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FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF 1959

JULY 2, 1959—Ordered to be printed

Mr. JOHNSTON of South Carolina, from the Committee on Post Office and Civil Service, submitted the following

REPORT

together with

INDIVIDUAL VIEWS

[To accompany S. 2162]

The Committee on Post Office and Civil Service, to whom was referred the bill (S. 2162) to provide a health benefits program for Government employees, having considered the same, report favorably thereon with an amendment, and recommend that the bill, as amended, do pass.

AMENDMENT

The committee amendment strikes out all of the bill after the enacting clause and substitutes therefor a new bill which appears in the reported bill in italic type.

BACKGROUND

Prepaid health benefits are available today to 123 million persons in the United States and assist in financing more than half of the Nation's hospital bill and a sizable proportion of the Nation's bill for physicians' services. The growth of voluntary health programs into a $4.5 billion industry is an indication of the value placed on the opportunity to budget medical expenses by the American people. More than 75 percent of those enrolled in prepaid health benefits plans are enrolled through the place they work, clear evidence of the recognition by private employers that participating with their employees in obtaining health insurance contributes to the well-being and efficiency of their workers.

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AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

The Federal Government has for many years lagged behind private industry in not making it possible for its employees to purchase health insurance at group rates by authorizing payroll deductions. That Federal employees are anxious to have the protection afforded by an adequate health program is plain from the fact that they have on their own initiative developed quasi-groups of various kinds. Employees have made arrangements with insurance companies, Blue Cross and Blue Shield, or have formed their own benefit and insurance organizations, or as union members purchased group policies.

LEGISLATIVE HISTORY

Starting in 1947, there have been at least 30 bills introduced in the House and Senate to establish a program for Federal employees providing for (1) payroll deductions for premiums, (2) Federal contribution, (3) latitude to select a health benefits plan that fits the employees' health needs.

The present administration has sponsored several types of proposals in the past. All of them have called for a Federal contribution. Extensive hearings were held in May and June of 1956 by the House Post Office and Civil Service Committee. In the past no bill has come out of committee in either the House or Senate, largely because there were disagreements about details between and among employee groups, the carriers and the proponents of the bills.

The Subcommittee on Health Insurance of the Senate Post Office and Civil Service Committee held hearings on S. 94 on April 14, 16, 21, 23, 28, and 30, 1959. Fifty-four witnesses were heard. In addition, numerous organizations submitted statements and exhibits. The report on the hearings covers 364 pages.

Unlike many proposals of the past this measure has the endorsement of—

The American Medical Association.
The American Hospital Association.
The insurance industry.
Blue Cross and Blue Shield.
Group practice plans.
Federal employee unions.

This is the first time all these interested parties to such a program have been in agreement.

FREE CHOICE AMONG PLANS

For most employees there would be a choice between two alternative plans—

1. A Blue Cross-Blue Shield and supplemental benefits "package" with basic benefits on a service basis, a deductible and a fixed ceiling on the amounts of coinsurance paid by the employee.
2. An insurance company "package" similar to No. 1, but providing cash indemnity benefits.

Employees belonging to a national employees association offering a qualified plan to its members, or living in an area served by a qualified group practice prepayment plan, would have the alternative choice of enrolling in such plans.

EFFECTIVE DATE

The bill would become effective on July 1, 1960.

STATEMENT

The bill provides Federal civilian employees with health benefits comparable to those available to other large employee groups by authorizing (1) payroll deductions and (2) an equal contribution by the Government to meet the costs of the program. It provides that employees may choose to participate or not and may select from among several plans offered by approved carriers. It provides for inclusion of the members of the employee's immediate fnmily, if desired, and for the continuation of benefits to future annuitants and their families, and for survivors. Separated employees may continue their protection without further Government contribution. The bill provides for the orderly development and administration of the program under the Civil Service Commission.

In developing a program of health benefits for Federal employees, the committee established a set of guiding principles to be observed. These principles fall into three categories; those relating to employee interests and concerns; those relating to the Federal Government as an employer; and those relating to governmental interest in the impact of so large a program upon the provision and cost of health service to the entire population. Some of these principles and the provisions of the bill which reflect them are closely interlocked and substantial modification of one would in turn affect another.

Principles related to the interests of employees

The program should embrace as many Federal employees as feasible.

It should provide coverage for members of an employee's immediate family.

For overseas employees and their families, coverage should be continuous whether or not they are overseas or on home leave.

The program should provide employees with benefits which they cannot obtain for themselves at a comparable cost.

Employees should within limits have freedom to select the kind of plan that they deem most suitable for their needs.

Employees should be provided with a health benefits plan that removes uncertainty as to the medical bills to be met out-of-pocket.

Premiums and costs should be fixed in advance on a relatively stable basis so employees can budget their health care expenditures.

The program should recognize the problems of the low income employee and be specifically designed to aid such employees in securing health benefits.

