the full payment of health and life insurance premiums by the Government as one of our dozen major legislative objectives in the 90th Congress.

As a bald statement of fact, this sentence may sound at first like a rather extreme demand—like the sort of demand one establishes for bargaining purposes in a long, drawn-out negotiation. But when we get down to examining the "nuts and bolts" of the situation, we find that it is neither extreme nor expendable as an item on the agenda.

In the first place, negotiations have already been going on for quite a long time, almost since the 86th Congress first enacted the Employees Health Benefits Act in 1959.

You might say, Mr. Chairman, we have been in effect telegraphing our punches in advance. Back in March of 1965, for instance, I appeared before this same subcommittee urging an increase in the Government's contribution for group life insurance premiums.

On that occasion I emphasized that the time is not too far distant when we must consider revision of the whole structure of premium payments on insurance and health benefits to bring them into alinement with the trends of the times and the needs of employees.

Again, in February of 1966, in testimony before this subcommittee, while again considering only insurance benefits I made the point that even equal sharing of insurance and health premium costs must be regarded as an interim measure only.

The fact is, of course, that the accelerating trend for a decade or more in both the insurance and the health benefits field has been more and more toward full payment of employee premiums by employers in private industry.

This hearing today, however, is concerned only with the Health Benefits Act of 1959, and therefore we shall restrict our testimony to that area of concern.

In general, any approach to the cost problem of health benefits must begin with acceptance of the premise that medical costs are spiralling upward out of all proportion to consumer prices generally.

This point has already been clearly established by the findings of the National Conference on Medical Costs which met here in Washington in the summer of 1966 at the call of the Secretary of Health, Education, and Welfare.

In pursuit of a Presidential directive to find out more about the high cost of medical care, some 300 conferees agreed that in the 20 years since the end of World War II, the cost of medical care rose 129 percent, while the price of all services only doubled.

More to the point, these experts found that hospital charges suddenly started shooting off the graph in the mid-sixties.

Between 1961 and 1962, for example, hospital care costs rose at a standard rate of 6 percent per year. But in 1966 they suddenly surged up 16.5 percent, the largest annual increase in 18 years. Out of our own experience, we can fill in the additional facts for subsequent years.

Mr. DANIELS. What would that rise be due to, Mr. Nilan?

Mr. NILAN. Well, we have talked about that, and we believe it is more than coincidental that it occurred about the time medicare went into effect.

Of course, as you know, the Congress has also been very much concerned—Mr. Mills and his Ways and Means Committee—over the substantial increase in medical and health coverage since the advent of medicare. So it perhaps would be coincidental with that, in addition to new expensive medical techniques being developed and other extensions of hospital services and facilities.

But it does seem more than coincidental that tremendous hospital and medical costs increased about the same time that medicare went in. The annual percentage of increased cost since 1966 has continued to hold at the higher levels, around 15 percent or more per year since that time.

This rate of increase will continue at this abnormal percentage through 1969 at least. Even if it drops back to a level of about 7 percent per year in the early 1970's, as the American Hospital Association now predicts, the upward spiral will still be increasing at a greater pace than inflation generally.

It is possible to make this same point in even more dramatic terms, in terms of the average hospital cost per patient day.

In 1961, for example, the average hospital cost per patient day ran to $35 on the average. By 1966, it had soared to $50. It is now predicted in all seriousness by our own actuaries as well as by other hospital plan experts that this average cost will hit the $100 per day mark for care in a semiprivate room in the near and foreseeable future.

I could go on in this vein for quite a while. There is abundant documentation available on the cost and the quality of medical care including the rising rate of doctors' fees.

But for our purposes today it is sufficient to observe that inflation and other factors are forcing the impoverished middle class, which includes the Nation's postal clerks, to pay penthouse prices for poorhouse care.

Consider for a moment exactly what is involved for our own membership in dollars and cents.

When the Federal health benefits program got underway in 1960, the U.S. Government contributed a maximum of $3.12 per pay period as its share of the premium cost.

Our own members at that time contributed the sum of $4.94 as their share of the total premium cost in our family high option plan.

Now for the contrast: Today the Federal Government's share has increased to $4.10 per biweekly pay period. The cost to the Government has gone up in this category just under $1; 98 cents to be exact.

Today our members are paying $13 as their share of the family high option coverage on a biweekly pay period basis. The cost to the customer in this case has gone up not less than $1, but more than $8; $8.06 to be exact.

Galloping inflation for the most part, plus some improvement in benefits for the least part, has pushed total premium costs per biweekly pay period to an all-time high of $17.10.

On a percentage basis, the Government today is paying 24 percent of the premium costs—less than a quarter—in contrast to only 6 years ago when the Government was paying 34.7 percent of the total premium cost.

In other words, as costs have risen unchecked, the employee has been called upon to carry more and more of the burden—the Government less and less.

In all fairness, I should point out perhaps that such comparisons might better start from November 1961 when our own health plan was first liberalized by eliminating the $50 deductible to allow more first dollar coverage, although certain exclusions were retained. The percentages differences in Government-employee contributions starting from this date gives the Government a slightly better statistical advantage. But, the total impact is pretty much the same.

With your permission, Mr. Chairman, I should like to submit at this point in my testimony a simple chart showing how dramatically the Government's percentage of contributions has declined, even from the later starting date. I have attached exhibit A for the information of the committee.

Mr. DANIELS. Without objection, so ordered.

(The exhibit referred to follows:)

EXHIBIT A.—UFPC HEALTH PREMIUMS 1961–68 (EACH 2-WEEK PAY PERIOD)

	7–60	11–61	11–63	11–64	1–66	1–67	1–68
Self and family, employee	$4.94	$5.86	$8.37	$8.94	$12.63	$11.65	$13.00
High option, Government	3.12	3.12	3.12	3.12	3.12	[1] 4.10	4.10
Code 342, total premium	8.06	8.98	11.49	12.06	15.75	15.75	17.10
Government contribution (percent) (base)		34.7	27	26	20	26	24

[1] Effective July 30, 1966: Government contribution was increased from $3.12 to $4.10, as a result of Public Law 89–504. The total premium remained the same.

Mr. NILAN. It can be noted from this chart that as total premiums increased, the percentage of Federal contribution by Government plunged until the passage of Public Law 89–504 in 1966, which temporarily alleviated the situation to some extent. But the renewal of decline in the Government's share is also pinpointed by this chart. Once more, as you will see, the cost to the employer is down—the employer in this case being Uncle Sam.

On this score, Uncle Sam occupies a unique position at odds with big business and with a lot of smaller industries, too. In fact, Uncle Sam is bucking a national trend. That trend, to put it bluntly, calls for the employer to pay for the full cost of employee health protection.

It used to be wryly said that big corporations aren't in business for their health. The fact is, however, that big corporations like General Motors, Ford, and Chrysler are in business for their health, if health is defined in terms of corporate profits, growth, and social responsibility.

They are also in business for the health of their employees because experience has proved that, too, is good business. And to prove the point, these huge corporations are paying 100 percent of the premium cost of employee protection.

Nor is it only the biggest corporations. Employers like Grumman Aircraft on Long Island, Xerox, Uniroyal, Goodyear, Aerospace Corp., and Continental Can, to name only a few of the glamor companies, are also paying 100 percent of the cost.

I don't mean to imply that this extends across the board as a corporate practice. But the trend is very definitely in this direction, and most of the smaller corporations pay at least 75 percent of the total premium cost; because, it's good business to do so in terms of improved morale, more contended employees, and, of course, greater productivity.

Mr. DANIELS. At that point, Mr. Nilan, isn't it also true that when the employers, such as these glamor corporations, pay the entire premium that it is a deductible expense, and, actually, the corporation is only paying about 50 percent?

Mr. NILAN. This may be true, Mr. Chairman.

Mr. DANIELS. In other words, the taxpayers are paying the other 50 percent.

Mr. NILAN. The rank-and-file employee in the private sector still derives the benefits. And, of course, it is reflected in his paycheck when he doesn't have these deductions included.

So I couldn't disagree with your observation, but necessarily the employees in private industry do benefit from this opportunity and postal clerks do not. Uncle Sam has yet to learn this simple lesson.

Anyone who doubts this conclusion is urged to read the testimony placed on the record by employee union leaders only last month in hearings before Mr. Nix's subcommittee on the whole broad question of postal employee morale.

In any case, evidence is abundant that the full cost of health care for virtually all employees will be borne by employers, big and small, before many more years have passed.

Health benefit plans involving 100 percent financing are not only available on a silver platter from more enlightened corporations, but are being achieved more and more through the process of collective bargaining, according to evidence gathered last year by researchers in the Office of Research and Statistics of the Social Security Administration.

A long-range study published in December of last year by HEW covering 100 selected collectively bargained health and insurance plans reveals that 69 are financed in full by the employer and 64 of these also include employee's dependents while only 28 share the cost between company and employee. The missing three units involve seamen groups who are covered by other arrangements.

This study was not meant to pinpoint model or even typical plans, nor was it listed as a representative sample. They were chosen because the 100 plans covered large numbers of workers in major industries, ranging from a thousand to several hundred thousand in 29 major industry groupings.

Researchers said, "The most striking gains since an earlier study in 1962 were the shifts in several plans from a schedule of cash allowances to payment of all reasonable and customary charges for surgical procedures—the standard for payments under medicare."

But the key fact I think is that better than two-thirds of health protection programs actually negotiated between labor and management in major industrial groupings with large numbers of employees provide full financing by the employer.

An even more dramatic trend was revealed a couple of years ago in a study released by Ernest B. Webb, California State Director of Industrial Relations, who cited surveys by his division of labor statistics and research. These showed in November 1966, through a study of 1,717 collective bargaining agreements that 87 percent of the workers covered by welfare plans had achieved health benefits whose full cost is paid by the employer.

Moreover, employer payments to union-management health and welfare funds had increased 28 percent in only 2 years and 56 percent in 5 years, with monthly employer contributions for a full-time worker ranging from $4 to as much as $84.87.

Another significant aspect of this study: The larger part of increased employer payments went toward providing expanded medical care benefits for employees and their dependents rather than for meeting higher medical care costs.

There are, we are certain, many other significant facts and figures both inside and outside Government to buttress our conviction that the Government of the United States is already late in terms of its responsibilities to its own hundreds of thousands of employees. H.R. 6351 will go a long way toward correcting that condition.

If we have done nothing else in our own time, we have established as a consensus that health care is a human right, and a vital human right at that.

This lofty ideal was formulated by the 1966 National Conference on Medical Costs and represented a sharp break with the traditional concept of the American Medical Association that health care is a privilege for those who can afford to pay the price.

Today, with rising costs, inflationary pressures and higher taxes, the Federal employees at the low-income end of the spectrum the traditional victims of inflation face the very real possibility within a few years that the old standards of AMA may rise to haunt them anew.

For, unless the Government takes over the full premium cost of health benefits for low-income Federal employees, medical care may very well once more become a privilege for only those who can afford to pay. And this, we can all agree, would be intolerable in our time.

Mr. Chairman and members of the committee, on behalf of the membership of the United Federation of Postal Clerks, we appreciate your consideration of our testimony in support of H.R. 6351, which proposes that the Government pay the entire cost of the Federal employees health benefits program.

Mr. Love and myself will be happy to respond to any questions that the committee may have concerning our statement. Thank you very much.

Mr. DANIELS. Mr. Nilan, I want to compliment you on a very fine statement. I enjoy listening to your testimony.

I have one question, Mr. Nilan. Upon the adoption of this law in 1959–60, one out of eight persons utilized hospital services. But, today, I understand the figure to be one out of seven. Can you give any reason why this increase in utilization of hospital services within the past 8 years?

Mr. NILAN. Well, my immediate response, Mr. Chairman, is that perhaps more people in this great country are able to enjoy the privileges of medical and hospital benefits because of increased participation in such programs in private industry particularly as well as in Government.

It bears out the point I am making that in previous times the middle- and low-income class could not afford the medical protection that they should have.

Mr. DANIELS. There has been a substantial increase from year to year of hospital costs and, particularly, in the 1960's. What is your opinion as to the fairness and reasonableness of the charges being made today by hospitals and by doctors?

Mr. Nilan, I think I will call on Mr. Love on that, but first I want to make one point that has concerned me in a number of areas I visited.

I am amazed, with all of the hospitals throughout the country—I am thinking of my home city of Minneapolis as an example, that have expanded their hospital and medicine facilities. There are new techniques, there are new machines, everything that is needed to provide a good, healthy community. However, each hospital has all of these services. And, frankly, I don't believe that it's always necessary.

I believe if there was a coordinated research center, or whatever you want to call it, where laboratory facilities would be available, where your different types of techniques or different types of X-ray machinery, whatever might be available, then it would be possible that a large number of hospitals in the community could share these facilities and equipments instead of each hospital having their own techniques and own machinery. I am sure this approach could alleviate part of these tremendous costs. But perhaps Jack Love might comment on that more directly, Mr. Chairman.

Mr. DANIELS. Go ahead, Mr. Love.

Mr. LOVE. Mr. Chairman, if I may, I would like to point out I think Pat has hit on the reasons why many of the costs have gone up. And to my knowledge we find very few hospitals that I could say were not charging proper costs.

But I believe, like Pat, that many of these costs are there because hospitals have more facilities than they need, and they do have to amortize the equipment.

Mr. DANIELS. Do you think hospitals provide all of these services and all of this modern, up-to-date equipment because of not knowing what emergency may arise and that they want to be in a position to render the necessary service in case an emergency does occur?

Mr. LOVE. Well, Mr. Chairman, if I may say something on that line, that could be true and probably is the intent. But the task force that examined these came out with a report that there were hospitals with equipment and all necessary facilities for open heart surgery and yet did not use the facilities. Yet these have to be paid for. And, I believe the same thing is true in many, many areas.

Mr. DANIELS. Then you think that there should be some sort of a medical center which would be available, within so many miles, to all hospitals?

Mr. LOVE. I think that that would be very helpful in helping to control the cost and helping to keep the cost down, Mr. Chairman.

Mr. NILAN. I think, Mr. Chairman, it is like any other business. Certainly I don't mean to suggest the hospital or medical profession is a business. But I think we do enter into the prestige of the individual hospital as much as we do in any business corporation. Where one hospital gets a particular piece of medical equipment, perhaps another hospital in the same area feels that, "Well, we may need this, so we will get it, too."

I know also I have read different publications—unfortunately I don't have them for the record—but for the first time in the last 12 or 16 months we are occasionally reading now where hospitals have beds that are unoccupied, where they are having a 78 or 82 percent occupancy, when only a few years ago they couldn't accommodate the number of people that they had to bring in for surgery and treatment.

I think it is possible that this is an area where many hospitals probably have overexpanded to the point where they do have beds lying unused. And it is just like in a hotel. If you have 20 percent of your rooms not being used, it is an overhead cost that must be borne by the entire——

Mr. DANIELS. Well, that situation doesn't prevail in my district.

Mr. NILAN. Perhaps not.

Mr. DANIELS. As a matter of fact, the converse of that is true. There is a shortage of hospital rooms and beds. Consequently, names are put on waiting lists until a room is available.

Mr. NILAN. I am thinking mainly of the exceptions, rather than any general situation.

Mr. DANIELS. Mr. Thompson, any questions?

Mr. THOMPSON. Thank you, Mr. Chairman.

I also wish we had some of that problem in our district in the South. We simply do not have enough hospital beds. But let me compliment Mr. Nilan on a very fine statement.

I would like to ask several questions. Are you familiar with the branches of the Government that do provide full hospitalization and medical care? Is that only in the military?

Mr. LOVE. It is only in the military as far as I know.

Mr. NILAN. Veterans' Administration as far as I know.

Mr. THOMPSON. I know here again, injecting a personal note, my daughter was born in an Air Force hospital, and she cost me something like 98 cents or something like that. But that was in Roswell, N. Mex., during the Korean war.

But this, of course, is being done for the military at present, and their dependents as well, I believe, are taking advantage of the hospitalization plans.

Our time is late, and I would just like to thank you very, very much for your statement. It is a very fine statement. I think there is much merit to the full cost of the medical care being borne by the Government.

Mr. NILAN. Thank you, Mr. Thompson. I appreciate it.

Mr. DANIELS. Thank you, Mr. Nilan and Mr. Love. We appreciate your coming.

Mr. NILAN. Thank you, Mr. Chairman.

Mr. LOVE. Thank you.

Mr. DANIELS. The next witness is Mr. Daniel Jaspan, legislative representative, National Association of Postal Supervisors.

TESTIMONY OF DANIEL JASPAN, LEGISLATIVE REPRESENTATIVE, NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

Mr. JASPAN. Mr. Chairman, I won't read the whole statement. I will just mention a few parts of it.

