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FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

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OF THE
COMMITTEE ON
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HOUSE OF REPRESENTATIVES



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NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 767

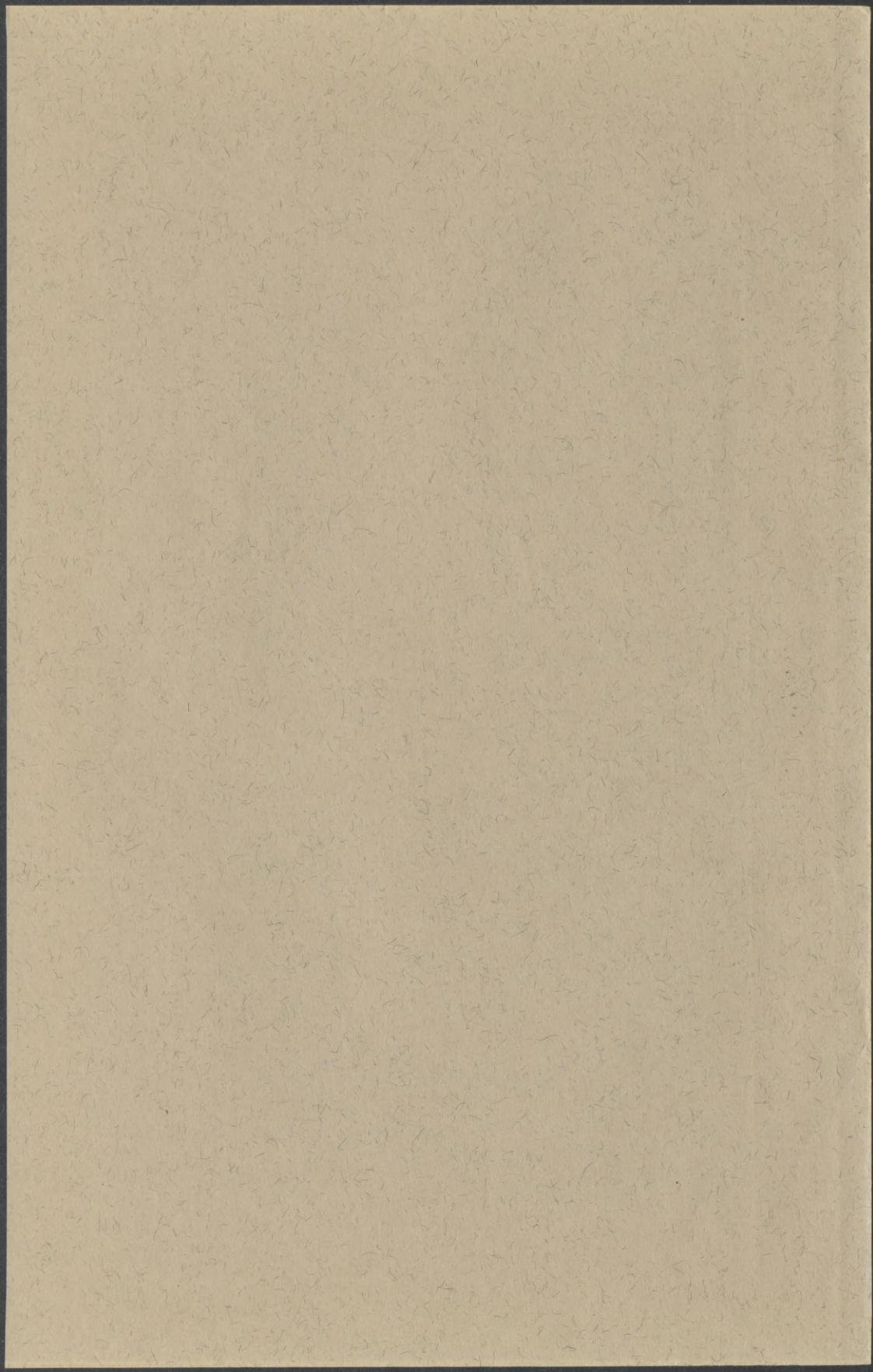
A BILL TO AMEND CHAPTER 89 OF TITLE 5, UNITED STATES
CODE, RELATING TO ENROLLMENT CHARGES FOR FEDERAL
EMPLOYEES' HEALTH BENEFITS

MARCH 18, 24, 25, AND 26, 1970

Serial No. 91-21

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





FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON RETIREMENT, INSURANCE,
AND HEALTH BENEFITS

OF THE

COMMITTEE ON
POST OFFICE AND CIVIL SERVICE
HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

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WASHINGTON : 1970

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FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

WEDNESDAY, MARCH 18, 1970

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

The subcommittee met, pursuant to call, at 10:10 a.m., in room 210, Cannon House Office Building, Hon. Dominick V. Daniels (chairman of the subcommittee), presiding.

Mr. DANIELS. The Subcommittee on Retirement, Insurance, and Health Benefits will now come to order.

The subcommittee meets this morning for the purpose of carrying out our responsibilities under the Legislative Organization Act in conducting a continuing review of the operations of the health benefits programs coming within the jurisdiction of this subcommittee.

The Federal employees' and retired employees' health benefit programs were enacted almost a decade ago. The initial employee program established the largest voluntary group health insurance plan then in existence in the United States, encompassing approximately 2 million Federal employees. Its purpose was to improve personnel administration in the Government by providing a measure of protection for civilian employees against the high, unbudgetable, and financially burdensome costs of medical services, with the subscription charges shared by the employees and the Government, as the employer. The retiree program, enacted the following year, established a related health insurance plan for those former employees who had retired prior to the implementation of the active employee program, and covered almost one-half a million retirees and survivor annuitants.

The incessant increases in hospital and medical care costs common to all segments of our society are reflected in these programs, and particularly in the Federal employees' health benefits plan. These rising costs are causing considerable anguish not only to employee and annuitant subscribers, but to employers and the purveyors of health insurance policies, as witnessed by the multitude of discussions on the subject in various congressional committees and throughout the country.

The apparent consequence of spiraling health care costs has been that premiums have had to be substantially increased in order to maintain present standards of benefits. A further consequence, because of the maximum dollar limitations imposed upon the Government's contribution, has been that the employees and annuitants are unrelentingly burdened with an ever-growing share of premium charges.

While the subcommittee's hearings will largely deal with the serious question of the inadequacy of the Government's sharing of premium charges—the basic problem being of such magnitude that it transcends the scope of our jurisdiction—I would express the sincere hope, in addressing ourselves objectively to the related problems of these programs, that our deliberations will have a salutary effect upon the larger issue.

Without objection, I offer at this point in the record H.R. 767, a bill which I introduced on January 3, 1969, to provide for the Government's contributions to health benefits premium charges be gradually increased, and that the Government ultimately assume the total payment of the charges.

(H.R. 767 follows:)

[H.R. 767, 91st Cong., first sess.]

A BILL To amend chapter 89 of title 5, United States Code, relating to enrollment charges for Federal employees' health benefits

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 8906 of title 5, United States Code, is amended to read as follows:

"(a) For pay periods which begin after June 30, 1969, there shall be contributed by the Government amounts necessary for the administrative costs and the reserves provided by section 8909(a) of this title.

"(b) For pay periods which begin after June 30, 1969, the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter shall be the following percentages of enrollment charges, exclusive of that provided by subsection (a) of this section: 50 percent for fiscal year 1970; 75 percent for fiscal year 1971; and 100 percent for fiscal year 1972 and for each year thereafter.

"(c) During the first pay period which begins in fiscal year 1970 through the last pay period which begins in fiscal year 1971, the amount necessary to pay the difference in the enrollment charge, after the Government contributions provided by subsections (a) and (b) of this section is deducted, shall be withheld from the pay of each enrolled employee and from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

"(d) (1) An employee enrolled in a health benefits plan under this chapter who is placed in a leave-without-pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed one year under regulations prescribed by the Commission. The regulations may provide for the waiving of contributions by the employee and the Government.

"(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within sixty days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph (1) of this subsection and implementing regulations.

"(e) The Government contributions for health benefits for an employee shall be paid—

"(1) in the case of employees generally, from the appropriation of funds which is used to pay the employee;

"(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

"(3) in the case of an employee of the legislative branch who is paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

"(4) in the case of an employee in a leave-without-pay status, from the appropriations or fund which would be used to pay the employee if he were in a pay status.

"(f) The Government contributions authorized by subsections (a) and (b) of this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose.

"(g) The Commission shall provide for conversion of biweekly rates of contributions specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent."

Mr. DANIELS. Our first witness this morning is the Honorable Robert E. Hampton, Chairman of the U.S. Civil Service Commission.

We also extend a welcome to you, Mr. Ruddock.

Mr. RUDDOCK. Thank you.

Mr. HAMPTON. Mr. Ruddock is our expert. Today I said, when I brought Andy up, if there is any question of policy, I will respond, but if it's something that really means something in the technical field, then it will be Andrew.

Mr. DANIELS. I am sure you brought along a very worthy associate.

Mr. HAMPTON. Yes, sir.

STATEMENT OF ROBERT E. HAMPTON, CHAIRMAN, U.S. CIVIL SERVICE COMMISSION

Mr. HAMPTON. Mr. Chairman and members of the subcommittee, we appreciate the opportunity to appear before your subcommittee to give you the Commission's views on the bill, H.R. 767. To put our views in proper perspective, I would like to back up just a bit to comment on the situation that has prompted the introduction of this and similar bills to increase the Government's contribution under the Federal employees health benefits program.

The Civil Service Commission considers administration of the Federal employees health benefits program to be one of its most important responsibilities. Although the program is not quite 10 years old, over \$3½ billion in benefits have already been paid. The program now covers 7.8 million people—2.5 million employees and annuitants, and 5.3 million wives, husbands, children—and some 2.3 million people actually receive health-care benefits each year. Consequently, we are very much concerned with the many problems involved in delivering and financing good quality health care, not only to the nearly 8 million people in our Federal employee universe, but also to all citizens.

I can assure this subcommittee that we and the insurance carriers that participate in the Federal employees health benefits program are very much concerned about the skyrocketing cost of providing health benefits protection. However, premiums must be sufficient to pay for the benefits provided, and the Commission must approve rate increases when it becomes necessary to do so in order to maintain the sound financial positions of the plans. The primary reasons for premium rate increases are the rising costs of hospital and medical care, and the increased use by employees, annuitants, and their family members of the services and facilities covered by their health benefits plans.

Neither the Civil Service Commission nor the carriers of health benefits plans under our program can effectively stop the spiraling costs of medical care. Solutions to the problems that beset the delivery and cost of medical care today can, in my opinion, be found only through new initiatives on the part of all parties concerned, including medical schools, physicians, institutional providers, the health insurance industry, government, and the public. In this connection, I would

like to quote briefly from a report to the Secretary of Health, Education, and Welfare by a distinguished task force, headed by Walter J. McNerney, that Secretary Finch appointed last July to study medic-aid and related problems. In transmitting some interim recommendations of the task force on November 12, 1969, Mr. McNerney said:

Our basic findings concerning the present health system are (1) it has serious organizational, financing, productivity and access problems, and (2) bolder moves than have characterized the last five years are required to achieve measurable improvement.

As is evident from this recent report and many news articles the Department of Health, Education, and Welfare, as well as private organizations, including insurance carriers, have been studying this problem and supporting programs intended to make delivery of health care more efficient and to lessen the rate of increases in the cost of such care.

I would now like to comment on H.R. 767 and similar bills. My recent letter to Chairman Dulski explains our position. If you agree, Mr. Chairman, I suggest that the letter be incorporated in the record at this point.

Mr. DANIELS. Without objection, the letter will be printed in the record at this point.

(The letter follows:)

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., March 17, 1970.

HON. THADDEUS J. DULSKI,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This report on H.R. 767, a bill "to amend chapter 89 of title 5, United States Code, relating to enrollment charges for Federal employees' health benefits", is in response to your request of February 4, 1970 for our current views on this bill. This report applies also to numerous other identical or similar bills which, if enacted, would increase the Government's contribution (ranging from 50% to 100% of enrollment charges) for Federal employees health benefits.

One of the bills, H.R. 10593, differs markedly from the others in that it would fix the Government's contribution at an amount equal to the entire cost of a certain specified minimum set of health benefits which all plans and options would provide. Presumably, the cost of the specified benefits and the Government's contribution would be redetermined from time to time, perhaps annually, but the bill is not clear on this point.

The minimum health benefits specified in the bill are—

- (1) Up to 180 days of hospitalization for each confinement;
- (2) Surgical benefits as outlined in a set schedule of fees with a maximum of \$500 for any one confinement;
- (3) Reimbursement for medical visits at \$10 per hospital visit, \$8 per home visit, and \$6 per office visit;
- (4) Diagnostic services as provided in a set schedule of fees;
- (5) First-aid treatment in full within 72 hours after an accident;
- (6) Regular hospital benefits for maternity plus up to \$200 for doctor's charges;
- (7) Nursing care up to \$20 per eight-hour shift for up to 180 days a calendar year;
- (8) Mental and nervous disorders for up to 30 days per calendar year;
- (9) Alcoholism and drug addiction for up to 30 days per calendar year; and
- (10) Dental and cosmetic surgery only when necessary for prompt repair of injury caused by an accident.

This minimum set of benefits is so drawn as to make it extremely difficult to ascertain with precision what it would cost. For example, the term "confine-

ment" in item (1) is not defined, the "set schedule of fees" in items (2) and (4) is not specified, and there is no indication as to whether the 30-day limitations in items (8) and (9) apply to hospital benefits only or to all benefits. Also the precise cost of this (or any other) set of benefits, which would have to be ascertained in order to fix the amount of the Government's contribution, depends on numerous variable factors, including, but not limited to, the age, sex, geographic distribution, and average family size of enrollees in a particular plan and the operating expenses of a particular carrier. Therefore, the cost of the same set of benefits would differ from one plan to another.

We asked the carriers of the two Government-wide plans to price the minimum set of benefits specified in H.R. 10593 and we did so ourselves. The best cost estimates, arrived at independently of one another, for these benefits, including 4 percent set-aside for reserves provided for by 5 U.S.C. 8909(b), are:

	Biweekly cost	
	Self only	Family
Civil Service Commission.....	\$6.58	\$20.13
Carrier A.....	6.93	20.31
Carrier B.....	8.23	20.92

We make two observations about these figures:

First, the \$8.23 is only \$.13 less than the total current cost of a self-only enrollment in the most expensive option offered by the Government-wide plans, which is \$8.36; the \$20.92 is \$.18 more than the total current cost of a self and family enrollment in the most expensive option offered by the Government-wide plans, which is \$20.74. Government contributions on the order of magnitude shown in the above table would exceed the total current cost of many other less expensive plans and options, as it does (by \$.18) for the self and family enrollment just cited.

Second, Government contributions on the order of magnitude shown in the above table are substantially greater than the current biweekly Government contributions of \$1.68 and \$4.10 toward a self-only and self and family enrollment, respectively. The annual cost to the Government under H.R. 10593 would skyrocket from the current \$231.6 million to well over \$1 billion.

For the reasons indicated, the Commission concludes that gearing the Government's contribution to the cost of a specified set of minimum benefits is impracticable and that the expense to the Government of a contribution so determined, based on the benefits specified in H.R. 10593, is prohibitive.

H.R. 767 would amend the health benefits law to provide that the Government eventually pay the total premium for all employees and annuitants enrolled in the various plans and options authorized under the law (including the one percent set-aside for administrative expenses, and the three percent set-aside for the contingency reserve). The bill proposes that the Government contribution to premiums be initially increased to 50 percent in July, 1969; to 75 percent in July, 1970; and finally to 100 percent in July, 1971. Employees on approved leave without pay to serve as full time officers or employees of an employee organization who elect to continue their enrollments would continue to pay the full cost of such enrollments. To update the bill, the years 1969, 1970 and 1971 should be changed to 1970, 1971 and 1972, respectively.

When originally enacted in 1959, the health benefits law provided for a Government contribution which would be set by the Civil Service Commission within a specified range at not more than 50 percent of the least expensive low option offered by the two Government-wide plans. The Government contribution was thus geared to paying one-half the premium for a package of benefits which, while moderate in cost, would be adequate for the needs of most employees; if an employee wanted more protection through the richer high-option benefits, he had to pay the additional cost. The initial distribution of enrollments between self-only and family coverage, between high and low options, and among the various plans resulted in the Government's contributing approximately 38 percent of the total premium for all enrollments, with employees and annuitants contributing the remainder.

As time went on, this 38 percent Government share of the total premium gradually diminished for two main reasons: (1) employees gravitated toward

the more expensive high options; and, (2) high-option premiums increased because the cost of medical care increased, because needed improvements in benefits were made, and because of the relatively high morbidity experience of persons who selected high options. In contrast, experience of the low options was very good because there was a strong tendency for healthy employees with healthy families to choose this less expensive coverage. Low-option premium rates therefore remained stable and the Government contribution, which was geared to these rates, could not be increased to reflect the increasing cost of medical care.

By 1966, the Government's share of the cost of health benefits was down from 38 percent to less than 30 percent of the total premium. Public Law 89-504, approved July 18, 1966, eliminated the tie-in of the Government contribution to the low option premium and increased the amount of this biweekly contribution from \$1.30 to \$1.68 for a self-only enrollment, and from \$3.12 to \$4.10 for a family enrollment. This had the effect of restoring the Government contribution to its initial 1960 level of 38 percent of total premium. Premium increases primarily for high options in January 1967, 1968, 1969 and 1970 have again diminished the Government contribution to approximately 24 percent of total premium. Stated in terms of dollars, the Government will contribute \$231.6 million during calendar year 1970 and employees will contribute \$726.4 million.

The Commission regards payment of total premium by the Government as economically unsound because of the multiplicity of plans which participate in the Federal employee program. There are 38 plans offering 54 options. Total biweekly premiums for a family enrollment range from \$7.48 to \$24.85, and for a self-only enrollment from \$3.08 to \$9.74. The level of benefits provided by each plan and option is commensurate with the premium. All employees have a choice of at least seven plans; some, depending on where they are located, as many as ten. This free choice feature of the program stimulates the keenest kind of competition among the plans to provide the best benefits for the least amount of premiums. It also provides a strong incentive for plans to keep their administrative expenses, which are charged against premiums, at a minimum. Equally important, it gives the employee an opportunity to select the level of benefits and premium expenditure he considers best suited to his own particular needs.

If the Government were to pay the total premium, employees would naturally choose the more expensive plans and options that provide the richest benefits. The only way plans could compete would be in the amount and kind of benefits they provided. Every plan would increase benefits until ultimately every plan would be covering 100 percent of all medical expenses and exploring possibilities of expanding coverage to include other types of related expenses (for example, \$100 a week while confined in a hospital or payment for a housekeeper after maternity). Insurance carriers would have little or no incentive for efficient or economical operation of their plans. The only way the cost to the Government could be controlled would be to have only one plan and prescribe by law precisely what benefits it would provide, as was done with Medicare for the Aged under Social Security.

During recent years, costs of hospital and other medical care have been rising considerably faster than the prices of other consumer goods and services and from all indications they will continue to do so. Plans under the program now have built-in features that help control these costs because the carriers realize that they must keep their premiums as low as possible to compete with other plans. Many plans pay benefits on a reasonable and customary charge or a fee schedule basis, which tends to keep charges of purveyors of medical services down. The fact that the employee himself may have to assume some of the cost through deductibles and coinsurance deters over-utilization of medical care. All plans exclude from benefits certain highly elective treatment or supplies (e.g. cosmetic surgery, nonprescription drugs) which helps keep their benefit costs and, consequently, their premiums down.

Now being explored are other methods, such as insurance coverage of convalescent hospitals, of slowing the increase in hospital and medical costs. Elimination of all inducement for insurance carriers to keep their premiums competitive by having the Government pay the full premium would negate these attempts to control costs, as well as existing controls, and materially accelerate the increases in medical care costs.

On the basis of present enrollment figures and premiums, the additional cost to Government if H.R. 767 is enacted would be \$266.6 million in fiscal year 1971, \$496.5 million in fiscal year 1972, and \$726.4 million in fiscal year 1973, the first twelve months for which Government pays they full premium. If enacted, that

cost will increase substantially as employees and annuitants, because it costs them nothing, change to more expensive options, as plans compete to provide richer benefits, as controls against high charges and over-utilization disappear, and as medical costs rise.

H.R. 767 would require the Government to assume (in 1972) the full payment of employees' contributions without reference or orientation to other fringe benefits and salary. The fringe benefits expenditures by Government and industry are already roughly comparable, and the Government is committed to a policy of achieving full salary comparability with private industry.

Assumption by the Government of the total cost of health insurance, as proposed by H.R. 767 and similar bills, would distort the existing comparability of total compensation. Such action would also be excessively costly and inconsistent with the Administration's efforts to reduce public expenditures.

For the reasons indicated above, the Commission strongly objects to the enactment of H.R. 767 and similar bills.

The Commission appreciates that the sharply rising costs of medical care and consequently of that portion of health benefit premiums not paid by the Government has resulted in less take-home pay for employees and annuitants. If the Committee agrees that relief in this respect should be granted, the Commission would like to offer for your consideration an alternative automatic adjustment plan which we believe would provide substantial relief and would maintain the integrity of the program. Essentially, our plan proposes annual automatic adjustments, beginning the first pay period in January 1971, to fix the Government contribution at 38% of the unweighted average high-option subscription charge of the two Government-wide plans (Blue Cross/Blue Shield and Aetna), the two largest employee-organization plans (National Association of Letter Carriers and United Federation of Postal Clerks), and the two largest of the group-practice or individual-practice plans (Kaiser Health Plan of Northern California and Kaiser Health Plan of Southern California), with the maximum contribution not to exceed 50% of premium. Collectively, the high and low options of these six plans cover about 90% of all participating employees.

The effective date of January 1971 would be in keeping with the President's objective "to control and contain the inflationary spiral," as reflected in his recommendation of a January 1971 effective date for Federal employee pay raises. It is also consistent with the calendar year basis on which our contracts with health-plan carriers are negotiated.

To illustrate, at present premium rates, this proposed adjustment plan would produce a biweekly Government contribution, beginning January 1971, for self only of \$2.72 (\$2.62 plus 4% overlay), as compared to \$1.68; the biweekly Government contribution for self and family would be \$6.96 (\$6.69 plus 4% overlay), as compared to \$4.10. Also, at present premium rates, adoption of this proposal would increase Government costs by \$137.7 million for the first full year. Beginning next January, though, premiums will probably be increased, the average for the six plans would be recomputed, and the Government's contribution would be adjusted to 38 percent of the new average, which would increase Government costs above the \$137.7 million. If we assume a 12% increase in health benefit premiums in January, 1971, enactment of our proposal would increase the Government's contribution for the fiscal year 1971 by about \$91 million.

For nearly all employees this proposal would decrease their health insurance contribution and increase their take-home pay. The use of the cited six plans as a basis of determining Government contribution provides a base which promises to be representative of trends in health insurance costs and, in addition, provides a substantial Government contribution which we believe is justifiable.

The Commission has drafted legislation to effect the above proposal.

The Bureau of the Budget advises that if the proposed legislation is amended as suggested its enactment would be consistent with the objectives of the Administration.

By direction of the Commission:

Sincerely yours,

ROBERT E. HAMPTON,
Chairman.

Mr. HAMPTON. H.R. 767, if enacted, would change the basis for establishing the amount of the Government contribution. The amount of the contribution is now set by law at a specific dollars-and-cents

figure, with the proviso that in no event may the contribution be more than one-half the premium.

H.R. 767 would eliminate the dollar amounts and express the contribution in terms of gradually increasing percentages of total premium costs until the Government, beginning July 1, 1972, pays the total premium for all employees and annuitants. This would result in a fourfold increase in the Government contribution from about \$232 million at present to about a billion dollars a year by July 1, 1972.

If H.R. 767 were enacted, this estimate can be expected to increase substantially, over and above the natural increases attributable to rising health-care costs, as employees and annuitants, because it costs them nothing, change to more expensive options, and as plans compete to provide ever richer benefits. The Civil Service Commission, therefore, cannot agree to the proposal in H.R. 767, which would require the Government to assume the full payment of premiums.

We all agree, I am sure, that an increase in the Government contribution is justifiable. Improvements in benefits, and more importantly, a steady increase in the cost of medical care, have driven up health benefits premiums each year since the Government's contribution was last adjusted in 1966. In the absence of an increase in the Government contribution, recent premiums increases have been paid entirely by employees and annuitants.

In the present situation, additional increases in health insurance premiums appear to be inevitable, and we believe that the Government should share the financial burden of these increases.

We have developed a method for automatically determining and adjusting the Government's contribution to premiums which I want to propose to the committee. We believe this method to be equitable to both employees and the Government.

The Government's share of the cost of health benefits has never been more than 38 percent of total premium, which includes both high-option premiums and less expensive low-option premiums. Our proposal is somewhat more generous in that it will peg the Government's contribution to the more expensive high-option premiums. The proposal has other advantages: it provides for automatic adjustments each year and it uses a premium base which is representative of the different kinds of health benefits plans that participate in the Federal Employees health benefits program. Our proposal is that each year we take the unweighted average of the premiums charged for the high options of the two largest plans in each category. This would include the two high options of both Government-wide plans, the National Association of Letter Carriers and the United Federation of Postal Clerks plans in the employee-organization plan category, and two Kaiser Foundation health plans in the comprehensive medical plan category. The Government's contribution for all employees would be fixed at 38 percent of this high-option average, except that the Government contribution could not exceed 50 percent of his premium for an employee enrolled in a low-cost plan.

If the committee adopts this proposal we should implement it beginning the first pay period in January 1971. This coincides with the beginning of the next contract year. Succeeding adjustments would be made at the beginning of each new contract year, effective the first pay period beginning each January. We prefer the adjustment in the

Government's contribution to be on a calendar year basis because that is the way our health benefits contracts run, and that is when premiums are changed. Just to illustrate how this proposal would work, if we applied it to 1970 premiums, the biweekly Government contribution for family enrollments would increase from \$4.10 to \$6.96 and for self-only enrollment from \$1.68 to \$2.72. The cost to the Government at current premium rates would be increased by \$11.5 million a month, or \$138 million a year more than the present contribution of \$232 million.

If we assume a 12-percent increase in health benefits premiums at the beginning of January, 1971, the present Government contribution of \$232 million will be increased by \$182 million for the calendar year 1971, or by \$91 million for the fiscal year which ends June 30, 1971. We believe this method is equitable to employees and the Government. We hope the committee will adopt it.

Mr. Ruddock and I will be happy to answer any questions you may have.

Mr. BRASCO. Mr. Chairman, will you kindly yield?

Mr. DANIELS. Yes, Mr. Brasco.

Mr. BRASCO. Mr. Chairman, Mr. Hampton, and Mr. Ruddock, I don't have any questions at this point. I just wanted to very briefly welcome you here and thank you for your statement. While we may not agree on how much the Government should contribute, at least we have a general agreement that the Government must contribute more than it is contributing now.

I want to apologize because I have to leave to go over to the Democratic caucus. We are considering some important matters there and I am part of their program, so to speak. So if you will forgive me, I must run.

Mr. DANIELS. Thank you, Mr. Brasco.

Chairman Hampton, permit me to commend you for your very brief but direct approach to the issue involved before us today.

I would like, however, to summarize your views, and I would like to ask you if my summary is correct.

You say (1) that the Civil Service Commission is seriously concerned with skyrocketing medical costs and the incessant premium increases required to meet these costs; (2) that the Commission, in administering the Federal employees program, can do little to stop the skyrocketing costs; (3) that you do not embrace the ideas proposed in the bill I introduced, H.R. 767; and (4) that you offer some measure of relieving employees and annuitants from the unfair burden of bearing the lion's share of the premium costs.

Although I would have welcomed a more generous offer on your part in support of my bill, I do want to compliment you for your brevity and for the candidness with which you have responded.

There are, of course, a number of areas that I feel must be explored during these deliberations, which are relevant to the larger problems. I am sure that the other members of the subcommittee have many questions to propound to you and to Mr. Ruddock.

Before proceeding to a discussion of some of the points presented in your prepared statement, there are several related points that I desire to pursue.

Are not the two Federal programs with which this subcommittee

and your Commission are mutually concerned, in essence, funding mechanisms, more so than purveyors of health care services—particularly in view of the 40 or more plans offered under both programs.

Mr. HAMPTON. Well, that is true. We administer the programs, rather than actually provide the services. That, of course, is the doctors and the hospitals. It is the contractor that we deal with mainly in administering the program.

Mr. DANIELS. In essence, it is a funding mechanism that you review, is that correct?

Mr. RUDDOCK. Could I just add to that? I believe the position of the Commission with respect to both the Federal employees' health benefits program and the retired employees' health benefits program is one of acting as a large employer. We contract with the insurers. The health services themselves are obtained, by and large, from the normal purveyors of health services. None of them come from the Civil Service Commission and, except in the case of the group practice and individual practice plans, they don't come from the insurance carriers. So normally they are just coming out of the general availability of those services in the public arena.

Mr. DANIELS. Fine.

Now, in the Federal employee program there are currently two Government-wide plans, 15 employee organization plans, and 21 prepayment group practice plans—a number offering two levels of benefits. Over the years, there has been some advocacy of reducing the multiplicity of plans or the creation of one plan only—to be administered by the Civil Service Commission—somewhat similar to the overall retirement or life insurance programs.

Would you give us the benefit of your views on such a suggestion or any of your other thinking as to whether, in view of your experience during the past decade, there may be a better way of doing the job?

Mr. HAMPTON. I have thought about it a number of times. There are advantages to having a number of different plans. One, there is a certain amount of competition among the carriers in terms of providing benefits at lower costs. This is a healthy situation because it does have the tendency to give us more benefits for less cost.

Second, there are a variety of different interests among people as to the types of benefits that they are interested in from their own family situation. I think this allows them to shop around and to pick and choose, which I think is a good thing. It also tends to keep the total cost down.

Mr. DANIELS. In other words, you do favor then the 38 plans that are in existence, some offering high options and others having two options—a low option and a high option as well? Do you say it supports the spirit of competitiveness among the various plans, is that correct?

Mr. HAMPTON. Yes, sir. And I think it also gives the employee a choice. The employee organizations that have their own plans take quite a bit of pride in offering this particular service to their members. I think it's important that they can do this.

We have kicked around the idea of the Government being self-insured and contributing for services under a scheduled plan of benefits. I am not sure that this would really meet the need. It sounds good. Maybe Mr. Ruddock has some further comments on that.

Mr. RUDDOCK. Just one little bit of perspective.

Let me say first of all that I don't think we need any more plans. On the other hand, I agree with the chairman completely, that the competition among the existing plans is a healthy thing. And, while we perhaps don't need 38 plans to provide that competition, I wouldn't know where to begin to reduce the number.

In the earlier years we were somewhat concerned that dealing with a multiplicity of plans would create high administrative costs in the Civil Service Commission. But if we put that in perspective, out of total premiums of almost a billion dollars a year, the Commission's administrative expense is just about \$1.5 million, which, expressed as a percentage of premium, is $15/100$ of 1 percent.

So even if we were to eliminate the total administrative expense of the Commission, we really wouldn't be having any noticeable impact on the premium of this program.

Mr. DANIELS. You anticipated my next question, which would go to the question of cost.

How much of the average premium dollar goes to the payment of administrative costs, taxes, profits, risk charges, and so forth, and how much is going toward the payment of actual benefits?

Mr. RUDDOCK. About 95 cents out of each dollar actually goes to health benefits. The administrative expenses of the carriers, the taxes which they are required to pay, and the risk charge—which is a profit item in those which are organized for profit—totals just about 5 percent. So that 95 cents out of each dollar is available for benefits.

Mr. DANIELS. If the Congress were to enact legislation, as has been proposed, to exempt premium charges under these programs from taxation by the States, would such savings significantly reduce premium charges and/or provide significantly greater benefits?

Mr. HAMPTON. We took a look at that when we were getting our comments on that particular legislation, and it would be most insignificant in terms of the reduction in premiums and overall cost. Mr. Ruddock may have some further figures. We didn't have any firm figures at that time. It was a few cents, wasn't it?

Mr. RUDDOCK. I think the total tax would only run about \$5 million for the total program. So that we are talking about no more than a few cents in premium.

Mr. DANIELS. Well, what prompted me to ask that question was that last year I introduced a bill to afford some measure of relief to NALC, which had a serious tax problem in the State of Wisconsin. I think the tax imposed on NALC's program in that State came to over \$300,000. I don't know what the outcome of that case has been, do you, Chairman Hampton?

Mr. HAMPTON. Andy may know. I think there were some penalties involved there.

Mr. RUDDOCK. The amount which they paid, I believe, Mr. Chairman, was a result of the fact that the tax had not been paid over a period of years and also included penalties. It's my understanding they have paid that under protest and now have a suit pending, seeking to get it back.

Mr. DANIELS. In other words, no conclusive action has been taken by the courts on that suit?

Mr. RUDDOCK. I don't believe so. If a decision has been reached, I am not aware of it.

Mr. DANIELS. Mr. Chairman, you touched briefly upon the primary reasons for rising premiums being the result of rising costs of health care and increased utilization of services and facilities. Would you kindly expand in some detail upon the various factors that influence those increased costs?

Mr. HAMPTON. Do you have any charts with you?

Mr. RUDDOCK. I don't have any neat chart that has all of those figures on one page. The cost of health care services, as we all know, has been rising faster than the consumer price index generally.

In addition, there has been a much bigger increase in the cost of hospital care than there has in some of the other health services. While increasing cost of health services is the biggest reason for increase in premium, we also have the factor that not only Federal employees but all of us in this country are using more health services than we used to. We go to the doctor more frequently. We go to the hospital more frequently. I'm certain that we are receiving better care than was available a generation ago.

Mr. DANIELS. Have you noticed any appreciable increase in the use of the programs since the enactment of the medicare program in 1966?

Mr. RUDDOCK. Yes, sir. The biggest increases in the costs of health care, I believe, have occurred within that period. Whether that is a matter of cause and effect or whether that is a situation where the increases would have occurred without enactment of medicare and medicaid, I do not know.

Mr. DANIELS. Do you think there is a greater concern today upon the part of the people about health care and, due to the fact that they do have coverage, they are taking greater advantage of it?

Mr. RUDDOCK. Yes, sir.

Mr. HAMPTON. It's educational and preventive medicine, I think. One of the things in that period is that medicare came in. What was going on in the hospital structure was that for many, many years food service workers, nurses, and people doing unskilled types of work in the hospital were way behind the general labor market in their salaries. In some of these areas where the costs of hospital care have reflected considerable changes, we have noticed that, in terms of dealing with nurses and people in our own establishment—where we pay a comparable wage—these costs have gone up to reflect a catch-up in the medical area.

Mr. DANIELS. If you know, to what extent would you say that these programs are being overutilized?

Mr. HAMPTON. I wouldn't say that they are being overutilized, Mr. Chairman. I think it's a question of people just being more concerned about their health, and when they have benefits that they pay for, they are going to use them. I think this is more it. I wouldn't think there was any overutilization.

Mr. DANIELS. Wouldn't you say then, if I understand you correctly, that there is a higher utilization of health services rather than an overutilization?

Mr. HAMPTON. I would say it would be more higher utilization than a question of overutilization. We will have some overutilization, but I think there will probably be isolated cases more than the average.

Mr. DANIELS. The Federal employees' health benefits law stipulates that premiums for the two Government-wide plans be determined

on a basis which your Commission judges to be consistent with the lowest schedule of rates generally charged for new group plans issued to large employers. Tell us the mechanics by which your office makes such determinations.

Mr. RUDDOCK. Yes, sir. We started that way, Mr. Daniels, with the two Government-wide carriers making an offer of a benefit structure and suggesting a premium. Since that time, each of them has been adjusted to reflect the actual cost experience of the plan. Now, each year, when we ask the carriers for their suggestions about contract changes and about premiums, they come in, they project their current experience, and they project and estimate the premium which is required to maintain financial soundness. The Commission reviews that. We also make our own projections.

Then the rate is fixed on a basis which we and the carriers agree will maintain financial soundness. If it should happen that we estimate too high a premium, this is only a temporary condition because any part of premium not used in benefits, taxes, administrative expenses, and the very small risk charges that are allowed, becomes a reserve set aside for that particular plan. It can't be used for any other purpose and would have the effect of keeping down the premium for the succeeding year.

Mr. SCOTT. Mr. Chairman, might I interject at this point?

Mr. DANIELS. Mr. Scott, the gentleman from Virginia.

Mr. SCOTT. We are talking about the various systems that we have resulting in competition between the carriers. How does that work in what you're saying now? I haven't heard anything about playing one company against another.

Mr. RUDDOCK. The competition would come about because each of the carriers is interested in developing a plan structure which is attractive to employees, and of maintaining a premium which, to the maximum extent possible, is attractive to employees. In the Government-wide Service Benefit Plan, for example, we have negotiated the kind of provision which will cover laboratory services performed outside the hospital as well as inside.

Now, this is a change from 10 or 15 years ago. This means that if laboratory services are needed there is no necessity to hospitalize the patient in order to have his health plan pay for it. So both we and the carriers are always looking for the kinds of provisions that will keep down the costs, rather than just let them run away.

Mr. SCOTT. What I'm getting at is do you have this same process with regard to each of the carriers, or is it a collective arrangement?

Mr. RUDDOCK. There is separate experience rating for each of the plans, with the exception of the group practice prepayment plans.

Mr. SCOTT. If one carrier wanted to get a higher percentage of the business from the Government, of the higher percentage of Government contracts, he could offer a plan that was more palatable to the employee.

Mr. RUDDOCK. Yes, sir.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. DANIELS. What percentage of the total enrollments are in the service benefit plan, the indemnity plan, the employee organization plans, and of prepayment group plans? Have you noted any drift toward the prepayment plans over the past decade?

Mr. RUDDOCK. Let me see if I can answer those in sequence.

Mr. DANIELS. I know I gave you a number of questions in one there. Suppose we start all over.

What percentage of the total enrollments are in high option plans?

Mr. RUDDOCK. Before I answer, Mr. Chairman, may I have the permission of the Chair to answer these from memory, with the assurance that they will be approximately correct and then correct the final figures in the record?

Mr. DANIELS. If you cannot give us the correct figures, I would suggest that you supplement your statement with a written report later on. This record will be open.

Mr. RUDDOCK. All right.

Mr. DANIELS. But if you have some idea what it is, we would like to hear it now.

Mr. RUDDOCK. All right. Between 85 and 90 percent of all enrolled employees are in high option.

Mr. DANIELS. Between 85 and 90 percent of all employee and retirees are in high options?

Mr. RUDDOCK. Yes, sir. The high options are by far more attractive than the low options. We started in 1960 with about 80 percent of all enrolled employees in high options and the drift has been toward the high options since then.

Between 55 and 60 percent of all employees are enrolled in the Government-wide service benefit plan. Between 20 and 25 percent are in the Government-wide indemnity benefit plan.

As I remember, we have about 15 percent in the employee organization plans and about 10 percent in the so-called comprehensive, the group practice and the individual practice group payment plans.

(The following figures were supplied for the record, all as of December 31, 1969:)

	Percent
High option.....	84.0
Government-wide service benefit plan.....	58.3
Government-wide indemnity benefit plan.....	21.3
Employee Organization plans.....	14.1
Group practice plans.....	4.7
Individual practice plans.....	1.6

Mr. DANIELS. Now the last part of that question.

Mr. HENDERSON. Could I ask a question right at that point, Mr. Chairman?

Mr. DANIELS. Yes, Mr. Henderson.

Mr. HENDERSON. I got the impression that the Government employees, speaking very generally are received by their doctor or their hospitals where they are admitted, on the basis that if they are Government employees they have good health benefit protection.

Would you comment on that?

Mr. RUDDOCK. I think it is generally accepted that the plans offered under the Federal employees benefits program tend to be quite comprehensive in their coverage. Most of the hospitals in the country will accept the registration card, the membership card, if you will, of a Federal employee as assurance that there are resources which will cover the hospital costs.

Mr. HENDERSON. Would you say that the drift toward the high option has contributed to this?

Mr. RUDDOCK. To the acceptance of these plans as being generally comprehensive?

Mr. HENDERSON. Yes.

Mr. RUDDOCK. Yes, sir.

Mr. HENDERSON. In the light of the high percentages that are in the plans that you mentioned, do we have any plans out of the numerous ones in effect that are not well-received, to your knowledge, by the medical profession or the hospitals?

Mr. RUDDOCK. No, sir; I don't know of any that are not well-received.

Mr. HENDERSON. Thank you, Mr. Chairman.

Mr. DANIELS. The last part of my initial question was, have you noticed any drift toward the prepayment plans—that is the clinical practices—over the past decade?

Mr. RUDDOCK. There has been an increase over the past 10 years in employees enrolled in group practice prepayment plans. I think that is for two reasons. One, there are more of them now than there were 10 years ago and, secondly, where they are operating in a community and where they enjoy a good reputation in that community they do tend to attract Federal employees, particularly those with large families, because the plan provides in most instances almost total care, actually in the facilities of the plan.

Mr. HAMPTON. I think it's a very innovative approach for some of these new plans, in that where there is a concentration of people they can offer almost complete coverage. I think this is one thing that may be growing, depending upon the nature of your community and how your population is distributed.

But it may be a move in that direction in terms of the delivery of health services, and it may be a growing thing that we will have to watch. Because it may be one method of getting at the reduction in the overall cost where they do have these preschedules, or so much for each office visit, so much for certain types of shots, so much for home visits, and things like that. And in these prepayment plans, that looks awfully attractive to them.

Mr. DANIELS. Your consulting actuaries, in their latest analysis, took note of the fact that both Government-wide plans are "aging"; that is, that about 14 percent of the total enrollment in those plans consist of annuitants. What impact is this "aging" having upon the program and its costs?

Mr. RUDDOCK. It's very definitely having an effect. The health care costs for people in the age group of annuitants tend to be roughly two and a half times the health care costs of younger people. This means that as you have more annuitants in a plan you have more people who are using health care at a greater rate than the younger employees.

So there is an element of the premium of the younger employees subsidizing the older employees, and particularly the annuitants. And as we go on, of course, we will have larger and larger numbers of annuitants in each plan.

Mr. DANIELS. Mr. Scott is recognized.

Mr. SCOTT. Mr. Chairman, in that connection, do the older annuitants generally have the family plan, or is it self-only? Or do you have any knowledge or any figures on that?

Mr. RUDDOCK. Almost all of those who are married have the family plan.

Mr. SCOTT. My thought is this: Has any consideration been given to having only the employee and the spouse without the children? It would seem to me that would counter what you are saying about the older people being sick more or having the need for the services. They don't have any children in their older years, and it is either the self-only or the self and spouse. Does that counteract what you have just been saying about the increased need for hospital care?

Mr. RUDDOCK. Only partly. I believe the cost of the two-person family—where they are older—will exceed the average experience of the younger family including children.

Mr. SCOTT. I see.

Mr. DANIELS. Do you feel that the deductible and coinsurance features of our plans are really effective, or have any effect upon the charges being made by doctors and others who are retained by the insured?

Mr. HAMPTON. Meaning the deductibles in the indemnity plan?

Mr. DANIELS. Yes; or any plans having deductibles or corridors.

Mr. HAMPTON. I am not sure that it has any real effect on the charges that are made by physicians. I haven't seen any evidence to that effect. Most physicians' charges are based upon community situations. I don't know how doctors arrive at their charges. You might know more about that, Andy.

Mr. DANIELS. Would it have any effect upon the utilization of the services?

Mr. RUDDOCK. I think it has some, but we don't have any precise way of measuring it. For example, the fact that the employee is going to have to pay the first part of the costs would mean that he wouldn't run out willy-nilly and incur a \$10 bill or a \$20 bill unless it was necessary. Actually, I don't think the deductibles have too much effect because I think, by and large, people are getting care when they need it. When you need medical care and you're working and have a salary, you're going to get that care whether your plan pays for it or whether you are going to have to pay for it out of your own pocket. A deductible should have a tendency to deter unnecessary utilization, but I don't think we have too much of that.

Mr. HAMPTON. Actually, the Blues, which has 55 to 60 percent of the people, also uses a deductible schedule for visits to physicians like the indemnity plan, which has about 20 to 25 percent of the people. I think it's a question of people going to a plan that they feel most fits their particular needs. Some people who are probably in good health, or feel that they are, are attracted to a plan where office visits are covered only after you meet the deductible.

But I haven't, from my experience and my conversations, seen anything where a deductible has affected the use or the rate that is charged by the physician.

Mr. DANIELS. Thank you.

Mr. Chairman, I have often heard the argument—and undoubtedly those arguments will be made in the course of this hearing—that large employers in major industries either provide cost-free health insurance to their employees, or pay 50 percent or more of the costs of their plans. Has the Commission been able to determine whether the benefits offered in those industry plans compare favorably with the Federal plan?

Mr. HAMPTON. There is quite a variable there. Some years back some private employers would pay 100 percent of the premium, or a higher percentage than we are paying. But this was for only the employee himself, in many cases. He had to pay for coverage for his family.

We have noticed a trend—I don't know, but Mr. Ruddock may have some firmer figures—that some employers now are beginning to pick up the full cost of the health benefits for their employees and are covering the families.

So there is a move in industry to do more in this area than we are presently doing.

In response to this, our feeling about health benefits is really not governed solely by the idea of a comparison of just one of the fringe benefits but in terms of the total package—how do we really compare totally.

If you look at the total situation on what are commonly referred to as fringes—that is your health benefits, life insurance, retirement, leave structure, and things like that—we are very competitive with industry. The figures that we had in 1966, comparing 1967 and 1966, indicated that we were about seven-tenths of a percentage point overall behind the total in industry.

Since that time, there are changes which indicate to us that we are pretty much nip and tuck with industry. While they may have greater benefits in one area, we have greater benefits in others. But there is pretty much, in the total package, a good relationship.

Mr. DANIELS. Do the major industry plans provide major medical insurance protection over and above basic coverage?

Mr. RUDDOCK. Yes.

Mr. HAMPTON. More and more they are doing that. More and more the plan of the larger employer in private industry compares very favorably with the benefit structures offered in our plans.

Mr. DANIELS. Where private industry pays the total cost, are they providing a \$35 per month plan or a \$15 per month plan?

Mr. RUDDOCK. Now closer to the \$35 plan. As one example of that, the Tennessee Valley Authority, for its trades and labor employees, where it's a negotiated benefit, is now contributing over \$24 per month which is almost 90 percent of the total premium. The TVA operates generally in an area of the country where health care costs tend to be a little lower than they are countrywide. So I would say that plan compares very favorably with our coverage.

Mr. DANIELS. Do the private industry plans continue after retirement?

Mr. RUDDOCK. They are mixed on that. Some do and some don't.

Mr. DANIELS. Mr. Henderson.

Mr. HENDERSON. On the point that Chairman Hampton made, how would you say that the Government's cost sharing would compare with prevailing practices of major employers in private industry after we adopted your proposal presented this morning?

Mr. HAMPTON. I would say that—

Mr. HENDERSON. You would be more favorable.

Mr. HAMPTON. We would be more favorable in total fringe benefits and our figures, as I say, are 1966 figures. If we were to apply recent changes in retirement and this particular package to those figures, we

would be better off by a few tenths of a percentage point. But if we were to gather new statistics from industry, we may find too that they haven't been standing still. So it would be difficult. It's just an impression.

Mr. HENDERSON. I would like to ask Mr. Ruddock if you could make available to us the coverage of specific industries? I raise this question because I recall that because of testimony in the other body, in which one of our major industries was cited as paying the full cost, there was a question about whether this was factually correct. Could you tell us, for example, how General Motors or Westinghouse or others' plans compare with the Government coverage?

Mr. RUDDOCK. We will supply that in more detail for the record. (See p. 34 for material furnished.)

Mr. RUDDOCK. But, by and large, they do compare favorably now with the plans we offer. That was not true some years ago.

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

Mr. DANIELS. Mr. Ruddock, you mentioned the fact that an analysis was made by the Bureau of Labor Statistics in 1966. Is that the latest comprehensive analysis? Or is there a later one, a more up-to-date one?

Mr. RUDDOCK. That is the latest study on that subject; yes, sir.

Mr. HAMPTON. I think it would be a good idea though if we could persuade the Bureau of Labor Statistics that we ought to really run a new survey.

Mr. DANIELS. I think it might be worthwhile. We may learn something from it.

Mr. HAMPTON. We will request that and see. It may be in the process.

Mr. DANIELS. Is there any truth to the report that information and experience of this program is looked at by the private insurers in order to gain some knowledge as to the premiums they were charged for non-Government programs?

Mr. HAMPTON. I think they would very definitely take a close look at everything we do in terms of benefit structures and rates. I'm not sure how much influence it has had on them, but as Mr. Ruddock says, they are moving closer to us in terms of benefits, whereas before they were offering less benefits but covering more of the costs. But Mr. Ruddock may have some specifics on that from his experience.

Mr. RUDDOCK. I think, just as we looked to what other employers and State and municipal governments were doing before we embarked on this program back in 1959, that some employers now going into the area of health benefits for employees will tend to look at everything that is available, including what we have.

But so far as premiums are concerned, while they might use ours as a guide going in, their premiums in the future would have to be determined by their own experience.

Mr. DANIELS. In attempting to place a finger upon some of the factors contributing to higher medical and hospital costs, shouldn't the role of physicians be recognized as the possible key to controlling a great part of health care costs—taking into account that it is the physician who determines whether a patient should be hospitalized, that he is the person who determines the patient's length of confinement in the hospital, and that he is also the one who orders the end-

less variety of costly services, such as drugs, X-rays, laboratory tests, and so forth?

Mr. HAMPTON. I don't quite follow that. I mean, would you repeat the first part, Mr. Chairman?

Mr. DANIELS. In other words, the doctor who is called in to tend to a patient, inasmuch as he has such control over the patient, he determines what hospital he shall go to, how long he shall stay in the hospital, isn't he a very important factor in this question of costs?

Mr. HAMPTON. Oh, yes, sir. I think very definitely. His actions would have some influence on that. I think that one of the things that increases costs is the number of tools that are available to the physician today in making the proper diagnosis and utilizing the latest techniques and knowledge. This has been such a rapidly changing thing that it has, of course, escalated the types of tools that he would use.

I think though that the contractors, in administering these programs, in many cases look at the type of treatment. I have seen a few individual cases, and I can't generalize too much from that, where there was some question as to whether or not there was more care than should have been delivered.

Mr. Ruddock may have had more experience with the care, I am sure he has, than I. But I have seen a few cases where there was some question as to the extent of this.

Mr. DANIELS. Do you have a comment on that subject, Mr. Ruddock?

Mr. RUDDOCK. I will comment apropos of what you have said and what Chairman Hampton has said. The Government-wide indemnity benefit plan at the present time is in the process of improving its method of overseeing charges by doctors. They use a system which involves a common central profile on each doctor who is performing services for which the plan pays. And then from that profile they can spot the doctor who is performing unnecessary services, overutilization and that sort of thing.

Mr. DANIELS. In overseeing what is done, what hospital service is being utilized and the charges made therefor, does your Commission or anyone, any Government agency, have any control over that?

Mr. RUDDOCK. We do not in the Civil Service Commission, no, sir. We have no direct relationship with the purveyors of services. We have no contract relationship with the doctor. We have no contract relationship with the hospital. That direct contact, the direct relationship there, is between our carriers and the purveyors.

Mr. DANIELS. What control is there over the charges that are made—whether the services are being unnecessarily rendered or are being overutilized? Is there any agency of the Government exercising any overseeing of that?

Mr. RUDDOCK. Not in our program; no, sir. That is being done by our carriers. They each have a provision which requires them to pay for services which are medically necessary, and with some frequency they decline to pay for services which are purely for cosmetic reasons, et cetera.

Mr. DANIELS. I am absolutely shocked by the charges made by some hospitals, for, say, a room. In New York it runs up to maybe \$100 a day. They refer to a room as a semiprivate room which is being shared with maybe two or three other patients. I don't know why it's referred

to as a semiprivate room, but still the charge may be \$50 or \$60 a day.

It seems to me something should be done about these charges. Some agency of the Government ought to look into it.

Mr. RUDDOCK. The Department of Health, Education, and Welfare, in its administration of the medicare program, does audit and oversee the costs of the hospital on which the charges are based. Now, the extent of control that this brings in, I am not so sure about. But that is the agency which gets directly involved in the accounts and records and the administrative expenses of the hospitals.

Mr. DANIELS. Has any survey or study been made and a report given on this question; do you know?

Mr. RUDDOCK. I am not aware of any report having been issued yet, sir.

Mr. DANIELS. Well, I have taken an awful lot of time. I now desire to recognize my colleague from North Carolina, Mr. Henderson. Do you have any questions?

Mr. HENDERSON. Thank you, Mr. Chairman.

The bill, H.R. 767, has no application to the retired employees benefit health program. But I am not unmindful of the circumstances of our retirees and the survivors covered by that program. The law allows the Government a contribution of not less than \$3 or more than \$4 per month for single enrollment, double this amount for family enrollment. The Commission has exercised its delegated authority by allowing, respectively, a Government contribution of \$3.50 and \$7. For what reason has the Commission not allowed these contributions as a maximum contribution by law?

Mr. RUDDOCK. If I may, I will give you a little history. When the Retired Employees Health Benefits Act was passed in 1960, we contracted for a so-called uniform plan, the idea being that many of these older people were not in existing plans and might have some difficulty in finding a carrier willing to take them at their ages. So we contracted for a uniform plan.

At the same time, the law authorized us to make the employer or Government contribution to those people who were enrolled in private plans, so we had a mixture. In some cases the Government contribution is added to the check of the individual and then he pays his premium to a private plan. If he is in the uniform plan, we deduct both his share and the Government share and we pay the carrier which happens to be Aetna in this particular case.

Shortly after that program went into effect, there were indications of increases in the cost of health care, and increases in premiums in the private sector. We had to increase the premium of the uniform plan. The Commission exercised its authority to increase the Government contribution from \$3 to \$3.50 for self only and from \$6 to \$7 for self and family.

Then when medicare came along, the first thing we did in the Civil Service Commission was to write into, not only the uniform plan for retired employees, but all our active employee plans an anti-duplication of benefits clause. This is a provision which says that this plan will not pay for a service which has already been paid for by medicare, recognizing that many of these people would also have a medicare benefit.

As a result of our action, the experience of the uniform plan took a dramatic turn. We reduced the premiums. We are charging the people who are in the uniform plan less since medicare came along than we were before. That experience continues to be favorable. In all probability we will be able once again to reduce that premium.

Most of the private plans rewrote their benefit structures so as to complement medicare rather than to duplicate it. And where that occurred, they have also had either lower premiums or at least a stability of premiums. There are a few plans which decided not to adopt an antiduplication of benefits provision, but decided that they would pay for a service even though medicare has already paid for that same service.

These are the plans which have had to increase their premiums, and will have to continue, unless we have a downturn of cost of health care.

In the light of this history, the Commission can't find any justification for increasing the Government contribution for this particular group.

I would point out that most of those people are also eligible for medicare, part A, and for part B, if they choose to pay the premium. If they are eligible for the part A they get the medicare benefit without payment of premium. For part B, the individual pays, I believe, the current rate of \$4 a month, and that is matched by the Government. So the Government's contribution with respect to these people in toto has been sizably increased.

Mr. HENDERSON. Did I understand that under medicare B, if they choose to pay for that, the Government does contribute?

Mr. RUDDOCK. Yes, sir. The part B premium paid by the individual pays only half of the cost of the part B benefit structure.

Mr. HENDERSON. Did you say we consider that a qualified plan for contribution purposes?

Mr. RUDDOCK. No, sir. That is not considered a qualified plan for purposes of our adding the Government's contribution to the annuity check under the retired Federal employees health benefits program.

Mr. HENDERSON. What would be your position if we amended the law to make medicare a qualified plan?

Mr. RUDDOCK. I think that would be an excellent idea.

Mr. DANIELS. Before we leave that subject, in referring to medicare, plan A is hospital services?

Mr. RUDDOCK. Yes, sir.

Mr. DANIELS. And Plan B is medical, is that right?

Mr. RUDDOCK. Yes, sir.

Mr. DANIELS. I wanted to get that in the record.

Mr. HENDERSON. We also have bills pending before our subcommittee that would extend the health benefit program and group life insurance program to certain, but not all, non-citizen employees—those whose duty stations are in the Panama Canal Zone. I anticipate that there will be overtures made to our committee as we consider this legislation.

What would be the position with regard to the merits of their case?

Mr. RUDDOCK. Both the life insurance and the health benefits acts exclude from their coverage non-U.S. citizens whose permanent duty station is outside one of the States of the United States.

There is one quite important difference, I think, with respect to the non-U.S. citizen employed in Panama, and that is that there is a treaty between the United States and Panama in which back in 1958 we promised to seek whatever legislation would be necessary to treat the Panama citizens employed by the United States equally with the way we treat U.S. citizens.

That commitment, so far as effective legislation is concerned, has not been carried out for life insurance and for health benefits.

I think the views of the Department of Defense which oversees the Panama Canal, and of the State Department because of the effect this might have on our relations with other countries, would be important on this point.

Mr. HENDERSON. Are you saying that we could make a distinction for the noncitizens in Panama, based upon the treaty?

Mr. RUDDOCK. Yes, sir. And I think the Civil Service Commission would be quite relaxed on the point.

Mr. HENDERSON. Mr. Chairman, I commend the witness for a very candid response on that point. I realize that there are other views that might be expressed.

Mr. Hampton, getting to your statement, how would you interpret the task force quotation that we are really saying that the whole system of delivery of medical service is the fault of serious problems and that radical changes of practices will be realized?

Mr. HAMPTON. Anything I would say, of course, would be an interpretation—not being directly involved in this. But I think it points up the fact that these costs that have gone up in the medical area have far exceeded any cost increases in any other sort of consumer goods, and this is in a sense a consumer good. What it says is that the organization of hospitals, doctors and other people involved in purveying this service, needs to be looked at as to how the service is rendered. I don't have any idea what their recommendations are to do this.

I pointed out earlier that one of the innovative techniques that they are using today is these community type of clinics, like Columbia, Maryland, and other places in the country where you get complete care the nurses and so forth are paid salaries—and there may be some profiteering, I don't know—but having this type of organizational structure, they are able to deliver these services at less cost.

I know that hospital administrators are meeting continually to try to develop new methods to keep the costs down. The hospital costs were kept down in the past because they were paying the people who worked there such a small wage, and they cannot continue to do that.

Mr. HENDERSON. We found this true in Government hospitals, particularly in Veterans' Administration hospitals.

Mr. HAMPTON. So what they have to do, rather than use the same organizational techniques and use their people in the same manner in which they were used in the past, is to think up new ways and new methods.

I understand in some hospitals now they have certain kinds of consoles that monitor a number of patients that can be watched by one person much better than where previously they had three or four. But the number of personnel per patient in the hospital structure—and I am not sure of this figure at all so I wouldn't want to be held to it—was about four to one. In other words, there are about four people in the delivery service to one patient, which is a big expense item.

I think the cost of construction of new facilities, new techniques, new machinery, have added to the problem. They are utilizing computers and a lot of effort is being made. But I think it really is a problem.

Mr. HENDERSON. I do have one question here. Quoting from page 5 of your statement: "The Government's share of the cost of health benefits has never been more than 38 percent on an average." Do you subscribe to the view that it was the intent of Congress, on developing the enabling legislation, that the new cost should be shared equally by the employee and the Government employer?

Mr. HAMPTON. You mean it should be a 50-50 proposition?

Mr. HENDERSON. Yes.

Mr. HAMPTON. I think originally as it was passed the assumption was maybe over the years it would be 50-50, but it was pegged at the low option for 50 percent. The shift has been into the high option and the 38 percent figure developed because you were paying 50 percent in the lower situation, but now we are paying about 24 percent, we are not even paying 38 percent.

Mr. HENDERSON. To what extent would you say the 38 percent is affected by the higher costs, Mr. Ruddock? Or can you tell us this? Can you go back and take the first few years when it became effective—before we began shifting over to the high option—and tell us what was the Government's share?

Mr. RUDDOCK. If we start at the beginning, and again a little history, as this legislation moved through the Congress, first the House and then the Senate, it moved through with the idea of a one-option setup. The idea of two options was thrown in just at the last minute, just before enactment of the legislation. And the idea of the two options was thrown in in the belief that there were some employees who would want, and who could afford, a higher level of coverage than was contemplated by the general plan.

Everyone was quite surprised in the initial enrollment that 80 percent of all Federal employees chose a high option rather than the low option. Everyone was surprised at that. So we started off the first day in operation averaging only 38 percent of total premiums. We never did have 50 percent. We have never been above 38 percent.

Mr. HENDERSON. So you are really saying, in your opinion, that the effect, if not the intent, were it based on the low-option plan, it would be 50-percent contribution, but the fact that coming to the forefront so quickly that 80-percent went to the high option so you had, in effect, a 38-percent average contribution by the Government under the law very early in the 1960's.

Mr. RUDDOCK. Yes, sir. The law itself provided that the Government contribution would be 50 percent of the cost of the least expensive low option of the two Government-wide plans.

Mr. HENDERSON. Mr. Chairman, will this be the rationale behind your arriving at the recommendation of 38 percent as proposed this morning?

Mr. HAMPTON. Yes, sir. On the 38 percent, our rationale is partly based upon a review of the total fringe benefits package and budgetary reasons, and the fact that this appeared to meet what we have been paying in the past. I don't think that over the years we should be wedded to any 38 percent. I think that the fringe benefit package, the total, should be reviewed annually and that appropriate adjustments

should be made in our total fringe benefits package to keep it comparable with what the large employers in the private economy are paying.

We felt that in this particular time, in terms of budgetary pressures and cost and the spiraling cost of this, we could meet what had been done in the past, and we could sustain this by having the automatic adjustments until such time that we feel that the fringe benefit package totally needs further adjustment.

Mr. HENDERSON. Finally, Mr. Chairman, as we consider this legislation, I would like to explore—either with Mr. Ruddock or Chairman Hampton—one thing you said this morning, because it would seem to me that it doesn't directly tie to the legislation.

I was impressed that the deductible features have little effect on the use of the benefit plans. What would be your opinion of the reception of the Government employees if we could get the plans changed to eliminate deductions.

I think that if we could show them that one of the things that might be accomplished as a fringe benefit is the removal of the deductibles.

Mr. HAMPTON. I think if we remove the deductible—and I would like for Mr. Ruddock to comment on this further—from the indemnity plan, that this would increase the premiums in order to cover the adjusted cost.

Mr. HENDERSON. Would you agree with me then that if we adopted your 38-percent proposal, that likewise if we put it on a percentage basis any action in the future such as this, that would increase the premium, would increase the Government's contribution and cost, wouldn't it?

Mr. HAMPTON. Yes.

Mr. RUDDOCK. That is a part of the plan. There would be an automatic adjustment the first pay period beginning in January of each year.

Mr. HENDERSON. I want to commend you for recognizing that whatever we do in this area, Mr. Chairman, that we do have in your proposal the intent to keep the ratio in the future.

Mr. HAMPTON. I think the automatic adjustment is really very much of a step forward. The last adjustment was in 1966. That was 4 years ago. Had we had an automatic adjustment the impact on the employee of all of these increases would have been considerably lessened from the standpoint of managing the fringe benefits package.

This also commits the Government each year when we go through the budget review process to include in the budget coming to the Congress the funds necessary to finance a good health benefits program.

I am sure if history repeats itself, there have been in these negotiations with the carriers negotiations for better benefits where there is a proven need. Of course the employees know what they want, and they want the best coverage.

Mr. DANIELS. The gentleman from Virginia, Mr. Scott, do you have some questions?

Mr. SCOTT. Yes, Mr. Chairman. I, too, appreciate the forthrightness of the witnesses today. I think, working together, we can get something that is acceptable to both the administration and the Congress.

I think a lot of employees are concerned with the fact that all of the expenses of hospital care and physician care are sometimes not paid under the contract.

Regardless of the salary that a person might make, is there a way that the contracts, when they are reexecuted, could include the full physician's charges? They ask how much you make and if you make above a certain amount and then it is subject to negotiation or subject to the physician charging you additional money. I know it says that he charges you the difference in his normal fee and the amount that is paid under the contract. And yet some employees feel that some physicians—I'm not making any general indictment—charge additional money, based on the income of the employee.

Is there a way to have a contract where the entire physician's fee, covering his services while the employee is in the hospital, would be paid under the contract and eliminating this discretionary right to charge additional money?

Mr. RUDDOCK. If I may respond to that. Let's look at the two Government-wide plans. The Indemnity benefit plan doesn't use a fee schedule but pays under the terms of the contract on the basis of the usual and customary fee of the physician. This would mean that if the physician suddenly decides that he is going to charge \$2,000 for a procedure that he normally performs for \$500, they are going to question it. They are going to take it up with the Medical Society. They are going to seek an adjustment in his fee.

But they do not pay on the basis of a fee schedule to the physician and then have the physician charge anything additional that he wants from the patient. Blue Cross, Blue Shield's service benefit plan has contracts with participating physicians and the situation you're describing, I think, is most nearly applicable in that plan. That is, they have traditionally operated on the basis that if your family income was under a certain level, say \$6,000 or \$8,000 or \$10,000, or whatever happened to be used, the payment made by the plan to the physician would be a payment that the physician had agreed that he would accept as payment in full and make no additional charge.

Now, if the individual's income was above this fixed limit, then the plan would pay to the physician the fee scheduled amount and, as you have indicated, he could charge an additional amount to the patient. They are moving in the direction of not using the fee schedule but paying on the prevailing fee.

Mr. SCOTT. Could not the contract have a provision that the participating physician would accept whatever amount is payable under the contract, without any additional charge to the employee, regardless of the amount of money that he happens to make?

Mr. RUDDOCK. Yes, sir.

Mr. SCOTT. I think, frankly, that it should be changed in that respect. And whether there is any gouging at all, the employees often fear that there will be. And I think that fear would be eliminated if that could be done. Would it take any legislation to accomplish this? Or could the Commission, when it is reconsidering contracts, do this on its own initiative?

Mr. RUDDOCK. It would not take legislation. Actually, the contract is a contract between the carriers and the physician, and the type of contract you're speaking of is exactly the type that Blue

Shield is now negotiating with physicians, and they have reached that point in almost all of the country.

One notable exception is in the Washington, D.C. area, where the physicians have not yet agreed to accept payment in full on a prevailing fee basis. They are still using a fee schedule in the service benefit plan in the Washington, D.C., area.

Mr. SCOTT. Is there anything this committee could do to encourage that this be done in every instance throughout the country? I don't speak for the committee. I do speak for myself. I would be glad to talk with other members of the committee, if that would be helpful, to have an expression of views from the committee. Because I have felt, as a long time Government employee, that this has been a flaw in the insurance policy that we have had. In talking with other employees, they felt the same way.

Mr. DANIELS. Will Mr. Scott yield at that point?

Mr. SCOTT. I'd be glad to yield.

Mr. DANIELS. There are some physicians who believe in the principle of charging according to the ability of the patient to pay. I remember a situation prior to coming to Congress, when practicing law back home in the State of New Jersey, where I represented a client who has hospitalized—the operation was a success but the patient died.

The surviving widow received a bill from the doctors for so many hospital visits, I think at \$50 per visit, making a sum total of x dollars. A week or two later, the doctor sent her a registered letter charging her \$250 per visit—five times the original charge.

I contested that suit on behalf of my client and fought the case out in court and fortunately the judge did agree with me. He did not subscribe to the principle of paying according to the ability of the client to pay. He felt that if doctors' services were worth x amount of dollars that the charge should be fair and should be reasonable and that charge should apply to everybody generally.

I think some measure of protection ought to be afforded the holders of these plans, by seeing to it that a patient is not overcharged, regardless of his means.

Mr. RUDDOCK. I think an expression of views from this committee might very well influence the negotiations between Blue Shield and the doctors in the Washington, D.C. area.

Mr. SCOTT. Mr. Chairman, I would like to suggest that the Chair bring this before the committee at the appropriate time in executive session so that we could consider it.

Mr. DANIELS. That suggestion will be noted.

Mr. SCOTT. Mr. Chairman, another question that concerns me is the ratio of payment that Chairman Hampton has discussed. As I understood it, he says that now the Government pays on the average of 24 percent of the cost of the contract, and that his proposal would raise that to 38 percent on the average, and it's tied to the high option plan. I wonder if it would be feasible—my own personal thought being that the Government should pay 50 percent, regardless of the option—or what would be wrong, if anything, or what the Chairman would see wrong with letting the employee choose the plan that he wants, as he does today, and then have a fixed percentage that the Government pays, regardless of the plan that the employee chooses.

In other words, why should he be penalized in percentage of payment if he chooses a high option rather than a low option?

Mr. HAMPTON. As I had mentioned earlier, the 38 percent was pegged on what had been the going rate since the health benefits program came into being. We feel that this is looking at the total fringe benefits practice as fair and equitable at this particular time.

Mr. SCOTT. I am just wondering, Mr. Hampton, though, it would be so simple for the employee to know where he stood if there was a formula whereby the Government would agree to pay a certain percentage, regardless of the plan. If he has the option of choosing different plans, either the high or the low option, and he knew that, regardless of what plan he chooses, a certain percentage—and my own thought is on an equal 50-50 basis between the employee and the Government—is there anything that could be done in this regard?

I may propose this to the committee when we are marking up the bill as a substitute, and I would like to have the benefit of the views of you gentlemen on this, so we would have it in the record, if that is proposed.

Mr. DANIELS. Before the Chairman undertakes to answer that question, let me say I chaired the subcommittee in 1966 which conducted the hearings with respect to this very same question before the committee. At that time the Government's contribution had depreciated from 38 to 28 percent. Your office came in. Your predecessor came before the subcommittee and agreed and consented to an increase in the Government's contribution to the original 38 percent, which became effective in August of 1966.

But I understand that the Government has been getting a cut rate shortly after that law went into effect, about 5 months later. Because of the high cost of the program, your share or contribution began to depreciate and has constantly been depreciating down to the present level. So for almost 4 years the Government has been getting a cut rate on this thing.

So now, as a matter of compromise, I think in all fairness to all Government employees, it would be reasonable to expect not to go to 38 percent but to 50 percent. I share Mr. Scott's view on this. As a matter of fact, the bill before us that we have under consideration now proposes an increase to 50 percent the first year and the next fiscal year to 75 percent and finally, in the third fiscal year, to 100 percent.

I realize the economic problem. I realize the fact that costs are high and it is the intent of this administration to curb rising costs and that it may not be practical at this particular point to shoot for a hundred percent contribution by the Government. But I do share Mr. Scott's view that 50 percent contribution by the Government is not an unfair or unreasonable approach to this—or a solution to this.

Mr. SCOTT. Thank you, Mr. Chairman, could you first just comment on the 50-percent provision that would be unchanging and, as the cost of the benefits increased, then if the Government paid 50 percent its contribution would also increase and there wouldn't be an additional burden on the employee.

Mr. HAMPTON. First you had asked about the 38 percent as a flat figure of any particular plan that the individual might choose. When we were going over a way to keep this plan on a level basis, we tried to figure out how you would do this in law. Since we have a specific

amount spelled out in law—it may be 38 percent for some plan or it may be a little less—we wanted to get away from the idea of a specific amount being spelled out in the law and to go to a percentage that we would maintain.

We had to take, our feeling was, an unweighted average in order to be paying essentially the same amount to every Federal employee without spelling the amount out in law.

Mr. Ruddock might want to add further to the difficulties of administering this.

Mr. SCOTT. Suppose the Congress did provide by law that the Government would pay 50 percent of any plan and that the employee would contribute 50 percent regardless of the amount. I am just asking of either of you two gentlemen as to why this should not be done. The Chairman and I have discussed this a number of times. I appreciate his comment, that we do share the same views on this. I know that neither of us want to urge the committee to report this out on that basis without knowing just how the Commission feels about it.

Mr. HAMPTON. For one thing, I haven't a flat percentage spelled out like that. One of the immediate effects would be a shift in plan and option, I think, that would take place.

Mr. SCOTT. In what manner?