Annuitants should join with active employees in contributing to costs and should receive equal assistance from the Federal Government in meeting costs.

Employees separated from the Federal service should be able to continue their benefit program as individuals on a conversion basis but without benefit of Government contribution.

Participation in the program should not terminate because of health or employment status or because of age.

Principles related to Government as an employer

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.

The Federal Government has a greater opportunity than other employers to influence soundly the development of health services and ways of financing their costs. This opportunity should be used to encourage all responsible and promising efforts and not be arbitrarily limited to any single approach. Reasonable competition among different types of programs will provide Federal employees with a better program. However, unrestricted competition could make the program administratively unwieldy and ineffective.

As with any program of this magnitude, continuing study should suggest possible improvement and change.

Principles related to the Federal Government's interest in the impact of this large program upon the provision and cost of health service to the entire population

The committee intends that in providing Federal employees with health benefits it shall foster the types of health benefit programs that encourage prevention and discourage unnecessary use of expensive facilities and services.

The committee also seeks to avoid setting in motion any forces that would inflate the costs of hospital and medical care for the total population.

Persons eligible to participate

Employees.—It is the intent of the committee that civilian employees generally be eligible to participate in the health benefits program.

The bill applies to overseas employees.

By regulation, the Civil Service Commission may provide for the exclusion of employees on the basis of the nature and type of employment or conditions pertaining thereto such as short-term appointments, seasonal or intermittent employment, and employment of like nature, but no employee or group of employees shall be excluded solely on the basis of the hazardous nature and type of employment or conditions pertaining thereto.

The bill does not include county office employees of the Agriculture Stabilization and Conservation Service of the U.S. Department of Agriculture. Such employees are not employees of the Federal Government but are employees of county committees. Since they are not paid by the Federal Government, there is no Federal payroll from which to deduct their contributions and no salary allotment from which the employer's share of the premium could be drawn.

Employees of the TVA are excluded, by request, from the legislation. The TVA has had its own health insurance programs since 1956 involving employer contribution and deduction from employees' paychecks.

Employees in leave-without-pay status may be authorized to continue their coverage and the coverage of members of their family. The Civil Service Commission is to promulgate appropriate regulations to take into account the different lengths of time employees are in leave-without-pay status and the factors such as illness, study periods, travel, etc. that make it appropriate or inappropriate for

the Government to continue its contribution toward the cost of benefits for such employees.

Noncitizens employed by the Federal Government in the United States are eligible to participate. Alien employees of the United States outside the United States, its possessions, and Territories are excluded. Employees of the Federal Government in the Commonwealth of Puerto Rico are included as are those in the Canal Zone.

Annuitants.—Annuitants who—

(1) retired on or after July 1, 1960, or

(2) retired other than voluntarily on or after the date of enactment but prior to July 1, 1960,

on an immediate annuity, with at least 12 years of service or for disability, may continue under the plan they selected and enrolled in before retirement or, in the case of annuitants mentioned in paragraph (2) above, in a plan of their choice.

The committee intends a liberal construction of the phrase "other than voluntarily."

Deferred annuitants, regardless of length of service, do not qualify for coverage because of the requirement that they be enrolled in one of the contemplated plans immediately prior to retirement.

Annuitants retiring after July 1, 1960, with less than 12 years of service who have been enrolled in a plan immediately prior to retirement have the right to convert their coverage to an individual contract of the plan in which they were enrolled as active employees.

The committee feels that the Federal Government has its greatest responsibility to those employees who have made the Federal service their career and who retire from the service at an age when other forms of health insurance are not readily available to them at reasonable cost. Attention is also called to the provisions of the bill which allow any employee leaving Federal service to continue under an individual noncancelable contract. Persons who leave the Federal service for private employment, where such benefits are widely available, are now likely to be protected through such means during the interim before they start drawing their deferred annuities.

Survivor annuitants of eligible retired employees (as defined in an earlier paragraph) and of employees who die in service after July 1, 1960, may continue their benefits if (1) they were enrolled in a plan prior to becoming survivor annuitants and (2) in the case of survivors of active employees, if the employee had completed five or more years of service prior to his death. The stipulation that there must have been 5 years of service on the part of the deceased employee is required in order that there be an annuity payment from which the annunitant's contribution can be deducted. Survivor annuitants not qualifying to continue under the plan have the right to continue coverage under an individual contract of the plan in which they had previously been enrolled.

Contributions by annuitants

The committee considered two major aspects of this problem, namely: (1) could equitable provisions be made for the payment, during the working lifetime, for benefits received during retirement and (2) could contributions from annuitants be made by deductions from annuity checks with reasonable facility. It was reported to the committee that less than one-quarter of Federal employees continue in

Federal employ long enough to become eligible for an immediate annuity upon separation from the service. Obviously, therefore, efforts to pay all non-Government costs for retirees from contributions of active employees would impose substantial costs on many employees who would never benefit from such mandatory contributions. It appeared, therefore, that administrative convenience was the only deterrent to annuitants sharing in the costs of benefits received during retirement. Since such participation in the program after retirement is optional with the annuitant, since the actual cost of benefits used by retirees is far above the average cost per person in the program, and since such benefits are not otherwise available to older persons at comparable costs, it seemed wise to provide for annuitants to continue to share in meeting the substantial costs of the benefits provided them.