Mr. DANIELS. All right. Without objection, your entire statement will appear at this point in the record.

Mr. JASPAN. Fine.

Mr. DANIELS. You may speak extemporaneously, then, and give your views to the committee on this important subject.

(The prepared statement of Mr. Jaspan follows.)

PREPARED STATEMENT OF DANIEL JASPAN, LEGISLATIVE REPRESENTATIVE, NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

My name is Daniel Jaspan. I am the Legislative Representative of the National Association of Postal Supervisors, composed of more than 33,000 postal supervisors, with members in all fifty states and in Guam, Puerto Rico and the Virgin Islands. Our members are employed in post offices, branches, stations, motor vehicle facilities, maintenance units, air mail facilities and mobile units.

We appreciate the interest of the chairman and other members of this subcommittee as evidenced by scheduling hearings on this most important subject. It is relatively new in industry in general, but this coverage is even more recent in the Federal Government.

When the Health Benefits Act was first enacted, we were disappointed when the government assumed only a minor share of the cost. Even at that time, many industries were paying the complete cost and the employees contributed nothing. Over the years, there has been little liberalization while the costs to the federal employees have been steadily increasing.

Even when the Federal Employees Health Benefits Act was passed many industries were paying the full cost not only of health insurance but also life insurance. Administration spokesmen have pointed out many times that the government leads in fringe benefits. This may have been true at one time, but as long ago as 1957 according to the United States Chamber of Commerce survey "Fringe Benefits 1957" many industries even then surpassed the government in the percentage of payroll spent for fringe benefits. Banks, finance and trust companies spent 31.7 percent of their payroll for fringe benefits. The petroleum industry averaged 27.3 percent of the payroll for fringe benefits; insurance companies 26.7 percent; miscellaneous nonmanufacturing (including coal mining, warehousing and laundries) 25.5 percent; chemicals and allied products 24 percent; and public utilities 23.5 percent. The Federal Employees Health Insurance Act helped to place the government (with an estimated 25 percent of payroll allocated to fringe benefits) into a more competitive position in fringe benefits at that time, but once more industry has forged ahead.

The Bureau of Labor Statistics releases a bulletin from time to time called the "Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining." This publication, Bulletin No. 1502, used the year of 1966 for its most recent data. At that time, 79 of the 100 companies listed paid the full cost of life insurance for its employees, while 67 of the companies paid the full cost of both health and life insurance.

The employees of those companies which did not assume the full cost paid relatively small amounts of money for their health insurance coverage.

We will not go into detail concerning the various plans, but we are certain that Bulletin No. 1502 would be most helpful to this committee. We believe that the government should assume a larger share of the costs of health insurance, especially since these costs are rapidly increasing. In fact, resolutions have been passed at all of our recent conventions asking that the government assume 100 percent of the cost.

In the May 1966 issue of "Pension and Welfare News" there appeared on Page 23 some excerpts from the report of "The Health Insurance Institute." This survey showed that at that time 50.1 percent of all firms in the United States paid 100 percent of the cost for group health insurance 47.5 percent shared the cost in some proportion, with most of them paying at least 50 percent.

Just to illustrate the growth in the number of firms paying the full amount of health insurance benefits, the same survey shows that in 1920, 33.6 percent of the employees made no contribution toward health benefits, in 1961, 39.7 percent; in 1962, 41.2 percent; in 1963, 45.6 percent; and in 1964, 47.5 percent.

As responsible citizens, we realize that the condition of the country's economy does not now permit the government to assume 100 percent of the cost. We suggest, however, that legislation be enacted quickly requiring the government to pay no less than 50 percent of the cost of health insurance. We suggest further that the government's share be increased each year by 10 percent. Thus, if the government pays 50 percent of the cost in 1969, this could be increased to 60 percent in 1970, 70 percent in 1971, and by 1974, the government would assume the total cost.

This plan would give the government a six-year period in which to increase its participation gradually and this would merely bring Uncle Sam in line with what has been happening in industry for many years.

We also suggest that the Health Benefits Act be amended so that in case of death of a spouse, the survivor can change to another plan at any time without waiting for an open season. There are some instances where it is essential that a more expensive plan be used during the lifetime of the employee, but a less expensive plan can provide necessary coverage for survivors.

We appreciate the opportunity of presenting our views.

Mr. JASPAN. Mr. Chairman and Mr. Thompson, of course we were disappointed that the Government just assumed a small part of the costs from the very beginning. At the time the Health Benefits Act was first enacted, great play was made of the fact the Government was using a large part of its payroll for fringe benefits. At that time the fringe benefits share of the Government was about 25 percent.

In 1957, 3 years before this went into effect, other organizations were using a much larger part for fringe benefits. For instance, banks, finance companies, and trust companies paid 31 percent of their payroll for fringe benefits.

There were a lot of other outside organizations paying much more, which I have listed in my statement, ranging from 31.7 down to 23.5 percent compared with the Government's fringe benefits of about 25 percent of payroll at that time.

I think it would be very helpful to the committee, Mr. Chairman, if you had the Bureau of Labor Statistics release called the "Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining," which showed in the latest one, issued in 1966, that 79 of the 100 paid the full cost of the life insurance, and 67 of them paid the full cost of both health and life insurance.

Mr. DANIELS. Do you have that bulletin, Mr. Jaspan?

Mr. JASPAN. I don't have it with me, but I do have a copy of it.

Mr. DANIELS. Could you supply the committee with a copy of it?

Mr. JASPAN. Yes, sir.

Mr. DANIELS. We will incorporate it in the record following your testimony, if you so desire.

Mr. JASPAN. I will be very glad to supply it. It is a thick booklet. I didn't bring it with me.

Mr. DANIELS. It is a thick booklet?

Mr. JASPAN. It is about this thick [indicating].

Mr. DANIELS. Then we will file it with the committee rather than incorporate it.

Mr. JASPAN. I have figures in here showing different firms were paying various amounts. I am not going to go into that, Mr. Chairman, due to a lack of time.

But I do have a suggestion. I would like to see this committee consider the idea of increasing the financing by the Government over the years. We know that the condition of the budget right now will not stand 100 percent financing. But we do believe that beginning in 1969 the Government could assume say 50 percent of the cost, and then increase it by 10 percent each year, 60 percent in 1970, and so forth, until the Government in 6 years would be paying 100 percent of the cost.

By 1974 they would equal private industry of about 15 years ago. We would like to see the committee consider that.

We have some resolutions passed by our conventions, in line with what Mr. Thompson and what you have asked about, having one nationwide health plan. We believe that that would cut the cost tremendously. We are not of the opinion that competition keeps the cost down, because we have the example of the life insurance plan.

We have a very good life insurance plan at low cost. It is one nationwide plan. And in our opinion, and according to resolutions passed at our conventions, we think that the most progressive step made would be to have one nationwide plan for health benefits as well as for life insurance.

Mr. THOMPSON. May I interrupt at this point? Let me say I appreciate your comments. I think there is some merit to this. And the concern I had is that I am afraid that sometimes people compete more or less for union membership based on a health insurance plan, which of course is part of the welfare of the workers, but I think that a union needs to do much more than this for its members. And a health insurance plan can be purchased from any insurance company whether it is associated with the Government or not.

So that was my concern, that it may be that one union or the other may have more of its activities directed toward recruiting on a specialized gimmick—I hesitate to use the word "gimmick"—but something of that sort.

And with the comprehensive health plan, if all of the various unions could get together and say, "This is what we need," it may be we could cut costs on it. And, I can't see the need for this competition in this area.

Mr. JASPAN. We know it has been used in membership drives by the different organizations, and in our opinion we are in business primarily to serve our members, not to be underwriters for health insurance or any other insurance.

And we certainly believe it would be much more economical to have one nationwide plan, because I am sure that the Government could get the best plan, the same as it did with life insurance.

Mr. DANIELS. What do you think would be the reaction of the carriers of the Government-wide plans if we advocated one nationwide plan?

Mr. JASPAN. It would probably be the same reaction that we had with our life insurance plan. At first there was a lot of opposition to it, but then it was given to one, Metropolitan Life Insurance I believe, which farmed out the business to all the other companies. They all got a share of it.

Now, I am sure that either Aetna or Blue Cross would be opposed to having one or the other accept it, but possibly it could be divided.

Mr. DANIELS. That leads to my next question. What do you feel would be the reaction of the other 34 organizations that presently have plans to such a proposal?

Mr. JASPAN. We know they would be opposed to it, Mr. Chairman. But we are looking at it not from the viewpoint of how it affects the organizations but how it affects the Federal employees, how they can get the most economical plan, how they can get the best plan.

We think that the health insurance or life insurance should be written so that the employees can get the best plan possible at the lowest possible cost.

Mr. THOMPSON. May I inject something at this point? Basically what you are saying is this: That you feel that the health insurance plan should be designed to provide the maximum benefits at the lowest cost to the employee, and the benefits should flow to the employee and not necessarily to the association that happens to be sponsoring this because they happen to have a certain plan and they attract memberships thereby?

Mr. JASPAN. Yes, sir. That is very well put, Mr. Thompson. That is the gist of what I had in mind.

Mr. THOMPSON. And by having the life insurance plans we now have, basically we have a better plan and a lower cost plan than if we had six or seven different people competing for it?

Mr. JASPAN. I hesitate to think what would happen if the life insurance had been set up the same way.

When the life insurance plan went into operation, a lot of organizations did have life insurance plans, and they were absorbed by this one plan. The organizations were given a certain amount of time to close out their own plans. It worked out very, very well. Everyone is happy with the Life Insurance Act and the way it was put into operation.

Mr. DANIELS. Well, Mr. Jaspan, I want to thank you very much for being present today and giving us the benefit of your views, and also for the frankness with which you have discussed this problem.

Mr. JASPAN. Well, of course, it is easier for us, Mr. Chairman, because we dont have any health benefits plan of our own. But even if we did, I would still be of the same opinion.

Mr. DANIELS. Mr. Sadler, the bells you hear at the present time mean there is a quorum call on the House floor, which happens to be the second call, so we will not have time to hear your testimony today, for which I apologize.

The subcommittee will adjourn and reconvene tomorrow morning at 9:30. We will be pleased to receive your oral testimony at that time, if you desire to return.

Mr. SADLER. Thank you.

(Whereupon, at 12:15 p.m., the subcommittee recessed, to be reconvened at 9:30 a.m., Wednesday, July 10, 1968.)

HEALTH BENEFITS PROGRAM

WEDNESDAY, JULY 10, 1968

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON RETIREMENT,
INSURANCE, AND HEALTH BENEFITS OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 9:30 a.m. in room 311, Cannon House Office Building, Hon. Dominick V. Daniels (subcommittee chairman) presiding.

Mr. DANIELS. The subcommittee will come to order.

The Subcommittee on Retirement, Insurance, and Health Benefits is meeting again this morning in continuation of its review of Federal employees health benefits programs.

The Chair wishes to express his regret that time did not permit the subcommittee to hear all the witnesses scheduled to testify yesterday. We do appreciate the cooperation of Mr. Carl K. Sadler, assistant legislative representative of the American Federation of Government Employees, in returning this morning to give the subcommittee the views of his outstanding organization. We will be pleased to receive Mr. Sadler's presentation upon the conclusion of the testimony of our colleague, the Representative of the 10th District of Virginia, Mr. Joel T. Broyhill, who served with distinction on the House Committee on Post Office and Civil Service for a number of years.

Mr. Broyhill, it is a pleasure to welcome your appearance before this subcommittee. You may proceed.

TESTIMONY OF HON. JOEL T. BROYHILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. BROYHILL. Thank you, Mr. Chairman. I might say it is like old home week coming back to this committee. As the chairman stated, I served on the Post Office and Civil Service Committee a little over 11 years.

I am very much concerned about matters under the jurisdiction of this committee, since they affect the careers and welfare of our Federal employees. I probably represent more Federal employees than any other Member of Congress, and it was with misgivings that I left this committee. I was required to do so in order to accept assignment to the Committee on Ways and Means.

I am here this morning to testify on behalf of H.R. 16555, which seeks to correct an existing inequity with regard to Federal employees as a result of enactment of the medicare program. The bill is somewhat technical. I have a prepared statement which I will submit for

the record, but I will try to explain informally just what the bill seeks to do.

Mr. DANIELS. Without objection, your prepared statement will be made a part of the record immediately following your oral presentation.

Mr. BROYHILL. I might say that the problem itself is one I believe the committee readily recognizes and will be sympathetic to doing something about it. H.R. 16555 is one approach to the problem. It may not be the only answer to the problem, but it may provide a base from which the committee might approach a solution.

Mr. DANIELS. It seems to me we are in an involved subject matter. I am somewhat familiar with the basic problem, but would like to know how you would propose to solve it.

Mr. BROYHILL. In 1965, as the chairman knows, the Congress approved the medicare program for all people over the age of 65. All people who were then 65 years of age were blanketed under the program. I am talking about part A, the hospitalization portion of the program. All American citizens were blanketed in the program whether they had social security or not, except Federal employees who retired after 1959. They were the only American citizens not blanketed in the program for part A benefits, the hospitalization portion of the medicare program paid through an additional payroll tax. Federal employees are the only American citizens not covered. There is another group not covered referred to in the report as aliens. I was a member of the Ways and Means Committee at the time and was very much concerned about excluding Federal employees. One of the reasons we did not cover them was that to do so would require a payroll deduction. The committee felt there was a question of jurisdiction involved, as to whether the Ways and Means Committee should impose a payroll tax on Federal employees for medical coverage when the Post Office and Civil Service Committee had jurisdiction. So, with a great deal of reluctance, I agreed with the committee that we should not consider Federal employees for mandatory coverage at that point. Some members felt Federal employees should be brought in under social security. As the chairman knows, there has always been a great deal of controversy over the question of whether Federal employees would benefit by being brought mandatorily under social security. We felt, rather than open Pandora's box, we would leave it alone. We did bring in Federal employees who retired prior to 1959. We provided a program for them not quite as liberal as for those who retired after 1959.

The inequity that was created was this: If a Federal employee had social security coverage by employment prior or subsequent to his Federal service, or by moonlighting during his Federal career, he would be entitled to the benefits under part A of the medicare program. Since he is automatically entitled to those benefits, the Federal Government or the insurance carrier is relieved of providing hospital insurance for such an employee over 65 years of age. Incidentally, when I talk of an employee I mean an employee or retiree over 65 years of age. Therefore, he has duplicated benefits. He is paid through social security by reason of other employment, and the Federal Government is still obligated to provide him benefits for which he has paid into the fund. The Federal Government should, for the same money he is

contributing into the fund, provide hospitalization beyond the medicare program.

Now let us take the Federal employee who does not have medicare. He is discrminated against because his neighbor, who has paid nothing, receives doctor benefits under part B, for which he pays $4 a month and for which the Federal Government pays $4 a month. These benefits are a duplication of the benefits the employer contributes to on behalf of the Federal employees health insurance program.

I know this is confusing but in substance we have duplication both in the part A mandatory portion and the part B voluntary portion of the medicare program. A Federal employee cannot fully benefit under the programs provided for all American citizens without relieving the Federal Government of its obligation as an employer.

Mr. DANIELS. Would the benefits that the employee would enjoy under the Federal employees health benefits program be identical to those provided by social security?

Mr. BROYHILL. Are they identical? They are practically identical. There are some benefits under the high option program that I believe are in excess of what medicare, both part A and part B, would provide, but in most cases it is a duplicated benefit. If a Federal employee is covered by medicare at the age of 65, he would likely be better off not to participate in the Federal employees health benefits program at all. If he is not covered by medicare—I am talking about the hospitalization program—there is no advantage to him to take the supplemental part B, the doctor's program, for which the Federal Government is contributing $4 a month for all American citizens. This bill, H.R. 16555, attempts to eliminate that inequity that exists.

Here, in substance, is what it will do: If a Federal employee is entitled to medicare, part A—the hospitalization portion—if he purchases the supplemental part B at age 65, which costs $4 a month for himself and $4 a month for each member of the family over 65 years of age, then he will receive all the high option program free of charge. Why should he receive it free of charge? Actually, the portion of the program to which the Federal Government contributes would pay for all benefits in excess of what the employee receives. This bill would exempt him from paying any premiums for the Federal employees health benefits program. He would have part A and part B and the cost to the Federal Government is negligible.

The employee not covered by medicare would receive a reduction in the cost of his high option program by the amount he pays for supplemental insurance. He would receive that free of charge.