Mr. HAMPTON. What's that?

Mr. SCOTT. In what manner would there be a shift?

Mr. HAMPTON. I think most people would immediately go to the high option of the most expensive plan that they could find.

Mr. SCOTT. And 85 percent are in there now.

Mr. HAMPTON. But in a variety of plans. The 85 percent in high options are in a variety of plans. I think this could create some problems.

On the other problems—of trying to equate this with paying most people the same amount of money, or paying everyone the same amount of money for a high option—I would have to have Mr. Ruddock go through the exercise on how this would be finalized.

Mr. RUDDOCK. I think the plan the Chairman has proposed tends to be more nearly equitable for all Federal employees, and I think it also would tend to keep the costs down more than would going to a flat percentage of whatever plan the individual would choose.

Mr. SCOTT. The cost to whom—the Government or to the overall costs?

Mr. RUDDOCK. The cost of health care. The plans vary in structure. They vary in cost. Each employee has a choice of a number of plans. Theoretically at least he chooses the plan that best serves himself and his family.

Under the Chairman's proposal, the 38 percent of the unweighted average of the six typical plans would result in a fixed dollar Government contribution. It will be fixed, but just for that year. Then it would change in January of the following year, if there is any change in premiums. So if premiums continue to go up, the Government contribution would automatically go up. But this would provide the same dollar contribution to each employee, leaving him free to select a plan that has a structure and a cost which fits his needs. And he pays the difference in the cost of the plan he chooses, that part of the cost which is over and above the Government contribution.

Mr. SCOTT. What is the merit in having a fixed dollar amount for the Government to pay? It would seem to me that it would be reasonable to have a fixed percentage of the total costs for the Government to pay rather than a fixed dollar amount and then leave discretion to the employee to determine just how high he wanted to go and the Government contributing on that basis.

Is this faulty reasoning? And what are your views on that?

Mr. RUDDOCK. I think only to the extent, Mr. Scott, that, since he would have to pay only half of the cost of whatever plan he chooses, he could get a larger Government contribution by choosing the most expensive plan.

Mr. SCOTT. But he also must match that, and it's more out of the pocket for him.

Mr. RUDDOCK. He must match it, and that would have an influence on his decision—but I don't believe as much influence as if the Government were going to pay a flat dollar amount and then what he had to pay was the difference between the Government contribution and the cost of the plan he chooses. He would have a tendency to shop for price a little bit more, I think, if he had to pay the total difference between the Government contribution and the cost of the plan.

Mr. SCOTT. I would think that he would perhaps fit the various plans to his needs and be able to do that, if he was paying half and the Government was paying half.

Mr. Chairman, you had some comment?

Mr. HAMPTON. What we were essentially saying to a Federal employee is, "Here is a 38 percent Government contribution for health benefits coverage, based on an unweighed average of the six major plans, a variety of plans. You can take this money and you can shop among any of a variety of plans."

You may be a member of the Letter Carriers or the Postal Clerks, and you want to be in their plan. So that is where you go. And these plans, seeing this, are inclined to negotiate a more favorable benefit structure, and one will try to get ahead of the other. This is very healthy competition.

The individual then can go to a plan, really, that fits his particular need. For a fraternal reason he may stay in his organization plan. But the organizational plan, in order to keep him interested, is going to have to meet some competition. I think this competition is good. I think it keeps down costs, not only to the individual but to the Government, and I think this is a healthy way to do it. Our assessment, when we reviewed this—which we put into our bill report on 767 on page 5 there—has some outline of some of our reasoning. It's just a judgment based on experience that this encourages competition, it gives the employee a maximum amount of options, and he wouldn't be forced to gravitate into something that would appear to be better.

Mr. SCOTT. Mr. Hampton, I don't see the different competition which is in whether the Government pays 50 percent or the 24 percent. Maybe I'm missing something in your discussion here, but it seems to me that the carrier would be looking to the overall amount that he receives rather than who pays the proportionate share. Am I missing something there?

Mr. HAMPTON. Let me give you an example of some figures—just a hypothetical case. Say you have employee A who is interested in

plan A, and the high option of that plan, say, is \$50. If you went to 50 percent, the Government contribution would be \$25. Then you have employee B who wants to go to plan B, the high option, of which the premium is \$40. The 50 percent share of that would be \$20.

So for one employee we would be paying \$25 for his plan, and for the other employee we would be paying \$20. There would be a difference in what we would be paying individual employees.

In order to give all employees the same amount in equity—and equity is an issue among competing groups—then we had pegged this as the unweighed average of six typical plans, which would give us a set amount which would meet this criteria for our employees. That is about the only way I can illustrate it.

Mr. SCOTT. Mr. Chairman, in all candor, I haven't grasped this yet. I have a few other questions.

Since the employees program's inception, there have been two types of enrollment—self only and self and family. A recently introduced bill proposes an additional type of enrollment—somewhere between the two existing types—of self and spouse.

Would you be in a position to comment on the feasibility of this additional category, where a person would just be covered for himself and his spouse? Obviously this is true of many older people, as their children grow up and leave the family.

Mr. HAMPTON. As far as the annuitants are concerned, as we discussed earlier, the cost of the benefits still would be higher there than it would be, say, in the younger families.

Mr. SCOTT. Well, say the young person, the young married couple who do not have any children—they pay the same as someone with 10 children? There is a difference in the benefits that they receive. Would it be feasible to have a third plan, in your opinion? Or would you prefer to just keep it at two?

Mr. RUDDOCK. It could be done. That was considered in the original setup of the plan. It was decided then—and I think wisely—that the plan would operate best if the number of different groups that were separately rated were kept to an absolute minimum. Many plans in their plan structure do have self only, self and spouse, self and family, and you can carry this a little bit further, self and family including one child, separately rated, self and family including two children, and three children. Then there is really no limit to the numbers of groups that you could find that you could separately rate.

Now, it's my opinion, based on our experience, that if we set up a category of self and spouse and separately rated that group, that the overall premium would come up at least as high as the premium required for self and family, where the family is included regardless of the size of the family.

Mr. SCOTT. You're saying that because more of the elderly people would have that?

Mr. RUDDOCK. Yes, sir.

Mr. SCOTT. Mr. Chairman, let me ask, do your studies or your statistics indicate what effect, if any, the advent of medicare has had on the experience of these programs? This was discussed briefly, but

should there be any change in the plans because of the advent of medicare?

Mr. HAMPTON. I think that most of that has been taken care of by the antiduplication of benefits clause. I don't see any change.

The only change that was suggested was the question in part B, making it a qualified plan.

Mr. SCOTT. Would you feel that all Federal employees should be covered by the medicare program, and that upon retirement they be covered under the health benefits program only to the extent of the complimentary or supplementary protection? Could you elaborate whether it's favorable or unfavorable upon the proposal?

Mr. HAMPTON. I don't see any real benefit in covering Federal employees under the medicare program, because that would require so many dollars a month. What is the figure?

Mr. RUDDOCK. If all Federal employees right now went under the hospital insurance tax, the Government's contribution as an employer would be about \$115 million a year. Employees, of course, would be required to pay a like amount in hospital insurance tax. They would pay the hospital insurance tax throughout their working career and in exchange would have the medicare part A when they reach age 65.

Mr. SCOTT. Mr. Hampton, what has been the Commission's reaction to your consulting actuary suggestion that major premium increases be permitted at the beginning of the odd calendar years, and there would either be no premium increases or merely minor adjustments allowed in the even years?

Mr. HAMPTON. We have not brought that up to the Commission yet for action.

Mr. SCOTT. You don't care to express any personal comment?

Mr. HAMPTON. No, sir, not at this time.

Mr. SCOTT. In more recent years there seems to be some trend in the health insurance field toward covering certain dental services. Could you give us further insight into these trends, and what the future might hold for our program in this area?

Mr. RUDDOCK. I think the trend and the experience with the dental plans is that they tend to be quite successful where the employer is going to pay the total cost. This means that all employees are automatically covered under the dental plan and, because we all have a little bit of reluctance about going to the dentist, the costs don't run away. They can be strictly controlled by the benefit structure.

In a program such as ours—where we have a choice of plans—unless we had a uniform dental structure in all of the plans we would have employees, who anticipate substantial dental expense, selecting a plan that covers that type of benefit. In other words, we would have a high degree of adverse selection.

I think the experience generally has been that where dental benefits are offered on an optional basis, adverse selection makes it very difficult to operate economically.

Mr. SCOTT. You wouldn't recommend that it be included at this time?

Mr. RUDDOCK. Not until we reached the point where the employer is prepared to pay the total premium. Then I think it's feasible.

Mr. SCOTT. How would that relate to eye care, optical care?

Mr. RUDDOCK. Certain types of optical care are covered at the present time.

Mr. SCOTT. I mean prescriptions for glasses and this sort of thing.

Mr. RUDDOCK. Basically the prescription for glasses, except after accident, and the cost of the glasses themselves are not covered under the present plans. I think they could be in the same category with the dental benefits.

Mr. HAMPTON. Yes.

Mr. SCOTT. Mr. Chairman, let me again thank the two witnesses. It has been very helpful.

Mr. DANIELS. I have three brief questions. I hope that we can get answers to them before the bells ring, indicating there may be a quorum call on the House floor. The House is about to go in session at any moment.

Do the \$6.92 and the \$2.72 rates cited in your statement on page 6 represent the amounts of Government contribution that would be made under your proposal if total premiums did not require further increases on January 1, 1971?

Mr. RUDDOCK. Yes. These would be increased by whatever percentage premiums are increased January 1, 1971.

Mr. DANIELS. So if the total cost goes up—by, I assume, 12 percent—next January, then those dollars and cents figures would rise proportionately?

Mr. RUDDOCK. By 12 percent, yes, sir.

Mr. DANIELS. Then the Government's increased contribution for the full calendar year 1971 would total \$182 million?

Mr. RUDDOCK. Yes, sir.

Mr. DANIELS. What would be the representative figures if Congress were to expand upon your basic proposal by increasing the high option contribution to 50 percent rather than 38 percent?

Mr. RUDDOCK. The Government cost will be increased by \$314.3 million for calendar year 1971.

Mr. SCOTT. Mr. Chairman, for clarification, is that if only the high option is 50 percent? Or do you have any figures if the Government paid 50 percent, regardless of the plan that is chosen? If it was throughout all of the plans, it would be a 50-50 proposition.

Mr. RUDDOCK. It would be slightly less generous than the 50 percent of the high option of the six plans, and the cost would be slightly less than the \$314.3 million. I don't know exactly how much.

Mr. SCOTT. Thank you, sir.

Mr. DANIELS. Upon what basis do you assume a 12-percent premium increase in 1971?

Mr. RUDDOCK. Mr. Daniels, that is based upon trends, and also for want of a more precise method of doing it. Twelve percent was the amount of increase in premiums in January of 1970. We have just assumed that, unless something changes, we will have a similar in-

crease in 1971 that could be less, hopefully. It could also, unfortunately, be more.

Mr. DANIELS. Chairman Hampton, and Mr. Ruddock, I want to compliment both of you gentlemen and express to you not only my personal thanks but the thanks of this committee for your candidness, your frankness and your straightforwardness, as you always display when you appear before this committee. Your testimony has been, indeed, very helpful.

I am, to say the least, very happy to see that you will at least recommend the Government increase its contribution to 38 percent.

Mr. HAMPTON. Thank you.

Mr. DANIELS. I might also state that I think you made a splendid suggestion with regard to the automatic adjustment. So therefore it won't be necessary, regardless of what figure we strike, to come back to Congress to ask for an adjustment every year or every couple of years.

We had scheduled to testify today Mr. Francis Filbey, national president of the United Federation of Postal Clerks, and Mr. Patrick Nilan and other representatives of that organization. But it is now almost 5 minutes after 12, and I would put you on, if you so desire, and take some of your testimony. I know that we are not going to be able to complete it.

It is the intent of the Chair to conduct 3 days of hearings next week on Tuesday, Wednesday and Thursday. You have a choice of proceeding today, and we will go as far as we possibly can go, or come back Tuesday.

Mr. NILAN. Mr. Chairman, the United Federation of Postal Clerks is always willing to comply with the chairman and members of the subcommittee. We will be happy to return at the appointed hour you designate next week.

Mr. DANIELS. I will schedule you as the first witness on Tuesday, March 24.

Mr. NILAN. Thank you, Mr. Chairman.

Mr. DANIELS. The subcommittee will stand adjourned until next Tuesday, March 24, at 9:30 a.m. We will meet in this committee room.

(Whereupon, at 12:05 p.m., the subcommittee adjourned, to reconvene on Tuesday, March 24, 1970, at 9:30 a.m.)

(The tabulation which follows was furnished for the record by the Civil Service Commission in response to a request at page 18.)

COMPARISON OF SIGNIFICANT HEALTH INSURANCE BENEFIT PROVISIONS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM'S GOVERNMENT-WIDE PLANS (HIGH OPTION), AND UNDER SELECTED PRIVATE INDUSTRY PROGRAMS

Covered expense	Federal employees health benefits program Government-wide plans (high option)			Private industry plans	
	Service benefit plan	Indemnify benefit plan		General Motors Corp.	General Electric Co.
Hospital: Basic: 1					Westinghouse Electric Corp.
Inpatient: Room and board	Semiprivate, in full ²	100 percent of 1st \$1,000 plus 80 percent of remainder.		Semiprivate, in full	Semiprivate, in full
Days	365 days per confinement			365 days	365 days a year
Ancillary services	365 days, in full ²			In full	In full
Outpatient, for—	In full ²			do.	do.
X-ray, laboratory, etc.				Required service, in full	In full
Emergencies	Within 72 hours—in full ²				
Supplemental: ³	Up to reasonable and customary charge for semiprivate room.				
Room and board	Reasonable and customary charge.			Covered above	Covered above
Ancillary	R.N. or licensed practical nurse				
Private nursing					
Physician and related: Basic: 1					
Surgery	Full cost regardless of income, except in Nevada, western New York, Connecticut, Washington, D.C., metropolitan area. ⁴			First \$500 for surgery, anesthesia, laboratory test, X-ray, and radiotherapy.	\$400 schedule, 85 percent of remainder.
Physician—in hospital					
Office visits	Not covered except for emergencies, X-ray and laboratory, and radiation therapy.			85 percent of amounts in excess of \$50 (\$125 for self and family).	85 percent of amount in excess of \$50 (\$125 for self and family).
Home visits					
Supplemental: ³	Reasonable and customary charges.			Covered above	Covered above
Office and home visits and, generally, all other services and supplies not listed above.					
Maternity:					
Hospital	Regular benefits	Regular benefits		Regular benefits	Regular benefits
Physician and related	do.	do.		do.	\$120 for normal delivery; other, regular benefits.

Extended-care facilities	Not covered	Not covered	730 days reduced 2 days for each day in hospital	Not covered	Not covered
Tuberculosis	Regular benefits	Regular benefits	Hospital care and in-hospital physician care, 30 days	Regular benefits	Regular benefits
Mental and nervous disorder	Regular benefits, also psychiatric care	Regular benefits, also psychiatric care	Hospital care and in-hospital physician treatment, 45 days; limited psychiatric care	Regular benefits, except for out-of-hospital psychiatric care—50 percent	Regular benefits, except for out-of-hospital psychiatric care—50 percent
Dental care	Excludes extractions, tooth repair except in case of accidental injury	Excludes extractions, tooth repair except in case of accidental injury	Excludes extractions and tooth repair	Extractions covered	Not covered
Visual care, hearing aid	Not covered	Not covered	Not covered	Eye exercise, hearing aid ⁵	Do,
Prescription drugs	See supplemental	Covered	Excess over \$2 per prescription	Covered	Covered
Supplemental: ³					
Deductible	\$100	See above	For salaried employees only \$100 to \$300, depending on salary	See above	See above, \$50 (\$125 for self and family). Does not apply to hospital and surgery.
Coinsurance	80 to 20 percent	80 to 20 percent	80 to 20 percent	85 to 15 percent	85 to 15 percent
Maximum, lifetime	\$50,000	\$50,000	None for employee; \$5,000 for dependent	\$100,000	\$100,000
Restoration, per year	\$2,000	\$2,000 ⁴	\$25,000 per benefit period		
Monthly premium, total	Self only	Self and family	Self only	Self and family	Self and family
Employer contribution	\$15.71	\$38.83	(6)	(7)	(7)
Employee contribution	3.64	8.88	\$0.40	\$1.15	0.9 percent of earnings plus \$8.33 per month. ⁹
	12.07	29.45		0.9 percent of earnings ⁸	(7) \$8.33 per month.

¹ Basic benefits are payable as indicated. Generally, expenses not so covered may constitute a claim under "Supplemental" benefits.

² In member hospitals and overseas; 80 percent of usual and customary charges in nonmember hospitals.

³ Supplemental benefits cover expenses described under basic not fully met by basic benefits and other expenses such as home and office visits, drugs, private nursing, orthopedic appliances, etc. The amount of the benefit is 80 percent of the amount of the reasonable and customary charges in excess of basic benefits, if any, and the \$100 deductible. The maximum amount applies to supplemental benefits only.

⁴ Plan pays in full the reasonable and customary charges, except in Connecticut, Nevada, and outside the United States where payment is made on the basis of a schedule of fees (\$2.50 to \$500);

and in Rochester, N.Y., Jamestown, N.Y., and Washington, D.C., where payment is accepted by participating physicians as payment in full only if the patient's family income does not exceed \$10,000 in Rochester, Washington, D.C., or \$7,500 in Jamestown.

⁵ Eye exercises by optometrist, hearing aid (subject to deductible and coinsurance) up to \$300 for a 3-year period.

⁶ Not a supplemental benefit. Applies to all covered expenses other than room and board.

⁷ Not available.

⁸ Employer pays full cost of basic benefits. Employee contributions here shown are for major medical benefits only.

⁹ Effective Jan. 1, 1971, employee contribution for employee coverage will be removed and contribution for self and family will be \$8.33 per month.

FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

TUESDAY, MARCH 24, 1970

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

The subcommittee met, pursuant to call, at 9:55 a.m., in room 210, Cannon House Office Building, Hon. David N. Henderson (acting chairman) presiding.

Mr. HENDERSON. The subcommittee will come to order.

Chairman Daniels has asked that I open the meeting this morning and chair it until his schedule will permit him to join us, and he is most hopeful of being able to do that shortly.

The Subcommittee on Retirement, Insurance, and Health Benefits is meeting this morning in continuance of its evaluation of the Federal employees' and retirees' health benefits programs. Without objection, the Chair desires to insert at this point in the record the administrative report on H.R. 767, submitted by the Bureau of the Budget.

(The document follows:)

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 18, 1970.

Hon. THADDEUS J. DULSKI,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives,
Washington, D.C.*

DEAR MR. CHAIRMAN: This is in reply to the Committee's request for a supplemental report on H.R. 767, "To amend chapter 89 of title 5, United States Code, relating to enrollment charges for Federal employees' health benefits."

The Civil Service Commission is submitting legislation which would provide, effective January 1, 1971, and thereafter in January of each year, for an automatic adjustment plan to fix the Government's contribution at 38% of the unweighted average high-option subscription charge of the six plans that collectively cover about 90% of all participating employees.

The Bureau of the Budget cannot support the provisions of H.R. 767, but recommends enactment of the Civil Service Commission's proposal.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

Mr. HENDERSON. Most of the scheduled witnesses represent large employee organizations which offer health benefits plans to their membership. It is expected, therefore, that these witnesses' testimony will be of invaluable assistance to the subcommittee during its deliberations on this most important subject.

Recognizing that those of you who are representating postal organizations have other business of emergent concern, may I say that the subcommittee will attempt to keep our questioning to a minnum, so that you will not be unduly detained from pursuing other matters of priority importance. I am confident, however, that those witnesses representing nonpostal employees are quite competent to discuss the programs and the problems at length and in depth.

I might add that we could ask the staff to develop with you for the record answers to questions that we might specifically want from those of you who feel that you could not stay for the full presentation this morning.

With those thoughts in mind, and in the interest of expediting this morning's session, let us proceed immediately to our first scheduled witness.

I might also add that any witnesses who would like to file their statements for inclusion in the record, they will be included in the record as if personally delivered this morning and in the order in which the witnesses have been scheduled by the staff.

Our first witness is Mr. Francis S. Filbey, national president of the United Federation of Postal Clerks and those who are accompanying him: Mr. Nilan, Mr. Love, Mr. Dubay, and Mr. Froh.

Mr. WOLKOMIR. Mr. Chairman, if I may before the proceedings start, I am president of the National Federation of Federal Employees. I would like our statement to be recorded as you have suggested for the record. We are in favor of H.R. 767, of course, and I would like to state that as a member of the National Health Advisory Committee, I am always available for any questions that the committee may present to us.

Mr. HENDERSON. Thank you, Mr. Wolkomir. If, at the end of the conclusion of any testimony we receive, any witnesses would want to supplement their statements, I am sure the staff would call this to our attention and we could arrange that.

Mr. WOLKOMIR. Thank you very much.

Mr. HENDERSON. Thank you, sir.

We welcome you, Mr. Nilan.

Mr. NILAN. Mr. Chairman, as you mentioned in your opening remarks, the post offices do have a few pressing problems and because of this, our national president, Francis S. Filbey, is unable to join us at the witness table this morning for some very obvious reasons, and with your permission we will proceed with our statement.

Mr. HENDERSON. Fine.

STATEMENT OF PATRICK J. NILAN, LEGISLATIVE DIRECTOR, UNITED FEDERATION OF POSTAL CLERKS, AFL-CIO, ACCOMPANIED BY JACK LOVE, SECRETARY-TREASURER; JOHN DUBAY, RESEARCH AND SERVICE ADMINISTRATOR; AND WALTER FROH, STAFF ECONOMIST

Mr. NILAN. Mr. Chairman and members of the committee, for the record, I am Patrick J. Nilan, national legislative director of the United Federation of Postal Clerks, AFL-CIO, with offices at 817 14th Street NW., Washington, D.C. I am very pleased to appear before the committee this morning with Jack Love, secretary-treasurer, and John Dubay, research and service administrator of our union's hospital

plan. Walter Froh, our staff economist, also is with us this morning as we present our testimony concerning H.R. 767 and the absolute need for the Government to pay the full cost of the Federal employees' health benefits program.

We speak in behalf of the Nation's 304,000 postal clerks, for whom we are the exclusive national representative for labor-management relations and collective bargaining with the Post Office Department. Our membership is exclusively in the postal clerk craft and is employed in post offices in all 50 States, the District of Columbia, Puerto Rico, Virgin Islands, and Guam.

Mr. Chairman, the United Federation of Postal Clerks is certainly deeply indebted to you for your sponsorship of H.R. 767, referring to Mr. Daniels, the chairman of the subcommittee, which is presently pending before this Subcommittee on Retirement, Insurance, and Health Benefits.

Our members and their families also commend you, Mr. Chairman, and members of this committee for scheduling these hearings on H.R. 767 because of the tremendous importance of this legislation which proposes the Federal Government to eventually pay the entire cost of health insurance for Federal employees and, equally important, for annuitants of the civil service retirement system.

We appear before you today, Mr. Chairman and members of this committee, to advocate passage of H.R. 767 to appropriately named the "Federal Employees' Health Benefits Act."

We also recognize that the Health Benefits Act is a monumental achievement to the everlasting credit of distinguished Members of the House and Senate Post Office and Civil Service Committees who originally formulated the program. We ask now that the program be updated and the Government assume the full cost of providing health benefits to Federal employees and annuitants.

Our statement this morning will present what we think is a convincing argument for the Congress to substantially increase the Federal Government's financing of its employees' insurance against the burdens of accident, illness, and hospitalization. However, we believe it is essential first to refer the committee to a recent study authorized by the Civil Service Commission which was made by Milliman & Robertson, Inc., a well-known and respected consulting actuary firm.

On page 15 of this January report, the consultants state:

It would seem desirable for the government to pay a larger part of the premium since the limitations now imposed have resulted in the decreasing percentage of contribution observed.

Considering the generally conservative nature of actuaries, especially in making such a report to the Government, we believe the suggestion to be almost mandatory, the relevant variable being the percentage of the premium cost the Government will in a responsible sense assume.

The consulting actuaries made a study of the financing of health and hospitalization plans of other large employers, apparently to suggest what financing role the Federal Government should assume. To quote from the report (p. 15):

A review was made of seven very large employer plans that had been recently revised, and which have benefits comparable to the government-wide plans.

In all instances the employer paid part of the cost; in three instances the entire

premium for both employees and dependents was paid by the employer; in only one case was the employee contribution more than \$3.00 for an individual enrollment or \$7.00 for a family enrollment.

By contrast, the present employee contribution to the lowest cost Government-wide high-option plan, for self and family, is \$29.45. (Shown in our table 1 of supplement I.)

Conclusion No. 3 in the actuarial firm's "Principal Findings Summarized" reports that "premium increases have largely been paid by the employee"—entirely, we must add, since July 1966, when the only increase to date of the Government's contribution raised its share. The report adds in this finding that "the maximum Government contribution has been specifically limited—at first to 50 percent of the lower cost low-option premium and then in 1966 to \$3,164 for the subscriber only category and \$8.88 for family * * * the Government contribution to the high-option plans is now about 25 percent as compared to around 38 percent originally."

However, this reality is put in better perspective when it is indicated that the intent of the Federal Government was, at the time of the implementation of the Federal Employee Health Benefits Acts in 1960, to pay half the premium cost, a fact not noted in the Milliman & Robertson report.

Immediately prior to that time nearly unanimous testimony before the committee indicated that nearly all employees would select the lower cost low-option plan. From the beginning Federal employees in great preponderance chose the high-option plan; therefore, the Government's original intent to cover half the premium cost has never been fulfilled. We believe the Federal Government should follow the lead of large employers in private enterprise and pay the entire cost.

It appears that the original sponsors of the Health Benefits Act were conscious of the costs and the limited incomes of Federal employees. As a result, a less costly "low option" benefit level plan could be subscribed to under the act, with the Government's contribution covering half the premium cost. Apparently as we mention, this resulted from almost unanimous testimony before the committee at that time, which suggested that nearly all employees would select the "low option" plan. A "high option" benefit level plan was also made available to Federal employees who were willing to pay the additional cost.

However, the considered estimates of the Federal employees' desire for insurance protection against the costs of medical care were not strong enough. From the beginning, Federal employees selected the "high option" protection. They wanted the inherent feeling of being protected against the relatively high costs of hospitalization, surgery, and medical care generally. We state and honestly believe and hope, Mr. Chairman, that you also feel that Federal employees should have the opportunity for this kind of protection at a minimal cost to the employee and his family.

To date, unfortunately, it has not worked out that way. Under the Federal Employees Health Benefits Act, the Government makes a uniform dollar-and-cents contribution to the employees' selected insurance plan. Originally, the Government's monthly contribution to a self-and-family plan was \$6.76, which was one-half of the cost of the least expensive Government-wide low-option plan, in accord with

the assumption that virtually all employees would select the low-option plan. However, most employees did not choose the low-option plan but rather elected the high-option plan instead. This decision by the overwhelming majority of Federal employees resulted in a highly disproportionate cost of at least \$10.70 or 61 percent or more, depending upon the plan selected.

But the real injustice, using as a standard the expressed intent of Congress to pay one-half of the employee's premium cost, has progressively made itself felt since that time. Since insurance coverage under the act was implemented in June of 1960, the premium cost to the employee of the least expensive Government-wide high-option protection (which most employees want and we think they should have) has increased to 275 percent of what it was, while the Government's share of the cost has dropped from 38.7 percent to 23.2 percent, a decline of 40 percent.

These changes took place because the Government's fixed-amount contribution progressively represented a smaller share of a rapidly increasing total premium cost. (The employee's plight was somewhat alleviated in 1966 when the Federal Government's monthly contribution was increased to \$8.88 by passage of Public Law 89-504.)

Mr. Chairman and members of the committee, before we consider in more detail the changes in Government-employee sharing of the premium cost, I wish to comment on the current distribution of enrollment in high-option and low-option plans, as of December 31, 1969.

Mr. Chairman, you may recall that on last week the Civil Service Commission witnesses were unable to give you a current date. This is based on their figure, and I am sure they will substantiate them in subsequent information given the committee. On that date, 2,575,800 Federal employees were enrolled in a Federal employees health benefits program. Of this total, 2,142,900, or 83 percent, were enrolled in a high-option plan and only 432,900 employees, or 17 percent, in a low-option plan.

Table 1 and chart A in the supplements accompanying this statement illustrate the changes in premiums and cost to Government and the employee that have taken place between 1960 and 1970.

As shown in table 1, the monthly premium for the lowest cost Government-wide high-option plan for self and family (Aetna) was \$17.64 in 1960. In 1970, the premium for the lowest cost Government-wide high-option plan for self and family (now Blue Cross/Blue Shield) is \$38.33. This cost represents an increase of 120 percent over the corresponding 1960 premium. The Government's legislatively fixed contribution declined as a percentage of total premium from 38.7 percent to 23.2 percent, a decrease of 40 percent. The balance left for the employee to pay increased from \$10.70 to \$29.45, an increase of 175 percent. Chart A illustrates these changes graphically, and, we might say, drastically.

There are established comprehensive medical plans and employee organization plans which offer coverage to Federal employees, in addition to the two Government-wide plans, Aetna and Blue Cross/Blue Shield. For whatever reason, an employee may elect to participate in one of these "other" plans, under which his premium cost may be considerably greater.

The United Federation of Postal Clerks, for example, has, we think, an excellent health benefits plan, subscribed to by a substantial part of our membership. From 1960 to 1970, the cost to the employee of the high-option self and family coverage increased 203 percent while the percentage of cost paid by the Government declined from 38.7 percent to 21.5 percent, a decline of 44 percent. Table 2 reflects the cost experience of the United Federation of Postal Clerks' health benefits plan.

Table 3 and chart B show the detailed 1960 and 1970 cost experience of the two Government-wide plans for self and family coverage, in terms of total premium cost, Government contribution and employee contribution, expressed as dollar and percentage amounts.

Chart B is a graphic reflection of the Government's contribution since 1960 as a percentage of the high-option self and family plan premium cost of the two Government-wide plans. For this coverage the Government's contribution share of the Blue Cross/Blue Shield service benefit plan has declined from 34.9 percent to 23.2 percent. For high-option self and family the Government's share of the Aetna indemnity benefit plan has decreased from 38.7 percent to 19.7 percent.

Whether the employee selects Aetna, Blue Cross/Blue Shield, or one of the employee organization or comprehensive medical plans, we think he is paying entirely too much out of his own pocket. We also believe and hope you do also, that he is carrying an extremely disproportionate and unfair share of the cost. This conclusion is particularly significant in the terms of Congress declared intention to have the employee not pay more than half of the premium cost for medical care insurance coverage—coverage to which he, as an individual, and the traditional and normal American family are entitled.

We think some changes should be made, Mr. Chairman, and the time is now. We believe this distinguished Committee on Retirement, Insurance, and Health Benefits, and the eminent House Post Office and Civil Service Committee, as a whole, should play their traditional leadership roles by guiding through the U.S. House of Representatives, early passage of this long-overdue legislation which would progressively increase the Government's share of the least expensive Government-wide high-option plan in three steps onto 100 percent of the premium cost. If I may mention at this point, Mr. Chairman, we are very pleased with the proposal by the Civil Service Commission, which would use six basic plans with the high-option level as a basis for computing premium costs, and we are very happy to inject at this point in lieu of the recommendation which we have just referred to.

The bill introduced by the distinguished chairman of this committee, Representative Dominick V. Daniels, is an outstanding bill. The United Federation of Postal Clerks supports it wholeheartedly and enthusiastically. It provides that the Government's contribution to health benefit premium costs would increase to 50 percent the first fiscal year—75 percent the second fiscal year—and eventually 100 percent the third year, and for each year thereafter.

In the balance of our statement, we will discuss the rising costs of medical care and the manner in which firms in private industry, especially large firms (and the Federal Government is the largest of all employers) provide an opportunity for their employees to be insured

against the high costs of hospitalization, surgery, and other medical care.

Again, the Chairman of the Civil Service Commission, Mr. Hampton, was very kind in stating that the Government was the largest employer and was a large employer on a contracting-out basis for the health benefit plans and again we commend the distinguished Chairman of the Civil Service Commission for supporting this part of our testimony.

Medical care costs, including the cost of hospitalization, surgery, physician and dentist fees, have risen rapidly in recent years and continue to accelerate faster than other prices in any other commodities or services. Before we document this, we will state two reasons for which increasing medical care costs are very relevant to postal clerks and other Federal employees.

First, as medical care costs rise, the portion of them not covered by insurance constitutes a much greater burden, especially for Government employees, particularly our postal clerks, in the lower pay grades and levels.

Second, as medical costs rise, the premium rate of insurance to cover these costs must necessarily rise, increasing the financial burden upon employees who must pay the balance of a larger premium, even if it is only a larger one-half.

In the post-World War II period, charges for medical care have risen persistently. Chart C illustrates this graphically. During the years from 1946 through 1969, the medical care component of the Consumer Price Index increased 158 percent to 258 percent of what it was. During these same years, the price index for all consumer items combined rose at a much slower rate, increasing comparatively by 88 percent.

An extremely alarming and disconcerting fact is that daily hospital rates have been increasing faster than any other component of the medical care price index, and in the postwar period, increased 595 percent. This means they increased to 695 percent of what they were in 1946. Over the same period of time, the price index for all consumer items increased 88 percent, and physicians' fees increased 142 percent.

During the 1950's, the medical care index rose to an average rate of 4.7 percent a year. It slowed during the early 1960's to an average of 2.5 percent a year as medical care prices followed the generally slower rise of all service industry prices. However, more recently medical care prices have increased at a faster rate, rising 6.6 percent in 1966, 6.4 percent in 1967, 6.1 percent in 1968, and 6.9 percent in 1969.

Within the medical care component, hospital room rates rose especially sharply, leaping 16.5 percent from December 1965, to December 1966. In 1967, hospital room rates increased an additional 15.5 percent.

Table 4 in the supplement to this statement tabulates hospital room rates in selected hospitals in 1965, 1969, and 1970, as reported by the officers of our United Federation of Postal Clerks hospital plan. From 1965 to 1970, rates in the nine hospitals rose over a range of from 60 percent at Children's Hospital in Los Angeles, Calif., to 93 percent at Holy Cross Hospital in nearby Silver Spring, Md.

The increase in medical care costs since 1959 is reflected in chart D in relation to the CPI for "all items." With a base period of 1957-59

equaling 100, the medical care index rose from 104.4 in 1959, when the Federal Employee Health Benefits Act was passed, to 155.0, the average for the 12 months of 1969. The latest reported index is 159.0 for January 1970.

The "all items" index increased from 101.5 in 1959 to 127.7 in 1969. The "all items" index for January 1970 was 131.8.

We believe, Mr. Chairman and members of this distinguished committee, that we have made it abundantly clear that medical care costs and the related cost of health benefits insurance have been and will continue to be a tremendous burden for Federal Government employees, and unless appropriate and timely action is taken by this Congress to relieve our postal clerks of at least a substantial part of this extremely heavy premium burden by reducing their share of the cost of health benefits insurance, this great and substantial financial burden for postal clerks and other Federal employees, as well as annuitants, Mr. Chairman, will certainly continue to accelerate.

However, before we depart from this point, we must emphasize that the bulk of our members and the majority of all Federal employees live in large cities and metropolitan areas in which the cost of medical care has obviously risen faster and to considerably greater heights than the Consumer Price Index as a whole. In 14 major cities it has risen substantially more than the U.S. city average for medical care. For Washington, D.C., the medical care index stands at the astronomical level of 180.4 (1957-59, 100), compared to 159.0 for the U.S. city average. Following closely behind are the cities of Cleveland, 179.0; Baltimore, 173.3; Detroit, 171.4; and Philadelphia, 171.1.

Table 5 in the supplement tabulates 21 cities in which the medical care index greatly exceeds the general Consumer Price Index of 131.8.

The many postal clerks and Federal employees in these 21 large cities, in particular, as well as those in the towns, villages, and the rural communities throughout this entire Nation need relief now in the form of a lower proportionate cost of medical care insurance within the Federal and Postal Service.

The need for adequate medical cost insurance to pay health benefits when illness or injury strikes has been clearly indicated. Every employee should have the opportunity to participate in a program which offers insurance to ease his burden in time of need. We believe, and sincerely hope, this committee will concur in our belief that the Federal Government in this great country of ours should take the lead and set an exemplary pattern of how an employer should cooperatively participate with employees in such health benefits programs—as a matter of fact, unfortunately and as the record clearly indicates, this has not been the case to date. The Federal Government has lagged considerably behind the employers in private industry and, regretfully, has not been providing leadership or an exemplary pattern in this area of health benefits for its employees.

The trend in private industry has definitely been toward the employer assuming the full cost of the employees' health insurance premium. Large employers such as the Government of the United States generally pay the full cost. Smaller employers pay at least half of the cost of their employees' health benefits premiums.

As reported in Bulletin No. 1530-87 published by the Department of Labor's Bureau of Labor Statistics, 64 percent of plantworkers

and 49 percent of officeworkers were employed in establishments which paid the full cost of their health insurance premium. And this particular survey among private employers was concerned with late 1966 and early 1967. Since that time, without question, this continuing and progressive trend has further and substantially increased these figures.

A 1969 Bureau of Labor Statistics Digest of 50 health and insurance plans, published by the Department of Labor in November as Bulletin No. 1629, reports on the health insurance plans for salaried personnel working for large employers in each of 50 major industries. According to the study, 50 percent of these employers paid the full cost of the employees' health and hospital insurance are listed below:

- Aluminum Co. of America.
- American Airlines.
- Burlington Industries.
- Campbell Soup.
- Caterpillar Tractor Co.
- Dupont.
- Greyhound.
- International Business Machine.
- International Harvester.
- International Paper.
- Kresge.
- Lerner Shops.
- Penn Central.
- Pittsburgh Plate & Glass.
- Radio Corp. of America.
- Swift & Co.
- Union Carbide.
- United States Steel.
- Weyerhaeuser Co.

These employees, each of whom represents a major industry, reflect a fair and reasonable cross section of the U.S. industrial scene. We sincerely believe the Federal Government should follow the lead of major industry employers, and, in some cases, even comparatively minor employers in the private sector, and move rapidly toward full payment of the premium cost of employees' health benefits insurance for Federal and postal employees.

The time is now, we believe, and we hope this distinguished committee concurs—the U.S. Government, if it cannot or will not be a leader in this most important area of health benefit protection and premium payments for its employees that at least at this time, in the year 1970, will follow the lead of major employers by moving quickly and responsibly toward ultimate full payment of health benefit premiums for postal clerks and other Federal employees.

In times of domestic crisis and administrative inaction, such as the ever-increasing financial burden for Federal employees under the Health Benefits Act, the Congress of the United States must once again display its traditional leadership role if the unrealistic and ever-increasing burden of health benefit premium costs which continue to plague the Federal employee are to be finally and, we hope, permanently resolved in equitable, satisfactory resolution of this issue.

In conclusion, Mr. Chairman and distinguished members of this committee, we have indicated our enthusiastic support and endorsement for the legislation, H.R. 767, pending before this committee. We strongly urge the provisions of H.R. 767 for ultimate 100 percent payment of Federal employee health benefit premiums. It is our hope that this statement which we have presented to you this morning with the related supplements, including charts and graphs, will convince you of the merit of our presentation in support of this badly needed legislation.

Thank you, Mr. Chairman and members of the committee, for permitting us this opportunity to express the position of the United Federation of Postal Clerks on the pending legislation.

My colleagues, Mr. Jack Love, secretary-treasurer; Mr. John Dubay, research and service administrator, both of our hospital plan; and Mr. Walter Froh, our staff economist; as well as myself will be very happy to respond to any questions concerning our testimony and cooperate in every way, Mr. Chairman and other members of this committee, concerning this most important pending legislation, H.R. 767.

Thank you, Mr. Chairman. Based on your opening statement, we assume that our supplements 1 and 2 will be included as part of the record without any further reference.

Mr. HENDERSON. Yes; without objection, it is so ordered.

(The material referred to follows:)

TABLE 1—MONTHLY PREMIUM, LOWEST COST GOVERNMENT-WIDE HIGH-OPTION PLAN, FOR SELF AND FAMILY
(MARCH 1970)

Year	Total premium	Employee contribution	Government contribution as percentage of total
1960.....	\$17.46	\$10.70	38.7
1969.....	38.33	29.45	23.2
Percentage change.....	+120	+175	-40

TABLE 2.—BIWEEKLY COST, UNITED FEDERATION OF POSTAL CLERKS' HEALTH BENEFITS PLAN—HIGH-OPTION, SELF AND FAMILY, (MARCH 1970)

	Total	To employee	To Government	Percent paid by Government
July 9, 1960, to Oct. 31, 1961.....	\$8.06	\$4.94	\$3.12	38.7
Nov. 1, 1961, to Oct. 31, 1962.....	8.98	5.86	3.12	34.7
Nov. 1, 1962, to Oct. 31, 1963.....	9.98	5.86	3.12	34.7
Nov. 1, 1963, to Oct. 31, 1964.....	11.49	8.37	3.12	27.1
Nov. 1, 1964, to Oct. 31, 1965.....	12.06	9.94	3.12	25.8
Nov. 1, 1965, to Dec. 31, 1966.....	15.75	12.63	3.12	19.8
Jan. 1, 1967, to Dec. 31, 1967 ¹	15.75	11.65	4.10	26.0
Jan. 1, 1968, to Dec. 31, 1968.....	17.10	13.00	4.10	23.9
Jan. 1, 1969, to Dec. 31, 1969.....	18.35	14.25	4.10	22.3
Jan. 1, 1970, to Dec. 31, 1970.....	19.05	14.95	4.10	21.5

¹ Government contribution increased from \$3.12 to \$4.10.

TABLE 4.—SEMIPRIVATE HOSPITAL ROOM DAILY RATES IN SELECTED HOSPITALS, 1965 AND 1970

Hospital	1965	1970	Percent increase since 1965
Providence Hospital, Oakland, Calif.....	\$37.00	\$65	76
Presbyterian Medical Center, San Francisco, Calif.....	39.00	72	85
Childrens Hospital, Los Angeles, Calif.....	42.00	67	60
St. Mary's Hospital, Reno, Nev.....	31.00	48-50	90
South Nevada Memorial Hospital, Las Vegas, Nev.....	32.00	(1)	-----
St. Francis Hospital, Jersey City, N.J.....	35.50	58	63
Community Hospital, San Gabriel, Calif.....	31.00	56	81
Washoe Medical Center, Reno, Nev.....	31.00	50	61
Holy Cross Hospital, Silver Spring, Md.....	29.00	56	93

¹ Not available.

Source: United Federation of Postal Clerks hospital plan.

TABLE 5.— February 1970 medical care cost index for cities surveyed

[1957-59=100]

Washington, D.C.....	180.4	Kansas City.....	163.4
Cleveland.....	179.0	Atlanta.....	159.4
Baltimore.....	173.3		
Detroit.....	171.4	U.S. city average.....	159.0
Philadelphia.....	171.1		
Scranton.....	169.3	San Francisco-Oakland.....	156.3
Cincinnati.....	167.7	Portland.....	155.9
Chicago.....	167.2	Los Angeles-Long Beach.....	154.7
Boston.....	166.5	Houston.....	152.0
New York City.....	165.7	Seattle.....	151.2
Pittsburgh.....	164.3	Milwaukee.....	150.0
Minneapolis-St. Paul.....	164.2	St. Louis.....	149.8

Source: Bureau of Labor Statistics, U.S. Department of Labor.

CHART A PERCENTAGE CHANGE IN COST OF LOWEST-COST GOVERNMENTWIDE
HIGH-OPTION PLAN FOR SELF AND FAMILY, 1960-1970

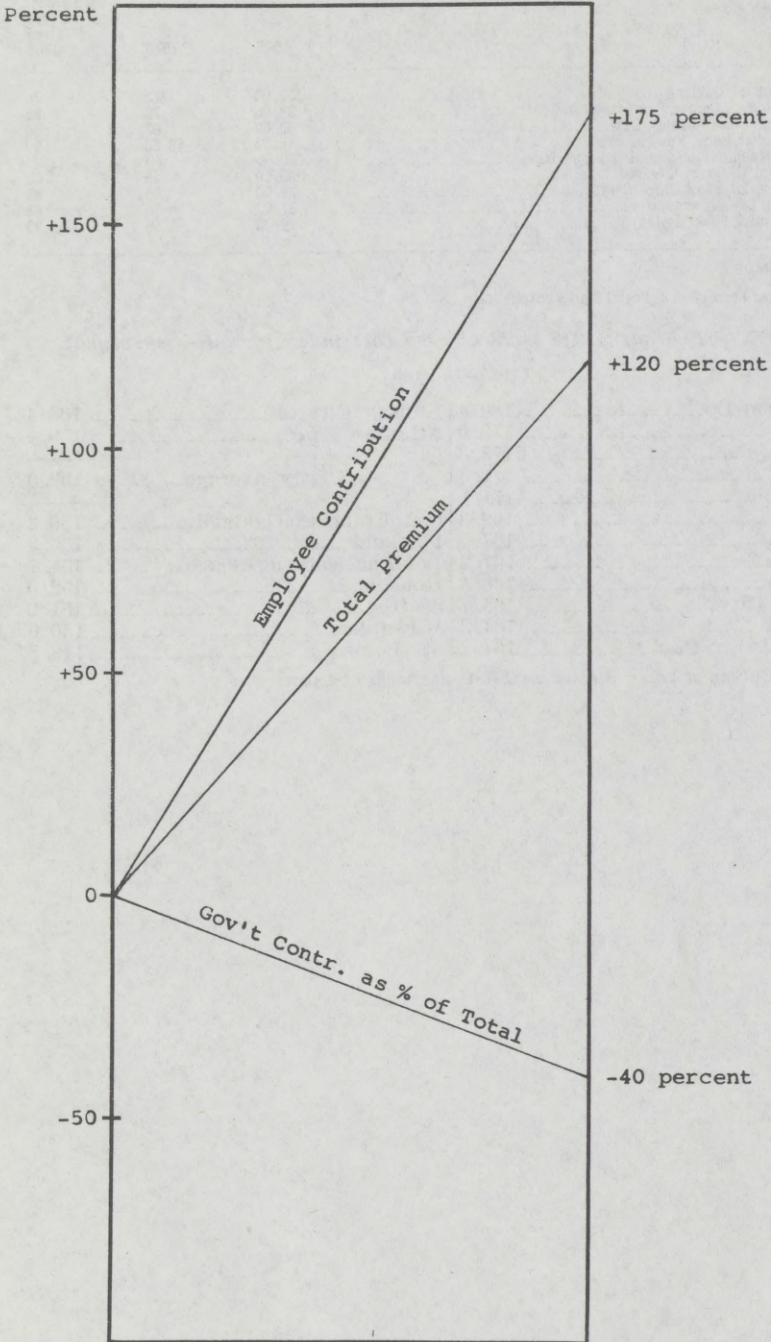


CHART B GOVERNMENT CONTRIBUTION AS PERCENTAGE OF HIGH-OPTION PLAN PREMIUM, 1960-1970

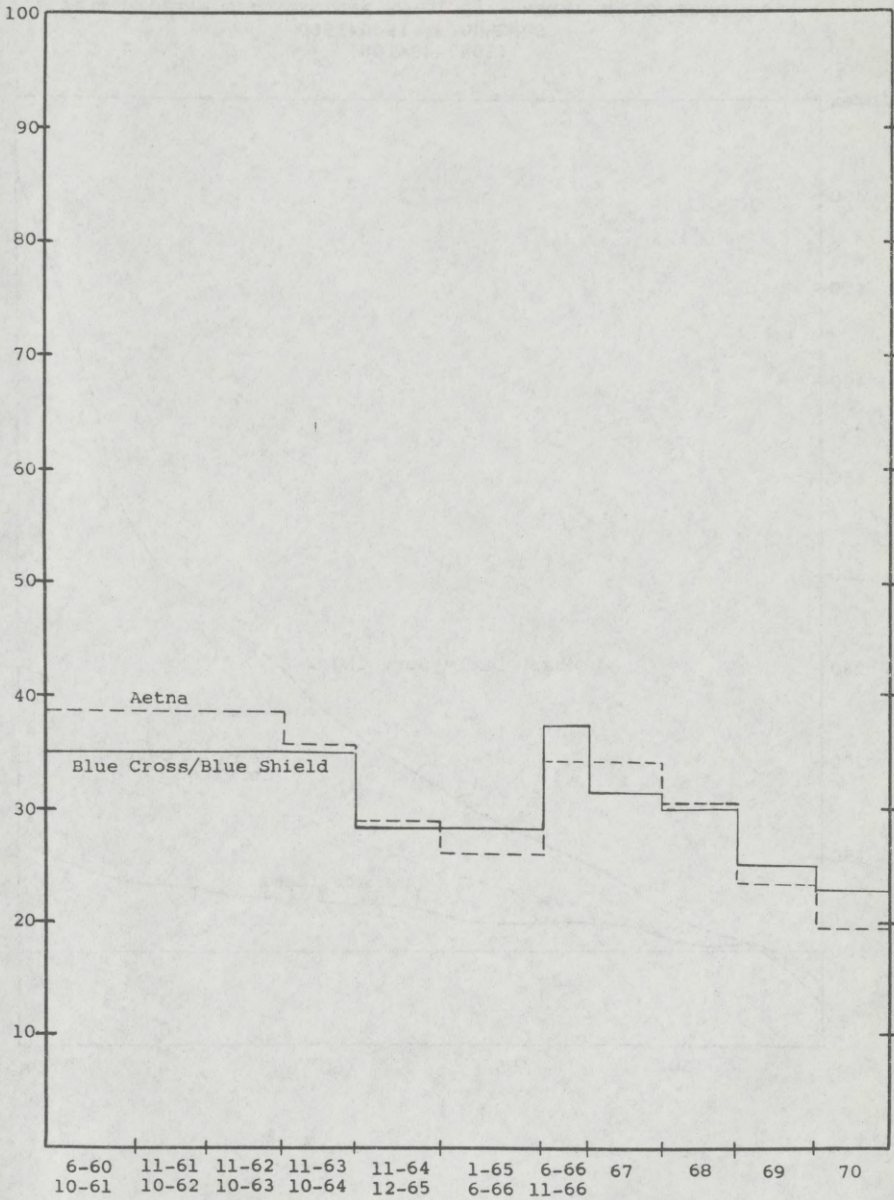
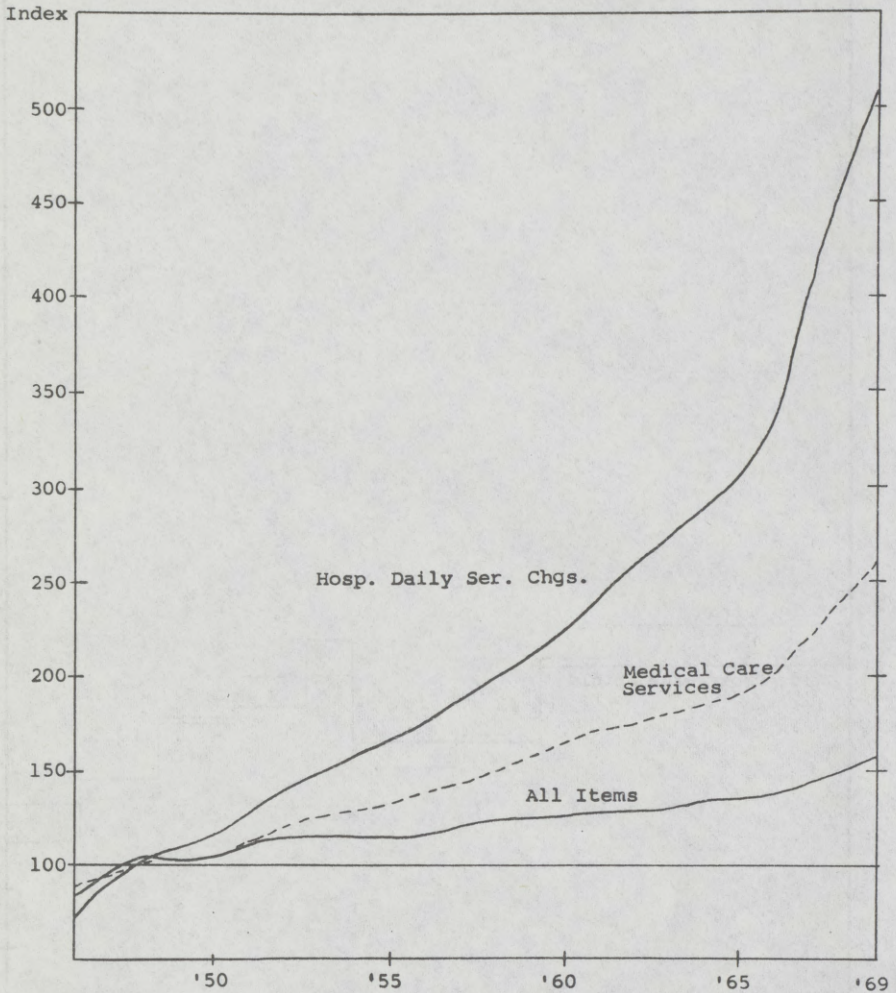
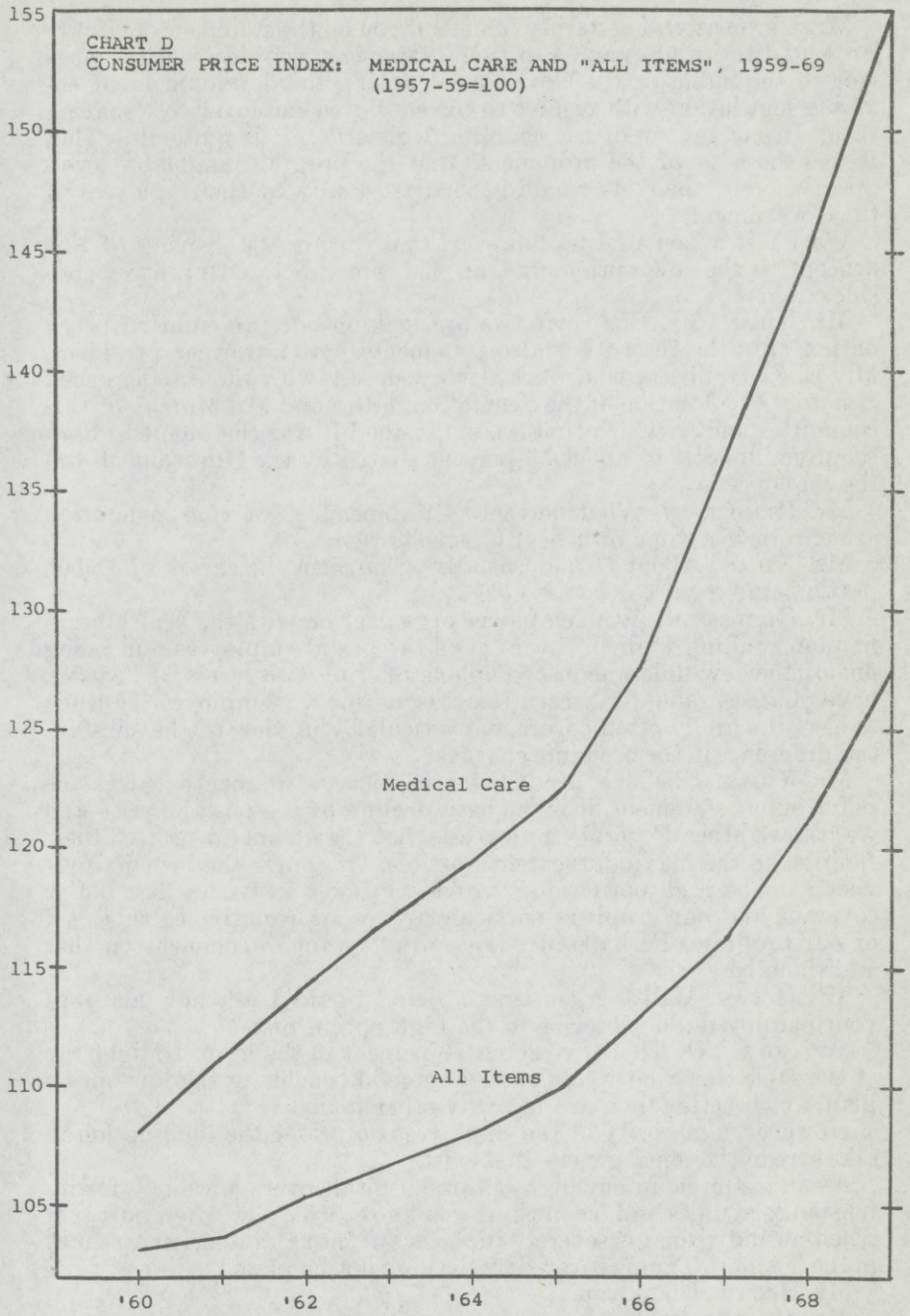


CHART C

CONSUMER PRICE INDEX, ALL ITEMS AND SELECTED MEDICAL CARE
SUBGROUPS, 1946-1969
(1947-49=100)





Mr. HENDERSON. I certainly commend you on the statement you have presented to us. On page 4 of your statement, you deal with a question of the intent of the Government during the development of enabling legislation with respect to the employee-employer cost sharing ratio. In my review of the enabling legislation, it is quite clear that it was the hope of the proponents that the program might be developed whereby the costs would be shared equally by the employees of the Government.

Wasn't it a fact of life, however, that during the gearing of this concept to the low option was, at that time, dictated by fiscal considerations?

Mr. NILAN. Mr. Chairman, we are making our presentation based on not only the record but also statements by our former president, Mr. E. C. Hallbeck, who worked very closely with the distinguished Senator Olin Johnson of the Senate committee and Mr. Murray of this committee and at which time we understood it was the intent to have the premium cost of about 50 percent shared by the Government and the employee.

Mr. HENDERSON. What percent of the members of your federation are enrolled in your own health benefits plan?

Mr. NILAN. About 50 percent, Mr. Chairman, in excess of 75,000 participants.

Mr. HENDERSON. As an employee organization with the health benefit plan ranking high in coverage of the postal employees and being one of the few union sponsored plans offering two levels of benefits, have you been able to discern the reasons for the employee tendency to elect the high option coverage, particularly in view of the substantial difference in the premium charges?

Mr. NILAN. I believe, Mr. Chairman, that as we mentioned at one point in our statement, it is the basic feeling of the postal clerk—and we believe other Federal employees—that they want to protect their families to the maximum extent possible. Of course the benefits provision in the high option does provide in most instances first dollar coverage and our members particularly are appreciative of this part of our program. Perhaps Mr. Love would want to comment on that additionally.

Mr. HOGAN. Will the gentleman yield? Could I ask how many of your employees do subscribe to the high option plan?

Mr. LOVE. Yes. There are about 70 percent in the high. I might say at the same time that we do have very good benefits in the low-option plan, much better than are in many other plans.

However, a majority of the employees do prefer the high-option to take care of the contingencies that exist.

As an example, in our high-option hospital coverage we pay for intensive care units and, as most of you know, it is very often now that when an individual is severely ill, he is put into an intensive care unit in the hospital. That is covered by the high option plan.

Mr. HOGAN. Thank you.

Mr. HENDERSON. Could you inform us whether or not it is possible that some indeterminate number of low-risk employees might be somewhat overinsured by enrolling in high option coverage?

Mr. LOVE. If any individual would know that he would be a low-risk employee individual, then perhaps he would go into the low-op-

tion plan more. But it has been my experience now, as an example, last year I went into a hospital three times and I have never been into a hospital since I was born.

Mr. HENDERSON. You look at it statistically and you might arrive at that conclusion. But looking at it on the experience of the individual you wouldn't come to that conclusion, would you?

Mr. NILAN. I think, Mr. Chairman, also when the average Federal and postal employee—in our opinion who is underpaid at the present time and really substantially underpaid—reads in the evening paper about the tremendous costs of \$90 a day for a hospital room and other severe related costs rising, spiraling costs of the medical and hospital benefits, I think it scares him. I think he says, "I think I had better try to provide for my family the best I can" and this is another reason he selects the best high option benefit plan because he can't afford to pay the supplemental costs that he may have to under a low option plan.

Mr. HENDERSON. In your statement, I believe it is on page 10, you emphasize the sharp rise in hospital room rates that occurred in 1966 and subsequent years. Since that was the year in which the medicare program became effective, do you contribute any of the sharp rise to its advent?

Mr. LOVE. We don't subscribe to that theory, but many people in the profession do say that that has caused it. We are in no position to know whether or not that did have an effect.

Mr. HENDERSON. Do you have any other reasons, satisfactory to yourself, or is it that you just don't understand what caused it?

Mr. LOVE. We think it has been more and more that employees, as well as anybody else outside of the Government, who have insurance are apt to use it when they need it, whereas if they didn't have it they wouldn't be going into a hospital.

Mr. HENDERSON. Let me ask if you believe that the rise in the cost of hospital room rent is a reflection of personnel cost increases in a hospital?

Mr. LOVE. To a certain extent that is probably true because traditionally hospital employees have been very badly paid. They are beginning to pay them better salaries. I would say that a number of reasons exist, and they are something over which our hospital plan has no control or any other hospital plan has any control over.

Mr. HENDERSON. In my opinion, it would seem natural that the rise in cost of the maintenance of the hospital rooms, and so on, would be reflected in the room cost. But I think you are right, that some of the other costs of the personnel in the hospital have been related directly to the room cost and it is somewhat difficult to tell just exactly why this has been true.

Mr. Nilan, I wanted to comment on the table and charts appended to your statement because it is quite obvious that they show the need for the increased Government participation in premium sharing. I certainly commend you and your associates for a job well done, not only in the statement but to the tables and charts appended. I believe that those are all the questions I have at this time.

The Chair recognized the gentleman from New York, Mr. Hanley.

Mr. HANLEY. Thank you, Mr. Chairman. I regret I was unable to appear during the course of the gentleman's testimony. Should I have

any questions I will submit them. The percentage of your membership which participates in your organization's plan—could you tell us what that percentage is?

Mr. NILAN. A little better than 50 percent.

Mr. HANLEY. I see. Do we have a statistic with regard to the percentage of the industries and the private sector who pick up 100 percent of the cost?

Mr. NILAN. We have that in the statement, Mr. Hanley.

Mr. HANLEY. Thank you.

Mr. HENDERSON. May I follow the gentleman's previous question at this point?

Mr. HANLEY. Yes.

Mr. HENDERSON. What portion of the other 50 percent of your membership are covered by other plans under the program?

Mr. LOVE. I would say almost all of the others are. They are in some plan or another.

Mr. HENDERSON. This 50 percent you are referring to are in the plan furnished by your organization, either high or low option?

Mr. LOVE. Right.

Mr. HENDERSON. The gentleman from Maryland is recognized.

Mr. HOGAN. I would also like to commend Mr. Nilan for his statement.

I was wondering if you had had a chance to read my bill, H.R. 10593 and can comment on that. It would immediately call for 100 percent payment of premiums of specified benefits. It seems to me that, with all due respect to the chairman of the subcommittee, H.R. 767 calls for percentage of what? I think this opens up a wider area of confusion, and it seems to me that the only way that you can do it is by gearing it to the specific benefits. I know that this is a complicated area and I am also aware that the Civil Service Commission looks more unfavorably on my bill than they do on the chairman's bill.

I wonder if you would comment, if you are familiar with H.R. 10593.

Mr. NILAN. Mr. Hogan, first let me say that we have been trying to get some additional copies of it. I got only one copy originally.

Mr. HOGAN. They are kind of scarce around the committee for some reason.

Mr. NILAN. I mean it seriously. I don't know where they are. I think my staff called your office to get a copy only last week when we were getting ready to testify but we haven't had a chance to review it, except for a general comment. Your proposal has considerable merit, also.

It is a question, which way do you want to go? The approach you use on paying 100 percent of certain benefits certainly would result in immediate 100 percent payment of these items which are particularly important to a member of a health plan. However, we feel that in order to permit a wide selection of plans which we are wholeheartedly in favor of, and I might add, we hope our members join our union plan we prefer H.R. 767. But to permit this type of a selection and the type of coverage and benefits available, we believe that the Commission proposal of last week—which would establish a higher base, using two of the larger employee plans, the two Kaiser plans

and the two Government-wide indemnity plans and the high option plans—if this approach were used with a continuing adjustment on the base cost and then ultimately the Government contribution increased to 100 percent, then being perfectly candid, we would prefer the H.R. 767 approach at least at this time.

Mr. HOGAN. Last week the Chairman of the Civil Service Commission, Mr. Hampton made a statement that the benefit package the Government employee enjoys may be better than that in private industry. I wonder if you would care to comment on that?

Mr. NILAN. I believe the last reference point—it is difficult to understand why the Bureau of Labor Statistics experiences this problem in developing a comparison—but the last comparison we have here is based on fiscal 1967, which is considerably outdated with the increased costs. This shows that for the Federal Government the fringe benefit package is 23.8 percent of payroll. The comparable sector within the private sector is 24.5 percent. The total picture, as far as the private sector, is 20.7 percent.

This is 3 years old, and frankly there are other analysis that have been made by independent organizations which are much more current. Unfortunately, I don't have the record with me. I believe the Chamber of Commerce only last year had developed an updated comparison and if I recall the private sector was about 0.4 to 0.7 of a percent above the Federal sector. So it is again a question which we don't challenge the Commission on, but, at the same time, we are not too sure it is a current or accurate analysis of the prevailing situation.

Mr. HOGAN. I frankly don't have much patience with the Civil Service Commission and the Budget Bureau constantly opposing the benefits to Federal employees on the grounds that we can't afford it. I think it is a question that we can't afford not to. Even if the Chairman's statement is accurate, I don't think that that is a legitimate justification for opposing legislation as is before the committee. Because I have always felt that the Federal Government ought to be at least in the lead in providing fringe benefits rather than lagging constantly behind them.

If we are going to attract to the Government service the outstanding employees we need to handle the public business, it seems to me we have to lead rather than follow.

Mr. NILAN. Thank you very much. I might add the real tragedy in the whole thing in comparing fringe benefits is that if we went back probably eight, ten, twelve or fifteen or twenty years, the Government was considered a leader in the area of fringe benefits because of the annual leave laws, sick leave laws, and so on.

And again not being able to document it at the moment, I am confident that this position has been completely reversed in the last 10 or 12 years, where the Government is falling more and more behind each year and private industry is overcoming the lead of the Federal Government.

Mr. HOGAN. Which also explains why the Government is a training ground for private industry.

Mr. NILAN. That is absolutely correct.

Mr. HENDERSON. The gentleman from Pennsylvania, Mr. Nix, is recognized.

Mr. NIX. Thank you, Mr. Chairman. I join the chairman and the other members of the committee in complimenting you, Mr. Nilan, on an excellent statement.

I noticed during the course of your testimony you mentioned the fact that postal employees were underpaid. You casually mentioned it. It seems to me that, with dramatic suddenness, that fact has been brought to the attention of the American people. I have no reservations in supporting completely this legislation. It is overdue and I think this committee and the Congress should act immediately in this field.

Thank you, Mr. Chairman.

Mr. NILAN. Thank you, Mr. Nix.

Mr. HENDERSON. Mr. Nilan, if I could ask you just to depart from this specific legislation we have before us this morning, and even suggest that if we could forget for a moment the crises that we find ourselves in, not only specifically with regards to postal service, but the broad problem of employee pay and benefits, what would be your reaction to a proposal that the executive branch of our Government be given broad powers to act in the area of pay and benefits without specific authority of the Congress in the immediate future?

Mr. NILAN. That is an excellent question. I am very happy to respond to it.

Oddly enough, if I may refer to the other body for a moment, Senator McGee and Senator Fong last Thursday introduced S. 3613, which is a postal reform proposal, not a corporation, not an authority, but there is a very excellent section in there which would permit the recognized postal employee organizations to do just exactly what you suggest—negotiate and bargain for wages and fringe benefits.

We are very much in support of the chapter—13, I believe it is—in that particular piece of legislation. We have no fear of collective bargaining on these issues. As a matter of fact, we might even welcome it. If we do, however, we want to be absolutely certain that the membership and the employee organizations representing them have the tools to effectively negotiate on these issues and be equals at the bargaining table, and not be in a subverted position. This has been our main concern through the entire past 12–14 month period. If I can say one further thing, we have not been convinced that the administration's proposal in its corporation or authority proposals in this area, and the type of collective bargaining they suggest, would permit us to be equals at the bargaining table.

Mr. HENDERSON. It might be that other witnesses who are not within the postal services could comment, but certainly I know you have been in this business a long time. What would you think of legislation broad enough that would set the pattern for all Federal employees, as well as postal, in this regard?

Mr. NILAN. Well, I certainly recognize that this would be important also and, assuming that our brothers in the Federal service share our interest or our concern, this would follow.

Mr. HENDERSON. One of the reasons I raise this question in connection with this specific legislation is that I think it is pretty obvious to members of the subcommittee—we heard the testimony last week and yours this morning—that if such broad authority had been existing, that I believe at least the action recommended by Chairman

Hampton last week could become effective much quicker than the legislation that our committee and the Congress might come up with on this.

Mr. NILAN. If I may say, Mr. Chairman, we would hope that the Congress in its wisdom and understanding of our problem, particularly at the present time, were to recognize that the postal employee in particular—and this applies to the Federal employees generally, but the postal employee in particular does not have parity with the workers in the private sector. We would hope that the Congress would give us that parity and equality on wages and fringe benefits and not have to wait a year to negotiate these in any other form of collective bargaining. We are substantially behind, as Congressman Nix indicated. We have been historically behind. Our position would be to have Congress raise us to the level of comparability on pay and fringe benefits with the private sector—and do it now. So that if he ever did enter into any system of collective bargaining, at least we would start as equals. We don't want to start at the bottom of the ladder and bring ourselves up. We want to start at a comparable level with our brothers and sisters in the private sector so there is complete equality at the time of starting negotiations with postal management.

Mr. HENDERSON. I don't want to take time from other witnesses, but I would comment that one thing I see here is what the average citizen, I think, has overlooked—and perhaps what Representatives in the Congress overlook—is that where the postal employee works is not a matter of choice by management or the employee himself, but it is determined by where the American public is. This is not true, necessarily, with regards to other Federal employment.

Thank you very much, Mr. Nilan, and your associates. You have done an excellent job and I commend you.

Mr. NILAN. Thank you very much, Mr. Henderson.

Mr. HENDERSON. Our second witness was to have been Mr. David Silvergleid, the president of the National Postal Union.

Mr. Silvergleid was here but informed the Chair of a previous commitment and the necessity for him to leave.

Mr. Edward L. Bowley, the legislative director, and Mr. Ben Evans, the secretary-treasurer of the National Postal Union health plan will represent the president. We are delighted to welcome both of you here this morning.

Mr. BOWLEY. Thank you. Today is the day for pinch-hitters. Our president was called away, Mr. Chairman, by the Secretary of Labor, hopefully that he might be able to help resolve the postal crisis that we find ourselves in. At least we can lend a helping hand in that direction.

Mr. HENDERSON. I am sure that the members of the committee are most appreciative of his efforts.

Mr. BOWLEY. Mr. Chairman, I am the legislative director of the National Postal Union and I had the privilege of serving the National Postal Union in the capacity of secretary-treasurer of its health plan for 7 years.

The gentleman on my right is the present secretary-treasurer of the health plan, Mr. Ben Evans.

STATEMENT OF DAVID SILVERGLEID, PRESIDENT, NATIONAL POSTAL UNION, AS PRESENTED BY EDWARD L. BOWLEY, LEGISLATIVE DIRECTOR, ACCOMPANIED BY BEN EVANS, SECRETARY-TREASURER

Mr. BOWLEY. Mr. Chairman and members of the subcommittee, we represent approximately 80,000 postal employees and 10,000 career Federal employees, and approximately 175,000 persons are covered by NPU's health benefit plan. I am accompanied by our legislative director, Edward L. Bowley, who administered our health plan for 7 years and the present secretary-treasurer of our health benefit plan, Ben Evans.