Beneficiaries of old age, survivors and disability insurance

The definition of an annuitant contained in section 2(b) as being a person retiring "under the Civil Service Retirement Act or other retirement system for civilian employees of the Government," does not intend that the old age, survivors and disability insurance program be held to be a "retirement system for civilian employees of the Government."

Federal employees compensation cases

The committee gave particular attention to the provisions for coverage of Federal employee compensation beneficiaries. The number of such cases resulting in permanent injury or death in any one year is small (1,400 permanently injured, 175 to 180 deaths annually). The compensation received under the FECA discharges the Government's special obligation to these cases. The committee, however, felt an obligation to provide the families of these cases with health benefits coverage equivalent to that available to them had not the injury or death occurred. The bill, therefore, classifies these persons as annuitants and survivors under the same terms as are applicable to other annuitant and survivor families.

Members of family.—The following members of the families of employees or annuitants are also eligible to participate:

1. Wives and husbands: A dependent husband of a female employee is defined as a husband incapable of self-support by reason of mental or physical disability, and who receives more than one-half his support from the employee or annuitant. Husbands of female employees not classed as dependent husbands are eligible to participate but no Government contribution is made on their behalf.

2. Children: A child is defined as an unmarried child under the age of 19 including an adopted child and a stepchild or recognized natural child who lives with and receives more than half his support from the employee or annuitant or an unmarried child regardless of age who is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching the age of 19 years and who is in fact dependent on the employee or annuitant for over one-half his support.

3. Where both husband and wife are employees, each may participate separately for themselves alone. If there are children and the employee wishes to enroll them, only one spouse may enroll for family coverage.

Various birthdays were suggested as being appropriate for ending coverage of children as dependents under family policies. S. 94 included children to age 19 unless they were enrolled in a full-time course of study at an educational institution; in that event coverage was extended to the 23d birthday. The Civil Service Commission's proposal of April 15 suggested an age limit of 21 for all children whether or not they were in school.

The committee was aware of the prevalence of college health plans and of inexpensive "education" health policies available for students. It also examined the prevailing provisions for terminating children's coverage under family policies in voluntary health insurance plans throughout the country. It concluded that it was desirable to cover children until the normal age for completing high school. At this age many young people cease to be dependent and become wage earners. Coverage to age 19 seemed, therefore, the most logical provision.

One person and family coverage and contributions

The committee considered a number of alternatives before it established the three levels of employee contributions and the two kinds of coverage—single and family—specified in the bill. In deciding against including a two-person type of coverage, the committee was convinced that two-person coverage should not be offered. Two-person families not interested in maternity benefits are usually those whose children are grown and who are approaching a period in life when their use of hospital and medical services is greater than that of young families including children. The cost of their benefits is comparable to that of younger families, including children.

The administering agency will make necessary regulations about the times at which employees may change their coverage from single to family coverage or vice versa. However, the legislation calls for filing of an application within 60 days of the occurrence of a change in family status unless the Commission prescribes otherwise.

The committee felt that the administering agency should be free to issue regulations concerning the times and conditions under which employees or annuitants could transfer from one health benefits plan to another. These regulations should be such that no one plan will become overloaded with annuitants because of transfers made immediately preceding retirement, or in anticipation of some special benefit of the plan to which transfer is sought.

Already retired Federal employees

Ways of including the present annuitant group in the program were explored in great detail. In the interests of having legislation that would be acceptable costwise, action has been deferred on a program for the already retired. The administration has opposed providing coverage for the presently retired and their dependents and survivors. The committee intends to devote the necessary time to a study of this large and complex problem.

Types of health insurance carriers considered and reasons for inclusions and exclusions

There are between 1,000 and 1,100 different insurance carriers offering health insurance to the public. This list includes (1) 71 Blue Cross plans, 8 Blue Cross-Blue Shield plans, 58 Blue Shield plans, a number of other nonprofit plans similar to these plans except that they are not affiliated with the Blue Cross Commission and the Blue Shield

Commission; (2) between 800 and 900 insurance companies; (3) 8 group practice prepayment plans presently enrolling community groups; (4) certain employee organizations with organized health insurance plans for their own members. In addition, a number of employee organizations have arranged contracts with insurance companies to provide health insurance coverage for their members on a group basis.

Many of the foregoing carriers are providing health benefits to Federal employees either through individual contracts or through contracts made possible by forming some kind of a group with a collection mechanism other than payroll deduction. Data were presented in the hearings showing that, taken together, the Blue Cross and Blue Shield plans covered approximately 1 million Federal employees and their families. Lesser numbers are enrolled by other identifiable groups, such as the Kaiser Health Plan, a group practice plan on the west coast with 70,000 Federal employees and their dependents enrolled, and the employee association sponsored plans.