Let me repeat. If the employee is covered by medicare, if he purchases the part B portion, then the Federal Government would provide all the high option free of charge. If he is not covered by medicare, which gives the hospitalization automatically and they can't provide it unless he has social security credits, the Federal Government will provide the supplemental part B to him free of charge. The net result would be the employee would receive, if covered by medicare, roughly $6 a month additional savings. He would not have to pay twice for the same benefits. If he is not covered by medicare, he would save the $4 a month that the supplemental part B would cost. What we would be doing would be having the carrier, or the Federal Government, pay the supplemental portion, part B, to underwrite or supplement what the Government is paying for the employee.

Again, the cost of either approach, whether the employee has medicare or not, would be practically negligible. It would present no problem because the carrier could pay into the social security program.

It is technical, and we had considerable difficulty drafting this bill. We had extensive discussions of this matter in the Ways and Means Committee. The administration naturally favored doing something about this problem, and administration spokesmen said so in discussing this in executive session. Incidentally, in the Ways and Means Committee when we are in executive session we have half the room filled with people from the executive branch, so we have experts on every phase sitting at the table with us when we discuss a problem. The Ways and Means Committee did want to do something about the problem. We talked of amending the Social Security Act itself to take care of Federal employees. But as we got into it further we discovered it would be too complicated to amend the Social Security Act to take care of it. The committee did mention in its report that an inequity exists and that something should be done about it.

Mr. DANIELS. I notice you have a report with you. What report do you have there?

Mr. BROYHILL. This is the report of the Committee on Ways and Means on H.R. 12080, which was the Social Security Act amendments of last year, when we increased the benefits under the old-age, survivors, and disability insurance system and liberalized somewhat the medicare program.

Mr. DANIELS. What page is that on?

Mr. BROYHILL. It begins on page 35, subparagraph (e) under the title "Coverage of Federal Employees," and ends at the top of page 37. It is quite lengthy but it goes in depth into the problem I am discussing this morning. It acknowledges that the inequity does exist but that solving it is somewhat out of our jurisdiction.

Mr. BROYHILL of North Carolina. Mr. Chairman, without objection I ask that these particular pages of the report be made a part of the record.

Mr. DANIELS. Without objection it is so ordered.

(The portion of the report referred to follows:)

(e) *Coverage of Federal employees.*—Your committee is aware of the gaps which exist in the protection of the Federal workers who do not have survivorship, disability, or retirement protection based on that employment.

A particular hardship exists in many instances when an individual dies during his first 5 years of Government service, when he is not yet entitled to survivorship protection under his Federal staff retirement system but he has lost his coverage under OASDI. A similar situation occurs when an individual dies shortly after leaving Federal service and before he has worked under OASDI long enough to be covered for survivorship benefits.

Additionally, an inequity may possibly exist in the relationship of the medicare program to Federal employees. Approximately 50 percent of our retired Federal employees are entitled to hospital insurance benefits under medicare on the basis of coverage acquired while serving in the armed services or working in private employment. If the retiree elects to pay the premium for coverage under the voluntary supplementary medical plan open to all of our citizens, he will enjoy health insurance protection approaching that afforded by the high option plans offered by the Federal Employees Health Benefit Act. In that case, the Federal Government is relieved of any obligation to contribute to his health care as an employee distinct from a member of the general public.

Those Federal retirees not entitled to hospital insurance protection under medicare cannot benefit from the voluntary supplemental plan toward which the Government currently contributes $3 per month on behalf of each participant.

Since the retiree must retain the health insurance plan he selected as an employee in order to have hospital insurance protection, the voluntary supplemental plan will duplicate coverage he already has. As he is not permitted to collect duplicate benefits, the voluntary supplemental plan is not worth the $3 per month the individual would be required to pay.

The administration's bill, H.R. 5710, contained a proposal under which credits for work subject to a Federal staff-retirement system would be transferred to social security in all cases where the worker or his survivors do not become eligible for staff-system benefits based on that work. Your committee also considered the possibility of extending social security hospital insurance coverage to Federal civilian employment, on the contributory basis that is applicable to such coverage of almost all other kinds of work. Although each of these ideas has some merit, your committee believes there should be further and more comprehensive study of the possible ways of including Federal employees in the program before any recommendation for change is made.

Of concern to your committee is a situation that can occur when Government employees, either active or retired, work in employment covered under the social security program and qualify for the minimum or low benefits. This situation occurs when the Government worked with a substantial Government salary works part time under social security or enters covered employment after retirement; in such cases he can become entitled to social security benefits (perhaps the minimum benefit) which will be heavily weighted in his favor, receiving a higher percentage of wage replacement on his social security earnings. The social security weighted benefit formula is designed for the worker who has low earnings from all sources all his working life.

The committee has directed the Social Security Administration to make a thorough study of all of the various problems which up to now have precluded the coverage of governmental employees under social security. The committee directs the Social Security Administration to conduct this study in close and constant cooperation with employee groups and with appropriate Federal agencies with a view to resolving the problems in a manner that is fair to both the governmental employees and the other members of the labor force that support the OASDI system. The report of the study, including positive recommendations for covering of Government employees on a basis that is fair to both Government employees and all other workers, is to be submitted to the Congress prior to January 1, 1969.

Mr. BROYHILL. Mr. Chairman, I was assisted in the drafting of this bill by the legislative counsel who sat in on the discussions in the Ways and Means Committee, so he knew quite a bit about the problem and the attitude of the Ways and Means Committee in trying to reach a solution. We also received help from the technical personnel of the Social Security Administration, though this was done on an informal basis.

I have a copy of a memorandum that this committee received from Mr. Andrew E. Ruddock, Director of the Bureau of Retirement and Insurance of the Civil Service Commission, which, again, is not an official position of the Commission but it does not indicate lack of agreement with the purposes of this bill. I think Mr. Ruddock indicates some employees may have to pay more. That was not the intent of the legislation. I think he is referring to the employees who retired prior to 1959 whose cost of benefits is somewhat less but the benefits are not as great. Really, an employee or retiree 65 years of age is hard put to decide what to do now. Will he take the supplemental? He knows he is duplicating the benefits but he is afraid to drop it. In the meantime, the Federal Government benefits at his expense.

Mr. DANIELS. I understand it is advisable for him to take the supplemental because he can't do it later; there are only certain times when it is open.

Mr. BROYHILL. That is correct.

Mr. DANIELS. I want to compliment you for bringing this to the attention of the committee and assure you we will go into the problem, and will also ask the Civil Service Commission to give a full report on your bill, H.R. 16555. We will try to work out any inequity that exists.

Any questions?

Mr. BROYHILL of North Carolina. In regard to the bill that has been introduced by the chairman of this subcommittee, H.R. 6351, do you have any comment on that? Would your bill be a supplement to it or an alternative?

Mr. BROYHILL. Is that the bill that provides a greater participation on the part of the Federal Government in the program?

Mr. BROYHILL of North Carolina. That is right.

Mr. BROYHILL. I would support that program. If that bill is enacted I think it would naturally follow you would have to sweeten this bill a little bit because it would still require the Federal employee to pay into the supplemental B portion.

As I said before, and I say again for emphasis H.R. 16555 is only one approach to the problem. There is an inequity. We should eliminate it. Whatever the committee does in that direction I think will be helpful. I have no pride of authorship and if the committee wants to take another approach to the problem, that is agreeable to me. But there is an inequity. The Ways and Means Committee, after considerable discussion, agreed there was an inequity but felt it was in the jurisdiction of this committee. I think we should get to it as soon as we can.

Mr. DANIELS. You seem to be well versed in the subject matter. I notice you were testifying without notes, so you are well versed in the subject matter.

Mr. BROYHILL. Thank you.

(As previously ordered, the prepared statement of Mr. Broyhill follows:)

PREPARED STATMENT OF HON. JOEL T. BROYHILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, it is a pleasure to appear here today in behalf of H.R. 16555, to amend the Federal employees and retired Federal employees health benefits program to insure that retired Federal employees do not have to pay twice for benefits provided both under such programs and under the health insurance program for the aged under the Social Security Act.

As the committee knows, Federal employees, annuitants, and their dependents who participate in Federal health benefits plans are penalized under present law. H.R. 16555 is designed to correct this inequity in existing law.

Under provisions of this measure, the supplemental medical insurance of the Medicare program would become the essential and mandatory unit of coverage for high option plans. Premiums would be based on the $4 SMI rate.

Five categories of employees and annuitants would be affected: (1) the single employee or annuitant with supplemental coverage and eligible for medicare; (2) the single employee or annuitant with high option not eligible for medicare; (3) the married employee or annuitant eligible for medicare whose spouse is also eligible for medicare; (4) the married employee who is not eligible for medicare and his spouse is; and (5) the married employee and annuitant and spouse neither of whom are eligible for medicare.

In the first group, the single employee on reaching age 65 and becoming eligible for Medicare would have his premium reduced to $4 per month, which would go to social security to enroll him in part B of the Medicare program.

In the second group, the single annuitant who is ineligible for Medicare on reaching age 65 would have his premium remain unchanged. However, he would receive the benefits of the SMI program as well as those provided for in his policy. The carrier, in turn, would forward $4 a month to the social security trust fund.

In the case of the married annuitant who is eligible for Medicare, his premium would be reduced to $4 and that portion of the premium chargeable for his spouse would remain unchanged. If the spouse is eligible for Medicare, his or her portion of the premium would reduce to $4 a month upon reaching the age 65.

The married annuitant who is ineligible for Medicare as well as his spouse would continue to pay the same premium he had contracted for originally. In any event, however, he and his spouse will be eligible for SMI benefits and the additional coverage contracted for in their plan.

Mr. Chairman, in all instances the Federal employee and annuitant will benefit by better protection. In those instances where he or his dependents or both are eligible for Medicare, they will then benefit from greatly reduced premiums.

Mr. Chairman, I believe this plan is sound financially, and should be acceptable to the actuaries of the private carriers and to the social security trust fund as well.

Mr. DANIELS. Our next witness is Mr. Carl K. Sadler, assistant legislative representative of the American Federation of Government Employees. Mr. Sadler, we thank you for returning here this morning. We are sorry we did not reach you yesterday.

TESTIMONY OF CARL K. SADLER, ASSISTANT LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, ACCOMPANIED BY STEPHEN A. KOCZAK, ASSISTANT DIRECTOR OF RESEARCH

Mr. SADLER. Thank you. I have with me this morning Mr. Stephen A. Koczak, our assistant director of research.

Mr. DANIELS. We are pleased to welcome Mr. Koczak.

Mr. SADLER. I would like to express Mr. Griner's regrets at not being able to be here this morning.

The American Federation of Government Employees has a continuing active interest in maintaining a Federal employees' health benefits program at least comparable to the plans evolving in private industry. As the largest organization of Federal employees in the country, with a current membership in excess of 285,000, our organization is committed to the principle that Federal employees are entitled to enlightened health, hospitalization, life insurance, and retirement benefits which do not lag behind the benefits currently applying in large-scale private industry.

The concept of comparability of Federal pay scales to equal those of private industry had been recognized as far back as 1962 in the Federal Salary and Reform Act of that year. Unfortunately, though written into law in 1962, one had to wait until the Postal Revenue and Salary Act of 1967 to set up a firm schedule to bring up Federal salaries to comparability with private industry not later than the first pay period in July 1969.

Our organization is most grateful that Congressman Dominick V. Daniels has decided to review the situation now appertaining in the Federal employees' health benefits program and we are confident that the concept of comparability will receive as much consideration from this subcommittee as that principle has received in the full Post Office and Civil Service Committee.

The trend in private industry is to full payment of hospitalization and health benefit premiums by the employer. Whereas just as little time back as 1962, most plans still required contributions by the employees, the latest figures available, those for 1966, show that the major industrial and craft organizations have come to accept the principle that the premiums should be paid completely by the employer.

As an indication of the rapidly accelerating trend in this direction in private industry, I request permission to place into the record a partial list of hospitalization and health benefit programs in private industry where the entire cost of the premiums is paid by the employer. That list appears as an appendix to my statement.

Mr. DANIELS. Without objection, that appendix will be made a part of the record immediately following your testimony.

Mr. SADLER. Thank you.

Our organization is realistic and we appreciate that budgetary considerations will probably influence Federal contributions to its employees' hospitalization and health benefit programs. Therefore, until such time hopefully in the near future when the Federal Government finally extends comparability in its health and hospitalization programs for its employees, we suggest that an intermediate formula be devised which would eliminate the most serious aspects of the current inequities.

Under the current rule for both maximum and minimum hospitalization and health benefits programs, the Federal departments and agencies pay biweekly only up to a maximum of $4.10 for an employee with dependents and $1.68 for an employee without any dependents, provided that in no case is the Federal employer's contribution more than 50 percent of the total premium.

Keeping in mind current budgetary problems and drawing on the wisdom of the solution regarding comparability of pay scales, we have a very simple formula to offer to bring equity over a period of several years to the Federal Government's contributions to its employees hospitalization and health benefit programs.

Our proposal is that on July 1, 1969, the Federal Government pay to every plan a contribution of at least 50 percent of the costs of the premium not to exceed 50 percent of the most expensive high-option Government-wide indemnity or service plan approved by the Civil Service Commission. Effective July 1, 1970, the Federal Government's contribution would be raised so as to pay every plan up to 75 percent of the most expensive high-option Government-wide plans; and on July 1, 1971, the Federal Government's contribution would be raised again so as to pay to every plan up to 100 percent of the total costs of the most expensive Government-wide high-option plans. The result, we expect, would be the elimination of all low-option plans by July 1, 1971.

Other plans for hospitalization or health benefits would continue to be approved by the Civil Service Commission, under the same provisions and procedures as have existed heretofore. It would be the understanding of all parties that that portion of the total costs of these plans in excess of the schedules which we have proposed above would be paid fully by the enrollees of these other plans or by the organizations sponsoring the plans, or by any arrangement worked

out mutually between the sponsoring organizations and the plan's enrolled members.

In summary, our organization submits the view that to achieve comparability with private industry hospitalization and health benefit plans, the Federal Government should be paying the entire premium of the approved Government-wide plans.

Because of budgetary considerations, we should like to propose that this be achieved over a period of 3 years. The first phase should come into force on July 1, 1969, with the Federal Government paying up to 50 percent of the Government-wide high-option costs; the second phase on July 1, 1970, with the Federal Government paying up to 75 percent of these costs; and the final phase on July 1, 1971, with the Federal Government paying up to 100 percent of these costs. We anticipate that, effective July 1, 1971, the low-option plans would cease to exist and employees would choose between the Government-wide plans and other plans in which they would be entitled to enroll.

In closing, I wish to thank again the distinguished chairman of this subcommittee, Representative Dominick V. Daniels, for affording our organization the opportunity to testify during this session of Congress on this very important subject of Federal Government contributions to the premiums of the hospitalization and health benefit plans for Federal employees.

(As previously ordered, the following compilation is inserted in the record.)

HOSPITALIZATION PLUS HEALTH BENEFIT PLANS FINANCED IN FULL BY PRIVATE EMPLOYERS

(Note.—The compilation shows the company and the labor union establishing the agreement by contract.)

The American Sugar Refining Co. (Brooklyn, N.Y.)—Longshoremen's Association.

Swift & Co.—Meat Cutters; Packinghouse Workers (UPWA); Packinghouse Workers (NBPW).

Armour & Co.—Meat Cutters; Packinghouse Workers (UPWA).

American Millinery Manufacturers Association (New York, N.Y.)—Hatters, Cap and Millinery Workers.

Campbell Soup Co. (Camden, N.J.)—Packinghouse Workers (UPWA).

Lumber industry, various employers (southern California)—Carpenters.

Furniture Manufacturers in Southern California, Industrial Relations Council of—Carpenters.

Brewers Board of Trade (New York, N.Y.)—Teamsters.

Clothing Industry, men's and boys' various employers—Clothing Workers. National plan.

Furniture industry, various employers—Furniture Workers. National plan.

Philip Morris, Inc.—Tobacco Workers.

Bigelow-Sanford Carpet Co., Inc.—Textile Workers (TWUA).

Continental Can Co., Inc., Robert Gair Paper Products Group—Papermakers and Paperworkers.

Printing industry, Chicago Lithographers Association, and other employers—Lithographers, Local 4.

The B. F. Goodrich Co.—Rubber Workers.

Bethlehem Steel Co.—Steelworkers.

Luggage and leather goods industry, various employers—Leather Goods, Plastic and Novelty Workers, National plan.

Publishers' Association of New York City—Typographers, Local 6.

Continental Can Co., Inc.—Steelworkers.

United States Rubber Co.—Rubber Workers.

The Firestone Tire & Rubber Co.—Rubber Workers.

Aluminum Company of America—Aluminum Workers; Steelworkers.