At the outset, Mr. Chairman, we would like to express our appreciation to you for scheduling hearings on this vital legislation. Your recognition of 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. It would be a truly outstanding achievement if the 91st Congress approved Government payment of health insurance premiums in addition to the recently enacted retirement law.

We are pleased to cite that numerous Members of Congress have introduced bills relating to the same subject, and that in the Senate, the Honorable Gale W. McGee (D.-Wyo.), chairman of the Senate Post Office and Civil Service Committee, has also introduced a bill to increase the Government's contribution toward health plan premiums, and his committee has concluded hearings. The subject of the Government's contribution to health insurance premiums is so important to our membership that our last national convention placed this at the top of our legislative goals.

Mr. Chairman, the continual rise in cost of hospital and medical care in this country has become a national scandal, so much so that it prompted the previous 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 aforesaid committee did not come up with the answers to 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 highlight 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 seriousness of the situation.

The 86th Congress provided a health benefits program to take effect July 9, 1960. Under this law 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 family coverage, particularly where greater

allowances are needed, since low option plans have limitations on most benefits. This move to high option plans has been necessary to meet steadily increasing hospital and medical costs. The last official figures released show approximately 85 percent of all eligibles are in high option plans. However, at this time between the two Government-wide plans, the service benefit plan has the lowest cost for low option, and even here the Government is presently paying less than 50 percent.

I want to say we are in agreement that the intent of the law, as far as we are concerned, is that Uncle Sam had intended to pay 50 percent of the premiums.

I would also like to point out at this time that at the present time even the lowest of the two Government-wide plans which are spelled out in the law presently are not paying 50 percent of the premium.

Maximum contributions by the Government initially was \$3.12 biweekly 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 \$4.10 biweekly. The total inadequacy of the Government's contribution is pointed up in two major areas. First, the increase in Government contributions referred to above failed to restore even the original percentage of premium paid by the Government. This is so since the overwhelming majority of enrollees are in the more expensive high-option plans, and most carriers have been compelled to double their high-option premiums since the inception of the program.

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

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
1969	13.96	4.10	18.06	22.70
1970	14.25	4.10	18.35	22.34

This table reflects the Government share, how it was decreased proportionately each year as the result of rising premiums of the NPU plan. Of course you will note that at the present time for the 1970 contract we are receiving, or the Government's share of cost toward a plan is, only a little over 22 percent. There have been a number of factors, I think, that are attributable to the high cost of hospitalization. One of these, of course, is that the annual cost per person for health care services has been increasing steadily ever since the Health Benefits Act became effective because of increases in the cost of individual services.

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 interceptions 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. Also, coverage was extended 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 Kennedy presented a program involving more coverage for the mentally ill in this country, and the Civil Service Commission requested all carriers to cooperate in this regard.

Public Law 88-284 liberalized eligibility to continue enrollment as an annuitant. By insurance standards this is an extremely high risk group.

National Postal Union was pleased to go along with all of these programs although these were all areas of cost to the carriers borne entirely by the enrollees, while there was no accompanying recommendation to increase the contributions by the Government.

More recently, alcoholism has become recognized as an illness, and the Civil Service Commission once again asked all carriers to take cognizance of the situation and provide benefits in this area, beginning with the 1969 contract year. National Postal Union responded by providing coverage in this very vital area, affecting millions of people in this country. But once again, we must point out that this, too, added more cost to the plan.

Now, Mr. Chairman, let us really discuss cost. Rises in hospital costs are presently averaging about 15 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.

Government calculations indicate medical costs have been rising faster than the total cost of living. Attached hereto, taken from the Wall Street Journal of March 3, 1970, is a table reflecting the monthly medical care cost rise indicating medical care costs rose 159 percent of the 1957-59 average from 158.1 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 1968 ranging from 10 percent to 25 percent of 1967 charges, and we were told by

our actuaries to expect even greater increases in 1970. All of the increases are compounded on the gross increases of previous years, of course, imposing a severe hardship on employees for whom adequate health insurance is a must. Additional exhibits attached hereto point out the severity of the situation.

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

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 \$78 in 1969 from \$68 in 1968. 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 \$93.67 in 1969. This pattern is 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 high costs are reflected in higher medical insurance premiums and higher taxes to cover expenses for such Government-sponsored programs as medicare, where premiums are also increasing continually, 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.

A recent report to the Civil Service Commission prepared by Milliman & Robertson, Inc., regarded by the insurance industry as one of the Nation's top consultants in the field, advised that health insurance premiums will double by 1975. The report projected premiums for the most comprehensive Blue Cross-Blue Shield Plan will climb to an annual \$907 over the present annual rate of \$460. The Government's contribution toward such coverage will remain at the present legal maximum of \$106.56 a year unless Congress acts soon on this important legislation. The report indicated that the two Government-wide plans can be expected to increase in premiums from 10 percent to 35 percent every 2 years between now and 1976. The cost of health care rose almost 73 percent since the late 1950's, while most consumer goods and services have risen 31 percent.

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 service 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 not been that doctors charge more when they know an individual has a health plan, that six office visits are often 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 oftentimes 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. As a result, specialists' fees come much higher.

As a labor union, we believe that workers' incomes (including physicians') 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 a decent income. It seems that the dedication and compassion of the majority of our doctors of today is long gone and has been replaced by the dollar tag with no concern for the human element. They seem to have only one price, that is, the highest price they possibly can find. 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 house is a thing of the past.

We believe something can 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 be borne by the Government.

S. 1772, introduced by the distinguished chairman of the Senate Post Office & Civil Service Committee, Senator Gale W. McGee (D-Wyo.), and the distinguished chairman of the Subcommittee on Health Insurance, Senator Quentin N. Burdick (D-N. Dak.) is definitely a step in the right direction. H.R. 767, introduced by the distinguished chairman of this committee, goes even further in that direction by providing the Government's contributions to subscription charges be increased to 50 percent of cost in July 1969; to 75 percent in July 1970; and 100 percent of costs in July 1971. But H.R. 767 does not indicate a percentage of what? Regardless of the percentage approved—38, 50, or 100, it is inconceivable that the Congress would approve of, or the Civil Service Commission would administer, a program that provides a different benefit for each employee, dependent upon which plan they are enrolled. We recognize that when there are 36 Government plans, all offering a different level of benefits and premiums, the Congress will have a difficult task in determining a method whereby all Federal employees would be treated equally. It was for this reason that NPU asked Hon. Larry Hogan, Republican, of Maryland, a Member of the House Post Office and Civil Service Commission and a member of this subcommittee, to introduce H.R. 10593—a bill that will provide a level of benefits that would equally apply to all Federal employees for which the Government would underwrite the full cost. All carriers could then remain competitive by offering an additional level of benefits that could include major medical coverage and optical or dental plans at a cost that would be borne entirely by the individual. The following reflects the benefits which would be offered by Congressman Hogan's bill:

The Government shall pay the entire cost of the following minimum basic benefits which shall be provided for all employees and annuitants and their families:

- (1) Up to 180 days' hospital coverage for each confinement;

- (2) Surgical benefits as outlined in the set schedule of fees with a maximum of \$500 for any one confinement ;
 - (3) Medical visits to be reimbursed at \$10 per hospital visit ; \$8 per home visit ; and \$6 per office visit ;
 - (4) Diagnostic services as provided for in a set schedule of fees ;
 - (5) First-aid treatment in full within 72 hours after an accident ;
 - (6) Maternity benefits to be treated as regular hospital benefits plus up to \$200 for doctor's charges ;
 - (7) Nursing care up to \$20 per eight-hour shift for up to 180 days a calendar year ;
 - (8) Mental and nervous disorders for up to 30 days per calendar year ;
 - (9) Alcoholism and drug addiction for up to 30 days per calendar year ; and
 - (10) Dental and cosmetic surgery shall be covered only when necessary for prompt repair of injury caused by an accident.
- These benefits shall be available to each employee, annuitant, and member of the family, separately.

Although we feel strongly that full payment of health insurance premiums by the Government has been unconscionably delayed, we recognize that the administration's insistence on a surplus budget may prove a big obstacle at this time. However, justified remedial action is long overdue, particularly in view of the growing trend in private industry for management to pay the full cost of health insurance for its employees.

This is not unique, Mr. Chairman. As a matter of fact, we find the Government lagging far behind private industry. Nearly every major industry in this country provides a health insurance program for its employees and in many instances, underwrites the full cost. Attached hereto is a chart reflecting a study conducted by the Institute of Health Insurance on 3,000 group contracts covering nearly 300,000 employees and their dependents, reflecting the percentage of employer-paid plans since 1960. In addition, a partial list of major industry which finances in full health benefits for their employees.

As a matter of fact, in this regard National Postal Union practices what it preaches. We have slightly more than 70 employees in our organization and all of them are provided with life insurance and a health benefits program, paid entirely by the union. An even better example are the employees of New York City—including teachers, 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, and so forth, 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, in our opinion, costs this Government as much or more than the benefits we are seeking. This is attributable a great deal to the vast difference in salaries and fringe benefits offered in the private sector.

Mr. Chairman, there are two other sections of the law which we feel should be amended. The first deals with enrollment periods 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 held the last one in November 14-28, 1969, 3 years after the previous one. 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" annually.

With respect to distribution of brochures, only the two Government-wide plans are distributed to all employees. 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 may qualify.

In conclusion, Mr. Chairman, we again want to thank you and members of this committee for providing us with the opportunity to present our views and for making known to the American public that you are cognizant of the problems that exist and are willing to take corrective action.

Mr. HANLEY. Mr. Bowley, I want to commend you in what appears to be excellent testimony. I personally am a proponent of the intent of the legislation. I note the inconsistency on the part of your union with the position of the American Medical Association with regard to the cause of the high costs of medical services. I tend to concur with your analysis as opposed to the analysis of the AMA, and the deeper you go in this subject the firmer you realize the necessity of a national health program.

The question, of course, is what do we do on an interim basis. And this is what we are trying to accomplish through this legislation.

I note that, although you represent approximately 90,000 Federal employees, there are 175,000 persons covered in your plan. Can you explain this?

Mr. BOWLEY. This includes the families of our members.

Mr. HANLEY. I see. How many members are in NPU as opposed to the number of participants?

Mr. BOWLEY. We have slightly over 50,000 of our members enrolled in our health plan and it represents something close to 60 percent.

Mr. HANLEY. The duration of your present plan, how long has it been in existence?

Mr. BOWLEY. Each contract runs for 1 year.

Mr. HANLEY. Pardon?

Mr. BOWLEY. Each contract is for 1 year. Are you saying the duration of the plan?

Mr. HANLEY. Of the plan.

Mr. BOWLEY. We have been in business since the inception of the program, 1960.

Mr. HANLEY. Mr. Hogan, any questions?

Mr. HOGAN. I, too, would like to commend the gentleman for his statement. I appreciate his comments about my bill in this area. Frankly, I have always thought that the Government ought to pay 100 percent hospitalization costs. In my own little business before I was elected to Congress, we did. As you observe, many other companies in private industry do.

But when we tried to determine a plan for the Government to pay 100 percent, we came up with the question which you alluded to, 100 percent of what? How many plans are there?

Mr. BOWLEY. There are 36.

Mr. HOGAN. Thirty-six plans and obviously they are competitive with each other and the cost of benefits are different. So whether you are talking about 50 percent or 75 percent or 100 percent, what is the Government going to pay the percentage of?

I know you asked this question and I don't think anyone has answered it.

Mr. BOWLEY. The Chairman of the Civil Service Commission in testifying last week, had offered a plan whereby they would use the two Government-wide plans, two employee organization plans and two comprehensive plans, take their high option premiums and then I imagine would divide them by six and come up with a figure which would be the Government's contribution.

I think a fallacy exists here. The plans will become extremely competitive in benefits, particularly the employee organization plans. These plans are used to induce membership, and every year premiums are going to continue to be forced to go up even higher with that type of a program. It would appear to me that you have got to offer a level of benefits that would apply equally to all Federal employees and any additional benefits, let the individual pay for himself. Everybody doesn't need a dental plan, or an optical plan. But there will be individuals attracted by such programs, and plans could be competitive in this area. Plans could also underwrite major medical-type programs.

But this is why we are very strongly in support of your bill, because we feel it is the only sensible solution in attempting to provide all employees of the Federal Government with equal benefits.

Mr. HOGAN. I am a great believer in competition. I think it is unfortunate that so much emphasis is placed on the two major plans which almost gives them an unfair competitive advantage over the other plans.

I agree with the idea which you advanced, about making the literature available on other plans. But from a practical point of view, I just don't think an employee could assess and assimilate some 30 different sets of brochures. Is there any other way to achieve this?

Mr. BOWLEY. Congressman, each employee is not eligible for 36 plans. You see in an area like Washington, D.C., for an example, a postal employee would probably be eligible for maybe eight or 10 plans. That is all. He wouldn't be eligible for the Kaiser plan out in California or the HIP plan in New York. He would be only eligible for plans in this area. He would be eligible for those employee organization plans that take all postal employees or of his particular craft. Where plans accept only one craft, he is only eligible for that one.

Mr. HOGAN. I still wonder if it is practical for an employee to get a whole stack of even 10 plans. But do the operators of the plans, such as the NPU, get a list of prospects as new employees are hired?

Mr. BOWLEY. No, we do not.

Mr. HOGAN. Wouldn't this be a sensible way to approach it and let you go out, as any salesman would, to explain the benefits of your plan?

Mr. BOWLEY. It would be wonderful if we were permitted to do that. But we are not permitted to do that. Many employees, as they come into the postal service, are there for months and sometimes years before they even find out there is such a thing as a union plan. The

only thing they know when they go into a personnel office is the Blue Cross. It is the first thing that comes to their mind.

Mr. HOGAN. And there is usually an employee in the office who is touting for Blue Cross?

Mr. BOWLEY. We don't want to accuse everyone of this, but this has been so.

Mr. HOGAN. Let's be practical. There really are.

Mr. BOWLEY. This has been so in many cases and it could be an individual who is a member of an employee organization and he could tout his plan.

Mr. HOGAN. Is there some way to resolve this?

Mr. BOWLEY. We think the employees are entitled to be informed of what is available to them.

Mr. HOGAN. I agree with that. But I am not sure that handing them 10 brochures is the way to inform them.

Mr. BOWLEY. Well, any way that they could be informed that there are plans available to them would be helpful. I don't think that the present system of handing them a booklet with 35 pages on this and that is going to be read. Somewhere on page 17 they say there are employee organization plans and a lot of new employees coming into the postal service aren't even aware of what an employee organization is. They are not even aware of unions. Even today there are Federal employees that don't understand that there are unions in Government.

There are postal employees that don't understand there are postal unions. They come in, you talk about joining a union and they say, "You can't have a union, you are a Government employee." They just are not informed and we think there should be some way to inform them as to what is available to them and what their rights are. They are given only 30 days in which to sign up in a plan when they are hired.

Mr. HOGAN. With relation to another part of your testimony with the spiraling hospital costs, this is a complex area and I am sure there are a lot of contributing factors.

It is a fact of life we have to live with, that the costs of providing medical protection and medical care definitely are rising.

You commented that physicians seem to charge more, and it is certainly true in the case of hospitals. From my own personal experience I know this, that when an individual is insured, that is just a license for the hospital to charge all that it possibly can. Is there any way that this can be curbed?

Mr. BOWLEY. I think only through action by Congress where they could establish controls of some type.

Mr. HOGAN. What could Congress do?

Mr. BOWLEY. I don't know, other than to place controls on what doctors are permitted to charge for various procedures. The doctors will charge whatever the going rate will bear. If you can pay \$50 for a visit they will charge you \$50 a visit.

Mr. HOGAN. I am concerned with the hospital charges that are escalated when they know that you are insured as you are concerned with the physician charges.

Mr. BOWLEY. We find as we stated in our testimony, in reviewing a number of claims on file, that for a particular illness which we think that there should possibly have been maybe four or five visits, in com-

paring it with similar cases, we find oftentimes they are brought back in for the fifth, sixth, and seventh visit, and we find no reason for it. We think the reason patients are asked to return frequently is because they have hospitalization and there is no problem in collecting their money.

In certain areas which we have been concerned with, we limit coverage, for example, a podiatrist, because we find when you go there the first thing he wants to do is take an X-ray, and he has got expensive equipment and some way or another he has got to pay for it. So we limit the services and the benefits in this area. We will pay for the X-ray to a podiatrist when there is a fracture involved, when there is in our opinion some reason to justify an X-ray.

Mr. HOGAN. This business about the information on the competitive plans, do you think it would be a good idea for the Government to have, say, a brochure with a description and an analysis of the plans, so the employee can get further information to one of those plans, depending on what he wants?

Mr. BOWLEY. I recommended and suggested this to the Civil Service Commission several years ago.

Mr. HOGAN. But they have not done it?

Mr. BOWLEY. Well, they made a joke of it, they said that would require something like a telephone directory. But I don't think it is really that much of a problem.

Mr. HOGAN. Thank you. I appreciate your testimony.

Mr. HANLEY. Mr. Bowley, on page 13 of your testimony, you suggest an open season annually. If this were the case, wouldn't this tend to complicate the administration of these programs? Wouldn't it encourage plan-hopping and pose a mechanical problem for those who are attempting to administer the plan?

Mr. BOWLEY. Most are going to remain with their plan. I think that the Civil Service Commission has testified before that the overall percentage of the people who change during "open seasons" is somewhere in the area of 2 percent. If that is the case, I don't see where that could entail a lot of administrative problems. In the case of employee organization plans, it is somewhat higher because of the competitive aspects within the organizations.

Mr. HANLEY. Well, then, in recognition of the 2 percent factor, wouldn't this in and by itself suggest that the current procedure is appropriate?

Mr. BOWLEY. Well, you are talking 2 percent of millions. The individual whose health needs change within a year are locked in. The individual who requires a particular benefit. If you are going to have 36 plans and offer different levels of benefits in all the plans—and this is partly why we are here today, to try to establish one level of benefits for all plans, this is why we support Congressman Hogan's bill, then provide frequent opportunities for changing plans as you and your family health needs require. When a family requires some type of mental illness care and another plan will provide more benefits for it, well, this is the system, permit him to change, not be locked in for 3 years and can't get out; this is the risk carriers have to take when there is an open season.

We think the open season should be annually and that people should have the opportunity to switch plans, based on their needs. If that was

the intent, that they would have the opportunity to change from one plan to the other, than let them do it annually.

Mr. HANLEY. Do you find that the availability of a health benefit plan actually serves as an attraction for new members to an employee organization?

Mr. BOWLEY. There is no question about that. There is no question about that at all. We have said it many times, though we would just as soon be out of the health insurance business.

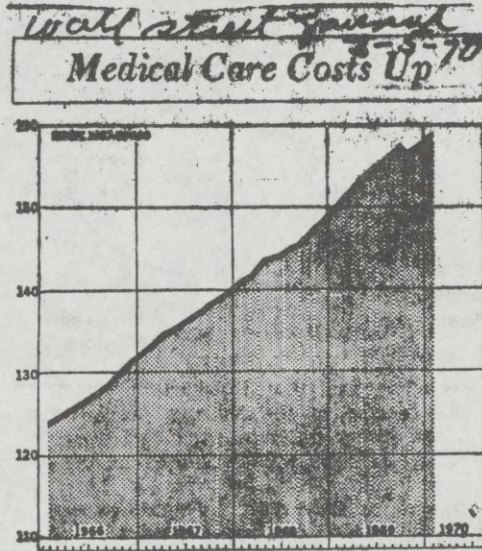
Mr. HANLEY. Well, it does serve quite a purpose in this sense.

Mr. BOWLEY. It really does. It is an inducement to union membership and it stabilizes union membership and there is no question about it.

Mr. HANLEY. I see. Again on behalf of the chairman and the committee, our appreciation for your testimony here this morning. We are delighted to have had you with us, Mr. Evans, and certainly you have contributed to the deliberations of this subcommittee. Thank you very much.

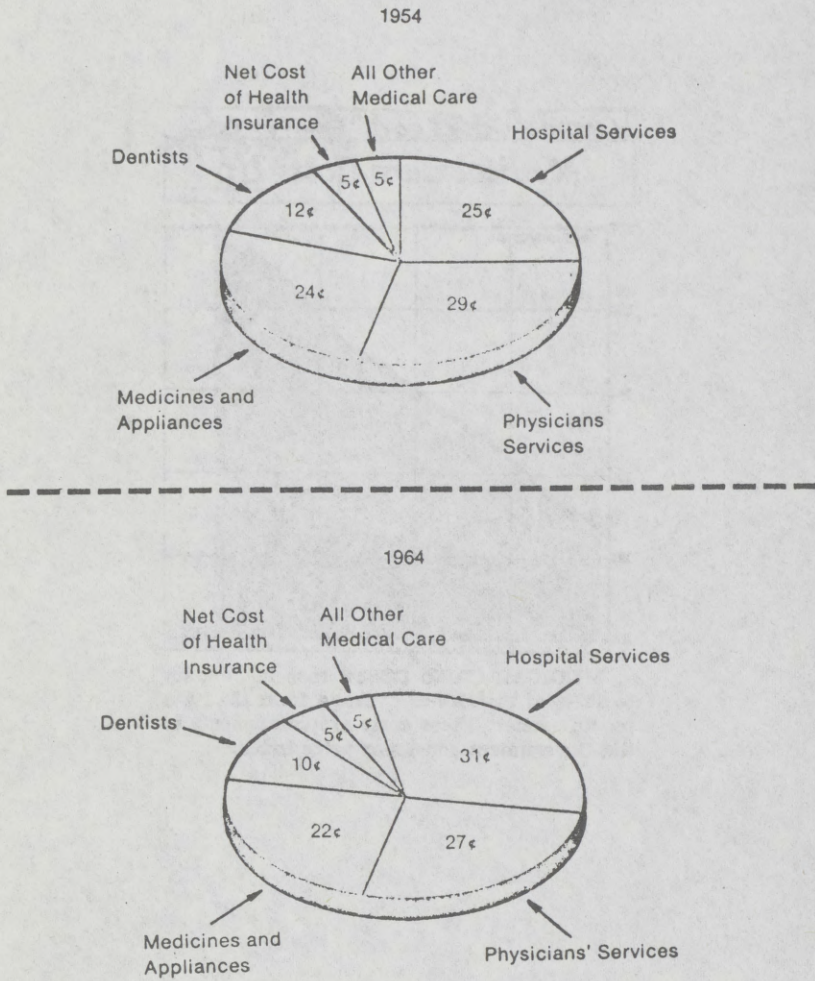
Mr. EVANS. Thank you very much.

(The attachments which follow were submitted by the previous witness.)



MEDICAL CARE COSTS rose in January to 159% of the 1957-59 average from 158.1% a month earlier. These costs are components of the Government consumer price index.

Distribution of the Medical Care Dollar



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

[From the Washington (D.C.) Post, Apr. 25, 1968]

AREA HOSPITALS PROJECT \$100-A-DAY RATE IN 1970

(By Stuart Auerbach)

Costs at three hospitals in the area will skyrocket to more than \$100 a day for each patient in 1970—far above national predictions, District Health Department projections show.

Daily costs at other private hospitals in the city will average less than \$100. But they still will be greater than the \$75-a-day costs predicted for 1970 in the Nation by the American Hospital Association.

Charges to private patients may be even greater than actual costs since hospitals are not always paid full costs for the care of indigents.

The Health Department's projections are based on cost figures submitted by the hospitals, plus estimated increases for each year until 1970. These increases, supplied to the Health Department by the Hospital Council for the National Capital Area, total 51.56 percent for the three years ending in 1970.

The Health Department is projecting hospital expenses to budget for the Medicaid program, which will pay "reasonable costs" to hospitals for patients who meet the eligibility requirements. Hospitals caring for indigents are now paid \$38 a day.

The three hospitals with the highest projected daily costs for 1970 are Children's \$107.07; Cafritz Memorial, \$103.09; and Georgetown University, 101.50.

Following close behind are the Washington Hospital Center, with a projected daily cost of \$93.31; George Washington University Hospital, \$89.41; and Freedmen's Hospital, \$84.54.

The average daily costs for all 12 private hospitals in the city in 1970 comes to \$84.21.

Some District officials fear that the sharply rising hospital costs could bankrupt the Medicaid program, which already has been cut because of a lack of money. Nationally, 45 percent of the Medicaid money goes to hospitals and nursing homes.

Costs vary widely from hospital to hospital in the city. At Casualty, for example, the projected daily cost for 1970 is \$51.73—half the cost of some other hospitals.

Costs at Children's Hospital are expected to be higher than normal because of the special care youngsters require. Cafritz Memorial Hospital is too new to have settled into accurate cost figures.

These figures include all expenses for caring for inpatients, except doctor bills.

Hospitals here and in the rest of the Nation blame the sharp increases in their costs on pay raises given to employees. Labor costs amount to about two-thirds of a hospital's expenses.

Traditionally, hospital employees have been among the lowest-paid workers in the Nation. Last year hospital employees were brought in under the National minimum-wage law and professional employees, including nurses, have won salary increases.

NATION IS WARNED OF HEALTH CRISIS

(By Thomas O'Toole)

The Nation is in the midst of a "health crisis," said a presidential commission yesterday—one that will worsen unless the country undertakes a sweeping reform of medical schools, hospitals, health insurers and even the way doctors themselves are licensed to practice.

The crisis we find ourselves in, said the National Advisory Commission on Health Manpower, whose 15 members (eight of them doctors) have studied the status of health services since May, 1966, is one brought on by a lack of leadership and an unwillingness to change within the health establishment.

The results, said the Commission yesterday in a report to President Johnson, are long waits to see a doctor, hurried, impersonal attention once the patient is seen, a shortage of hospital beds and services, uneven distribution of care and costs rising sharply "from levels that already prohibit care for some and create major financial burdens for many more."

To challenge this "crisis of care," the Commission recommended no fewer than 58 major changes in the way the U.S. health care system is to work. And while asking for voluntary acceptance of its proposals, the Commission nonetheless indicated they might have to be enforced.

"Unless these changes are accomplished more quickly than has ever been possible in the past," the Commission warned, "a more serious health crisis is inevitable."

Among its 58 curatives, the Commission prescribed a few sure to stir controversy for years to come:

For doctors and dentists: Back-to-school refresher courses or periodic examinations for renewal of their licenses to maintain their skills and guard against malpractice and "unnecessary or overly expensive tests and treatments" by some.

For hospitals: Financial rewards for efficiency and quality care sufficient enough "to make it unprofitable for a hospital to reduce quality and community service just in order to lower costs."

For health insurance organizations: Encouragement to revise their payment procedures to share savings with hospitals and individual physicians who demonstrate medical ability.

For medical and dental schools: Incentive grants to those who raise their output of doctors and dentists and a denial of funds to those who do not.

For medical and dental students: direct financial aid over their course of study, internship and residency, with an option to repay the loans over a long term or through direct governmental service, either in the military, Public Health Service or a Poverty Corps for doctors.

While these last two recommendations are clearly to increase the supply of health professionals, the Commission insisted they were made to meet future needs and expansion.

"The crisis at the present time," it said, "is not simply one of numbers," to raise the number of practicing doctors, dentists, nurses and auxiliary personnel. "We must first improve the system through which health care is provided."

One way to improve the health care system, recommended the Commission, would be to draft doctors through the communities where they work instead of through their own home towns.

So outdated is the present method of Selective Service that it has left some towns with overnight doctor shortages. Not long ago, a Commission member said, Vanderbilt University Medical School was left without a Pathology Department when its seven-man staff (from seven different states) was drafted all at once.

Perhaps the best way of upgrading the health care system, the Commission said, would be through what it calls a "peer review" system, certain to be one of the most controversial of the Commission's proposals.

What the Commission would like to see in the U.S. is a series of review boards, at the city, county and state levels, at the hospital level, and at the health insurance organization level.

In effect, these review boards—made up of prominent physicians and health officials—would demand that doctors and hospitals account for their actions.

Besides peer review, the Commission made other specific recommendations to improve the health care system. Among them:

Gradually disapprove and phase out the Third Preference part of the immigration law that each year admits 7000 new foreign medical graduates into the U.S., where almost 20 per cent of all new medical licenses given each year go to foreign-trained doctors. Not only are these doctors poorly trained by U.S. standards, claims the Commission, their entry into the U.S. represents the "worst kind of brain drain" in the world today.

Give the highest priority to improving health care for the poor and needy. "No clear-cut solution for care of the disadvantaged has been developed," the Commission concluded. "We urge that experimentation be markedly expanded with recognition of the special problems of this segment of the population."

INCREASES IN ROOM AND BOARD RATES

Hospital and date	Private	Semi-private	Ward
Butterworth Hospital, Grand Rapids, Mich:			
December 1969	\$41 to \$44	\$37 to \$38	\$34 to \$35.
July 1968	\$40 to \$43	\$36 to \$37	\$33.
Childrens Hospital of the District of Columbia:			
January 1970	\$75 to \$78	\$69	\$66.
April 1969	\$67 to \$70	\$61	\$58.
Doctor's Hospital, Phoenix, Ariz.:			
July 1969	\$60 to \$80	\$49 to \$68	\$45 to \$47.
January 1968	\$50 to \$70	\$45 to \$60	
Immanuel Hospital, Mankato, Minn.:			
September 1969	\$23 to \$36	\$29	\$24 to \$27.
November 1967	\$22.95 to \$33.95	\$20.95 to \$22.75	\$22 to \$23.75.
Maine Medical Center, Portland, Maine:			
April 1968	\$50 to \$55	\$48 to \$50	\$45.
March 1967	\$45	\$40	\$37.
Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.:			
August 1968		\$46 to \$64	
February 1967		\$46	
Mercy Hospital, San Diego, Calif.:			
April 1970	\$61 to \$72	\$54	
May 1968	\$55 to \$70	\$48	
Peoples Community Hospital Authority, Michigan (includes 4 hospitals):			
July 1968	\$42	\$37	\$35.
July 1967	\$40	\$35	\$33.
Redlands Community Hospital, Redlands, Calif.:			
June 1969	\$52	\$44 to \$48	\$42.50.
April 1968	\$46 to \$52	\$42 to \$46	\$40.50.
Santa Monica Hospital, Santa Monica:			
November 1969	\$58 to \$66	\$56 to \$60	\$52 to \$56.
April 1968	\$55	\$53	\$49.
Sibley Memorial Hospital, Washington, D.C.:			
January 1970	\$64 to \$73	\$53	\$49.
April 1969	\$55 to \$65	\$45	
Sierra Hospital, Fresno, Calif.:			
January 1970	\$54	\$50	\$48.
March 1969	\$47	\$43	\$41.
Memorial Hospital, Long Beach, Calif.:			
August 1969	\$52 to \$54	\$47	\$45.
April 1968	\$50 to \$52	\$45	\$43.
Mercy Hospital, San Diego, Calif.:			
April 1969	\$61 to \$72	\$54	
May 1968	\$55 to \$70	\$48	
St. Joseph Mercy Hospital, Pontiac, Mich.:			
January 1970	\$56 to \$61	\$52 to \$57	\$48 to \$53.
January 1968	\$52	\$47	\$42.
Archbishop Bergan Mercy Hospital, Omaha, Nebr.:			
April 1969	\$53	\$40.67 ¹	\$35.
May 1968	\$48	\$37	\$30.
St. Barnabas Medical Center, Livingston, N.J.:			
February 1969	\$60	\$40	
January 1968	\$60	\$40	
Underwood Memorial Hospital, Woodbury, N.J.:			
June 1968	\$51	\$36 to \$39	
January 1967	\$35 to \$46	\$28 to \$30	
Presbyterian Hospital, Charlotte, N.C.:			
August 1969	\$43.50 to \$48.50	\$39 to \$42.50	\$38.50.
August 1968	\$40 to \$45	\$37.50 to \$39	\$35 to \$35.50.
Elyria Memorial Hospital, Elyria, Ohio:			
June 1968	\$45.50 to \$50	\$42 to \$43	\$40.50.
December 1967	\$41.50 to \$46	\$38 to \$39	\$36.50.
St. Francis General Hospital, Pittsburgh, Pa.:			
March 1970	\$84 to \$99 ²	\$73 to \$85	\$79. ²
July 1968	\$65 to \$78 ²	\$55 to \$65	\$49. ²
Le Bonheur Children's Hospital, Memphis, Tenn:			
August 1969	\$44 to \$47	\$39	\$33.
June 1968	\$40 to \$43	\$35	\$29.

¹ Average.² All inclusive rate.

Mr. HANLEY. I am advised that Mr. John F. Griner, who is scheduled to be our next witness, is unavailable. Instead, and representing him, will be Clyde M. Webber, executive vice president of American Federation of Government Employees, accompanied by Carl K. Sadler, as legislative representative, and James H. Lynch, as assistant legisla-

tive representative, along with Mr. Stephen Koczak as research director for that organization.

We are delighted to have you with us this morning, gentlemen. Will you proceed?

STATEMENT OF CLYDE M. WEBBER, EXECUTIVE VICE PRESIDENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ACCOMPANIED BY CARL K. SADLER, LEGISLATIVE REPRESENTATIVE; JAMES H. LYNCH, ASSISTANT LEGISLATIVE REPRESENTATIVE; AND STEPHEN KOZAK, RESEARCH DIRECTOR

Mr. WEBBER. My name is Clyde Webber, as you indicated. We are pleased to be here this morning. President Griner asked me to convey his regrets that he was unable to attend this hearing.

In the name of the American Federation of Government Employees, representing over 650,000 Federal employees in exclusive recognition units, I wish to express our organization's appreciation to the chairman of this subcommittee and to its other members for the opportunity of testifying today on H.R. 767, a bill to bring equity and justice to Federal employees in the matter of health and hospital benefits.

This is the third time in less than 2 years that I am speaking formally before a congressional committee on this very important subject of health and hospitalization benefits. And, I am most disappointed to report, each time I have appeared the situation has become worse.

Today, I have to report not only a worse situation but one which is more bleak than ever existed before in the entire history of the Federal employees' health benefit system.

So far as health and hospitalization programs go, the Federal employee is being treated not only as a second-class American citizen—he is being not only treated far worse than the citizens working in the private sector, but he is actually also worse off than 10 years ago, when the Federal employees' health benefit system was installed.

At the very outset, I should like to recall the legislative history behind Public Law 86-362 establishing the Federal employees' health benefit system.

This history shows clearly that the primary, original intent of the committees drafting this legislation, and of the Congress enacting it, was to provide to Federal employees a contributory health benefits system comparable to that available at that time to employees of large-scale private industry. The Senate report is explicit on this point, stating that "as an employer concerned with attracting and retaining the services of competent personnel, the Federal Government should offer employee-benefit programs comparable to those of other large employers."

As to the sharing of costs, the House report (on pages 11 and 12) further stressed the similarity with private enterprise programs by stating that "it is expected that the Government contributions prescribed by the Commission will be 50 percent of the subscription charge to the approved plans in which most employees are enrolled. Thus the Government and the employee or annuitant will each contribute 50 percent of the subscription charge."

One would have expected, from these clear expressions of congressional intent, that Federal employees were being provided a health

benefits program equal to that available to employees of large-scale private enterprise at the rates then current, which was a 50-50 split of the costs.

This expectation was not fulfilled because, at the outset, the Civil Service Commission interpreted the word "plan" not to mean a global, comprehensive plan, including both the low and high options, but solely the low-option portion of a global plan. This interpretation was based, it now appears, on the assumption that the majority of employees would choose the low option and, therefore, low option would qualify as the plan "in which the most employees enrolled."

This assumption turned out not only to be totally wrong but, still worse, it diverted the development of the Federal employees' health benefit program away from the intent of Congress. A system developed, therefore, in which today the low-option plan, in which a minority of 16.9 percent of employees is enrolled, determines the contributions which must be paid by the majority of 83.1 percent of the Federal employees enrolled in the high options.

Is it fair that the interests of this minority of 16.9 percent determine, and, in fact, undermine the interests of the majority of 83.1 percent? Moreover, who constitutes these 16.9 percent?

So far as I can ascertain, the greater part of the Federal employees or annuitants who enroll in the low-option plans are the spouses of persons who are already enrolled in some other private or Federal basic plan or medicare. Therefore, it would appear that they are interested primarily in obtaining health benefit coverage which only supplements another program at minimal cost.

But the Congress did not legislate Public Law 86-362 primarily for the benefit of this small group. The Congress was interested not in providing supplemental health benefits but in fundamental, basic major health benefit coverage.

Thus, the intent of Congress has in fact been turned upside down. The tail is really now wagging the dog.

We are pleased to see that Civil Service Commission Chairman Robert Hampton in his testimony before your subcommittee has recommended that high-option plans be the base for the Government's contribution and that annual readjustments of contributions be made as costs change in the future.

Let us contrast what the situation was in 1960 and what it is today, 10 years later.

In 1960, altogether 1,738,828 Federal employees were enrolled in the Federal health benefit program. Of the total enrollment, 81 percent chose high option and only 19 percent chose low option. The largest number of employees, 943,377 or 54.2 percent was enrolled in the Government-wide service benefit plan, administered by Blue Cross-Blue Shield. Within this plan, 82 percent chose high option and only 18 percent chose low option.

In 1970, altogether 2,575,837 Federal employees (and annuitants) are enrolled in the health benefit program. Of the total, 83.1 percent chose high option and only 16.9 percent chose low option. The largest number of employees (and annuitants), 1,508,613, or 58.2 percent was enrolled in the Government-wide service benefit plan. Within this plan 88.1 percent chose high option and only 11.9 percent chose low option.

Thus, a contrast of the 1960 and 1970 rates of the Government-wide service benefit plan, and of the changes in the share of the Govern-

ment's and the employees' contributions during these 10 years, will provide a good initial insight into what happened in the interval.

The following table affords this comparison:

GOVERNMENTWIDE SERVICE BENEFIT PLAN (ADMINISTERED BY BLUE CROSS/BLUE SHIELD)

Type of enrollment	1960 rates ¹		1970 rates ¹		Difference between 1960 and 1970 Rates ¹
	Amount	Percent	Amount	Percent	
HIGH OPTION					
Self only: Total.....	\$7.39	100.0	\$15.71	100.0	\$8.32
Government pays.....	2.82	38.1	3.64	23.1	.82
Employee pays	4.57	61.9	12.07	76.9	7.50
Self and family: Total.....	19.37	100.0	38.33	100.0	18.96
Government pays.....	6.76	34.8	8.88	23.1	2.12
Employee pays	12.61	65.2	29.45	76.9	16.84
LOW OPTION					
Self only: Total.....	5.64	100.0	8.32	100.0	2.68
Government pays.....	2.82	50.0	3.64	43.8	.82
Employee pays	2.82	50.0	4.68	56.2	1.86
Self and family: Total.....	14.21	100.0	20.37	100.0	6.16
Government pays.....	6.76	47.5	8.88	43.5	2.12
Employee pays	7.45	52.5	11.49	56.5	4.04

¹ Monthly rates.

From the foregoing table it is clear that, during the 10-year interval, 1960 to 1970, the total costs for enrollment in the Governmentwide service benefit high option family plan almost doubled, going from \$19.37 per month, or \$232.44 per year, to \$38.33, or \$459.96.

In the 10-year period, the employees' contribution increased by \$16.84 per month, or \$202.08 per year, while the Government's contribution increased by only \$2.12 per month, or \$25.44 per year. Thus the employee's share of the increase was fully eight times the rate of increase paid by the Government.

As a result, today the employee is paying \$29.45 per month, or \$353.40 per year, for health benefits while the Government is paying only \$8.88 per month, or \$106.56 per year. In percentage terms, the employee pays 76.9 percent while the Government pays 23.1 percent.

The increase alone in the employee's contribution, amounting to \$16.84 per month, or \$202.08 per year, is itself almost double the total amount the Government pays today, which is \$8.88 per month, or \$106.56 per year.

What, may I ask, has happened to the intent of Congress that the health benefit program available to Federal employees be in some fashion comparable to that provided by large-scale American private enterprise?

What has happened even to the intent that the Federal employer pay at least a contribution equal to that of the Federal employee so that the burden is shared 50-50?

We were disappointed to see that Mr. Hampton recommended an increase in the Government's contribution to only 38 percent of the

new proposed high option base. That is, this 38 percent of the new high option base is still not anywhere near to the original intent of Congress.

I have cited up till now only the experience with the most widespread of the Federal health benefit programs, which happens also to be the least expensive in its rates.

If we look at the experience of the other major plans, the Federal record is even worse. I request the permission of the chairman to incorporate into the record of my statement, as annex I, a table comparing the government-wide service benefit plan with four other major plans, including the one offered by my own organization, the American Federation of Government Employees.

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

Mr. WEBBER. I should like to observe here only that the total monthly cost of these other plans ranges from the AFGE plan of \$41.54, or \$498.48 per year, to the family health program in California of \$464.67, or \$560.04 per year. In every case, the Government's monthly contribution is limited to \$8.88, or \$106.56 per year, resulting in a yearly expenditure of from \$391.92 to \$453.48 by the individual Federal employee. In percentage terms, the Government's share of one plan's premium has fallen as low as 19 percent of the total and, in the best case—the AFGE plan—it is only 21.3 percent today.

While the Federal employee has been suffering this major regression in his status during the last decade, what has been happening in large-scale private enterprise?

As I stated in the beginning of my testimony, in 1960 the usual situation in private enterprise was a 50-50 sharing of the costs of the employees' health and hospitalization benefits programs.

By 1970, the situation of the private enterprise employee had improved so much that in large-scale private enterprise the employer paid 100 percent of the costs. The employee paid nothing at all for those programs which were equivalent in benefits to the Government-wide Service Benefit plan managed by Blue Cross-Blue Shield.

As proof of this situation, I request your permission, Mr. Chairman, to insert into the record, as annex II, the provisions of six major private enterprise health benefit plans which were in effect in the first half of 1969, covering the following companies: Aluminum Co. of America, Detroit Edison Co., General Motors Corp., International Business Machines Corp., Penn Central Co., Radio Corp. of America.

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

Mr. WEBBER. In short, we find that in every major branch of private enterprise, including basic metals, electric power, automobiles, business machines, railroads, and electronics; in every kind of human endeavor, the employee is receiving full coverage in health and hospitalization services as a fringe benefit.

Thus, these private enterprise employees are receiving additional earnings in the form of employer contributions to health benefit premiums of between \$390 and up to \$450 more per year than Federal employees.

These additional earnings of private enterprise employees represent a significant difference in real income, amounting to approximately 10 percent annually in the lowest grades and constituting more than 6 percent of the average earnings at the GS-5/PFS-5 level.

In the classified service alone, according to the latest census published, there were 547,269 Federal employees in grades GS-1 through GS-5; in the Postal Field Service, there were an additional 497,769 Federal employees; and there were over 512,000 wage board employees whose wages were equivalent to GS-1 through GS-5 in the classified service. Altogether, there are today, therefore, approximately 1.5 million Federal employees whose real annual income is 6 to 10 percent lower than the real income of comparable private enterprise employees solely because of the discrimination they suffer in the matter of health benefit contributions.

This is why I turn to you and ask, why does the executive branch discriminate so greatly against its own loyal employees? Why are these Federal employees treated like second-class American citizens, treated in fact much worse than the citizens of many foreign countries?

To indicate that these six private corporations are not alone in paying the full costs of employee health benefit and hospitalization programs, I request your further indulgence to permit me to insert into the record, as annex III to my statement, a selected list of other major American enterprises which provide these benefits at no cost to their employees.

Mr. HANLEY. Without objection, so ordered.

Mr. WEBBER. The fact that more than 60 major enterprises, covering in some cases entire industries, are included shows that by 1970 it has become the normal practice for major-scale American industry to pay 100 percent of the health benefit insurance contributions of their employees.

The bill, H.R. 767, before your subcommittee, introduced by the chairman, contains the ideal solution to restore equity and justice to the present regressive Federal health benefits system. Like all good legislation, its approach is realistic and its remedies are by stages.

What does the bill propose that we do?

First of all, it proposes that right now, in this present fiscal year, the Federal Government immediately begin contributing to each plan at the rate of 50 percent of the total contribution.

Taking the Government-wide service benefit plan's high option family program as a basis, this would mean that, on a monthly basis, the Government's contribution right now would rise to \$19.16 from the present \$8.88, an increase of \$10.28 per month, or \$123.36 per year.

It would also mean that the employee's contribution would drop from the present \$29.45 per month to \$19.17, a decrease of \$10.28 per month, or \$123.36 per year.

In this fashion, in its first year, the bill would bring the present degenerating Federal employees' health benefit system up to that level which Congress intended it to have as far back as 1960. That is, the Federal employer and the Federal employee would be paying 50-50 of the costs.

In its second phase, the following fiscal year, the bill would raise the Federal employer's contribution to 75 percent of the contributions.

To be sure, this would still leave the Federal employee considerably behind the private enterprise employee, in the matter of health benefit contributions.

Again, taking the Government-wide service benefit plan as the model, this would raise the Government's share in the following year up to \$28.74 from the \$19.16 rate of the first year schedule, which is an increase of \$9.58 per month, or \$114.96 per year. The Federal employee's share would simultaneously drop from \$19.17 per month to \$9.59, or \$114.96 per year.

In its third and final phase, the bill would require the Federal Government's share to rise from \$28.74 to \$38.33 per month, a further increase of \$9.59 per month, or \$115.08 per year.

And in its final phase, the plan would finally give comparability to the Federal employee by eliminating any payments he would be required to make to the basic Government-wide high-option plan.

The Federal employee on that date would finally emerge as a normal American citizen. He would no longer be a second-class American in terms of health benefits coverage.

The other great merit of H.R. 767 is that it takes into account the serious budgetary situation with which the U.S. Government is today confronted.

How much additional would the plan cost the Government each year over the three-phased period?

According to the estimates supplied to us by the actuaries of the Civil Service Commission, it is calculated that the total contribution income of all plans in force during 1970 will be \$958 million, most of which will be expended in benefits but a goodly portion of which will be retained as reserves.

Of this \$958 million, under the present regressive system, the Federal employees' contribution annually is \$728 million and the Federal Government's share is only \$230 million.

Under the provisions of H.R. 767, providing for an immediate 50-50 sharing, the Federal Government's contribution would rise in the first full fiscal year from \$230 million annually to \$479 million, an annual increase of \$249 million. Thus, the additional cost to the Government in the first year would be less than \$250 million.

The following fiscal year, the Federal Government's total cost would be \$718.5 million, or a further increment of \$239.5 million annually. This volume of increase would be approximately equal to the increase in the first year.

In the final, or third fiscal year, the total cost to the Government would be \$958 million, up a further \$239.5 million over the preceding year.

From the foregoing, it is clear that H.R. 767 judiciously divides the transition, from the present antiquated system to a proper modern system based on comparability with private enterprise practices, into three stages extended over 3 years.

The additional cost each full fiscal year, moreover, is less than \$250 million over the preceding year, or approximately 1 percent of the estimated total Federal payroll. The average per capita cost of the increment each year per Federal employee would be between \$80 and \$85. And the average per capita incremental cost to the country would be about \$1.25 for each person in the population.

As I stated at the outset, only 16.9 percent of the Federal employees today are enrolled in low option. Yet, the very existence of this low

option insurance is one of the overriding factors determining the maximum amount which the Federal Government contributes to employee health costs. This would hold true, unless appropriate amendments were added, even if H.R. 767 was enacted. For this reason, I recommend that you might consider adding language providing that the actual dollar amounts to be paid by the Federal Government would be based on 50, then 75, then 100 percent of that Government-wide plan option in which the majority of the Federal employees were actually enrolled. Today, that plan would be the Government-wide service benefits high-option plan, administered by Blue Cross/Blue Shield.

However, in the interests of the American taxpayer, and of good accounting of public money, I should like to recommend also that an effort be made to obtain the actual costs of the various options now being offered. Is low option really paying for itself today? Or, perhaps, is it itself subsidizing high options?

I urge your committee to inquire from the Comptroller General as to possible legislative language which would be incorporated into H.R. 767 to require periodic detailed reports to the Congress on the true costs of these various options. Only on this basis, will be American taxpayer be assured that the contributions are properly compensated by benefits.

Without prejudice to eventual further legislative changes in the matter of low options, I urge your committee to consider amending H.R. 767 to stipulate that any low-option plan approved by the Civil Service Commission must include in its level of benefits at least 60 days of hospitalization, instead of the present 30 days provided in the current Government-wide service benefit plan, administered by Blue Cross-Blue Shield. Such an amendment might contain additional language requiring that any approved low-option plan must also provide a certain minimum fixed percentage of the benefits provided by the high-option plan of the same sponsor.

I'd like to make an aside here, if I may. We discussed this in this much detail because the current rates of contribution for the programs are determined by the low-option plans. And with the assertion by representative administration, the Chairman of the Civil Service Commission, Mr. Hampton, that they favor the use of the high options as a base rather than the low options, of course, this is not as important as it would be. We felt that if the level of benefits of the low option were raised to a point where satisfactory health services were provided to the employees of the Federal Government, that this would in fact cause an appropriate increase in the cost in the low-option prices so that it would be reflected in the overall contributions which would be made to the Federal employees.

But since the administration has indicated as being in favor of the high-option base, certainly we are in accord with that.

However, in line with the thinking which we have expressed here, we would infer from Mr. Hampton's testimony that because of the percentage figures which were used—that is the 38 percent for high option and not to exceed 50 percent for low option—that the Commission would expect that the low-option plans would provide at least 75 percent of the coverage of the high-option plans, as that is the ratio that exists between 37½ and 50 percent.

In the 10 years that the Federal employees' health benefits plan has been in existence, one fact stands out clearly. If we are to have a plan that can develop in ways comparable with large-scale private enterprise plans, a new formula must be devised for the maximum dollar amount of the Federal contribution.

In 1960, given the restrictive interpretations placed on Public Law 86-362, the Civil Service Commission approved plans which resulted that year in global contributions of only 38 percent by the Government and 62 percent by Federal employees. Under the pressure of rising hospital, surgical and medical expenses, the Government's contribution steadily and rapidly declined thereafter until, in 1965, it was less than 30 percent. This was a deterioration at an average rate of $1\frac{1}{2}$ percent per year. Under Public Law 89-50, passed in 1966, the global Government contribution was restored to 38 percent. However, the seeds of an even worse deterioration were also planted by that legislation which fixed by statutory limitation the Government's maximum biweekly contribution at \$1.62 for self alone and \$3.94 for self and family.

Although these new rates were at that time higher than the previous actual Government contributions, they were nevertheless already lower than the permissible rates under the original law of 1959. And they provided no possibility for fiscal stability or growth.

As a consequence, in the 4 years since 1966, the Government's global contribution has fallen again, this time approximately from 38 percent to 24 percent, a drop of almost 14 percent in 4 years. This is an average deterioration rate of 3.5 percent per year, or more than double the rate of decline experienced under the original legislation.

If we are to avoid the repetition of this history, it would appear necessary to write language which provides for an automatic increase of the maximum Government contributions to keep pace with rising costs. The simplest way to achieve this might be to provide no maximum dollar limitations at all. However, if Congress wishes to retain firm control over maximum rates, another way would be to provide a reasonable maximum fixed dollar rate at each phase of the transitional stages (at the times when the Government pays 50 percent; when it pays 75 percent; and when it pays 100 percent) and to stipulate that yearly increases thereafter could not exceed the preceding annual rates of contribution by a maximum percentage, for example, 10 percent.

At this time, it would be premature for us to express preferences for any alternative solution over another. However, we strongly urge that H.R. 767 be appropriately amended to provide some kind of necessary flexibility in maximum rates so as to assure both growth and fiscal stability during the period of rising prices.

H.R. 767 has other merits besides those already cited. While establishing a modern health benefits contribution system for Federal employees comparable to that of private enterprise, this bill in no way impedes the development of other plans for hospitalization or health benefits which would continue to be approved by the Civil Service Commission, under the same provisions and procedures as they existed heretofore. It would be, of course, the understanding of all parties that that portion of the total costs of these other plans in excess of the schedules for the basic Government-wide plan would be paid fully by

the enrollees of these other plans, or by the organization sponsoring the plans, or by any arrangement worked out mutually between the sponsoring organization and the plan's enrolled members.

A further merit of H.R. 767 is that it redresses the present inequity imposed today on Federal employees who in effect are paying the entire administrative costs of the current Federal employees' health benefit program as well as the contributions to maintain contingent reserves.

Superficially, it might appear that these costs are shared. However, a closer look reveals that today the total contributions made to the health benefits program are based on two factors. The first represents the actual 100-percent contribution for buying the insurance. The second represents a tax of an additional 1 percent for administrative costs plus a further 3 percent for the contingent reserves. Thus the contributions are actually 104 percent of purchased benefits.

The Government deducts 4 percent from all contributions incomes paid into the plans and forwards to the various plan managers the balance.

Under H.R. 767, this procedure would be abolished immediately and the costs for administration of the plan and for contingent reserves will be paid entirely by the Government. This will bring the Federal employees' health benefit system into line with the practices used by the Social Security Administration and the Veterans' Administration. It will also eliminate the tax of approximately \$40 million now imposed on Federal employees.

In summary, our organization endorses fully the provisions incorporated in H.R. 767 to improve the financing of the Federal employees' health benefit system.

We see merit in requiring the Federal Government to pay the full costs of administering the plan (now 1 percent of contributions) and of setting up contingent reserves (now 3 percent of contributions). At this time, these are, in effect, a special tax paid by the Federal employees.

We endorse the eventual assumption of the full costs of the contributions to a basic health benefits program by the Federal Government as a step to give Federal employees in this area of health care a fringe benefit comparable to that already provided to employees in the private sector.

Out of consideration for the needs of the taxpayers, we have accepted, of course, the concept that this transition should take place over 3 fiscal years.

We have also requested your committee to consider perfecting H.R. 767 either by eliminating the limitation of the dollar amount of the maximum Federal contribution or by devising some other formula which does not erode benefits.

We have also suggested that you might wish to obtain the views of the Comptroller General to determine the true costs of each of the high and low options of the Government-wide plans. This would appear especially necessary to assure that the contributions to one option are not diverted to the advantage of another.

In addition, we have proposed that the benefits in any approved low-option program include at least 60 days of hospitalization and that they provide a certain minimum fixed percentage of the benefits provided by the high-option plan of the same sponsor or carrier.

Mr. Chairman, I wish again to express our appreciation for the opportunity you have given me to testify today in support of H.R. 767. And I assure you of the fullest support and cooperation in the enactment of this bill into law.

Mr. HANLEY. Mr. Webber, I want to commend you and your organization for this very comprehensive testimony and certainly a great deal of time and effort went into its preparation.

You state that your organization represents over 650,000 Federal employees. How many employees are dues-paying members of the AFGE?

Mr. WEBBER. 325,000 at this time. What we stated was that we have exclusive recognition under an Executive order. We have been awarded exclusive recognition for over 650,000 Federal employees.

Mr. HANLEY. And of this number, how many members are enrolled in the AFGE health benefits plan?

Mr. WEBBER. Approximately 19,000.

Mr. HANLEY. About 19,000 of 325,000?

Mr. WEBBER. Yes. We suffer, I would say, to a considerably larger degree the same problems that the last witness presented to the committee—that is in terms of distribution of brochures, of having an opportunity for our people to be notified about the AFGE program when they are initially employed in an establishment. For example, in this last open season, the brochures of the AFGE which were distributed to all the members of AFGE, many of them were not received until the open season was over.

Mr. HANLEY. I see.

Mr. WEBBER. We have presented a vigorous protest to the Civil Service Commission regarding this problem. We are still looking for a resolution of it.

Mr. HANLEY. Does the AFGE administer its own plan, or do you have an arrangement with an insurance carrier?

Mr. WEBBER. We administer the plan. It is underwritten, however, by Mutual of Omaha. We have a contract with them.

Mr. HANLEY. That is just one contract with one carrier?

Mr. WEBBER. That is right. We have two levels of benefits—a high and a low option. But it is one carrier which pays the benefit.

Mr. HANLEY. Can you tell us what percentage of the premium dollar is expended for the carriers' profit, taxes, and other administrative costs? Will you have that percentage available?

Mr. WEBBER. I know that the company is restricted by the procedures of the program to receive only the administration expense, and they have to pay out the contributions other than the administrative allowance.

Mr. HANLEY. But do we have that percentage factor?

Mr. WEBBER. We could get that, and we will be glad to provide it to the committee.

Mr. HANLEY. If you will. I think it would be helpful. We would like to ascertain how much of the premium dollar is actually spent for benefits. So if you can provide that information, it could be helpful to us.

Mr. WEBBER. All right.

(The information referred to follows:)

The requested information has been extracted from the Annual Accounting Statements for the AFGE Health Benefit Plan which have been filed with the U.S. Civil Service Commission for the last 5 reporting periods from November 1, 1964 to January 1, 1970.

Subscription charges (premiums):

Nov. 1, 1964 to Jan. 1, 1966-----	\$4, 217, 524. 30
Jan. 1, 1966 to Jan. 1, 1967-----	3, 441, 454. 30
Jan. 1, 1967 to Jan. 1, 1968-----	4, 128, 867. 54
Jan. 1, 1968 to Jan. 1, 1969-----	3, 810, 973. 00
Jan. 1, 1969 to Jan. 1, 1970-----	4, 270, 357. 00
Total -----	19, 869, 176. 14

Health benefit charges (claim payments):

Nov. 1, 1964 to Jan. 1, 1966-----	4, 764, 441. 97
Jan. 1, 1966 to Jan. 1, 1967-----	2, 957, 131. 90
Jan. 1, 1967 to Jan. 1, 1968-----	3, 834, 786. 93
Jan. 1, 1968 to Jan. 1, 1969-----	3, 654, 078. 00
Jan. 1, 1969 to Jan. 1, 1970-----	4, 509, 759. 00
Total -----	19, 720, 197. 80

Administrative charges—Underwriter:

Nov. 1, 1964 to Jan. 1, 1966-----	168, 700. 97
Jan. 1, 1966 to Jan. 1, 1967-----	137, 658. 17
Jan. 1, 1967 to Jan. 1, 1968-----	165, 154. 70
Jan. 1, 1968 to Jan. 1, 1969-----	152, 438. 00
Jan. 1, 1969 to Jan. 1, 1970-----	170, 095. 00
Total -----	794, 046. 84

Gain (+) or loss (-):

Nov. 1, 1964 to Jan. 1, 1966-----	-976, 212. 61
Jan. 1, 1966 to Jan. 1, 1967-----	+147, 473. 20
Jan. 1, 1967 to Jan. 1, 1968-----	-97, 461. 31
Jan. 1, 1968 to Jan. 1, 1969-----	-202, 703. 00
Jan. 1, 1969 to Jan. 1, 1970-----	-656, 377. 00

Cumulative loss----- -1, 785, 278. 00

In addition to the above statistics, requested by the Subcommittee, it should be noted that, unlike Blue Cross/Blue Shield, which pays no State taxes, the AFGE must pay 2.2% State tax annually. Besides the administrative charges of the carrier, AFGE also has administrative expenses of its own. While AFGE could charge up to 6.6% annually for its own administrative expenses, a budgetary limit of 6.0% has been placed by policy decision on these expenses.

Mr. HANLEY. In the third paragraph on page 2 of your statement, Mr. Webber, you cite an excerpt from the committee's report which accompanied the bill, S. 2162, as amended by the House. The paragraph following the one you cite read as follows:

There may be some plans or options within the plans which will provide benefits superior to the benefits under other plans or options and for which the subscription charge per enrollment will exceed the sum of the prescribed maximum government contribution, plus a matching contribution from the employee or annuitant. Where an employee chooses to enroll in such a superior benefit plan or option, the excess portion of the subscription charge will be withheld from his salary.

Would you concur in the observation that the text which you cite was one of hope or expectation, but that the text which I have quoted was, in fact, the ultimate intent of the Congress?

Mr. WEBBER. I would say that the total text there, I would think, would be the intent of Congress.

Mr. HANLEY. That it was the intent of Congress?

Mr. WEBBER. The total text.

Mr. HANLEY. Then you are not saying that the Civil Service Commission's interpretation of the original law was actually in conflict with the law? You are not saying this, are you?

Mr. WEBBER. I would say that there are many possible interpretations of the law and apparently the Civil Service Commission took the interpretation which cost the Federal Government the least money. And we feel that the interpretation did not bring the level of benefits up in these low option plans which they selected as the base for the payment of these benefits up to the level of benefits which were commonly given to employees in private industry, even at that time.

Mr. HANLEY. Then in essence and instances there is a conflict with the law, and it isn't necessarily in accord with the intent of Congress?

Mr. WEBBER. That is what we feel.

Mr. HANLEY. I see. Was not the Commission constrained to negotiate contracts within the maximum dollar limitations which were imposed by the original law?

Mr. WEBBER. The maximum dollar limitations imposed by the original law authorized the Civil Service Commission to not less than \$3 or more than \$4.25 biweekly, which was never reached under the original health benefit program up until the time the adjustment was made and a new ceiling was established, which happened to be lower than the \$4.25 biweekly authorized in the original legislation.

Mr. HANLEY. In recognition, of course, of the fact that the law requires only that the two Government-wide plans offer two levels of benefits, a high and a low option, and I am sure that you are equally aware that the law permits other plans to offer high and low options?

Mr. WEBBER. In our testimony we have indicated that; and we have also offered in our testimony to recommend that the high option plan of the one that is most widely accepted by the people in the Federal service be used as a base. And in excess of the contributions made on the base plan, of course, people would receive additional benefits provided they were willing to pay for those additional benefits.

But we did recommend that the high option of the most widely accepted plan be used as the base. And we are in harmony, I want you to know, with the recommendations of Chairman Hampton. This also seems to be an equitable way, by using the high options of these three different groups of plans—and again the most widely used of those particular kinds.

Mr. HANLEY. In recognition of the seemingly low percentage of participation in the low option plan, why do you continue to offer such a selection?

Mr. WEBBER. We have many members who are married and whose wives work or whose husbands work and their spouses are covered by plans of various companies, contributory or noncontributory plans. And each of the plans, whether the employer makes a contribution, has a limitation in the amount of benefits which can be paid so that the amount of benefits cannot exceed the actual costs of medical care.

So if a man and his wife are both covered by contributory programs and the premiums are very low, both of them can expect, that by the

application of their spouse's plan, to have the basic plan which they subscribe to supplemented by their spouse's plan to cover the entire costs of hospitalization.

And then too, we have many annuitants who have continued their plan on into their pension time and these people are covered by part of medicare. Some of them are fortunate enough to have a sufficient amount of social security time in their background so that they can elect to be covered by both parts of medicare. Again they use the low option as a supplemental feature so that all of their hospitalization and medical costs are paid.

Mr. HANLEY. Can you tell us what percentage of your participants take advantage of the low option plan?

Mr. WEBBER. It is very small. It is about 25 percent.

Mr. HANLEY. Mr. Hogan, any questions?

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

Mr. HANLEY. If I can pursue this for just another moment or two, we do have a time problem. Would you not think that a goodly proportion of low option enrollees are really low risks and low utilizers of services, some of whom feel that their health care needs don't require the high option coverage?

Mr. WEBBER. I have to agree that, in view of the amount of money that these people earn, this million and a half people that we cited in our testimony, people who receive pay at rates less than the GS-5 rate, that many of them have to elect to take a minimum type of medical coverage because they need their income for other reasons than medical care. And they simply take risks that they would not elect to take if they had the opportunity and a sufficient amount of funds to get proper medical care coverage.

Mr. HANLEY. Have you been able to observe whether the low option participant percentage has increased or decreased with the advent of medicare?

Mr. WEBBER. I could not state that. We will get that information for you, Mr. Chairman.

Mr. HANLEY. All right. If you will, please.

(The information requested follows:)

Speaking in the broadest terms, the AFGE has not observed any significant *Statistical* change in the percentage of low option since the installation of Medicare.

However, we would wish the Committee to realize that it would be difficult to draw any but very tentative conclusions from this fact.

First of all, we are at a disadvantage in responding to the question asked because the Civil Service Commission is still analyzing the results of the last open season. Consequently, our comments are dated as to their validity.

Secondly, the Civil Service Commission has amended its regulations recently making it possible for civil service annuitants to change from high option to low option immediately on the date they become eligible for Medicare and not await open season. Although future statistics may be more revealing, past statistics need to be interpreted qualitatively as well as quantitatively because of these changes.

Even so, we believe that the general experience of all systems has been in the direction of substantiating the testimony we have given in an overwhelming manner.

Mr. HANLEY. Do you object to annuitants with full medicare coverage using the low option of their Federal health benefits as a supplement to medicare. Is there any objection?

Mr. WEBBER. Not on our part.

Mr. HANLEY. While it is true that originally the Government contribution was geared to the low option level of benefits, wasn't that principle, in effect, abolished in 1966 with the new maximum Government contribution being set, which was not geared to the low options?

Mr. WEBBER. I don't know whether I could answer that statement accurately because the new level which was prescribed at that time brought it overall up to some 38 percent. There had been such a constant erosion of it that there has never been in history any high option program that ever got 50 percent of the contribution paid. The most, as I understand it, that was ever paid was 50 percent of the low option. And there were few programs which had that.

In our table in annex I we show the amounts of money which were involved at various times. We have the January 1, 1970 figures. I know that we have tables here. I think the tables are in the testimony here, that show the 1960 rates and 1970 rates. I know that we can provide information as to precisely what the situation was when that law was amended in 1966, and we will be glad to do so.

Mr. HANLEY. All right. If you will, please.

(Information requested follows:)

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEE HEALTH BENEFIT PLAN

Type of enrollment	1966 monthly rates	
	Amount	Percent
High option:		
Self only:		
Total.....	\$10.40	100.0
Government pays.....	2.82	27.1
Employee pays.....	7.58	72.9
Self and family:		
Total.....	27.30	100.0
Government pays.....	6.76	24.7
Employee pays.....	20.54	75.3
Low option:		
Self only:		
Total.....	3.56	100.0
Government pays.....	1.78	50.0
Employee pays.....	1.78	50.0
Self and family:		
Total.....	11.06	100.0
Government pays.....	5.53	50.0
Employee pays.....	5.53	50.0

Mr. HANLEY. I notice that on page 11 you ask if low options are subsidizing high options. Wouldn't it also be appropriate to ask if high options are subsidizing low options?

Mr. WEBBER. I think that is what we state there.

Mr. HANLEY. Was that the intent there? Did you have that in mind?

Mr. WEBBER. I urge the committee to inquire from the Comptroller General as to the possible legislative language. However, in the interest of the American taxpayer—

Mr. HANLEY. You are on page 11?

Mr. WEBBER. The second paragraph. "However, in the interests of the American taxpayer and of good accounting of public money, I should like to recommend also that an effort be made to obtain the actual costs of the various options now being offered. Is low option really paying for itself today? Or perhaps is it itself subsidizing the high options?" So we are asking both sides of the question.

Mr. HANLEY. Then would it be accurate to say that you don't really advocate the abolishment of low option coverage, but rather encourage that level of benefits to be made more attractive than they are? Is this right?

Mr. WEBBER. We are encouraging first that the Federal Government, over a period of time, assume the full cost of a comprehensive health care program equal to the high option of the program which is most universally subscribed to by Federal employees.

We are also recommending there be a continuation of low option for those people who might want them. I would suspect, however, that when the time arrives when high option is universally available to Federal employees that all the Federal employees will avail themselves of the high option if the Federal Government pays the expense of this particular kind.

If there are organizational programs, other programs which offer benefits in excess of the high-option program which is most universally subscribed to, then the employees or members of that organization will be expected to pay any excess costs for those desirable benefits.

Now, in the interim period, the 3-year period, we would expect that the low option would continue. But I would expect, that as a matter of practical thinking, that everyone who is eligible for the maximum level benefits, of course, would want to have them.

Mr. HANLEY. Could your plan compete with other plans if the Government paid the total cost of the program without any limitation whatsoever on those costs? Could your plan continue to be competitive?

Mr. WEBBER. I am sure that our plan would be competitive—our high-option plan would be competitive—with the Aetna plan. The benefits are considerably the same. We think our benefits are better for our members than the Aetna plan. The prices are very close, one to the other.

Mr. HANLEY. In your effort to be competitive, would this encourage a richer package?

Mr. WEBBER. It may. For example, here in Washington, D.C., our locals have recently worked out a group dental program. Our people are paying for it themselves. If such a program were authorized and permissible for approval by the Civil Service Commission and our members elected to pay for it, probably there would be such a benefit in the program.

Mr. HANLEY. I see.

Mr. WEBBER. But some of these things, of course, at this time are prescribed from being included in the program. The costs are very expensive for some of them. And we have tried to hold our level of benefits roughly commensurate with the benefits of the indemnity plan most generally offered in the Federal service.

Mr. HANLEY. Organizations which compete with yours for membership, do they also have health plans?

Mr. WEBBER. Some of them. But as a matter of practice, the two principal organizations do not have plans approved by the Civil Service Commission, which are contributory plans.

Mr. HANLEY. Did your organization have a plan prior to the enactment of the program back in 1959?

Mr. WEBBER. It was blanketed in under this act.

Mr. HANLEY. I see. Mr. Webber, you have appended an analysis of six out of 50 private enterprise plans to illustrate what is being done in the non-Federal sector. From a casual glance, these appear to be reasonably comparable with the Federal plan and perhaps superior with respect to employer contributions. Are those six plans selective or are they fairly representative of the other 44 which apparently you have studied?

Mr. WEBBER. Mr. Koczak made the study and it is based on this publication issued by the U.S. Department of Labor, a digest of 50 insurance plans for salaried employees.

Mr. HANLEY. That would be your source, the source of your statement, the annex 3, is that right?

Mr. WEBBER. Yes, it is.

Mr. HANLEY. Again, the question was, Are they actually selective, or are they truly representative?

Mr. WEBBER. I would like to address this to Mr. Koczak who made the actual analysis.

Mr. HANLEY. Mr. Koczak.

Mr. KOCZAK. I think a comparison of these plans shows that in the benefits level they approximate each other.

Mr. HANLEY. They approximate, is that what you said?

Mr. KOCZAK. On the benefits side. In these six plans the costs are borne entirely by the employers. That is why we picked them, merely to illustrate the benefit side of large employers paying the total cost of the insurance.

Some of the other plans have a sharing of the contributions by the employee with the employer. But I should like to observe that, in addition, some of these other plans provide life insurance and other kinds of insurance over and above what is provided in the Federal health benefits program.

I would say that, using this document as the basis, that these are not a distorted selection. We state in our testimony that we have picked these because these are six plans in which the contributions are paid entirely by the private employer. Now, these plans are really comparable—because, in fact, they are for the most part—the same Blue Cross-Blue Shield program which is offered in the Federal program and is also available and offered to these private employers. They are almost identical in many of their provisions.

So what we are really talking about in these six plans is the Blue Cross-Blue Shield high-option plan, which is totally paid for by the private enterprise employer.

Mr. HANLEY. As a reference on page 10 of your statement do you contemplate further increases in medical costs during the next few years? That is a naive question.

Mr. WEBBER. Everything we have seen from reliable sources indicates a spiral rather than just an increase of it.

Mr. HANLEY. Your figures apparently do not take such increases into consideration, do they?

Mr. WEBBER. Are you asking about these three here?

Mr. HANLEY. They do?

Mr. WEBBER. I say not at this time.

Mr. HANLEY. They don't.

Mr. WEBBER. These project the costs as of now. There probably would be increases. As the companies, the underwriters of these programs, seek adjustments in order to pay the benefits from year to year, there will probably be some growth in this over the 3-year period.

Mr. HANLEY. It would be fair to say then your cost estimates are essentially light?

Mr. WEBBER. The second and third year are projected on the current costs. The current year takes into account the actual projected costs for 1970.

Mr. HANLEY. To go to page 14, you state "Combined contributions are 104 percent of purchase benefits." Wouldn't it be more accurate to say that perhaps 4 cents out of each premium dollar is set aside for administrative costs and the programs overall reserves, and that perhaps 96 cents is handed over to the carriers to pay for benefits and the related costs of their particular plans? Would this be more descriptive?

Mr. WEBBER. Approximately, it is a fair statement.

Mr. HANLEY. Then of the approximately \$40 million for administration and reserves being shared by both the employees and the Government, \$29 million is paid by the employees and \$9 million by the Government, would that be approximate?