It is obviously not feasible for the Federal Government to participate in any approach to payroll deductions and Government contributions for health insurance involving direct dealings with hundreds of different carriers. Furthermore, the history of health benefits programs indicates three major advantages accrue to employees from the formation of large groups. These advantages are (1) lower cost for broader benefits, (2) administrative savings, and (3) continuity of coverage.

At the same time, the committee recognized the validity of statements made by a number of witnesses that competition among carriers and plans was healthy and should tend to produce lower costs than if only one approach using one carrier or syndicate of carriers were used to cover all employees. For this reason, among others, the use of a single mechanism suggested by the Civil Service Commission in its testimony on April 15 was not considered as the most desirable approach.

The committee further recognized that the service benefit approach employed by the Blue Cross and Blue Shield plans to provide benefits was widely accepted both by the public generally and by Federal employees in particular.

The arrangements whereby Blue Cross members may enter hospitals without an advance deposit and leave the hospital with a minimum payment for items not covered by Blue Cross seemed desirable for low-income employees. Blue Shield's guarantees of full payment of surgical and inhospital medical bills incurred by member families with incomes below certain ceilings likewise appeared to be a helpful arrangement that should be made available to those employees wishing this provision. These features of Blue Cross and Blue Shield plans are the reason they are referred to as service benefits plans.

The committee was impressed with the fact that a majority of Federal employees had already selected the service benefit approach by enrolling on their own motion in a Blue Cross-Blue Shield plan. The committee was however aware that it could not determine employee preferences in this matter because, in the absence of payroll deductions, no adaptations of standard group insurance policies have been made generally available to Federal employees.

Testimony before the subcommittee indicated that the Blue Cross-Blue Shield plans were prepared to offer a national service type

plan. That the insurance companies were likewise prepared to offer Federal employees a single national plan was indicated in the testimony of the witness for the insurance industry and was also evident from the Civil Service Commission's proposal of April 15 and from its second proposal of May 18.

Witnesses representing prepaid group practice plans impressed the committee with the scope of benefits these plans were able to provide. The value of the preventive and diagnostic services they provide and the reductions in use of hospitals achieved by use of outpatient facilities were noted.

Witnesses from employee organizations sponsoring health insurance plans for their members described the benefits they have made available to employees, former employees, and retired employees. Genuine hardships would be created for these plans and for the employees enrolled in these worthy efforts if the largest segment of their enrollment were prevented from continuing to participate. The plans would not be able to continue operation if confined to retired and former employees; the retired in particular would suffer.

The committee reached the conclusion that it could accomplish its several objectives by permitting employees to have a limited number of choices among carriers using the several approaches indicated. The bill therefore contains provisions which would permit employees to select from among:

(1) A national service type plan.
(2) A national cash indemnity plan.
(3) Group practice plans where they exist.
(4) Employee organization plans sponsored, contracted for, and administered in whole or substantial part by a national employee organization, available only to members of the sponsoring organization.

Most employees would have dual choice as between a service and a cash indemnity plan (No. 1 and No. 2 above). Some employees might well have four choices. The multiple choice possibility would arise only for employees eligible to belong to an employee organization with a sponsored plan and/or for employees living in the localities where there are qualifying prepaid group practice plans.

The degree of choice provided by the bill appears to permit competition between the two major sources of health benefits. It allows employees to select service plans such as Blue Cross-Blue Shield or cash indemnity plans. It permits the continuation of those employee plans whose participants might suffer if their enrollment of Federal employees melted away. It permits employees who wish to obtain their medical care through group practice arrangements to do so.

Benefits provided under the plans

The information provided the committee indicated that the prepayment health benefits being purchased in the United States today are continually evolving. Ten years ago benefits only for hospitalization costs were usual. Today more and more of the items contributing to a family's total medical care expenditures are being included in prepaid arrangements.

Not only is the range of prepayment benefits expanding, but diverse methods of financing health benefits also are being continuously developed. Since 1950 two important new approaches have been introduced

and are being increasingly tested by various carriers. The first of these added a new rider called "major medical expense benefits" to the hospitalization and surgical-medical benefits generally included in existing insurance policies. Under plans providing these riders to the basic benefits, the insured person is responsible for paying certain fixed sums for charges incurred that exceeded basic benefits. This is called the corridor or the deductible. If incurred charges are more than this corridor, the major medical expense rider pays 75 percent or 80 percent of the remainder up to a large maximum dollar amount.

The second approach does away with the concept of basic hospital and surgical benefits and instead calls for a deductible paid by the insured patient; after the patient has paid this amount, expenses exceeding the deductible are paid in large part (75 percent or 80 percent) by the insurer, with the patient paying the remaining 20 percent to 25 percent—again up to a large maximum. This approach is sometimes referred to as comprehensive insurance.