Chase Brass & Copper Co., Inc.—Automobile Workers.
United States Steel Corp.—Steelworkers.
Weirton Steel Co.—Independent Steelworkers Union.
Massachusetts Leather Manufacturers' Association—Leather Workers; Meat Cutters.
Minnesota Mining & Manufacturing Co.—Oil Chemical and Atomic Workers.
California Metal Trades Association—Various unions.
Radio Corporation of America—Electrical (IUE); Electrical (IBEW).
American Can Co.—Steelworkers.
Caterpillar Tractor Co.—Automobile Workers.
North American Aviation, Inc.—Automobile Workers.
Ford Motor Co.—Automobile Workers.
Pullman Inc. (Pullman-Standard Div.)—Steelworkers.
General Motors Corp.—Automobile Workers.
Johnson & Johnson (New Brunswick, N.J.)—Textile Workers (TWUA).
Construction industry, Associated General Contractors of America, and other employers (northern California)—Carpenters.
Jewelry industry, Associated Jewelers, Inc., Jewelry Crafts Association, and other employers (New York, N.Y.)—Jewelry Workers, Local 1.
Doll and toy industry, National Association of Doll Manufacturers, and other employers (New York, N.Y.)—Toy and Novelty Workers, Local 223.
Various Employers, St. Louis, Mo., area—Machinist, District 9.
Association of Master Painters and Decorators of the City of New York, Inc.—Painters, District Council 9.
Construction industry various employers (western Pennsylvania)—Various unions.
Trucking industry, local cartage and over-the-road freight, various associations, and individual employers, Central States, Southeast and Southwest areas—Teamsters.
Distributors Association—Longshoremen's & Warehousemen's Union, Locals 6 and 17.
Truck Owners Association of California—Teamsters.
Deere & Co.—Automobile Workers.
Coal industry (bituminous), various employers—United Mine Workers.
Railroad industry, various employers—Various nonoperating railway unions.
National Automobile Transporters Association—Teamsters, National Truckaway & Driveaway Conference.
Retail, wholesale, and warehouse industries, various employers (New York, N.Y.)—Retail, Wholesale & Department Store Union, District 65 (65 Security Plan).
New York Shipping Association, Inc. (Port of New York)—Longshoremen's Association.
Maritime industry, various employers, Atlantic and gulf coasts—Maritime Union.
Maritime industry, various employers, Atlantic and gulf coasts—Marine Engineers.
Hotel Association of New York, Inc.—New York Hotel & Motel Trades Council.
Restaurant industry, various employers (New York, N.Y.)—Hotel & Restaurant Employees, Local 89.
Realty Advisory Board on Labor Relations, Inc. (New York, N.Y.)—Building Service Employees.
Retail drug industry, various associations and employers (New York, N.Y.)—Retail, Wholesale & Department Store Union, Local 1199.
Retail trade industry, various employers (New York, N.Y.)—Retail Clerks.
Laundry industry various employers (New York, N.Y.)—Clothing Workers.
Maritime industry, various employers, Atlantic and gulf coasts—Seafarers.
Construction industry, various employers (New York, N.Y.)—Carpenters.

Mr. DANIELS. Mr. Sadler, under your proposal you would achieve comparability with some of private industry's health benefit programs in approximately 3 years?

Mr. SADLER. Right.

Mr. DANIELS. And you would eliminate all the low-option plans?

Mr. SADLER. We feel this in effect would in itself eliminate the low-option plans because the Government would eventually be paying the full 100 percent of a high-option plan.

Mr. DANIELS. And the Government employee, since he was getting it for nothing, would naturally ask for that high-option plan?

Mr. SADLER. That is right.

Mr. DANIELS. Do you feel if the Government paid the entire cost of the program, this would produce greater efficiency and that perhaps the cost might be reduced?

Mr. SADLER. I don't know, Mr. Chairman. Perhaps Mr. Koczak could touch on that.

Mr. KOCZAK. It would certainly be more efficient because the problem of administration would be eliminated. What is today the high-option plan would be the general plan available to everybody without any contribution by the Federal employee. The other plans would provide supplemental benefits which our members feel they want over and above what the Federal Government is providing. So it would certainly make the administration more efficient. As to the general rise in hospitalization in any case, it may turn out there would be an increase in cost, but that would not be because it is less efficient; it would in fact keep the increment in cost at a lower level.

Mr. DANIELS. Then, would it not be in the best interest of the Government to have one plan for all Federal employees?

Mr. KOCZAK. We are of the opinion that if one had only one plan and there was no possibility of any supplemental, this would be a hardship on the employees. In fact we are proposing one plan. There would be one plan, either the service or the indemnity plan. Now there are two plans, the Blue Cross type and the Aetna type. So in effect there would be only one plan that would be offered without any contribution by the Federal employee. On top of that, whatever any employee might wish to have—for example, if he is a Foreign Service officer or a postal employee who felt he had a peculiar problem—we feel they should be permitted to take it because they are paying fully for that. Rather than going to another company they would have available a supplemental plan.

So we would have one general plan free of charge to the employee and another plan tailored to the needs.

Mr. DANIELS. You would eliminate the 36 plans presently in existence, except to take care of the special needs of employees such as postal employees?

Mr. KOCZAK. In fact that is already happening. There are 36 sponsors of plans but only 54 plans. Eighteen have already eliminated the low-option plan. All we are doing, we are moving rapidly in this direction over a 3-year period.

Mr. DANIELS. Do you know how many Federal employees are enrolled in high-option plans and how many are enrolled in low-option plans?

Mr. KOCZAK. I do not have that information here but we understand they are approximately 80 percent.

Mr. DANIELS. In high-option plans?

Mr. KOCZAK. Yes.

Mr. DANIELS. Any questions, Mr. Hanley?

Mr. HANLEY. I regret my tardiness due to another committee meeting. I assure you I will read the testimony.

Mr. THOMPSON. Pursuing a little further the idea of one basic plan that would be funded completely by the Federal Government, do you

have any idea what the additional cost of this would be if we were to fund the plan?

Mr. SADLER. We would be happy to supply this to the best of our ability. I don't know that we have any figures at this time on that.

Mr. THOMPSON. I would appreciate that information.

You provide a method for our consideration whereby over a 3-year period the Federal Government would assume full responsibility. How do you feel about a little longer period, such as 5 years, so long as we do achieve the goal of 100-yercent financing by the Federal Government?

Mr. SADLER. Of course we prefer the shorter period. We think the time has come when we must do something about the amount of payments by the Federal employees into this thing, which has increased considerably. Any step in the direction of comparability in a reasonable time—and I think 5 years might be a reasonable time, although it would be too great a burden on the employee to have a longer period than 5 years.

Mr. THOMPSON. I for one have always been impressed by you and some of the other union officials with knowledge of the subject, and basically you have been a great aid to this committee. But as you probably noticed, in my testimony yesterday I did not feel the solicitation of union membership should be based on who has the best hospitalization plan. Do you basically support the concept of one plan that would be similar to our life insurance plan whereby all employees would be given this particular plan at no expense to them?

Mr. SADLER. As I stated a moment ago, we subscribe to the theory that the need would exist for one basic plan, but we also recognize the fact that most of the organizations have peculiar needs within the area of hospitalization that might require them to have supplemental programs over and above the guaranteed 100-percent program of the Government. So we certainly would not subscribe to any thought of taking away this opportunity of the organization to supply supplemental benefits.

Mr. THOMPSON. How would we take away the right of employees to buy an additional plan simply by providing one basic plan that we would feel would take care of the needs of the employee and his family? Wouldn't the employee have a right to purchase any plan he wanted to?

Mr. SADLER. He might have, but the program is established now to allow the different groups to provide different coverages, and all this would do under our plan is stabilize the Government's coverage so that in effect what you are saying would happen and in turn continue the right of organizations to provide supplemental benefits where they or the employees would pay the full cost.

Mr. THOMPSON. I feel the employee should always have that right anyway. I would look on that as an entirely different subject than the basic plan.

Mr. SADLER. We find that our membership—and I am sure the membership of other organizations—insist very strongly upon certain benefits within their own plan, and I can't envision their being too willing to accept only one plan without any supplementals in it.

Mr. THOMPSON. If we do finally settle on one plan I think it would be only after all the people involved would enter into a discussion of

what the basic needs are of those representing all the employees. So I think there is a very real possibility or probability that the basic plan would negate the need for any additional program.

Mr. SADLER. That is primary the way we feel.

Mr. THOMPSON. Thank you very much, Mr. Chairman.

Mr. DANIELS. Mr. Sadler, I note at the beginning of your statement you say your organization has a current membership in excess of 285,000. How many of those members participate in your plan?

Mr. SADLER. I am not certain exactly. It is in the thousands and thousands. I am not absolutely certain. It seems to me it is somewhere around 20,000.

Mr. DANIELS. Would you furnish this committee with a supplemental statement and incorporate in that statement the number of members who participate in your own health insurance plan?

Mr. SADLER. Yes, sir.

Mr. DANIELS. You have suggested providing for full payment of premium by the Government over a 3-year period of time.

Yesterday we had a witness, Mr. Jaspan, legislative representative of the National Association of Postal Supervisors, who advocated a plan whereby the premium would be paid over a 6-year period of time; 50 percent at the outset, and then a 10 percent increase each year thereafter, so that full payment would be achieved over a 6-year period. Mr. Thompson alluded to this previously. How do you feel about that?

Mr. SADLER. As I stated to Congressman Thompson, we think something should begin on this matter. Whatever the wisdom of the subcommittee may be as to the answer to the problem we would be more than happy to accept it. However, we feel, as we have stated, that 3 years is an ample period of time to wait for full coverage from the Government if we were going to begin comparability; if this concept is agreeable to the subcommittee, and I am sure it is because they have already indicated their support for the principles of comparability.

Mr. DANIELS. In other words, you recommend that we adopt this philosophy and you are willing to go along with any reasonable means of achieving it?

Mr. SADLER. That is right.

Mr. DANIELS. I notice that you were present this morning when our colleague from Virginia testified, Congressman Joel Broyhill. He testified in connection with a bill in which he is interested, H.R. 16555. You heard his testimony. Do you have any comment to make on his testimony?

Mr. SADLER. Only this, Mr. Chairman: That we feel Mr. Broyhill has the interest of the Federal employee at heart and we certainly endorse the concept which he brought forward before the subcommittee this morning—to eliminate the necessity for the Federal employee being overcharged or being placed in peculiar situations such as he alluded to this morning concerning these two aspects of coverage under the two plans. We certainly endorse the concept he brought forth this morning.

Mr. DANIELS Thank you. It has been a pleasure to have you.

Mr. SADLER. Thank you, sir.

Mr. DANIELS. Our next witness will be Mr. James H. Rademacher, vice president, National Association of Letter Carriers. You may proceed, Mr. Rademacher.

TESTIMONY OF JAMES H. RADEMACHER, VICE PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS

Mr. RADEMACHER. Mr. Chairman and members of the committee, my name is James H. Rademacher, and I am vice president of the National Association of Letter Carriers. We have more than 205,000 members located in every State and possession of the United States. Our headquarters is at 100 Indiana Avenue, here in Washington, D.C.

Mr. DANIELS. Before you go further, would you introduce your colleagues?

Mr. RADEMACHER. On my immediate right is our very able secretary-treasurer, Mr. J. Stanley Lewis. To his right is our administrative assistant in our health benefits department, a man with a long career in the health benefit field, Mr. John T. Donelon.

In the audience we have a committee of our organization which is studying the feasibility of establishing a dental program which has much to do with what this committee is studying today, Mr. C. J. Venneman, of St. Louis, and Mr. E. U. Barnes, of Jacksonville, Fla., along with Mr. Hy Sandbank, of New York. They are here today to witness these hearings, Mr. Chairman.

I would like to begin, if I may, by expressing our deep and sincere gratitude to you, Mr. Chairman, for introducing the bill under discussion today, H.R. 6351, which would provide that the entire cost of the Federal Employees Health Benefits Act would be paid by the Federal Government. I would also like to thank your colleagues in the Congress for having introduced similar legislation: Mr. Fino, Mr. Rosenthal, Mr. Charles H. Wilson, Mr. Nix, Mr. Helstoski, Mr. Brasco, Mr. Matsunaga, Mr. Gilbert, Mr. Halpern, Mr. Addabbo, Mr. Ryan, Mr. Farbstein, Mr. Scheuer, Mr. Bingham, Mr. Ottinger, and Mr. Podell. We appreciate their generosity of spirit and the liberalism which has inspired their action.

There probably has been no piece of fringe benefit legislation which has done more good for postal and Federal employees than has Public Law 86–382, which was signed into law on September 28, 1959. It became effective on July 1, 1960.

This was a magnificent forward step, taken by the Congress, in the field of human welfare and enlightened personnel procedures. It is a milestone in the history of intelligent human engineering in the Federal establishment.

We of the National Association of Letter Carriers are especially proud of the insurance program we have developed as a result of this act. We now have 134,000 members participating in the program. Counting their families, we estimate that approximately half a million people are protected by our insurance. Since the NALC plan began operation on July 1, 1960, we have paid out more than $180 million in insurance claims. We handle about 1,000 claims every day, and we pay out approximately $2.7 million in claims every month.

We have the largest operation among all the 14 plans sponsored by Federal employee organizations, and we rank third largest among all the 36 plans currently operating under the law. Best of all, we take great pride in the fact that out of every dollar we receive in premiums, we pay out 94 cents in sick benefits. Less than 6 cents of every premium dollar go for administrative costs and building up the necessary reserve.

As you can imagine, this program represents a tremendous effort in the alleviation of human suffering, in the creation of human security, in the maintenance of human dignity. We are grateful that Congress has given us this opportunity to render such enormous service to our membership and to their families.

Nonetheless, since 1959 the world has moved considerably in the field of health insurance and, also, in many ways the present program has not worked out the way that Congress intended it to work out.

It was obviously the intention of Congress when the law was originally passed that the Government and the employees should be 50–50 partners in this enterprise. This was never the case. The Civil Service Commission today estimates that the Government pays only 38 percent of the total cost, and the employee pays 62 percent.

We have reason to feel that this estimate is far too generous to the Government. Our program calls for a biweekly deduction from our members, under the high-option plan, which the vast majority have, of $7.98. The total cost is $12.08, so the Government pays only $4.10 or 34 percent.

Since our premium is well below the average cost of the 36 plans in existence, the percentage of the Government's participation must necessarily shrink as the cost to the individual employee increases.

I regret to say, also, that the Civil Service Commission has denied employees their full benefits under the law in its operations within the plan. Under Public Law 86–382 the maximum contribution by the Government per employee was $3.12. However, on July 18, 1966, this ceiling was raised, through Public Law 89–504 to a maximum allowable of $4.25 on a biweekly basis. However, the Civil Service Commission has made an artificial maximum of $4.10 biweekly and sticks to it, despite the lopsided percentages of participations.

In the NALC, Mr. Chairman, we are constantly fighting the battle against increasing our premiums. We know it is a losing battle, because medical and hospital costs keep increasing. The Bureau of Labor Statistics reports that since the Health Benefits Act was passed, hospital expenses have risen 53 percent; doctor's fees have risen 22 percent. All other expenses have risen sharply, except the cost of prescription drugs, which have remained relatively stable. As the costs go up, the premiums eventually must follow. But, of course, under present law and present practice, whenever the premiums go up, the percentage of Government participation decreases. So, unless something constructive is done about the present law, we can look forward to a steadily dwindling percentage of Government participation and a wider gap between the original intent of Congress and actual practice.

I mentioned earlier that the world has moved in the field of health benefits since the passage of the original act in 1959.

In 1960 the Health Insurance Institute investigated some 3,000 health insurance plans in the private sector, covering approximately 300,000 employees, and found that 34 percent of the plans provided for full coverage of costs by the employer. In 1964 the same survey showed an increase in the percentage to 47.9 percent. In 1966, the figure stood at 50.1 percent.

And last year, 1967, the figures showed that 63 percent of the health benefits plans in private industry provided for full coverage by the employer at no cost to the employee.

I think these figures prove that the Federal Government which should be the model employer in the country, the paragon of all employers, is not doing a very good job of following the best modern practice in the private sector.

At least two-thirds of all private employers are paying the entire cost of their employees' health benefits plans. The Government is among the less-enlightened lower one-third—and it is paying only one-third of the total cost—while the employee pays a full two-thirds. This makes the Government a very backward employer indeed by the standards of 1968.

I would like to add, Mr. Chairman, that postal employees in Great Britain have had free medical and hospitalization care provided by the Government for almost 80 years.