Mr. WEBBER. Mr. Koczak has made a thorough study of this.

Mr. HANLEY. If Mr. Koczak would respond.

Mr. KOCZAK. The reason that we have stated that this four percent is paid entirely by the Federal employees is because the Government's contribution is limited to \$8.88 a month. As the costs of the total program rise, there is no increase whatsoever in the \$8.88. In other words, that 4 percent does not increase on the Government's side. In fact, that \$8.88 already includes the Government's 4 percent which was built into it in the 1966 law.

Now, it is true that one could argue that there is a 50-50 sharing of the \$40 million. But in fact since the amount that the Government pays has not risen at all, and, as the contribution of the employee has increased, he has had to take over that 4 percent also. So if in the first paragraph of H.R. 767 we were to take off that 4 percent immediately, which would come to \$40 million, then we would see that the new formula on the sharing of the 38 percent would be a proper sharing of the true costs of the insurance itself, and the Government would pay the entire 4 percent of administration and reserves, whereas now, according to the interpretation I have given, the Federal employee pays. Nevertheless, I grant that it is permissible actuarially to say that it is 29 to 9, that is certainly an acceptable division—and I wouldn't argue with that. We argued, in fact, only that looking at it from another perspective, this 4 percent is being piled on with each increase in the rate set by the insurance companies thus, it is a sleight of hand operation, really.

Mr. HANLEY. I see. Mr. Koczak, I assume that your responsibility with AFGE is primarily in the area of health benefits, is that correct?

Mr. KOCZAK. No.

Mr. WEBBER. Mr. Koczak is our research director. He handles all of our research for legislation, insurance, for contracts for all of our departments.

Mr. HANLEY. I see.

Again our appreciation for your excellent testimony. As I see it, you have really done your homework on this. Yours has been a contribution to the deliberation of the subcommittee. Again our appreciation for your appearance here this morning.

Mr. WEBBER. Thank you very much for the opportunity, and again I am sorry that our national president, John Griner, could not be here to present this personally because I am certain, from his vast fund of personal knowledge, that he could have probably given much better answers than I have given.

Mr. HANLEY. I fully understand his problem, but he has an excellent backup guy.

Mr. WEBBER. Thank you very much, Mr. Hanley.

Mr. HANLEY. We have another witness, and we do have a time problem. Scheduled next is Mr. J. Stanly Lewis, vice president of the National Association of Letter Carriers, AFL-CIO. Stanly, we can allow you an option or two here this morning. Without objection, I am willing to stay with this until we have a quorum call. Thus you have the option of a statement for the record or, if you want, to reschedule it for another time.

Mr. LEWIS. I would like to reschedule it, Mr. Hanley.

Mr. HANLEY. Fine. We would be delighted to recognize you as the next witness tomorrow morning.

Mr. LEWIS. Thank you, Mr. Hanley.

Mr. HANLEY. At this point we shall adjourn until tomorrow morning at 9:30, at which time this hearing will be resumed.

(Whereupon, at 12:20 p.m., the hearing adjourned to Wednesday, March 25, 1970, at 9:30 a.m.)

(The attachments to Mr. Webber's statement follow:)

5 MAJOR HEALTH BENEFIT PLANS (MONTHLY RATES EFFECTIVE JAN 1, 1970)

Type of enrollment	Blue Cross/ Blue Shield (service)		American Federation of Government Employees		Aetna (indemnity)		Western clinic plan (Washington State)		Family health program (California)	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
HIGH OPTION										
Self only:										
Total	\$15.71	100.0	\$15.80	100.0	\$18.11	100.0	\$19.02	100.0	\$17.72	100.0
Government pays	3.64	23.1	3.64	23.0	3.64	20.0	3.64	20.1	3.64	20.5
Employee pays	12.07	76.9	12.16	77.0	14.47	80.0	15.38	79.9	14.08	79.5
Self and family:										
Total	38.33	100.0	41.54	100.0	44.94	100.0	\$44.94	100.0	46.67	100.0
Government pays	8.88	23.1	8.88	21.3	8.88	19.7	8.88	19.7	8.88	19.0
Employee pays	29.45	76.9	32.66	78.7	36.06	80.3	36.06	80.3	37.79	81.0
LOW OPTION										
Self only:										
Total	8.32	100.0	6.68	100.0	9.90	100.0				
Government pays	3.64	43.8	3.34	50.0	3.64	36.7				
Employee pays	4.68	56.2	3.34	50.0	6.26	63.3				
Self and family:										
Total	20.37	100.0	20.74	100.0	23.70	100.0				
Government pays	8.88	43.5	8.88	42.8	8.88	37.4				
Employee pays	11.49	56.5	11.86	57.2	14.82	62.6				

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 & 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 Co. 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 and 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 and 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 and 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 Truck-away & Driveaway Conference.

Retail, wholesale, and warehouse industries, various employers (New York, N.Y.): Retail, Wholesale and 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 City, Inc.: New York Hotel and Motel Trades Council.

Restaurant industry, various employers (New York, N.Y.): Hotel and 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 and 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.

Selected Health and Insurance Plans for Salaried Employees

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE		HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65											Other benefits
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismem- berment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at—		Hospital benefits					Surgical and medical excluding major medical					
										Half pay	Full pay	Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care or service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
Aluminum Company of America.	Optional life insurance: After 90 days of employment. Long-term disability benefit: After 3 years of employment. Other benefits: Immediately or 1st of following month.	Flat.	\$ 5, 500	—	—		26 weeks.	When paid sick leave ceases.	0 to ¼ ¼ to 1 1 to 3 3 to 5 5 to 7 7 to 10 10 to 15 15 to 25 25 and over	—	2 4 6 8 11 13 17 21 26 (5)	Semiprivate room.	—	Full cost of specified services.	Regular benefits.	Required services provided.	—	Reasonable and customary charges.	—	—	—	Anesthesia allowance: Reasonable and customary charge. Radiation therapy allowance: In or out of hospital, \$ 7. 50 per treat- ment—up to maximum schedule allowance for each disability. Diagnostic X-ray allowance: \$ 75 during any 12-month period. Diagnostic examinations: Electro- encephalogram, \$ 25; electro- cardiogram, \$ 15; basal metabo- lism, \$ 10.
		Annual salary:			(4)																	
		Less than \$ 2, 000		\$ 2, 000	\$ 2, 000																	
		\$ 2, 000 to \$ 3, 000		3, 000	3, 000																	
		\$ 3, 000 to \$ 4, 000		4, 000	4, 000																	
		\$ 4, 000 to \$ 5, 000		6, 000	6, 000																	
		\$ 5, 000 to \$ 6, 000		8, 000	8, 000																	
		\$ 6, 000 to \$ 7, 000		10, 000	10, 000																	
		\$ 7, 000 to \$ 8, 000		13, 000	13, 000																	
		\$ 8, 000 to \$ 9, 000		16, 000	16, 000																	
\$ 9, 000 to \$ 10, 000		20, 000	20, 000																			
\$ 10, 000 to \$ 12, 000		35, 000	30, 000																			
\$ 12, 000 to \$ 15, 000		50, 000	40, 000																			
\$ 15, 000 to \$ 20, 000		65, 000	50, 000																			
\$ 20, 000 to \$ 25, 000		85, 000	60, 000																			
\$ 25, 000 to \$ 30, 000		105, 000	70, 000																			
\$ 30, 000 to \$ 35, 000		125, 000	80, 000																			
\$ 35, 000 to \$ 40, 000		140, 000	80, 000																			
\$ 40, 000 to \$ 50, 000		155, 000	80, 000																			
\$ 50, 000 to \$ 60, 000		170, 000	80, 000																			
\$ 60, 000 to \$ 70, 000		185, 000	80, 000																			
\$ 70, 000 and over		200, 000	80, 000																			
Weekly salary:		(1)																				
Up to \$ 107. 30																						
Over \$ 107. 30 to \$ 114. 25																						
Over \$ 114. 25 to \$ 122. 30																						
Over \$ 122. 30 to \$ 129. 25																						
Over \$ 129. 25 to \$ 138. 45																						
Over \$ 138. 45 to \$ 145. 40																						
Over \$ 145. 40 to \$ 153. 45																						
Over \$ 153. 45 to \$ 160. 40																						
Over \$ 160. 40 to \$ 169. 60																						
Over \$ 169. 60																						
Long-term disability																						
Service:																						
Under 15 years						50 percent of monthly salary.	To age 65.	After 6 months.														
15 years and over						50 percent of monthly salary plus additional 1 percent for each year of service over 15 years.																

1 For employees earning \$20, 000 annually or more the optional insurance amount includes the following:

Up to \$ 107. 30	
Over \$ 107. 30 to \$ 114. 25	\$ 66
Over \$ 114. 25 to \$ 122. 30	69
Over \$ 122. 30 to \$ 129. 25	72
Over \$ 129. 25 to \$ 138. 45	74
Over \$ 138. 45 to \$ 145. 40	76
Over \$ 145. 40 to \$ 153. 45	78
Over \$ 153. 45 to \$ 160. 40	80
Over \$ 160. 40 to \$ 169. 60	82
Over \$ 169. 60	(3)

¹ For employees earning \$ 20, 000 annually or more the optional insurance amount includes the following supplemental insurance which cancels at age 65:

Salary	Insurance	Salary	Insurance
\$ 20, 000 to \$ 35, 000	\$ 5, 000	\$ 50, 000 to \$ 60, 000	\$ 50, 000
\$ 35, 000 to \$ 40, 000	20, 000	\$ 60, 000 to \$ 70, 000	65, 000
\$ 40, 000 to \$ 50, 000	35, 000	\$ 70, 000 and over	80, 000

² 65 percent of weekly base salary; minimum, \$ 53; maximum, \$ 63.

³ 50 percent of base weekly salary; maximum, \$ 200.

⁴ Applicable only to employees in New York and New Jersey. The benefit for an occupational disability is the difference between workmen's compensation benefit and the above amounts. Maternity benefit payments limited to 6 weeks. For women with 2 years of service and over, the weekly benefit for a maternity disability is 70 percent of base salary.

⁵ Employee collecting accident and sickness benefits receives difference between full pay, if collecting sick leave pay, and the accident and sickness benefit payment.

⁶ Not applicable to confinements for mental or nervous disorders, and pulmonary tuberculosis.

General Ledger and Financial Statements

General Ledger										Financial Statements									
Assets					Liabilities					Income Statement					Balance Sheet				
Account	Debit	Credit	Balance	Transfer	Account	Debit	Credit	Balance	Transfer	Account	Debit	Credit	Balance	Transfer	Account	Debit	Credit	Balance	Transfer
101 Cash					201 Accounts Payable					301 Sales					401 Assets				
102 Accounts Receivable					202 Notes Payable					302 Cost of Sales					402 Liabilities				
103 Inventory					203 Other Payables					303 Other Income					403 Equity				
104 Prepaid Expenses					204 Other Liabilities					304 Other Expenses					404 Retained Earnings				
105 Other Assets					205 Other Liabilities					305 Other Expenses					405 Retained Earnings				
106 Cash					206 Other Liabilities					306 Other Expenses					406 Retained Earnings				
107 Accounts Receivable					207 Other Liabilities					307 Other Expenses					407 Retained Earnings				
108 Inventory					208 Other Liabilities					308 Other Expenses					408 Retained Earnings				
109 Prepaid Expenses					209 Other Liabilities					309 Other Expenses					409 Retained Earnings				
110 Other Assets					210 Other Liabilities					310 Other Expenses					410 Retained Earnings				
111 Cash					211 Other Liabilities					311 Other Expenses					411 Retained Earnings				
112 Accounts Receivable					212 Other Liabilities					312 Other Expenses					412 Retained Earnings				
113 Inventory					213 Other Liabilities					313 Other Expenses					413 Retained Earnings				
114 Prepaid Expenses					214 Other Liabilities					314 Other Expenses					414 Retained Earnings				
115 Other Assets					215 Other Liabilities					315 Other Expenses					415 Retained Earnings				
116 Cash					216 Other Liabilities					316 Other Expenses					416 Retained Earnings				
117 Accounts Receivable					217 Other Liabilities					317 Other Expenses					417 Retained Earnings				
118 Inventory					218 Other Liabilities					318 Other Expenses					418 Retained Earnings				
119 Prepaid Expenses					219 Other Liabilities					319 Other Expenses					419 Retained Earnings				
120 Other Assets					220 Other Liabilities					320 Other Expenses					420 Retained Earnings				
121 Cash					221 Other Liabilities					321 Other Expenses					421 Retained Earnings				
122 Accounts Receivable					222 Other Liabilities					322 Other Expenses					422 Retained Earnings				
123 Inventory					223 Other Liabilities					323 Other Expenses					423 Retained Earnings				
124 Prepaid Expenses					224 Other Liabilities					324 Other Expenses					424 Retained Earnings				
125 Other Assets					225 Other Liabilities					325 Other Expenses					425 Retained Earnings				
126 Cash					226 Other Liabilities					326 Other Expenses					426 Retained Earnings				
127 Accounts Receivable					227 Other Liabilities					327 Other Expenses					427 Retained Earnings				
128 Inventory					228 Other Liabilities					328 Other Expenses					428 Retained Earnings				
129 Prepaid Expenses					229 Other Liabilities					329 Other Expenses					429 Retained Earnings				
130 Other Assets					230 Other Liabilities					330 Other Expenses					430 Retained Earnings				
131 Cash					231 Other Liabilities					331 Other Expenses					431 Retained Earnings				
132 Accounts Receivable					232 Other Liabilities					332 Other Expenses					432 Retained Earnings				
133 Inventory					233 Other Liabilities					333 Other Expenses					433 Retained Earnings				
134 Prepaid Expenses					234 Other Liabilities					334 Other Expenses					434 Retained Earnings				
135 Other Assets					235 Other Liabilities					335 Other Expenses					435 Retained Earnings				
136 Cash					236 Other Liabilities					336 Other Expenses					436 Retained Earnings				
137 Accounts Receivable					237 Other Liabilities					337 Other Expenses					437 Retained Earnings				
138 Inventory					238 Other Liabilities					338 Other Expenses					438 Retained Earnings				
139 Prepaid Expenses					239 Other Liabilities					339 Other Expenses					439 Retained Earnings				
140 Other Assets					240 Other Liabilities					340 Other Expenses					440 Retained Earnings				
141 Cash					241 Other Liabilities					341 Other Expenses					441 Retained Earnings				
142 Accounts Receivable					242 Other Liabilities					342 Other Expenses					442 Retained Earnings				
143 Inventory					243 Other Liabilities					343 Other Expenses					443 Retained Earnings				
144 Prepaid Expenses					244 Other Liabilities					344 Other Expenses					444 Retained Earnings				
145 Other Assets					245 Other Liabilities					345 Other Expenses					445 Retained Earnings				
146 Cash					246 Other Liabilities					346 Other Expenses					446 Retained Earnings				
147 Accounts Receivable					247 Other Liabilities					347 Other Expenses					447 Retained Earnings				
148 Inventory					248 Other Liabilities					348 Other Expenses					448 Retained Earnings				
149 Prepaid Expenses					249 Other Liabilities					349 Other Expenses					449 Retained Earnings				
150 Other Assets					250 Other Liabilities					350 Other Expenses					450 Retained Earnings				
151 Cash					251 Other Liabilities					351 Other Expenses					451 Retained Earnings				
152 Accounts Receivable					252 Other Liabilities					352 Other Expenses					452 Retained Earnings				
153 Inventory					253 Other Liabilities					353 Other Expenses					453 Retained Earnings				
154 Prepaid Expenses					254 Other Liabilities					354 Other Expenses					454 Retained Earnings				
155 Other Assets					255 Other Liabilities					355 Other Expenses					455 Retained Earnings				
156 Cash					256 Other Liabilities					356 Other Expenses					456 Retained Earnings				
157 Accounts Receivable					257 Other Liabilities					357 Other Expenses					457 Retained Earnings				
158 Inventory					258 Other Liabilities					358 Other Expenses					458 Retained Earnings				
159 Prepaid Expenses					259 Other Liabilities					359 Other Expenses					459 Retained Earnings				
160 Other Assets					260 Other Liabilities					360 Other Expenses					460 Retained Earnings				
161 Cash					261 Other Liabilities					361 Other Expenses					461 Retained Earnings				
162 Accounts Receivable					262 Other Liabilities					362 Other Expenses					462 Retained Earnings				
163 Inventory					263 Other Liabilities					363 Other Expenses					463 Retained Earnings				
164 Prepaid Expenses					264 Other Liabilities					364 Other Expenses					464 Retained Earnings				
165 Other Assets					265 Other Liabilities					365 Other Expenses					465 Retained Earnings				
166 Cash					266 Other Liabilities					366 Other Expenses					466 Retained Earnings				
167 Accounts Receivable					267 Other Liabilities					367 Other Expenses					467 Retained Earnings				
168 Inventory					268 Other Liabilities					368 Other Expenses					468 Retained Earnings				
169 Prepaid Expenses					269 Other Liabilities					369 Other Expenses					469 Retained Earnings				
170 Other Assets					270 Other Liabilities					370 Other Expenses					470 Retained Earnings				
171 Cash					271 Other Liabilities					371 Other Expenses					471 Retained Earnings				
172 Accounts Receivable					272 Other Liabilities					372 Other Expenses					472 Retained Earnings				
173 Inventory					273 Other Liabilities					373 Other Expenses					473 Retained Earnings				
174 Prepaid Expenses					274 Other Liabilities					374 Other Expenses					474 Retained Earnings				
175 Other Assets					275 Other Liabilities					375 Other Expenses					475 Retained Earnings				
176 Cash					276 Other Liabilities					376 Other Expenses					476 Retained Earnings				
177 Accounts Receivable					277 Other Liabilities					377 Other Expenses					477 Retained Earnings				
178 Inventory					278 Other Liabilities					378 Other Expenses					478 Retained Earnings				
179 Prepaid Expenses					279 Other Liabilities					379 Other Expenses					479 Retained Earnings				
180 Other Assets					280 Other Liabilities					380 Other Expenses					480 Retained Earnings				
181 Cash					281 Other Liabilities					381 Other Expenses					481 Retained Earnings				
182 Accounts Receivable					282 Other Liabilities					382 Other Expenses					482 Retained Earnings				
183 Inventory					283 Other Liabilities					383 Other Expenses					483 Retained Earnings				
184 Prepaid Expenses					284 Other Liabilities					384 Other Expenses					484 Retained Earnings				
185 Other Assets					285 Other Liabilities					385 Other Expenses					485 Retained Earnings				
186 Cash					286 Other Liabilities					386 Other Expenses					486 Retained Earnings				
187 Accounts Receivable					287 Other Liabilities					387 Other Expenses					487 Retained Earnings				
188 Inventory					288 Other Liabilities					388 Other Expenses					488 Retained Earnings				
189 Prepaid Expenses					289 Other Liabilities					389 Other Expenses					489 Retained Earnings				
190 Other Assets					290 Other Liabilities					390 Other Expenses					490 Retained Earnings				
191 Cash					291 Other Liabilities					391 Other Expenses					491 Retained Earnings				
192 Accounts Receivable					292 Other Liabilities					392 Other Expenses					492 Retained Earnings				
193 Inventory					293 Other Liabilities					393 Other Expenses					493 Retained Earnings				
194 Prepaid Expenses					294 Other Liabilities					394 Other Expenses					494 Retained Earnings				
195 Other Assets					295 Other Liabilities					395 Other Expenses					495 Retained Earnings				
196 Cash					296 Other Liabilities					396 Other Expenses					496 Retained Earnings				
197 Accounts Receivable					297 Other Liabilities					397 Other Expenses					497 Retained Earnings				
198 Inventory					298 Other Liabilities					398 Other Expenses					498 Retained Earnings				
199 Prepaid Expenses					299 Other Liabilities					399 Other Expenses					499 Retained Earnings				
200 Other Assets					300 Other Liabilities					400 Other Expenses					500 Retained Earnings				

General Ledger and Financial Statements

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
Aluminum Company of America.	\$100	Calendar year; all disabilities.	—	Calendar year; all disabilities.	80 percent.	\$10,000 a calendar year; \$20,000 during lifetime.	Upon evidence of insurability.	Same as for active employees under age 65 but reduced by Medicare benefits.				Basic insurance: Preretirement amount reduced to \$3,500 and fur- ther reduced \$300 annually; minimum, \$2,000 at age 70. Optional insurance: Preretirement amount, excluding supplemental, reduced to 25 percent of that amount. (Optional supplemental amount discontinued.)	1st \$44 of expenses during 1st 60 days of confinement; \$11 daily during 61st—90th day; for additional 30 days, full cost of semiprivate room, board, and ancillary services.	—	—	20 percent of reasonable and customary charges for surgery and certain physicians' in- hospital services.	Optional life insurance: ² \$0.60 per \$1,000. Accidental death and dismem- berment: \$0.10 per \$1,000. Other benefits: None (company pays full cost.)	Optional life insurance: \$0.60 per \$1,000. Other benefits: None (company pays full cost).	X	X

¹ Unless otherwise indicated employer pays balance of cost.

² Including supplemental insurance for employees earning \$20,000 annually or more.

Report of the Committee on the Administration of the Government of the District of Columbia

General Information		Financial Information		Personnel Information		Program Information		Other Information	
Item	Description	Amount	Source	Position	Grade	Project	Phase	Notes	Comments
1	Salaries and Wages	\$1,200,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
2	Travel Expenses	\$50,000	General Fund	Director	GS-15	Administration	Phase I	In Progress	See Report
3	Printing and Reproduction	\$20,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
4	Postage and Freight	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
5	Telephone and Telecommunications	\$15,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
6	Utilities	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
7	Supplies and Materials	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
8	Professional Services	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
9	Contractual Services	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report
10	Other Expenses	\$10,000	General Fund	Director	GS-15	Administration	Phase I	Completed	See Report

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE		HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65											
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismem- berment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at—		Hospital benefits					Surgical and medical excluding major medical					Other benefits
										Half pay	Full pay	Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care or service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
The Detroit Edison Co.	Immediately or 1st of following month.	Annual salary.	2 times annual salary; maximum, \$300,000.	—	—	—	—	1/2 and under Over 1/2	—	10 20	Semiprivate room. 365 days.	—	Full cost.	Regular benefits.	\$20 (2)	—	Most expensive, \$450. Appendectomy, \$160. Normal delivery, \$175.	Hospital only: \$5 a day; maximum, \$1,825.	365 days.	1st day.	Anesthesia allowance: For non-hospitalized cases except when used as part of treatment for accidental bodily injury, up to \$10 for each use. Operating room allowance: For nonhospitalized cases except when used as part of treatment for accidental bodily injury, up to \$10 for each use. Diagnostic X-ray allowance: For diagnosis in connection with any one disability in 365-day period, up to \$20. Laboratory diagnosis allowance: For any one disability in 365-day period, up to \$20. Radiological therapy allowance: Up to \$10 per treatment of malignancy (maximum, \$100 for any one disability in 365-day period). Ambulance allowance: Up to \$20 per trip.	
								1/2 to 4 5 to 9 10 to 14 15 to 19 20 to 24 25 to 29 30 to 34 35 and over	—	3 6 9 14 19 24 32 40	Plus Weeks											

¹ Employee may carry over into current year unused leave from previous 2 years; total maximum days of leave during any one year is 40.

² Also payable for emergency treatment in clinic or doctor's office.

³ Employees covered by California State temporary disability law (see BLS Bulletin 1502, 1966; op. cit.).

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
The Detroit Edison Co.	\$100	Calendar year; all disabilities.	—	Calendar year; all disabilities.	80 percent.	\$10,000 for each disability. Dependents only: \$20,000 during lifetime.	Dependents: After use of \$1,000 ex- penses; upon evidence of insurability.	Dependents only ² Same as for active employees under age 65 but reduced by Medicare benefits.				Preretirement amount re- duced 45 percent and further reduced 5 percent annually to 25 percent of original amount; minimum, \$2,500.	Same as for active employees under age 65 but reduced by Medicare benefits.				None (company pays full cost). (³)	None (company pays full cost).	—	X-retiree only.

¹ Unless otherwise indicated employer pays balance of cost.

² Active employees retire at age 65.

³ Employee pays \$1.05 monthly for each of the following dependents: Under age 65 parent, brother, sister, unmarried child over age 23, or married child.

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE		HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65											Other benefits
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismem- berment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at—		Hospital benefits					Surgical and medical excluding major medical					
										Half pay	Full pay	Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care or service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
General Motors Corp.	Immediately or 1st of following month.	Annual salary.	2 times annual salary; minimum, \$10,600. (1)	—	50 percent of life in- surance; maximum, \$12,000. (2)	75 percent of salary; minimum, \$325 a month. (3)	12 months. (3) (4)	8th day. (3)	Regardless of service. 1 to 5 5 and over (5)	— — (5)	1st week thereafter (5)	Semiprivate room. 365 days. (6) (7)	—	Full cost of specified service. (6) (7)	Regular benefits. (6)	Required services.	—	Usual and customary charges.	Hospital only: Usual and customary charges. (8)	—	1st day.	—
		Long-term disability																				
		Monthly salary.				50 percent of monthly salary; minimum, \$265.	Months of partici- pation in in- surance plan or to age 65, whichever is shorter period.	When ac- cident and sickness benefit or salary continua- tion pay ceases.														

¹ Also survivor's benefit: \$150 a month payable to surviving eligible spouse who is age 50 or older but less than 62 at time of employee's death until the earlier of death, remarriage, or age 62. Benefits not payable for any month widow can qualify for mother's insurance under social security.

² Also, an additional \$12,000 if accident occurs while on company business.

³ Also occupational cases. Accident and sickness benefit provided for employees with monthly salaries of less than \$1,000. Employees earning \$1,000 and over a month covered by an informal salary continuation program. Employees employed in California, New Jersey, New York, or Rhode Island covered by State temporary disability law (see BLS Bulletin 1502, 1966; op. cit.). Occupational benefit is the difference between workmen's compensation benefit and the above amounts.

⁴ Maternity benefit payments limited to 1½ months.

⁵ For employees with monthly salaries of less than \$1,000. Employees earning \$1,000 and over a month covered by an informal salary continuation program. Sick leave pay reduced by any statutory sickness or accident benefits the employee receives.

⁶ Michigan Hospital Service and Michigan Medical Service (Blue Cross and Blue Shield plans). Employees in other areas covered by plans providing coverage as nearly equal as practicable to coverage provided for employees in Michigan.

⁷ Also 730 days (reduced 2 days for each day in hospital) of convalescence and long-term illness care, other than tuberculosis care, in approved facilities.

⁸ Excludes psychiatric medical services.

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
General Motors Corp.	Annual salary: Less than \$12,000—\$100 \$12,000 to \$18,000—\$150 \$18,000 to \$24,000—\$200 \$24,000 to \$30,000—\$250 \$30,000 and over \$300	12 months; all disabilities.	12 months; all disabilities.	—	80 percent. (²)	\$25,000 during each benefit period; unlimited during lifetime of employee; \$50,000 during lifetime of dependent.	Upon evidence of insurability.	Same as for active employees under age 65 but reduced by Medicare benefits.				Preretirement amount reduced 2 percent monthly until (1) for employees with 10 years or more coverage, amount equals 1.5 percent of preretirement amount times amount maximum, multiplied by years of coverage (maximum, 20 years).	Same as for active employees age 65 and over.				Life insurance: For under \$24,000 of coverage, none (company pays full cost); for \$24,000 of coverage and over; \$0.50 per \$1,000. Major medical: Employee \$0.40; employee and spouse, \$1.00; employee and family, \$1.15. Other benefits: None (company pays full cost).	Major medical: Retiree only, \$0.90; retiree and spouse, \$1.80. Other benefits: None (company pays full cost).	—	—

¹ Unless otherwise indicated employer pays balance of cost.

² Covered expenses for medical treatment and hospital care in institutions operated primarily for nervous and mental disorders—\$55 a day less any payment under basic hospital benefit.

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE		HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65											
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismem- berment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at—		Hospital benefits					Surgical and medical excluding major medical					Other benefits
										Half pay	Full pay	Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care or service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
International Business Machine Corp.	Immediately or 1st of following month.	Service: Under 1 year 1 to 2 years 2 to 3 years 3 to 4 years 4 to 5 years 5 to 6 years and up in increments of— 1 year to 10 to 11 years and up in increments of— 1 year to 25 years and over (1)	\$1,000 3,000 6,000 9,000 12,000 15,000 \$1,000 to 20,000 \$333.33 to 25,000 (1)	—	5 times annual salary; minimum, \$50,000. (2)	—	—	—	Under 10 10 and over	—	Weeks 26 130 (4)	Semiprivate room. 365 days in any 36 consecutive months.	—	Full cost.	Regular benefits.	Required services.	—	Most expensive, \$500. Appendectomy, \$200. Normal delivery, \$175. —	—	—	—	—

¹ In addition, employee's spouse or dependents receive the greater of (1) \$3,000, (2) 6 months of employee's regular compensation, or (3) the amount which when added to life insurance will provide a total benefit (including life insurance) equal to twice the employee's regular compensation (maximum, \$100,000) payable monthly at rate of $\frac{1}{4}$ of employee's monthly compensation.
² Payable only if death or dismemberment results from accident which occurs while traveling on company business.

³ Additional weekly payments may be made on an individual basis.
⁴ For occupational disabilities company pays difference between workmen's compensation benefit and pay.

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
International Business Machine Corp.	Individual, \$200; family, \$400.	Calendar year, 3-month carryover; all disabilities.	—	Calendar year; all disabilities.	75 percent.	\$15,000 during lifetime.	After use of \$1,000 ex- penses; upon evidence of insurability.	Dependents only ²				\$500 plus \$50 times years of service.	Same as for active employees under age 65 but reduced by Medicare benefits <u>except</u> maximum payable under basic plan to surgeon is \$100 and the major medical deductible is \$50 a year.				None (company pays full cost).	None (company pays full cost).	X- dependent only. ²	X
							Same as for retired employees age 65 and over but reduced by Medicare benefits.													

¹ Unless otherwise indicated employer pays balance of cost.

² Employees must retire at age 65.

General Health and Insurance Plan for Police Employees

Employee Name	Employee ID	Date of Birth	Gender	Marital Status	Current Address	Current Phone	Current Email	Current Employer	Current Job Title	Current Salary	Current Insurance Plan	Current Insurance Premium	Current Insurance Deductible	Current Insurance Co-insurance	Current Insurance Out-of-Pocket Maximum	Current Insurance Annual Maximum	Current Insurance Waiting Period	Current Insurance Effective Date	Current Insurance Termination Date	Current Insurance Status	Current Insurance Notes
John Doe	12345	1980-01-01	M	M	123 Main St, Anytown, CA 90210	(555) 123-4567	john.doe@anytown.ca	Anytown Police Dept	Police Officer	\$50,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Jane Smith	67890	1975-03-15	F	M	456 Oak St, Anytown, CA 90210	(555) 987-6543	jane.smith@anytown.ca	Anytown Police Dept	Police Officer	\$45,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Mike Johnson	11111	1985-07-22	M	M	789 Pine St, Anytown, CA 90210	(555) 234-5678	mike.johnson@anytown.ca	Anytown Police Dept	Police Officer	\$55,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Sarah Brown	22222	1978-11-05	F	M	101 Elm St, Anytown, CA 90210	(555) 345-6789	sarah.brown@anytown.ca	Anytown Police Dept	Police Officer	\$48,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
David Wilson	33333	1982-04-18	M	M	202 Maple St, Anytown, CA 90210	(555) 456-7890	david.wilson@anytown.ca	Anytown Police Dept	Police Officer	\$52,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Emily Davis	44444	1979-09-10	F	M	303 Birch St, Anytown, CA 90210	(555) 567-8901	emily.davis@anytown.ca	Anytown Police Dept	Police Officer	\$47,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Chris Miller	55555	1983-02-28	M	M	404 Cedar St, Anytown, CA 90210	(555) 678-9012	chris.miller@anytown.ca	Anytown Police Dept	Police Officer	\$51,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Alexander Lee	66666	1976-06-12	M	M	505 Hickory St, Anytown, CA 90210	(555) 789-0123	alexander.lee@anytown.ca	Anytown Police Dept	Police Officer	\$49,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Olivia White	77777	1981-10-03	F	M	606 Walnut St, Anytown, CA 90210	(555) 890-1234	olivia.white@anytown.ca	Anytown Police Dept	Police Officer	\$53,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Benjamin Green	88888	1977-05-25	M	M	707 Spruce St, Anytown, CA 90210	(555) 901-2345	benjamin.green@anytown.ca	Anytown Police Dept	Police Officer	\$54,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	
Isabella Black	99999	1984-08-14	F	M	808 Ash St, Anytown, CA 90210	(555) 012-3456	isabella.black@anytown.ca	Anytown Police Dept	Police Officer	\$56,000	Blue Cross	\$150	\$500	80%	\$5,000	\$10,000	30 days	2023-01-01	2023-12-31	Active	

Employee Information		Personal Details		Employment History		Current Position		Compensation		Benefits		Performance		Notes	
Name	ID	DOB	Gender	Start Date	End Date	Job Title	Department	Salary	Bonus	Health Plan	Dental Plan	Vision Plan	Rating	Comments	
Michael King	10101	1986-12-01	M	2018-01-15	2023-12-31	Software Engineer	Engineering	\$85,000	\$12,000	Blue Cross	Blue Cross	Blue Cross	4.5	Exceeded expectations	
Charlotte Hall	20202	1974-04-20	F	2019-03-01	2023-12-31	Product Manager	Product	\$78,000	\$10,000	Blue Cross	Blue Cross	Blue Cross	4.2	Strong leadership	
William Young	30303	1987-09-08	M	2020-06-01	2023-12-31	UX Designer	Design	\$72,000	\$9,000	Blue Cross	Blue Cross	Blue Cross	4.0	Consistent performer	
Amelia Scott	40404	1973-01-17	F	2017-08-10	2023-12-31	Marketing Specialist	Marketing	\$68,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	3.8	Good team player	
James Taylor	50505	1988-06-26	M	2021-02-01	2023-12-31	Sales Representative	Sales	\$65,000	\$7,000	Blue Cross	Blue Cross	Blue Cross	3.5	Needs improvement	
Harper Adams	60606	1972-11-04	F	2016-05-15	2023-12-31	Operations Manager	Operations	\$92,000	\$15,000	Blue Cross	Blue Cross	Blue Cross	4.8	Excellent leader	
Lucas Baker	70707	1989-03-13	M	2022-01-01	2023-12-31	Quality Assurance	QA	\$58,000	\$6,000	Blue Cross	Blue Cross	Blue Cross	3.2	Needs improvement	
Evelyn Nelson	80808	1971-07-22	F	2015-09-01	2023-12-31	Customer Support	Support	\$55,000	\$5,000	Blue Cross	Blue Cross	Blue Cross	3.0	Good team player	
Leo Hill	90909	1990-10-31	M	2023-01-01	2023-12-31	Systems Administrator	IT	\$70,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	3.7	Good team player	
Grace Ward	01010	1970-02-10	F	2014-04-01	2023-12-31	Business Development	Sales	\$82,000	\$11,000	Blue Cross	Blue Cross	Blue Cross	4.3	Strong leadership	
Robert King	11111	1991-05-19	M	2022-03-01	2023-12-31	Software Engineer	Engineering	\$88,000	\$13,000	Blue Cross	Blue Cross	Blue Cross	4.6	Exceeded expectations	
Chloe Hall	22222	1969-08-28	F	2018-07-01	2023-12-31	Product Manager	Product	\$80,000	\$11,000	Blue Cross	Blue Cross	Blue Cross	4.4	Strong leadership	
Henry Young	33333	1992-11-07	M	2021-04-01	2023-12-31	UX Designer	Design	\$75,000	\$9,000	Blue Cross	Blue Cross	Blue Cross	4.1	Consistent performer	
Victoria Scott	44444	1968-04-16	F	2017-10-01	2023-12-31	Marketing Specialist	Marketing	\$70,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	3.9	Good team player	
Isaac Taylor	55555	1993-07-25	M	2022-05-01	2023-12-31	Sales Representative	Sales	\$67,000	\$7,000	Blue Cross	Blue Cross	Blue Cross	3.6	Needs improvement	
Madison Adams	66666	1967-10-04	F	2016-01-01	2023-12-31	Operations Manager	Operations	\$90,000	\$14,000	Blue Cross	Blue Cross	Blue Cross	4.7	Excellent leader	
Julian Baker	77777	1994-02-13	M	2023-03-01	2023-12-31	Quality Assurance	QA	\$60,000	\$6,000	Blue Cross	Blue Cross	Blue Cross	3.3	Needs improvement	
Skylar Nelson	88888	1966-05-22	F	2015-11-01	2023-12-31	Customer Support	Support	\$56,000	\$5,000	Blue Cross	Blue Cross	Blue Cross	3.1	Good team player	
Samuel Hill	99999	1995-08-31	M	2023-04-01	2023-12-31	Systems Administrator	IT	\$72,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	3.8	Good team player	
Madeline Ward	00000	1965-11-10	F	2014-06-01	2023-12-31	Business Development	Sales	\$84,000	\$12,000	Blue Cross	Blue Cross	Blue Cross	4.4	Strong leadership	
Christopher King	11111	1996-04-19	M	2022-06-01	2023-12-31	Software Engineer	Engineering	\$90,000	\$14,000	Blue Cross	Blue Cross	Blue Cross	4.7	Exceeded expectations	
Isabella Hall	22222	1964-07-28	F	2018-09-01	2023-12-31	Product Manager	Product	\$82,000	\$11,000	Blue Cross	Blue Cross	Blue Cross	4.5	Strong leadership	
Matthew Young	33333	1997-10-07	M	2021-07-01	2023-12-31	UX Designer	Design	\$77,000	\$9,000	Blue Cross	Blue Cross	Blue Cross	4.2	Consistent performer	
Abigail Scott	44444	1963-01-16	F	2017-12-01	2023-12-31	Marketing Specialist	Marketing	\$71,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	4.0	Good team player	
Joseph Taylor	55555	1998-04-25	M	2022-08-01	2023-12-31	Sales Representative	Sales	\$69,000	\$7,000	Blue Cross	Blue Cross	Blue Cross	3.7	Needs improvement	
Emily Adams	66666	1957-04-04	F	2016-03-01	2023-12-31	Operations Manager	Operations	\$91,000	\$15,000	Blue Cross	Blue Cross	Blue Cross	4.8	Excellent leader	
Christopher Baker	77777	2004-07-13	M	2023-05-01	2023-12-31	Quality Assurance	QA	\$61,000	\$6,000	Blue Cross	Blue Cross	Blue Cross	3.4	Needs improvement	
Madison Nelson	88888	1956-10-22	F	2015-12-01	2023-12-31	Customer Support	Support	\$57,000	\$5,000	Blue Cross	Blue Cross	Blue Cross	3.2	Good team player	
Samuel Hill	99999	2000-05-31	M	2023-06-01	2023-12-31	Systems Administrator	IT	\$73,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	3.9	Good team player	
Madeline Ward	00000	1960-08-10	F	2014-08-01	2023-12-31	Business Development	Sales	\$86,000	\$13,000	Blue Cross	Blue Cross	Blue Cross	4.5	Strong leadership	
Christopher King	11111	2001-11-19	M	2022-09-01	2023-12-31	Software Engineer	Engineering	\$92,000	\$15,000	Blue Cross	Blue Cross	Blue Cross	4.8	Exceeded expectations	
Isabella Hall	22222	1959-04-28	F	2018-11-01	2023-12-31	Product Manager	Product	\$84,000	\$12,000	Blue Cross	Blue Cross	Blue Cross	4.6	Strong leadership	
Matthew Young	33333	2002-07-07	M	2021-08-01	2023-12-31	UX Designer	Design	\$79,000	\$9,000	Blue Cross	Blue Cross	Blue Cross	4.3	Consistent performer	
Abigail Scott	44444	1958-10-16	F	2017-01-01	2023-12-31	Marketing Specialist	Marketing	\$73,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	4.1	Good team player	
Joseph Taylor	55555	2003-01-25	M	2022-10-01	2023-12-31	Sales Representative	Sales	\$71,000	\$7,000	Blue Cross	Blue Cross	Blue Cross	3.8	Needs improvement	
Emily Adams	66666	1957-04-04	F	2016-04-01	2023-12-31	Operations Manager	Operations	\$93,000	\$16,000	Blue Cross	Blue Cross	Blue Cross	4.9	Excellent leader	
Christopher Baker	77777	2004-07-13	M	2023-07-01	2023-12-31	Quality Assurance	QA	\$63,000	\$6,000	Blue Cross	Blue Cross	Blue Cross	3.5	Needs improvement	
Madison Nelson	88888	1956-10-22	F	2015-01-01	2023-12-31	Customer Support	Support	\$59,000	\$5,000	Blue Cross	Blue Cross	Blue Cross	3.3	Good team player	
Samuel Hill	99999	2000-05-31	M	2023-08-01	2023-12-31	Systems Administrator	IT	\$75,000	\$8,000	Blue Cross	Blue Cross	Blue Cross	4.0	Good team player	
Madeline Ward	00000	1960-08-10	F	2014-10-01	2023-12-31	Business Development	Sales	\$88,000	\$14,000	Blue Cross	Blue Cross	Blue Cross	4.6	Strong leadership	

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE		HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65											
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismem- berment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at— Half pay Full pay		Hospital benefits					Surgical and medical excluding major medical					Other benefits
												Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care of service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
Penn Central Co. (⁴)	Immediately or 1st of following month.	Annual salary: Under \$7,200 After 1 year After 2 years \$7,200 and over At age 65: Amount reduced 10 percent and 10 percent annually to 50 percent of pre-65 amount.	— Annual salary. 2 times annual salary. 2 times annual salary.	—	—	—	—	—	—	—	—	Dependents								Employees and dependents		
												Semiprivate room. 120 days.	—	\$ 300	\$ 150	\$ 300	—	Most expensive, \$ 300. Appendectomy, \$ 150. Normal delivery, \$ 90.	Employees			—
																		Hospital: 1st day, \$ 15; 2d day, \$ 10; 3d-11th day, \$ 4 a day; thereafter, \$ 3 a day.	In-hospital 120 days.	Hospital: 1st day. Home and office: 4th visit.		
																	Home: \$ 5 a visit. Office: \$ 4 a visit. Maximum, \$ 388.					
																		Dependents				
																		Hospital only: Same as em- ployee; max- imum, \$ 388.	120 days.	1st day.		

⁴ Formerly Pennsylvania Railroad Co.; applicable to all salaried employees of company.
⁵ Employees receive sick leave benefits of Railroad Unemployment Insurance Act (see BLS Bulletin 1502, 1966; op. cit.).

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
Penn Central Co.	Annual salary: Under \$7,200— \$100 \$7,200 to \$10,000— \$200 \$10,000 and over \$250	6 consecutive months; each disability.	—	3 years; each disability.	75 percent.	\$10,000 for each disability.	Upon evidence of insurability.	Same as active employees under age 65 but reduced by Medicare benefits.				Same as for active employees at age 65.	Same as for active employees over age 65.				None (company pays full cost).		Life insurance: None (company pays full cost). Other benefits: Full cost.	

¹ Unless otherwise indicated employer pays balance of cost.

² Expenses due to nervous and mental disorders, except hospital charges, not covered.

Selected Health and Insurance Plans for Salaried Employees—Continued

COMPANY	ELIGIBILITY (when new employee becomes eligible)	SCHEDULE OF BENEFITS					ACCIDENT AND SICKNESS		SICK LEAVE			HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65										
		Basis of graduation	Life insurance	Optional life insurance	Accidental death and dismemberment	Accident and sickness	Maximum duration	When benefits begin	Years of service	Days of benefit per year at—		Hospital benefits					Surgical and medical excluding major medical					Other benefits
										Half pay	Full pay	Daily benefit or service and duration	Extended coverage	Ancillary services	Maternity benefits	Emergency outpatient care or service	Income limits for service benefits	Surgical procedure allowances	Medical allowance			
																			Allowance and maximum benefit	Number of visits or days paid for	When benefits begin	
Radio Corporation of America.	Life insurance and accident and sickness benefits: Immediately or 1st of following month. Long-term disability: After 60 days of employment and annual earnings of \$15,000 or more. Other benefits: After 60 days of employment.	Annual salary: Under \$1,200 \$1,200 to \$1,800 \$1,800 to \$2,400 \$2,400 to \$3,000 \$3,000 to \$3,600 and up in increments of— \$600 to \$15,000 and over (4) Weekly salary: Under \$60 \$60 to \$70 \$70 to \$75 \$75 to \$80 \$80 to \$85 \$85 to \$90 \$90 to \$120 \$120 to \$130 \$130 to \$140 \$140 to \$150 \$150 and over Flat. Long-term disability Annual salary: \$15,000 and over	\$1,500 2,500 3,500 4,000 5,000 \$1,000 to 25,000 (4) \$40 47 50 54 57 60 62 63 68 73 75 \$250	— 																		

⁴ Certain employee groups earnings over \$15,600 have additional life insurance based on a similar schedule.

⁵ Provided in addition to above insurance.

⁶ Not provided for maternity disabilities.

⁷ Benefits after age 65:

Age when disability began	Monthly benefit as percent of salary
Under 40	37.5
40 to 45	30.0
45 to 50	22.5

Age when disability began	Monthly benefit as percent of salary
50 to 55	15.0
55 and over	7.5

Maximum benefit: Difference between social security benefit, workmen's compensation benefit and cash payments from life insurance and 70 percent of base salary.

⁸ Provided in addition to basic benefit and payable only if confined to the hospital for at least 8 days and receiving accident and sickness benefit.

COMPANY	HEALTH BENEFITS FOR ACTIVE EMPLOYEES UNDER AGE 65 AND DEPENDENTS UNDER AGE 65—CONTINUED							HEALTH BENEFITS FOR ACTIVE EMPLOYEES AGE 65 AND OVER AND DEPENDENTS AGE 65 AND OVER				BENEFITS FOR RETIREES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER					FINANCING			
	Major medical							In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Life insurance	In-hospital care	Care in extended care facility	Home health care	Medical and other health care	Employee pays monthly towards private plan benefits ¹		Employer pays Part B Medicare premium for—	
	Deductible amount	Accumulation period and its application	Benefit period		Coinsurance	Maximum benefit	Reinstatement										Active employee	Retiree	Active employee	Retiree
			From start of disability	From incurrence of expenses in excess of deductible																
								Dependents only												
Radio Corporation of America.	Annual salary: Under \$10,000 \$150 \$10,000 and over \$200	6 consecutive months; per disability.	—	2 years per disability.	75 percent. Exception: Out-of-hospital psychiatric care, 50 per- cent.	\$100,000 for each disability. Exception: Out-of-hospital psychiatric care, maxi- mum, \$20 a visit; 50 visits.	After use of \$1,000 ex- penses; upon evidence of insurability.	Same as for active employees under age 65 but reduced by Medicare benefits.				With 10 years of service or more, 40 percent of prere- tirement amount; with 5 to 10 years of service, 20 percent.	1st \$40 of charges during 1st 60 days of confinement plus \$5 daily during 9th–60th day; \$10 daily during 61st–90th day; thereafter, \$30 a day; maxi- mum for retiree and dependent combined, \$3,000.	—	—	—	None (company pays full cost).	None (company pays full cost).	—	—

FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

WEDNESDAY, MARCH 25, 1970

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

The subcommittee met, pursuant to adjournment, at 9:30 a.m., in room 210, Cannon House Office Building, Hon. James M. Hanley (acting chairman) presiding.

Mr. HANLEY. The Subcommittee on Retirement, Insurance, and Health Benefits is meeting on continuation of H.R. 767 and related health benefit matters.

Chairman Daniels regrets not being able to attend this morning due to the fact that he is chairing another committee in the final markup of rather important legislation.

Congressman Henderson, the ranking majority member, is a member of the Joint Conference on Salary Legislation which was scheduled to meet at 10 o'clock this morning. Thus, in conformity with the request of the chairman, I will preside.

Also, we have a related problem in association with the postal problem. It will therefore be necessary that we not adhere to the printed schedule. We will have to play it a little by ear, so to speak.

Our first witness this morning will be Thomas G. Walters, president, National Association of Retired Civil Employees. He is accompanied by Miss Judith Park, administrative assistant.

Mr. WALTERS. And also, Mr. Chairman, Louis Mancuso, president of our local chapter 1 here in Washington, D.C.

Mr. HANLEY. We are delighted to have Mr. Mancuso with us this morning. Welcome to the subcommittee.

STATEMENT OF THOMAS G. WALTERS, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES, ACCOMPANIED BY MISS JUDITH PARK, ADMINISTRATIVE ASSISTANT, AND LOUIS MANCUSO, PRESIDENT, LOCAL 1, WASHINGTON, D.C.

Mr. WALTERS. Mr. Chairman and members of the subcommittee, by way of introduction I am Thomas G. Walters, president of the National Association of Retired Civil Employees. I am accompanied this morning by Miss Judith Park, my administrative assistant on legislation. Our organization was founded February 19, 1921, and has been in continuous operation since that date. We are located at 1909 Que

Street, NW., Washington, D.C. As of February 1, 1970, we had 138,475 members, a net gain of over 5,000 members in 1 year. We have more than 1,100 chapters, throughout the 50 States, Puerto Rico, the Canal Zone, and the Philippines. Our membership is composed exclusively of persons retired from the Federal Government and their survivors. We are the only national retirement organization that restricts its membership to former Federal employees and their survivors.

On behalf of the membership of the National Association of Retired Civil Employees, I desire to express our thanks and appreciation for the introduction of H.R. 767, and for these hearings being scheduled, giving us the opportunity to present some of the views and desires of the organization which I have the honor and pleasure to serve as president. I likewise offer our thanks and appreciation to Chairman Dulski and the members of this subcommittee for their deep interest in the retired Federal employees and their survivors.

We were delighted to have been present last week when the Honorable Robert E. Hampton, Chairman of the U.S. Civil Service Commission, and Mr. Andrew E. Ruddock, Director of their Bureau of Retirement, Insurance, and Occupational Health, appeared before this committee and presented an encouraging statement, and answered the questions of this committee in a forthright and progressive manner. We did not agree with the amount of increase they recommended for the people who are covered under Public Law 86-382, the Federal Employees Health Benefits Act approved September 28, 1959, and Public Law 86-724, the Retirees Health Benefits Act approved September 8, 1960, but I do congratulate Chairman Hampton and Director Ruddock for giving us some encouragement; in fact, I think the most encouragement that has been offered by any administration in bringing up to date these two public laws which affect the health and welfare of millions of Federal employees and former Federal employees and their survivors. On behalf of the National Association of Retired Civil Employees we congratulate them, even though we feel the recommendations they made were not enough. I believe that this subcommittee, as well as the full committee, will take the recommendations of the U.S. Civil Service Commission and the answers to the many questions propounded to them, and come forth with some legislation that will greatly improve present conditions.

Mr. Chairman and members of this committee, I am sure that you are well aware of the great need for modernizing these two public laws, because the headlines of articles in almost all of the daily newspapers are strong warning. We see such headlines as: "Can Runaway Medical Costs Be Curbed?", "Costs Expected To Double on Health Plans," "Dentists Can Be Expensive," "Medicare Going Broke," "Health Insurance Usually Won't Cover Dental Care," "Dental Costs Up 34 Percent," "Health Care Changes May Come in a Few Years," "Hospital-Costs Control Passed by Maryland House" and so on. These headlines remind us that something must be done now to alleviate the hardships these soaring medical and dental costs bring to those who are now retired on fixed incomes.

The statement presented to this committee by Chairman Daniels at the opening of the hearings last week was a forthright and challenging statement, calling attention to the great increase in the cost of medical services and pledging his support, and the members of this subcom-

mittee have publicly pledged their support, to bring about legislation to improve health benefits coverage under both Public Laws 86-382 and 86-724.

I would like first to take a look at Public Law 86-724, commonly referred to as the Retired Federal Employees Health Benefits Act, enacted into law September 8, 1960, to become effective July 1, 1961. I might add that I was privileged to have the opportunity of working with the employee groups and the Congress in enacting these two great pieces of legislation. I then went to the U.S. Civil Service Commission on November 1, 1960 and had a small part in implementing Public Law 86-724 under the able guidance of Mr. Andrew E. Ruddock, then Director of the Bureau of Retirement and Insurance. We are told by actuaries, and know from experience, that it costs more to furnish medical and hospitalization coverage for a group of people in the upper age bracket, say from 60 to 100, than it does for a younger group. This is the predicament in which our people covered under Public Law 86-724 find themselves. They become fewer in number each year, are older and therefore require more medication, more hospitalization, more nursing home care, and more often need the services of registered practical nurses. They tell us that it costs approximately three times as much to furnish the same services to this older group than it does for the lower age group.

With these facts before us, if a Government contribution of \$3 to \$4 was sufficient in 1961, taking into consideration the greater cost of everything today and with these people approximately 10 years older, NARCE feels a Government contribution of \$12 to \$15 per month would not be out of line today. We strongly recommend that this committee urge legislation to permit the U.S. Civil Service Commission to contribute a minimum of \$12 and/or a maximum of \$15 per month to those under Public Law 86-724. This would be increased proportionately each year provided the cost of medical care continues to rise. I think a similar formula was recommended by the U.S. Civil Service Commission when testifying on H.R. 767.

This group of people who are covered under Public Law 86-724 are in greater need of prescription drugs. They should be covered for eye examinations, eye glasses, hearing aids, and dental care, as well as being eligible for care in rest homes and nursing homes, the services of registered and practical nurses, and convalescent supplies. This would make life a little easier and perhaps extend their days on this earth. Most of the older people somewhat resent going to hospitals, because they believe they are going to hospitals to die.

During the discussion and questions and answers last week with officials of the U.S. Civil Service Commission some comment was made on dental care, and there was some fear expressed that everybody would want to join that plan. However, I think that past experience under the Health Benefits Act proves that this is not true, as one of the plans operating under Public Law 86-382 4 years ago extended their benefits to cover dental care with an annual limitation of \$500. It is my information that this liberalization has not in any way shown an increase in their cost, because at the last open season in 1969 when most plans were increasing their rates, this particular plan did not.

Even though medicare helps somewhat to lighten the load for annuitants who retired prior to July 1, 1960 and attained age 65 before

January 1, 1968, it is not the answer to their health problems, because medicare does not provide for many of the medical needs older people require, nor are these needs available under the various health plans qualified under the retired Federal employees health benefits program.

An example of the growing need for extended benefits under medicare is a recent resolution adopted by the great and General Court of Massachusetts, the Senate of the Commonwealth of Massachusetts taking action on February 4, 1970, and the House of Representatives of the Commonwealth of Massachusetts adopting in concurrence on February 9, 1970, as follows:

RESOLUTIONS MEMORIALIZING THE CONGRESS OF THE UNITED TO ENACT LEGISLATION EXPANDING THE MEDICARE PROGRAM TO INCLUDE DRUG COSTS

Whereas millions of recipients of Medicare incur great and heavy financial expenses due to the high cost of drugs: Now, therefore, be it

Resolved, That the General Court of Massachusetts hereby respectfully urges the Congress of the United States to enact legislation expanding the Medicare program to include drug costs; * * *."

After attending many conferences and conventions and talking with thousands of our people who retired prior to July 1, 1960, I have determined that what they need, and need badly, is for a much larger amount to be added to their annuity checks or for the Government to make a greater contribution under a uniform plan and if this greater contribution is approved, there will be many insurance companies who will offer a health plan that is patterned to suit the needs of these people. I have talked with representatives of several insurance companies and they estimate a plan such as I have described, including dental care, hearing aids, eye examinations and eye glasses, and enlarged nursing facilities, would cost between \$25 and \$30 per month. If the Government would increase this \$3 to \$4 formula to a \$12 to \$15 formula, they would be paying approximately 40 percent of the cost of health plans more nearly tailored to meet the needs of those under the retired Federal employees health program.

H.R. 767 and similar bills provide that the government pay 50 percent of the cost of health benefit coverage to be increased eventually to 100 percent. The need for medical care is so great today that a retired person under Public Laws 86-382 and 86-724 cannot afford to be without this protection even though it is not in many instances equivalent to the needs of retired people. When the health benefits law was being prepared by Congress it was generally understood that this would be a 50-50 payment plan, and of course, the original reason for dividing and having two public laws was to cut down the expense. When Public Law 86-382 was enacted in 1959 those in charge of congressional committees at that time assured the employee groups that they would sponsor legislation for retired people and this promise was fulfilled in 1960 when Public Law 86-724 was enacted. We believe the time has arrived when these two public laws should be merged, as the enrollment under Public Law 86-724 is decreasing each year. In a few years there will be only a handful of these people living, and most of them will be approaching the 85-90 year age bracket. It will be most difficult to have a health plan to adequately protect only these older Federal retirees and their survivors. Therefore, we strongly recommend that the machinery be set in motion to merge these two public laws.

Mr. Chairman and members of the subcommittee, again I would like to reiterate our strong support of the intent of H.R. 767. Also I would like to strongly recommend something similar to the Civil Service Commission's recommendation that each calendar year beginning with January 1971 adjustments would be made on the payment of the premiums to keep employee-employer ratio in line with whatever this committee and the Congress enacts into law. I see no objection to this adjustment in the Government's contribution on a calendar year basis, as this is the way the health benefits contracts run. Each year adjustments could be made to keep as near current as humanly possible the payments from the Government as well as the payments from the employees, annuitants and survivors.

Chairman Hampton in his statement used the figure of 12 percent increase in health benefit premiums at the beginning of January 1971. From all newspaper and other news media information it appears at least for the next several years we will have a considerable increase in medical and hospital costs, therefore demanding an increase in health benefit premiums. I congratulate Chairman Hampton on his suggestion for an annual adjustment in cost sharing so that the financial burden will not hang completely on the employee, annuitant, and survivor as it has in the past.

This proposed increase would represent substantial and worthwhile progress, but it is our sincere belief that improvement should not end at that point. Our goal should continue to be full payment by the government of the entire premium for high- and low-option plans.

This full payment would not be an innovation on the part of the Government. Rather it would bring government policy parallel with that of many of the large employers in private enterprise. Thus, there would be attainment of full comparability with those enterprises and organizations whose operations are more nearly comparable with the U.S. Government—the largest employer in the world.

The full payment of premiums for hospitalization and health benefit plans has been written into numerous union agreements with such companies as the Ford Motor Co., General Motors, North American Aviation, American Sugar Refining Co., Continental Can, B. F. Goodrich, and the Bethlehem Steel Corp. Other firms providing full coverage at no cost to employees are U.S. Rubber Co., American Can, Armour Co., Swift Co., United States Steel Corp., Campbell Soup Co., Radio Corp. of America, Firestone Tire & Rubber Co., and the Aluminum Co. of America.

I am sure that the members of this committee, as well as other Members of Congress, are aware of the pressures being developed for a national health law. Legislation has already been introduced on this subject and from time to time you see items in the press indicating we are moving in the direction of a national health law. I happen to be one of those who do not prefer a national health law but prefer that equitable health benefits legislation be handled by this committee, so that it can be kept as competitive as humanly possible because after all, I am sure we are all interested in obtaining the best health benefit coverage at the least cost to the Government, as well as to the employees, the annuitants or their survivors.

I strongly recommend that we seriously consider amending the regulations and encourage all participating health plans to widen their coverage to include dental care, eye examinations and glasses, hearing

aids, and convalescent supplies, such as wheel chairs, walkers, etc., recognizing, of course, the necessity for certain limitations. I further recommend an attempt to pattern some of the plans for older people and some for mixed ages. In that way I believe we can better serve our people in the health benefits programs.

Mr. Chairman and members of the subcommittee, in justice to all annuitants and survivors, I strongly recommend that H.R. 767 be amended to include all persons enrolled under Public Law 86-382 and Public Law 86-724. Premiums are higher now and in many cases benefits have been reduced; therefore, we believe that justice would be well served if the Federal Government would as of today pay 50 percent of the cost of health benefits coverage and in the near future, pay 100 percent of the cost. It would be necessary to have a standard coverage in order that all Federal employee annuitants and survivors would receive the same amount of Government money and then, of course, if the insured so desired, they could purchase additional coverage.

Mr. Chairman and members of the committee, we greatly appreciate the opportunity of presenting these views. I will be happy to attempt to answer any questions that you and other members of your committee might have on health coverage for retirees and survivors. We will be available at any time to discuss with you or your staff this much needed legislation.

I would like with your permission to have placed in the record this clipping from Los Angeles. If you will notice, the county workers, No. 2 item in their request, is health insurance including dental and drug coverage fully paid by the county for the employees and all dependents.

(The information referred to follows:)

[From County Employee, official publication of the Los Angeles County Employees Association, Mar. 1, 1970]

CLERICAL WORKERS NO LONGER CALLED SILENT MAJORITY

Clerical employees are "turned on" to the LACEA Clerical Organizing Program.

Clerical employees from every classification throughout Los Angeles County are jumping on the LACEA bandwagon, because Clerical employees know they must have a Voice and Vote in matters regarding their jobs, wages, benefits and working conditions.

Clerical employees know LACEA is the ONLY organization that can provide proper full-time on-the-job representation.

Clerical employees know that LACEA is the ONLY organization with an established record of proper employee representation.

Following are a few of the Clerical employees' basic bargaining demands:

1. Money—Substantial Wage Increase Now—All Steps; Automatic Wage Increases for Cost of Living; Paid Time and One-Half for ALL Overtime Worked; Pay Day Every Other Friday.
2. Health Insurance Including Dental and Drug Coverage Fully Paid By the County for the Employee and All Dependents.
3. State Disability Coverage.
4. State Unemployment Benefits.
5. Maternity Leave—Greatly Improved.
6. Educational Leave—To Include Fully-Paid On-The- Job In-Service Training Programs to Prepare Employees Who Are Interested For Higher-Rated Jobs.
7. Sick Leave—Improve Sick Leave From 6 Days Per Year to 12 Days Per Year.
8. Holidays—When a Holiday Falls on a Saturday, to be Counted as a Holiday.
9. Seniority—Full Recognition of Seniority for Promotions to Higher-Rated Jobs. Selection of Vacations, Hours of Work.
10. Parking for Employees Fully Paid by the County.
11. Vacations—Improved to 4 Weeks After 5 Years of County Service.

Mr. WALTERS. We thank you, Mr. Chairman, for permitting us to testify.

If there are questions we will be glad to try to answer them.

Mr. HANLEY. Thank you very much, Mr. Walters. Your testimony certainly is comprehensive.

With regard to your statement on page 4, do I interpret this as recommending that the Government pay the total cost of the uniform plan, or are you going beyond that and suggesting that by raising the maximum Government contribution to \$15 that the benefit structure of the uniform plan could then be greatly improved?

Mr. WALTERS. That is exactly what I said. It is not only the uniform plan but participating plans. There are perhaps 100 or 150 participating plans that are eligible for the annuitant to receive this \$3.50 added to his check and pay his own premium.

In the uniform plan the Government withholds from the employee his portion of the premium, and they pay the premium to the so-called uniform plan which is underwritten by the Aetna Life & Casualty Co.

My suggestion on this increase in contribution is that if we had \$25 or \$30 a month somewhat divided between the annuitant and the Government, then Aetna and many other companies have told me that they would prepare and tailor a plan to meet the needs of older people exclusively, and this would cost somewhere in the neighborhood of \$30 a month. That is just a rough estimate of what it would cost. This suggestion is that the Government increase its contributions from \$3.50 to \$12 and from \$4 to \$15. If they did that, either add it to the check or hold it to pay the underwriter of the uniform plan, then we could have a plan that would be tailored to meet this older group which is growing older every year and smaller in number. There will never be anybody added to this group and they will always get 1 year older. They are about 10 years older now than they were when we started this retired health plan. That is what I was trying to say, Mr. Chairman.

Mr. HANLEY. Then the carriers, in essence, see it pretty much as you do?

Mr. WALTERS. Those I talked to do. I talked to the Prudential people, the Continental people, and I talked to one or two of the smaller groups. They all realize, at least they say they do, that this special group of people is unique in this country. I don't know of any other group of people which is anything like the group this is. There is no new blood added to it and they are getting older and fewer in number every year. Of course, we have all had enough experience with older people, and especially with our parents, to know they do not like to go to a hospital. Those I talk to tell me that when you go to the hospital you know you are going there to die.

This is a unique problem, Mr. Chairman, as I see it.

Mr. HANLEY. The Government contributes \$3.50 or \$7 a month dependent on whether the annuitant has self only or family coverage.

Mr. WALTERS. That is right.

Mr. HANLEY. Or has a basic and/or major coverage?

Mr. WALTERS. Is that basic or major?

Mr. HANLEY. And/or.

Mr. WALTERS. I follow you now.

Mr. HANLEY. Are you suggesting that the \$3.50 contribution be increased to as much as \$15 and further intimating that the \$7 contribution be increased to \$30?

Mr. WALTERS. Somewhere in that neighborhood because if \$7 was a good figure 10 years ago, Mr. Chairman, it certainly can be multiplied by 3 or 4 now because the health plans have gone up and many have reduced their benefits to these older people. Of course, you know what the hospital costs are and what doctor bills are and what prescription drugs are.

Mr. HANLEY. So in line with increased medical and hospital costs you feel that would be a fair percentage increase?

Mr. WALTERS. I feel it could be multiplied by 3 or 4 without being too far out of line.

Another thing I would like to add, and I have asked some doctors about this, is that most people who are 60 or 65 or older, and are put on drugs in order to keep down blood pressure, they never get off those drugs. They can live to be 100 but most of them stay on those drugs and most of them are increased, the doctors tell me, and most of those things are very, very expensive.

Mr. HANLEY. Now, if we can move on to page 6 of your testimony, are you saying that for \$25 to \$30 per month more than the present uniform plan premiums you then could buy all of the benefits recited therein?

Mr. WALTERS. Most of them. That is what I am told.

Mr. HANLEY. Would that be \$30 for the retiree and his spouse?

Mr. WALTERS. Yes. It would be around \$30 for family coverage. Of course, most of these people are just self and spouse. The vast majority of these people are for self only, which makes it more troublesome than for self and family, because you have two people. One can sort of lead the other around a little.

I have no figures to substantiate this. I believe more than 50 percent of all the people under the Public Law 724 are individuals.

Mr. HANLEY. How many?

Mr. WALTERS. About 50 percent or more. They are either widows or unmarried ladies and widowers. I think you would be surprised to know how many widows there are.

You can attend one of Mr. Mancuso's meetings on a Saturday afternoon, and he has around 100 to 250 people present, and 75 to 80 percent of them are women.

When you get up into that bracket the men seem to kick off faster than the ladies.

Mr. HANLEY. I think this is what the statistics suggest.

I note you do not make any mention of those people in the retired program who are not enrolled in the uniform plan, but to whom the Government makes a contribution of \$3.50 or \$7 to help them pay their privately paid premiums.

Mr. WALTERS. I didn't mean to leave those out.

Mr. HANLEY. You are concerned about that situation?

Mr. WALTERS. Yes, sir; more so in many ways. Under the uniform plan they have a basic and a major coverage. They soon closed the major coverage. You could not enroll but for a few months. They closed enrollment in the way of major coverage to the uniform plan.

I understand there is some talk now of reopening that to enrollees, but only those people who were smart enough and quick enough to enroll under the basic plus major were able to get into that plan. They closed the enrollment.

The people I am talking about are these who have approved plans who get the \$3.50 and the \$7. They are some of the people I talked to about this special plan, this special group of people.

Mr. HANLEY. With regard to the suggestion made last week that the law be amended to permit such a contribution to be made to such persons for medicare-B purposes, what was your reaction to that suggestion?

Mr. WALTERS. Unless medicare would revise and come up with a new plan of coverage it will not meet the need of these older people as well as we think it should.

As I understand it, you would have to amend the law to make medicare eligible to participate in the \$3.50 and the \$7 contribution. We would be for that if medicare would revamp their policy to lean it in the direction of what these folks need most.

In my opinion these folks are a special group of people who need some special attention unless we merge them. I think the best answer is to merge them with Public Law 382 for many reasons. They would be mixed with a younger group and there would be more money available and everything else.

However, this other plan would work to some extent, Mr. Chairman, if medicare would tailor a plan such as some of these private companies have agreed to do, provided we get enough money in the kitty.

Mr. HANLEY. And if the amendments you suggest were not agreed upon then what would your reaction be?

Mr. WALTERS. I would be disappointed partially. If my suggestions were not adopted I would be disappointed.

I want to be practical. I have been around here a long time. Somebody said that when Mr. Hampton was here, only two people were in the room who were also here when this thing was first passed. I want to be practical. I would rather have two-thirds of a loaf of bread than no bread at all. That is my philosophy.

Mr. HANLEY. This is obviously the suggestion of your great legislative accomplishments.

Mr. WALTERS. I don't expect you, as good a friend as you are to these people, and as much as you would like to do it, I don't expect all this today or tomorrow.

Mr. HANLEY. We certainly appreciate your realistic views on this matter.

To refer to your testimony on page 7, you advocate the merger of the employee and retiree program. Do I interpret you as saying in essence that the program applicable to pre-July 1960 retirees be abolished and that those persons be absorbed into the active employee program?

Mr. WALTERS. I think it should be done along that line. Ten years from now there will be scarcely anybody in this other program, realizing what nature is. It was generally understood by Senator Neuberger and many others, that somewhere down the road they would be merged. I think I am safe in saying that when this was being discussed the employee groups held out for a long time that there would be just one plan. However, the cost was so much until the Budget

Bureau, as usual, balked, and Senator Neuberger and others insisted that they divide the group, and the employee groups finally agreed. That is what brought it about.

I do feel very strongly that the two plans should be merged. Then we could set up perhaps two or three different plans, one plan to cover older people. These insurance companies are willing to cooperate with us, and employee groups are, too. They would come forth with some plans to meet the mixed group and some plans to meet this special age group.

Mr. HANLEY. In recognition of your concern and that of other witnesses with regard to aging of the active employee program, there have been suggested solutions, such as, that retired employees be transferred out of the Federal health benefits program into the medicare program, and that a supplemental or complementary policy be furnished them in lieu of either high or low option Federal coverage. What would your assessment of that suggestion be?

Mr. WALTERS. Basically and overall you could not object to the theory that is behind this. Before I commit myself I would like to see what the makeup of it would be. However, looking at it from a broad viewpoint it sounds logical and good.

The thing I am worried about and the thing I am particularly concerned about is that somewhere, somehow, we should find a plan which more nearly meets the needs of these older people. That is my greatest concern.

Really this is the only real concern—and finding enough money to pay for it.

Of course, from what these so-called experts with the life insurance companies and hospitalization people have told me, to tailor a plan to emphasize nursing homes and wheelchairs and other things that older people need, hearing aids, and so on, it will cost somewhere around \$30 a month.

We would be happy to sit down with you, the staff, and others, and try to work out something. I am sure we are all trying to reach the same goal, to do something to better the living conditions of these people.

Mr. HANLEY. Obviously you are being completely objective in your pursuit of the answer.

With regard to your testimony on page 8 you mention that a number of companies provide cost-free health protection to employees.

To what extent, in terms of benefits and financing, do those industry plans apply to the time of a worker's retirement?

Mr. WALTERS. Some of these carry into retirement, but I do not have them broken down. Some reduce their coverage when they go into retirement, but I would be glad to go into it further. These figures came from the Labor Department. I would be glad to cooperate and try to get some of that. They do not all carry it fully into retirement.

Mr. HANLEY. Without having made an in-depth study of this, would you say that the post-retirement intent of many is simply to supplement medicare?

Mr. WALTERS. I don't know.

Mr. HANLEY. If you can develop some information on that it would be helpful to the subcommittee.

Mr. WALTERS. I will do so.

Mr. HANLEY. If I correctly analyze your testimony you have urged a substantial increase in Government contributions to the retiree program, but on the other hand you have urged that it be blanketed into the active program. Of the two which would be preferable?

Mr. WALTERS. It is like putting off an operation. Today it would perhaps be better to give more money and have a special plan developed for them, but tomorrow or the next day we will have to merge them because you know better than I that in a few years there will not be enough of these people left to justify an underwriter to give them a good plan unless the price goes sky high. It is like putting off an operation, it just does not have to be done today but you know it will have to be done one of these days.