In the population of the United States, a total of about 100 million persons had basic hospitalization and surgical benefits and 11 million had major medical expense as a rider or supplement to these benefits at the end of 1958. A growing number of persons are enrolled in the prepaid group practice plans; about 5 million people were eligible for benefits in plans of this type at the end of 1958.

The committee felt it would be desirable from the employees' standpoint for the legislation to permit revision of benefits so that advantage could be taken of new developments in this rapidly evolving field.

For this reason the bill provides for basic benefits in the usual patterns now applicable to 100 million persons but gives latitude for the adaptation of alternatives of existing or new types as they are developed and proven useful and sound.

Basic benefits that may be provided

The bill provides a broad framework within which the Civil Service Commission can develop specific contracts for benefits. Programs of basic benefits coupled with supplemental benefits (major medical expense) and insurance company benefits (of the type referred to as comprehensive), which impose an initial deductible paid by the patient and invoke coinsurance on the remainder can both be provided. While no maximum amounts of benefits are specified in the bill, the Civil Service Commission would have authority to establish such maximums. The committee considers it unwise to tie the Civil Service Commission's hands by specifying dollar maximums or to spell out in detail the specific benefit structures. Further limitations might prove to be unnecessary and undesirable, or some kinds of benefits might, in time, become inordinately expensive in relation to the service received by employees. Furthermore, the committee recognizes that this country may be on the threshold of several major breakthroughs in the field of medicine and in the provision of medical services partly as a result of the many programs initiated by the Congress to encourage and support medical research and health services. Therefore, the committee believes it unwise for the legislation to freeze the pattern of benefits so that future contracts could not rapidly adapt to new developments in this field.

As guidance in negotiating contracts, the bill indicates the types of benefits that should be provided by at least one of the health benefits

plans which the Civil Service Commission may approve under the legislation. The language of the bill recognizes that the detailed description of benefits to be made available under it will flow from the contracts authorized by the bill and requires that this description be given to those eligible to participate.

Hospital benefits

At least one of the health benefits plans is expected to provide benefits equivalent to the full cost of hospital care in semiprivate accommodations in a general or acute special hospital for 120 days in any period of continuous care, or for 120 days in the aggregate in any period of such hospitalization separated by 90 days or less.

These benefits would apply to the cost of the semiprivate room and board and to the other items of hospital care such as use of the operating room, the recovery room, the cystoscopic room, laboratory tests, X-ray tests and treatment, drugs, dressings and casts, general nursing care, anesthesia, oxygen, and so forth.

The committee learned that room and board charges of hospitals generally account for only about half the costs patients incur in the hospital. This emphasizes the importance of benefits which provide adequately for the necessary use of all aspects of hospital service, not simply room and board charges.

If the patient exhausts his benefits under the above provision, he would be entitled to further protection under the supplemental benefits provisions described later.

If the patient occupies a private room, the additional cost over and above that of a semiprivate room would not necessarily be part of this benefit. The Civil Service Commission would be empowered to include or exclude this cost from coverage under supplementary benefits.

In the case of tuberculosis and nervous and mental conditions, general hospital benefits are limited to 30 days.

The committee understands that only a fraction of 1 percent of all admissions to general hospitals stay more than 120 days so that the provision for a 120-day benefit sets a high standard. They further understand that it is frequently medically desirable to provide short-term intensive treatment for mental conditions in the environment of a general hospital. Longer treatment appears to call for a special type of hospital.

Surgical benefits

At least one of the health benefits plans would be expected to provide surgical expenses benefits that would provide payment in full of the surgeon's fees for a large segment of Federal employees enrolled in that plan.

The standards outlined in the bill for surgical benefits anticipate coverage of charges that are customary for Federal employees in the first nine grades of the classified pay system. Thus the Civil Service Commission would not be expected to contract for surgical benefits of larger amounts than the great majority of employees would ordinarily be charged by their attending surgeon. This standard appeared desirable to the committee to avoid having legislation affecting 4.5 million people operate to artificially inflate the charges for these services.

Normal obstetrical services are not included under surgical benefits but are eligible for special benefits. Abnormal deliveries, on the other

hand, including ectopic pregnancies and caesarean sections, are included.

Surgical services provided outside the hospital can be included. They are among the ambulatory patient benefits described later.

The bill contemplates the provision of benefits for in-hospital dental surgery.

In-hospital medical benefits

At least one of the health benefits plans would be expected to provide in-hospital medical benefits. These are payments for physicians' nonsurgical visits to hospitalized patients, such as heart cases, pneumonia cases, and the like. The standard would allow such visits during 120 days of hospitalization. at amounts per visit that would be customary for the vast majority of Federal employees. Such matters as the number of visits per day that would be paid for is left to the Civil Service Commission.