Last year the Department of Labor's Bureau of Labor Statistics, in its Bulletin No. 1502, examined 100 of the largest health insurance plans created through collective bargaining. Of the 100 plans examined, 69 provided that the employer pay the entire cost of the premiums for employees and their dependents; and another 17 provided for the employer to pay the entire cost of hospitalization for the employee, with an added small premium to be paid by the employee if he wanted to include his dependents.

The average letter carrier today is paying almost $4 a week for his health insurance. This is no small item in the budget of a low-paid worker. On the average it represents about half of what he pays for clothing and, as I have said, the trend is toward a higher and higher premium cost, with lower and lower take-home pay for the worker.

Our retired annuitants are having an even tougher time in meeting the costs of health insurance. It is actuarially impossible to charge retired annuitants the same premiums we charge younger members and offer the same benefits.

Our letter carrier annuitants at age 65 now pay between $17 and $25 a month for almost identical health insurance protection that practically every other citizen receives free under part A of medicare. That is why we were so pleased that Congressman Broyhill expressed himself on this subject this morning. It is extremely important that some attention be given to this problem and we hope that the Ways and Means Committee will in the very near future consider legislation in this regard.

We feel strongly that either Public Law 86–382 and/or the Medicare Act should be amended to cover Federal annuitants at age 65 under part A of medicare without any additional premium cost to them. There is ample precedent, as you know, for blanketing in under social security large segments of workers, and it would be very helpful if this could be done for Federal retirees who are having great difficulty in buying insurance protection at an age when they need it the most.

I might add that Federal annuitants at age 65 are now eligible, like all other citizens, to elect part B of medicare at a current premium of $4 per month per person. If they are eligible for part B, I cannot see why they could not also be made eligible for part A.

Something along these lines must be done soon if the present plans under Public Law 86–382 are to survive. I know we will eventually be forced by actuarial considerations to raise the premium on our retirees. This would mean increasing health insurance costs for those who are least able to pay and who need protection and help the most.

It would be most unfair to those who deserve our most tender consideration, but under present law there is no way we could prevent it.

The Civil Service Commission, early in 1967, did suggest the working out of some kind of system whereby Federal employees would pay minimum social security and, at age 65, be transferred over to medicare, part A. Our organization opposed the plan at the time because the package plan including this particular idea called for a substantial increase in the current employees' contribution to his retirement. But if the annuitants could be transferred to medicare, part A—directly—without increasing the contribution to retirement, we would be strongly in favor.

Mr. Chairman and members of the committee, I am grateful for having this opportunity of discussing this program and this proposed liberalization of the law before you. We are grateful that this very forward-looking legislation has been introduced and that you have called hearings on it. There is no doubt whatsoever that the trend throughout major industry in the private sector is for complete payment of costs by the employer and all health insurance. The Federal Government, which is the greatest employer in the Nation, is falling far, far behind the best practices of private industry, and equally far behind the standard, generally accepted, run of the mill, routine practices of private industry.

Passage and enactment of H.R. 6351 would mean an enormous amount to the letter carriers of the country. It would be a tremendous morale factor in the Postal Establishment, where morale is not very high at the moment. And it would be a great inducement in recruiting talented young men into the postal service. There could be no fringe benefit with greater appeal than this.

If we are going to preserve the postal service with any vestige of efficiency and consistency, we must be competitive with private industry in persuading our best people to say on the job, and to attract our proper share of talented and ambitious new employees. The Post Office is far from competitive at the moment, but this bill, H.R. 6351, will go a long way toward making it competitive in at least one very important area.

We thank you, Mr. Chairman and members of the committee, and we are available at this time for any questions the committee might pose.

Mr. DANIELS. First, in behalf of the members of this subcommittee, I wish to extend my compliments to you for a very fine statement.

I also want to compliment the National Association of Letter Carriers with regard to your health insurance program. I note that approximately two-thirds of your membership participate in your own program, and that you are operating the program in a very economical way—only 6 cents of every dollar going into reserves and the payment of administrative costs. I think that is an exceptionally fine manner to handle the program. Your organization deserves praise for its work in that regard.

Mr. RADEMACHER. Thank you.

Mr. DANIELS. In referring to annuitants who are currently in your health program, you mentioned that their costs after age 65 come to between $17 to $25 a month. Why should their costs be any different from the employee? Does not the law provide that the charge shall be the same for both?

Mr. RADEMACHER. Mr. Donelon will respond to that.

Mr. DONELON. There is no difference except the $17 figure represents a monthly deduction whereas the employee deduction is made biweekly.

As a matter of fact, it goes like this: The biweekly deductions amount to 26 a year. The monthly deductions amount to 12 a year.

Mr. DANIELS. The charge is the same?

Mr. DONELON. Benefits and the charge are the same.

Mr. DANIELS. The manner of payment causes it to come out the same?

Mr. DONELON. The employee pays $7.98 biweekly. Multiply that by 26 and you will get the same sum as if you multiplied the other figure by 12. The premiums and benefits are the same and remain unchanged at any age.

Mr. RADEMACHER. We pointed that out on page 5, Mr. Chairman, just to show the relativity between the premium and the fact that every other citizen receives free, under part A of medicare, the same protection.

Mr. DANIELS. While I am the original sponsor of this type of legislation, I must also be practical and realistic. I know that Congress this year has adopted a surtax law plus a reduction in the budget of some $6 billion, and that the climate is not right for this legislation at the present time.

I wholeheartedly agree with you that the U.S. Government should be the leader in advancing rules and programs for the benefit of our employees.

I wonder what your thought would be on recommending the payment by the Government of the entire premium over a period of time. We have had two proposals offered by previous witnesses; one recommending a 3-year approach, and another a 6-year approach. Have you any thoughts on that?

Mr. RADEMACHER. Mr. Chairman, I might say, perhaps facetiously and perhaps realistically, that I am surprised to note that the people on this side of the rostrum are trying to do the work of the Congress in compromising the legislation before us. I was surprised to hear representatives of employees take the responsibility of the Congress in their hands and recommend compromises on a bill before we even have the committee sitting down into executive session.

We are not in any compromising mood. Everything we have said is true and everything that you have said is true—that the economy of this country is in such condition that perhaps we had better not have bills enacted that will add to the problems.

However, many corporations are going to have to pay this surcharge that the Congress just enacted. Yet every employee of those corporations will enjoy better fringe benefits this year. They will enjoy better pay raises this year, despite the fact that these corporations are being taxed over and above what they have been taxed in the past.

Naturally we are a realistic organization. We are a responsible organization. We are responding here today to a request that we give our views on your legislation plus the other bills which have been introduced. It is our contention that the language of the proposal is realistic. It would make the Government a leader. For that reason we urge the enactment in toto.

Naturally if you are not going to pass the bill in toto until next year we will not be too mad about it, but we cannot sit on this side of the table and urge that it take place over the next 3 years or 6 years. We feel that the need is now.

We see the type of people coming into the postal service that are using our postal service as a steppingstone elsewhere in comparing benefits.

Believe me, Mr. Chairman and members of this committee, when they look at the benefits of health insurance and how much it will cost them, they then make a determination whether they are going to stay in the postal service. Those are remarks given most respectfully in response to your question.

Mr. DANIELS. I compliment you for your honesty and frankness in answering the question.

Mr. Hanley?

Mr. HANLEY. I want to commend the gentleman, too, for a very excellent statement. I look upon this as a very comprehensive statement.

I want to compliment the National Association of Letter Carriers for its obviously fine health benefits plan, judging from the membership participation and the minimal administrative cost.

I want also to express my deep regrets to the association with respect to the recent passing of your national officer, Mr. Phil Lepper. I look upon this as a loss to the cause of organized labor in this country. I had the pleasure of participating with him in conference in New York about a week previous to his death. My deep regrets to your association for this loss.

Mr. RADEMACHER. We appreciate those remarks, Congressman Hanley, and we want you to know that this passing of Phillip Lepper is the fifth death that our executive council has suffered in 5 years, all five younger officers. We appreciate the fact that you have injected your views into the record on this subject.

Mr. HANLEY. His death, I am sure, creates a vacuum within your association.

Again I think that your statement here certainly will assist in the deliberations of this committee. It is interesting to note that you say Great Britain has picked up the entire costs for a period of about 80 years.

Are there other nations that do likewise that you are aware of and other postal systems?

Mr. RADEMACHER. It is our understanding that nearby Canada has enjoyed the same benefits for several years.

Mr. HANLEY. Again I appreciate your statement on the plight of the retired annuitants.

Mr. RADEMACHER. Congressman Hanley, you mentioned the retirees. If I might add this: One word in behalf of letter carrier annuitants who retired prior to July 1, 1960. This group is not eligible for coverage under Public Law 86–382 which became effective in 1960.

These pre-1960 annuitants are insured under another health benefits law, Public Law 86–724, which was enacted July 1, 1961.

Under this act, the Government contributes up to $3.50 per month per person, restricted to annuitant and spouse, the total cost of the premium. We think the Government can do much better for these old-timers, as a matter of fact.

The Civil Service Commission, as I understand it, currently is authorized to increase the Government's contribution to $4 and we would hope this committee, as a result of these hearings and this testimony, would urge this administrative move on the part of the Commission.

Mr. HANLEY. Obviously they endure a highly inequitable position. Let us hope it can be remedied. I have no further questions, Mr. Chairman.

Mr. DANIELS. The gentleman from Georgia, Mr. Thompson.

Mr. THOMPSON. I am particularly impressed with your testimony wherein you point out that 94 cents out of every dollar goes for sickness benefits and only 6 cents goes for administrative costs and reserves.

Do you have any indication, or are there any figures that you know of, which can be made available to this committee as to what is the percentage of administrative costs of the other plans?

Mr. RADEMACHER. I will give you one example and then other information.

In Washington, D.C., it is our understanding that the return is 79 cents on the dollar with 21 cents for administrative costs, and all of this information which you are seeking is in the current issuance of the Civil Service Commission on the subject of health benefits. In their later report they have a complete breakdown of administrative costs for each plan which I shall be happy to send to you and the committee.

Mr. THOMPSON. I would appreciate having it.

(The material referred to is as follows:)

BENEFITS PAID AND ADMINISTRATIVE CHARGES—FEDERAL EMPLOYEE HEALTH BENEFIT PLANS

Plan and option experience-rated plans	Subscription income received and accrued		Benefits paid and accrued		Other expenses [1]			
					Administrative charges		Risk charges	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$537,243,317	100	$509,025,178	94.7	$19,847,852	3.7	$5,778,393	1.1
High option	486,711,736	100	465,860,220	95.7	17,700,334	3.6	5,268,123	1.1
Low option	50,531,581	100	43,164,958	85.4	2,147,518	4.2	510,270	1.0
GOVERNMENT-WIDE PLANS								
Total	$439,602,426	100	$414,368,901	94.3	$14,711,832	3.4	$5,356,985	1.2
High option	403,879,242	100	384,920,652	95.3	13,431,189	3.3	4,919,566	1.2
Low option	35,723,184	100	29,448,249	82.4	1,280,643	3.6	437,419	1.2
Service Benefit Plan:								
Total	316,860,168	100	300,803,958	95.0	11,002,705	3.5	3,802,322	1.2
High option	295,873,853	100	284,484,732	96.2	10,274,326	3.5	3,550,486	1.2
Low option	20,986,315	100	16,319,226	77.8	728,379	3.5	251,836	1.2
Indemnity Benefit Plan:								
Total	122,742,258	100	113,564,943	92.5	3,709,127	3.0	1,554,663	1.3
High option	108,005,389	100	100,435,920	93.0	3,156,863	2.9	1,369,080	1.3
Low option	14,736,869	100	13,129,023	89.1	552,264	3.7	185,583	1.3
EMPLOYEE ORGANIZATION PLANS								
Total	$86,331,561	100	$84,530,427	97.9	$4,261,731	4.9	$333,149	0.4
High option	72,887,816	100	72,076,030	98.9	3,510,488	4.8	294,779	.4
Low option	13,443,745	100	12,454,397	92.6	751,243	5.6	38,370	.3
American Federation of Government Employees:								
Total	4,217,524	100	4,840,254	114.8	313,807	7.5	54,828	1.3
High option	3,659,953	100	4,432,272	121.1	273,294	7.5	47,579	1.3
Low option	557,571	100	407,982	73.2	40,513	7.3	7,249	1.3
American Foreign Service Protective Association	1,072,829	100	1,234,205	115.0	88,742	8.3	17,487	1.6
Government Employees Benefit Association:								
Total	1,860,401	100	1,605,689	86.3	105,916	5.7	37,208	2.0
High option	1,714,213	100	1,523,597	88.9	97,592	5.7	34,284	2.0
Low option	146,188	100	82,092	56.2	8,324	5.7	2,924	2.0
Government Employees Hospital Association:								
Total	3,291,681	100	3,378,404	102.6	169,531	5.2	49,375	1.5
High option	2,919,785	100	2,965,734	101.5	150,374	5.2	43,797	1.5
Low option	371,896	100	412,670	110.9	19,157	5.2	5,578	1.5
Group Insurance Board, Panama Canal	526,252	100	437,923	83.2	48,079	9.1	10,525	2.0

See footnotes at end of table, p. 61.

BENEFITS PAID AND ADMINISTRATIVE CHARGES—FEDERAL EMPLOYEE HEALTH BENEFIT PLANS—Continued

EMPLOYEE ORGANIZATION PLANS—Continued

Plan and option experience-rated plans	Subscription income received and accrued		Benefits paid and accrued		Other expenses [1]			
					Administrative charges		Risk charges	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
National Alliance of Postal and Federal Employees:								
Total	$261,719	100	$231,345	88.4	$12,668	4.9	$5,234	2.0
High option	238,358	100	218,320	91.6	11,536	4.8	4,767	2.0
Low option	23,361	100	13,025	55.8	1,132	4.8	467	2.0
National Association of Letter Carriers:								
Total	30,974,467	100	29,057,021	93.8	1,233,519	4.0		
High option	26,030,513	100	24,813,303	95.3	1,020,367	3.9		
Low option	4,943,954	100	4,243,718	85.8	213,152	4.3		
National Association of Post Office and General Services Maintenance Employees:								
Total	877,943	100	751,325	85.6	41,360	4.7	14,925	1.7
High option	809,663	100	691,551	85.4	38,143	4.7	13,764	1.7
Low option	68,280	100	59,774	87.6	3,217	4.7	1,161	1.7
National Association of Post Office Mail Handlers, Watchmen, Messengers and Group Leaders:								
Total	534,148	100	442,865	82.9	47,005	8.8	10,683	2.0
High option	523,413	100	435,152	83.1	46,061	8.8	10,468	2.0
Low option	10,735	100	7,713	71.9	944	8.8	215	2.0
National Federation of Post Office Motor Vehicle Employees:								
Total	542,661	100	438,144	80.7	27,711	5.1	9,768	1.8
High option	523,347	100	425,205	81.2	26,724	5.1	9,420	1.8
Low option	19,314	100	12,939	67.0	987	5.1	348	1.8
National League of Postmasters of the United States:								
Total	1,773,736	100	1,460,129	82.3	86,814	4.9	35,475	2.0
High option	1,351,038	100	1,127,064	83.4	66,570	4.9	27,021	2.0
Low option	422,698	100	333,065	78.8	20,244	4.8	8,454	2.0
National Postal Union:								
Total	13,200,920	100	13,523,719	102.4	670,007	5.1		
High option	11,412,687	100	11,642,897	102.0	579,221	5.1		
Low option	1,788,233	100	1,880,822	105.2	90,786	5.1		
National Rural Letter Carriers' Association:								
Total	5,896,028	100	5,068,427	86.0	273,990	4.6	76,649	1.3
High option	4,974,981	100	4,381,755	88.1	231,189	4.6	64,675	1.3
Low option	921,047	100	686,672	74.6	42,801	4.6	11,974	1.3
Special Agents Mutual Benefit Association	2,186,746	100	2,271,954	103.9	47,812	2.2	10,992	.5
United Federation of Postal Clerks:								
Total	19,114,506	100	19,789,023	103.5	1,094,770	5.7		
High option	14,944,038	100	15,475,098	103.5	784,784	5.3		
Low option	4,170,468	100	4,313,925	103.4	309,986	7.4		

Total	$11,309,330	100	$10,125,850	89.5	$874,289	7.7	$88,259	0.8
High option	9,944,678	100	8,863,538	89.1	758,657	7.6	53,778	.5
Low option	1,364,652	100	1,262,312	92.5	115,632	8.5	34,481	2.5
Foundation for Medical Care, Stockton, California	508,076	100	401,541	79.0	43,186	8.5	4,466	.9
Group Health Insurance, Inc., New York:								
Total	1,944,291	100	1,760,718	90.5	177,754	9.1	51,787	2.7
High option	882,694	100	853,779	96.7	73,886	8.4	23,367	2.6
Low option	1,061,597	100	906,939	85.4	103,868	9.8	28,420	2.7
Health Insurance Plan of Greater New York:								
Total	813,178	100	825,600	101.5	25,948	3.2	16,263	2.0
High option	510,123	100	470,227	92.2	14,184	2.8	10,202	2.0
Low option	303,055	100	355,373	117.3	11,764	3.9	6,061	2.0
Hawaii Medical Service Association	3,569,530	100	3,317,157	92.9	183,780	5.2		
National Hospital Association, Oregon	374,199	100	303,724	81.2	37,420	10.0	7,484	2.0
North Idaho District Medical Service Bureau, Inc	60,071	100	55,359	92.2	6,428	10.7		
Physicians Association of Clackamas County, Oregon	11,215	100	14,161	126.3	575	5.1		
Physicians and Surgeons Association, California	147,800	100	128,639	87.0	13,302	9.0	2,956	2.0
Seattle Letter Carriers Medical Services, Inc	212,140	100	187,823	88.5	17,163	8.1	5,303	2.5
Seguros de Servicio de Salud de Puerto Rico, Inc	721,267	100	646,852	89.7	83,266	11.5		
Washington Physicians Service	2,947,563	100	2,484,276	84.3	285,467	9.7		

[1] Certain other expenses not shown.