I would like to add one thing. I am also attempting to say that under Public Law 382 the Government should pay at least 50 percent. You said my emphasis was on Public Law 724. I am more concerned about Public Law 724, honestly, because they are people who are more helpless than the others, but I am supporting wholeheartedly, and so is this organization, raising at least 50 percent the contribution of the government as well as the employee and eventually look to 100 percent payment by the Government.

Mr. HANLEY. How many of the retirees are in the pre-1960 program, as opposed to the latter one?

Mr. WALTERS. There are a good deal more under Public Law 724 than in Public Law 382, because only those who have retired in the last ten years are under Public Law 382. Everybody who had retired prior to that time I don't know how to break down. Miss Park said those figures are available. We will be glad to supply them.

Mr. HANLEY. Very well, if you can provide them for subcommittee use.

Mr. WALTERS. I am sure there are many more of the retirees under Public Law 724 than under Public Law 382. Miss Park will get those figures.

(The following information was furnished.)

According to U.S. Civil Service Commission figures as of June 1969, there are 175,000 Civil Service retirees enrolled under the Retired Federal Employees Health Benefits Program; 80,000 of them covered by the Uniform Plan and 95,000 covered by one of the approved private plans. There are approximately 124,000 retirees who are eligible for coverage under the Retired Employees Plan, but who are not covered and receive no Government contribution toward a health plan.

Again, as of June 1969, Civil Service Commission figures show 393,000 retirees enrolled under one of the so-called Active Employees Health Benefits Plans. Therefore, there are about three times more retirees covered under the Active Employees Health Benefits Program than covered under the Retired Federal Employees Health Benefits Program, but approximately 231,000 retirees are receiving no health benefits contribution or coverage at all from the Federal Government.

Mr. HANLEY. To relate for a moment to your appendage which indicates the legislative objectives of the Los Angeles County employees, there is no indication that these people enjoy such type of health benefits, does it?

Mr. WALTERS. I don't know. This came through the mail with no explanation. I simply supplied it for whatever it might be worth. I have not checked into it, Mr. Chairman. One of our active members out there mailed it in and said "Look what the employees will get in Los Angeles County."

Mr. HANLEY. Counsel suggests the question—are they going to get it?

Mr. WALTERS. That's like the man who hasn't died yet.

Mr. HANLEY. Again our deep appreciation for your testimony this morning. I think I speak for the entire committee when I say that we recognize your great expertise in this field. The committee is indeed privileged to be the beneficiary of your testimony.

Mr. WALTERS. Thank you, Mr. Chairman, for those kind words. We want it to continue that way. Anything we can do to help this committee we will be most happy to do.

Mr. HANLEY. We will look forward to working closely with you.

Our next witness this morning is Mr. Dan Jaspán, legislative representative, National Association of Postal Supervisors. With Mr. Jaspán is Mr. Don Ledbetter, the secretary of that association.

Gentlemen, in behalf of the committee it is a privilege to welcome you here this morning.

**STATEMENT OF DAN JASPÁN, LEGISLATIVE REPRESENTATIVE,
NATIONAL ASSOCIATION OF POSTAL SUPERVISORS, ACCOMPANIED BY DON LEDBETTER, SECRETARY**

Mr. JASPÁN. Thank you, Mr. Chairman. It is a pleasure to be here.

My name is Daniel Jaspán. I am the legislative representative of the National Association of Postal Supervisors, composed of more than 33,000 postal supervisors, with members in all 50 States and in Guam, Puerto Rico, and the Virgin Islands. Our members are employed in post offices, branches, stations, motor vehicle facilities, maintenance units, airmail facilities, and mobile units.

We appreciate the opportunity of appearing before this subcommittee to give our views on a subject of tremendous importance to all Federal employees. We would really be ungrateful if we did not express at this time our gratitude to the chairman and members of the committee for their previous actions which led to much beneficial legislation. Public Law 91-93, which was enacted last year, primarily through the efforts of Chairman Daniels and the subcommittee, is a real landmark in employee legislation. On behalf of our membership, we thank you, Chairman Daniels, and all of the members of the committee.

You are all well aware that we were disappointed when the first Health Benefits Act was enacted in 1959. We believed—and I am sure this applies also to Members of Congress—that the Government would assume no less than 50 percent of the cost of health insurance. We were disappointed when we found that the Government would pay 50 percent of the low option plan but considerably less for high option. Despite action taken by this committee and the Congress, the Government percentage of the contribution has steadily declined and now is only about 25 percent. This places a tremendous burden on all employees due to the constantly increasing costs of health insurance. Benefits has increased considerably less than the premiums.

We believe that H.R. 767, introduced last year by Congressman Daniels, is a good basis for further action. Although we would like to see the Government assume a greater share of the cost immediately, an immediate increase from the present approximately 25 to 50 percent of the cost the first year would be helpful. The increase to 100

percent coverage by two 25-percent increases would be most welcome.

As we have pointed out previously, more and more industries are paying 100 percent of the cost and have been doing so for many years. When we testified before this subcommittee almost 2 years ago, we listed some of the many firms that pay 100 percent not only of health insurance costs but also life insurance premiums. According to the Bureau of Labor Statistics figures on health insurance, 70 of 100 companies listed in their release—bulletin No. 1502—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.

There are few, if any, industries in the United States where the employer does not contribute at least 50 percent of the cost. At one time, the U.S. Government was the leader in fringe benefits but, due mainly to less and less coverage of health insurance, many companies pay out a larger percentage of the payroll for fringe benefits than does the Government.

There are some other items, in addition to cost, that we believe should be considered by the subcommittee. In the first place, we believe that provision should be made for all plans to include dental insurance. Two years ago, a dental care program covering most basic dental services was negotiated between the Northwest International Association of Machinists Benefit Trust and the National Association of Dental Service Plans. Under the 3-year contract, 33,000 IAM members and their dependents will be covered up to \$750 per year per individual. There was a time when dental coverage was prohibitive but, since more and more plans are being negotiated, we believe that with more than 2 million Federal employees covered, contracts could be negotiated at low cost if applied to all plans.

We suggest also that this committee consider a better coordination between medicare and our health benefits plans. Retirees must continue to pay the full premium beyond the age when employees in private industry are given free medicare hospital coverage. This is a rather severe penalty on Federal employees who have paid premiums on life insurance for many years and must continue to pay the increasingly higher premiums each year when their income is at its lowest.

Federal employees are about the only U.S. citizens who are not entitled to medicare A. If they want health insurance coverage, they must continue to pay high premiums. We suggest that the committee consider one of two plans: either provide free medicare A for all Federal employees who reach age 65, or permit the continued coverage under the health insurance plan carried by the employee without any further costs after retirement. This would be an interim program until the Government assumes 100 percent of the cost, in accordance with provisions of H.R. 767.

The magazine *Business Insurance*, in its March 2 issue states:

A disturbing report for the Civil Service Commission predicts Federal employees' health insurance premiums will increase between 10 and 35 percent every 2 years between now and 1976, probably averaging between 20 and 25 percent. The report was prepared by one of the Nation's top actuarial consulting firms, Milliman & Robertson.

The report was submitted to the Civil Service Commission January 24, 1969, but just recently made public.

With these tremendous increases facing us—in addition to the many increases already made in the health insurance premiums—it is of the utmost importance that legislation be enacted as quickly as possible to grant Federal employees and retirees immediate relief. Health insurance is extremely necessary, but the rapidly increasing premiums are making it very difficult for Federal employees and retirees to continue this important coverage. We suggest that the committee also explore another angle—eliminating the many competing plans and having just two nationwide plans: (1) the service type, and (2) the indemnity type insurance. We firmly believe that this will lead to better coverage at a lesser cost. We note, in looking over the summary of financial operations of the plans released by the Civil Service Commission, that the administrative costs for the high option plans are only 2.9 percent for the indemnity type and 3.3 percent for the service benefit plan. Compare this with the various employee organization plans ranging from 3.2 to 6.3 percent.

In the interest of reducing operational costs of the various plans, resolutions have been passed at many of our conventions requesting that employee plans be eliminated and that there be a nationwide plan not requiring membership in any organization. We believe that this can lead to more economical plans with greater benefits. We respectfully urge the subcommittee to make a further study of this suggestion.

There is another important item which I believe should be explored by this committee. I have noted personally that, when it is necessary for me to have medical treatment one of the questions asked is whether I have health insurance. Apparently, the doctor's fee is based on whether or not there is such coverage. This procedure may or may not be ethical, but, if fees are increased where there is coverage, this could be one of the many items leading to the continually increasing costs of the plans.

We mentioned earlier in our testimony that we would like to have legislation providing for free medicare A for Federal employees who reach age 65, or the elimination of health insurance premiums for Federal employees who retire. In the meantime, we respectfully request that this subcommittee take some action to reduce the cost immediately of health benefits insurance for those Federal employees who are entitled to medicare. Even though the charges are prorated and only the supplemental charges are paid by the health insurance plans, the employee still must pay the full premium. We can see no reason for this and believe that the Congress could take immediate action to have the various carriers reduce the premium for those employees thus adversely affected.

We are confident that this subcommittee, which is composed of such dedicated and sympathetic Members of Congress, will rise to the occasion and report legislation that will be most beneficial, not only to supervisors, but to all Federal employees.

Thank you for the opportunity of appearing before this subcommittee to present our views.

Mr. HANLEY. Thank you very much, Mr. Jaspan. Certainly your testimony is very helpful.

I understand your organization does not sponsor a health benefit plan.

Mr. JASPAN. That is right, Mr. Chairman. We don't have any. That is one of the reasons we can suggest that you eliminate all of them.

Mr. HANLEY. Has your organization ever considered the sponsorship of a plan?

Mr. JASPAN. We did consider it very carefully and we discarded the idea for various reasons. One of them, our members are of an older age group and the cost would be much more expensive, even though few of our members would have to have maternity benefits.

Another item is that many of the employees, or most of the employees, belong to some health benefit plan before they become supervisors, and there are very few among those who would change plans.

Another thing, we seriously have believed that this should not be used as a membership gimmick. We are not in the insurance business. We are here to serve our members with the Post Office Department, legislatively, and so forth, and we do not believe it should be used just for membership purposes.

Mr. HANLEY. Your contention, then, is that such a program should not be an incentive factor insofar as membership in any of this type of organization is concerned?

Mr. JASPAN. That is how we feel. There is another reason, too, Mr. Chairman. We believe nationwide plans could be much more efficiently run and at lower cost, the same as the national life insurance plan. It is an excellent plan because there is only one nationwide plan.

Mr. HANLEY. You commented on the dental aspects. The dental plan referred to in your statement—do you have any idea with regard to what the cost of such a plan would be?

Mr. JASPAN. No. The article did not mention the cost. We looked into this ourselves. We find that the cost is very high the first year. Everybody has work done which they have been putting off for years. After that it tapers off. It is possible there would be an additional cost, but with 2 million employees we believe it would be a very reasonable amount, especially after the first year.

Mr. HANLEY. Are you suggesting that a separate dental care plan be established and administered by the Civil Service Commission as opposed to the 38 carriers?

Mr. JASPAN. It should be part of all the plans. The reason I believe that—well, it should be a compulsory plan. Any time you have an optional plan the cost can go up since few people may take it, whereas if it is part of every plan everyone would have it and that keeps the cost down, particularly after the first year.

Mr. HANLEY. Is it true that Federal employees, by virtue of this employment, are not subject to medicare A? However, since about 50 percent of all Federal retirees draw social security benefits, by reason of private employment or self-employment, that only one half of the Federal work force may not become eligible for medicare A?

Mr. JASPAN. I imagine that is true. I don't know whether the percentage is 50, but it is probably a fairly high percentage.

Mr. HANLEY. Would this be one of the deterrents to a practical coordination with medicare?

Mr. JASPAN. I don't think so. The fact that 50 percent are already covered should make it less costly to cover the other 50 percent.

Mr. HANLEY. The fact that all Federal employees and their spouses are not in the same relative position?

Mr. JASPAN. I don't think that would make it any more costly. It seems to me that would keep the cost of it down since there would be only 50 percent of the coverage necessary rather than 100 percent of the coverage.

Mr. HANLEY. You have suggested the possibility of eliminating 36 of the existing 38 plans. You would abolish, as I understand it, the 15 union-sponsored plans. What about the status of employees who participate in the 21 prepayment plans? Would you say they could no longer avail themselves of that kind of health care?

Mr. JASPAN. It would not make much difference to us which plans would be used as long as there is some nationwide plan that everybody could have. When the life insurance program was started there were employee organizations who had their own insurance coverage and they were all absorbed into the life insurance plan. Some arrangements possibly could be made this way, or perhaps they can coordinate their own plans with the two nationwide service indemnity plans. We are interested in efficient and economic planning. We feel the more participants there are the more costly it will be.

I mentioned the administrative costs are more for all of the other plans except the two nationwide plans.

Mr. HANLEY. The suggestion was offered by a witness yesterday that the open season be on an annual basis as opposed to a 3-year basis, assuming that all of the present plans continue to be available. Do you have a position on this?

Mr. JASPAN. We have not taken a position as an organization, but personally I do not see any reason to have it more often. Every time there is an open season for switching plans I believe only about 1 percent of the employees switch over from one to another. It is a very small percentage. I do not think it is worth the extra cost. That adds to the administration of the plans. If possible they should have an open season more often to change from high option to low option or vice versa, but going from one plan to another is not worth the cost.

Mr. HANLEY. Since statistics evidence that about 90 percent of all Americans have some type of health insurance, and with doctors knowing that fact, do you really think that they moderate the fees charged to the 10 percent who have no protection?

Mr. JASPAN. Let me tell you what they do. I know one doctor in particular whose regular office visit is \$6. I know somebody who went to him with medicare coverage and paid \$10 a visit. I am sure the doctors do adjust their fees according to whether or not you have coverage.

Mr. HANLEY. This is most unfortunate. Apparently it has become a rather widespread practice.

Mr. Hogan?

Mr. HOGAN. I want to commend Mr. Jaspán not only on his fine statement today but his fine representation of his organization.

I have a bill, too, which I am sure you are familiar with, Mr. Jaspán, which would call for the Federal Government immediately to pay 100 percent of the cost of specified benefits. Would you care to comment on that? This is opposed to the approach this bill takes.

Mr. JASPAN. I am very much in favor of a bill of your type, Mr. Hogan. I would like to see some of those fees revised because the bill was written a year ago and most of the fees went up since then. For example, you have an office visit \$6. I have been notified by my doctor

it will be \$8 from now on. With revision yours would be an excellent basis for deciding what the Government would pay or what they should base their payments on. You have everything spelled out; 100 percent would be ideal. We are just trying to be realistic even though we support that idea and we are worried that if we ask for too much this time we will not get anything.

Therefore we would like to see your approach but perhaps in stages under the present conditions.

Mr. HOGAN. My legislation is in the unenviable position of having the Nixon administration and the majority of the committee opposed to it. However, I do appreciate your comment.

Mr. JASPAN. We are certainly in favor of the way you spell it out in the bill. There must be something to peg costs to. We say the Government should pay 50 percent, 75 percent, or 100 percent. Of what?

Mr. HOGAN. That is right. To me this is a much more logical approach because it specifies what you pay a percentage of.

Mr. JASPAN. I like that approach very much.

Mr. HOGAN. Why don't you run for Congress?

Thank you, Mr. Chairman.

Mr. HANLEY. The gentleman has perhaps given you a good idea.

Mr. JASPAN. I am not in his district.

There is another idea I was toying with. I don't know what percentage the committee will come up with. I hope it will be more than 38 percent. Until they reach 100 percent I would like to see this idea carried out—for example, say they would settle for 45 percent now or 50 percent, or whatever it is. Then have the Government from then on, until they reach 100 percent, assume the cost of any increased premiums. They have been going up each year. Rather than have the percentage figure stay at 38, 45, or 50, have that as the bottom figure. Let the Government assume the increases which we get every January now. They have been pretty substantial increases every year. Do that until the time comes where they will pay 100 percent of the cost.

Mr. HANLEY. Again our appreciation for your fine testimony here. If I can relate to another topic for just a moment, that would be a word of commendation to your association and its membership for their efforts throughout the prevailing postal dilemma. Certainly it has been observed, and the service that your membership has provided has been exemplary.

Mr. JASPAN. We appreciate that, Mr. Chairman. As you know, not one supervisor has supported the strike or gone on strike. Every supervisor has been working as many as 12 hours a day to try to keep the mail moving.

We are very much worried now because if the administration and the Post Office Department follows the usual pattern they will make an adjustment to those employees who went out on strike without considering us. We are very much concerned about that.

We just hope those pressure tactics do not result in such a settlement.

Mr. HANLEY. Again our appreciation to you and Mr. Ledbetter for your time and effort here this morning.

Mr. JASPAN. Thank you, Mr. Chairman.

Mr. HANLEY. Our next witness will be Mr. W. H. Ryan, national coordinator of the Government Employees Department, International Association of Machinists & Aerospace Workers.

Mr. Ryan, we are delighted to have you with us this morning.

STATEMENT OF W. H. RYAN, NATIONAL COORDINATOR OF GOVERNMENT EMPLOYEES DEPARTMENT, INTERNATIONAL ASSOCIATION OF MACHINISTS & AEROSPACE WORKERS

Mr. RYAN. Thank you, Mr. Chairman.

Mr. Chairman, and members of the subcommittee, at the outset, I want to express the appreciation of the president of the Metal Trades Department, AFL-CIO, Mr. Maywood Boggs, to the distinguished chairman and members of this subcommittee for scheduling congressional consideration on this important subject relating to the obligation of the Government to assume the premium cost of health and hospitalization insurance covering Federal and postal employees and their families.

The cost of medical care, surgery, and hospitalization has skyrocketed since the enactment of the act, and corresponding increases in premium costs and additional types of coverage adopted by the private sector industry have necessitated a review of the act to determine what changes are appropriate and desirable after 11 years of experience with the law. Eleven years ago the Government's share of the premium for a very limited coverage amounted to approximately 38 percent and the employee paid the balance of 62 percent of the premium. The present Government's share of the premium cost for very limited coverage was reduced to approximately 24 percent and the employee's share has increased to 76 percent.

It is, therefore, proper and desirable that the Government reexamine its position in order to more clearly align its obligation and responsibility to reflect the practices of the more progressive private enterprise health and hospitalization coverage.

According to the Bureau of Labor Statistics study which began early in 1966—4 years ago—and released as Bulletin No. 1502, a digest of 100 selected health and insurance plans under collective bargaining reveal that 59 private industry firms or conglomerate of firms paid the full premium cost of health insurance—see attachment A to this testimony—and 13 firms paid most of the premium cost of the health insurance—see attachment B of this testimony. Only 25 firms of the 100 surveyed firms paid less than 50 percent of the premium cost.

The Bureau of Labor Statistics in its Bulletin No. 1629 dated November 1969 reported a digest of 50 health insurance plans (survey made in early 1969) for salaried employees in the private sector. Thirty-four firms out of the 50 surveyed paid 100 percent of the premium cost of health and hospitalization insurance—see attachment C to this testimony. The balance of the firms all paid over 50 percent for the premium cost of coverage.

It has consistently been our contention that the Federal Government should be a leader in progressive employment practices, and we urge this subcommittee to give serious consideration toward supporting legislation which would have the Government pay the full premium cost of coverage equal to the high-option service benefit—Blue Cross-Blue Shield—plan with additional coverage for full dental and annual health examinations for employees and their dependents.

The dental insurance field is embarked upon an explosive growth, according to Burton E. Burton of Aetna Life & Casualty Co. It was projected that 50 million persons will be covered by 1975. This projection has recently been scaled down because the current inflation has modified the original projection. It is projected now that 30 million people will be covered by 1975.

Almost all dental insurance is a fringe benefit provided by employers; about half of the people are covered as a result of contracts negotiated by labor unions.

About one-fifth of the International Association of Machinists & Aerospace Workers 1 million workers are now covered by dental insurance. Often when our union negotiates dental coverage for a plant (blue-collar) workers, the company involved provides its white-collar employees with the benefit as well.

The exact services covered by dental insurance vary widely as they do in medical insurance; the more paid in, the larger the benefits. A very fairly typical program is that provided by McDonnell-Douglas Corp.; for about 80,000 employees in six States.

The plan covers the workers, their spouses, and dependent children. It pays up to \$600 for each family member each calendar year. The plan is called a deductible and copay. The worker must pay the first \$25 for each family member, up to \$75. He must also pay 25 percent of the bill, with the insurance covering the remaining 75 percent up to \$600. The covered services include examinations, cleaning, fillings, extractions, root-canal work, and gum treatments. The plan does not cover orthodontics—the straightening of teeth.

Presently, 52 commercial insurance companies are writing group dental plans. In January 1969 these companies covered about 3,100,000 people. The health insurance council, a trade group, estimates the companies now insure between 4,300,000 and 4,800,000, a fantastic growth in 12 months, according to C. D. Harding, associate director of the council.

In reference to coverage for full annual physical examinations, it seems logical and good sense to provide for annual diagnostic examinations to detect early stages of catastrophic and terminal diseases so that corrective action can be taken where appropriate to arrest and/or cure these diseases. An expanded health coverage program of this nature will in time pay off by decreasing the ever-escalating need for new hospital and nursing facilities. The need for new hospital and nursing facilities is increasing with our population explosion, and if steps are not taken soon to detect in early curable stages, diseases which are catastrophic and of a terminal nature, then we can expect to pay the higher price for additional facilities in the years ahead.

For the additional information of the subcommittee as the last attachment to this testimony I have provided table B-5, titled "Health Insurance, and Pension Plans," appearing on page 115 of the Bureau of Labor Statistics Bulletin No. 1575-87 dated 1967 through 1968. This table depicts the percentage distribution of plant and officeworkers employed in the establishments having formal provisions between employer and unions for the various types of fringe benefits coverages. This table depicts the percentage of contributory and noncontributory plans and is broken down to indicate hospitalization plans, surgical coverage, medical coverage, and catastrophic coverage. There it will

be noted that a very large percentage of these plans are noncontributory plans—meaning that the employer pays the full premium cost.

Mr. Chairman and members of the committee, Mr. Maywood Boggs, president of the metal trades department of the American Federation of Labor and Congress of Industrial Organizations has directed me to express the appreciation of the department for the opportunity to give the views of the 22 national and international organizations affiliated with the department, and we urge you to subscribe to our suggestions in this very pressing matter of expanding coverage and the Government's absorption of the premium cost of health and hospitalization insurance for Federal and postal workers and their families.

I shall be happy to respond to any questions for which I am qualified to respond to.

I would like to respond to a question you asked of Mr. Walters, and that is the trend in the private sector for paying the full cost of coverage for those who are retired.

Mr. HANLEY. Please do so.

Mr. RYAN. In this same bulletin that I refer to, of the 50 percent that were selected for survey, 31 of the firms pay the full premium cost of this health coverage for their retired employees and 11 of the 50 pay a portion of the cost.

Mr. HANLEY. I appreciate that information, Mr. Ryan.

Mr. Ryan, initially I will move that your attachments be incorporated into the record of this hearing.

(The information referred to follows:)

[Attachment A]

LIST OF HEALTH INSURANCE PLANS WHERE COMPANY PAYS FULL COST

The American Sugar Refining Co. (Brooklyn, N.Y.).	Publishers' Association of New York City.
Swift & Co.	Continental Can Company, Inc.
Armour & Co.	United States Rubber Co.
American Millinery Manufacturers Association (New York, N.Y.).	The Firestone Tire & Rubber Co.
Lumber industry, various employers (southern California).	Aluminum Co. of America.
Industrial Relations Council of Furniture Manufacturers in southern California.	Chase Brass & Copper Co., Inc.
Brewers Board of Trade (New York, N.Y.).	United States Steel Corp.
Upholstering and allied trades industries, various employers.	Weirton Steel Co.
Clothing industry, men's and boys', various employers.	Massachusetts Leather Manufacturers' Association.
Furniture industry, various employers.	Minnesota Mining & Manufacturing Co.
Dress industry, Affiliated Dress Manufacturers, Inc. and other employers (New York, N.Y.).	California Metal Trades Association.
Bigelow-Sanford Carpet Co., Inc.	Radio Corp. of America.
Continental Can Co., Inc., Robert Gair Paper Products Group.	American Can Co.
Printing industry, Chicago Lithographers Association and other employers.	Caterpillar Tractor Co.
The B. F. Goodrich Co.	North American Aviation, Inc.
Bethlehem Steel Co.	Ford Motor Co.
Luggage and leather goods industry, various employers.	Pullman, Inc. (Pullman-Standard Division).
	General Motors Corp.
	Johnson & Johnson (New Brunswick, N.J.).
	Construction industry, Associated General Contractors of America, and other employers (northern California).
	Jewelry industries, Associated Jewelers, Inc., Jewelry Crafts Association, and other employers (New York, N.Y.).

[Attachment A]—Continued

LIST OF HEALTH INSURANCE PLANS WHERE COMPANY PAYS FULL COST—Continued

Doll and toy industry, National Association of Doll Manufacturers, and other employers (New York, N.Y.).	Retail, wholesale, and warehouse industries, various employers (New York, N.Y.).
Various employers (St. Louis, Missouri, area).	New York Shipping Association, Inc. (Port of New York).
Association of Master Painters & Decorators of the City of New York, Inc.	Maritime industry, various employers Atlantic and Gulf Coasts.
Construction industry, various employers (western Pennsylvania).	Hotel Association of New York City, Inc.
Trucking industry, local cartage and over-the-road freight, various associations and individual employers, Central States, Southeast and Southwest areas.	Restaurant industry, various employers (New York, N.Y.).
Distributors Association.	Realty Advisory Board on Labor Relations, Inc. (New York, N.Y.).
Truck Owners Association of California.	Retail drug industry, various associations and employers (New York, N.Y.).
Deere and Co.	Retail trade industry, various employers (New York, N.Y.).
Coal industry (bituminous), various employers.	Laundry industry, various employers (New York, N.Y.).
Railroad industry, various employers.	Construction industry, various employers (New York, N.Y.).
National Automobile Transporters Association.	

[Attachment B]

PLANS WHERE COMPANY PAYS MOST OF COST

National Biscuit Co.	Brown and Bigelow (St. Paul, Minn.).
Campbell Soup Co. (Camden, N.J.).	Pittsburgh Plate Glass Co.
Cone Mills Corp.	Lever Bros. Co.
Wyandotte Worsted Co.	American Radiator & Standard Sanitary Corp. (Louisville, Ky.).
American Seating Co. (Grand Rapids, Mich.).	International Harvester Co.
International Paper Co. (northern division).	Kennecott Copper Corp. (Western Mining Divisions).
Honeywell, Inc. (Minneapolis, Minn.).	

[Attachment C]

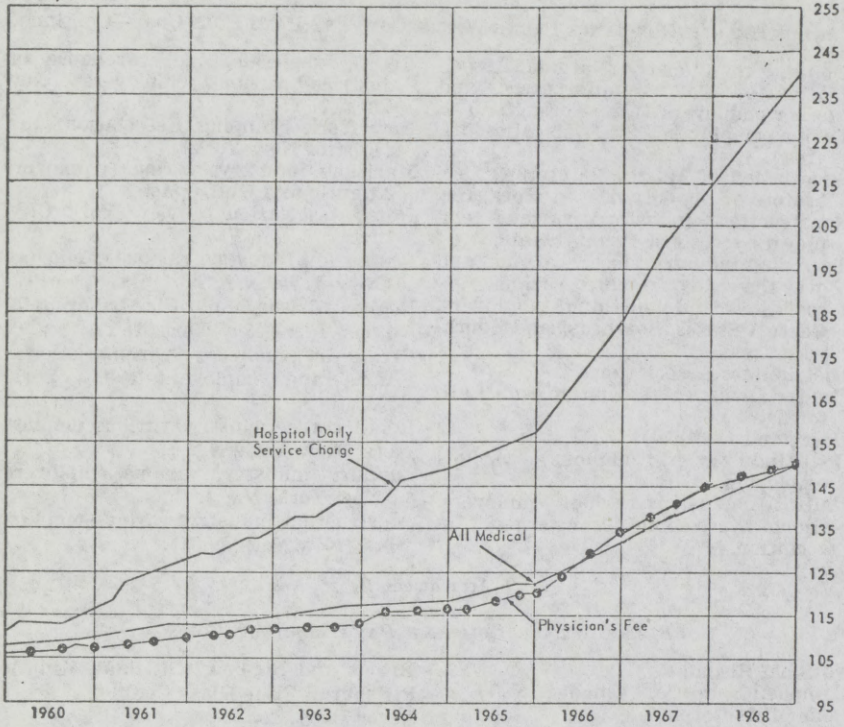
LIST OF FIRMS PAYING FULL PREMIUM COST OF HEALTH INSURANCE FOR SALARIED EMPLOYEES

Aluminum Co. of America.	The Goodyear Tire & Rubber Co.
American Airlines.	The Greyhound Corp.
American Telephone & Telegraph Co.	Interco, Inc.
Associated Lerner's Shops of America, Inc.	International Business Machine Corp.
Burlington Industries, Inc.	International Harvester Co.
Campbell Soup Co.	International Paper Co.
Caterpillar Tractor Co.	S. S. Kresge Co.
The Chase Manhattan Bank.	McCoy Corp.
Cluett, Peabody & Co., Inc.	North American Rockwell Corp.
Crown Zellerbach Corp.	Penn Central Co.
The Detroit Edison Co.	Radio Corp. of America.
Douglas Aircraft Co., Inc.	Spero Gyroscope Co.
McDonnell Douglas Corp.	Swift & Co.
E. I. du Pont de Nemours & Co.	T. R. W., Inc.
Eastman Kodak Co.	Union Carbide Corp.
General Motors Corp.	United States Lines Corp.
Gimbel Brothers, Inc.	United States Steel Corp.

Source: BLS Bulletin No. 1629 November 1969.

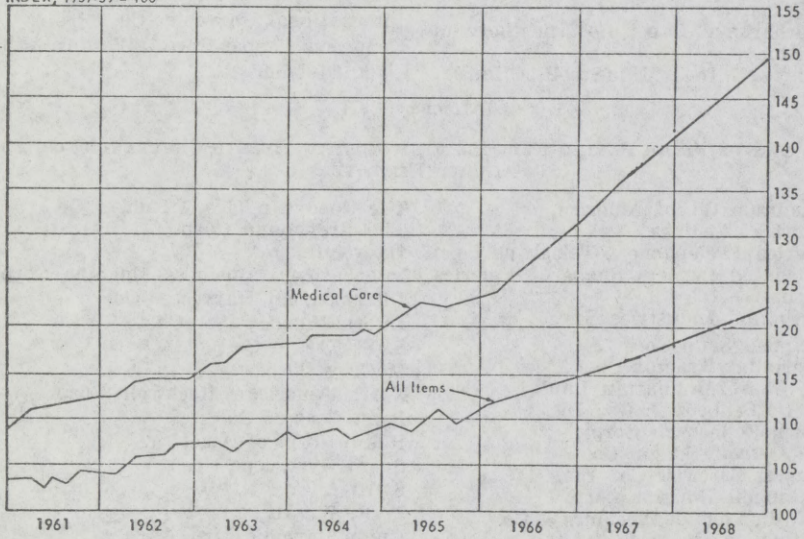
MEDICAL CARE PRICES

INDEX, 1957-59 = 100



CONSUMER PRICES

INDEX, 1957-59 = 100



SOURCES: 1960-1965 - U.S. Health, Education and Welfare Dept.
 1966-1967 - U.S. Dept. of Labor; Bureau of Labor Statistics

Mr. HANLEY. In behalf of the committee I want to express our appreciation to you for your very fine testimony. I note that it places great emphasis upon enlarging the benefit structure to include normal dental care.

Do you have any idea with regard to how large an increase in premiums would be required if all 38 plans provided such coverage?

Mr. RYAN. We just recently checked this. This occurred after my testimony was prepared. We added 40,000 airline families to our dental coverage in our contracts. These are members and their families of Continental Airlines, United, Northwest, TWA, and North Central Airlines.

The insurance pays 75 percent of the charges up to the amount set in a fee schedule. They have a fee they go by.

Mr. HANLEY. This fee schedule to which you refer is sponsored or set up by whom?

Mr. RYAN. It would be one of the insurance companies which underwrite it. I do not have the name of the insurance company involved here but I can get it for the committee.

Mr. HANLEY. This schedule would be in accord with that of the dental association?

Mr. RYAN. They work out some sort of an arrangement and the fees allowed on the schedule are, for example, \$4 for an office visit, \$4 for single X-ray, and \$1 additional for each up to 12 and \$8 for a single extraction and \$6 for each addition, \$15 for anesthesia, and \$155 for dentures.

The actual premium cost of that I do not have but I can get it for the committee. In fact, I can get a contract for the committee if you desire.

Mr. HANLEY. Fine, if you will provide that for committee use it will be helpful.

By accomplishing what would be the ideal situation, whereby all costs of all plans would be fully financed by the Government irrespective of any particular cost of plans, would you envision dental and eye care services being provided to the full extent under such an ideal arrangement?

Mr. RYAN. Yes, sir; I would.

Mr. HANLEY. I have no further questions. Again, in behalf of the committee I want to express our appreciation to you for your fine testimony and for your efforts here this morning.

Mr. RYAN. Thank you, sir.

(The material requested for the record is as follows:)

INTERNATIONAL ASSOCIATION OF MACHINISTS & AEROSPACE WORKERS,
Washington, D.C., March 30, 1970.

Mr. RALPH J. DEVLIN,
Staff Assistant, Subcommittee on Retirement, Insurance, and Health Benefits,
Cannon House Office Building, Washington, D.C.

DEAR Mr. DEVLIN: Last Wednesday, March 25 when I was testifying before the Subcommittee relative to health benefits legislation I agreed to furnish the Committee with a copy of the dental plan negotiated by our Organization with the various airline carriers.

In keeping with that commitment please find the attached, xeroxed copy of the plan referred to.

The employers have placed a payroll cost of five cents per hour per employee for the operation of this plan. The employer contributes 100% of the premium cost.

Sincerely yours,

WILLIAM H. RYAN,
National Coordinator, IAMAW,
Government Employees Department.

(Enclosure.)

DENTAL PLAN

ELIGIBILITY OF EMPLOYEES AND DEPENDENTS, INCLUDING EFFECTIVE AND TERMINATION DATES OF INSURANCE

- (1) Same as for the UAL A&S plan.
- (2) A service which began before insurance becomes effective is not covered.
- (3) A service in process at the time insurance terminates will be covered if the service is completed within three months following termination of insurance.

AMOUNT OF PAYMENTS

- (1) *Payments.*—75% of the dentist's usual and customary fee for the service but not to exceed 75% of the Covered Expenses for the service.
- (2) *Maximum Payment.*—\$600 of payments for any one person for Covered Expenses incurred in a calendar year.
- (3) *Covered Expenses and Services.*—Per the Table of Covered Expenses.

EXCLUSIONS AND LIMITATIONS

- (1) Exclusions or limitations comparable to the "General Limitations" of the UAL A&S plan.
- (2) Services which are provided for under the UAL A&S plan.
- (3) Services purely cosmetic in nature.
- (4) Prosthetics for the same missing teeth more frequently than once every two years.
- (5) If different methods of treatment are available, coverage will be based on the lowest Covered Expense which provides professionally adequate service.
- (6) Coordination of benefits, the same as in the UAL A&S plan, will apply toward any other plan (as defined in the UAL A&S plan), including double coverage of the same person under this dental plan.
- (7) Services in connection with any orthodontic work or with the correction of malocclusion or congenital malformation.

SPECIAL COVERAGE TRANSFER PROVISION

- (1) Two dental procedures which, by custom and not contract, have been covered under the UAL A&S plan surgical schedule will now be covered only under the dental plan.

Procedure	A. & S. plan surgical allowance	Dental plan covered expense
Single impacted tooth.....	\$35.00	\$45
Each additional impacted tooth.....	17.50	30
Gingivectomy, per quadrant.....	14.00	60

Table of covered expenses

Services	VISITS AND DIAGNOSTIC	Covered expense
Office visit for treatment and observation of injuries to teeth and supporting structure, other than for routine operative procedures-----		
Professional visits after hours (dentist may elect payment on basis of services rendered or visits, whichever is greater)-----		\$4
Prophylaxis—children to age 14-----		10
Prophylaxis—to include scaling and polishing-----		6
Topical application of stannous fluoride (one treatment including prophylaxis under age 4)-----		9
Topical application of stannous fluoride (one treatment including prophylaxis—payment limited to once each year to age 18)-----		12
Emergency treatment—palliative per visit-----		14
Film covered expenses (including examination and diagnosis) :		5
Single film-----		
Additional, up to 12 films, each-----		4
Entire denture series, including examination consisting of at least 14 films (bite wings if necessary)-----		1
Intraoral, occlusal view, maxillary or mandibular, each-----		17
Superior or inferior maxillary, extra oral, 1 film-----		4
Superior or inferior maxillary, extra oral, 2 films-----		10
Bite wing films, including examination :		15
2 films-----		
4 films-----		5
Additional films, each-----		7
		1
ORAL SURGERY		
Extractions (all covered expenses include postoperative visits) :		
Uncomplicated single tooth-----		8
Each additional uncomplicated tooth-----		6
Surgical removal of erupted teeth (by report) :		
Impacted single tooth-----		45
Each additional impacted tooth-----		30
Alveolar or gingival reconstruction :		
Alveolectomy (edentulous), per quadrant-----		25
Alveolectomy (in addition to removal of teeth), per quadrant-----		10
Alveoplasty with ridge extension, per arch-----		42
Removal of palatal torus (or by report)-----		35
Removal of mandibular tori, per quadrant-----		35
Excision of hyperplastic tissue, per arch-----		32
(NOTE.—A covered expense will be established by the insurance company for any service or oral surgery not listed above and not covered under the surgical schedule of the UAL A. & S. plan.)		
ANESTHESIA		
Anesthesia—general -----		15
PERIODONTICS		
Emergency treatment (periodontal abscesses, acute periodontitis, etc.)----		10
Subgingival curettage, root planning per quadrant (not prophylaxis)----		12
Correction of occlusion per quadrant-----		12
Gingivectomy per quadrant (including postsurgical visits)-----		50
Gingivectomy, osseous or muco-gingival surgery per quadrant (includes postsurgical visits)-----		60
Gingivectomy, treatment per tooth (fewer than 6 teeth)-----		10
ENDODONTICS		
Pulp capping-----		6
Therapeutic pulpotomy (in addition to restoration, per treatment)-----		6
Vital pulpotomy-----		12
Remineralization (Caoh, temporary restoration) per tooth-----		10

Table of covered expenses—Continued

<i>Services</i>	<i>Covered expense</i>
Root canals:	
Culturing canal.....	\$7
Single rooted canal tooth therapy.....	45
Birooted tooth canal therapy.....	60
Trirooted tooth canal therapy.....	75
Apicoectomy (including filling of root canal).....	50
Apicoectomy (separate service).....	35

(NOTE.—Covered Expenses do not include final restoration or necessary roentgenograms.)

RESTORATIVE DENTISTRY

Amalgam restorations primary teeth:	
Cavities involving one tooth surface.....	6
Cavities involving two tooth surfaces.....	9
Cavities involving three or more tooth surfaces.....	12
Amalgam restorations permanent teeth:	
Cavities involving one tooth surface.....	8
Cavities involving two tooth surfaces.....	11
Cavities involving three or more tooth surfaces.....	15
Gold restorations:	
One tooth surface.....	35
Two tooth surfaces.....	40
Three or more tooth surfaces.....	50
Onlays extra per tooth.....	10
Silicate, acrylic, plastic restorations:	
Silicate cement filling.....	9
Acrylic or plastic filling.....	11
Crowns:	
Acrylic.....	60
Acrylic with metal.....	75
Porcelain.....	75
Porcelain with metal.....	100
Gold (full).....	65
Three-fourths gold.....	60
Stainless steel (primary).....	17
Stainless steel (permanent).....	20
Gold dowel pin.....	10

PROSTHETICS (INCLUDES FIXED BRIDGES)

Pontics:	
Cast gold (sanitary).....	40
Steele's facing.....	45
Tru-Pontic type.....	55
Porcelain based to gold.....	80
Plastic processed to gold.....	55
Removable (unilateral bridges): one piece casting, chrome cobalt alloy clasp attachment (all types) per unit—including pontics.....	20
Recementation:	
Inlay.....	5
Crown.....	5
Bridge.....	10
Repairs, crowns and bridges: Repairs—based on time and laboratory charges (by report)	

Dentures:

Dentures, partial dentures and reline covered expenses include adjustments for 6 month period following installation. Fees for specialized techniques involving precision dentures, personalization or characterization must be paid for by the patient.	
Complete maxillary denture-----	\$155
Complete mandibular denture-----	155
Immediate (See service below.)	
Partial acrylic upper or lower with gold or chrome cobalt alloy clasps—base-----	75
Teeth and clasps—extra per unit-----	5
Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles—base-----	150
Teeth and clasps—extra per unit-----	5
Simple stress breakers—extra-----	14
Stayplate—base-----	30
Teeth and clasps—extra per unit-----	3
Immediate splint denture-----	70
Denture adjustment-----	4
Office reline—cold cure—acrylic-----	15
Denture reline-----	35
Denture duplication (jump case) per denture-----	55
Repairs, dentures, acrylic:	
Broken denture, repairing (no teeth involved)-----	12
Replacing missing or broken teeth, each additional-----	3
Adding teeth to partial denture to replace extracted natural teeth:	
First tooth-----	25
First tooth with clasp-----	30
Each additional tooth and clasp-----	5
Partial denture repairs—based on time and laboratory charges (by report)	

SPACE MAINTAINERS

Covered expenses include all adjustments within 6 months following installation:

Fixed space maintainer (band type)-----	35
Removable space maintainers with stainless steel round wire rest only-----	40
Stainless steel clasps and/or activating wires, in addition per wire or clasp-----	5
Study models-----	5
Removable inhibiting appliance to correct thumb-sucking-----	40
Fixed or cemented inhibiting appliance to correct thumb-sucking-----	40
Office visit for observation, adjustment and activation per visit-----	4

Mr. HANLEY. Our next witness will be Mr. Claude Olmstead representing the National Rural Carriers Association. Mr. Olmstead is accompanied by John W. Emeigh, director of health benefits for the association, and Lester F. Miller, its secretary.

Gentlemen, I am delighted to welcome you here this morning. It will be a pleasure to listen to your testimony.

STATEMENT OF CLAUDE OLMSTEAD, NATIONAL RURAL LETTER CARRIERS ASSOCIATION, ACCOMPANIED BY JOHN W. EMEIGH, DIRECTOR OF HEALTH BENEFITS; AND LESTER F. MILLER, SECRETARY

Mr. OLMSTEAD. Regretfully, President Alfrey is unable to be here this morning. I am Claude E. Olmstead, vice president of the National Rural Carriers Association. I am accompanied by Mr. John W. Emeigh, director of our health insurance program, and on his left by our national secretary, Mr. Lester F. Miller.

We would like to take this opportunity to thank the distinguished chairman of the committee for introducing H.R. 767, the bill under consideration, to increase the Government's contribution under the Federal health program.

Due to the experience and knowledge of Mr. Emeigh in regard to our health plan and the Federal program generally we have asked him to present our testimony at this time.

Mr. HANLEY. Proceed, Mr. Emeigh.

Mr. EMEIGH. Mr. Chairman and members of the subcommittee, my name is John W. Emeigh. I serve as director of health insurance for the National Rural Letter Carriers' Association, an organization representing approximately 62,000 regular, 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 6,000 annuitants.

Our organization does appreciate this opportunity to present our views and comments on H.R. 767, which would increase the Government's contribution toward the cost of health insurance to 50 percent and provide for two additional increases resulting in the Government assuming full cost of this fringe benefit in a later year.

The National Rural Letter Carriers' Association gives its full support to this legislation. It would provide a major improvement in the funding formula as originally adopted and as presently exists. The original formula, established by the 1959 act, 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, increased the contribution to a maximum of \$4.10 per pay period. Unfortunately, the 1966 act continued the fixed dollar contributions formula and thus was merely a temporary resolution of the cost problem for employees participating in the program.

When the Federal health program was enacted in 1959, it was anticipated that the majority of employees would elect coverage under low options. The general intent, based on the legislative history, would indicate that the Congress desired to set the Government's share of the cost at 50 percent. It was assumed that the majority of employees would elect the low option. It was the premise that this would, on the average, provide an adequate level of protection. The original Government contribution did cover 50 percent of low-option coverage. The vast majority of employees, however, elected coverage under high options. Quite evidently the majority recognized the desirability of securing the best health insurance protection available. Experience of the years has certainly demonstrated that it was wise to insure in high option. In each open-season enrollment period since the program started in 1960, the net result has shown a constant movement to high option. Although the results of the recent November 1969 open season are not yet released, it is estimated that more than 90 percent of all insureds will now hold high-option coverage.

It is quite understandable that anyone who has any knowledge of health insurance would elect coverage under a high rather than low option. Claims experience has very often disclosed the inadequacy of low-option coverage. Employees and annuitants desire to select what

they hope is an adequate type of health insurance protection but, unfortunately, many make a selection based in large part on premium costs. When processing claims, however, we become painfully aware that many individuals foolishly selected low-option coverage based more on premium cost than on the level of protection afforded.

Although insureds are generally aware of the fact that low option coverage provides a limited level of protection, it is questionable that a majority understand the degree of protection they are forfeiting by selecting the less costly coverage. Speaking for the National Rural Letter Carriers' Association, we have consistently made every effort to acquaint our members with the fact that they are purchasing a greater protection by electing coverage in the high option. Our educational effort has had a desirable effect. Almost 1,200 of our insureds moved to the high option of our plan during the open-season enrollment period last November. Almost 2,000 employees transferred their enrollment to our plan at that time and only 111 chose low option. This indicates that the experience of employees with health care costs, and probably a better understanding of their own health program, causes them to realize the importance of securing the best coverage they can. It is somewhat disappointing, however, that almost 2,700 of our insureds are still in the low option. This represents an approximate 11 percent enrollment in the low option of the Rural Carrier Benefit Plan. This closely coincides with the percentage of enrollment in low options in the Federal program as a whole.

We, of course, do not know why all of these persons have elected health coverage which they know provides limited benefits. We believe, however, that one of the principal reasons for this is the simple fact that the employee is paying an undue share of the premium cost in high options. The bill under consideration will correct this and relieve our insureds of the heavy financial burden which they presently bear.

We trust that with a proper financial relief in this area of premium cost, we would then see an even greater movement into high-option coverage. There are very unfortunate cases that arise when an individual in low option requires major medical care and/or is struck with a catastrophic medical problem. At this time he discovers that his voluntary election of a substandard type of coverage renders only a substandard type of protection.

This discussion relative to the value of low and high options is presented to provide some background on a recommendation we would like to present.

The law presently requires that the two Government-wide plans offer two levels of benefits. About 90 percent of all persons are now enrolled in the higher level of benefits. With the enactment of a new costing formula to provide financial relief for the insureds, we would suggest that the present requirements for offering two options be eliminated. This would permit the two Government-wide plans to offer a single level of benefits at a subsequent date.

This would not be immediate but would likely come to pass in the near future. Our recommendation for a change in this area merely removes the legislative restriction but the trend clearly indicates that a better program for all concerned is possible where only one level of benefits is provided in a plan.

The most pressing need for action, of course, is a new funding formula. When the Federal program became effective in July 1960,

the Government's contribution resulted in a Federal payment of approximately 38 percent of the premium cost. Over the years, however, the percentage contribution of costs by the Government has dwindled due to the liberalizations of benefits within the plan, greater utilization by the insureds, and more importantly, due to the rise of health care costs, all of which have mandated increased rates.

It is important to note that the major cost of premium increases has been due primarily to the spiraling costs of health care and not to liberalizations or new coverages provided in the benefit structure. This fact was recently documented in a report prepared for the Civil Service Commission by Milliman & Robertson, Inc., a firm of consulting actuaries. In their analysis of the two Government-wide plans, they noted:

Premium increases for both the Service Plan and the Indemnity Plan have been several times greater than benefits added—about eight times greater for the high option plans and about three times greater for the low option plans. Thus, higher payments under the original benefit provisions have accounted for much of the additional premium needed.

This sharp increase in costs for the same benefits is primarily responsible for the sharp increase in premiums. Benefit changes have, of course, contributed to the cost problems. 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.

This association wholeheartedly endorses these actions to expand coverage and improve the benefit structure of the plans. In addition to any action initiated by the Civil Service Commission, 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 of our plan have been liberalized considerably over the years.

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 9-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 \$16.03 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 \$11.93 per biweekly pay period.

You will note that Government's share of the cost has increased approximately 32 percent while the increase of costs to the employee

has increased 104 percent. Stated differently, the employee is paying approximately 75 percent of the cost for self-and-family enrollment in high option and the Government is paying approximately 25 percent.

This spread in the percent of costs borne by the Government and the employee will continue to widen with the passage of time unless corrective legislation is enacted. It is vital, in improving the funding formula, that a new method be adopted which will eliminate any fixed dollar contribution on the part of the Government and assess a percentage of cost which will be automatically adjusted in line with experience of the plans.

We were very pleased to hear the recommendation presented by the Civil Service Commission. We would like to compliment Robert E. Hampton, Chairman; and Andrew E. Ruddock, Director, Bureau of Retirement, Insurance, and Occupational Health, of the Civil Service Commission, for proposing a funding formula which will both establish a percentage contribution by the Government and also tie the Government's contribution to the premium costs of the more expensive high options.

The proposal of the Commission represents a tremendous step forward. It is similar to the funding formula set forth in S. 1772, a bill introduced by the chairman of the Senate Post Office and Civil Service Committee, Gale W. McGee, Democrat, of Wyoming, and cosponsored by Quention N. Burdick, Democrat, of North Dakota, chairman of the Senate Health Insurance Subcommittee. This organization supported the formula proposed in the Senate bill which would set the Government contribution at 50 percent of the least expensive of the higher level of benefits in the two governmentwide plans. The proposal of the Civil Service Commission is similar with the exception that it would use the average of the premiums charged for the high options of the two largest plans in each category of plans in the program. We testified in support of the formula provided in S. 1772, however, the two methods are so similar that either formula is acceptable—both represent a most constructive improvement.

The ultimate goal of this association is to have the Government assume 100 percent of the cost. However, we recognize that this can be accomplished only by a formula which will assess higher costs to the Government over a period of years. We recommended, however, that whatever formula is decided upon by the committee that the Government contribution will at nothing less than 50 percent.

Mr. Chairman, members of the committee, ample testimony has been presented to substantiate that a large number of employers in the private sector of the economy presently pay at least 50 percent of the premium for health insurance plans covering their employees. We do not intend to burden this testimony with the voluminous data and statistics on this point inasmuch as this record is already available to the committee. We would like to call attention, however, to Bulletin No. 1502 issued by the Bureau of Labor Statistics, Department of Labor, in 1966. This is an analysis of 100 selected health and insurance plans which were developed under collective bargaining. Of the 100 plans, 63 of them paid the entire premium for employees and their dependents. Undoubtedly, agreements reached since that date would show that a larger percentage of these plans are now paying the full cost. This does substantiate that the Government is far behind in the per-

centage of contributions it makes for this fringe benefit of health insurance.

The U.S. Government should not be trailing United States Steel, RCA, Ford, General Motors, B. F. Goodrich, and other prominent major employers in this country. That such a situation exists merely highlights the fact that the proposal contained in H.R. 767 is sound and in line with progressive practice in private industry.

Mr. Chairman, members of the committee, we would like to mention one other area where we believe an improvement should be made in the Health Benefits Act. Amendments to the Civil Service Retirement Act, enacted in Public Law 91-93, provides survivor annuity protection to Federal employees after 18 months of creditable service. The Health Benefits Act requires an enrollment of 5 years before survivors can continue enrollment in the health plan of the deceased employee. We believe the act should be amended to permit surviving spouses and children to enjoy health benefits protection in line with the same service requirements establishing eligibility for survivorship annuities. We trust the committee will consider this change in marking-up a bill dealing primarily with the change in the funding formula of the Federal health program.

Mr. Chairman, members of the committee, to summarize, we are making the following recommendations in connection with the legislation under consideration.

The first of our recommendations is that the Health Benefits Act be amended to eliminate the present requirement which mandates two levels of benefits in the two Government-wide plans. This does not mean that we are stating they should be forced to discontinue them, but we do believe that in view of the fact that approximately 90 percent, perhaps more when the effect of the last open season is known, are now enrolled in high option coverages only that it may, in the foreseeable future, be most desirable that one or both of these plans would be permitted to go to a single level of benefits.

We believe, and speaking for the Rural Carrier Organization, that within our own plan this is a desirable move. Yet there is a certain negative aspect for an organization to take this step when the law presently mandates that the two large Government plans must still contain the two level benefits.

Our second recommendation is that the Health Benefits Act be amended to permit survivor annuitants to continue health insurance enrollments in line with the same service requirements established for employees. The reason we present this recommendation, Mr. Chairman, is that in the recent Retirement Act amendments that required creditable service for survivorship annuities has been reduced from 5 years to 18 months. We recently had one of our insureds pass away after approximately 22 months of service. The widow and the surviving children are eligible for survivorship annuity under the amendments to the Retirement Act made last year. However, the 5-year requirement for continuing health benefits for these people still remains as part of the Health Benefits Act. We believe that the two should be drawn together and this restrictive part of the Health Act should be amended to conform to the Civil Service Retirement Act.

Our third recommendation is that the present fixed dollar formula for determining the Government contribution to the cost of the Federal health plans be eliminated. That is what has created the present

problem. Costs are going up. The Government's percentage cost has gone down because of the fixed dollar payment, and the employees' percent of cost has risen rather rapidly.

Our fourth recommendation is that a new funding formula similar to the proposal in S. 1772, or as proposed by the Civil Service Commission to tie the Government contribution to the higher level of benefits, be adopted.

Our fifth recommendation is that the Government contribution under the formula as we have recommended be set at at least 50 percent of the cost and that the Government contribution be automatically adjusted to maintain that percentage in subsequent contracts.

Our sixth recommendation is that provisions be included in any bill marked up by the committee to provide for the Government to assume a contribution in excess of the initial 50 percent in subsequent years. This is in line with the provision in the bill under consideration, H.R. 767, which provides for a 25 percent additional payment by the Government in the subsequent year and an additional 25 percent moving it to 100 percent of cost.

We are realistic and the 25 percent in two following years may be high, but we believe that some provision should be made to have the Government assume a higher cost in the future years.

With those recommendations, Mr. Chairman, may I also express our appreciation for this opportunity to appear before you and present our views and note these items that we believe would make any bill approved by the committee a rather ideal one.

Mr. HANLEY. Well, Mr. Emeigh, having some knowledge of your expertise in the field of health benefits, I have great regard for what you have said and the recommendations contained in your testimony. Certainly the committee will give each of them a great deal of consideration.

With regard to the low-option aspect of these plans, I take it that by preference your association would prefer to drop the lower coverage?

Mr. EMEIGH. We believe it would be rendering a service to the persons who are enrolled. When a person such as myself, who is directly involved with claims administration, runs on to these rather sad cases where an employee has experienced a major medical problem, or he or a member of his family has run into a catastrophic type of medical care, we discover that he has exercised a very penny-wise and pound-foolish judgment in selecting low option. The statistical fact is that 90 percent approximately have known this and have elected the high option coverage.

As pointed out in the text of our testimony, we believe that one of the major reasons that some of this 10 percent has continued to be in low option is the fact of cost. There is quite a difference in cost between the two, and some people make a judgment that they will risk the need for better health protection for some additional money in their paychecks. We believe legislation such as that under consideration will, in large measure, remove that reason and make it possible for those in the low option to move to the high option.

Mr. HANLEY. We have a bit of a problem inasmuch as we are advised that some of the people who are intimately involved in the administration of the plans are low-option subscribers. Do you have any comment on the rationale here?

Mr. EMEIGH. It is a completely individual judgment on the part of each individual. Perhaps in analyzing the particular plan they are in, in relation to their present health condition, and what in their own mind they may believe is going to be their experience they may determine that low-option coverage is adequate.

I know, also from experience, that certain individuals in our own plan have purposely elected low option coverage because in light of their own financial situation, and this type of an analysis I have just spoken about, they believe that they will risk the cost of a high health bill in relation to the difference in premium.

Mr. HANLEY. Unless the Government were to provide cost-free coverage would it not be somewhat unfair to persons who feel that low option coverage is adequate for their needs to impose upon them the necessity of buying high option insurance? We, in effect, would be telling the Chevrolet owner that he should buy a Cadillac?

Mr. EMEIGH. I do not believe that is quite correct, Mr. Chairman. In line with our suggestion we are not requesting action which would eliminate low options. We are requesting action which would make it possible to do so in the future.

If, in future open seasons, there should be a continuing reduction of the number of people in low option I believe that there are many advantages for all concerned in eliminating it eventually.

One of the problems we have, and it is a minor one but it is nonetheless rather important, is the fact that certain people will elect low option coverage and then, when a major problem comes upon them, they exercise the option to choose that Cadillac you are speaking about. We believe there is somewhat of an unfair aspect in permitting a man to be in a plan and use this cheaper coverage, pay less into this, not contribute to the financial stability of it, and then at the time he has a major problem, merely by placing his name on a piece of paper, moving over and benefiting from the higher coverage which his fellow employees have been contributing to over the years, so it can be analyzed in many different ways. However, I think this aspect of adverse selection is something that should be considered.

We are not trying to mandate a high level and expensive type of coverage. We just believe that the history of the program demonstrates that it may be desirable to have a single level of benefits in each of the plans in future years.

Mr. HANLEY. Your testimony is related to the report of Milliman & Robertson, Inc. In reviewing their report I am sure you have noted the finding that high options have never financially stood on their own feet, but, in contrast, the low option experience has been quite favorable. Did you detect that in the report?

Mr. EMEIGH. Yes, and this is true in the Rural Carrier Benefit Plan. The reason for it is, of course, that the known liability in low option coverage can be much more easily determined on an actuarial basis because you have the limitations of coverage set on fixed dollar amounts, and with the experience of utilization which has been built up you can form a much more accurate judgment as to what the liability will be.

In addition, the low options do not assume the expansion of health care costs in the manner that the open end type of coverage in the

high option provides, and therefore it is difficult to look into the future even with the projections we have and determine for a group as a whole what the additional cost of high option will be because we do not have these fixed dollar limits. We pay whatever the costs might be. That explains really why the low options are able to stand on their own versus high options.

Mr. HANLEY. You then do not feel that by forcing low risk persons into high option coverage that we would be in some degree requiring them to subsidize the higher risk people?

Mr. EMEIGH. I think that is exactly right if taken just in that context. Looking into the future, the low risk person, whomever he may be, will very likely, if for no reason except that he will grow older, enter into a high risk category. We believe there is an element of justice in looking at the group as a whole in establishing that single level of benefits so that during this participation in the plan he is contributing his fair share toward the cost of that plan. It comes back to the idea of adverse selection to which I addressed myself previously.

Mr. HANLEY. You related in your comments to the open season aspect of this. Some have suggested that as opposed to the 3-year open season we should utilize a 1-year open season program.

Mr. EMEIGH. Speaking for the Rural Letter Carriers Association we could not subscribe to that recommendation. Quite the contrary, Mr. Chairman, we believe that some in-depth analysis should be given to the open seasons and perhaps they should be eliminated completely.

There is a tremendous problem of administration in connection with open season changes. For example, we are still today making telephone calls to the postal data centers to secure verification of coverages which were changed during the open season. It will be some period of time before all of the records that are placed on computers are in such condition that we once again rely entirely upon our data processing in determining coverage.

I believe a better system very likely would be developed. I think it would be unfair to lock people in. I see no reason why this opportunity to change once each 3 years could not be provided on an individual basis after a man is in a plan 3 years without the expense and the headaches of trying to promote an open season and tell everybody with great publicity that this is what you should do. Give him the opportunity to do it after enrolled in a plan for 3 years and then set up some schedule of opportunity to do it following the 3-year period, and, I think very importantly, set an effective date for their change perhaps in line with the medicare 3 months requirement so that once again we would take into consideration this possibility of adverse selection. In this way you would not be locking people in. You will be giving them an opportunity to change under the same type of time limitation that you have with an open season. I think you would eliminate a great many problems that arise when you tell the entire work force of the U.S. Government that here is 30 days, gentlemen, look over 38 contracts, or, to be practical about it, perhaps five or six for which they are eligible and make a judgment whether you want to change.

I think the pressures of making that judgment at a set time within a 3-year period has as much adverse effect as good effect.

Mr. HANLEY. Certainly your observations are well taken. How long has your association sponsored a plan? When did it first do that?

Mr. EMEIGH. We established our private plan in 1955. Inasmuch as we had an organization-sponsored plan in existence when the 1959 act was passed we established the rural carrier benefit plan as of July 1, 1960, under that act.

Mr. HANLEY. I can assure you that the subcommittee will direct its attention to the possibility of extending health benefits coverage to the survivors of short-service employees. Again I want, in behalf of the committee, to express our appreciation to you and your associates for your efforts here this morning. Your testimony certainly is most comprehensive. Again I reflect upon your great expertise in this particular field and what you have offered will contribute greatly to the deliberations of this committee.

Again our appreciation for your presence here this morning.

Mr. EMEIGH. Thank you, Mr. Chairman.

Mr. HANLEY. Our next witness will be Mr. William S. Lawson, president, National Federation of Professional Organizations.

STATEMENT OF WILLIAM S. LAWSON, PRESIDENT, NATIONAL FEDERATION OF PROFESSIONAL ORGANIZATIONS, ACCOMPANIED BY JAMES D. HILL, EXECUTIVE DIRECTOR; AND ARTHUR SPILLERS, EXECUTIVE DIRECTOR, ORGANIZATION OF PROFESSIONAL EMPLOYEES, DEPARTMENT OF AGRICULTURE

Mr. LAWSON. Mr. Chairman, with your permission Mr. Hill and myself are accompanied by Mr. Arthur Spillers, executive director of the Organization of Professional Employees, Department of Agriculture, one of our larger constituent organizations.

Mr. HANLEY. We are delighted to have you with us this morning, gentlemen.

Mr. LAWSON. Mr. Chairman, this testimony is presented in behalf of the National Federation of Professional Organizations, composed of the following organizations:

Air Traffic Control Association, Inc.

Airways Engineering Society

Association of Senior Engineers of the Naval Ship Systems Command

Federal Plant Quarantine Inspectors' National Association

National Association of Federal-State Employees

National Association of Federal Veterinarians

National Association of Government Engineers

National Labor Relations Board Professional Association

National Society of Professional Engineers

Naval Civilian Administrators Association

Navy Field Safety Association

Organization of Professional Employees of the U.S. Department of Agriculture

Patent Office Professional Association

Society of Real Estate Appraisers

We wish to congratulate the committee for its attention to the important problem of health costs, and the health insurance costs, of Federal employees.

We have had considerable reaction from Members during the past several years about the increased health insurance premiums due to

the rapidly rising cost of medical and hospital services. For example, the biweekly cost of low coverage under the indemnity plan for an employee and his family in 1967 was \$6.24, of which the Government's contribution amounted to \$3.12 or 50 percent of the total cost. The biweekly cost of this coverage in 1970 is \$10.94, of which the Government pays \$4.10 or 37.5 percent of the total. During this 3-year period, the total biweekly cost increased \$4.70, while the Government increased its contribution only \$0.98. In contrast, the biweekly cost of the high option indemnity plan for an employee and his family in 1970 is \$20.74, of which the Government contributes \$4.10 or 19.8 percent of the total cost.

During recent years, the trend in the private sector has been for management to assume a greater proportion of the cost for employees' insurance. In a majority of instances the employer pays the full cost. A 1967 study of employee benefits made by the U.S. Chamber of Commerce of 1,150 firms revealed that 3.2 percent of the payroll was paid for various types of insurance. Eighty-four firms reported insurance payments amounting to 6 percent or more of the payroll. The report also shows that "payments for insurance was reported by 98 percent of both manufacturing and nonmanufacturing firms." A breakdown of the amount paid out by the firms for health insurance was not given. However, the Outlook section of the February 18, 1969, issue of the Wall Street Journal states:

Health insurance, like the Blue Cross plan, is an outstanding type of unseen income today. It's been estimated that as of 1967 almost 163 million Americans had some type of private health insurance, and insurance men figure that probably three-fourths of these are covered by group policies either wholly or partly paid for by employers.

This simply supports something we already know—that group health insurance has during the past few years become a part of our way of life. Surveys over the past few years by the Bureau of Labor Statistics report that almost 100 percent of employees in private industry have health insurance plans. In 1962 the Congress enacted the Federal Salary Reform Act, providing that Federal salary rates shall be comparable with those in private industry. Even before that, in 1959, the Congress had enacted a provision for a health insurance program for Federal employees. In this respect the Congress provided for a fringe benefit for Federal employees which was intended to be comparable to that of employees in the private sector. As we understand it, the original intention of the Congress was that the Government should pay 50 percent of a low option plan, leaving it to the individual employee whether he wished to subscribe to increased benefits at his own expense. We also understand that, because of the substantial number of employees who did in fact subscribe to high option plans, the original Federal contribution in fact was 38 percent, and that this has now decreased over the years to 24 percent.

H.R. 767, by increasing the annual Federal contribution, would accomplish an eventual 100 percent financing of employee health insurance premium payments by the Federal Government. The Civil Service Commission has proposed a Federal contribution of 38 percent of high option plans, and not to exceed 50 percent of low option plans. This, indeed, would be an improvement over the present situation, and, in addition, the Commission proposal would also insure that the percentage would remain constant, despite rising premium costs.

Although we congratulate the Commission for this constructive step, we suggest that it does not go far enough. We do support the concept of a percentage contribution, which would fluctuate annually with changes of premium. Since enactment of the original Federal health benefit plan in 1959, the Congress has found it necessary to amend the law three times, and is now considering it again. Despite this fact, the percentage of Federal contribution has decreased from 38 percent to 24 percent over the years. The Congress, and this committee, should not be required to devote annual attention to the question of the appropriate percentage of the Federal contribution, which will continue to be necessary if a dollar amount is continued to be used.

We point out that the Congress has been committed for some years to the concept of Federal employee pay comparability with private industry pay. This concept necessarily includes Federal employee fringe benefits as compared with those in private industry. In private industry today we believe that in a majority of industries management pays the entire cost of medical insurance premiums, and in those industry plans in which the employees contribute, management pays over half of the cost. Year by year, it is our impression that the percentage of management contribution continues to increase. This is the direction in which our society is heading. A proposal that, in the Federal service, the employer pay 38 percent of the cost simply lags behind comparable practice prevailing in private industry, and in future years will continue to be even more out of step.

Let us consider the statistics which have been gathered on this subject. The Bureau of Labor Statistics of the Department of Labor has collected data on fringe benefits in private industry since the enactment of the Federal Salary Reform Act of 1962. The Department has regarded fringe benefits as a part of the Federal salary which the Congress intended to be comparable with private industry. The Bureau's first survey was made in 1963, and in the preface to its report on this subject the Bureau said:

As the Nation's largest employer, the Federal Government has an obligation to develop and maintain a sound program for compensating its employees—a program which is equitable both to the employees and to the country's taxpayers. Moreover, policies adopted by the Federal Government may have a substantial impact on employment and compensation practices in private industry.

The Federal Salary Reform Act of 1962 is a landmark in the evolution of Federal pay practices. It declares that, as a matter of policy, "Federal salary rates shall be comparable with private enterprise salary rates for the same levels of work." To implement this declaration, the statute calls upon the President to have prepared "annually a report which compares the rates of salary fixed by statute for Federal employees with the rates of salary paid for the same levels of work in private enterprise as determined on the basis of appropriate annual surveys conducted by the Bureau of Labor Statistics, . . ." Furthermore, the President is to report this comparison and his recommendations for revision of Federal practices annually to the Congress.

In keeping with this legislative mandate, the Bureau of Labor Statistics conducts annually a national survey of salary rates for a wide variety of professional, administrative, technical, and clerical jobs. Information is collected from a sample of establishments to provide representative data for much of the private industry sector of the economy.

It is recognized that basic salary normally is only part, although the major part, of total employee compensation. Particularly since World War II, a host of supplementary pay practices (commonly called fringe benefits) have become established as integral parts of the compensation package. Consequently, the Bureau of the Budget and the Civil Service Commission, which share responsi-

bility for analyzing results of the BLS salary survey and for preparing the President's recommendations to the Congress on Federal pay, expressed a need for data on supplementary pay in private industry.

The Bureau of the Budget and the Civil Service Commission, therefore, requested BLS to conduct a study of supplementary compensation in private industry which could be analyzed in conjunction with the BLS salary survey.

In this report the Bureau found that private industry was devoting an amount equivalent to 1.6 percent of basic wages to hospital, surgical and medical plans, while the Federal Government was devoting only 1 percent of basic salary for this benefit; that industries with noncontributory plans (paid wholly by management) paid 1.9 percent of basic salary, and that industries with contributory plans paid 1.4 percent of basic salary and the employees paid 0.9 percent. The Bureau said, "... about two-thirds of the employers with contributory arrangements paid over half the cost of hospitalization, surgical and medical plans . . ."

A later BLS survey of industries in 85 metropolitan areas for 1966-67 showed that 94 percent of companies had hospitalization plans of which 64 percent were noncontributory; that is, paid wholly by the employer, 93 percent had surgical plans, of which 63 percent were noncontributory, and that 78 percent had medical plans, of which 53 percent were noncontributory.

Another survey of the Bureau of Labor Statistics, a study of employee compensation in private industry for 1966, found that for that year management paid an amount equivalent to 2.5 percent of basic wages for life, accident, and health insurance, but in the Federal Government the Government paid only an amount equivalent to 1.4 percent of basic wages for this purpose. The same survey showed the extent to which employers now pay the entire premium; 85 percent of officeworkers were covered by insurance plans of which 44 percent were contributed to by the employee, and 41 percent were noncontributory; as to nonoffice workers, 76 percent had insurance plans, of which 31 percent were contributory and 45 percent were noncontributory.

A later study by the Bureau of Labor Statistics, of benefits provided by private employers in 85 metropolitan areas for 1967-68 showed that 95 percent of employees were covered by hospitalization and surgical plans, and 54 percent by plans which were noncontributory, that is, paid wholly by the employer.

A 1969 survey by the Bureau of Labor Statistics of health and insurance plans in 50 large companies disclosed that 26 paid the entire cost of health insurance premiums, 22 were contributory by employees, and in two some classes of employees contributed and others did not.

To summarize, health insurance is a fringe benefit of the Federal employee which the Congress intended to be comparable with that of employees in private industry. But the Federal Government has lagged behind, and the proposal of the Civil Service Commission would perpetuate the lag. In private industry today, the employer contribution, as a percentage of basic wages, is almost twice that of the Federal Government, more than half of private industry health insurance plans are financed solely by the employer, and in those which are contributory the employer pays more than half. In our view, the proposal of 100 percent Federal financing, as embraced in H.R. 767, at least as to a basic plan, is required if the promise of comparability is to be kept.

We understand that the Commission's objection to total Federal financing is simply one of cost. The Commission proposal of 38 percent employer financing is estimated to cost an additional \$182 million per year while 100 percent employer financing would cost an additional \$768 million per year, or a total of approximately \$1 billion. We have no reason to doubt the accuracy of these statistics but we suggest that they are of comparatively minor relevance. We are experiencing an era of inflation. Federal pay comparability will undoubtedly continue to cost additional moneys annually. This fact is probably involved in most congressional legislation, but the Congress cannot abdicate its responsibility to legislate because of it. The Government must pay the price of inflation just as each individual employee must do so. We might point out that inflation also adds to Government income tax revenues, not just to Government expenditures.