Ambulatory patient benefits

Some health benefits plans are able to provide medical and other benefits to ambulatory patients. To the extent practicable, reasonable, and desirable, the Commission could approve of the provision of these benefits since they may reduce to some degree the use of more costly in-patient accommodations.

Other ambulatory patient benefits that may be included are services in the case of accidental injury, minor surgery in the doctor's office and such diagnostic and treatment services as can be included.

Obstetrical benefits for normal deliveries

The committee heard testimony that the benefits paid for hospitalization of maternity cases and for the services of the physicians performing the deliveries require substantial portions of payments for health service. Other data indicated a rather wide range in the costs of such hospital care and in the fees customarily charged by the attending physician. Average hospital charges per semiprivate patient ranged from $125.31 in Kansas to $215.51 in New York City. Under Medicare the average charges per case for hospital care and the physician have amounted to $334 with the hospital's charges averaging about $150 and the physician's charges $184.

The employee family expecting a child is in a different position from a family faced with an emergency operation. There is time for planning for a baby's advent; also it is a benefit that not all employees will need. The bill introduces an element of coinsurance in the benefit for normal deliveries. For employees in the lower grades the level of benefits should cover most, if not all, of the expenses for normal delivery. Protracted and costly complications of pregnancy can be provided for under the supplemental benefits section of the bill.

Supplemental benefits that can be provided by the plans

The preceding five types of benefits are often categorized as "basic benefits." The bill provides for supplemental benefits, which may be applicable in the event of a costly illness ("major medical expense") but could be equally applicable for types of expenses not coming within the purview of "basic benefits" and "major medical expense." These benefits are applicable to the expenses incurred in either hospitalized and nonhospitalized illnesses. Benefits for these additional charges for health services are also paid for types of expenses not ordinarily included as standard benefits such as some private duty nursing services, prescribed drugs, physical restoration services.

In the course of the hearings, the committee became aware of the wide variation in the forms of supplemental benefits available. Some applied the corridor per illness, others per year, and the deductibles varied widely. Maximum amounts payable ranged from $5,000 to $20,000. The coinsurance was sometimes 25 percent and sometimes less.

There was recognition that an illness so costly that it exhausted basic benefits and the benefits under the supplementary program would leave the patient little opportunity to pay unknown amounts of coinsurance. The committee concluded that the scope of such benefits should be suggested but not fixed by statute.

Under this structure, the individual would pay a corridor of $100 for additional charges for health services. He would also pay 20 percent of the next $1,400 of such additional charges ($280) and the insurance would pay 80 percent ($1,120). Additional charges in excess of $1,500 would be covered in full by the insurance.

An illustration will indicate how this benefit operates:

A heart case that spent 6 months in the hospital and incurred costs of $5,500 would have 93 percent of his costs covered, 69 percent by basic benefits and 24 percent by supplemental benefits. The details follow:

Costs:	
(1) 180 days in semiprivate room at $16 a day	$2,880
(2) Oxygen, special drugs, electrocardiograms, laboratory tests, physiotherapy, ambulance	1,895
(3) Special duty nurses for 5 days	225
Total hospital bill	5,000
(4) Physicians' charges	500
Total bill	5,500

The division of the charges between insurance benefits and the patient himself would be:

Basic insurance pays for 120 days at $16	$1,920
Hospital "extras" during 120 days	1,500
Physicians' fees, $4 a visit for 100 visits	400
Basic insurance pays	3,820
Balance to which supplemental benefits apply	1,680
Patient pays corridor	100
Amount subject to supplemental benefits	1,580
Patient pays 20 percent of $1400	280
Insurance pays remainder	1,300

Another example is of a 4-year-old child with nephrosis. The total bill was $3,054. It involved 32 days in the hospital and heavy expenses for physicians and drugs outside the hospital:

Basic insurance pays	$1,080
Supplemental insurance pays	1,594
Patient pays	380
Total	3,054
Expenses incurred:	
Hospital room and board (32 days)	570
Other hospital services	382
Physicians (home, hospital, and office)	516
Drugs and medicines (out of hospital)	1,444
Diagnostic studies (out of hospital)	96
Miscellaneous (out of hospital)	46
Total	3,054

How the program would operate

Before examining specific parts of the proposed legislation, the overall framework should be understood. The implementation of the act would require several stages. The first stages would probably take nearly 6 months.

(1) The Civil Service Commission would formulate specific and detailed proposals for the health insurance programs it would expect to offer employees including:

(*a*) A national Blue Cross-Blue Shield offering.

(*b*) A national insurance company indemnity benefit offering.

(*c*) Plans sponsored by national employee organization for their members.

(*d*) Offerings by group practice prepayment plans in the areas in which they operate.

(2) A series of meetings between Civil Service Commission officials and carriers interested in participating in the program would follow. In these meetings the costs of different benefits and the savings in premiums that might be achieved from eliminating one or another benefit would be thoroughly explored. The cost of adding or substituting other benefits would also be investigated.