Source: U.S. Civil Service Commission 1966 Report.

Mr. THOMPSON. Let me follow up with a couple more questions. You may have determined that I am interested in the possibility of one comprehensive plan for all employees. I do not know what the administrative costs of this particular type plan would be but I am very impressed with the low administrative cost that you have here.

Are there any factors in your organization which make it unique whereby you can have a lower administrative cost than just one big plan?

Mr. RADEMACHER. First of all, I will have to state unequivocally that because of the pride we have in our own accomplishment we are opposed to the initiation and inauguration of one single plan. We think, among other things, that the competitive nature of many plans is helpful to the employee. You also have the problem within crafts of type of employee and type of member. I refer to sex. The letter carriers deal generally with men. For that reason our rates are what they are today.

In regard to your other views and thoughts on this subject, we feel that one big plan which would encompass all Federal employees with the complete cost paid by the Government would cost about 20 percent for operation.

We do not have any exorbitant salaries in our plan. We have elected and appointed officials. We have an espirit de corps in our group. We are concerned about our members, and members are the officers supervising the plan. I think this is a very important difference between plans and the more reason we would not favor one major plan.

We think it would cost the Government a tremendous amount of money where there is no competition. We think that the employee would suffer.

For example, in our particular plan, my daughter just gave birth to a baby and it cost over $400 altogether because of a few complications.

In another plan the total paid would have been $200. Here again we have competition which is good in the future for the Government and presently for the member of the plan because we can provide greater benefits than other plans are providing.

That is the amazing thing, and we are not here today to brag about ourselves, but with the evidence we have presented here today about the costs, administrative costs, and so on, as we can keep that cost at a minimum we are also providing maximum benefits which in most instances are far superior to any other plan.

Mr. THOMPSON. I am very, very impressed with your low administrative cost. I have some background in insurance. In fact, I have extensive background in insurance, primarily aviation insurance. The company with which I was assistant Southeast manager originated the trip insurance which you buy at the airport. I believe only 5 cents out of every dollar goes to pay claims. The rest goes to the airports for concessions and overhead. You have 95 percent overhead, so you have just about reversed the situation here. I think you are certainly to be commended.

I am not going to ask you the questions I have asked the others as to how you feel about phasing of the plan. I recognize in the plan that you are a rational individual and you would rather have something enacted now which would very definitely provide some time in the near future a plan which would be paid for by the Government

rather than to stick to a method which may not be acceptable to the Congress at this time. I will not ask you that question. I think you made yourself clear on it.

Mr. RADEMACHER. I will not answer it, either, since you did not ask it, Mr. Thompson. However, I would like to make an observation.

We appreciate the fact that you are knowledgeable in the insurance field and that you have so many fine ideas on the subject. We have watched with interest the questions that you have asked on these subjects as long as you have been on this committee. We certainly appreciate the interest that you personally have displayed.

This is a factor which affects every Government worker. Certainly this organization, the National Association of Letter Carriers, is realistic and responsible enough to know that this subcommittee could not possibly favorably recommend at this time complete payment by the Government. However, as a result of the hearings and testimony and evidence we feel that the least that can be done is to urge the Civil Service Commission to exercise the authority they do have and pay more. They can raise that Government contribution to $4.25 and they can certainly raise the retirees to $4. They have the authority to do this. We would hope that the committee might recommend that.

Mr. THOMPSON. Thank you very much.

Mr. DANIELS. Thank you, gentlemen.

Our next witness will be Mr. C. O. Henderson, executive director, Organization of Professional Employees of the Department of Agriculture.

TESTIMONY OF C. O. HENDERSON, EXECUTIVE DIRECTOR, ORGANIZATION OF PROFESSIONAL EMPLOYEES OF THE DEPARTMENT OF AGRICULTURE

Mr. HENDERSON. My name is Christopher O. Henderson. I am executive director of the Organization of Professional Employees of the Department of Agriculture. We have about 8,500 professional employees of the Department of Agriculture as members.

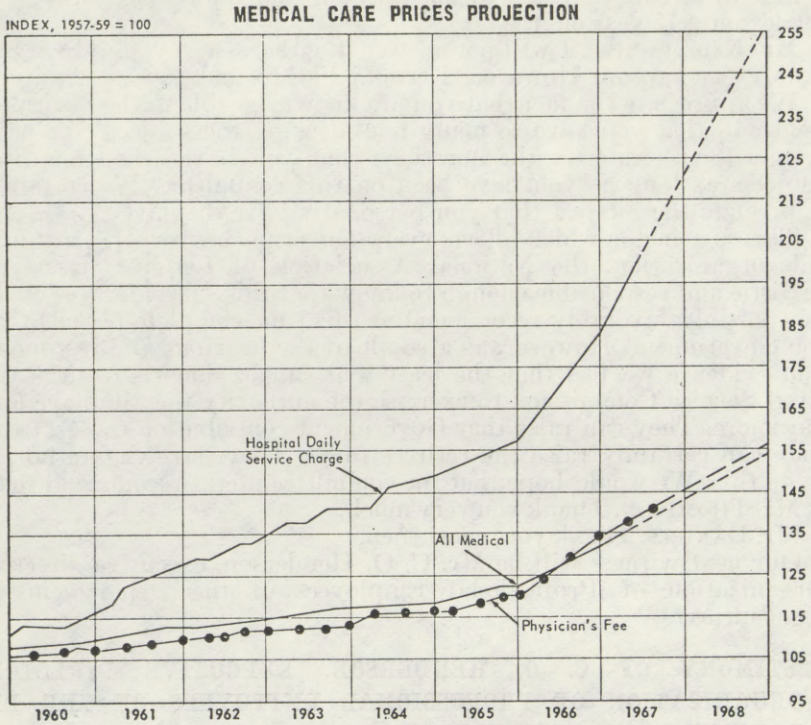
There is no question about the value of the Federal employees health benefits program. Its administration as a group program by the Civil Service Commission has provided some control and many improved benefits to the employee. If properly utilized, the program should provide preventive care and be of direct value to the Federal service by reducing the sick leave taken. It should also be a means of increasing employee efficiency.

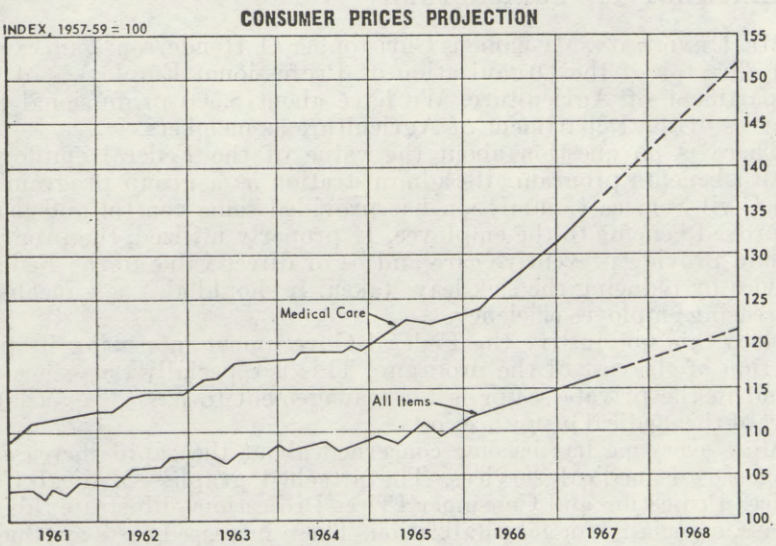
Does this not justify the Federal Government increasing its proportion of the cost of the program? This is especially true since the trend in the private sector is for management to pay all or a large part of the medical insurance costs.

Most everyone has become concerned about the rapid increase in the cost of medical services. The attached graphs—Medical Care Prices Projection and Consumer Prices Projection—illustrate this increase, especially for hospitalization. These increased costs are due to several factors such as increased labor costs, improved facilities and services, and rapid increase in demands for services which has often prevented the most efficient administration of hospitals.

We have attached a couple graphs showing this increased cost.

(The charts referred to follow:)





SOURCES: 1960-1965 – U.S. Health, Education and Welfare Dept.
1966-1967 – U.S. Dept. of Labor; Bureau of Labor Statistics
1967-1968 – Straight line projections and GHA estimates.

LEGEND: – – – – – – Straight line projections.

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Mr. HENDERSON. What can be done about controlling these rapidly increasing costs? It would appear that hospitalization potential for a reduction in cost provides the best opportunity. Some of the questions which might be asked are:

Is full hospital care needed by all who are admitted?

Can some of the patients (normally admitted to hospitals) be treated or examined on an outpatient basis?

Is it possible that many convalescent patients might be better domiciled in facilities similar to a hotel or motel near the hospital?

The Friday, July 5, Wall Street Journal carried an article on "Between Hospital and Home—Convalescent Homes Use Motel Methods in Providing Reduced-Cost Sickbed Care." The article reports that one firm alone has completed 16 such homes or centers, 12 are under construction, and 50 more are in various stages of development. An example of the lower cost possibilities is that the centers require three persons to each five patients, whereas hospitals have 2.6 employees for each patient.

SUMMARY

The Federal employees health benefits program is a tremendous step forward in providing employees with adequate medical attention. The program should also be directly responsible for a more efficient Federal staff. It is recommended that the Federal Government increase its part of the health insurance cost to 50 percent.

A special inquiry should be made of the rapidly rising medical costs, especially in the use of hospitals and related facilities. If expedient, take such action needed to insure more efficient use of these facilities.

Thank you, Mr. Chairman, for the privilege of appearing before your committee at this time.

I have a clipping in the event you want to pursue this matter further, Mr. Chairman, and I also had handed to me yesterday by Mr. French Hyre, chairman of our subcommittee on insurance, the July 1968 issue of Changing Times.

The man who wrote this is a specialist in the field of insurance. He has an excellent article on hospitals and hospital bills, why they go up and up, why it is happening and why they are going up. There is nothing profound about it except it brings to light quite a few problems and ways some of the hospitals and some of the health insurance programs are trying to combat these increased costs.

We thank you very much for the privilege of presenting this testimony before you.

Mr. DANIELS. Mr. Henderson, the article which appeared in the Wall Street Journal on Friday, July 5, to which you referred, will be incorporated in the testimony.

(The newspaper article referred to follows:)

[From the Wall Street Journal, July 5, 1968]

BETWEEN HOSPITAL AND HOME—CONVALESCENT HOMES USE MOTEL METHODS IN PROVIDING REDUCED-COST SICKBED CARE

(By Paul E. Steiger)

MEMPHIS.—From the blurbs, it sounds like any other fairly plush motel—wall-to-wall carpeting, color television, programed music, a thermostat in every room. There's only one difference: To get in, you have to be sick.

The institution in question is called a convalescent center. Proliferating rapidly across the nation, such centers offer rooms, beds and basic health services for patients recovering from surgery or serious illnesses. Unlike conventional nursing homes, however, they tend to specialize in caring for patients who are expected to recover within three or four weeks. And they do so at a cost substantially below that of hospital care.

The resemblance to motels isn't accidental; most convalescent centers have deliberately borrowed a number of techniques, as well as decor, from the motel business. Indeed, the Memphis center described above is owned and operated by Medicenters of America Inc., formed in 1965 by Kemmons Wilson and Wallace Johnson, the two top executives of Memphis-based Holiday Inns of America Inc.

The crush on conventional hospital facilities caused in part by the advent of such programs as "medicare" and "medicaid" has been a powerful spur to the development of convalescent centers. Medicenters, for example recently opened its 16th center, this one in Grand Junction, Colo. An additional 12 centers are under construction and 50 more are in various stages of development. By 1970, the company hopes to have 110 facilities open or under construction in 35 states.

One of the newest entrants in the business is Sheraton Corp. of America, which recently broke ground in Burlington, Vt., for its first "continuing care center." A Sheraton spokesman declines to specify the company's expansion plans, but he says Sheraton is "actively negotiating for sites in other cities." Sheraton is a subsidiary of International Telephone & Telegraph Corp.

LESS COSTLY THAN HOSPITALS

Convalescent centers usually are staffed by nurses and located near major hospitals. Rates vary widely, but generally they total only 30% to 60% of hospital care costs, which average about $50 a day in most areas and up to $100 a day in several major cities. Sheraton, for example, plans to charge $18 to $35 a day. Medicenters charges $18 to $22 daily for private rooms, $14 to $20 for semiprivate accommodations.

The low rates are largely a reflection of the fact that convalescent centers don't require the extensive facilities needed in a hospital. Staff can be kept to a minimum, typically a ratio of three employes (ranging from nurses to janitors) to each five patients. Patients are admitted, and their care is directed, by their own physicians. By contrast, the average hospital has 2.6 employes for each patient.

Convalescent center chains also are able to keep costs down by the use of mass purchasing, standardized construction and uniform operating procedures. Most of the centers have between 100 and 175 beds. Few are built with less than 50, and American Institutional Developers, a Philadelphia-based chain founded in 1964, has one as large as 426 beds. American recently opened its 10th center in Naples, Fla. It has 16 more under construction and another eight on the drawing boards.

In many cases, convalescent centers prove even less expensive than home recuperation. Dr. Joe F. Schooler, a Fort Worth orthopedic surgeon, says his mother entered a nearby Medicenter after undergoing an operation for cancer. "She needed constant care," he recalls. "If she had gone home, it would have meant three nurses around the clock. You can't afford that unless you're John D. Rockefeller."

The cost at the convalescent center was about $219 a week, including drug and other costs, says Dr. Schooler. At home, he figures, costs would have been close to $430 a week.

PLEASING TO THE STAFF

In addition to their attractions for patients, the centers' "motor hotel atmosphere" helps in recruiting staff, their operators contend. This is significant in the face of nursing shortages in many areas. "We've been able to draw many nurses out of early retirement," says a Medicenters spokesman. He says many nurses prefer the convalescent centers to nursing homes because the centers tend to keep our terminal patients, who abound at many nursing homes.

In their recruiting, the convalescent centers try to avoid antagonizing other institutions. They pay nurses at the going rate, but not above. "We discourage applications from nurses already employed at a hospital," says one convalescent center official. He adds that the centers also take care to refer long-term patients they reject to nursing homes for treatment.

One national hospital authority warns of an "ultimate possibility" that a conflict could arise between the profit aims of convalescent centers and the need to insure high standards of care. But so far, he adds, some of the chains "are already

proving successful, and it may be that the chain approach will produce more efficient operations than the small, individual speculator."

Health authorities estimate variously that between 20% and 60% of the patients in hospitals at any given time are receiving "extended," or convalescent, care. The centers themselves figure that, in effect, they are able to free three hospital beds for each patient they take, since typically over a 24 to 28-day period a hospital bed will have three occupants.

The final say on the duration of a patient's stay comes from a review committee of doctors retained by the center for that purpose. The patient's doctor can appeal this decision to a local medical group, but most centers maintain a firm stance. "It the patients look as if they're becoming long-term, we bounce them out," says a Medicenters spokesman. Such patients, he notes, are then referred to a nursing home.

Convalescent centers generally have a heavy proportion of elderly patients, because they take longer to recuperate from an illness or an operation, and most centers won't take patients under 15 or 16 years old because of the special problems they present.

Indeed, one chain, Safecare-Careage, tends to locate its centers in small cities such as Seaside, Ore., and Redding, Calif., where it says there is usually a greater concentration of older people. Safecare-Careage is a recently formed partnership between Safeco Inc., a large Seattle insurance holding company, and Careage Corp., a privately held Bellevue, Wash., concern. The partnership already has 12 convalescent centers in operation and plan to open 17 more this year.