The subject of an adequate health insurance program for Federal employees is not merely one of the fair percentage of the employer contribution; it also necessarily involves questions of the extent of coverage and the control of escalating medical costs. Medical costs in recent years have far exceeded the general increase in the cost of living. See the attached charts. These are subjects requiring intensive study. Much has already been written. See for example, the article entitled "Trends in Negotiated Health Plans," and its extensive bibliography in the May 1969 issue of the Monthly Labor Review, a publication of the Department of Labor. We respectfully suggest that this is a subject which should have the attention of Congress, for the benefit of all citizens, but that it should be delegated to the Bureau of Labor Statistics and the Department of Health, Education, and Welfare, which have staffs of the necessary numbers, competence, and expertise and, further, that the conduct of such a study should not delay immediate action on the problem of adequate Federal financing. We suggest that the committee bill on this subject contain provisions directing the appropriate agencies to conduct such a study and to report to the Congress, but that this be a separate matter from committee action on the question of the appropriate percentage of employer contribution. We feel strongly that the Federal contribution should at the least, be 100 percent of a basic plan, leaving to employees the option to acquire extended coverage, catastrophe (major medical) or other additional benefits as they may wish at their own expense.

We would like to call attention to one additional change which we feel should be made in the health insurance law; 5 U.S.C. 8905(b) (2) provides that an annuitant is entitled to elect health insurance coverage if at the time he becomes an annuitant he is a member of the family of an employee. However, 5 U.S.C. 8901(3) (B) defines annuitant as a member of a family who receives an immediate annuity as the survivor of an employee who dies after completing 5 years of service. It appears that this 5-year period should be changed to 18 months to correspond with section 206, Public Law 91-93 (Civil Service Retirement Amendments of 1969) enacted October 20, 1969, amending 5 U.S.C. 8341, which provides for survivor annuities where an employee or Member dies after completing at least 18 months of civilian service.

We thank the committee for the opportunity to express our views on this important subject.

(The charts attached to the witness' statement are as follows:)

Table B-5. Health, Insurance, and Pension Plans

(Percent distribution of plant and office workers employed in establishments having formal provisions,¹ by type of plan and type of financing in all metropolitan areas, by industry division and region, 1967-68.)

Industry division and region	Insurance, plans										Sickness and accident insurance and/or sick leave					Retirement pension plan		No health, insurance, or pension plan		
	Life		Accidental death and dismemberment		Hospitalization		Surgical		Medical		Catastrophe		Sickness and accident insurance		Sick leave (full pay and no waiting period)		Sick leave (partial pay or waiting period)			
	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans	Non-contributory plans	All contributory plans		Non-contributory plans	
	Plant workers																			
All industries and regions ⁵	93	66	62	42	94	65	94	64	100	55	49	30	81	63	47	19	12	74	62	2
Industry division:																				
Manufacturing	96	71	66	48	98	72	98	71	83	61	46	28	86	75	57	13	7	80	70	1
Transportation, communication, and other public utilities	97	68	63	28	98	54	98	54	61	48	63	64	78	37	27	31	29	78	64	2
Wholesale trade	92	63	66	44	94	61	93	60	82	52	59	36	81	51	37	37	20	68	56	1
Retail trade	86	50	52	32	85	48	84	48	68	40	49	20	78	46	30	23	23	66	47	4
Finance, insurance, and real estate	77	62	54	42	79	59	78	58	68	51	20	15	57	42	34	22	6	41	33	13
Region:																				
Northeast	93	73	59	43	94	72	94	72	79	59	42	28	84	69	55	21	8	77	67	2
South	89	47	53	25	89	42	89	41	66	50	52	21	70	50	28	18	14	61	47	5
North Central	95	71	65	47	96	69	95	69	64	61	45	28	90	78	61	10	10	78	69	1
West	93	70	76	57	97	73	97	73	94	71	71	52	74	53	25	36	19	75	61	1
Office workers																				
All industries and regions	96	58	62	33	95	50	94	49	86	44	79	39	82	43	26	60	9	83	62	1
Industry division:																				
Manufacturing	97	63	69	44	97	66	97	65	89	59	74	42	89	60	40	65	5	86	67	(*)
Transportation, communication, and other public utilities	98	64	62	20	99	44	99	44	95	40	92	67	85	26	15	57	22	79	62	(*)
Wholesale trade	95	53	67	37	93	48	92	48	85	43	72	34	84	46	27	59	5	73	50	1
Retail trade	91	37	49	21	88	32	87	31	64	26	61	14	86	38	16	34	31	74	39	1
Finance, insurance, and real estate	98	55	55	27	94	38	93	37	87	33	88	34	73	20	15	61	4	89	68	(*)
Services	88	52	60	33	85	38	85	37	77	33	72	30	72	55	20	57	3	69	48	3
Region:																				
Northeast	97	63	58	34	93	53	92	52	83	44	75	39	81	47	33	61	6	85	64	1
South	95	49	58	25	94	38	94	38	82	33	79	32	77	37	18	52	12	78	55	1
North Central	96	58	63	35	95	51	95	51	87	47	76	36	85	51	31	55	11	82	62	1
West	97	55	74	39	98	52	98	52	94	50	90	52	87	27	12	74	8	84	62	(*)

¹ "All plans" include those plans for which at least part of the cost is borne by the employer. "Noncontributory plans" include only those plans financed entirely by the employer. Excluded are legally required plans, such as workmen's compensation, social security, railroad retirement, and compulsory temporary disability insurance required in New York and New Jersey.

² For further details, see footnote 3 to table in appendix A.

³ See footnote 3 to table B-1.

⁴ Unduplicated total of workers receiving sick leave or sickness and accident insurance shown separately. Sick leave plans are limited to those which definitely establish at least the minimum number of days' pay that can be expected by each employee. Informal sick leave allowances determined on an individual basis are excluded.

⁵ Includes data for real estate in addition to those industry divisions shown separately.

⁶ Less than 0.5 percent.

Mr. HANLEY. Mr. Lawson, we appreciate your testimony this morning. From my evaluation of it, it pretty much concurs with much of the testimony which has been presented by witnesses prior to you.

We are most appreciative for your contribution and certainly it will be helpful in our deliberations.

I have no questions and simply want to thank you for your appearance here this morning.

Mr. LAWSON. Thank you, Mr. Chairman.

Mr. HANLEY. Our next witness this morning will be Mr. Jack A. Waller, legislative representative, International Association of Fire Fighters.

STATEMENT OF JACK A. WALLER, LEGISLATIVE REPRESENTATIVE, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, ACCOMPANIED BY ALVIN DAVIS, FIELD REPRESENTATIVE

Mr. WALLER. Thank you, Chairman Hanley. With me this morning is Mr. Alvin Davis, field representative of the International Association of Fire Fighters in charge of our Federal employees section.

Mr. HANLEY. Mr. Waller, we are delighted to have you here this morning along with your associate, Mr. Davis.

Mr. WALLER. I want to express our appreciation in being able to testify here in behalf of our membership.

Mr. HANLEY. You may proceed.

Mr. WALLER. Mr. Chairman and members of the committee, our union consists of approximately 150,000 members in the United States and Canada, of which over 4,000 are employees of the Federal Government. All of our members are professional firefighters employed by States, counties, municipalities, the Federal Government and a limited number of industrial firefighters. We are so structured that within our organization Federal firefighter union officials meet at least annually on a State level with all other local union officers, and on an international level once every 2 years. The employees of one segment of our government are well aware of the working conditions, the fringe benefits and the salaries received by fire fighters in any other areas of government.

I am not going to repeat in this testimony the figures on what is happening on health benefits in the private sector. I know other organizations have already adequately covered this phase. It is our intention to show that the Federal Government as an employer is not providing for its employees' "Health Benefits" on a par with other governmental entities. I know you gentlemen are well aware of the fact that the Federal Government presently contributes about 25 percent of the total cost of health benefits, with the employee paying 75 percent. When the health plan was enacted in 1959, the intent was for the Federal Government to pay 50 percent of the low option coverage. Rising costs of health benefits have been the leading factor in bringing about an inequitable ratio between employer and employee costs, and since 1959 the local governments have assumed an ever-increasing share of health benefit costs for their employees.

The first attachment shows that 19 cities, with a population of over 500,000, pay on the average 82.3 percent of the total cost of health—14 pay the total cost of health benefits. The average dollar contribution by the 19 cities is \$145.13 annually, compared to the Federal

Government's \$43.68 contribution for single coverage and \$106.56 for multiple coverage.

The second attachment is a random sampling of 20 cities under 500,000 taken from the files of our research department. We are sure that this sampling is a reasonable composite of the total cities of our country, and indicate that our municipalities are paying 64.5 percent of the total cost of health benefits for their employees.

The International Association of Fire Fighters believes that in the field of health benefits for employees, the Federal Government should be the leading employer. We support the approach to this problem as embodied in H.R. 767, introduced by the chairman of this committee, Hon. Dominick Daniels, and urge this subcommittee to report the same to the full committee.

In our effort to find the dollar costs for the health benefit in the municipality we found it difficult because so many of our large cities provide clinics which give doctor, hospital, and nursing care in many instances, and prescription drugs to firefighters. They are not figured into the total cost of the health benefit under a policy which is bought for the public employee. We found this problem difficult. I do not think the dollar figures actually show what the municipalities are spending for the firefighter and his family.

Again we express our appreciation for being able to testify in behalf of our membership.

Mr. HANLEY. The two attachments to which you referred in your testimony without objection will be inserted in the record of this hearing at this point.

(The attachments referred to follow :)

EMPLOYER'S CONTRIBUTION TO FIREFIGHTERS HEALTH PLAN IN SELECTED CITIES¹

City	Population	Employer contribution to health plan	
		Percent	Amount
New York, N.Y.	7,781,984	100.0	\$384.72
Chicago, Ill.	3,550,404	100.0	148.80
Philadelphia, Pa.	2,002,512	100.0	216.00
Detroit, Mich.	1,670,144	100.0	148.20
Baltimore, Md.	939,024	60.0	173.19
Houston, Tex.	938,219	100.0	179.88
Cleveland, Ohio	876,050	100.0	148.44
Washington, D.C.	763,956	40.0	-----
St. Louis, Mo.	750,026	0	-----
Milwaukee, Wis.	741,324	100.0	130.00
San Francisco, Calif.	740,316	100.0	180.00
Boston, Mass.	697,197	50.0	73.80
Dallas, Tex.	679,684	100.0	69.00
New Orleans, La.	627,522	100.0	53.76
Pittsburgh, Pa.	604,332	13.0	24.15
San Antonio, Tex.	587,718	100.0	-----
Seattle, Wash.	557,087	100.0	-----
Buffalo, N.Y.	532,759	100.0	102.00
Cincinnati, Ohio	502,550	100.0	-----
Average employer contribution	-----	² 82.3	-----

¹ Cities with population of 500,000 above.

² The 82.3 percent employer contribution rate includes the city of St. Louis, Mo., wherein firefighters must bear the total cost for health insurance.

Source: Research and Education Department, February 1970.

EMPLOYER'S CONTRIBUTION TO FIREFIGHTERS HEALTH PLAN IN OTHER CITIES (AT RANDOM)

City	Varied population	Employer contribution to health plan (percent)
Fairfield, Conn.....	56,000	100.0
Wilmington, Del.....	90,000	100.0
Burlington, Iowa.....	35,000	50.0
Carlsbad, N. Mex.....	25,000	50.0
Monroe, La.....	65,000	50.0
North Platte, Nebr.....	18,000	100.0
La Grande, Oreg.....	10,100	41.0
Sheboygan.....	50,000	90.0
Creston, Iowa.....	9,000	35.0
Weehawken, N.J.....	13,000	100.0
Olympia, Wash.....	21,400	45.0
Brunswick, Maine.....	18,000	50.0
Helena, Mont.....	25,000	23.0
North Reading, Mass.....	12,000	50.0
Gulfport, Miss.....	55,000	3.0
Emeryville, Calif.....	2,696	75.0
Bonita, Calif.....	8,700	100.0
Flagstaff, Ariz.....	28,000	37.0
East Chicago, Ind.....	56,000	90.0
Eugene, Oreg.....	78,000	100.0
Average employer contribution.....		64.5

Mr. HANLEY. Beyond that, again I want to express our appreciation to you and Mr. Davis for your appearance here this morning. It has been a contribution to our efforts and you have our gratitude.

Mr. WALLER. Thank you.

Mr. HANLEY. Our next witness will be Mr. J. Stanly Lewis, vice president of the National Association of Letter Carriers, AFL-CIO.

With Mr. Lewis is Mr. Austin B. Carlson, director of the health benefits plan for that association, and also Mr. Glenn M. Hodges, assistant director of the health benefits plan for that association.

Gentlemen, it is a pleasure to welcome you here this morning.

STATEMENT OF J. STANLY LEWIS, VICE PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS, AFL-CIO; ACCOMPANIED BY AUSTIN B. CARLSON, DIRECTOR, HEALTH BENEFITS PLAN, AND GLENN M. HODGES, ASSISTANT DIRECTOR

Mr. LEWIS. Thank you, Mr. Chairman. We apologize for our tardiness but we were attending a meeting of some of our members in New Jersey on a vital issue facing us at this time.

Mr. HANLEY. We appreciate your problem and we wish you well in your negotiations.

Mr. LEWIS. Thank you very much. We appreciate your good wishes.

Our business address is 100 Indiana Avenue NW., Washington, D.C. 20001. Our membership numbers in excess of 210,000, located throughout the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

With me this morning is the very able director of our health benefit plan, Mr. Austin B. Carlson and the assistant director of our health benefit plan, Mr. Glenn M. Hodges.

On behalf of our organization, Mr. Chairman, I should like to express deep appreciation for your active, continuing interest in developing a more effective health benefits program for Federal

workers, as well as a more equitable division of premium costs between employer and employee.

We recognize with gratitude your sponsorship of H.R. 767, a measure that would obligate the Federal Government to underwrite fully the cost of the Federal employees' health benefits program. We support your bill wholeheartedly. We hope this bill will be amended to expedite the complete payment of the health benefit program in this current year rather than over the next several years.

Associated with your efforts are many of your colleagues in the House of Representatives, including Congressmen Wilson, Teague, Corman, and Tunney, of California; Congressmen Brasco, Ottinger, Scheuer, Halpern, Bingham, and Farbstein, of New York; Congressmen Collier and Pucinski, of Illinois; Congressmen Conyers and Riegle from my own State of Michigan; from your own State of New Jersey, Mr. Chairman, I am pleased to commend the support of Congressmen Howard and Helstoski; still other sponsors include Congressmen Thompson, of Georgia; Tiernan, of Rhode Island; and Fraser, of Minnesota; as well as Mr. Duncan and Mr. Pepper, of Tennessee and Florida, respectively; and similar measures have also been introduced by Congressmen Kastenmeier, of Wisconsin; Gonzalez, of Texas; and Matsunaga, of Hawaii.

For more than 80 years, various NALC representatives before me have appeared before the Congress to advocate changes in the wages and working conditions of letter carriers. Looking at that long period in terms of overall effort, it would be difficult to cite a single piece of legislation that was more welcome at enactment than the Federal Employees' Health Benefits Act of 1959—Public Law 86-382.

It was a long time coming, but come it did in 1959 after many years of cooperative efforts on the part of great numbers of people and groups.

At its passage, the bill was described in glowing terms. It was truly a landmark piece of legislation. Those connected with its passage had every right to be proud, including the Congress, the executive branch, employee unions, and the insurance industry. Our own organization hailed Public Law 86-382 as "a milestone in the history of intelligent human engineering in the Federal Establishment." Our membership ranked its passage on equal terms with the 1916 compensation for injury law, and the basic retirement law 4 years later in 1920.

Unfortunately, the bloom of that initial enthusiasm has long since wilted and faded away. What was a shining hour to a great many people in 1959-1960 has long ago become a tarnished memory.

Why? one asks.

The answer, in my opinion, is to be found in the almost total neglect of Government to redeem its promises of 10 years ago to employees. Only once during the past decade has the formula for sharing of premium been adjusted. That was in 1966. Otherwise, it was a decade of "benign neglect" about which we have been reading in recent weeks.

Our organization has some familiarity with the requirements for operating a health benefits plan. We have been in the business since 1905. In that year we established our own program for partial reimbursement of earnings due to injury and illness. (There was no sick or annual leave law in those days.)

As the record will show, medical care costs sharply escalated at the conclusion of World War II. Our membership became increasingly

aware of these rising costs and, in 1948, approved the extension of our 1905 program to include a hospitalization-surgical benefits schedule. This program became operative in 1950.

In the years between 1950 and 1959, we joined with others in importing our Government-employer to enter into a program of sharing premium costs with its employees. P.L. 86-382, effective July 1, 1960, was the result of those efforts. At passage, our organization became a charter underwriter.

I think it is important to sketch briefly the history leading up to the approval of the Federal Employees' Health Benefits Act. I find that the various excuses advanced by then Government spokesmen for not enacting a health insurance program are practically the same today for not keeping it in harmony with current medical cost realities. In 1959 they conceded the need for a health insurance program, but resisted on the grounds it would cost money. Today they admit the need for improvements but resist change because it will cost money.

Prior to 1959, the Federal Government had for many years lagged behind private industry in not sharing premium costs with its civilian employees, or making it possible for them to purchase health insurance at group rates by payroll deductions.

The picture was quite different in the private sector. In 1959, it was conservatively estimated that better than 75 percent of those enrolled in prepaid health plans were enrolled through the place where they worked. More than one-third of those enrolled through the place of their employment paid nothing toward the cost of their premium; the employer assumed 100 percent of the total premium charges. That one-third figure has increased year by year. By early 1968, the Health Insurance Institute (based in New York City) reported that 63 percent of all employees covered in more than 3,000 large group plans surveyed paid nothing toward the premium cost of their health insurance.

I might say at this point with regard to cost sharing that spokesmen of the executive branch have a habit of airily dismissing any reference to private companies that pay all, or a larger share of premium, than does the Federal Government. This tack is pursued even when the data presented are cited from Government sources.

I recall a survey published a few years ago by the Department of Labor. It examined in some detail 100 of the largest group health insurance plans in the country resulting from collective bargaining. When we testified that 69 of those plans provided full coverage for the worker and his family at no expense to the employee, and another 17 fully covered the employee but required a nominal premium charge to include his dependents, we were told by spokesmen for the Civil Service Commission that we were dealing in "generalizations." Their argument was to the effect that these employer-pays-all programs probably did not provide very good coverage. And, besides, they argued, one had to look at the overall cost of operating our Government.

On the first point, I would suggest the Commission's argument indicates a remarkable naivete as to what is going on through collective bargaining in the outside world. I am not suggesting that any or all of these programs offer indemnity at 100 percent for all medical expenses incurred between cradle and grave.

However, when it can be demonstrated that a plan is meeting hospital semiprivate rates and paying a high proportion of other expenses incurred by the insured person for those items of health care

against which the insurance was purchased, that plan cannot be characterized as inadequate. Obviously, the goal is 100 percent reimbursement, but 80 to 85 percent is still good protection in today's market, if one takes into account the various illnesses generally excluded or limited as to benefits, plus the deductible and coinsurance features found in practically all group plans. Many of these industrywide plans also provide free life insurance, loss-of-pay insurance, routine dental care, and regular physical checkups for the employee and his family.

Government also likes to pat itself on the back about its fringe benefits, specifically, the percentage of payroll costs that goes into these supplemental benefits. Actually, the Government admits it lags behind private industry. The most recent Government figures I have seen show private industry spending 24.5 percent of wages and salaries, against the Government's 23.8 percent. However, the February 16, 1970, issue of Business Insurance reported on a recent survey of 8,000 large companies—the average cost for fringe benefits was reported to be pushing the 30 percent mark.

Two observations occur to me. One, the Government is silent on what it costs the employee for his fringe benefits. For example, the average letter carrier spends almost twice as much for his medical care as compared to the 7 percent of total personal consumption expenditures of the average citizen.

Effective the first of this year, our contribution toward retirement increased one-half of 1 percent to a total of 7 percent. That surely ranks among the highest employee costs to be found in any contributory retirement system.

The second thought is that if Government is not actually proud to lag behind private industry, it certainly seems content in a secondary role, not only in fringe benefits but in practically every other facet of employment. Our organization submits that being second to the private sector deserves no plaudits. Government should try harder.

With respect to the argument that Government should be excused from meeting its fair share of our health insurance premium because of a tight fiscal situation, or because other projects have a higher national priority, or because someone in the Bureau of the Budget decides fairness and equity would be inconsistent with administration policy, I have only one answer.

Any business—in or out of Government—that claims it must maintain substandard wage scales and less than fair fringe benefits to stay in business has no moral right to remain in business. In my opinion, it is not only immoral for the Government to maintain that posture, it is also irrational for the Government as an employer to continue to presume that Federal personnel should gladly and willingly pay a stiff economic penalty to be on the payroll.

Actually, the Government would be shortsighted, indeed, if it measured the cost of an improved health insurance plan in dollars alone. Decent wages, fair working conditions, adequate fringe benefits—each and all of these have been demonstrated to bring about a more stable work force, as well as a more efficient and more productive work force. Above all, the happy blending of all these factors results in a more stable family structure. Basically, this is what it is all about. That is why we are here this morning, Mr. Chairman. We are talking about people and their health care needs. We are not talking about

some budget figure arbitrarily arrived at down in the Bureau of the Budget.

I would suggest a recent statement by the AFL-CIO executive council sums it up very succinctly. The statement declared: "We do not believe the Government should buy a budget surplus at the expense of its workers."

We hear and read every day about national priorities. There are those who say we should pursue the space or lunar program until we land a man on Mars. Others insist we should first see to it that some of our fellow citizens land on their feet here on earth before going out into space. For every exponent of a bigger and better ABM system, I suppose you could find those who think it is more important to eliminate the various hazards polluting our environment. I admit, frankly, that I do not have the answers to these various differences.

But we want to be heard if fixing national priorities means we again go to the end of the line and, like Lazarus at the table, we are told patiently to await whatever crumbs are handed to us.

I need not remind you, Mr. Chairman, that Federal employees are people. Your entire tenure in Congress has demonstrated that you know that as well as anyone in or out of Washington. And since Government workers are people, and production and efficiency comes from people—healthy people, I should add—it ill behooves the Federal Government to delay any longer a correction of the present inequity found in our health insurance program.

Earlier in my statement, I mentioned the pleasures and expectations the passage of Public Law 86-382 generated 10 years ago. The only sour note throughout the history of the act has been a formula whereby the employee has consistently paid almost two-thirds of the total premium cost. This clearly was not the intention of the 86th Congress in approving the measure. The clear intent was no less than a 50-50 sharing of costs.

Except for some low-option plans and certain self-only enrollments, the contribution by Government has never equaled 50 percent of the total cost. In fact, it has never exceeded 38 percent for the overwhelming majority of employees.

For purposes of example, permit me to cite the history of our own high option, family plan (in which 85 percent of our membership is enrolled). All figures represent deductions and Government contributions on a biweekly basis:

	Total cost	Government share		Employee share	
		Amount	Percent	Amount	Percent
1960.....	\$8.74	\$3.12	35.7	\$5.62	64.3
1961.....	8.74	3.12	35.7	5.62	64.3
1962.....	8.74	3.12	35.7	5.62	64.3
1963.....	8.74	3.12	35.7	5.62	64.3
1964.....	9.61	3.12	32.5	6.49	67.5
1965.....	9.61	3.12	32.5	6.49	67.5
1966.....	10.10	3.12	30.9	6.98	69.1
1967.....	12.08	4.10	33.9	7.98	66.1
1968.....	12.08	4.10	33.9	7.98	66.1
1969.....	12.08	4.10	33.9	7.98	66.1
1970.....	14.67	4.10	27.9	10.57	72.1

As these figures indicate, we are worse off in 1970 than we were in 1960 when the law was enacted.

Actually, the figures I use make the Government look better than it deserves. That is because we have one of the lowest biweekly premiums among the 36 participating plans. The use of our own rate schedule has the effect, therefore, of making the distortion less glaring. Were you to use the highest rated programs, for example, the spread narrows down to 20 percent by Government and 80 percent by the employee. That is a disgraceful situation.

This lopsided apportionment of costs was not what the 86th Congress had in mind in approving the act. The printed report that accompanied the bill at enactment included the following:

The Committee recognized that the maximum amounts indicated could not remain unchanged over a long period of years, any more than the cost-of-living has remained frozen. Medical care costs will undoubtedly fluctuate at least as widely as other items of living costs. The Committee believes that the Congress will continue to be responsible to the needs of the employees and will appropriately act to keep the proposed program in consonance with future developments.

That report was correct in one respect, but far amiss on a second point.

Medical care costs most certainly have gone up during the past 10 years. They have not only matched the increases in all other items; they have outrun them by a great margin.

From 1960 through January of 1969, the Bureau of Labor Statistics reports that the Consumer Price Index for all items in the index budget increased slightly less than 25 percent. During that same period, the cost of all medical care items increased by 52 percent. Contributing factors to that startling figure include a 55-percent increase in physicians' fees and a 155-percent rise in hospital daily charges. Only charges for prescription drugs remained relatively stable during the same period.

If the 86th Congress correctly predicted an increase in medical care costs as time went on, it almost drew a blank with the suggestion that subsequent Congresses would "keep the proposed program in consonance with future developments."

The first, last, and only adjustment made in the Government's share of the total premium cost was in 1966. The biweekly contribution for high option, family plan increased from \$3.12 to \$4.10 or about 31 percent. This during a period when, as indicated, medical expenses increased by 52 percent.

Unfortunately for the consumer, the end is not in sight. Perhaps it is a subject not properly before this committee, nevertheless, our organization wants to associate itself with the widespread demand that the Congress take whatever steps it deems appropriate to halt the present uncontrolled, runaway escalation of medical costs.

Without a brake on these rising costs, there can be only one result. With every rise in medical care costs, premiums will follow—but with one significant drawback. The insured is not going to realize more or better benefits for his increased premium payment; every cent of it will be required to enable the underwriter to break even, or to avoid deficit spending.

Where there is any kind of improvement in the benefit structure, the employee will be obliged to assume the entire cost of the increased or

new benefit, in addition to the full cost of meeting the general rise in medical care charges.

The situation with respect to our own plan is, perhaps, a valid example.

In drawing up our contract for 1970, we were anxious to improve our surgical schedule to bring it more in line with present-day surgery fees. We also felt the need to alter the method by which we considered pre- and post-operative charges. We know from the recommendation of our actuary that a 10-20 percent increase in general medical costs could be expected in 1970. This last was based on an actual 13.4-percent increase in our claims experience in each of the previous 4 years.

We elected to load into the premium for 1970 a 14-percent factor for anticipated general increases, with the remainder of the dollar increase going to pay for the improved surgical schedule. The end result was a biweekly increase in costs to the employee of \$2.59 for high option, family enrollment.

Thus, our biweekly premium increased from \$7.98 to \$10.57. The total biweekly cost is \$14.67. With the employee paying \$10.57 or 72.1 percent of the total, the Government contributes only 27.9 percent.

The point I am making is simple. Not only did the employee assume 100 percent of the cost required for more premium to offset general increases in medical expenses, he also had to finance 100 percent of the charge for bringing his schedule of surgical benefits more in line with current surgical charges.

This puts the average letter carrier in a very unenviable position. He finds that it is costing him 88 percent more each payday for his health insurance than he paid 10 years ago. Without the 31.4 percent adjustment the Government made in 1966, the employee's biweekly cost in 1970 over 1960 would have been 107 percent. The future is even more bleak. He is told by all the experts that medical costs are going to continue to increase by anywhere from 15 to 25 percent for each of the next 4 or 5 years. To the extent that prediction comes true, the letter carrier knows that he will have to absorb those increases out of his take-home pay—unless the Government acts and acts promptly. What the Government must do is provide a massive transfusion of dollars. Tokenism will not do the trick. If the employee is required to bear the full economic impact of each succeeding premium increase, there can be but one logical conclusion: The law of diminishing returns will ultimately take over.

Our own actuary's estimate of rising medical costs has ample support among his peers.

In recent weeks, the Civil Service Commission released a very disturbing report. It was prepared by one of the Nation's top actuarial consulting firms, Milliman & Robertson, Inc., of Seattle, Wash. It was submitted to the Commission January 24, 1969, but was not made generally public until recently.

The report predicts Federal employees' health insurance premium will increase between 10 and 35 percent every 2 years between now and 1976, probably averaging between 20 and 25 percent.

These predictions are based largely on anticipated higher payments for doctors' services, higher hospital charges, the use of more expensive equipment and greater administrative costs.

Using Blue Cross-Blue Shield as an example, the report estimated that by 1975 annual premiums will climb to over \$800 from the present \$460, even with no improvements in benefits.

This projection is based on increases—from the \$423 premium in 1969 when the study was made—of 28.1 percent in the 2 years through 1971, another 21.1 percent in the next 2 years, and another 21.2 percent in the following 2 years.

Should there be a mere 5 percent improvement in benefits in 1971, 1973, and 1975, the annual premium would increase to over \$900.

Unless the Government's contribution toward premium is increased from the present yearly legal maximum of \$106.56 (26 pay periods $\times$ \$4.10) I wonder how many of the present 2 million employees insured under Public Law 86-382—plus their 6 million dependents—will be able to afford health insurance 2, 3, or 5 years hence.

I mentioned briefly that we had adjusted our surgical schedule for the 1970 contract year. Were I sitting on the other side of this hearing table, that comment would pose a question of the witness in my mind. I am sure our organization accepts as a valid inquiry a question asking how the benefits of our plan (and possibly others under Public Law 86-382) compare with what we might term "commercial insurance" for want of a better term.

Frankly, I think most plans operating under Public Law 86-382 offer the insured reasonably adequate benefits for the premium dollar asked. By that, I also mean to say that a fair return in benefits is made for the premium charged. I would not say that our plan is richer in benefits than the average commercial plan. Nor can I testify that our benefit schedule fails to measure up to the average commercial plan, except perhaps in one or two areas. These would include preventive medicine, that is, regular physical checkups and, possibly, better dental care. We would like to add these refinements to our benefit schedule, as we would also like to enlarge some of the benefits now payable—mental care, for example. However, I see no way to reach out for those goals, much less attain them, unless the Government does at least its fair share.

The point one must constantly keep in mind in talking about insurance benefits is that the patient almost invariably has a balance he must personally meet after insurance reimbursement. Many people have the idea that a health insurance plan "pretty much takes care of" the problem of medicine expenses.

Perhaps there is available a cradle-to-grave type of coverage that pays all expenses at 100 percent of the incurred cost. However, I am reasonably certain that, if such coverage does exist, the average letter carrier could not possibly buy it on his present postal wages.

Actually, the proportion of costs covered by health insurance has increased very slowly over the past 10 years. A recent Department of HEW statistic indicates only a 8.7 percent increase in consumer health expenditures being met by health insurance in 1968 over 1958.

During practically the same period, the average citizen paid nearly twice as much for his uninsured health care expenses—\$128 in 1960 compared with \$238 in 1968.

This says, in effect, that premium costs have increased between 1960 and 1968 without any significant increase in benefits; and the

indication is also that people were additionally required to almost double the amount of out-of-pocket cash they spent on medical care not reimbursed by insurance. I think these national figures apply with equal validity to employees insured by Federal Government plans.

In 1967, the Health Insurance Association of America conducted a study of the relationship between the charges incurred by insured persons for health care expenses and the benefits provided to such persons by their group health insurance policies. The survey included 58 insurance companies which write 70 percent of all group policies. The sampling amounted to more than 40,000 claims.

The results of this study were recently published in the "1969 Source Book of Health Insurance Data."

The study revealed that group medical care insurance reimburses 80 percent of all expenses covered by insurance. Basic coverage only paid 79 percent of covered expenses reimbursed. For comprehensive major medical plans, the proportion was also 79 percent. It was 83 percent for persons covered by a combination of basic plan with supplementary major medical.

Covered hospital expenses were reimbursed 86 percent, including 83 percent of room and board charges and 89 percent of ancillary hospital expenses.

These figures reflect almost precisely our own claims experience. For example, we are paying 83 percent of room and board costs, plus 88 percent of hospital miscellaneous charges. Total covered hospital expenses are reimbursed at 86 percent.

Overall, we are paying a fraction under 82 percent of all covered expenses—surgery, X-ray, et cetera.

This means, of course, a personal responsibility by our insured of about 18 percent over and above insurance benefits for covered expenses, plus 100-percent personal expenses for charges not covered by insurance.

Perhaps a second valid question would ask how efficiently plans are operated under Public Law 86-382. Obviously, I can speak only for our own plan.

I have no hesitancy in saying that, in my opinion, we operate our plan conservatively with respect to overhead, and liberally with respect to the amount of each premium dollar we return in the form of benefits. Our administrative overhead is about 4 percent of earned premium income. Slightly more than 1 percent is placed in reserve. Better than 94 percent of every premium dollar is returned to the subscriber in the form of benefits. I hasten to add one further comment with respect to the last statistic. It does not mean we pay 94 percent of every claim considered by the plan; I wish we could. I wish we could pay 100 percent of every incurred expense. The 94 percent represents the amount of the premium dollar paid to us that is sent back to the insured in reimbursement of his expenses. As stated a moment ago, the ratio between charges incurred and insurance reimbursement is 82 percent versus 18 percent.

On the basis of our own experience, I do not see any likelihood of belt tightening in the day-to-day underwriting of our plan. If we are going to move along with the advances in medical care, with each improvement adding higher premium costs, the answer must come

from a more equitable sharing of premiums on the part of Government.

Mr. Chairman, I should like to comment very briefly on one other concern we have with the present Federal employees' health plan.

Unless steps are taken to determine who is going to insure the retired Federal employee, and how his insurance is going to be financed, it is a reasonable prediction that (1) Federal annuitants are soon going to be priced out of the health insurance market, or (2) Public Law 86-382, as we now know it, will cease to exist.

As you are aware, Mr. Chairman, retirees pay the same premium and receive precisely the same benefits as active employees. There are two things wrong with that kind of setup. In the first place, the Federal retiree can ill afford a monthly premium ranging from \$23 to \$35 and up for practically the same insurance protection the average citizen at age 65 gets under medicare for \$4 per month.

Secondly, if plans under Public Law 86-382 are to continue to pay the same benefits to the elderly population within the Federal family for the same premium charged younger men in the active work force, you are figuratively banging your head against an actuarial wall. It simply cannot be done over a long period of time, without bankrupting the plan. The only alternatives are to establish an actuarially sound premium for older subscribers, or establish a separate benefit schedule. To do the first, I fear, will simply price the average annuitant out of the insurance market. The second is manifestly unfair. We are opposed to both alternatives.

As an example of what all plans are faced with, the average hospital confinement of an older person is about three times the duration of the younger person—2.7 percent longer to be exact. The premium is the same for both. This is not surprising, since we all require more medical care as we advance in years.

As a matter of fact, back in 1964, the actuarial consulting firm previously referred to in my testimony—Milliman & Robertson, Inc.—was engaged by the Civil Service Commission to conduct a study of the experience and rates of six selected plans under Public Law 86-382. Our plan was one of those selected for study.

One of the findings was concerned with the future financial stability of the entire program if it continued to insure annuitants and their dependents for the same premium rates as charged active employees.

The study found that in 1964 annuitants represented 7.5 percent of the combined number of employees and annuitants insured under the act. It was estimated that by 1970 this figure would increase to 16.7 percent. Insofar as our own enrollment figures are concerned, this 1964 estimate has proved to be reasonably accurate. As of December 31, 1969, annuitants represented 13.0 percent of our total enrollment of 134,500 employees and annuitants.

Claim frequencies are distinctly higher for annuitants than for employees, and apparently the same is true for dependents of annuitants when compared to employees.

It was also suggested that claim frequencies for annuitants and dependents were increasing at a faster rate than the corresponding claim frequencies for employees and their dependents.

It was estimated that by June 30, 1970, the proportion of total benefits paid to annuitants and their dependents would be 26.0 percent.

That estimate has proved to be somewhat higher than our actual experience. About 15 percent of our total benefits are being paid to annuitants and their dependents.

However, I believe that the 1964 estimate has been influenced by the subsequent enactment in 1966 of medicare. Under present regulations, a patient insured by both medicare and a Public Law 86-382 plan has his covered expenses reimbursed first by medicare; the Public Law 86-382 plan then computes and pays its benefits. We estimate that, in the absence of medicare benefits, our percentage of total benefits paid to annuitants and dependents would probably be 4 percent to 5 percent greater than the 15 percent figure cited above.

We suggest as a possible solution the transfer of Federal annuitants, at age 65, to protection under part A of medicare. Perhaps some type of supplementary insurance policy would be required to take up the slack between present coverage and medicare coverage, but that should present no great obstacle. I would, of course, include spouses under this suggestion.

Federal annuitants (and spouses) at age 65 are now eligible to apply for and receive the benefits of part B of medicare. Thus, all we are treating with in this suggestion is part A of medicare.

When medicare was enacted in 1965, a special provision allowed Federal employees who had retired prior to July 1, 1960, to be blanketed in under part A of medicare, even though their Federal employment excluded them from social security coverage and benefits thereof. But the estimated 200,000 persons retiring subsequent to July 1, 1960 had no eligibility for part A, at age 65, unless they also had social security credits. What I am referring to, then, is this post-1960 group of Federal annuitants without social security credits.

This is the annuitant and spouse group that is paying from \$23 to \$35 and more per month for practically the same coverage a man and wife under medicare is getting for \$8 per month (\$4 being the per person monthly cost of part B; part A is without premium cost to the beneficiary).

This is not a new or original idea. As a matter of fact, two agencies of Government have explored the idea—the Civil Service Commission being one and the Department of Health, Education, and Welfare the other. The last agency included the results of a study reported on January 19, 1969, to the House Ways and Means Committee and to the Senate Committee on Finance. Insofar as I know, no action by either committee has occurred beyond receiving the HEW report.

It might be helpful to everyone seriously concerned about the future of Federal annuitants, as well as Public Law 86-382, if the committee would request the appropriate agency or agencies in Government to comment on the long-range effect of continuing the present program as it is. I am firmly convinced that our retired people cannot much longer hope to pay the premium that will be required of them. By the same reasoning, I have no trouble in seeing all plans under Public Law 86-382 in serious financial trouble in the not too distant future, if the present benefit and premium structure applies to all subscribers, regardless of age.

Mr. Chairman, we feel very strongly that our request for a fair shake in the matter of health insurance represents a reasonable request. The correction we are asking for by this testimony is long overdue. No one

can deny that the employees have been patient. Nevertheless, that patience wore very thin, as evidenced by last week's breakdown in the mail service. One thing is certain. The problem is not going to yield to rhetoric alone. What is needed is positive action—now—to fulfill the commitment made by Government to its employees 10 years ago.

We thank you, Mr. Chairman, and members of the committee. We are available now or at any time later for any questions.

Mr. DANIELS. Mr. Lewis, I want to compliment you for a very fine statement. I apologize for not being here earlier. However, having met you earlier this morning I did inform you that I would be absent due to the fact I had to preside as Chairman of the Select Subcommittee on Labor. We were marking up a very important bill, a bill which the administration is anxiously awaiting action on by the Congress—and for which Congress was criticized for not having acted promptly. I don't know whether there will be any criticism today insofar as the majority is concerned, because not one of the minority attended the meeting. However, we reported the bill out in spite of it.

I trust you will excuse my absence not only today, but yesterday when I was in the same situation.

I did read your statement and I have a couple questions which I have prepared and which I would like to present to you.

How many of your 210,000 members are also enrolled in the National Association of Letter Carriers Health Benefit Plan?

Mr. LEWIS. I will ask Mr. Carlson to answer those questions.

Mr. CARLSON. Mr. Chairman, of the 210,000 members that we have, we now have over 140,000 who are enrolled in our health benefits plan.

Mr. DANIELS. Referring to page 4 of your statement, you are aware of the Civil Service Commission's testimony last week in which the witnesses expressed the opinion that in recent years large private employers have made great advances in providing their employees health insurance.

Would you interpret their testimony as an admission that the benefit structure of large employer plans is comparable to the Federal plan, but that private industry excels in that they pay, if not the total cost of the programs, a substantially greater portion than the Government does on behalf of its employees?

Mr. LEWIS. It would be our experience, Mr. Chairman, from the surveys that we have taken, that the benefits paid by these companies in which they pay 100 percent of the premium parallel to a great degree the benefits paid by plans covered under Public Law 86-382. The premium structure is almost the same and the benefit structure very similar. There may be a benefit here and there paid by industry and not the Government, and vice versa. Benefits are very comparable. The premium structure is very comparable. The only difference is that the employer pays nearly 100 percent in most cases as against a very low percentage by the Government.

Mr. DANIELS. It is quite apparent from your testimony that all of us, we in the Congress and you in the dual role as an employee representative and as a health benefits carrier, have been unable to adequately assess the trends in the health care field, let alone cope with it.

If I were to summarize it accurately, you are saying that the only immediate answer to the problems which beset the Federal employees programs, at least from the enrollees' standpoint, is for the Govern-

ment to fulfill its responsibility as the employer by substantially increasing its share of the cost?

Mr. LEWIS. That is the only immediate answer to this, Mr. Chairman. There must be some other permanent answers wider in scope than this. There must be some effort made to reduce medical costs. By what means I cannot say. I am sure Members of Congress are considering this very carefully because it is of great concern not only to Federal employees but to average citizens, and particularly to older people.

Our only immediate answer would be a greater participation on the part of the Government in the premium sharing. Perhaps there should be some long-range looking into this in trying to stabilize the cost of medical insurance in the long run.

Mr. DANIELS. It was my own thought, as chairman of this subcommittee, to make an extensive study of the entire health plan, hospital costs, doctor bills, and so forth, to see what could be done to really reduce or stabilize the cost as a whole. I think a study of this nature should be made.

In fact, I have asked the Chairman of the Civil Service Commission if he knew of any studies that have been made. To his knowledge none have been made. I think this is a field that some agency of Government should explore.

Mr. LEWIS. I agree with you 100 percent, Mr. Chairman. If such a study is made you can be assured of the complete cooperation of our health plan as well as of our organization, in any way we can assist.

Mr. DANIELS. Thank you.

On many occasions Federal employees and annuitants have urged Members of Congress to deny both the Civil Service Commission and the carriers with whom they contract the right to further increase premium charges. Apparently they feel medical costs will cease to increase if hospitals and doctors are denied higher payments for their services.

In your opinion, what would be the ultimate effect if the Congress were to enact such a moratorium, say, for example, beginning in the next contract year?

Mr. LEWIS. It would have one or two effects. If such a plan were put into effect to put a moratorium on premium rates without any limitation upon increasing hospital charges, or doctors' charges, the plans would either go bankrupt, or you would find that the enrollees in the plans would be forced to pay out of their own pocket an even greater percentage of noncovered expenses than what they have to pay at the present time.

It is the old adage—you can spend a dollar only once. We, as a plan, now return in benefits 94 cents of every premium dollar we take in. We are not allowed unilaterally to increase premiums, but if costs continue to rise, we are going to reach an impossible situation where there would be no place to draw moneys from.

Mr. DANIELS. And on the other hand if you endeavor to reduce the premiums the only way you could carry on successfully would be to reduce the benefits.

Mr. LEWIS. That is true. If we are required to reduce premiums, or hold them at a standstill, then all we can do is reduce benefits.

We are one of the few plans, as shown in the chart on page 8 of our testimony that, in a period of 10 years, have increased premiums only four times. Most plans have been forced to increase their premiums at every annual contract period. We enroll only members of the association. We underwrite the plan ourselves and administer it as conservatively as we possibly can, keeping our overhead and maintenance costs down to less than 4 percent of the premium dollar turned over to us.

We increased our premium in 1970. That is the first time since 1967. The years 1968 and 1969 did not see an increase in our premiums because we realized our people could not afford to pay it.

Mr. DANIELS. How much of your premium dollar is being expended for benefits?

Mr. LEWIS. We are paying back to our enrollees about 94 percent of every dollar we take in; 94 cents of every dollar we take is being paid back to the enrollees in benefits.

Mr. DANIELS. And the balance of 6 percent is what?

Mr. LEWIS. Operating, administrative costs. We are currently putting slightly more than 1 percent of premium cost in reserve. Administrative costs run slightly in excess of 4 percent.

Mr. DANIELS. I congratulate your organization for doing an excellent job.

Mr. LEWIS. Thank you.

Mr. DANIELS. On page 18 you suggested a possible solution to the problem of the programs "aging"—that medicare A be made available to all Federal annuitants and a supplemental coverage be offered under our program. Have you any idea of what it would cost the annuitant to have a supplemental policy which would cover in full those expenses not covered by medicare?

Mr. LEWIS. What we are suggesting in this statement is that those who are retired from the Federal service and who are denied access to medicare provisions because they are not covered under social security unless they have had a sufficient number of quarters to allow them coverage be included in that coverage. The Government would pay the cost for medicare through the Social Security Act. We are asking that this same medicare coverage, which is now costing our people from \$23 to \$35 a month, be extended to our annuitants. While this coverage given by medicare is probably not sufficient in every instance, it certainly is a big boon to those elderly people, particularly those on retirement, in paying for their medical costs.

Mr. DANIELS. My question was directed to medicare A rather than medicare B.

Mr. LEWIS. If I didn't respond, I didn't understand the question.

What we are asking here is that the Federal employee annuitants be given the privilege of having medicare A coverage paid for out of the Civil Service Commission, to extend part A coverage to them. This part A coverage is given to all social security annuitants without charge. I don't know what it presently costs the Government for this type of coverage to the part A annuitants. Certainly it is not excessive. The same coverage should be extended to the retirees of Federal service, as well as social security people.

Mr. DANIELS. And the cost for the payment of that protection should be either coming out of the Treasury or the social security fund?

Mr. LEWIS. That is our suggestion; yes, sir. What you would be doing actually would be adding those Federal annuitants to the rolls, which would be a small percentage of the total annuitants covered by social security.

Mr. Carlson has a comment.

Mr. CARLSON. Mr. Chairman, 13 percent of our total enrollment involves annuitants under our plan, and of the total costs, benefits paid, this amounts to about 15 percent of our total costs. So it is very close.

Mr. DANIELS. Have you any idea as to the cost of similar complementary coverage provided in the non-Federal sector?

Mr. LEWIS. I do not believe we are prepared to answer. We will be glad to try to find costs. We are not prepared to give any costs of that type at the present time.

Mr. DANIELS. I have no further questions. Again I want to express my thanks to you, gentlemen, for your appearance here and for the testimony which has been given.

Mr. LEWIS. Mr. Chairman, we want to thank you because despite your other commitments and even though you were tied up, for coming and being with us at this time. We understand your busy schedule. We are appreciative not only of your sponsoring H.R. 767 but scheduling these hearings and giving us the opportunity to testify.

Mr. DANIELS. Thank you.

We shall stand adjourned until 9:30 tomorrow morning.

(Whereupon, at 12:25 p.m., the hearing adjourned to Thursday, March 26, 1970, at 9:30 a.m.)

FEDERAL EMPLOYEES' AND RETIREES' HEALTH BENEFITS

THURSDAY, MARCH 26, 1970

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

The subcommittee met, pursuant to adjournment, at 9:30 a.m., in room 210, Cannon House Office Building, Hon. Dominick Daniels (chairman of the subcommittee) presiding.

Mr. DANIELS. The Subcommittee on Retirement, Insurance, and Health Benefits will come to order.

This morning we will proceed with the taking of testimony on health benefits legislation pending before this subcommittee.

Our first witness today is Mr. John A. McCart, operations director of Government Employees Council, AFL-CIO. I extend a most cordial welcome.

You may want to read your statement or summarize it. You may proceed in the fashion you see fit, Mr. McCart.

STATEMENT OF JOHN A. McCART, OPERATIONS DIRECTOR, GOVERNMENT EMPLOYEES COUNCIL, AFL-CIO

Mr. McCART. Thank you, Mr. Chairman.

With your permission, I would like to have the full statement incorporated in the record and to summarize it briefly.

Mr. DANIELS. Without objection, it will be so ordered.

(The prepared statement follows:)

PREPARED STATEMENT OF THE GOVERNMENT EMPLOYEES COUNCIL, AFL-CIO

Mr. Chairman and members of the subcommittee, the Government Employees Council and its 34 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. 767 authorizing the Federal Government to defray the entire premium cost of health benefits coverage for employees and their families. The fact that 17 of your colleagues in the House—3 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. The Council is grateful for their genuine concern over a problem, which becomes more serious with each passing year.

When the general health plan was enacted in 1959, the principle underlying cost was that the employer and employee 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, approximately 85% 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 about 38%. But as the total cost increased, the Government's contribution declined to a point in 1965 where it was less than 30%. The following year, Congress acted to restore the 38% Government contribution (Public Law 89-504).

In 1967, 1968, and 1969 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 24.7% of the total cost of the high option plans. Put another way, 85% of the employees are paying more than three-fourths 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 among other employers in financing employee health coverage.

For more than 30 years, unions and management of the Tennessee Valley Authority have agreed to wage and salary levels and fringe benefits for employees through the collective bargaining process.

At present, TVA and its employees have a contributory health benefits program. The ratio of employer and employee contributions for family, high option coverage is 90% and 10%. For salaried workers, TVA pays 80% of the cost and the employee contributes 20%.

Table I appended to this statement supplies the actual monthly premium rates for these two groups of employees.

The method of arriving at this formula is of more than passing interest. A survey of some 50 private firms in the area serviced by TVA is undertaken. In addition, the Federal Government's practice is reviewed. The parties bargain on the basis of this study.

The most impressive point is that the private industry data producing the TVA method of financing is acquired in the following states—Tennessee, Kentucky, Mississippi, Alabama, and Georgia. As a matter of fact, introduction of the Federal Government's contribution formula has a depressing effect on the situation in TVA.

Another perspective is given in studies of new health insurance policies written by private insurance companies undertaken by the Health Insurance Institute. They reveal that between 1963 and 1968 more than 40% of the employees had the total cost of their group health insurance paid for by the employer.

The February, 1970, issue of the Bureau of Labor Statistics' Monthly Labor Review contains an examination of changes in health benefits payments for salaried employees. A comparison of percentage of plant and office workers whose health care premiums are defrayed solely by employers is included. It shows clearly that for both categories of workers a large and growing number of companies are extending free health insurance. A simple table illustrating this is found in attached Table II.

Another Bureau of Labor Statistics study highlights the employer expenditure in private industry and Federal Service. Its publication "Employee Compensation in Selected Industries, 1966" (Report 353—November, 1968) disclosed that for life, accident, and health insurance, private companies expended 2.5% more of payroll on these items than the Federal Government.

It is clear, then, that other industries have 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 October, 1969, 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 * * *."

With the heavy weight of evidence offered above, it becomes clear that H.R. 767 provides modest, but sorely needed relief from the inequitable financial burden now carried by Federal workers in the area of health insurance.

During this series of hearings, the American Federation of State, County and Municipal Employees, AFL-CIO, will recommend favorable action on H.R. 9136, introduced by Representative N. C. Nix, a distinguished member of the full Committee. Identical bills have been offered by Congressmen Robert H. Mollahan and Bob Eckhardt.

Their purpose is to extend to non-citizens employed by United States agencies in the Canal Zone the same benefits now available to citizens. The Council endorses that union's proposal.

The AFSCME will offer ample justification for the legislation. It is sufficient for the Council to observe that the United States some years ago accepted an international commitment to provide pay and benefits to non-citizens employed in the Zone equal to those received by United States citizen employees.

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 associates in the House.

TABLE I.—TENNESSEE VALLEY AUTHORITY EMPLOYER AND EMPLOYEE SHARE OF HEALTH BENEFITS PREMIUMS

	Total premium	TVA pays	Employee pays
Salaried employees:			
Individual.....	\$10.25	\$8.30	\$1.95
Family.....	27.85	21.90	5.95
Trades and labor:			
Individual.....	9.18	7.90	1.28
Family.....	26.77	24.05	2.72

TABLE II.—PROPORTION OF WORKERS IN METROPOLITAN AREAS COVERED BY NONCONTRIBUTORY HEALTH PLANS, 1967-68

	Plantworkers	Officeworkers
Hospital.....	65	50
Surgical.....	64	49
Basic medical.....	55	44
Major medical.....	30	39

Mr. McCART. As you know, the Government Employees Council is comprised of 34 AFL-CIO unions representing in excess of 100,000 Federal employees. We appear today to announce our support of H.R. 767. We are grateful to you and your colleagues in the House and the full committee who have introduced legislation on this score.

It occurs to us this is an indication of the deep interest of the Members of the House in the problem confronting Federal employees with respect to financing their health benefits coverage.

The record is replete with much testimony relative to the prevailing practice in the private sector, so it is not necessary for me to expand on that.

At the present time you know that the average contribution of the Federal Government to the health benefits program is under 25 percent.

What this really means is that 85 percent of the employees in the program are paying 75 percent of the cost of the program in contrast to what we find in the private sector.

When we had an opportunity to appear before you earlier on this subject, we pointed to the experience of the Tennessee Valley Authority.

As you know, the health benefits of those employees are fixed under a survey made by the TVA and the unions, and then they negotiate the ratio of contributions by TVA and the employees.

As a result of this process, TVA is now contributing 90 percent of the cost of the health program for the trades and labor employees and 80 percent of the cost for the salaried workers.

Our statement has appended to it table 1, which supplies the exact figures on coverage, the monthly cost of coverage, and the portion of contribution made by employees and TVA management.

The interesting thing about the TVA experience is that the survey I mentioned includes such States as Tennessee, Kentucky, Mississippi, Alabama, and Georgia.

As a matter of fact, if the Federal Government's contribution formula were not included in this survey, the contribution which TVA makes would be even higher than it is today.

The Health Insurance Institute publishes an annual report on the growth of health benefits coverage in private industry. The latest report indicates that between 1963 and 1968 more than 40 percent of the new policies written by the industry provided for the employer to bear the entire cost.

The latest figures that we are able to locate on the extent of free hospital and surgical, basic medical care, provided by private employers, appeared in the Bureau of Labor Statistics monthly Labor Review for February 1970. The results are shown in attached table No. 2.

Not only has the Government Employees Council had a continuing interest in this pressing problem, but the American Federation of Labor, Congress of Industrial Organizations itself directed its attention to the problem at its last convention in Atlantic City in October 1969.

The AFL-CIO approved a program for Federal employees and included was this item, "Legislation for the Federal Government to defray the entire cost of health benefits."

So that the entire labor movement has an interest in this matter as well in behalf of Federal workers.

The conclusion is inevitable that H.R. 767 is a very badly needed piece of legislation. Actually, it is modest in its three-stage formula for the Federal Government to assume the entire cost of this benefit.

There is one other matter, Mr. Chairman, that I would like to bring to your attention.

Later today, I notice that the American Federation of State, County, and Municipal Employees is scheduled to appear. They will be directing their attention to H.R. 9136, introduced by Congressman Nix, as well as H.R. 767. H.R. 9136 and several companion bills in the House extend health benefits and life insurance coverage to noncitizen employees in the Canal Zone. That union will be able to supply you with ample justification for its position in support of H.R. 9136.

I think it is necessary for me to note only that in 1955, the United States, in a memorandum to a treaty, made a commitment to the Republic of Panama that it would provide parity for the noncitizens with the U.S. citizen employees.

That parity has been achieved in the areas of wages and retirement, but has not been secured in fringe benefits such as health and life insurance.

So we encourage the subcommittee to include in H.R. 767 the basic proposal of H.R. 9136.

Mr. Chairman, that concludes my presentation. I again want to express the appreciation of our organization for your prompt attention to the matter and what we hope will be favorable action in the very near future.

Mr. DANIELS. Thank you, Mr. McCart. I am sure you are aware of the fact that last week when Mr. Hampton, the Chairman of the Civil Service Commission, appeared before this committee to testify, that unlike previous witnesses representing the administration, he came forward and acknowledged that the Government's contribution at the present time is too low and recommended that it be increased to 38 percent; not of the low-option costs as provided by law today, but of the high-option costs, in which program 85 to 90 percent of Federal employees are now enrolled.

In addition thereto he further recommended another provision of automatic adjustment; so that when the Government's contribution fell below the 38 percent of the high-option cost that it be automatically restored to the 38 percent. This thus avoids the necessity of you coming back to Congress and pleading a new case.

You will recall it was only about 3 or 4 years ago that we had the same problem before this committee.

So, if the automatic adjustment feature is adopted, it will not be necessary to have hearings every couple of years when the costs fall below the 38-percent figure.

What do you think about that?

Mr. MCCART. I was gratified to hear Mr. Hampton's testimony on that point, gratified from the standpoint that it differed somewhat from our past experience where administrations have advocated no change at all.

So his formula for the 38 percent is certainly a step in the right direction. In the terms of your bill it is obviously inadequate.

Further, the proposal to provide automatic adjustments is very sound. The problem that we have had with the legislation since its enactment in 1959 is that it has a dollar figure in it. So it means that the formula of the employee and the Government's contribution is based on dollar amounts. Whenever an adjustment is needed, it is necessary to enact legislation.

It seems to us that it would be much more realistic to put this on a percentage basis or in some other legislative language that will not make it necessary to go through this kind of legislative activity every time an increase is needed.

All the projections are that there will be additional increases in the cost of medical care. It seems to us what will happen if you do not take this course is that the unions will be coming to Congress year after year to ask for some relief. So the idea of providing a formula in the legislation which will make the Government and the employees' contributions flexible is sound. That does not detract from our support of H.R. 767, Mr. Chairman.

Mr. DANIELS. Mr. McCart, referring to table 1 annexed to your statement, you show how the premiums are arrived at under TVA, as compared with the trades and labor organizations.

Would you be good enough to show me how these figures are arrived at? Are they through collective-bargaining negotiations?

How does one differ from the other, if there is a difference?

Mr. McCART. Mr. Chairman, in both instances they are arrived at through a collective-bargaining process. This process occurs after the Tennessee Valley Authority and the unions involved, either the trades and labor unions or the salaried employee unions, make a survey in the States of Tennessee, Kentucky, Mississippi, Alabama, and Georgia.

Following that survey, then the parties sit and bargain as to its application.

It is noteworthy that the figures in these States produce the rate of contribution that exists in TVA.

Furthermore, the fact that the Federal Government's rate of contribution is included in the survey has a depressing effect. So that if the Federal Government's contribution were excluded, the rate of contributions by TVA, which is now 90 percent and 80 percent, would be even higher. This occurs on the basis of a survey in private industry, in the States that we do not ordinarily consider as highly industrialized, high-wage areas.

Mr. DANIELS. I note on page 4 of your statement that the AFL-CIO favorably recommend action on H.R. 9136, a bill introduced by my colleague, Congressman Nix, to extend to noncitizens employed by the U.S. agency in the Canal Zone the benefits of hospital and life insurance.

You stated, however, that there is a treaty between the Canal Zone and our Government whereby such actions should be taken; is that correct?

Mr. McCART. Yes; in 1955, Mr. Chairman, the two countries agreed to a memorandum of understanding annexed to the basic treaty. In that memorandum of understanding, the U.S. Government agreed basically that it would provide equality of treatment for the noncitizens. This has been accomplished, to some extent, since these noncitizens are now covered by civil service retirement. There is an equal wage base. But they do not receive health benefits and life insurance coverage.

I rather imagine one of the reasons is that the two pieces of legislation, life insurance and health benefits, were enacted very shortly after the memorandum to the treaty was completed. Perhaps it was an oversight because of the timing.

But inasmuch as the U.S. Government has committed itself to equality for the noncitizens and the citizens who work side by side, it would certainly appear just that health benefits and life insurance benefits be extended to these noncitizens.

Mr. DANIELS. I am looking at the Health Insurance Act. Under subsection 8901 of definitions, it refers to an employee and it excludes from its meaning a noncitizen employee whose permanent duty station is outside the United States. Perhaps that might be the reason why they have not been included.

Mr. McCART. It is. You will recall Mr. Hampton addressed himself to this point. These employees are specifically excluded under the Health Benefits and Life Insurance Act from coverage.

Mr. DANIELS. Mr. Hampton did indicate that he would look upon an amendment favorably.

Mr. McCART. That is my impression. I was very happy to learn that, because in the past the Civil Service Commission has been quite silent on this point.

Mr. DANIELS. Mr. Hampton the other day did indicate he would look upon it favorably provided, of course, it was restricted to the Canal Zone employees because of the agreement that you referred to, which is attached to the treaty.

Mr. McCART. Yes; we are not recommending at this juncture that this be extended worldwide. We think there is a special relationship between the United States and the Republic with respect to the operation of that canal.

As a matter of fact, if we were to advocate that it be extended worldwide to noncitizens, we might be doing some of them a disservice, because some of them enjoy better benefits than we have in our own country.

Mr. DANIELS. Do you have any knowledge as to how many noncitizens would be involved at the Canal Zone?

Mr. McCART. Seven thousand. The cost would not be great.

As a matter of fact, I think the American Federation of State, County & Municipal Workers will supply you with cost information as well as the numbers to be covered.

Mr. DANIELS. Thank you.

I have no further questions. I appreciate your presentation.

Mr. McCART. Thank you, Mr. Chairman.

Mr. DANIELS. Our next witness is Mr. Vincent L. Connery, national president, National Association of Internal Revenue Employees.

STATEMENT OF VINCENT L. CONNERY, NATIONAL PRESIDENT, NATIONAL ASSOCIATION OF INTERNAL REVENUE EMPLOYEES, ACCOMPANIED BY ROBERT M. TOBIAS, STAFF COUNSEL

Mr. CONNERY. Mr. Chairman, it is a pleasure for me to be here this morning. I am accompanied by our staff counsel, Mr. Robert M. Tobias.

Mr. DANIELS. All right, Mr. Connery. You may proceed.

Mr. CONNERY. Thank you.

My name is Vincent L. Connery. I am president of the National Association of Internal Revenue Employees. Our union numbers close to 30,000 members—all IRS employees—and we are the exclusive collective bargaining representative for about 45,000 employees in all operational and geographic areas of the Service. For over 30 years NAIRE has been working in IRS; and today we are happy to appear before this committee as the principal spokesman for IRS employees throughout the country.

H.R. 767 is designed to eliminate the employees' out-of-pocket contribution to premium charges under the Federal employees' health benefits program. Under the scheme of the bill, the governmental responsibility for these charges would be phased in to a full 100 percent over a 2-year period.

This bill is unusually forward looking and NAIRE supports this goal 100 percent. We certainly applaud any effort to grant Government employees similar benefits to those enjoyed by employees in almost all of the larger industrial operations in the private sector. This goal is consistent with congressional policy enunciated almost a decade

ago. In short, H.R. 767 aims to grant Federal employees by 1971 what almost all major business and industry granted to its employees 5 to 10 years ago and to its executives many years prior to that.

The inescapable trend in private employment has been toward non-contributory health insurance plans. These are plans, of course, in which the employer absorbs the full premium and administration costs. In effect, the insurance benefits have become an element of employee compensation. It is time that they were treated as such for Federal employees as well.

According to the latest available figures, of those industries surveyed which had insurance plans, over 61 percent were employee noncontributory for the basic hospitalization coverage and 60 percent were employee noncontributory for surgical coverage. Even for the more unusual medical and catastrophic coverage, it was still true that a majority of those were employee noncontributory plans. As it happens the latest data available from the Bureau of Labor Statistics is taken from a survey made in fiscal 1967-68. There is every reason to believe that the percentages just quoted are even higher today.

Another possibly even more meaningful index of this fringe benefit gap is a comparison between what the Federal Government pays and what private employers pay for health benefits programs. Such a comparison has been made by the BLS. It is expressed in terms of a percentage of basic wages and salaries. The contrast is striking. According to the latest figures, some 3.3 percent of private wages are allocable to health benefits programs, whereas the Federal Government's expenditure for the same benefits is only 1.4 percent of wages.

It is plain, therefore, that if we are serious about the policy of comparability, it is now time to phase in noncontributory health plans within the Federal service. There can be no dispute as to the existence of an ever-widening "comparability gap" between Federal and private employees on this critical element of total compensation.

Even the administration seems to agree—up to a point. I have read with interest the testimony before this committee of Chairman Robert Hampton of the Civil Service Commission, in which he acknowledges the need for greater governmental participation but proposes a "compromise" solution that would peg the employer contribution—for all practical purposes—at about the 38 percent.

In my view, the administration proposal does not even rise to the dignity of a "compromise." It is nothing more than a token gesture, rationalized on grounds of cost, calculated to forestall serious confrontation with a major issue for all Federal employees, and ignores one of the major issues confronting all citizens of the United States.

Certainly, cost is a relevant factor for this committee to consider—along with all the other factors militating toward the achievement of economic justice for Federal workers and fulfillment of the fundamental pledge of comparability. But as we see it, the key to cutting costs is not a stubborn resistance to any enlargement of the Government's premium obligations. The wiser course would be for the administration to bend its efforts, in meaningful ways, to slow down the spiraling costs of medical services and to deal more imaginatively with the task of managing reserves. At one point, Chairman Hampton took note of the pressing need for "bolder moves" in overall administration of the health benefits program. Clearly, if the administration

undertook bolder moves in the areas of fiscal management and a slow-down of medical service charges, the result would be more socially beneficial than the negativistic lack of simply refusing to absorb any more premium costs.

NAIRE urges the committee to accept the challenge of Chairman Hampton and expand the scope of its inquiry beyond the question of premium reimbursement to consider the more basic question of skyrocketing medical costs. H.R. 767 deals with the effects—high insurance costs to Government employees—and not with the causes—high medical costs.

The basic problem is the geometric increase in medical costs which are reflected in the concurrent increases in the insurance costs.

The basic cause of the problem is an unsupervised and unchecked industry running wild. What results is the exploitation of the American public by the medical industry.

For example, we see the drug industry which has for years been uncontrolled by agencies responsible for their supervision. We see a situation where a private institution controls the medical training, the supply of medical doctors, and the accreditation of medical institutions. The fact that there has been widespread fee-gouging by the medical industry is almost public knowledge due to the recent medicare and medicaid hearings. All of these factors, of course, have a direct bearing on the costs associated with receiving medical treatment.

The medical industry up to now has performed for its practitioners and their associates a perfectly masterful public relations job of portraying its people as white knights on spotless chargers or kindly care-worn doctors out in the middle of the night in all kinds of weather.

However, we now find the image makers have created only a mirage. The reality is that a workingman today simply cannot afford a serious illness, the result of which is often bankruptcy and death. The workingman—any person of moderate income—receives only rudimentary medical attention and is prostrate for longer financially than he is medically. We say this must stop. The Government, on behalf of all its citizens, must cease paying homage to the multibillion-dollar medical industry and assume its proper role of leadership in this serious national problem.

This committee, we believe, has an opportunity to begin the process of arresting the seemingly inevitable increase in medical costs which lead to the inevitable increase in insurance rates.

Quite apart from its obvious economic virtue previously discussed, H.R. 767 contains a very important hidden benefit: It could act as a catalyst, leading the Government to take more vigorous action aimed at reform of American medical practice in terms of its basic economics.

If the Government is obligated to pay 100 percent of the medical premium insurance costs for Federal employees, it will necessarily be motivated to begin to assume a responsible role in the ascertainment of reasonable costs and fees. With a financial stake in the health benefit plans, we can be sure the Government will examine with a very keen eye any proposals for premium increases. The Government may also make closer audits and tighten administration of the plans.

We suggest the committee consider an amendment to H.R. 767 giving the Civil Service Commission the authority and the staff necessary to conduct the investigations into the costs used by the insurance companies to justify their requests for higher premiums.

The Civil Service Commission is shackled without facts. When the insurance companies come to bargain about rate increases, the CSC has no means of determining the validity of their claims. The CSC may suspect the cost figures to be inflated or unjustified; however, without the staff or authority to conduct audits, the CSC must blindly accept the statistics offered by the parties who have the most to gain by inflated figures.

If the Civil Service Commission were given this authority, and the staff necessary to carry out the mandate, proper administration of the Government insurance program may provide the needed impetus to break the cycle of higher medical costs necessitating higher insurance premium costs, which in turn encourage higher medical costs. And so the endless spiral goes.

The cycle must be broken and, we believe, this committee has an opportunity to make a contribution toward achieving the goal of high-quality medical care at reasonable costs.

However, we do not view our recommendations as a panacea or cure-all for the problems we have described. We are aware that other committees in the Congress are responsible for considering legislation to supervise the medical industry itself. But we urge the approach described as a beginning. Coupling the concept of 100-percent premium reimbursement with our suggestion of granting to the Civil Service Commission investigatory powers, will make, we believe, a meaningful piece of legislation even more effective.

In summary, H.R. 767 is both a timely and necessary measure. It is mandated by the doctrine of comparability. And the central point, which the administration may have overlooked, is that H.R. 767 is designed to support those goals clearly enunciated by the administration.

We would like to thank this committee for its splendid work and for its continuing interest in the problems of Federal employees.

Thank you for this opportunity to express our views.

That is the conclusion of my statement, Mr. Chairman. If there are any questions, we would be happy to try to answer them.

Mr. DANIELS Thank you, Mr. Connery.

I notice on page 2 of your statement you make reference to the fact that 60 percent of basic hospitalization coverage are employee-non-contributory for surgical coverage and 61 percent for basic hospitalization coverage.

Of course, being an Internal Revenue man, you do understand that in private industry where the employers are generous to this extent, and where they pay the entire cost, they charge that off against their income as a deductible expense. Of course, that makes it an entirely different situation than that posed to the Federal Government, where it is all coming out of the Treasury.

Do you acknowledge that fact?

Mr. CONNERY. Yes; I think there is some validity in the point, Mr. Chairman.

A corporation deducting its medical costs, under the present tax rates, the Government would be picking up one-half of those costs, the corporation being subjected to 50-percent tax rate.

So the Government would share equally in any of the costs being deducted on a corporate return.

Mr. DANIELS. Do you think the generosity of private corporations would be as great if the Government did not make a contribution to it?

Mr. CONNERY. I think that the trend that we speak of on page 2 has been so well set that industry would do this. After all, industry, any businessman, passes along of necessity any of his operating costs to his customers; and his customers are willing to accept this.

This is an accepted fact of life in the private sector. Businessmen generally regard it as such.

Mr. DANIELS. I do not want to convey an erroneous impression here that I am opposed to even the contents of my own bill, H.R. 767. I am a firm believer in the principle that the Government should be an exemplary employer and should set very high standards, not only with respect to pay but all fringe benefits.

I just wonder if any distinction could be made, however, from demanding full contribution from the Government as compared with private industry.

Mr. CONNERY. Actually, in response to your question, Congressman, it strikes us that what is the measure that has been employed by the Congress as enunciated, as you know, in 1962, I believe, the doctrine of comparability; the Government has been comparing itself as an employer with the private sector and has concluded that it comes up far short of the mark.

Actually, I would find it very difficult, myself, to speculate as to the motives of businessmen or people in the nongovernmental sector generally as to what they might do, assuming they had to pick up the entire cost of the plan. But the facts of the matter are that the Government is only picking up one-half of the share of the cost, since they are picking up one-half of the profits in the form of taxation.

Any man entering into business today who incorporates himself or his business, the Government takes 50 percent of the net profits in the form of income taxes. The States, on the other hand, add to that.

So I would think that since the cost of the man's products takes all of these factors into consideration, were the Government tomorrow to abandon the income tax, the 100-percent contribution idea would continue.

Mr. DANIELS. Actually, the tab would be picked up by the consumer?

Mr. CONNERY. That is what I say, the ultimate cost of the product; I quite agree.

Mr. DANIELS. I might say to you that if your counsel, Mr. Tobias, wishes to supplement your statements, he is at liberty to do so.

Mr. CONNERY. Thank you very much.

Mr. TOBIAS. Thank you.

Mr. DANIELS. I notice in this morning's newspaper, Mr. Connery, two articles. One has reference to the high cost of Blue Cross-Blue Shield medicare.

The Social Security Administration reveals that in the District of Columbia the administrative costs for medicare in 1969 were \$5.46, as against the national average of \$3.46.

Then there is another statement by Secretary Finch of HEW with regard to spiraling health costs. He states that the administration proposed last night that the Government help create new systems of health care which would compete with individual doctors and hospitals for

the Nation's health dollar. He said he would ask Congress for authority to foster the development throughout the Nation of a variety of health maintenance organizations that would sell prepaid health care.

Further on he stated, and I quote: "We are not getting our money's worth" from the present medical care system.

Do you care to comment on that?