(3) On the basis of the exchange of information and understandings reached during the meetings, the Civil Service Commission would be prepared to receive firm contract offerings from the various carriers. These offerings would cover premium costs and contain detailed specifications of the benefits. Administrative costs, the carrier's proposed method of operating (such as establishing a clearinghouse enrollment and transfer procedures, etc.) and all other matters that would enter into the final contracts would be submitted for study.

(4) The CSC would determine which offers it wished to select as approved health benefits plans. It would limit the number of plans to two national plans, the group practice plans, and the four or five employee association plans that could qualify.

(5) The CSC would send copies of the proposed contracts to the Advisory Council for its information.

(6) The CSC would transmit to the Committees on Post Office and Civil Service of the Senate and the House of Representatives copies of any proposed contracts to be entered into and regulations proposed to be promulgated, for the purpose of placing into operation health benefits plans under this act.

(7) The Civil Service Commission would then enter into contracts with the selected carriers.

(8) The Civil Service Commission would indicate in regulations the format etc. to be used by each of the selected carriers in setting forth a description of its plan and its costs, exclusions, etc. These descriptions would be circulated to every Federal employee eligible to participate in the health benefits program.

(9) On the basis of the descriptions of the plans, and where practicable and desirable through meetings of employees, employees would be informed of the options available to them. (The legislation requires that employees shall have the opportunity to make "an informed choice."). Within a reasonable length of time employees would then complete and sign a form indicating the plan of their choice if it is their intention to come under the program. Also, this

form would constitute an authorization for payroll deductions for the employee's portion of the premium.

(10) The forms would yield the necessary data for determining the distribution of employees among the various health benefits plans and for determining the proportion of employees electing single or family coverage. The cost to Government for the aggregate of the various options can be established at this point.

(11) Payroll deductions would be made for the first pay period starting on or after July 1, 1960.

(12) Most, if not all, of the selected health plans would have established a central office of their own to handle the program applicable to the employees that had selected their plan. These offices would receive an initial listing of their enrollees classified as to whether single coverage or family coverage was selected. Employees would be issued some evidence of enrollment under the health benefits plan selected. Separated employees and new employees would be subsequently reported to the carriers. The mechanisms for such reporting may vary among carriers.

(13) Each employee under the program would be issued a booklet setting forth the benefits to which he and his family are entitled, explaining the way this plan operated and giving him information about keeping records of his medical expenses, entering hospitals, filing claims, and the like.

Contributions and costs

In the preparation of this legislation, the committee was faced with three choices in regard to the contributions from employees and Government:

(1) Amounts of employee and Government contributions could be omitted entirely from the bill.

(2) Maximum contributions by the employee or by the Government could be specified, leaving the other party's contribution open.

(3) Maximum contributions by Government and by the employee could both be specified.

Each of these choices had advantages and disadvantages which the committee weighed. The committee selected the third approach, and has specified in the bill the maximum amounts to be contributed by the Government and by employees.

Having the legislation contain specific maximum figures had the virtue of informing those who are to be aided by the legislation what maximum their share and that of the Government might be. It places a specific monetary ceiling on proposals carriers can make under the program. It establishes the principle of a 50–50 sharing of costs by Government and employees, regardless of the plan selected by the employee. Secondly, by agreeing to match a "rich," a "thin" or an in-between benefit package, the Government is indicating its willingness to foster the broadest forms of health service while giving the employee his free choice among alternative plans.

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 in living costs. The committee believes that the Congress will continue to be respon-

sive to the needs of employees and will act appropriately to keep the proposed program in consonance with future developments.

The committee recognizes that older employees and those retiring in the future have somewhat heavier demands for health services than younger employees and have little or no opportunity to provide in advance for the cost of these services. At the same time, it recognizes that, in the initial phases of this program, the proportions of annuitants to active workers will be small and that the average age and utilization of the annuitants initially covered will be lower than that of all persons past age 62 or 65. The committee believes that future annuitants will welcome the opportunity to participate in the program and to share in the cost of their coverage in the same amount as when they were employed, while receiving greater benefits because of their greater use of health services. It has been suggested that this added cost be "prefunded." This is not contemplated by the bill because (1) the costs of services needed by retirees many years in the future is unpredictable within reasonable limits, (2) substantial contributions would be required from many active employees who would not benefit from such contributions, (3) a complex fiscal and administrative structure would be established to perform a function that at best can be only partially carried out, and (4) the added costs of a growing number of retirees, while they will become large in the aggregate, will increase only a small varying amount each year. Therefore, the committee chose to deal with the problem of the cost of future retirees on a "pay-as-you-go" basis.

Having chosen to state the maximum amounts of Government and employee contributions in the bill, these amounts were then established at a level which the committee believes are somewhat above the sums called for by the national contracts in the initial phases of the program. Thus ample time would be provided to study the experience with this large and unique group. At the same time, the maximum contributions stipulated appear high enough to allow the most complete (and therefore the most expensive) of the group practice plans to be a participant.