METHODS OF FINANCING

The chains use a variety of methods of financing and managing their centers. Some are owned directly and leased to operators, while others are operated by the parent company itself. Construction and start-up costs are understood to average between $5,000 and $10,000 a bed exclusive of land costs.

The industry is too young to offer any reliable indications of its profit potential, convalescent center operators say. Last year, American Institutional earned $53,901, or 8 cents a share, up from about 1 cent a share in 1966. This year it expects to earn "at least $500,000," or 75 cents a share, according to E. Charles Conway, president.

In the year ended March 31, Medicenters earned $150,000, or 13 cents a share, up from $9,600, or 1 cent a share, the year before. John DeCell, executive vice president, says the company anticipates earnings to improve by an unspecified amount in the current fiscal year.

The centers tend to make their advertising pitch indirectly. Medicenters, for example, runs ads asking companies, employes and insurance companies whether their group health coverage includes "getting-well benefits in recuperative facilities." When opening a new center, American throws a private cocktail party and buffet for local physicians and health officials to acquaint them with the facilities. The next day, splashy newspaper ads summon the general public to an open house. "We're mainly out to sell the concept of extended care," says Mr. DeCell. "If we do that, we'll get our share of the business."

Mr. DANIELS. The Chair wishes to thank you for your appearance here today and giving us the benefit of your views. I have no questions.

Mr. Hanley?

Mr. HANLEY. I have no questions, Mr. Chairman.

Mr. DANIELS. Mr. Thompson?

Mr. THOMPSON. I have an observation, Mr. Chairman.

I appreciate very much your attached chart which shows the medical care price projections. The hospital daily service charge seems to be skyrocketing way out of proportion to other items. Do you have any thought as to the reason for this?

Mr. HENDERSON. This article in the "Changing Times" gives some of the reasons.

As I mentioned in the testimony, more services are being provided. They are learning more and more about treating people and as they learn more they have to have additional equipment for that purpose so that the overhead costs are increasing.

Apparently the main reason for the increased cost is labor. It has been necessary for them to increase the wages and salaries for those who work in the hospitals a great deal in the last 2 or 3 years. They have had a shortage of nurses, and in order to attract people into the nursing profession they have had to increase salaries, in some places considerably above what they were even 2 or 3 years ago.

You also have an increase in overhead, and in many cases it is said to be due to poor administration. The demand for hospital care has been growing rapidly, and hospitals have been built fast. When you have a program of this kind you are not as likely to be as careful with the dollar as you would be if you could do it a little more slowly.

In some cases these increased costs are due to hospitals buying equipment and facilities when they are not needed. Equipment for open-heart surgery may be installed when there may be very little need for it. There appears to be a need for some coordination among hospitals in providing such facilities.

Mr. THOMPSON. Thank you very much. I certainly appreciate your statement. I have nothing further, Mr. Chairman.

Mr. HANLEY (having assumed the chair). Thank you, Mr. Henderson, for your appearance this morning. You have provided a real service, particularly as Mr. Thompson reflected on your graph relative to the price projection. It is most helpful to us.

Inasmuch as there are no further witnesses this morning the record will remain open for a reasonable length of time to incorporate further testimony. With that, we shall adjourn the subcommittee, subject to the call of the Chair.

(Whereupon, at 12:05, the subcommittee adjourned, subject to the call of the Chair.)

(The following statements were received by the subcommittee for inclusion in the record:)

STATEMENT OF THOMAS G. WALTERS, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

Mr. Chairman and members of the subcommittee, my name is Thomas G. Walters, president, National Association of Retired Civil Employees, the only organization made up exclusively of retired Federal, Postal, and District of Columbia employees with more than 134,000 members. Our Washington office is at 1909 Que Street NW., Washington, D.C.

Mr. Chairman, we greatly appreciate your scheduling these hearings and it has long been my opinion that the Federal Government should pay the entire cost of health insurance for those employees and dependents who retired prior to July 1, 1960, as well as those employees commonly referred to as active employees and those who have retired since July 1, 1960. Attempting to be a practical lobbyist, it appears that Congress is not at this time in a mood to pay the entire cost, so we plead with you to recommend that two-thirds of the total cost be paid by the U.S. Treasury for those health benefits provided for in Public Law 86–382 (Federal Employees Health Benefits Act of 1959) and Public Law 86–724 (Retired Federal Employees Health Benefits Act of 1960).

Public Law 86–724 provided benefits for persons retired prior to July 1, 1960. These benefits were devised back in 1960 for "retirees" and in nowise measure up to those provided for employees under Public Law 86–382. Thus, today we have retirees with Government insurance under each of these laws which provide different benefits. The early retirees (prior to July 1, 1960) eligible only for the lesser benefits. An increase in the Government contribution for the early retirees—prior to 1960—would provide not only for continuing their Government health insurance, but as self-respecting citizens, assure them that they are meeting the

cry of the times in not depending on their Medicare insurance to meet all needs.

The Federal Government today is paying a smaller percentage of those covered by Public Law 86–382 than they were when this program was originated, this being brought about because of the increased cost of health benefit coverage. I am not particularly strong for a law reading in percentage of the cost but I do believe that a dollar amount should be inserted that would be at least two-thirds of the cost of the health plans.

Under Public Law 86–382 (prior to 1960) payment has been increased from $3 to $3.50 each but it is my understanding that under the present law the Civil Service Commission could increase this to $4 per person coverage or $8 for family coverage. Perhaps a memorandum from your committee to Chairman John Macy of the Civil Service Commission might bring about the Commission's ruling that they pay the maximum under the provision under the law.

As you and all members of this committee and your staff know, several thousand annuitants and survivor annuitants are existing on a mere pittance and a few dollars per month to be applied to health benefit coverage would be greatly appreciated.

I think we should keep in mind that several thousand employees have retired since July 1, 1960, and their incomes have been greatly reduced but their premium rates for health benefits have consistently advanced and most likely will continue to advance so we strongly recommend that the Federal Government greatly increase its contribution for those covered under Public Laws 86–382 and 86–724.

Mr. Chairman, with your permission, I would like to quote excerpts from the Evening Star, July 2, "Federal Spotlight" by Joseph Young:

"Government employees can expect to pay higher premiums for their health insurance benefits by the end of the year.

"Rising hospital and medical costs are expected to result in most of the health insurance carriers requesting higher rates. They have until August 31 to make the requests.

"Government employees will not have a chance to switch plans this year because the next 'open season' in which they can do this will not begin until November 1969.

"Because of this, the Civil Service Commission has asked the insurance carriers to keep any premium increase request they make as modest as possible. The Civil Service Commission makes the final decision on all premium increase requests.

"However, many of the insurance carriers say that sharply rising medical and hospital costs—which in some cases will increase as much as 25 percent—makes it imperative that Federal employee premiums be increased by a fairly substantial margin.

"Under the present system, the Government pays less than 30 percent of the total premiums' cost, with the result that the great burden falls on Federal employees.

"For example, under the Government-wide Blue Cross-Blue Shield plan, employees under the self and family high-option plan pay $9.50 every 2 weeks for their coverage. Under the Government-wide AETNA indemnity plan, employees pay $9.30 every 2 weeks.

"Some of the union plans, which have richer benefits, are even more costly. Employees under high option plans pay as much as $13.44 biweekly.

"Thus, the continuing increase in premiums that has occurred through the years poses a real problem for employees as well as the carriers."

Mr. Chairman and members of the subcommittee, this being my first appearance before a congressional committee since assuming my duties as president of the National Association of Retired Civil Employees on July 1, 1968, I am happy that it was to discuss the health benefits program, in which I am extremely interested and in which I had a small part in contacting Members of Congress for approximately 10 years before it was finally approved and for more than 6 years I was privileged to be at the U.S. Civil Service Commission when these programs were initiated and I like to think that I had a small part in getting this health benefits show on the road. Again, I thank those on this committee, on behalf of the members of NARCE for the privilege.

STATEMENT OF NATHAN T. WOLKOMIR, PRESIDENT, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

My name is Nathan T. Wolkomir. I am president of the National Federation of Federal Employees, which is the oldest and largest of all the independent general unions of Federal employees.

The National Federation of Federal Employees is glad for the opportunity to submit its ideas on the problems it has encountered in the administration of the Federal employees' health benefits program during the 8 years the program has been in effect. While this program has been most beneficial to the Federal employees, we believe changes should be made to render the program even more beneficial.

It is our understanding that approximately 80 percent of the nearly 2,500,000 employees covered by the program are covered by contracts issued by Blue Cross-Blue Shield and the Aetna Life Insurance Co. Accordingly, an analysis of the workings of the programs of these two companies should provide a representative cross-section of the problems in the Federal employees' health benefits program. Our comments are, for the most part, based on experience with these two companies.

Appendix A presents in tabular form the rate and participation structure for the years 1960 and 1968 for the high option self and self and family, low option self only and self and family for Blue Cross and for Aetna. Looking at the Blue Cross data first, for the self only, high option contract, code 101, the total cost per biweekly pay period rose from $3.41 in 1960 to $5.57 in 1968, or an increase of 63.3 percent. The agency contribution dropped from 38.0 percent in 1960 to 30.1 percent in 1968, correspondingly the employee's contribution increased from 61.9 percent in 1960 to 69.9 percent in 1968. For self and family, high option, code 201, the cost increased from $8.94 to $13.60, or 52.1 percent. At the same time the contribution by the agency declined from 34.9 percent to 30.1 percent, and the employee's contribution increased from 65.1 per cent in 1960 to 69.9 percent in 1968.

The experience for Aetna is similar, with the self only, high option contract, code 201, the cost increased from $3.12 to $5.40 or 73 percent. At the same time the agency contribution dropped from 41.7 percent to 31.1 percent and the employees contribution went up from 58.3 percent to 68.9 percent. For self and family high option, code 202, the contract cost increased from $7.06 to $13.40 or 89.8 percent. The agency contribution dropped from 44.2 percent to 30.6 percent and the employee's contribution correspondingly increased from 55.8 percent to 69.4 percent.

For the low options, the Blue Cross contracts increased in cost from $2.60 to $3.36 (29.2 percent and from $6.56 to $8.20 (25 percent) for self only, code 104, and self and family, code 105, respectively. For the self only contract, the agency contribution constituted 50 percent both in 1960 and 1968. For self and family, the agency contribution increased from 47.6 percent to 50 percent with a corresponding decrease in the employee's contribution from 52.4 percent to 50 percent. The Aetna contracts increased from $2.60 to $2.92 (12.3 percent and from $6.24 to $7 (5.8 percent) for self only, code 204, and self and family, code 205, respectively. In both instances the agency contributions constituted 50 percent of the cost in 1960 and in 1968.

The data for the low options lose much of their significance when it is realized only about 300,000 employees out of the approximately 2,500,000 covered have contracts for which the agency pays 50 percent of the cost. Thus despite the much lower costs, ranging from $2.92 to $8.20, the less rapid rise in rates, ranging from 5.8 percent to 29.2 percent, and with the agency paying 50 percent of the cost, despite all of these, seven out of eight employees elect to take the high option contracts. This is not to say an increase of 29.2 percent is reasonable, only that while the low option contracts meet a need, they do not meet the needs of the majority of the employees.

For those contracts which seven out of eight employees elected, the cost has risen from 52 percent to nearly 90 percent between 1960 and 1968. At the same time the contribution paid by the agency declined from an average of 36.5 percent to 30.1 percent for Blue Cross subscribers and from 42.9 percent to 30.8 percent for Aetna subscribers. The contribution by the employee increased from an average of 63.5 percent to 69.9 percent for Blue Cross and from 57.1 percent to 69.2 percent for Aetna subscribers. Thus for seven out of eight employee subscribers the gross cost of the service has increased from more than 50 percent to nearly 90 percent at the same time their proportion of the gross costs have increased

by 10 percent to 20 percent over what they were in 1960. And this for a service that is second only to food and shelter in importance to the employees.

Clearly such trends cannot be permitted to continue indefinitely and, while the costs of administration and the profits of the insurers should continue to receive close critical scrutiny, more far-reaching action is required. For what they may be worth, the NFFE offers the following for consideration by the subcommittee as possible means of coping with these problems.

One change which needs to be effected is to require the employing agency to pay 100 percent of the cost for the health benefits program. The trend in industry unmistakably is toward the employer paying 100 percent of the costs of the program and the trend in the Federal Government should be the same. As a first step, the agency's share of the costs should be increased to 50 percent on all contracts. This should be followed with legislation increasing the agency's contribution on a phased basis until the agency is bearing 100 percent of the cost.

Concurrently studies should be conducted to learn what can be done to reduce the rate of increase in costs for medical services. Would greater attention to healthful working conditions and other illness preventing measures reduce significantly the need for medical services? One consideration especially which comes to mind is the increase in the emotional illnesses of Federal employees. What part does incomptent supervision play in the growth of these illnesses among Federal employees? We suspect that thorough-going study would establish that improved supervision would reduce significantly the incidence of emotional illnesses with corresponding decreases in medical costs as well as retirement due to disability. We are equally confident such decreases would pay several times over what it would cost to identify incompetent supervisors and take appropriate corrective action. We strongly urge action is initiated in this area without delay.

Another study which should prove to be fruitful is what can the employees and physicians do to keep the changes to the health benefits programs to the absolute minimum? Included here would be essential versus desirable medical treatments, reasonableness of costs, length of hospitalization and similar questions to make both the employees and the physicians properly cost-conscious. Not to the detriment of the health of the employee, of course, but as efficient a treatment program as possible with due regard for the health of the employee.

The experience of the 8 years from 1960 to 1968 should have provided data for more equitable contracts. For example, a subscriber who looks to his health and avoids a charge to the health benefits program for a stated period of time, should be entitled to have the same coverage but at less cost than a subscriber who is constantly costing the program. Some insurance companies reward the safe driver, so why not reward the person who does his share in reducing the charges to the health benefits program? Another possibility is different rates for subscribers in different age groups. Are the present high and low options the best coverages which can be worked out? In view of the relatively small number who subscribe to the low option there are grounds for believing there can be more suitable contracts developed within the existing price structure. Another question which needs to be explored is extending the coverage of dependents of subscribers. It seems to us the subscriber should be entitled to include in his contract any relative whom the subscriber legally claims as a dependent for purposes of the Federal income tax.

We do not pretend that this is an extensive itemization of the problems worthy of study. But we do believe it represents a beginning of such an identification. On behalf of the National Federation of Federal Employees I desire to thank you for the opportunity to bring to the attention of this subcommittee some of the facets of the Federal employees' health benefits program, which in our opinion are worthy of further study by the subcommittee.

STATEMENT OF HAROLD MCAVOY, NATIONAL PRESIDENT, NATIONAL ASSOCIATION OF POST OFFICE MAIL HANDLERS, WATCHMEN, MESSENGERS AND GROUP LEADERS, AFL–CIO

The National Association of Post Office Mail Handlers, Watchmen, Messengers, and Group Leaders, AFL–CIO are most appreciative to you for introducing H.R. 6351.

Our national organization wholeheartedly endorses this worthy legislation which would authorize the Federal Government to defray the entire cost of health benefits coverage for employees and their families.

Our national organization fully endorses the concern of the chairman of this subcommittee on Retirement, Insurance, and Health Benefits that all postal employees suffer pay cuts, etc., by recurring increases in health insurance premiums due to incessant rises in medical and hospital costs.

As you must fully realize, at this time, Mr. Chairman, our people are at the bottom of the pay schedule of the Post Office, and I ask you to try to understand the hardships that our people are undergoing day in and day out to keep their heads above water.

Thank you Mr. Chairman and members of your committee for the privilege to give you and your committee the thinking of our membership.

STATEMENT OF JOHN J. MURPHY, NATIONAL PRESIDENT, NATIONAL CUSTOMS SERVICE ASSOCIATION

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to submit the views of our association on a matter of vital interest to our members.

Health benefits are without a doubt one of the most important and vital fringe benefits received by an employee. Not alone does it affect the employee but it has a direct effect on the members of his family. It is a benefit he can ill afford to be without. However, the premiums have risen to a point where they are a heavy burden.

I am certain that it is common knowledge that the cost of medical service has risen considerably over the past years. To keep abreast of the increased cost, the carriers have been forced to raise premiums. As a result of the increased premiums the Government employee has had, in effect, a pay cut.

Health benefits in private industry have been steadily improved in the last few years to provide coverage for substantially all medical expenses. Private industry, in most instances, bears the full cost of health benefit plans for both hourly and salaried employees.