Mr. CONNERY. Yes.

First, I was very gratified to note in this morning's paper that the Secretary was expressing, in essence, the same concerns that we were.

Unfortunately, as I point out in our statement, the Secretary seems to be hung up on the matter of dealing with effects. Talking about premiums and selling of perhaps more efficient insurance policy is not going to cure this problem. The fact of the matter is the producers of the product are uncontrolled and no matter what you, I, or the Secretary do about it, in the form of coming up with a more efficient insurance policy, that is not in and of itself going to put your people in better hospitals, it is not going to provide them with reasonable medicines; it is not going to create the research and development needed to come up with the better product.

We have all kinds of experience now where the Government is spending, as the Secretary notes, \$10 billion a year and he sees it going up to \$20 billion in the next 5 years. But it is decidedly unfortunate that he does not appear to direct his attention to the group which is to a large extent responsible for the situation.

They are not being forced to come up with a better product. The American people are getting a brand X in the way of medical treatment for ever-increasing costs.

If the Government is going to simply concern itself with attempting to alleviate the costs but not dealing with basic cause, they are never going to be able to put a handle on this situation.

Mr. DANIELS. How do you think the Government may attack the basic cause to which you refer?

Mr. CONNERY. Well, as I indicate in my statement, Mr. Chairman, the present regulatory committees—I think it has been brought out in other areas of the inquiry—the present Government departments are not using the authority they have to effectively police this industry.

The administration is not staffing and asking for sufficient funds to go in there and police this industry.

Mr. DANIELS. You say the necessary Government agency or agencies. Now, to which do you specifically refer?

HEW?

Mr. CONNERY. For example, I am thinking of the Health, Education, and Welfare Department, Mr. Finch's department. As I recall, the National Institute of Health authorities have recently complained publicly over severe cuts in their budget on basic medical research.

I am talking about the agency that regulates the manufacturers of ethical drugs. They are not policing the industry.

Mr. DANIELS. Do you refer to the Food and Drug Administration?

Mr. CONNERY. Yes.

Mr. DANIELS. I doubt if they have the authority to go into the question of costs. I think their authority is more involved in guaranteeing or assuring the American public that it receives pure foods and medicines.

I doubt very much if that agency is vested with the authority to regulate costs.

Mr. CONNERY. Actually, we do not contend that the agency has that authority. However, they have authority to prevent inferior drugs from reaching the market. There are many instances now in evidence where they either do not have the staffing to achieve that goal which is supposed to be the mission of their service, and in the case of the Health, Education, and Welfare Department, we have seen, as I say, this recent evidence of severe cut-backs at the National Institutes of Health.

Mr. DANIELS. Along that line, this morning I also read a news release issued by Chairman Teague of the Veterans' Affairs Committee of the House of Representatives, in which he was severely critical of the lack of adequate funds for maintenance of two veterans' hospitals in New Jersey. It is the hospital at East Orange and the psychiatric hospital at Lyons, N.J.

His report indicates that the hospitals attached to universities have an average of three employees to each patient, but generally there is about 2.75 employees to each patient in private sector hospitals; but in the veterans' hospitals throughout the country it is about 1.5 employees per patient.

He also noted the fact that the New Jersey VA hospital directors reported to the Veterans' Affairs Committee that they did not receive sufficient moneys to staff these hospitals. I think at East Orange they would need about 700 full-time permanent staff employees, and at the Lyons Hospital over 200 more, to bring them up to only a 2 to 1 ratio.

And in order to meet the payroll of those that they presently have on the staff, they were taking money out of the maintenance and equipment account. This is a sad commentary upon our country.

Here we are involved in a war over in Vietnam, and we have thousands and thousands of boys coming back who are maimed and injured. They have made a great sacrifice for our country, and are entitled to the best of medical care. This is along the line that you are talking about.

Mr. SCOTT. Will the gentleman yield?

Mr. DANIELS. I would be happy to.

Mr. SCOTT. Mr. Chairman, I received a similar letter from Chairman Teague, and I do serve with him on the Committee on Veterans' Affairs.

After receiving it and a petition from a group of hospital workers from Massachusetts, I wrote to the Administrator of Veterans' Affairs and asked for his comments on this. I received a reply that does tend to refute some of these charges.

The first two pages do relate to the Boston hospital. The remainder, however, relates to the hospital training generally. With your permission, perhaps rather than to unduly burden the record, if we could just insert at this point the portion of the letter beginning at the bottom of page 2 that relates to the veterans hospital program generally and the efforts that the Veterans' Administration has made to meet the need.

Mr. DANIELS. Mr. Scott makes reference to a letter of the Veterans' Administration signed by Mr. Donald E. Johnson, Administrator, addressed to the Honorable William L. Scott, House of Representa-

tives, Washington, D.C., dated March 19, 1970. For the record, we shall insert this portion of the letter starting with the last paragraph on page 2 thereof down to the end thereof.

(The excerpt referred to follows:)

The average staffing ratio between medical employees and patients has been improving throughout the VA each year for several years. While many Federal agencies have received reductions in funds as an anti-inflationary measure, the VA has not received such a reduction. Inflation, however, has increased operating costs and reduced the buying power of funds, and this problem continues to plague the operation of all hospitals.

The President has shown his concern for the medical care of veterans by recently authorizing 1500 additional full-time employees for the VA, of whom 83 percent were specifically for the hospital and medical program. Even more recently, he has provided additional funds for several problem areas. Furthermore, he has proposed an increase for medical care in fiscal year 1971 so that the total will be the highest sum devoted to this purpose in the history of the VA.

After my meeting with the three spokesmen of the employees, I felt they had a better understanding of the situation than before. The Hospital Director, who is one of our most outstanding hospital administrators and has the full support of the Chief Medical Director, has also met with them to further clarify these matters. The Hospital Director has assured them that recommendations for improvement are always welcome, and theirs will be given careful consideration.

Thank you for the opportunity to present this information.

Sincerely,

DONALD E. JOHNSON,
Administrator.

Mr. DANIELS. But as I understand it, going further with regard to Mr. Teague's statement, his committee intends in the near future to conduct an investigation.

Mr. SCOTT. That is correct. He has advised the membership of the committee that hearings will be held, but I do think when we hear charges one way that we ought to hear the reply to the charges.

Mr. DANIELS. I think we ought to review the entire record, not just part of it, or the views of one man. I realize that you just have the remarks of one individual, when you have that, you have just one side of the coin, and we should see both sides of the coin.

Mr. SCOTT. I share the concern of the chairman and the Committee on Veterans' Affairs about anything that would adversely affect veterans but it is very easy to just make charges and what Chairman Teague has done, I believe, is he has taken each State—I received comments about the veterans hospitals in Virginia and apparently you received them in New Jersey and other Members have indicated they received similar statements about hospitals in their States. So, apparently the chairman of the Committee on Veterans' Affairs is having the staff go down each State and make comments and advise the Members of the House with regard to the hospitals in their particular State. I do think it is well when something like this is done. I don't criticize the chairman of the committee because he is interested in veterans as I am and I am sure you are. But I think it is well to let the head of the Veterans' Administration, when a charge is made that there is inadequate hospital care for veterans, to have his reply to this also in the record.

Mr. DANIELS. I wholeheartedly agree with you.

Mr. SCOTT. Thank you.

Mr. DANIELS. Mr. Connery, Chairman Hampton, in his testimony the other day, stated that neither the Civil Service Commission or the carriers of health benefit plans under our program can effectively stop the spiraling cost of medical care. In other words, he is without jurisdiction to do that. His office acts more or less as an educational bureau for the purposes of dissemination of information and as a funding and contracting agent through its administrative authority. They welcome the idea that there are so many plans that one competes with the other, and feels that plans should not go ahead and offer so many additional benefits without reflecting the costs in their premiums. It naturally would have to reflect itself in the cost and that is the reason why some plans are more costly than the others. But he believes in competition between the various plans. Do you desire to comment on that?

Mr. CONNERY. Actually, we are suggesting that the Commission's role be broadened, that we quite agree with the Chairman's observations as regards the Commission's status in the area. And we are suggesting that the Commission be charged with the responsibility of a truly bargaining these rate increases. Again, as far as competition is concerned, my family is in business, we are consumers of industrial products, and we are aware that through the various things we buy, the competition is often cited as being this oversimplification of supply and demand but the fact of the matter is that when we go out and buy trucks or we buy local supplies or we buy most anything that there are only a few producers and we find it impossible to believe that an organization that is turning out 56 percent of the automotive products in this country can only sell their trucks for the same price as the company that is turning out 11 percent of the production, that we note there are only perhaps three producers, maybe four. We note that there are only three or four producers of local equipment when we go to buy, yet their prices are the same. There is a sameness to it. The rise and fall is the same. I wonder about the competition that really exists. But once again, the competition between insurance carriers is not going to solve this problem, in our view. There has to be regulations of the producers of the product and if we continue to ignore that fact, I am afraid, as I say in my statement, that we will always be dealing with effects and not with causes.

Mr. DANIELS. Then, are you saying that the Civil Service Commission is not driving a hard enough bargain, that it is merely going through the motions of negotiating contracts?

Mr. CONNERY. I am saying, Mr. Chairman, that the Civil Service Commission is in the same position in dealing with this question as they are in dealing with the question of agencies within the Federal Government which they are charged with supervising right now. For example, take the question in the Internal Revenue Service. We had a discussion with Internal Revenue management as to what the classification and grade should be of the agents performing attorney services within the Internal Revenue Service, your estate and gift tax agents. For reasons of their own, the Internal Revenue Service management vociferously disagreed with us that these men should be granted the rank and recognition of attorneys, although we insisted and laid out the fact that their jobs, their very basic job is the interpretation of

State statutes as they apply to Federal taxing regulations. A pure and simple attorney position.

Now, we took the question to the Civil Service Commission and in our discussions and debates up there with the Commission and with Internal Revenue management it was perfectly clear what the problem was. The Commission simply has no staff to go out and investigate the propositions that an agency sends up to them to weigh. They have to accept. It is much the same thing as a position that I would be in as a former revenue agent were I investigating the gentleman's books and records if I could just simply go in and talk with him while sitting at his side are accountants and attorneys who would give responses, but I have no way of getting the books and records to check the responses. And this is the position we have found the Civil Service Commission in time and again, that they have no staff to go out and check the validity of the representations that the resident services management was making then and the same thing happens here—the carriers come up and they make a good case, I am sure, but I have heard other skilled people make good cases that fall apart under analysis and the authority to investigate. And that is what we are saying here, that the Commission doesn't have the means, they don't have the staff, and they don't have the authority to go out and inquire into the representations that are being made to them. We are not blaming the Commission. We are asking that the Commission be put in a position of truly negotiating these things, and you can't negotiate or make a tax determination without the right to investigate the representations that are being made by the taxpayer. And the same thing is true in regard to representation of an insurance carrier.

Mr. DANIELS. When you say the Commission should have sufficient staff to investigate, would you have the Commission go so far as to look into the cost that is being charged by doctors and hospitals for medicines and other services being rendered?

Mr. CONNERY. For example, it is one thing determining the validity of, say, a \$500 procedure, or a number of dollars cost to operate. The fact that the bill has been paid is one thing. It is quite another in the cost.

For instance, the General Accounting Office determines time and again, most often the cost is determined to be valid but the procedures are so hopelessly inefficient that they deserve criticism which the General Accounting Office often metes out to the various people that they are given the responsibility of dealing with. It is that sort of thing that we are asking the Commission be provided with if they are going to be given the responsibility of bargaining or determining the validity of the costs being asked by the carriers. You should not only have the authority to investigate but to require and receive information. This is something that is not the case now, and as a result they have to in the last analysis accept whatever is presented to them, although there might be some face-saving adjustments down the line. Someone could come in perhaps hoping to arrive at x dollars of premium and come in as a matter of course and ask for x plus one and one-half and so-called negotiated down to what they would be more than happy to have in the first place.

At the present time, our concern is that the Federal employees have to come up with the premium costs and ultimately we hope the Fed-

eral Government will come up with these costs, that neither of these parties have any meaningful voice in determining their validity. It is only that which we seek to insure that all of the parties to the transaction are getting a fair shake.

Mr. DANIELS. I recognize the gentleman from Virginia.

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

Mr. DANIELS. I have no further questions.

Mr. Connery, thank you for your consideration.

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

Mr. DANIELS. Our next witness is Mr. Alan J. Whitney, executive vice president of the National Association of Government Employees.

**STATEMENT OF ALAN J. WHITNEY, EXECUTIVE VICE PRESIDENT,
NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES, ACCOMPANIED BY ROGER P. KAPLAN, ASSISTANT GENERAL COUNSEL**

Mr. WHITNEY. Thank you, Mr. Chairman. For the record, I am Alan J. Whitney, executive vice president of the National Association of Government Employees. I am accompanied today by Mr. Roger Kaplan, our assistant general counsel. Mr. Kaplan recently joined our national staff. He was previously in the employment of the U.S. Bureau of Customs.

The National Association of Government Employees welcomes this opportunity to comment on H.R. 767, which was introduced by the chairman. We also want to express our gratitude to you, Mr. Chairman, for introducing this bill which not only would go a long way toward bringing present Federal employees to the level of health insurance benefits offered by many of the most progressive private American employers, but also would make Federal employment more attractive to prospective workers.

If the Federal Government hopes to compete in the job market for new employees, it must offer benefits to compensate for a lack of true comparability in wages. When many of our private employers offer benefits' packages including 100-percent payment of health insurance premiums, the Federal Government can do no less if it hopes to recruit top talent for Government service.

While it is too late to take the lead in offering 100 percent premium payment for health insurance, the Federal Government can still stay among those employers in the forefront by offering, if not exceptional, at least adequate benefits for its employees.

If nothing else, justice and equity demand that the Federal Government pay the full cost of health insurance premiums. Equitable treatment of its present employees is even more important than recruiting new employees or trying to maintain a progressive image.

It was not until 1960 that the present insurance program was adopted. Since that time, the Federal Government has never contributed more than 38 percent of the aggregate premium costs. The promise has been there, but the actual benefits to employees have never materialized. Since 1960, the Government's contribution has declined, under the fixed dollar contribution limit, to approximately 24.2 percent.

What began as a contribution of more than one-third has dropped in just 10 years to less than one quarter. If hospital and medical costs

continue to rise at their present rates, premiums will increase yearly, and the Government's contribution will begin to approach one-fifth of premium costs, then one-sixth, then one-tenth.

The Government's biweekly contribution now is fixed at \$1.68 for self-only enrollment and \$4.10 for self and family.

In January of this year, all but six of the health insurance plans available to Federal employees increased their premiums substantially.

The two governmentwide plans, available to all Federal employees and which cover by far the greatest number of employees and annuitants, made these biweekly increases in their high option, self, and family plans:

Service Benefit Plan (Blue Cross-Blue Shield): \$12.16 to \$13.59, an increase of \$1.43.

Indemnity Benefit Plan (Aetna): \$13.31 to \$16.64, an increase of \$3.33.

For the former this was an increase of nearly 12 percent; for the latter the increase was just barely under 25 percent.

But the most important fact to be noted is that every penny of these increases must come from the employees' pockets.

As premiums continually increase, it is the employees' take-home pay that suffers, not the U.S. Treasury.

While some increases were lower than those cited above, some were higher (all high option, self, and family plans):

The Foreign Service Benefit Plan increased its biweekly premium by \$7.82; the GEBA Health Benefit Plan was up by \$3.92; the Motor Vehicle Employees Benefit Plan was up by \$4.39; and the Group Health Association of Washington, D.C., premium was up by \$4.14.

But even where the premium was up by less than a dollar biweekly, this adds up to many dollars each year from the pockets of Federal employees, annuitants, and their families.

We realize that these increases reflect, in many cases, more and better health and medical benefits. Yet this still does not make the burden any easier to bear for the employee with a family to support and constantly rising prices for everything he must buy in addition to health insurance.

Last week's statistics from the Labor Department underlined the problem. The cost of living rose once again, and this time by five-tenths of 1 percent. And, as usual, hospital costs were among the leaders of those goods and services on the rise.

The Department reported that the cost of medical care was up seven-tenths of 1 percent for February, up 1.1 percent for 1970, and up 5.8 percent since February of last year. (Whether it is any comfort or not, this rise is still less than that of food and housing for the year ending in February.) The Consumer Price Index for medical care for February, according to the Labor Department, stood at 160.1. This meant that with 1957-59 equaling 100, it cost \$160.10 in February 1970 to get the same medical care \$100 would have bought in 1957-59.

Increases in hospital room rates were the main contributor to the rise in medical care costs. What this means—and it is a surprise to no one; members of this committee, administration officials, and least of all to Federal employees—is that health insurance premiums will have to increase again next January to cover these burgeoning medical care costs.

On Wednesday of last week, Chairman Hampton, of the Civil Service Commission, told this committee that the Commission assumed a 12-percent premium increase in 1971 based on cost trends and at the same time said that the Commission could not support H.R. 767.

He then generously—or what may have seemed generous to administration officials—offered an alternative plan whereby the Government would finance up to 38 percent of the premiums.

This hardly appears to be very generous when one considers that many employers contribute 100 percent toward the premium cost for their employees' health insurance.

Chairman Hampton noted that passage of H.R. 767 "would result in a fourfold increase in the Government contribution * * *". According to Mr. Hampton, the Government's contribution would jump from \$232 million now to approximately \$1 billion were the bill passed. In other words, the Civil Service Commission Chairman is worried that the Federal Government might have to pay the \$700 to \$800 million that otherwise would be deducted from the paychecks of Federal employees.

We cannot elicit or express any sympathy for his position.

Mr. Hampton then went on to say:

If H.R. 767 were enacted, this estimate can be expected to increase substantially, over and above the natural increases attributable to rising health-care costs, as employees and annuitants, because it costs them nothing, change to more expensive options, and as plans compete to provide even richer benefits.

The additional burden of the cost between the low and the high option is sometimes impossible for employees to bear. If the Government were to contribute the entire premium cost, this could mean the difference between adequate and inadequate health care for an employee's family.

It must be remembered, too, that the present premium payment system is a regressive one. The premium cost is fixed; it is the same for everyone, be he a Federal executive or a low-paid hourly worker. Thus, the premium payment takes a much larger percentage of the salary of the low-paid employee than it does of the well-paid executive.

We are sure the members of this committee will not be swayed in their determination to provide a benefit the Federal employee so justly deserves. We who speak for the Federal employees better understand his problems in making ends meet than he does a cost-conscious administration.

We might point out, also, that it is an administration determined to hold employees back from the goal of true comparability. In his budget message, President Nixon proposed that a pay raise which should be forthcoming July 1, be postponed until January 1, 1971. Thus, employees would have to wait more than a year to achieve comparability with what salaries in private industry were when the Labor Department's survey was made. At the same time, new increases will be tacked on to the employees health insurance premium deductions. Federal employees are going to be asked to fight inflation by having their deserved pay raises deferred for 6 months. But are hospitals, laboratories, pharmaceutical suppliers, doctors, nurses, and hospital employees going to be asked to fight inflation by keeping their costs down and holding health insurance premiums steady?

That is as unlikely as an administration's delivering everything it promises during an election campaign.

A study by Milliman & Robertson, Inc., consulting actuaries, submitted to the Civil Service Commission in January 1969, made some interesting observations which should be of interest to the members of this committee and to all Federal employees.

In its general comments on the adequacy of benefits (p. 14) the study stated:

The contribution toward premiums by large employers to their hospital and medical group insurance plans is usually greater than is the case for the government wide plans. A 1962 survey of 100 health insurance plans under collective bargaining and which was updated in 1966 indicated that about 60 per cent of the organizations had the employer pay all benefits for both employees and dependents . . .

The study went on to say:

A review was made of seven very large employer plans that had been recently revised, and which have benefits comparable to the government-wide plans. In all instances the employer paid part of the cost; in three instances the entire premium for both employees and dependents was paid by the employer; in only one case was the employee contribution more than \$3.00 for an individual enrollment of \$7.00 for a family enrollment. It would seem desirable for the government to pay a larger part of the premium since the limitations now imposed have resulted in the decreasing percentage of contributions.

Chairman Hampton apparently read this and took this into account in his presentation to this subcommittee.

The mere fact that this 38 percent was the largest contribution the Government ever made toward health insurance premiums is hardly a reason to revert to it now. The Civil Service Commission should be looking forward, not backward.

A Federal contribution of 38 percent, under the formula laid out by Chairman Hampton, appears to us still to leave much inequity in the system. Not only will an employee have to pay the other 62 percent, by no means an insignificant sum considering health insurance premium costs, but in some instances the contribution would not even be 38 percent but some lower figure.

The Commission's plan pegs the Government's contribution to an unweighted average of the premiums charged for the high options of the two largest plans in each category (governmentwide, employee organization, and comprehensive medical plan.)

According to Mr. Hampton:

The government's contribution for all employees would be fixed at 38 per cent of this high-option average, except that the government contribution could not exceed 50 per cent of his premium for an employee enrolled in a low-cost plan.

It is obvious that by using this "average" the Government would avoid paying the full 38 percent in many cases. For high option plans that are more costly than "the unweighted average" of the two largest plans in each category, the Government would get by paying less than 38 percent. By using this method, most employees will be deceived into thinking the Government will contribute 38 percent of their health insurance premiums, as it is the most widely quoted figure with regard to this matter, but later many will become aware that the Government is not putting in that much at all, and never intended to.

Chairman Hampton asserted that the premiums will rise by 12 percent next year. Looking even farther ahead, Milliman and Robertson, in its study, predicted a similar and perhaps even greater increase in the coming years.

Among its principal findings, the study included a prediction that premiums for the two Government-wide plans "can be expected to increase between 10 and 35 percent every 2 years between now and 1976, probably averaging between 20 percent and 25 percent."

This means flatly that, under current law, Federal employees will bear the total cost of these increases, and that under the CSC's plan the employess will bear most, but not all, of it.

Only under the conditions as would be imposed by H.R. 767 will the Federal employees be able to get out from under these suffocating health insurance premium costs. Under this proposed legislation, the cost will be borne by that party which is most able to bear it—the Federal Government.

The Civil Service Commission has ignored a fact which was undoubtedly quite apparent to the chairman of this subcommittee when he introduced H.R. 767. The fact is the Federal Government can exact much greater leverage and persuasion in trying to fight rising medical and hospital costs than can several million employees and annuitants and 38 insurance carriers scattered around the country. If the Federal Government were paying 100 percent of the premiums, it would be much more conscious of constantly rising medical costs.

Combined with its medicare program, a Federal interest in the cost of hospital and medical care could exert a strong influence in working to keep costs down. As things now stand, the Government's cost is relatively fixed, rising only as additional employees are brought into the system. Thus, it has little incentive to control costs. Those most interested in controlling costs—the employees and annuitants—are the ones with the least clout. Even the carriers and employees and annuitants together cannot approach the Federal Government in real power when it comes to controlling runaway hospital and medical costs.

Merely because he is a Federal employee a person should not be the underdog when it comes to health and medical coverage. How can it look when an employee of the Government of the richest Nation on earth is lagging behind so many others in fringe benefits? Too, the Federal employee is not even in a position where he can bargain collectively to obtain such a benefit as total payment of health insurance premiums. Instead he must petition Congress through unions and other employee organizations, and hope that Congress will feel sympathy for his plight and grant the benefit which he seeks.

Since the administration will not show leadership in trying to provide greater benefits for its employees in the form of 100-percent premium payments by the Government, the credit for such leadership must go to Congress; more specifically, to the chairman of this subcommittee, who has introduced the legislation now being considered.

The Civil Service Commission only was able to react, not take the first step in this important area. The administration offered its plan only after Representative Daniels began hearings on his bill promising full premium payment by the Federal Government. That Congress

should have to be the leader in proposing this legislation is clearly a sign that the Federal Government's top personnel agency, the Civil Service Commission, is far behind not only Congress in progressive thinking, but behind much of private industry.

Total Federal payment of health insurance premiums is not a crumb to be dropped by a generous Congress before Federal employees. It is something they deserve for their loyalty and hard work. It is something they have earned.

Nothing less than a 100-percent Government contribution to premium costs can adequately compensate for the past burden of high insurance premium costs, but help also in a small way for the failure of the Government to provide salary comparability.

That health insurance is an absolute necessity cannot be doubted. Unless one is wealthy, a major illness can consume all of one's income besides using up one's savings.

Few, if any, employees can afford not to have health insurance, yet the point may be approaching when some employees cannot afford health insurance, or at least the option they should have to assure peace and adequate protection in the event of major illness.

Thank you, Mr. Chairman.

Mr. Chairman, that concludes my prepared statement. I would like to add one point.

Mr. DANIELS. You are permitted to do so.

Mr. WHITNEY. Thank you, sir. I just wanted to note that yesterday our association presented to the leaderships in both the House and the Senate and to the President a proposal for the establishment of what we have called a Federal Salary and Fringe Benefit Authority.

What we contemplate is that there would be established an authority which would have regulatory power over the setting of both Federal wages and salaries and also the fringe benefits such as retirement, health insurance and life insurance. It is our feeling in proposing the establishment of such an authority that a major factor in the situation which we have today, where the Federal employee does lag behind the private sector in virtually all of these areas is because year in and year out the administration and the legislative branch engage in a tug of war, the Congress on the one hand trying its best to provide what in its view are adequate benefits and adequate salaries and wages for the Federal worker, the administration on the other hand, primarily in the person of the Bureau of the Budget, doing its best to hold down the costs of any such benefits to the lowest level possible. It is our feeling that much of the labor strife which we are experiencing even now in the Federal Government is due to this annual tug of war and the lengthy procedure we must go through in finally achieving benefits, which in the end are perhaps not as much as the employees feel they should receive and perhaps not as much as the Congress feels they should receive.

It is our feeling that by establishing this authority we would be able to eliminate this extraneous factor. The authority as we envision it would consist of two Members of the U.S. Senate, two Representatives from the U.S. House of Representatives, one from the Executive Office of the President, one from the Bureau of Labor Statistics in the Department of Labor, and four from the Government labor move-

ment; and these individuals on the authority, from among themselves, would elect a nonvoting chairman.

Our reason for not confining the regulatory authority of this body to Federal wages is that we feel much more attention and much more thought must be given to considering the total package in terms of real income to the Federal employee. In other words, we can't isolate wages and treat them totally apart from the cost of health insurance premiums, life insurance and the retirement contribution which the employee makes on the biweekly basis. That concludes my statement.

Mr. DANIELS. I assume this plan to which you have referred, was submitted yesterday at the conference taking place with the heads of the various employee organizations who are meeting with the Secretary of Labor for the purpose of settling the present postal strike.

Mr. WHITNEY. No, sir. This was presented by messenger. No non-postal are involved and, as a matter of fact, even some postal unions are not engaged in the discussion with the Secretary of Labor. We were not present.

Mr. DANIELS. So, it was sent to the President by private messenger.

Mr. WHITNEY. Yes, sir, and also the speaker of the House and the majority leader.

Mr. DANIELS. Would this authority to which you refer be independent of the Civil Service Commission?

Mr. WHITNEY. It would, sir. We think a great deal of study, of course, is necessary to determine just how it would be structured and how it would be enabled, but we think of it generally in terms of having regulatory authority similar to that which now resides in, for example, the CAB with regard to commercial airline passenger rates. We realize this would take legislation, very broad legislation—we consider it a reform measure—which would provide that this authority annually would conduct public hearings and in this legislation Congress and the executive branch, in effect, would agree that the findings of the authority would be implemented annually and would be based on surveys annually in all of these various areas which it would have authority over.

Mr. DANIELS. In addition to serving on this committee I serve on the Education and Labor Committee and, no doubt, some form of legislation will be emanating from our committees dealing with this problem. I would be very much interested in your plan and if you have an extra copy of it I would like to have it.

Mr. WHITNEY. We will be glad to furnish it.

Mr. DANIELS. I want to thank you for your testimony. I am very much interested in what you have to say. I have no questions.

I recognize my colleague from Virginia, Mr. Scott.

Mr. SCOTT. Let me join you, Mr. Chairman, in welcoming our witness, Mr. Whitney and Mr. Kaplan, who is with him.

You know there are several passages in your testimony, Mr. Whitney, that I have reservations about. One is where you indicate the plight of the Government employee and his working conditions not being comparable to that of private industry. Of course, this committee is interested in the Government employee and that is the purpose of having the committee.

I did appreciate your favorable comments about our chairman and I share those and do commend him for taking the leadership in sponsoring this bill. So, I would agree with you in that respect. But this has been to a large extent nonpartisan in that members from both sides, both of the major political parties, are interested in the welfare of Government employees. And I expect that I represent more Government employees or as many as any Member of the Congress, being from nearby Virginia and I have people coming in and out of my office all the time seeking Government jobs. These are people in private industry that want to get in the Government and I just wish that I could help them get Government jobs. So, if it was as bad as you picture it I wouldn't have all of these people coming in.

Let me ask you how old is your organization?

Mr. WHITNEY. As the full fledged labor union, we are approximately 8 years old.

Mr. SCOTT. What is your approximate membership?

Mr. WHITNEY. Approximately 168,000.

Mr. SCOTT. Where is your primary base? Where do your members come from?

Mr. WHITNEY. They come from virtually all departments and agencies. I would say in terms of absolute numbers our greatest membership is in the Department of Defense. However, we represent the Weather Bureau, 8,000 air traffic controllers in FAA, VA hospitals, and so forth.

Mr. SCOTT. Are your headquarters here in Washington?

Mr. WHITNEY. That is right.

Mr. SCOTT. Do you have locals throughout the country?

Mr. WHITNEY. We have in excess of 1,000 locals throughout the country.

Mr. SCOTT. In how many States?

Mr. WHITNEY. Virtually all of the States.

Mr. SCOTT. Another thing, Mr. Whitney, I would like to comment on and that is your criticism, and it is criticism, of Chairman Hampton of the Civil Service Commission. Chairman Hampton, I believe, is as good a friend as the Government employee has. You know he doesn't have free rein. Even the President of the United States doesn't have free rein to operate this Government. We have all kinds of overlapping departments, bureaus, and the chairman just referred to the fact that he serves on two committees here in the House. We perhaps have more Government agencies than we should have. Books have been prepared about overlapping. Mr. Hampton can't do all of the things that he would like to do. As you brought out in your testimony, to an extent his attempts are restricted by the Budget Bureau and by the overall Government activities.

I just think any attack on Chairman Hampton is unwarranted and I am criticizing your prepared statement, despite your valiant attempt at tempering those remarks during your oral presentation.

Mr. WHITNEY. If I may clarify, I would like to say first, I have known Mr. Hampton since 1964 and I have counted him as a friend since that time. I personally think there is no one individual in the Federal Government, especially in the upper regions of the bureaucracies, as fair in his attitude toward the conditions under which the

Federal employees must work, the pay structure, fringe benefits, local working conditions, and the quality of supervision they must work under.

I think it is very unfortunate, and I would certainly apologize at great length, if we somehow conveyed the impression we were personally criticizing the Chairman of the Civil Service Commission. Mr. Hampton is the last executive branch official we would criticize on a personal basis.

In my added remarks I hope I made it clear that what we are unhappy with is—and this reflects the feeling of the membership, I believe—the tenor of public statements which have been made by the administration; the proposal, for example, to put off the July 1 pay raise until January 1 when even the administration itself issues data which shows the Federal employees on July 1 deserved an average of 5.7 percent in pay raises to bring them up to private industry.

Our people know, because we have educated them, that the data on which the Government relies in developing pay scales is quite a bit out of date. For example, the data which the Commission used and the Bureau of the Budget used in developing the scales which showed the need for a 5.7-percent average increase on July 1, much of the data which was collected resulting in those figures is 12 to 18 months out of date. Additional increases have taken place in these areas over that intervening period. In many cases we think, if the facts were known, up-to-date data would indicate that a 13- to 14-percent increase in pay is called for this July 1. So, I am speaking of the mood of the Federal employees as they see things transpiring and as they also see substantial gains taking place in the private sector as a result of very tough bargaining by very strong unions among the major industries in the private sector.

Mr. SCOTT. Mr. Chairman, if the witness in any way by "tough bargaining" has indicated Government employees going on strike, let me advise him it is not in the interest of the Government employees to go on strike, because I have talked with various Members of the Congress and I think it is just so overwhelmingly repugnant to the American way of settling matters that the Government employee is not going to profit from any such thought as this.

Let me say I have probably worked with the Government a great deal more years than the present witness. I am in my 30th year of Government employment, and I have held some of the very menial jobs as well as some of the top jobs in the executive branch of the Government and do understand the Government employee's problems. The Members of Congress are committed to full comparability of pay and working conditions, and we share the thought that you have just expressed that the Bureau of Labor Statistics' figures are roughly a year out of date. They are behind, and for my part, I will support a revision in pay as of the first of July. So, you have friends on this committee and in the Congress generally.

The real point of what I am saying is, just be sure that your criticism is warranted and not just a broad brush criticism or getting into personalities such as criticizing the Chairman of our Civil Service Commission. I think he is just a splendid man and is doing the best possible job.

Mr. WHITNEY. I hope I made it clear I agree with you.

Mr. SCOTT. I appreciate your clarification.

Mr. DANIELS. I would like to join in your remarks, Mr. Scott. In the short period of time it has been my pleasure to know Chairman Hampton I have drawn the conclusion that he is a wonderful man, and I have the highest regard and respect for him. I think he is a very reasonable man, too, and he seems to understand the problems of the employees to a much greater extent than some other Government administrators.

Mr. WHITNEY. I wholeheartedly support that view, Mr. Chairman. If I could respond to one point Mr. Scott made—

Mr. DANIELS. We are not going to get into a fight and bring the strike situation in here, but I do want to ask one question with reference to it. I saw something in the paper this morning about the air traffic controllers being involved yesterday in a slowdown.

Mr. WHITNEY. They refer to it as a "sick-out."

Mr. DANIELS. That is a new expression. We hear them every day.

Mr. WHITNEY. It is a euphemism for a strike.

Mr. DANIELS. Are the members of that group of air traffic controllers members of your organization?

Mr. WHITNEY. I couldn't say categorically that none of them are because there are joint memberships among the three major groups that represent them. But I can say unequivocally that we went to great lengths in contacting our national representatives and local officers around the country in the 2 or 3 days leading up to yesterday's activity and advised them that what this rival organization was urging them to participate in constituted, whatever else they called it, a strike, a withdrawal of services, and telling them this is patently illegal and a violation of law and a violation of Executive Order No. 10491, and we urged them to report to work.

I would like to think we played a part in the fact the threatened sick-out for the most part has fizzled. In other words, where they are claiming something on the order of 5,000 traffic controllers would yesterday not report for work—as a matter of fact, about 450 air traffic controllers did not report for work and called in sick—I would like to think that our representations to the controllers had something to do with that fact.

I would also like to point out—and this is to the point I believe—that our national president, Kenneth T. Lyons, is quoted this morning in no less than three major newspapers—the Wall Street Journal, the New York Times, and the Washington Post—as stating flatly that the National Association of Government Employees opposes strikes in Federal service. We have made this very plain.

I must admit it has given us some tough moments with our own membership because they do have valid grievances, and we are doing all we can in the framework of the law and of the Executive order to achieve redress of these grievances.

Yet, there is a great deal of unrest not only among air traffic controllers but among other categories as well, but this association, for one, will not condone illegal activity in the Federal Government.

Mr. DANIELS. Secretary of Transportation Volpe says their grievances are exaggerated. Do you agree with that statement?

Mr. WHITNEY. I am not sure whether Secretary Volpe is referring to the specific allegations of the professional air traffic controllers' organization or if he is saying the complaints which our organization has made in behalf of the air traffic controllers are exaggerated. If he is implying the latter, I would have to disagree very strongly. The NAGE contends, and even the administration itself admits, that the air traffic controller work force is drastically understaffed.

Last summer we made a personal representation to the head of the Agency asking him somehow to come up with additional funds to provide for payment of overtime staffing of the Washington Center because controllers were working as many as 12 to 14 hours consecutively on the radar scopes. Air traffic since then has not decreased, if anything it has expanded, so the situation is worse today than it was a year ago when we made the representation. We do feel early retirement is justified for air traffic controllers.

Mr. DANIELS. You made reference to the expression "withdrawal of services" by the air traffic controllers. Do you make a distinction between that expression and the term "work stoppage," and is there any difference between those two expressions and the word "strike"?

Mr. WHITNEY. I think that the effect of whatever action is taken, if it results in a close down or partial inhibition or total inhibition of an agency mission, that whatever else it is called, it is nothing more than a euphemism for the word strike. I contend the organization engineering this activity is simply trying to cloud the issue.

Mr. DANIELS. Thank you, sir.

Are there any further questions?

Mr. SCOTT. Since I have been critical of some of the statement, let me commend the witness with regard to the statement on page 5 regarding the contribution of the Government and the employees to the health program, and after all, that is the subject of our hearings today. My own thought is that there should be a 50-50 contribution regardless of whether the employee elects to use the high option or the low option. Leave it in his discretion. It is that way now on the high or the low option. But not base the Government's contribution on one option or the other but just say to the employee "You choose what you want and then you pay 50 percent of it and the Government will pay 50 percent."

I know many employees, perhaps your own union, would like for the Government to pay 100 percent. But when we get to 50 percent we are going in the direction, I am sure, that you would have us go.

Mr. Chairman, there is one further thing that just came to my mind. There was a statement I heard on the radio going home last night to the effect that in the package agreement with the postal workers there was a provision that the Government would pay a hundred percent of health benefits for the postal workers. I don't know who made that statement, if it was made. It was reported over the radio. But if it was made, in my opinion, it was made without any authority because that is the very purpose of this hearing that we are having now. It may be this committee will agree to that, I don't know, but it is certainly premature for anybody to make any statement as to just what we are going to do in the field of health insurance.

Thank you, Mr. Chairman.

Mr. DANIELS. With regard to the last statement, I might say as a member of this committee that subject of health benefits is not within the confines of the conference that exists between the House and the Senate on salary legislation. Whatever agreement is effected by the conference committee has to be within the limitations of the bill passed by the House and the substitute adopted by the Senate, and there is nothing, to my knowledge, in H.R. 13000 dealing with the question of health insurance premiums.

Mr. WHITNEY. If I may clarify, we heard the same report and it is my understanding that statement was made by a local postal union president in New York City.

Mr. SCOTT. The source is a local postal union president?

Mr. WHITNEY. Yes.

Mr. SCOTT. Thank you, and thank you for your testimony.

Mr. DANIELS. Thank you, Mr. Whitney.

Our next witness is Mr. Raymond D. Vanderhorst, president of the National Association of Agricultural Stabilization and Conservation Service County Office Employees.

STATEMENT OF RAYMOND D. VANDERHORST, PRESIDENT, NATIONAL ASSOCIATION OF AGRICULTURAL STABILIZATION AND CONSERVATION SERVICE COUNTY OFFICE EMPLOYEES, ACCOMPANIED BY CLYDE R. PAYNE, SECRETARY-TREASURER; AND ROBERT L. SCALES, VICE PRESIDENT

Mr. VANDERHORST. Thank you, Mr. Chairman and distinguished members of this committee.

I am Raymond D. Vanderhorst, president of the National Association of ASCS County Office Employees, better known as NASCOE. We certainly appreciate this opportunity to appear before you today in support of health benefits legislation.

I have with me today, Mr. Clyde Payne, our secretary-treasurer on my right, who has a short statement he would like to file for the record, and on my left is Mr. Scales, vice president of our national organization. Also Mr. Dillard Lassiter, our legislative representative here in Washington has accompanied us.

NASCOE is a voluntary organization of county office employees who carry out various Federal farm programs, assigned to them by the Congress and the Secretary of Agriculture. The headquarters for ASCS is in the U.S. Department of Agriculture here in Washington, D.C. There are also State and county ASCS offices in each State that administer only these Federal farm programs.

There are approximately 3,000 county ASCS offices in the United States employing in excess of 14,500 employees of which over 14,000 or 97 percent belong to NASCOE. So, you can see why we are proud of our membership and organization.

While county ASCS employees are technically employed by the county ASC committees, all of our functions are Federal. The Congress in its wisdom, put us under the Civil Service Retirement Act, the Federal Employees Group Life Insurance Act, and the Federal Employees Health Benefits Act, effective July 10, 1960. For this, we are eternally grateful.

NASCOE feels that the Federal Government is presently paying a disproportionate share of the health benefits program when compared to a very large segment of private industry, many of which are paying the total cost of the program.

Federal employees are presently paying about 77 percent of health insurance premiums while employees in private industry are paying only 15 percent on the average. We believe the Government should pay a share at least equal to the average in private industry; however, we will leave the percentage amount to the wisdom of this committee and the Congress as a whole.

I realize I have a short statement, but someone told me you like short statements. So, I will say in conclusion, Mr. Chairman, we appreciate the opportunity to present this testimony and wish to commend you for your efforts to more equitably share the cost of the health benefits program.

Mr. DANIELS. Mr. Vanderhorst, where is the principal office of NASCOE located?

Mr. VANDERHORST. Sir, we do not have an office as such. All of our officers are nonpaid officials who are elected at a national convention that we have each year. We have full-time jobs in our respective county offices administering farm programs. We do all the work that we do in behalf of our fellow employees on our annual leave time, which we are on today.

Mr. DANIELS. Where do you come from?

Mr. VANDERHORST. Oskaloosa, Iowa, in Mahaska County.

Mr. DANIELS. Do you know the distinguished member of our full committee, H. R. Gross?

Mr. VANDERHORST. Yes, sir; I certainly do.

Mr. DANIELS. I certainly appreciate the fact that you traveled such a long distance to come here and give us the benefit of your views.

Mr. VANDERHORST. Thank you.

Mr. SCOTT. Might I comment to the gentleman, commend him on his statement and tell him that a statement, in order to be immortal, does not have to be everlasting. You got your point of view before us.

I would like for the Government to assume a larger percentage of the cost of health benefits and we appreciate having your views.

Thank you, sir.

Mr. DANIELS. Mr. Payne, do you desire to submit your statement for the record?

Mr. PAYNE. Just submit it for the record, fine, Mr. Chairman.

Mr. DANIELS. If there is no objection, your statement will be inserted in the record.

(The prepared statement follows:)

STATEMENT BY CLYDE R. PAYNE, SECRETARY-TREASURER OF THE NATIONAL ASSOCIATION OF AGRICULTURAL STABILIZATION AND CONSERVATION SERVICE COUNTY EMPLOYEES

I am Clyde R. Payne, Hamilton County ASCS Executive Director, Jasper, Florida, and Secretary-Treasurer of the National Association of ASCS County Employees.

The National Association of Agricultural Stabilization and Conservation Service Employees (NASCOE) is a voluntary organization of County Agricultural Stabilization and Conservation Service Employees—hereafter referred to as ASCS employees. Approximately 97% of the 14,000 ASCS employees are members of NASCOE from every county and state. The sole purpose of this organization is

to promote the welfare of its members. Each state has a state organization of ASCS county employees and is affiliated with NASCOE and has two members on the Board of Directors. NASCOE has national officers and an executive committee representing the five geographic areas of the United States. They are:

Area, name, city, and state:

Northwest: Gordon West, Grand Forks, N. Dak.

Southwest: Elmer Cheek, Jr., Carlsbad, N. Mex.

Southeast: Chenault James, Morehead, Ky.

Northeast: Evelyn Yeagle, Collegeville, Pa.

Midwest: Cecil Smith, Harrisburgh, Ohio.

Officers:

President: Raymond Vanderhorst, Bussey, Iowa.

Vice president: Robert Scales, Plankinton, S. Dak.

Secretary treasurer: Clyde R. Payne, Jasper, Fla.

Past president: Woodrow Jones, New Boston, Tex.

All officers, committeemen, etc. are ASCS employees with no salaried personnel, but we do have on a retainer basis Mr. Dillard B. Lasseter, P.O. Box 270, Washington, D.C. 20044, who keeps us advised on legislative activity and assists us in legislative work.

The Agricultural Stabilization and Conservation Service employees administer *Federal programs* assigned to them by the Congress, Secretary of Agriculture, Executive Orders, etc. The headquarters for ASCS is in the United States Department of Agriculture Building, Washington, D.C. There are also state and county ASCS officers who administer *only* Federal programs. City, county or state governments have no connection with the national, state or county level of ASCS.

ASCS employees on the county level administer directly to the farmers of the U.S. a great number of the complex USDA farm programs, such as the Soil Bank, Agricultural Conservation, Marketing Quotas (tobacco, cotton, wheat, peanuts and rice), Commodity Credit Loans, Cropland Adjustment, Wool Incentive Payments, Sugar, Feed Grain, etc. These are practically all the action programs of the USDA.

As you know, County ASCS employees are not under Civil Service. However, we enjoy many benefits of Civil Service employees such as life and health insurance, retirement, severance pay, etc. These benefits have been granted us by your Committee and the Congress within the past ten years.

Our employees are paid entirely by the Federal Government and work entirely under provisions of the Federal Government and are eternally grateful to your Committee and the Congress for past action.

We are here today to respectfully request you to increase the Government contribution for health insurance. We understand in almost all cases private industry pays all or practically all the cost of employees' health benefits. We feel the Government should do for its employees the same as private industry. We do not specifically state the amount of contribution the Government should make on health benefits, but leave the amount to your wisdom.

We appreciate the opportunity to appear before this Committee and the 14,000 county ASCS employees hope you will see fit to increase the amount of Government contribution for health benefits by a substantial amount.

Mr. DANIELS. Our next witness is Mrs. Gloria Riordan, legislative representative of the American Federation of State, County & Municipal Employees.

STATEMENT OF GLORIA RIORDAN, LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES

Mrs. RIORDAN. Mr. Chairman and distinguished members of the subcommittee, I am Gloria Riordan, legislative representative of the American Federation of State, County & Municipal Employees, AFL-CIO.

I regret that our president, Jerry Wurf, who had planned to present this testimony, was unable to get here. He is out of town on an emergency, about which you may have read, in Atlanta. He will not get in until the end of the day—today.

Our union is comprised of 450,000 public employees, including some 7,330 employees of the U.S. Government in the Panama Canal Zone. It is primarily in behalf of these Canal Zone employees that I am here today, although I also wish to express strong support for H.R. 767, Congressman Daniels' proposal to increase the Federal contribution to employee health benefit premiums, in stages, to 100 percent.

There are currently 14,731 employees of the U.S. Government in the Panama Canal Zone, of whom 10,850—or approximately three-quarters—are not citizens of the United States.

Noncitizen employees have constituted the bulk of our Government's work force in the Canal Zone during the digging of the Panama Canal and since its opening in 1914. They have performed loyally and well for the United States.

For many years it has been a matter of extreme irritation on the part of the Panamanians and their Government that we have denied to noncitizen employees many of the benefits of employment accorded Federal employees who are U.S. citizens. Such unequal treatment is in direct contravention of repeated promises of equality which have been made by our Government to the Republic of Panama and represents a constant source of anti-U.S. feeling among Panamanians.

As early as December 23, 1908, 6 years before the canal opened, the Secretary of War issued an order declaring as a matter of public policy that the principle of equality of opportunity and treatment would be maintained. The policy was restated by Executive orders issued on February 2, 1914, and again on February 20, 1920.

In 1936, 1955, and, more recently, in 1963, the U.S. Government assured the Republic of Panama that this was still its position.

In connection with the treaty negotiations of 1936, the United States Government forwarded a note to the Republic of Panama stating:

Regarding Panamanian citizens employed by the Panama Canal or by the Panama Railroad, I have the honor to state that the Government of the United States of America, in recognition of the special relationship between the United States of America and the Republic of Panama with respect to the Panama Canal and the Panama Railroad Company, maintains and will maintain as its public policy the principle of equality of opportunity and treatment set down in the Order of December 23, 1908, of the Secretary of War, and in the Executive Orders of February 2, 1914, and February 20, 1920, and will favor the maintenance, enforcement or enactment of such provisions . . . as will assure to Panamanian citizens employed by the Canal or the Railroad equality of treatment with employees who are citizens of the United States of America.

In 1939, President Franklin D. Roosevelt asserted his determination to implement the declaration of parity in Canal Zone employment practices. On the occasion of the signing of a law authorizing new construction in the Canal Zone, the President stated:

I intend * * * to ask Congress in its next session to amend the present law so that it may conform with the obligations acquired in respect to Panama, to concede to the citizens of Panama opportunity and treatment in employment for the Canal Administration and the Panama Railroad Company equal to that offered to those who are citizens of the United States.

The promise of parity was again made in 1955. In that year the United States concluded a new treaty with the Republic of Panama. In connection with those negotiations the U.S. Government transmitted to the Republic of Panama a memorandum of understandings in which the following promise was made:

The United States will afford equality of opportunity for citizens of Panama for employment in all United States Government positions in the Canal Zone for which they are qualified and in which the employment of the United States citizens is not required in the judgment of the United States for security reasons.

In 1963, again in connection with treaty negotiations, our Government reaffirmed the policy in a joint statement with the Government of Panama.

Mr. DANIELS. Who do you refer to when you say "our" Government? Do you mean the Department of State?

Mrs. RIORDAN. Yes. This did come from the Department of State.

Mr. DANIELS. Thank you.

Mrs. RIORDAN. Dated August 2, 1963, it reads:

The United States Government has prepared a draft bill for presentation to the Congress of the United States which would make available to Panamanian employees of the United States Government in the Canal Zone the same governmental health and life insurance benefits as are available to the United States citizen employees.

Despite repeated lipservice to equal treatment in the Canal Zone, equality has not yet been achieved, although some progress toward that objective has taken place.

Noncitizen employees are today covered by a retirement program. Increasingly, noncitizens are being placed in positions of responsibility, positions which in the past were open only to U.S. citizens.

Many inequities remain, however. Unlike citizen employees, noncitizens are still denied health insurance and life insurance. Bills which would extend such coverage to foreign national employees in the Canal Zone are pending before your subcommittee, sponsored by Congressman Nix (H.R. 9136), Molloy (H.R. 9751), Olsen (H.R. 9757), and Eckhardt (H.R. 9924). I would hope that they will have the support of the members of this subcommittee.

I have been at a loss to understand why the Congress has shown such reluctance to extend to these loyal employees such basic benefits of employment.

It cannot be argued that the outlay will throw the Federal budget out of balance. On the contrary, all costs of canal operation are covered by canal receipts. The Panama Canal Company, for fiscal year 1969, reports net operating revenue of \$15,566,098—after payment to the U.S. Treasury of operating costs and interest payments on the U.S. investment.

The Panama Canal Company informs us that the annual cost of extending health and life insurance benefits to noncitizen employees is estimated as follows:

1. Coverage of noncitizens under the Federal Employees' Health Benefits Act of 1969	\$1,500,000
2. Coverage of noncitizens under the Retired Federal Employees' Health Benefits Act of 1960	200,000
3. Coverage of noncitizens under the Federal Employees' Group Life Insurance Act of 1954	250,000
Total	1,950,000

The total annual expenditure for health and life insurance benefits, if applied to today's work force, would come to less than \$2 million, an amount which can be covered without any stress out of net operating revenue of the Panama Canal Company and the Canal Zone government.

We believe that when this subcommittee reviews our Government's employment practices with respect to three-quarters of its employees in the Canal Zone, it will want to rectify the inequities—from the standpoint of wise and decent employment practices, as well as from the standpoint of living up to our international commitments.

We Americans like to think of our Government as leading the way in matters affecting the welfare of individuals. It therefore comes as something of a disappointment when we observe the Federal Government trailing far behind private employers and a substantial number of the States and cities in respect to health benefits for its employees.

I will not cite the statistics of health benefits coverage in private employment because I understand you have already received testimony on that. But I would like to give you examples of locations in which we have contracts with public employers, State, local, and county, which are paying full costs right now of health benefits for their employees.

These would include Detroit, Milwaukee, Dayton, Houston, New York City, and New York State.

The State of Michigan pays 90 percent and Massachusetts pays 75 percent, but both of these latter programs include major medical as well as plus all costs for dependents.

We join with our fellow AFL-CIO Government unions in urging this subcommittee to approve H.R. 767, with coverage for noncitizen employees in the Panama Canal Zone. While congressional approval of this measure is pending, we further urge you to seek amendments to existing legislation to extend life and health insurance to non-citizen Federal employees in the Canal Zone and health benefits to retirees.

For the Congress of the United States, this package of employee benefits for noncitizens in the Canal Zone is a small matter without impact on the Federal budget. But for 10,850 individuals and their families, it is a matter of great magnitude.

They are looking to you for some of the security which most of us in the United States have long since come to expect as a fundamental condition of employment.

Mr. DANIELS. Thank you, Mrs. Riordan, for your testimony.

If I may refer to your statement on page 4, you point out that in 1955, under the treaty made by the United States with the Republic of Panama, the United States would accord equality of opportunity to citizens of Panama for employment in all U.S. Government positions in the Canal Zone.

Subsequently, the agreement was implemented by a statement in 1963 whereby the U.S. Government would grant to noncitizen employees the same governmental health and life insurance benefits that were made available to the citizen employees of the United States, is that correct?

Mrs. RIORDAN. Yes.

Well, the equality of opportunity for employment is not exactly the same as the equality of health benefits and other fringe benefits. I was simply tracing the numerous promises of equality in the various aspects of employment opportunity and benefits which have been made to the Panamanians.

Mr. DANIELS. Referring to page 6 of your statement, where you set forth the estimated annual costs of extending life and health insurance benefits to noncitizen employees, you have some figures there which total to an estimated cost of \$1.950 million.

Is that figure based upon the present contribution that the Government is making of approximately 24 percent?

Mrs. RIORDAN. Yes.

Mr. DANIELS. Or is it 38 or 100 percent of total contributions?

Mrs. RIORDAN. It is based on the percentage contribution which is in effect now. These are estimates made by the Panama Canal Co. on the basis of their present employment and present percentage of the Federal contribution.

Mr. DANIELS. Take item 1, which specifically states: "Coverage of noncitizens under the Federal Employees' Health Benefits Act of 1959", you have the figure \$1.5 milion. Does that apply to the present active work force?

Mrs. RIORDAN. Yes.

Mr. DANIELS. Item No. 3, coverage of noncitizens under the Federal Employees' Group Life Insurance Act of 1954, the figure there is \$250,000. Does that apply to your present active work force, too?

Mrs. RIORDAN. I am assuming so. These were the figures I asked for and these are the ones I received. So I am assuming this does.

Excuse me, Mr. Chairman, does it appear to you there is some incongruity?

Mr. DANIELS. No; I just wanted to make sure it is clear for the record, for anyone reading the record to have the right figures.

Do the noncitizen employees have health insurance of any kind today?

Mrs. RIORDAN. They have the opportunity to participate in a group plan for which they pay 100 percent.

Mr. DANIELS. No Government contribution?

Mrs. RIORDAN. There is no Government contribution at all.

Mr. DANIELS. How do their contributions compare to that of the Federal employees?

Mrs. RIORDAN. I am sorry; I am not conversant with that. I do not know.

Mr. DANIELS. In substance, what you are seeking is that the agreement which implemented the 1955 treaty with reference to Government health and life insurance coverage be extended to the non-citizens employees in the Canal Zone?

Mrs. RIORDAN. Yes.

Mr. DANIELS. Now that matter was presented to Chairman Hampton when he appeared here and testified last week. He gave the impression to the Chair that he would look upon that favorably. However, we have a question now of some agencies of the Government having jurisdiction in the subject matter.

While I personally look favorably upon your request that these noncitizens be covered, I am going to ask the opinion of the Department of State.

I would like to find out what their position is on the matter. I hope they will endorse the views that you have expressed and which Chairman Hampton has expressed.

Mrs. RIORDAN. Thank you very much, Chairman Daniels.

Mr. DANIELS. If we do get a favorable report from the Department of State, I promise you now that I will recommend that to my colleagues on the committee when we meet in executive session to mark up the bill.

Mrs. RIORDAN. Thank you very much.

Mr. DANIELS. Thank you.

The next statement before the subcommittee is that of Congressman James C. Corman. It will be received for the record as though read in full.

TESTIMONY OF HON. JAMES C. CORMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. CORMAN. Mr. Chairman, I appreciate this opportunity to appear before the committee in support of legislation I have introduced to improve the health benefits program for Federal employees.

Early in 1969, I introduced H.R. 9415, which would require the Federal Government to eventually assume the full cost of the health insurance program available to Federal civilian employees under a three-phase formula: The Government's present contribution to the program to be increased to 50 percent in July 1969; to 75 percent in July 1970; and to eventually assume the responsibility for payment of the total cost in July 1971. Since 1 year has already passed, the dates must be changed to reflect appropriate years.

There is ample justification for this proposal. As the cost of medical care rises, so do the premiums for health insurance. However, the Congress has provided that the Federal Government pay only a fixed dollar amount, which leaves increases in premiums to be borne by employees. And, the cost of these premiums for employees has become insupportable.

When the Federal employees health benefits program was being established, it was contemplated that the Federal Government would pay approximately one-half of the cost of the premium. The assumption was that most employees would opt for the low- rather than for the high-benefit plans. However, the great majority (85 percent currently) of employees chose the high benefit option and the Federal Government's share of the cost was about 38 percent when the program went into effect in 1960.

Since medical costs have continually soared, the Government's contribution in 1966 was increased by 33 percent in order to restore the ratio which had existed when the program was inaugurated. Also, due to a greater awareness on the part of our citizens of health care, health services are being used more extensively. Consequently, the rising cost of medical care has resulted in Federal employees paying

an average of 72 percent of the cost of their premiums. For instance, in 1960 the premium for the Blue Cross high option was \$19.37. The current premium is \$38.33, or 199 percent of the 1960 premium. Aetna's high option premium, which was \$17.46 in 1960, is now \$44.94, or 257 percent of the 1960 premium. As a result, the Federal Government now pays 28 percent of the total cost of the program rather than the 38 percent it paid in 1960 or the 50 percent which was contemplated as the Federal payment when the program was established.

These figures point out a steadily deteriorating situation and demonstrate the urgency of relieving Federal employees and retirees of the totally unfair burden of bearing the major share of constantly spiraling medical costs. My approach to the problem would be to have the Federal Government eventually pay the total premium for active and retired personnel as provided in my bill.

In matters concerning Federal employees, we have been striving for many years to match the goals that industry has already reached. This is the principle of comparability about which we beat the drums each time a statutory pay raise for Federal personnel is contemplated. At each enactment, we magnanimously state that "these increases have done much to close the gap between compensation for Government employees and those in private industry." We may have closed the gap in compensation—at least for the time being—but other fringe benefits, such as retirement and health insurance, still lag far behind.

A 1968 study, "Benefits for Active and Retired Workers Age 65 and Over," by the Department of Labor indicates that approximately 85 percent of private employers who provide health insurance for active or retired employees pay the full premium. If comparable treatment were afforded Federal employees it would be especially meaningful to retired civil service personnel. These are the persons who bear the added burden of living on fixed retirement incomes at a time when the mere contemplation of retirement causes grave concern. Without the availability of medicare benefits, the Federal program, which is their only assurance of health care protection, costs more than a retiree should have to bear.

Mr. Chairman, I also want to refer to another bill that I recently introduced to liberalize the Government's health insurance program. While not to be considered a specific alternative proposal to H.R. 9415, my second bill provides for a liberalizing clause which I have always felt should have been included in the original legislation.

My proposal would authorize the election of health benefits coverage by employees and annuitants for themselves and their spouses at a special rate based on coverage of two persons; in effect, establishing a third category of coverage.

My objective is to again assist the retired Federal employee, although its need is certainly as justified for the active employee. The proposal works in a simple manner. Let us take a hypothetical case: A young man presently entering Government service is enrolled in the "self only" category, at a monthly cost to him under the high option Aetna plan of \$14.47, the Government paying \$3.64. Should he marry, he would convert to "self and family" and remain there through retirement regardless of any increase or later decrease in his family status with, at present rates, his contribution being \$36.06 a month; the

Government paying \$8.88. There is quite a gap between \$14.47 and \$36.06.

Under the provisions of my proposal, this same young man would convert at marriage to "self and spouse" category at a cost somewhere between these two figures. Should his family status change to include a child, he then changes his enrollment to "self and family," at a higher premium. Should he remain in Government until his children are independent, he could convert to the status of "self and spouse," and remain there through retirement, at a considerable savings to himself.

My proposal calls for contributions in the new category to be based on a simple formula, rather than merely doubling the cost of the "self only" category, because this latter addition, in low option plans, would result in only a few cents increase in the Government contribution and very little savings to the employee.

I believe that the provisions of H.R. 16468 are not only fair and equitable to all Federal employees, but extremely important to those who are retired or facing retirement.

Mr. Chairman, there is no doubt that the time has come for the Congress to liberalize health benefits for Federal employees, both active and retired. There is no group that deserves more consideration from Government than those who have made public service a lifetime career. Retirees, living on retired income, are certainly in no position to meet the costs of present-day medical care. In many cases, they have great difficulty in meeting the increased cost of premiums for health protection plans. The Congress must give special and immediate attention to this problem.

I would ask the committee first to consider my proposal to permit the Federal Government to join the many private enterprises that provide completely free health insurance for their employees during their active employment and throughout retirement years.

Should this proposal not meet with favor, and the committee decides to only increase the Government's share of the cost of health benefits program, I would ask the committee to consider adding another enrollment category to the existing program. In this way, at least those who are retired will benefit from the reduced cost of premiums that my bill will provide.

Thank you.

Mr. DANIELS. The next statement before the committee is from Hon. Robert W. Kastenmeier. It will be entered in the record as though read in full.

TESTIMONY OF HON. ROBERT W. KASTENMEIER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. KASTENMEIER. Chairman Daniels and members of the subcommittee, I very much appreciate the opportunity of presenting this statement on behalf of your chairman's bill, H.R. 767 and the identical bill which I have sponsored, H.R. 12580. As you well know, this legislation would relieve employees and annuitants of the disproportionately large share of the premium charges under the Federal employees' health benefits program, by requiring that the Federal

Government progressively increase its contribution until it eventually assumes the entire cost of the program.

There are two overriding factors which have persuaded me of the urgency of this legislation, including the rising cost of medical care and the extent to which firms in the private sector fund plans to insure their employees against the high costs of medical care, including hospitalization and surgery. In addition, the recent postal strike, although to a certain extent resulting from problems that are peculiar to the Post Office Department, strongly dramatizes the fact that Federal employees in the lower paid groups, and this includes the vast majority of postal workers, are particularly in need of relief that this legislation would offer.

When first enacted in 1959, the Federal health benefits law provided for a Government contribution which would be set by the Civil Service Commission within a specified range of not more than 50 percent of the least expensive low option offered by the two Governmentwide plans. The Government contribution was thus geared to paying one-half the premium for a package of benefits which, while moderate in cost, would be adequate for the needs of most employees. The initial distribution of enrollments between self only and family coverage, between high and low options, and among the various plans resulted in the Government's contributing approximately 38 percent of the aggregate premium for all enrollments, with employees and annuitants contributing the remainder. By 1966, the Government's share of the cost of health benefits had declined from 38 percent to less than 30 percent of the total premium. Public Law 89-504 had the effect of restoring the Government contribution to its initial level of 38 percent of the aggregate premium, but premium increases in 1967, 1968, and 1969, have again diminished the Government contribution to approximately 27 percent of the aggregate premium. As I pointed out earlier, this constitutes a much greater burden for all Federal employees, but it has a particularly great impact on those in the lower pay grades and levels, including, of course, the great majority of those in the postal service.

In any case, Federal employees are paying an extremely disproportionate share of the cost of their alternative health plans, at a time when the trend in private industry has definitely been toward the assumption by the employer of the full cost of employees' health insurance programs. Many large employers—and the Federal Government is the largest of all—now carry the full cost and many small employers pay at least half of the cost of their employees health benefits premiums.

In fact, according to statistics appearing in the February 1970, Monthly Labor Review, at the end of 1968 an average of 57.2 percent of the production workers in metropolitan areas had employers who bore the full cost of a broad range of health and life insurance benefits. Of those classified as office workers, 42.7 percent were similarly covered.

In addition to the fact that significant numbers of employers are now paying the full cost of their employees' basic health and life insurance coverage, all of us realize that medical expenses themselves have increased tremendously during the past 10 years. Using a base

period of 100, the cost of living itself has risen from 103.1 in 1960 to 127.7 in December 1969. During the same period, however, medical care has increased from a 1960 level of 108.1 to the 1969 figure of 155. In other words, while the cost of living has risen 23.9 percent from 1960 to 1970, medical costs, as a separate item have risen 30.4 percent.

This, of course, has put a very great burden on Federal employees, as well as on the entire consumer public. Unless appropriate action is taken by Congress to relieve Federal employees of a substantial part of this burden, the problem will continue to accelerate, particularly for older employees and annuitants whose limited incomes make them particularly tragic victims of the high cost of medical goods and services.

It is time for the Federal Government to set the standard for employees' health benefits programs. A convincing case exists for the full payment of the costs of such a program by the Government, and there is more than ample justification for the enactment of this legislation now, and not at some future date. I do not subscribe to the argument that such expenditures are out of the question because of budgetary considerations. It is time that we stop subsidizing the arms race and the defense industry, and start directing our energies toward the solution of the human problems of our individual citizens. The legislation under consideration is particularly appropriate since Federal employees are usually the first to be asked to make the sacrifices perpetually required of our domestic sector.

I need hardly add, Mr. Chairman, that I most urgently support affirmative action on the pending legislation. I thank the committee for its time.

Mr. DANIELS. The subcommittee will adjourn subject to the call of the Chair.

However, I wish to announce publicly that the record will be kept open for the next few weeks for the receipt for any additional statements of interested parties.

(Whereupon, at 11:49 a.m., the committee adjourned, subject to call.)

(The statements and letters which follow were received by the subcommittee for inclusion in the record:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 8, 1970.

HON. THADDEUS J. DULSKI,
*Chairman, Post Office and Civil Service Committee,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: It is my understanding that your Committee has under consideration Congressman Daniel's bill, H.R. 767, to amend the law pertaining to retirement, insurance, and health benefits for federal employees. In view of your Committee's interest in improving the law and finding more equitable solutions for these benefits, I would appreciate that your Committee also consider incorporating my bill H.R. 8511 into Mr. Daniel's bill, H.R. 767.

As the Committee knows, federal employees, annuitants, and their dependents who participate in federal health benefits plans are penalized under present law. My bill, H.R. 8511, is designed to correct the inequity in existing law that permits federal employees and retirees to pay twice for health benefits provided for under the existing Federal Employee Health Benefits Program and under the Health Insurance Program for the aged under the Social Security Act.

Under provisions of my bill 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.

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.

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.

I testified on this matter before the Committee during the hearings on H.R. 6351, 90th Congress, on July 10, 1968. My testimony for the Committee's information is contained on page 39 thru page 45 in the Committee document, Serial No. 90-40.

I appreciate the opportunity to make my views known to you on this matter and request this letter be made a part of the record of the hearings on H.R. 767.

With warmest regards, I am,

Sincerely,

JOEL T. BROYHILL,
Member of Congress.

STATEMENT OF BREMER EHRLER, POSTMASTER AT LOUISVILLE, KY., AND PRESIDENT
OF THE NATIONAL ASSOCIATION OF POSTMASTERS OF THE UNITED STATES

Mr. Chairman and members of the committee, my name is Bremer Ehrler and I am the Postmaster at Louisville, Kentucky. I am also President of the National Association of Postmasters of the United States, representing ninety percent of all postmasters on active duty. Also included among our membership are a large number of retired postmasters who, like postmasters, have a great interest in the subject of these hearings—health benefits programs.

First, Mr. Chairman, on behalf of the members of the Association I am proud and privileged to represent, the postmasters of the United States, I want to thank you for this opportunity to place on the record of these hearings our position relative to health benefits programs for Federal employees and retirees.

Mr. Chairman, our position is quite clear and brief—we favor the payment by the Federal Government of the entire health insurance premium for all Federal employees and retirees. Health insurance has become a basic necessity in our society.

In the private sector of our economy, employers have long recognized the necessity of health insurance and its full payment by the employer has become an established part of fringe benefits provided their employees. We feel that the Federal Government can do no less.

It is not our purpose, Mr. Chairman, to repeat the many points that have been made during these hearings as to why the Federal Government should assume the full cost of this insurance. There is little we could add that would be new.

Our purpose is to add to the voices already supporting this plan those of the postmasters of the United States. We wish to commend you, Mr. Chairman, and the members of your Committee, for your concern and interest in this area and we offer our full support for your efforts in behalf of all Federal employees and retirees.

Thank you.

STATEMENT OF CHESTER W. PARRISH, PRESIDENT OF THE NATIONAL FEDERATION OF POST OFFICE MOTOR VEHICLE EMPLOYEES, AFL-CIO

Mr. Chairman, and members of the committee, my name is Chester W. Parrish, President of the National Federation of Post Office Motor Vehicle Employees, AFL-CIO. Our National Headquarters is located at 412 Fifth Street, N.W., Washington, D.C.

Mr. Chairman, we very much appreciate your concern and interest, and the interest of this Committee, in the serious problem of health insurance costs presently assessed against employees covered under the Federal Employees Health Benefits Act of 1959. We are grateful that you have scheduled hearings on this pressing matter. Your bill, HR-767 and the many other bills which have been introduced by Members of this Committee and other Members of the House of Representatives, would alleviate the gravity of this problem for our members, other Federal workers and annuitants enrolled in plans established under the 1959 Act by revising the contributions formula now in effect.

The National Federation of Post Office Motor Vehicle Employees is one of the organizations which sponsor a health plan for its members under the Federal program—our plan is the Motor Vehicle Employees Benefit Plan.

When the Federal health program became effective in July 1960, the law provided for a Government contribution of not more than 50% of the least expensive low option offered in the two Government-wide plans. This formula resulted in a Government contribution of \$1.30 for Self Only enrollments and \$3.12 for Self and Family enrollments. This contribution was geared to paying for a package of benefits which was moderate in cost but which did provide a generally adequate level of protection.

Under the funding formula set in 1960, the Government contribution was sufficient to pay 50% of the cost of benefits in our High Option. The High Option premiums in 1960 in our Plan (bi-weekly) were as follows:

Enrollment	Contribution		Total biweekly cost
	Government	Employee	
Self only.....	\$1.30	\$1.30	\$2.60
Self and family.....	3.12	3.12	6.24

We began our Plan in 1960 with a benefit structure geared primarily to providing financial protection against the costs of hospitalization, surgery, maternity and limited benefits for out-patients services. The costs of health care at that time made it feasible to offer such a Plan, and in addition, the limited income level of many of our members seemed to indicate that it was desirable to offer a plan with moderate benefits which would prove too costly for the Motor Vehicle Craft whose employees we represent. Taking this approach in 1960 permitted our Federation to offer a Plan which provided 50-50 division of costs between the employee and the Government. However, with each passing year, it was necessary to improve the benefits offered. This was due to the fact that many benefits were stated in dollar amounts and had to be liberalized to keep pace with increasing costs. Further, certain new benefits were added to upgrade the level of protection. Some of these benefits, such as coverage for mental and nervous conditions, were requested by the Civil Service Commission; others were deemed merited based on our experience in the operation of the Plan.

Also, with each passing year the premium cost continued to rise. It is important to note that the sharp rise in premium was due primarily to the spiraling costs of health care and not to liberalizations in the benefit structure. This fact was recently documented in a report prepared for the Civil Service Commission

by Milliman & Robertson, Inc., a firm of consulting actuaries. In their analysis of the two Government-wide plans they noted that:

"Premium increases for both the Service Plan and the Indemnity Plan have been several times greater than benefits added—about eight times greater for the high option plans and about three times greater for the low option plans. Thus, higher payments under the original benefit provisions have accounted for much of the additional premium needed."

Mr. Chairman, Members of the Committee, this finding in regard to the two Government-wide plans is similar to the experience of our own Motor Vehicle Employees Benefit Plan. It is indeed the crux of the issue before this Committee.

If no benefit improvements had been made in the health plan since 1960, the current unfair division of costs between the employee and the Government would be practically the same as it is today. This is because the major increase in premium cost has been to meet the increasing costs of securing the same level of health care which was provided in the 1960 contracts. This merely highlights again that the contributions formula of the Federal program is totally unrealistic. It establishes a fixed dollar contribution by the Government and forces the employee to assume the full cost of inflation in the pricing of all items of his medical care needs. It is a problem which must be corrected if the U.S. Government is to fairly meet its obligation as an employer.

The Government in 1960 contributed an approximate 38% of the cost of the health program. The division of costs deteriorated from 1960 to 1966 when the Government share had shrunk to less than 30% of the cost. Public Law 89-504 approved July 18, 1966, increased the amount of the bi-weekly contribution from \$3.20 to \$4.10 for Self & Family enrollment. This did raise the Government contribution to the approximate 1960 level of 38%. Once again, however, the 1966 law set a dollar amount for the Government contribution, and since that date the continuing increase in the cost of medical care has again created a disproportionate division of premium cost between the employee and the Government. Today, the Government contribution is less than 25% in the program as a whole. In our Plan—the Motor Vehicle Employees Benefit Plan—the total bi-weekly cost (Self & Family) is now \$16.37 and the Government contribution is \$4.10! Our insured members are paying \$12.27 per pay period or 75% of the cost and the Government is paying 25%. This is not only unfair to our members, it is totally unrealistic especially in consideration of the practice in private industry. Numerous private employers now pay 100% of the cost of the health plans granted their employees. Among these are A.T. & T., Dupont, Standard Oil, Eastman Kodak, Goodyear, Union Carbide and RCA. The list could go on and on. It is time, in fact long past due, that the U.S. Government treat its employees equitably with those in the private sector of our economy.

Our Federation has attempted to meet its responsibilities as an organization sponsoring a health plan. To more adequately help our members meet the costs of quality health care, our Plan, as of January 1, 1970, provides a more comprehensive package of benefits.

We found it necessary to add coverage for out-patient medical expense and provide certain major-medical type of benefits. Our Federation sought this improvement in our Plan after being directed to do so by action at our last National Convention held in Atlanta, Georgia, in 1968. In determining what changes were necessary to properly upgrade our Plan we also noted the problem which existed for those insureds who had elected Low Option coverage. Although the Plan had less than 200 insureds in the Low Option, we discovered some very sad cases where catastrophic illness struck a person covered under Low Option and where the limited benefits provided fell far short of paying even a reasonable amount of the total expense. Because of this, our National Executive Board recommended elimination of the Low Option with the contract beginning January 1, 1970. The 200 insureds who were in Low Option are now covered under our single level of benefits which is an improved version of our former High Option. We feel confident that many of these insureds had elected Low Option strictly on the basis of cost as they felt they could not afford the higher premium. They did not know the tremendous difference between the level higher premium of High Option. They did not know the tremendous difference between the level of protection granted under High Option versus Low Option. Unfortunately this meant that the person who needed protection the worst, when hit by huge medical bills; was the individual who had the least protection.

It was for this same reason that we upgraded the benefits of our High Option for it is absolutely necessary today that health insurance provide protection against the high costs of necessary medical care. We now have such a plan and the protection compares favorably with the High Options of most plans. The employee's share of the cost of Motor Vehicle Employees Benefit Plan is \$12.27 bi-weekly for Self & Family enrollment. Many other plans are higher—Blue Cross is \$13.59, Aetna is \$16.64. We note this not to compare rates but rather to highlight the fact that this problem of cost is common to all employees regardless of the Plan in which they may be enrolled. It is a financial burden upon all Federal workers, a problem which can be resolved only by legislation being considered by this Committee.

Mr. Chairman & Members of the Committee, on behalf of our Federation I urgently request that you expedite action on a bill to correct this situation. As previously stated, our goal is to have the Government assume full cost of this important fringe benefit program. It is recognized that this may be difficult to accomplish in one step and for this reason, we recommend as a minimum immediate improvement, a revised contributions formula similar to that contained in S-1772, a bill co-sponsored by Senators Gale W. McGee (D-Wyo) and Quentin N. Burdick (D-ND). S-1772 would eliminate the set dollar contribution formula and set the Government contribution at amounts equal to one-half the premium cost of the less expensive of the high options offered by the two Government-wide plans. The least expensive of these two plans presently is Blue Cross with a total bi-weekly premium for Self & Family of \$17.69. Thus under the formula of S-1772, the Government premium would be increased from \$4.10 to \$8.85 per pay period. The practical result of this is that it would restore the 50-50 division of cost as it was when the program was established in 1960, setting the Government contribution for Self & Family at \$8.18 and the employee's contribution at \$8.19 per bi-weekly pay period. This would relieve the unfair financial burden currently placed on our insureds and place the Government on the road toward an employer role comparable to that existing in private industry. Employees—our members—are surely in need of this relief and we trust this Committee will see fit to adopt this or a similar formula.

We would then recommend that the Committee consider a provision in this bill which would assess a higher than 50% contribution by the Government in subsequent years, in order that we may eventually match private industry practice.

Mr. Chairman, again may I express our appreciation to you and the Members of this Committee for this opportunity to present our views and recommendations on this vital issue. Thank you for your consideration. We trust the Committee may be able to draft and report a bill in the near future.

STATEMENT OF NATHAN T. WOLKOMIR, PRESIDENT, NATIONAL FEDERATION OF
FEDERAL EMPLOYEES

Mr. Chairman and members of the subcommittee, my name is Nathan T. Wolkomir. I am President of the National Federation of Federal Employees, which is the pioneer and largest of the independent general unions of Federal employees. For over 50 years the NFFE has been promoting the welfare of Federal employees and the public interest.

The NFFE is glad to have the opportunity to submit its thoughts on the Federal Employees' Health Benefits Program. We strongly support H.R. 767, which you introduced, Mr. Chairman. In my testimony before the Subcommittee on Health Benefits and Life Insurance of the Senate Post Office and Civil Service Committee on S. 1772, a Bill to provide that the Federal Government shall pay one-half of the cost of health insurance for Federal employees and annuitants, I urged amendments to S. 1772 to include the additional provisions in H.R. 767; namely that the agency contribution to the cost of health insurance be raised to 75 percent for the fiscal year 1971, and 100 percent for the fiscal year 1972 and for each year thereafter. Mr. Chairman, we are grateful to you and to the members of the Subcommittee for the interest manifested in this subject as evidenced by the legislation introduced and these hearings.

The trend in private industry is toward the employer paying 100 percent of the costs of health plans. I am attaching an exhibit to my statement showing this trend very conclusively. This exhibit is in the form of a factually and statistically detailed article on health insurance plans published in the February, 1970 issue of the U.S. Department of Labor's Monthly Labor Review. I request that this exhibit be incorporated with my testimony in the official transcript of these important hearings.

Almost all companies provide liberal medical care benefits, either through combined basic hospital and major medical plans or through comprehensive medical plans. Approximately 80 percent of the Government employees covered by the Federal Employees' Health Benefits Program are under the health plans of Blue Cross-Blue Shield and Aetna Insurance Company. Premium increases under these plans have been more than the benefits added—about eight times greater for the high option plans and about three times greater for the low option plans. Higher payments under the original benefit provisions have accounted for much of the additional premium. We understand that higher payments for medical services and higher hospital costs can be expected in the future. Thus, the premiums for the health plans of Blue Cross-Blue Shield and Aetna Insurance Company will probably increase between 10 and 35 percent every two years between now and 1976. Thirty out of thirty-six health plans have recently increased their premium rates.

Studies should be conducted to see what can be done to reverse the trend toward ever-increasing costs for medical services and hospital care. I realize that these increased costs are tied in with the general economic picture of inflation but these particular costs have sky-rocketed to the point where they have become a really serious problem to middle and low income groups. And these services are second only to food and shelter in importance. We therefore feel that this matter urgently warrants early and intensive study and remedial action.

Perhaps greater attention to healthful working conditions and illness preventive measures would reduce some of the need for medical services and hospital care. I believe that improved supervision qualities in supervisors could reduce the incidence of emotional illnesses and certain physical disabilities as well. The NFFE is constantly identifying incompetent supervisors and urging that appropriate corrective steps be taken. Another matter requiring close scrutiny is the costs of administration of the health plans of the insurers of the Federal Employees' Health Benefits Program and the profits of the insurers.

The recent increases in premiums of health insurance to annuitants have been extremely hard for many of them to bear, that is, those who live on less than subsistence levels. By increasing the agency contribution, which in turn, would reduce the annuitant contribution, retiree and survivor annuitants would be able to purchase more of the necessities of life that many cannot now afford to buy on their small incomes. I know that the Subcommittee will remember the profoundly serious problems of this group in considering legislation to increase agency contribution. This Subcommittee is especially aware of the difficulty many in this group have to supply themselves with the necessities of life and the adverse effect of the recent increases in health insurance cost upon their standard of living.

H.R. 767 would increase the agency contribution to the cost of health insurance for the fiscal year 1970 to 50 percent, 75 percent for the fiscal 1971, and 100 percent for the fiscal year 1972 and for each year thereafter. If H.R. 767 is enacted into law the trend in the Federal Government will be the same as the trend in private industry, namely, to pay 100 percent of the costs of the program. I understand that the government contribution to the high option plans is now approximately 25 percent as compared to about 38 percent originally. The trend in private industry is to pay more of the costs of health insurance while in the Federal Government the trend has been the exact opposite as indicated by the steady, persistent decline of the government contribution to the high option plans from around 38 percent to 25 percent.

The NFFE feels that the contracts of insurers should provide for increased care coverage in nursing homes. More and more patients are using the facilities of modern nursing homes. And, of course, the costs of care in a nursing home are less than in a hospital. There is a greater demand for modern nursing home care and in recent years we have seen new construction projects in this field throughout the country. Thus, because nursing homes can and do provide the special care required for long-term illnesses or geriatric conditions—

care which is not and cannot be supplied economically or otherwise by hospitals generally—it is essential for the Federal Employees' Health Benefits Program to provide for increased coverage in modern nursing homes. All considerations point unmistakably in that direction. It is possible that greater coverage would keep care in a hospital to the absolute minimum certainly not to the detriment of the health of the employee, but rather as an efficient program with due regard to the employee's health.

In our daily contacts with our members in virtually all departments and agencies we find a very deep interest and concern in the Federal Employees' Health Benefits Program, particularly the agency contribution versus the contribution of the employee or annuitant. A heavy proportion of inquiries relate to this matter and the costs of medical care, the escalation of those costs, and the inadequacy of our programs to meet the unusually high costs of illnesses when the illnesses are in any way protracted. Because of all the factors involved there are no issues of more profound concern to Federal employees than this, and almost none which equals it in impact upon the employee and his family. The NFFE urges that the health insurance coverage be extended to the fullest extent feasible.

We do not offer these comments as a definitive analysis and itemization of all of the issues involved in the very complex problem of health care and benefits of which the members of this Subcommittee are aware and have been devoting so much time and study . . . but rather as an indication of our views on some of the most pressing aspects of the problem and susceptible of immediate action by the Subcommittee and the Congress during this session. On behalf of the National Federation of Federal Employees I desire to thank you for the opportunity to bring the Subcommittee some of the facets as we see them of the Federal Employees' Health Benefits Program.

The Federal Government should assume a leadership role in health insurance and show the way to the private sector. That is not the case now but the legislation here under consideration is a very useful step in the right direction. It is our hope that favorable action on health insurance legislation can be achieved in this session of Congress. The need grows more urgent with each passing day.

Again, Mr. Chairman, I express my thanks to you and to the members of the Subcommittee for your interest in and action on this subject.

[Exhibit A]

CHANGES IN HEALTH AND INSURANCE PLANS FOR SALARIED EMPLOYEES

(By Dorothy R. Kittner*)

Major companies substantially improved the health and insurance protection of their salaried employees during the past 6 years. Although improvements in both the levels and types of benefits provided salaried workers were almost always unilaterally made by the employer, they often reflected gains achieved by production workers through collective bargaining. Some of the changes, however, reflected the employer's awareness of the necessity of broader and greater coverage to meet changing standards of health care protection and rising living costs, particularly medical costs.

Health and insurance plans for salaried workers generally provided greater income protection and more comprehensive coverage than plans for production workers. In particular, plans for salaried workers included optional life insurance, long-term disability benefits, and major medical benefits more frequently than those for production workers. Also, salaried employees, unlike most production workers, often continued to receive their regular pay while temporarily absent from work because of illness.¹

*Dorothy R. Kittner is an economist in the Division of General Compensation Structures, Bureau of Labor Statistics.

¹ In 1967-68 for example, about 4 out of 5 of the office workers in metropolitan areas as compared with 1 out of 2 of the plant workers had a major medical benefit, and 7 out of 10 of the former group and 3 out of 10 of the latter group had a paid sick leave plan. Separate data on the incidence of optional life insurance and long-term disability benefits for the various groupings of employees are not available. However, all indications are that these benefits are much more prevalent for salaried employees than for production workers. *Wages and Related Benefits, Part II: Metropolitan Areas, United States and Regional Summaries, 1967-68* (BLS Bulletin 1575-87).

Some recent improvements in salaried employee benefit plans represent interesting innovations and special benefits supplementing or liberalizing existing private plan benefits, while others involve new ways of supplementing government-provided benefits, such as Medicare and disability pensions. In the income area, a special survivors' benefit, which provided certain survivors a percentage of the deceased employee's salary for at least 12 months, was increasingly superimposed on basic and optional life insurance benefits.² In the health area, liberal benefits for convalescent and nursing home care, psychiatric care, and dental care are now added to health care packages. Service benefits, covering surgical-medical care for all employees regardless of their incomes, became more frequent as more plans paid all reasonable and customary charges of physicians and surgeons instead of a fixed allowance.³

Although benefits paid for solely by the employer (noncontributory) became more common, many workers still had to pay part of the cost of their health and insurance plans. In 1968, as in the previous 5 years, more than 40 percent of all employees surveyed by the Health Insurance Institute participated in non-contributory programs, and more than half were in contributory ones.⁴ Of course, as implied by the term "optional," all employees with optional life insurance coverage paid at least part of its premium, and those with long-term disability and major medical benefits coverage usually helped finance it. As in the past, the proportion of office workers with noncontributory benefits lagged behind the proportion of plant workers whose benefits were similarly financed. The only major exception to this generalization is in the area of major medical coverage, as shown in the following tabulation, showing the proportion of workers in metropolitan areas during 1967-68 covered by noncontributory benefit plans:

Benefit	Plant workers, 1967-68 period	Office workers		
		1967-68 period	1963-64 period	Percent increase since 1963-64
Life insurance.....	66	58	54	7
Accidental death.....	42	33	28	18
Weekly accident and sickness.....	47	26	21	24
Hospital.....	65	50	46	9
Surgical.....	64	49	44	11
Basic medical.....	55	44	36	22
Major medical.....	30	39	28	39

Nevertheless, since 1963, there has been a noticeable increase in the proportion of office workers covered by plans paid for entirely by their employers.⁵

In 1963 and again in 1969, the Bureau of Labor Statistics compiled a digest of health and insurance plans covering salaried employees of major companies.⁶ These plans, selected to illustrate only those of large manufacturing and non-manufacturing firms, are not necessarily typical plans, nor are they a representative selection. Improvements in the plans contained in the BLS digest frequently occur earlier than in other plans, and innovations are often made in them which, with appropriate modifications, are later adopted by others, and thus are pattern-setting. The following discussion, limited to these plans, examines changes made between 1963 and 1969.

² This benefit which provides certain survivors a percentage of the deceased employee's salary for at least 12 months, is also payable in addition to the survivors benefits of a pension plan.

³ See Donald M. Landay, "Trends in Negotiated Health Plans: Broader Coverage, Higher Quality Care," *Monthly Labor Review*, May 1969, pp. 3-10, and J. F. Follman, Jr., "Health Insurance Plan Design Trends—Coverage and Benefits," *Pension and Welfare News*, February 1969, pp. 13-22.

⁴ *New Group Health Insurance: I. Policies Issued in 1968: II. The Five-Year Trend, 1963-1968*, Health Insurance Institute, New York, N.Y. (This survey is based on an analysis of the group health insurance policies, providing health care and income replacement benefits, written by insurance companies between January 1 and March 31, 1968, and an analysis of benefits provided employee groups of 25-499, which the Health Insurance Institute stated represents group health insurance trends.

⁵ See BLS Bulletins 1575-87 and 1385-82.

⁶ *Digest of 50 Selected Health and Insurance Plans for Salaried Employees, Spring 1963* (BLS Bulletin 1377), and *Digest of 50 Health and Insurance Plans for Salaried Employees, Early 1969* (BLS Bulletin 1629). All, except one plan, were included in both digests. Thirty-six of these plans are in manufacturing industries and 13 in nonmanufacturing industries.

PREVALENCE OF BENEFITS

While all plans provided for basic life insurance in 1963 and 1969, almost twice as many provided optional life insurance as in 1963 and almost 3 times as many paid special benefits to relatives of deceased employees. Long-term disability benefits were provided by almost half the companies studied—a fivefold increase since 1963 when only approximately 1 in 10 provided such benefits.⁷

Since 1963, there has been a slight decline in the proportion of plans that offer basic hospital and surgical-medical benefits to their active employees and their dependents, but in 1969, as in 1963, those not offering basic benefits offered comprehensive major medical plans, which usually provided broader protection than most basic benefit plans. Between 1963 and 1969, three of the plans substituted comprehensive major medical benefits for basic hospital-surgical-medical benefits. Major medical benefits now are offered by nine-tenths of the plans studied. In 1963, slightly more than four-fifths of them had this benefit.

Psychiatric care and treatment in facilities other than hospitals are now specifically offered in three plans. Previously, no plan had a benefit solely for this type of care. However, the basic hospital benefits of most plans provided coverage for hospital confinement for short periods due to mental and nervous disorders, and the major medical benefit, when available, covered a limited amount of out-of-hospital psychiatric treatment both in 1963 and 1969.

In both years, 4 out of 5 of the companies continued life insurance coverage for their employees after retirement and 2 out of 3 continued health benefit coverage. Upon retirement at age 65, optional life insurance is usually discontinued, basic life insurance is reduced, and health benefits are modified so as to supplement rather than duplicate Medicare. Since 1963, only three companies, which previously required the retirees to pay the full cost of their health benefits, discontinued health benefits for retirees. Of course, salaried employees of these companies who retire at age 65 are eligible for Medicare protection, as are most employees age 65 and over in private industry.⁸

PLANS COVERING ACTIVE EMPLOYEES

Financing

In early 1969 about 1 out of 6 of the companies paid the full cost of all benefits, except optional (added) life insurance. Basic life insurance was provided without charge to employees of more than 2 out of 5 of the companies studied; in 1963, more than half the plans required employee contributions. Optional life insurance was generally offered on a contributory basis but only two of the plans required employees to pay the full cost of their added insurance.

Long-term disability benefits, generally not provided in 1963, were fully paid for by about 30 percent of the firms that offered them. About 30 percent of the other companies with this benefit required employees to pay the full cost of it. In the remaining cases, company and employees shared the cost.

Roughly half of the companies studied paid the full cost of all health benefits covering their salaried employees. Five of these, however, required their employees to contribute toward or pay the full cost of their dependents' coverage. In addition, seven companies paid the basic health program's full cost but required their employees to contribute toward major medical coverage. Six years earlier, more than two-thirds of the plans required employees to contribute toward their own basic benefits.

The striking change in the financing of health and insurance benefits for salaried workers during the past 6 years became apparent only when the same package of benefits available in 1963 was compared with those available in 1969. By early 1969 one-third of the companies paid the full cost of benefits available to salaried employees and their dependents, compared with one-seventh in 1963.

Life insurance

Since 1963 almost half of the companies made one major change or more in the life insurance benefit offered salaried employees. The most typical change being a revision of the benefit schedule or formula to provide almost everyone

⁷ This protection was rarely available in 1963. However, since the exact incidence of this protection in 1963 is unknown the change in prevalence since then is also unknown.

⁸ Medicare, the Federal health plan for individuals age 65 and over, became effective July 1, 1966. Hospital benefits are available without charge to those qualifying for Social Security old age benefits and the medical benefits are available to those paying the monthly premiums.

with greater protection. In a few cases, however, only those workers at the lower or higher salary levels profited by the revisions. Different levels of coverage were eliminated between 1963 and 1969 in those few cases where greater life insurance coverage had been provided men than women. At least for insurance purposes, all of the companies treated men and women employees alike.

The level of life insurance protection for salaried employees is generally geared to salary levels. In early 1969, basic and optional coverage provided by most companies ranged from an amount approximately equal to annual salary to 4 times salary. Six years earlier, maximum coverage provided by several companies was much less than annual salary and only one company had insurance limits which exceeded 3 times salary. A few plans adopted changes between 1963 and 1969 that adversely affected some future participants—generally those to be hired into entry-level jobs—while improving the plan for all others. This type of revision does not adversely affect the benefits of current plan participants, but does occasionally result in lower benefits being offered to future participants at certain entrance-level salaries than prevailed under the superseded plan. One of the ways that this can occur is illustrated by changes in the Douglas Aircraft Co., Inc. plan. In 1969, the Douglas plan provided basic coverage equal to annual salary plus optional coverage in the same amount; 6 years earlier, the plan had offered \$9,000 basic coverage to all employees plus optional coverage based on an earnings schedule. As a result basic coverage for employees currently hired at \$5,000 and \$10,000 is \$5,000 a year less than it was in 1963. Those workers previously employed at these salary levels continued to receive the insurance protection they had previously enjoyed. However, because basic coverage under this plan is now based on annual salary, new employees earning over \$9,000 yearly get more noncontributory insurance coverage than they would have received in 1963.

Some modifications made by companies in the life insurance benefit increased the basic coverage amount provided by the company on a noncontributory basis without affecting total coverage. This was accomplished in one of the plans by eliminating the contributory optional insurance provided in 1963 and increasing the free basic insurance by a corresponding amount.

Income protection benefits

Income protection was usually provided during temporary disability periods either by an insured weekly accident and sickness benefit, the company's self-insured paid sick leave plan, or both. The "building block" approach used when both these benefits are provided guarantees employees, with few exceptions, full pay for a specified period and part pay for an additional period.⁹ A significant number of companies also provided nonmanagerial employees income protection benefits during long-term disabilities.

Accident and sickness benefits

For most employees the accident and sickness benefits offered by the companies were considerably higher than those available 6 years ago. Nevertheless, higher-paid employees frequently were eligible for a smaller fraction of their salary than lower-paid employees. For example, with few exceptions, the size of the benefits in early 1969 for the \$5,000-a-year man ranged between 50 percent of weekly salary and 75 percent, the median plan paying between 60 and 65 percent. By contrast, the size of the benefit for the \$10,000-a-year man ranged from 25 percent to 75 percent with the median plan paying between 40 and 45 percent of weekly salary. The amount of the benefit and the ratio of benefit to average salary rose substantially between 1963 and 1969. For example, the \$5,000-a-year employee's benefit in 1969 averaged \$59 (62 percent of his weekly salary) as compared with \$55 (57 percent of salary) in 1963.

Between 1963 and 1969, only a few plans extended the duration of accident and sickness benefit periods. Three plans made changes with two of them doubling the period to 52 weeks (none had a longer period) from 26 weeks and the other, to 26 weeks from 13 weeks. One out of 5 companies with accident and sickness benefits provided them for 52 weeks in 1969 and 7 out of 10 for 26 weeks. In 1963 about one-eighth of the plans with accident and sickness benefits made payments for 52 weeks and two-thirds for 26 weeks.

⁹ Formal paid sick leave plans which are now provided by about 3 out of 5 of the 50 Digest companies are not discussed in this article. They are summarized in BLS Bulletin 1629.

Long-term disability

These benefits are usually designed to assure totally disabled employees an income until age 65 when normal retirement benefits under private pensions typically become available.¹⁰ Because age and long service are rarely considered in determining the employee's eligibility, these plans are of special importance to young and new employees, who could not qualify for regular disability retirement benefits under their company's retirement plan, and to employees with short service who are entitled only to small inadequate disability retirement benefits. Following the qualification standards developed under Social Security, the plans required employees to be totally disabled for 6 months to become eligible for benefits. While waiting, they usually collect some weekly accident and sickness benefits, sick leave pay, or both.¹¹

Under long-term disability plans, all eligible employees typically are guaranteed a specified monthly income. The benefit paid never equaled full pay, but together with other benefits generally provided at least half pay. The actual amount paid by the plan, however, usually depended on the employee's Workmen's Compensation, Social Security, and private retirement plan benefits. Most of the companies explicitly reduced monthly benefit payments by these other payments. One, however, deducted only half of the employee's Social Security benefit. Of course the few companies paying benefits without a Social Security reduction probably considered Social Security payments in establishing the benefit formula. This type of consideration seemed particularly likely in the case of one plan that established a monthly payment equal to 25 percent of monthly salary plus 35 percent of salary in excess of \$550 monthly (in 1966 and 1967, earnings above this amount were not subject to Social Security taxes).

Most plans provided payment until the employee's disability ended or until he reached age 65, whichever occurs first. However, under one plan, the employee's length of service determined the duration of benefit payments. Those with less than 5 years of service received payments for 5 years; those with 5 but less than 15 years received benefits for a period equal to their length of service, and those with at least 15 years of service, received them until normal retirement.

The monthly payment under long-term disability plans (as shown in table 1) was calculated with four exceptions, by using a "percentage of salary" formula, frequently with an upper limit on the monthly benefit. The excepted plans either graded the percentage used in the computation according to salary and service, paid a larger proportion of an employee's salary during the first part of his disability than later on, used a combination flat amount and percentage-of-salary formula, or paid a flat amount based on an earnings schedule.

Hospital benefits

Basic hospital benefits are not quite as common in the plans in 1969 as they were in 1963. Two plans that dropped this benefit, as well as one that never had it, helped defray hospital expenses by providing comprehensive major medical benefits. Many of the remaining plans provide hospital benefits that differ in one respect or more from those in effect in 1963. The principal changes involved lengthening the duration of benefit payments, switching from cash benefits to service benefits, and increasing cash allowances for room, board, and ancillary services.

Service hospital benefits, such as those provided by most Blue Cross plans, have a built-in cost adjustment feature. Because they cover the full cost of hospital confinements for specified periods, the monetary value of service benefits increases as hospital charges for room, board, and ancillary services increase and as more services—often requiring expensive new machinery and personnel—are provided owing to technological advances in hospital care and treatment. The value of and protection provided by the plans with service benefits increased significantly during the past 6 years.¹² In particular, the protection provided by the six plans that switched from cash to service benefits since 1963 was superior to that provided previously.

¹⁰ Long-term disability benefits are income protection benefits for employees totally disabled for over 6 months. The monthly payments, usually a high percentage of the employee's salary when combined with Social Security and workmen's compensation benefits, generally continue until age 65 (unless he recovers earlier) when he ordinarily becomes eligible for full regular benefits under his company's private pension plan.

¹¹ Both paid sick leave and weekly accident and sickness benefits have brief waiting period requirements or none at all. Weekly accident and sickness benefits were payable for at least 6 months in all but three of the plans.

¹² According to the Bureau of Labor Statistics Consumer Price Index, hospital semi-private room charges increased 66 percent in the 5-year period, and operating room charges and certain diagnostic services rose over 41 and 16 percent, respectively.

TABLE 1.—*Distribution of plans by long-term disability benefit formula*

<i>Benefit formula for monthly disability payment</i>	<i>Number of plans</i>
All digest plans with long-term disability benefit.....	23
Including Social Security and other statutory benefits, and private disability retirement benefits:	
50 percent of salary.....	14
No maximum payment.....	1 ¹ 9
Maximum payment (\$1,000 to \$3,125 monthly).....	2 ² 5
60 percent of salary.....	3
No maximum payment.....	2
Maximum payment (\$2,000 monthly).....	1
66⅔ percent of salary (maximum, \$2,000 monthly).....	1
80 percent of after-tax salary (maximum (\$3,000 monthly).....	1
25 percent of salary under \$550 monthly, 35 percent of salary over \$550.....	1
Graduated amount based on salary.....	1
Graduated percent of salary based on salary and service ³	1
\$100 plus 50 percent of salary over \$400 monthly ⁴	1

¹ Under one plan only employees earning \$6,600 annually or more, are eligible for benefit. One plan provided a minimum benefit of \$265 monthly, another paid ⅓ of salary during 1st 24 months, and another paid employees with at least 15 years of service, an additional 1 percent of salary for each year of service over 15.

² Under 1 plan only employees with earnings of \$400 monthly or more are eligible for benefit, and under another, only employees earning \$15,000 annually or more.

³ Only employees with annual earnings of \$7,000 or more were eligible for benefit.

⁴ Applicable to employees with less than 15 years of service, employees with at least 15 years of service received \$100 plus 30 percent of salary over \$400 monthly.

Most of the Digest plans provided service-type benefits with only about 1 out of 5 paying cash allowances. These plans have substantially higher room and board allowances than in 1963, the amounts ranging from \$14 to \$40 a day compared with \$12 to \$18 in 1963, and averaged \$28 instead of about \$15. Only one plan paid under \$20 a day but 5 paid at least \$30. As a result, since 1963 the 87-percent increase in the average room and board allowance of the plans with cash hospital benefits surpassed the 66 percent increase in semiprivate room and board charges reported in the Bureau's Consumer Price Index.

Not only have the major companies covered a larger proportion of the hospital charge because of a switch to service benefits for room and board or payment of higher room and board allowances, but about half the companies also increased the maximum number of days for which full benefits were payable. By early 1969, over three-fifths of the plans provided full benefits for 120 days or more of hospital confinement compared with one-half in 1963 and the number of plans providing full coverage for at least 365 days of hospitalization increased from 8 to 11.

Additional improvements were made by plans that shifted from cash to service benefits for room and board. They changed their ancillary service benefit from a cash allowance to the full cost of specified services. In addition, plans that increased the duration of room and board benefits also made identical increases in the period during which the ancillary services were payable. The maximum allowances of plans which paid the full cost of such services up to a specified amount, ranged from \$300 to \$450 with two exceptions. One of the excepted plans paid \$150 and the other, \$800. In 1963 only two plans with cash benefits had an ancillary allowance of \$300 or more.

Surgical benefits

Over half of the companies revised their plans' surgical benefits by raising the maximum payable for surgical procedures. In addition, six companies improved their surgical benefit by switching from fee-for-service benefits to full payment of reasonable and customary charges. Under the scheduled benefit plans, allowances for all procedures were not affected to the same extent, the greatest increase generally occurring in those for the most expensive operations.

Basic medical benefits

Over half of the companies with basic medical benefits (benefits for non-surgical treatment by a physician) revised these benefits during the past 6 years. In addition to paying the entire surgeon's fee, four plans also paid a reasonable and customary fee to physicians for in-hospital nonsurgical treatment instead of providing a cash allowance as in 1963. These plans, like most of those with basic medical benefits, did not cover medical treatment in the home or

doctor's office. The remaining ones slightly raised the allowance for in-hospital (and if covered, out-of-hospital) visits. As a result, 11 plans (up from 4 in 1963) paid at least \$5 for an in-hospital treatment.¹³

Major medical benefits

In early 1969, three-fourths of the 44 plans that had a major medical benefit, specified a uniform amount of medical expenses (the deductible) that employees, regardless of their earnings, had to pay before the major medical benefit became operative. In 1963, two-thirds specified a uniform deductible. This difference from 1969 levels reflected a decrease in the proportion of plans with a deductible graded by employee's annual earnings. However, because all plans dropping a deductible tied to earnings retained a minimum deductible of \$100, the change to the uniform amount did not aid lower paid employees. In fact, only two companies reduced the deductible for everyone—one reducing the amount from \$100 to \$75, and the other, from 4 to 3 percent of earnings. Most plans allowed employees to meet the deductible by accumulating all medical expenses for an entire calendar year. This and other types of deductible accumulation periods are summarized in table 2.

Plans modified the coinsurance provision by raising the proportion of charges the plan paid from 75 percent to 80 percent thereby lowering the proportion the employee had to pay from 25 to 20 percent of costs. These modifications and the addition of three plans that did not have a major medical benefit in 1963 raised the proportion of plans with an 80/20 percent coinsurance provision to three-fourths from three-fifths.

TABLE 2.—*Major medical benefits: deductible accumulation period, early 1969*

<i>Accumulation period</i>	<i>Number of plans</i>
All Digest plans with major medical benefits-----	44
Per disability-----	11
2 months-----	1
3 months-----	3
4 months-----	1
6 months-----	4
12 months-----	2
All disabilities-----	33
6 months-----	3
12 months-----	6
1 calendar year ¹ -----	23
2 years ² -----	1

¹ With "carry-back" to last 3 months of preceding year.

² Applicable to other than hospital and surgical expenses.

The most frequent and often the most significant change in major medical benefits made since 1963 involved the maximum benefit payment. Several plans removed the restriction on plan payments for a single disability, thus providing greater protection for a catastrophic illness. However, they placed a limit ranging from \$20,000 to \$100,000 on total plan payments to any employee during the employee's lifetime. These lifetime limits were always higher than the maximums "per disability" previously specified. Those plans that retained the limitation on payments for each disability at least doubled the amount the plan paid before coverage ceased.

In 1969 as well as in 1963 the other plans with revised maximum payments had no limit other than a lifetime one. The limit in early 1969 was usually \$20,000—double the \$10,000 maximum in 1963. Maximum payments specified in the 44 plans with major medical benefits in early 1969 and the period to which they apply are shown in table 3.

PLANS COVERING RETIREES

About two-thirds of all the companies continued to provide health benefits for retirees, three-quarters provided life insurance coverage, and about one-half of them continued to provide both life insurance and health benefits to retirees. In addition, retirees of some companies carried paid-up life insurance policies

¹³ For plans that paid a higher allowance for treatment during the first 2 days of hospitalization on a lower allowance after several days of hospitalization, the allowance referred to is the one payable for treatment on the third day.

(fully paid for during their active working years) into retirement and almost all age 65 and over were eligible for Medicare.

All retiree benefits were paid for by about half of the companies providing these benefits. Almost three-fifths of those with health benefits for retirees paid the full cost, and three-fourths of those extending life insurance paid for it. Of the 14 companies that provided both life insurance and health benefits and required retirees to pay some of the cost, only three required them to contribute toward the cost of both benefits; the remaining companies divided almost evenly between those that required them to contribute only for their life insurance and those that required them to contribute only for their health benefits.

Changes in the financing of health and insurance benefits for retirees during the past 6 years, like those for active employees, were most striking when compared with the package of benefits available in 1963. In 1969, 60 percent of the companies paid the full cost of benefits provided compared with only 35 percent in 1963. This large increase was probably due in part to Medicare's making it possible for five companies with retiree health benefits in 1963 to either assume the full cost of these benefits or to discontinue retiree-financed health benefits.¹⁴

Life insurance

The amount of life insurance coverage extended to retirees has increased over the years, primarily because a retiree's life insurance coverage is related to his coverage prior to retirement, and, as pointed out previously, life insurance coverage for active workers has increased since 1963. However, the amount extended was still usually much less than that available prior to retirement. The practice of many companies was, as in the past, to gradually reduce employees' retirement coverage over a period of about 5 years to from 25 to 50 percent of that available before the initial reduction. As in the past, a few companies reduced preretirement coverage to a nominal amount, such as \$1,000, immediately after retirement.

TABLE 3.—MAJOR MEDICAL BENEFITS: MAXIMUM PAYMENTS AND BASIS OF PAYMENTS, EARLY 1969

Basis of payment and maximum amount	Number of plans			
	Total	With disability limit	With benefit period limit	
All digest plans with major medical benefits.....	44			
Plans with limits applying only to each disability or benefit period, total.....	13	10	3	
\$5,000.....	1	1		
\$10,000.....	7	5	2	
\$15,000.....	1	1		
\$20,000.....	2	2		
\$25,000.....	1		1	
\$100,000.....	1	1		
		Limit for each disability (1/2 lifetime maximum)	Limit for each benefit period (1/2 lifetime maximum)	No other limit
Plans with lifetime limits, total.....	31	1	8	22
\$5,000.....	1			1
\$10,000.....	9		5	4
\$15,000.....	4	1	1	2
\$20,000.....	11		2	9
\$25,000.....	1			1
\$30,000.....	1			1
\$40,000.....	1			1
\$60,000.....	1			1
\$100,000.....	1			1
Other.....	1			1

¹ Limit each benefit period is ¾ lifetime maximum.

¹⁴ Medicare provides more comprehensive hospital, medical, and other health care benefits than virtually any private health plan formerly provided for people age 65 and over.

Employees of some companies that did not continue life insurance coverage after retirement had a combination of group-term and paid-up insurance coverage for active employees. Under this arrangement, the employee's contributions bought units of paid-up insurance, which accumulated over the years, and the employers contributions bought term insurance equal to the difference between the amount of paid-up insurance purchased by the employee and the total amount of insurance specified in the plan. Because the paid-up portion of the employee's total insurance coverage was available to him when his employment terminated, long-service employees of these companies, when they retire, had most or all of the coverage possessed immediately prior to retirement.

Health benefits

Like other employees in private industry who are over 65 years old, salaried employees who retired at that age were generally eligible for the hospital and medical benefits of Medicare.¹⁵ Customarily, companies let their employees, who are eligible for Medicare's Part B (medical) insurance be responsible for paying the premium for their coverage and that of their dependents.¹⁶ However, nine companies paid some of the cost and three of them paid the full premium for the retiree and his spouse.

Two companies purchased Part B coverage for both their eligible active and retired employees and their eligible dependents by paying the entire monthly premiums of \$4 for each individual. One company paid the original premium of \$3 for all eligible groups except dependents of active employees (the employee paid the balance of his premium and all of the premium for his dependents).¹⁷ Another company paid the full premium only for retirees; the latter had to pay it for their dependents. The following tabulation shows the number of companies paying the Medicare premium in full or in part for each of the eligible groups:

Eligible group (65 years and over)	Full medicare premium	Part of medicare premium
Active employee	6	1
Dependents of active employees	6	
Retired employees	4	2
Dependents of retired employees	3	2

All companies providing benefits for retirees in 1963 (except the three that discontinued coverage since then and those adding this coverage, modified their benefits during the past few years to avoid duplication of Medicare benefits. They did this by using one of the following three methods developed by the insurance industry: Under one method, the "benefit carveout," Medicare benefits are deducted from the same or similar benefits provided workers under age 65; under another, the "building block" method, payment is made for specific services or expenses not covered by Medicare; and under the third, the "major medical" method, partial payment (commonly 80 percent) is made for practically all medical expenses not covered by Medicare in excess of a certain amount.

Over two-fifths of the 43 companies with retiree health benefits used the "benefit carveout" approach. However, the benefits extended frequently differed from those available prior to retirement. For example, basic hospital and medical benefits might be available for a shorter period, the major medical deductible might be larger, or the maximum payment under the major medical benefit might be smaller.

Roughly equal proportions of the remaining companies utilized the "major medical" and "building block" methods. Companies using the former method extended to retired employees the major medical benefits available to active em-

¹⁵ To be eligible for Medicare hospital benefits employees have to be entitled to primary Social Security benefits. For details on the benefits provided under Medicare, see *Your Medicare Handbook: Health Insurance Under Social Security* (U.S. Social Security Administration, 1968). For a discussion of Medicare's effect on private insurance plans and how private plans have adapted to it see Dorothy R. Kittner, "Negotiated Health Benefits and Medicare," *Monthly Labor Review*, September 1968, pp. 29-34.

¹⁶ Part A (hospital insurance) of Medicare is paid for under the Social Security program by active employees under 65 and their employers.

¹⁷ Prior to January 1, 1969, the premium for Part B of Medicare was \$3.

ployees under age 65 or a cut-down version of it (a higher deductible lower maximum payment, or both). Those using the last method either paid some or all of the Medicare deductibles and certain charges that the retiree otherwise had to pay, provided benefits for certain major expenses (private duty nursing care and out-of-hospital drugs) that are not covered by Medicare, or both.¹⁸

STATEMENT OF RICHARD I. WEVODAU, LEGISLATIVE REPRESENTATIVE, NATIONAL ASSOCIATION OF POST OFFICE AND GENERAL SERVICES MAINTENANCE EMPLOYEES, AFL-CIO

Mr. Chairman and members of the committee, for the record, my name is Richard I. Wevoda, and I am privileged to serve as Legislative Representative for the National Association of Post Office and General Services Maintenance Employees, AFL-CIO. We have National Exclusive Recognition for the 24,600 Maintenance employees of the Post Office Department and National Formal Recognition for the approximately 13,000 Maintenance employees in the Public Buildings Service of the General Services Administration.

We appreciate this opportunity to offer our views and comments on H.R. 767, the bill introduced by the distinguished chairman of the Subcommittee. We feel this bill is of the utmost importance to all postal employees and of particular importance to the many employees of the Maintenance Craft who are in PFS Levels 1 through 4.

Under the funding formula set in the 1960 Health Benefits Act, the contribution by the Government was sufficient to pay 50% of the cost of the benefits in our High Option. The bi-weekly premiums in the High Option of our Plan in 1960 were as follows:

Enrollment	Contribution		Total biweekly cost
	Government	Employee	
Self only.....	\$1.30	\$1.30	\$2.60
Self and family.....	3.12	3.12	6.24

These premiums were sufficient to pay for benefits then offered to primarily provide protection against the costs of hospitalization, surgery and maternity. The costs of these services at that time made it possible to provide this moderate financial protection against the cost of health care. Our Plan at that time provided only a limited type of out-patient coverage, however, in consideration of the income level of many of our members we designed a plan which would not impose a heavy financial burden on the Maintenance Craft of employees whom we represent. The Plan at that time permitted a 50-50 division of costs between the Government and the employee.

Experience has shown, however, that employees, realizing the need for better health insurance protection, selected High Option coverage. This was contrary to thinking at the time of the enactment of the Act. At that time it was anticipated that the majority of employees would elect coverage under the Plan's Low Option. More than 85% of all persons enrolled under this program enrolled in the High Option. It was quite understandable that anyone who has any knowledge of health insurance would generally elect coverage under a High Option rather than the Low Option. Claims experience often discloses the inadequacy of Low Option coverage. Although we recognized the desire of employees and annuitants to select what they hoped was an adequate type of health insurance protection, and made such selection based on premium costs, we also became painfully aware, when claims were processed, that many individuals had selected coverage based more on premium cost than the level of protection afforded. Low Option coverages, although providing excellent insurance for the premium cost involved, simply failed to offer the degree of protection which is anticipated by those who elected such coverage.

¹⁸ The hospital deductibles are the first \$44 during the first 60 days of confinement, \$11 daily during the 61st to 90th days, and \$20 daily during the 91st to 150th days; the convalescent home deductible is \$5 daily for 80 days; and the medical and other health care deductible is the 1st \$50 of charges (Medicare pays 80 percent of charges in excess of \$50).

For this reason, during the 1969 Open Season on health insurance we eliminated the Low Option and made improvements in our High Option benefits—improvements which experience had shown were necessary to maintain a benefit structure that would provide protection in line with the increased costs and services.

The Government contribution set in 1960 represented an approximate 38% of the cost of the health program. The inflationary spiral in cost of medical care following that date rapidly resulted in a serious disproportionate division of costs—the Government dollar contribution remained fixed and higher costs to provide the same benefits were assessed entirely on the employees—our insured members. We sought corrective action for this problem and in 1966, with the enactment of Public Law 89-504, the Government contribution was increased from \$1.30 to \$1.68 for a self only enrollment and from \$3.12 to \$4.10 for a self and family enrollment. Unfortunately, although this offered some immediate financial relief to employees, it merely restored the Government contribution to the approximate 38% of costs as originally provided in 1960. Setting a dollar amount as the Government contribution permitted the same problem, an unfair division of costs created due to inflation, to continue. Since 1966 the costs of health care has continued to soar and, once again, the higher costs have all been assessed against the employees. The Government contribution has now shrunk to less than 25%. In our Plan, a self and family enrollment now costs the employee \$11.54 each bi-weekly pay period. The Government contribution of \$4.10 set in 1966, represents only about 26% of the total cost. The disproportionate cost borne by the employee must be corrected. The U.S. Government is lagging far behind private industry in this area. Statistics abound to clearly establish that the trend in the private sector is for many major concerns to pay the entire cost of health insurance for their employees. Well over half are paying at least 50%. We strongly urge this Committee to approve and report a bill in line with H.R. 767 as introduced by the Chairman, Mr. Daniels, which will immediately raise the Government contribution to not less than 50%.

In line with this, Mr. Chairman, we would recommend consideration of the formula provided in S-1772, a bill co-sponsored by Senators Gale W. McGee (D-Wyo) and Quentin N. Burdick (D-ND), which has won approval of the Senate Post Office and Civil Service Committee. Under this formula the Government contribution would be set at one-half the premium cost of the less expensive option of two Government-wide plans. Blue Cross (Service Benefit Plan) is currently the less expensive. The Blue Cross bi-weekly premium cost for self and family, high option, is \$17.69. If the formula of S-1772 were adopted it would set the maximum Government contribution at \$8.85 per bi-weekly pay period. This would immediately restore the 50-50 division of costs in our plan—the Maintenance Employees Benefit Plan—which existed when the program started in 1960. This would set the Government contribution in our Plan at \$7.62 (an increase of \$3.52 over the current contribution) and reduce our members bi-weekly contribution from \$11.54 to \$7.62 (a reduction of \$4.02). Although we advocate, and will strongly support legislation to have the Government assume even a larger portion of the health costs, we do believe that this formula would be a tremendous step forward.

Mr. Chairman, Members of the Committee, the testimony presented by ourselves and by others who have appeared before you certainly substantiates the problem and amply justifies corrective action. We would hope that the Committee may see fit to draft and promptly report a bill which will eliminate the fixed payment formula for the Government.

STATEMENT BY THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association, a federation of state organizations representing over 15,000 optometrists, is pleased to have this opportunity to present its views on the need for eliminating existing barriers affecting delivery of allowable optometric services to Federal employees eligible for such benefits under the Federal Employees' Health Benefits Act. The recommendations included in this statement would not expand the present list of allowable services and would not materially affect costs of the present program.

More than 8-million eligible individuals are being denied access to the services of optometrists, who are fully trained and State licensed to perform eye care services allowed under the Federal Employees' Health Benefits Program.

Two of the three largest insurance carriers participating in the program refuse to recognize optometrists as qualified independent health care practitioners and as "doctors" as specified or permitted by law in all 50 States and the District of Columbia.

Many beneficiaries of the Federal Employees' Health Benefits Act and optometrists they have consulted have experienced inconvenience, embarrassment and unexpected expense as a result of failure by the Civil Service Commission and two of the three major carriers to initiate corrective action. The AOA has repeatedly sought redress, to no avail, and has now concluded that specific corrective legislation is the only avenue of relief available.

A vast majority of eligible Federal employees are covered by contracts issued by one of the following carriers: Aetna Life and Casualty Company; Blue Cross-Blue Shield; or the Group Health Associations of America. Of all Federal employees covered by one or another of these three plans, some 80% are covered by Aetna or Blue Cross-Blue Shield. Neither of these two plans authorizes payment for optometric services unless the beneficiary is referred to an optometrist by a physician. This exclusion is the result of language in the contracts of these two carriers which specify that for purposes of their plan, only doctors of medicine (M.D.), doctors of osteopathy (D.O.), dentists, and podiatrists are included within the definition of "doctor."

The Aetna definition reads as follows:

"'Doctor' is a duly licensed doctor of medicine (M.D.) or a duly licensed doctor of osteopathy (D.O.). The term includes surgeons and other specialists if they meet this definition. A duly licensed dentist is also considered a 'doctor' for purposes of the dental work and oral surgery covered by the Plan, and a duly licensed podiatrist (chiropodist) is considered a 'doctor' for purposes of the foot conditions covered by the Plan. Types of practitioners not specifically mentioned above are not considered 'doctors' for purposes of this Plan."

The Blue Cross-Blue Shield plan defines a doctor in this manner:

"'Physician' is any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place the service is rendered. For services covered by the Plan, doctors of dental surgery (D.D.S.), doctors of medical dentistry (D.M.D.), and doctors of surgical chiropody (D.S.C.) when acting within the scope of their licenses, are deemed to be physicians. No practitioners other than those specified above shall be deemed to be physicians for purposes of this Plan."

One major carrier, Group Health, however, has seen fit not only to recognize optometry as the independent health care profession it is, but goes one step beyond and provides the services of one or more optometrists on the clinical staffs of Group Health facilities.

The exclusion of optometrists as providers of eye care under two of the three major plans presents extreme difficulties for some beneficiaries. One type of difficulty stems from the relative lack of board-certified ophthalmologists throughout the United States. There are today some 5,500 such practitioners throughout the country, concentrated in major metropolitan areas. The 18,000 optometrists in practice today, however, are conveniently distributed among 6,237 cities and towns. According to information obtained from the Civil Service Commission, some 35.6% of all individuals eligible for services under the Health Benefits Act are engaged in Federal employment in locations other than major metropolitan areas.¹ The inconvenience and the expense which result can readily be recognized. When allowable eye care services are required, beneficiaries of the program should have the option of going directly to conveniently located optometrists if they so desire, thus avoiding the expenditure of time and money necessary to obtain such services from ophthalmologists.

The present situation has also created unwarranted confusion in the minds of beneficiaries who fail to understand why their insurance contracts do not accord optometrists recognition as doctors. These beneficiaries are correct in their belief that a doctor of optometry is no less a doctor than the doctor of medicine, the doctor of dental surgery, or the doctor of surgical chiropody.

¹ Developed from data in Civil Service Commission "Annual Report of Civilian Employment in the United States by Geographic Area," GPO pamphlet SM 68-2.

To illustrate this, we would like to call your attention to the case of the daughter of a beneficiary in New York City. To quote the optometrist who cared for her: "(name) is an esotrope who has had two unsuccessful operations and some unsuccessful pharmacological therapy with miotics (all paid for by Aetna). I have worked with her since mid-August, 1969. She is now aligned with fusion and stereopsis and should be ready for dismissal after 4 or 5 more sessions. Much of our work to date has been involved with alleviating the extra-ocular muscle artifacts resulting from adhesions caused by the unsuccessful surgery..."

In the New York City case quoted, a claim was filed; reimbursement was made but later rescinded with the explanation that the optometrist "does not meet the definition of 'doctor' as defined in your brochure. Therefore, his charges should not have been reimbursed."

This is only one of many cases in which claims by beneficiaries have been denied reimbursement for allowable services under the Plan when performed by optometrists. The contract calls for provision of such services.

It is clear that such situations cause serious interferences with existing doctor-patient relationships between optometrists and their patients who are Federally-employed. This kind of interference cannot be allowed or condoned under a Federally-created program. This is inconsistent with the Federal government's desire to preserve and protect existing doctor-patient relationships and to allow complete freedom of choice of vision care practitioners.

Because the Federal Employees' Health Benefits Act is a Federal program authorized by the Congress, it is the inherent responsibility of the Congress to see that no executive department or agency be permitted to ignore the frequently stated Congressional intent of avoiding interference with established doctor-patient relationships.

There is abundant evidence of the intent of Congress with respect to the utilization of optometrists' skills in Federally sponsored or supported programs. Notable among these are: Social Security Act, Title V, Section 505(a) (13) providing for Grants to the States for Maternal and Child Welfare; Social Security Act, Title X, Section 1002(a) (10) providing Grants to States for Aid to the Blind; Social Security Act, Title XVI, Section 1602(a) (12) dealing with Grants to States for Aid to the Aged, Blind and Disabled; Social Security Act, Title XIX (Medicaid); and Title III, Section 324(b) of the Public Health Laws, providing medical and optometric care for public health personnel at remote stations.

And finally in the definition section of the Vocational Rehabilitation Act, 29 USC 41 (Section 10 of P. L. 90-391) the Congress stated:

"Such term also includes, after full consideration of eligibility for any similar benefit by way of pension, compensation, and *insurance* the following services and goods provided to or for the benefit of a handicapped individual . . . (a) (iv) eyeglasses and visual services as prescribed by a physician skilled in the disease of the eye or by an optometrist."

Recently, the Department of Defense Deputy Assistant Secretary for Health Affairs issued the following memorandum regarding payment of optometrists under the Civilian Health and Medical Programs for the Uniformed Services (CHAMPUS):

"It is requested that you modify your publications, and those of CHAMPUS, so that, henceforth, a qualified doctor of optometry who is practicing within the scope of his license may be compensated under the CHAMPUS for authorized care provided an eligible beneficiary without the necessity of having his patients referred to him by a physician."

The memorandum, dated November 12, 1969, was directed to the Surgeon General of the Army and signed by Louis M. Rousselot, M.D., the Deputy Assistant Secretary for Health Affairs.

A subsequent communication was sent to CHAMPUS contractors over the signature of Brigadier General Louis J. Hackett, Jr. on January 14, 1970, stating: "Effective November 12, 1969, a qualified doctor of optometry who is practicing within the scope of his license may be compensated under the CHAMPUS for authorized care provided an eligible beneficiary without the necessity of having his patient referred to him by a physician . . ."

From these and other Federal government actions, it seems clear that the intent of Congress is to allow eye care to be provided by either a board certified ophthalmologist or an optometrist. Because the contract of insurance between

the carriers and the Federal government is authorized by Federal legislation, it is a glaring inconsistency for the Federal government to allow a private insurance carrier to circumvent a broad and well-stated legislative intent, whether such circumvention is intentional or inadvertent.

Federal policy as stated by the Congress is in full accord with State licensure of the health care profession of optometry and exercise of appropriate State police powers to regulate the profession. All fifty States and the District of Columbia recognize, license, and regulate the practice of optometry as an independent health care service just as they recognize, license and regulate the practice of medicine, osteopathic medicine, dentistry, and podiatry. All are recognized by the U.S. Office of Education and, through accrediting bodies, by the National Commission on Accrediting.

An even more blatant violation is committed in those jurisdictions which have specifically recognized and attempted to correct this problem by enacting provisions in their State health insurance laws to require freedom of choice of vision care practitioners. These amendments were adopted to prevent insurance carriers from engaging in discriminatory practices against optometrists.

In spite of these explicit prohibitions, two of the major insurance carriers participating in the Federal Employees' Health Benefits Program have devised a method of circumventing State laws providing for freedom of choice of vision care practitioners.

Evidence of this is contained in a November 12, 1965 letter from Aetna explaining their denial of reimbursement for optometric services. That letter stated, in part:

"After careful consideration, it has been determined that the position which we have taken with respect to charges by optometrists under this contract should not be changed. The Government-wide Indemnity Benefit Plan is not a New York contract. This contract was signed and issued in the District of Columbia and we do not feel that a New York insurance law is applicable to claims paid under this policy. * * * Our goal under the contract is to provide an identical level of benefits for all federal employees enrolled under this plan whether they live in New York or any other State. Therefore, we do not feel that we should be guided by individual state laws which might vary the benefit level in one or more States."

It is interesting to note that variations in the level of benefits provided from State to State are of such great concern to the carrier when dealing with optometry, yet the carrier is totally unconcerned about similar variations with regard to another independent health care profession. By defining doctors of osteopathy as "doctors" for purposes of the Aetna plan, a variation in level of benefits is propounded, because the osteopathy statutes of four States (Arkansas, Louisiana, Mississippi and Montana) specifically prohibit doctors of osteopathy from performing surgery.

We find it highly inconsistent for the carrier to defend its denial of reimbursement for optometric services on the basis that to do so would create variations in the level of benefits provided to eligible Federal employees living in different States. To achieve consistency, the carrier must include optometrists in its definition of "doctors".

A similar inconsistency exists with reference to the Blue Cross-Blue Shield plan. This carrier's definition of "physician" specifies that a practitioner must be practicing within the scope of his (State) license to qualify as a provider of service under the Plan. This indicates a commendable desire of Blue Cross-Blue Shield to recognize the rights of States to legislate and enforce their own laws. Yet, on the other hand, Blue Cross-Blue Shield chooses to disregard the fact that every State accords full recognition and licensure to optometrists.

The practice of denying reimbursement for optometric services provided by optometrists has continued for at least four years, despite a letter from the U.S. Civil Service Commission dated March 30, 1965, which informed the carriers such logic was in error. However, it is apparent that neither the Commissioner nor the carriers will resolve this problem.

The American Optometric Association would like to point out that the discriminatory practices against optometrist, presently engaged in by the two largest carriers under the Federal Employees' Health Benefits Program, work to make second-class citizens of Federal employees who select the coverage of either the Aetna or Blue Cross-Blue Shield plan. This is true whether their coverage is compared with fellow employees who purchased the Group Health Association plan or those individuals who are eligible for professional health care under

CHAMPUS in the military establishment. All are Federal employees and should have equal access to the full range of benefits the applicable program provides.

The American Optometric Association believes equity for beneficiaries could be achieved by adoption of appropriate amendments to specifically prohibit discriminatory actions by the carriers, and require that any Federal Employees' Health Benefits contract signed with the Civil Service Commission must provide for direct beneficiary access to the professional services of physicians, osteopaths, dentists, optometrists, and podiatrists for allowable services each practitioner is licensed to perform.

Adoption of one of the following amendments to 5 U.S.C. 8903 is recommended:

"(b) Except with respect to a health benefit plan under subparagraph (a) (4), any plan which provides benefits for any vision services shall provide payment for such services to a physician skilled in the diseases of the eye or an optometrist, whichever the beneficiary may select."

OR:

"(b) Except with respect to a health benefit plan under subparagraph (a) (4), any plan which provides benefits for any health service within the lawful scope of practice of a duly licensed physician, osteopath, dentist, optometrist, or podiatrist, shall at least provide payment or reimbursement for such benefits whenever the service is performed by any such duly licensed practitioner."

We believe adoption of either of these amendments will result in elimination of the inequities permitted by the language of the present law. Upon enactment of these amendments, beneficiaries of the program will have available the full range of health care benefits envisioned by the original legislation, without interference from the Federal government or its contractual insurance carriers with the free choice of vision care practitioner.

Adoption of these amendments would in no way increase the allowable services nor materially affect the cost of the program to the Federal government, but would serve to remove the present inequities and make professional vision care for all beneficiaries available from the practitioners of their choice.

STATEMENT OF DON B. GOODLOE, LEGISLATIVE REPRESENTATIVE, WASHINGTON
TEACHERS' UNION

Gentlemen of the Subcommittee on Retirement, Insurance and Health Benefits, House Post Office and Civil Service Committee, the Washington Teachers' Union is desirous of the privilege of submitting testimony in behalf of HR767 now under consideration by this Subcommittee. At the outset, we should explain the unique position of D.C. public schoolteachers in regard to this type of legislation. Our retired personnel are not under the jurisdiction of the Postoffice and Civil Service Committees, for purposes of retirement legislation. They are, however, covered by the same laws as Civil Service Annuitants, as far as Life and Health Insurance are concerned.

Our organization, therefore, wishes to support legislation to improve the health benefits of our members, who have retired under PL86-382 and PL86-724.

We support HR767 for substantially the same reasons as other witnesses who have presented testimony to your Subcommittee. We think the Government should begin to pay a larger share of the cost of the health programs covered by existing laws and eventually assume the entire financial responsibility for them. Inasmuch, however, as previous testimony has ably supported these objectives, we shall not discourse, at length, in regard to all of them. Rather, we shall concentrate on one suggested amendment to PL86-382 and PL86-724.

The Washington Teachers' Union regards it as a serious inequity that employees who retired after July 1, 1960 are not included under the Medicare Amendments to the Social Security Act. Doubtless, Congress had reasons for not giving these individuals such coverage, when it acted to make such an exception. Since that time, nevertheless, conditions have changed.

Many of these retirees are finding it difficult to pay the increased cost of their health benefit plans. The benefits of Medicare are, moreover, being improved by legislation. Eventually, it may not compare as unfavorably with government health insurance, as it did formerly.

We, consequently, propose that at the age of sixty-five, those who retired after July 1, 1960 should be given the option of retaining their Civil Service Health Benefit Coverage or being included in Medicare. Some might consider its prudent to continue paying for the benefits available under government health insurance. Others might consider themselves financially unable to do so. Our Union thinks that such an option would be fair to all concerned.

Our organization proposes, moreover, that those covered by PL 86-724 be given the same choice. Including them under the benefits of PL 86-382 would cost very little. It would, furthermore, cost less and less as time goes on. There can be no additions to this group; and their number is accordingly, constantly diminishing. In addition, it would certainly be fair and just to give them the Medicare option, along with other annuitants.

The Washington Teachers' Union, as an affiliate of the American Federation Teachers and the National AFL-CIO, for these reasons and others given by previous witnesses, strongly supports the enactment of HR 767 into law, with the amendments we have suggested. We, therefore, urge your Subcommittee to report this proposed legislation favorably and strive for its adoption by the 91st Congress.

Our organization also highly appreciates the privilege of presenting our views to this Committee.

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 HR 767, a matter of vital interest to our members.

We do not intend to take the time of this Subcommittee unduly, by repeating the many factors on which there is substantially unanimous agreement. We would however, like to emphasize a few points very briefly.

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 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.

The Government's contribution to the payment of premiums is lagging and is not comparable to the pattern which has been adopted by private industry. Health benefits in private industry have been steadily improving over the past few years and now provide coverage for substantially all medical expenses. In most instances, especially in the larger companies, the full cost of benefit plans are paid for both hourly and salaried employees.

The latest statistics show that medical costs have been sky-rocketing to an unbelievable extent. Some recent figures show costs running as high as \$100 a day for semi-private facilities. While we are at a loss to understand these costs, which to us seem exorbitant, nevertheless, they must be paid. The net result of the increased cost is that the premiums for hospital insurance have also been rising. The net effect of this is to cause the Government employees to experience what is actually a "pay cut." By this we mean that his government salary has been reduced by the amount he must now pay in increased premiums for medical and hospital insurance.

The effect on retired employees is even more drastic. As a retired employee, he receives a set sum of money in his annuity that is 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.

We realize that there are objections to the Government paying the entire premium, because of the cost involved. However, there is a matter of principle and fair-dealing between the Government and its employees concerned. We think that this should be faced up to, so that the Federal employee is not treated badly, simply because of a matter of money. We recommend that a formula be worked out that would lessen the initial cost impact but would provide equity for the employee.

There is nothing unusual about this and it does not, in any way, confer special privilege on the Federal employee. It is simply the continuation of a practice that has been common in private industry for many years.

It is our view that if these recommendations are followed, they would contribute substantially toward improving morale throughout the Federal Service. We believe that employees would recognize this move as an attempt on the part of the Government, as an employer, to give a consideration to its employees in a very necessary area of their employment.

We are greatly encouraged by the statement of Civil Service Commission Chairman Hampton, who indicates that the Government's share of the cost of health benefits will be increased and will provide for automatic adjustments each year. While we feel that this is a very small and hesitant step, nevertheless, it is moving in the right direction.

Mr. Chairman and Members of the Subcommittee, we strongly support HR 767 and advocate its immediate passage. We believe it will be a giant stride in bettering Federal employee morale and will enable the Federal Government to assume its responsibilities towards its employees. As the country's largest employee, certainly the Federal Government should lead the way in providing a fringe benefit as basic as a realistic hospitalization plan.

Thank you very much for this opportunity to be heard.

THE VOICE OF MARITIME LABOR,
Washington, D.C., April 8, 1970.

The Hon. DOMINICK DANIELS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN DANIELS: We ask that you amend H.R. 767 to extend Federal group life and health insurance benefits to Federal employees in the Canal Zone who are not citizens of the United States.

The United States has accepted an international commitment to provide equal pay and benefits to non-citizen employees to that received by U.S. citizen employees. It is interesting to note that the Panama Canal Company, the largest employer of non-citizens in the Canal Zone, has continually recommended the extension of the health benefits coverage to all of their employees.

The continuing rise in daily hospital charges and doctor's fees has raised the premium that an individual has to pay to get coverage to the level that many of the workers cannot afford coverage. This then puts them and their families in a welfare position when they become ill.

It is patently unfair to have two workers working side by side doing basically the same work with one receiving considerably more in base wages and fringe benefits just because of citizenship. Enactment of H.R. 767, without making provision for coverage for the non-citizen workers in the Canal Zone, will further increase the disparity that currently exists between the citizen and non-citizen employees.

On behalf of the National Maritime Union which represents approximately 8,000 workers in the Canal Zone, we ask that you make the necessary amendments to H.R. 767 to extend the health benefits to all workers in the Canal Zone.

Sincerely yours,

HOYT S. HADDOCK,
Executive Director.

STATEMENT OF LONNIE L. JOHNSON, NATIONAL PRESIDENT, NATIONAL ASSOCIATION OF POST OFFICE MAIL HANDLERS, AFFILIATED WITH THE LABORERS' INTERNATIONAL UNION, AFL-CIO

Mr. Chairman and members of the committee, my name is Lonnie L. Johnson. I am the National President of the National Association of Post Office Mail Handlers, Watchmen, Messengers and Group Leaders, affiliated with the Laborers' International Union of North America, AFL-CIO.

We want to express our appreciation for the opportunity to appear here this morning to testify on H.R. 767, which is of vital interest to the more than 50,000 Mail Handlers we represent exclusively across the country in labor-management relations and collective bargaining with the Post Office Department.

We also want to take this opportunity to commend you, Mr. Chairman and members of the Committee, for holding hearings on H.R. 767 because of the tremendous importance this legislation holds for all Federal employees. We strongly advocate passage of H.R. 767 to amend the "Federal Employees Health Benefits Act" and we believe our testimony will make a convincing case for favorable Congressional action on this bill.

Recent labor unrest within the Federal Government in general and in the postal service in particular emphasize the need for the Federal Government to satisfy the modern criteria of a good employer. It could be argued that the Federal Government as an employer should set the standard by which all others should be measured.

Our times show us the need for stability in employment; we have legislated controls over employee benefit plans to ensure the security of the individual; our regulation of such plans encourages employer payment of costs and sufficiency of benefits to meet individual needs. In the material which follows we propose to show that as an employer the Federal Government not only is not leading the way but has failed to maintain the standards it set for itself 10 years ago. We will follow this with some specific proposals.

As it was originally conceived, the Federal Employees Health Benefits Act provided the framework within which proper health care could be financed for Federal employees. The intention, partially realized in 1960, was for the Federal Government to pay half the cost of basic benefits. The Federal Government contribution was pegged to a fixed dollar amount of \$6.76 per month for an employee with family coverage.

In 1960, this was exactly 50% of the premium for the "low option" under the lowest cost plan. At that time the "high option" premium rate on the same plan was just \$3.94 or 29% greater than the "low option" plan. Based on testimony before the committee, it was presumed, at that time, that "low option" benefits would be the basic coverage elected by the large majority of participants. "High Option" benefits were expected to be elected by relatively few, higher paid employees. Developments since that time have run entirely contrary to this expectation. By far the largest majority of participants in programs under the Federal Employees Health Benefits Act have elected "high option" plans. As of December 31, 1969, 83% of the 2,575,800 Federal employees enrolled under Federal Employees Health Benefits Act plans had elected "high options". This is not difficult to understand if we consider the uncertainty in the level and incidence of expenses for health care. The need for security against unexpected losses in this area is an important one regardless of income level.

In 1960, the participant who elected the "high option" in the lowest cost plan paid not 50% of his total insurance cost but 61.3%. The commitment of the Federal Government to a fixed dollar amount of contribution did not respond to the fact that there was an inflationary trend in health care expenses. By 1965, under the same plan, the Federal Government's contribution was still pegged at \$6.76 while the employees' contribution had increased almost 80% to \$19.15. Thus, in a program where the original expressed intention had been for the majority of participants to pay exactly $\frac{1}{2}$ of the total cost, we find that within 5 years of inception the majority of participants were in fact paying 73.9% of the total cost during the same period there was a general trend in the private sector toward more and more employer participation in the costs of employee benefit programs. Government employees were faring far worse in this area than employees in the private sector.

By 1970, under the same plan, Federal Government contributions had been increased slightly to a flat amount of \$8.88. However, the total cost of this plan had increased to \$44.94. Thus, the employees' contribution had increased since inception by 240% to \$36.06 per month, 80.3% of the total cost. This is obviously not consistent with the original intent of the program.

The Mail Handlers Benefit Plan, as revised January 1, 1969, shows a similar disparity between employee and government contributions. The monthly rate under the "high option" for an employee with a family is \$32.85. Of this the Federal Government pays \$8.88, the employee pays \$23.97 or 73% of the total cost.

The National Association of Post Office Mail Handlers, Watchmen, Messengers and Group Leaders, with the cooperation of the Civil Service Commission, has managed to control costs under its program as much as possible under the pressure of run-away inflation in the cost of health care. In spite of these efforts the present system of contributions presents an unreasonable and increased burden on the individual participant.

The financial burden imposed upon the individual participant, described above, has arisen from three primary sources. First accelerating inflation in the cost of providing adequate health care; second, changes in the prevailing attitude toward the employers role in employee benefit programs; and third, the basis for government contribution under the Federal Employees Health Benefit Act.

As we all know, the costs of health care in the United States have increased rapidly in recent years. A commonly used indicator of such costs is the average hospital expense per day room daily rate. This index has gone from less than \$10 in 1946 to over \$60.00 in 1968. This index will exceed \$70 in 1970. There are few hospitals in the entire country whose rates have not increased as much as 60% during the last 5 years and many have doubled. An excellent source of statistics in this field are the consumer indices developed by the Bureau of Labor Statistics of the Department of Labor. It is clear that the cost of medical care services has increased at a far faster rate than living costs in general. The reasons for this are essential to the nature of the services provided. Changing patterns of health care and technological improvements have increased certain cost. Changing patterns of compensation especially among maintenance and service employees have sharply increased the cost of operating health care institutions.

An ancillary purpose of health insurance is to promote better use of health care facilities and to improve the health of participants through preventive medicine and early care. Many employers recognize this by paying the cost of the broadest possible benefits. The return to the employer on this investment is a healthy, loyal and persisting staff of employees. It has been estimated that improvements in worker efficiency more than pay for the cost of a good employee benefit program.

In a report prepared for the Civil Service Commission by one of the nation's top actuarial consulting firms, Milliman & Robertson, Inc. and submitted January 24, 1969, it was estimated that health insurance premiums for Federal employees would increase at an average rate of 20 to 25% every two years until 1976. Expert opinion is that the inflationary spiral in the cost of health services has not ended and may have entered a period of even steeper increases. In the report, the consultants state, "It would seem desirable for the government to pay a larger part of the premium, since the limitations now imposed have resulted in the decreasing percentage of contribution observed."

There certainly can be no question that the problem of financing the cost of health care for Federal employees is acute, current and urgent. During recent years there has been an increasing tendency for employers and employees alike to emphasize employee benefit programs. At one time it was common to think of such benefits as providing emergency care in the event of disaster. Today, employee benefit programs are an essential part of the compensation structure of every major employer in the United States. In labor negotiations, benefits and contributions are negotiated on the same basis as wage and salary increments. Invariably each succeeding contract has provided greater and greater benefits with increasing employer participation. A 1969 study shows that 50% of the large employers in the country paid the full cost of employees' health insurance. These include representatives of every major industry in the United States. The reasons for this trend both sociologically and economically are beyond the purview of this analysis. The factors influencing it are increasing and it is reasonable to expect that in the future almost all major employers will provide such benefits without requiring employee contributions.

This leads us to the position of the Federal Government as an employer. Federal Government contributions under the Federal Employees Health Benefits Act have been described in detail above. The fact that the government contribution has provided a decreasing percentage of total costs arises from the level contribution required by law as compared to sharply increasing total cost. How can this inequity be corrected on a non-discriminatory basis? It is clear that any level contribution toward a sharply increasing total will again become inequitable within a very short period of time. The final test of the adequacy and equity of any system of contributions toward a benefit program is in the proportion of actual benefits that can be purchased by those contributions. The only way that such equity may be ultimately achieved would be by the full payment of health care costs by the Federal Government for all of its employees.

HR 767 is aimed directly at meeting that goal by providing that the Federal Government ultimately pay the full cost of the employees' health benefits program. We strongly urge this Committee to take favorable action on this bill. Mail Handlers need relief from this increasing financial burden they can ill afford to bear in these times of inflation and other heavy demands on their paychecks. This bill offers an excellent opportunity for the government to step forward and provide leadership in this area.

Mr. Chairman and members of the Committee, we want to express our appreciation for the opportunity to testify on this vital legislation.