The Government's contribution to the Federal Employees Health Benefits Act is lagging and not comparable to the pattern which has been adopted by industry.

A retired employee, receives a set sum of money, considerably lower than his employable income and upon which he must budget his future needs and existence and the need for protection against the high cost of medical and hospitalization expenses. Premium payments for such protection continues to rise. Such increases become burdensome upon the retiree by continually lowering his fixed income which is already heavily budgeted for his normal needs.

In view of prevailing conditions and in view of these facts as outlined in this statement, our association recommends that the entire cost of the Federal employees health benefits program be borne by the Government. We respectfully ask that this recommendation be given favorable consideration by this committee.

JULY 15, 1968.

Hon. DOMINICK V. DANIELS,
Chairman, Subcommittee on Retirement, Insurance and Health Benefits,
House Post Office and Civil Service Committee,
Washington, D.C.

DEAR CHAIRMAN DANIELS: Your public hearings of July 9 and 10 were for the purpose of making an objective appraisal of the Federal Employees' Health Benefits Program, with particular emphasis on evaluating the Government's participation in premium charges, as you stated in your announcement. You recently voiced your concern that Federal employees suffer annual pay cuts by recurring increases in health insurance premiums due to incessant rises in medical and hospital costs.

Senator Olin D. Johnston, on June 12, 1959, stated that the Civil Service Commission would be charged "with the responsibility for making continuing studies of the operations of the Government Health Benefits Act in all its aspects, including the extent to which it meets the needs of employees and annuitants and for reporting its findings to Congress."

In fact, the law does *not* give this responsibility to the Civil Service Commission, and there is no Government agency concerned with studying how best to meet the needs of employees and annuitants.

By law, "The Commission shall make a continuing study of the operation and administration of this Act, including surveys and reports on health benefit plans

available to employees and on the experience of such plans." (There are also provisions for reports from carriers.) (Section 11(a) of Public Law 86-382.) There is no reference to the "needs of employees and annuitants."

Just before this law was passed, according to a statement on the same day by Senator Richard Neuberger, there was a two-day consultation with representatives of the insurance industry. There is no evidence in any of the Hearings leading up to this Act of any consultation with economists, health economists or general economists. Had economists been consulted and sufficiently influential, the law would not now relieve the Civil Service Commission from any responsibility to study the Health Benefits program in terms of whether it meets the needs of those it is designed to help.

I have placed evidence into the records of hearings of the Ways & Means Committee and Finance Committee of the Senate that the "actuarial science" dominating the rate-making of the insurance industry is not adequate for understanding health economics. My special reference there is the Social Security Medicare program, but the same evidence is applicable to the Government Employees' Health Benefits Program.

The law says: "Rates charged under health benefit plans described in section 4 shall reasonably and equitably reflect the cost of the benefits provided." It goes on to say that service benefit plans and indemnity benefit plans (blandly ignoring that the former raises economic questions not found in the latter) shall have their rates "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 benefit plans issued to large employers, etc." What is "consistent"? There is no evidence here for any concern to "meet the needs of employees and annuitants" in the best way possible. This would call not only for consideration of how much money is spent, but how well the money is spent, i.e. what the employees and annuitants get for it.

Rates designed to "reflect costs" means cost-plus. Therefore the same criticism may be made of the Federal Employees' Health Benefits Program that economists make of the Social Security Medicare program, which attempts to cover something called "actual costs," measured in monetary terms. It is the proper function of the actuary to see that such "costs" to the fund set up to cover them is likely to be matched by revenue into the fund. The economists, however, is mainly interested in something else, which he calls "real costs," not measured in unadjusted monetary terms.

The interest in "actuarial soundness" does not necessarily bring with it an interest in the economic problem of getting the most either for Social Security Medicare money or for money spent by the Civil Service Commission for health benefits. The economist's main concern is not with money but with what money buys; that is, he asks for the best health results at a given cost or the least cost for given health results. He wants to know what is being paid for, why it costs so much, and how to get it at less cost. In actuarial parlance, every benefit to a human being is a cost to a fund but in economic language every benefit has a cost we want to minimize. Economy means not merely foreseeing the future, as in a crystal ball or an actuarial report, but shaping the future to get the most from limited resources.

The Social Security law has an unsatisfactory concept of "reasonable cost" as the basis for Medicare payments for health services. The Civil Service Health Benefits law is equally unsatisfactory in this respect. In the case of Medicare, a first halting step has been taken to improve the situation by an amendment to the law (Title IV, Section 402) which authorizes the H.E.W. Secretary to engage in "experiments" to provide for "incentive payments" towards bringing about greater "efficiency" and "economy" in hospital and medical services. But the Civil Service Commission is not required to contemplate this kind of improvement in its program. It has no mandate to reduce costs, only to "reflect costs." This means that only by reducing benefits can any program under Civil Service purview reduce "costs" in the sense of making do with limited budgets.

The published record of the Ways and Means Committee on H.R. 3920 ("Medical Care for the Aged") 1964 (Part 5, page 2497), contains my letter to the Continental Casualty Company, asking for "light on the economic principles whereby hospitals price the services they provide." A representative of this company testified before the Subcommittee on Health of the Elderly, Special Committee on Aging of the Senate, on April 27, 1964, that they were not qualified to discuss "the cost of health care itself"; they only considered "the cost of the insurance process; administrative and marketing costs, costs of paying benefits, and a risk charge or profit." In no other economic field would anyone get away with concern only for the marketing of goods to the neglect of improved produc-

tion. And the record shows that only people of this sort were consulted when the Federal Employees' Health Benefits Program was set up.

We need to get sound economics into the picture. On June 28, 1967, before the National Conference on Medical Costs, the then H.E.W. Secretary John Gardner called for a "radical shift of emphasis" from the "financing mechanism" to the examination of "the efficiency, the productivity, and the logic of the system by which health care is delivered." This approach was resisted by the Social Security Administration. Before the same conference, Commissioner Robert M. Ball, in his address, showed no interest in cost reduction, as conceived by the economist, but only, as he put it, and his is the concept now in the Civil Service Law, "correctly to reflect the cost." This is an accounting problem for the past and an actuarial problem for the future, but not a "how to do it" problem which must be solved to make Medicare, Medicaid, the Federal Employees' Health Benefits Program, and other competing and complementary programs work with reasonable success with limited resources. Now in spite of, and perhaps slowed down by, Social Security Administration resistance, the law has been amended to at least get them started in the right direction. This has not yet been done for the Civil Service Commission.

A proposal to get the Government to pay a larger amount on behalf of its employees and annuitants, in health benefit plans under Civil Service supervision, I understand, is before you. This may be desirable, but it does not get to the heart of the problem. Thinking must begin on the problem of better economy in the spending of funds and economic resources in this area. True economy means spending less money for the same goods, but it also means getting more for the same money, or if more money is spent, getting a proportionately greater value for additional dollars spent. In the case of service benefits, as distinguished from indemnity benefits, the Government is spending not only a part, specified in dollar amounts, but the whole amount. For example, I am a Civil Service annuitant and I belong to the Group Health Association. The whole amount taken out of my check going to the Group Health Association, which gives me service benefits, is money spent by the Government in my behalf. In fact, I am the beneficiary, but the Government is the purchaser. (This is true of service benefits but not of indemnity benefits. In the latter case, the beneficiary is also the purchaser, and from the Government there is but a transfer payment to him.)

The Group Health Association has been raising its rates periodically, and I am unable to judge from information provided to me, whether these increases are justified. Since I am an economist, I would be in a position to have, not necessarily the only true answer (there is no such thing), but an intelligent opinion. I am unable to get assistance here from the Civil Service Commission, which is spending my money but can't tell me how well it is doing the job. I have a letter from a Civil Service Commission official (dated August 11, 1966) stating that they "are not responsible for how the Plan's managers justify rate increases to its members."

This is a caveat emptor approach, which has no place in a Government program. The result is passing the buck, and frustration for me. The "Plan's Managers" justify rate increases to its members by pointing to pressures from the Civil Service Commission as a reason for increasing rates and for their abrupt way of doing it which prevents informed discussion of the matter.

I wrote the Civil Service Commission for material to satisfy me that they do not neglect the interest of the "final consumers," i.e. the needs of employees and annuitants for whom it "buys" health programs. All I got was the report for the fiscal year, and this does not fill the bill.

I have no specific proposal to make at this time, but I ask that this letter be put into the record of your Hearings on the Federal Employees' Health Benefits program. Judging by the effect, which I can document, of material by me in the records of various Congressional Committees, this will be helpful in prodding Government officials to engage in economic analysis of programs under their care. Also, it will contribute to public discussion of these questions.

Yours sincerely,

SIDNEY KORETZ.

STATEMENT OF JOHN W. EMEIGH, DIRECTOR OF HEALTH INSURANCE, NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is John W. Emeigh and I serve as director of health insurance for the National Rural Letter Carriers' Association, an organization representing approximately 62,000 rural, retired, and substitute rural letter carriers. The association sponsors the Rural Carrier Benefit Plan of Health Insurance which, as an employee-organization plan approved under the Federal Employees Health Benefits Act of 1959, provides health insurance coverage for more than half of the rural carriers of this country and almost 5,000 anuitants.

Mr. Chairman, we would like to join with the many others who have submitted testimony to this committee and express our appreciation to you for the introduction of H.R. 6351 and the scheduling of hearings to gather the views and compile data relative to the problem of spiraling health costs and the funding of Federal health plans approved under the 1959 act.

We would also like to express our appreciation to the many other Members of the House of Representatives, including the five members of the House Post Office and Civil Service Committee, who have sponsored legislation similar to H.R. 6351.

This association endorses and gives our full support to the legislative goal set forth in H.R. 6351 introduced by Chairman Dominick Daniels, which would provide that the Government pay the full cost of health benefits for Federal employees. When legislation was enacted in 1959 to provide the important fringe benefit of health insurance for Federal and Postal workers, the funding formula assessed approximately 50 percent of the cost to the Government. Specifically the legislation provided that the Government share of the cost would be set at 50 percent of the cost for the lowest rate in the low options of the two Government-wide plans. This formula established in 1960, set the U.S. Government contribution at a maximum of $3.12 per pay period for its employees. Public Law 89–504 enacted in 1966, provided some improvement in the contribution formula by increasing the Government's share to a maximum of $4.10.

Over the period of the past 8 years however, medical care costs have soared, coverage provided under the Federal health plans has been liberalized and, evidently, due to a greater awareness of health care, utilization of benefits provided in the Federal plans has also grown. These factors have all played a part in a rather alarming increase in the dollar output to provide health benefits.

The liberalization of benefits has for the most part been borne entirely by the employees and annuitants. The Federal Government, through the U.S. Civil Service Commission which administers the health program, has from time to time recommended and requested liberalization of benefits in order to provide a greater health care coverage in those areas where experience has shown a particular need. This has resulted in a liberalization of benefits within the plans. In addition, the law has extended coverage by including persons for whom coverage was initially denied and this also has contributed to an increased cost. These areas include expanding coverage to include foster children, setting the coverage for unmarried dependents up to age 22, liberalizing benefits for mental illness, and providing of other general liberalizations of benefits for those insured in the Federal program. The National Rural Letter Carriers' Association has consistently sought to meet the health care needs of its members by expanding benefits in those cases where experience has shown a need of greater coverage in order to provide the maximum possible assistance to our insureds in meeting the costs of health care. Thus, the benefits have also been liberalized considerably.

The impact of the growth in benefits, and in the cost of providing those benefits, is illustrated by the increase in premium rates over the 8-year period the Rural Carrier Benefit Plan has been in existence. In July 1960, when the plan was established, the total cost for self and family coverage under the high option, on a biweekly pay period basis, was $9. The Government's contribution was $3.12 and the employee contributed $5.88.

The present biweekly cost is $12.64 for self and family coverage under the high option of the Rural Carrier Benefit Plan. The Government's contribution is now $4.10 and the employee bears the far greater burden by paying the remaining cost of $8.54 per biweekly pay period.

You will note that the Government's share of the cost has increased only 31 percent, while the cost to the employees has risen 45 percent.

It is vital that consideration be given to a new funding formula in order to permit the Government to match the participation of industry in this important

fringe benefit area and to relieve the insureds—Federal employees and annuitants—of the unfair burden of continuing to assume the lion's share of the increasing costs of providing these important benefits.

Action should not be delayed on this important matter because the cost situation, serious as it is, will certainly grow worse with the passing of time. Numerous witnesses before this committee have already cited statistics to document the problem of spiraling health care costs in this country. Many national magazines have carried articles to document this very serious problem. For example, articles have recently appeared in Forbes, Changing Times, U.S. News & World Report, and have also been carried by thousands of newspapers across this country.

The Government is, of course, aware of this problem and the President has acted by appointing a Commission to look into the problem to determine what, if anything, can be done to moderate the rapidly increasing cost of health care for our citizens. Unfortunately, no study, in our opinion, is going to reverse the trend which has become so painfully clear—a trend which clearly indicates that health care costs are going to continue to rise approximately 12 percent per year.

Because we do recognize this serious problem, we are pleased to appear before this committee and testify on this important legislation introduced by Chairman Daniels. Industry wide fringe benefit programs clearly demonstrate that the ultimate goal, if the U.S. Government is to fulfill its role as a model employer, is to have the full costs of health insurance paid by the Government. As a practical matter, however, we recognize that this is a goal which cannot be immediately achieved. The fact that we cannot immediately achieve the desired goal, however, should not deter this committee from developing an improved costing formula that would more fairly assess the cost of health insurance to the Government.

We would like to suggest a new formula for consideration by this committee. When the initial formula was enacted, it provided a contribution by the Government in an amount not to exceed 50 percent of the cost of the lowest premium in the low option of one of the two Government-wide plans. Experience has clearly demonstrated, however, that the low options do not, generally, provide adequate coverage. For this reason, the vast majority of Federal employees have elected to enroll in the high option. Thus, although the intent was to have the Government contribution at least an approximate 50 percent when the health plans were established, the formula has failed to keep pace with the expanded coverage provided and with the liberalizations in the benefit structures which were necessary to provide an adequate type of protection in line with increased costs of medical care.

We would recommend that the funding formula be changed to tie the Government contribution to the high option in the manner in which it was initially established by being tied to the low option. This suggested formula would set the maximum Government contribution in an amount equal to 50 percent of the cost of the self and family enrollment in the high option of the Government-wide plan with the lowest premium. This formula would provide a contribution equal to 50 percent of the costs for those persons who have elected coverage in low options. This is the contribution currently in effect for almost all persons enrolled in low options.

The importance in the change of the formula, however, would be to first recognize that adequate health care, and the protection against the cost of such care, is tied much more closely to the benefit structures of the high option than to those in the low option. Secondly, it would put meaning into the costing formula by updating it in a manner to assure that the U.S. Government was striving to match the experience which has been demonstrated industrywide in providing this important fringe benefit for employees. This would be a very important step forward in improving the present funding formula. The lowest premium, for self and family, in a Government-wide plan is presently the biweekly premium of $13.40 which is presently in effect for the Government-wide indemnity plan. If our recommendation were adopted, it would see a Government contribution in an amount of $6.70 per biweekly pay period. This maximum contribution should be paid to those insured under self and family enrollments in the high options of all plans but would be limited to an amount not to exceed 50 percent of the total costs in any option of any plan.

If this formula were adopted, it would, using the example of the Rural Carrier Benefit Plan, increase the Government's contribution from $4.10 to $6.32—an amount which would be equal to 50 percent of the present cost of enrollment for self and family under the high option and which, as you will note, would be

within the maximum contribution of $6.70 under our suggested formula based on existing rates.

We would then suggest further that the committee draft legislation to provide that the Government contribution would be increased in an amount which would cover an additional 10 percent of the costs each subsequent year until the goal set forth in the Daniels' bill would be reached. Under this formula, the Government contribution would never reach a complete 100 percent of the costs in all plans but it would closely reach this goal. We believe that the goal of a complete 100 percent payment by the Government is impractical because it would destroy the privilege of each plan exercising its own judgment in determining the benefits which should be offered to the persons enrolled. Under this formula, however, each plan would be privileged to retain the right of determining the benefit structures, and the total costs of the plan, but it would grant all employees the right of selecting the plan which they believed best for themselves and their families. And, under this selection process, they would be assured of the right to select the plan under which they would enjoy the maximum contribution provided by the Government which, under our suggested formula, would be at least 50 percent if such bill were adopted and eventually up this to 100 percent of the total costs.

Mr. Chairman, we would like to express our appreciation for the privilege of submitting this testimony to your committee and we trust that a bill may be reported which will provide financial relief to our employees and annuitants in connection with the funding of their health insurance benefits.

Thank you for this opportunity to submit our views, comments, and recommendations.

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