The maximum contributions to be withheld from employees' salaries and annuitants' annuity checks, and matched by the Government are as follows:

Maximum biweekly contribution

	Employee or annuitant	Government
Individual employee	$1.75	$1.75
Male employee and family (children covered to age 19)	4.25	4.25
Female employee, dependent husband and children (to age 19)	4.25	4.25
Female employee, nondependent husband and children (to age 19)	6.00	2.50

When both husband and wife are employees or annuitants, each may enroll for himself alone at the rates for individual employees.

Aggregate costs

Data on the number of married women working for the Government, or the number of instances where husband and wife are both Govern-

ment employees, do not exist. To arrive at aggregates the cost estimates that follow assume that:

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

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

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

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

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

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

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

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

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

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

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

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

The Federal employees health benefits fund

The bill creates a fund which is a repository for, and keeps separate for the purposes of this bill, the amounts deducted from employees' salaries and the Government's contributions. The moneys in the health benefits fund are to be used for three purposes:

(1) to pay the premiums or subscription charges under policies or contracts purchased from or entered into with carriers;

(2) to pay necessary expenses incurred by the Commission in carrying out the act; and

(3) to provide an adequate reserve to assure stability of subscription rates over a reasonable period.

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

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

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

The Advisory Council

A guiding consideration in the preparation of the bill has been that the proposed program is not only for the benefit of employees but is being financed to a large degree by the employees themselves. Secondly, the Government in contributing its share of the cost has a large stake in the sound operation of the program. In addition, the Government has an obligation to foster such programs as will not be deleterious to the public generally. With these considerations in mind, the Advisory Council has been constituted from—

(1) representatives of agencies of the executive branch of the Government concerned with employment and employee relations, with provision of medical care and its cost and with governmental finances;

(2) three employee representatives; and

(3) public representatives conversant with the provision of hospital and medical care, trends in medical care and public health and the like.

The Commission, of course, could consult with and seek the advice of experts in the field of health benefits without legislative direction or authorization. However, there would be no assurance of this being done. The committee thought that because of the lack of experience by the Civil Service Commission with a program of this kind and due to the absence of facts upon which to base decisions, it would be well to require and give official standing to a strong and competent advisory group. The committee thinks this action will assure adequate consideration to all parties and result in proper administration of the program. The committee does not intend that this advisory group involve itself in the administrative functions of the program.

The committee hopes that the employee organizations will by some appropriate process undertake to select and suggest to the President individuals qualified to bring to the council a full reflection of the views and interests of Federal employees and their associations.

The committee felt it was inappropriate for the carriers in a contractual relationship with Government under the legislation to be included on an Advisory Council. Full and frequent consultation by

the Civil Service Commission with representatives of the carriers on technical aspects of the administration of the legislation is anticipated and intended.

Quarterly meetings of the Advisory Council are stipulated in the bill. It is the committee's belief that sessions at least four times a year would facilitate the Advisory Council's understanding of the complex field of health benefits, their impact on the economy and result in a more effective program under the bill.

Studies and reports

The committee feels that section 11 of the bill, in which continuing study of the operation and administration of this act by the Civil Service Commission and the Advisory Council is required, is a most important provision. It requires continuing analyses not only of the fiscal aspects of the program but also of the utilization of the benefits. It calls for study of such matters as possible overutilization and misuse of health services, of the proportions of employees' medical expenses being met by the benefits and for recording whether service benefits guaranteed to employees in the lower grades of the Federal pay scale are in fact being provided. Carriers are required to furnish such reasonable reports from their records as the Commission deems necessary to carry out its studies.

On the basis of the studies contemplated, the Commission will have a factual basis for recommendations it may wish to make for improvement of the program.

The retirement and life insurance programs now constitute a large part of the Commission's operations. With the addition of a health benefits program, the Commission's operating functions could suffer unless it is properly organized to absorb the additional burden.

The life insurance reserve fund is now approaching the $200 million mark. It is contemplated that the health insurance reserve could go as high as $30 million. The retirement fund now disburses over $600 million annually.

It is contemplated that the Bureau will spend much time with carriers in developing the health program. This will require the full-time services of a competent Bureau Director authorized to speak for the Chairman of the Commission.

There is nothing magic in the formula which gives the Executive Director wide latitude of authority over personnel services as well as the civil service functions of the Commission.

For these reasons, the committee recommends the creation of a Bureau of Retirement and Insurance responsible to the Chairman with a Director at grade GS–18. This provision would add very little cost to the budget of the Commission, would greatly facilitate the operating functions and would permit the Executive Director to concentrate his efforts and time toward maintaining and improving the civil service merit system.

EXPLANATION OF THE BILL BY SECTIONS

Section 1.

Creates a short title: "Federal Employees Health Benefits Act of 1959."

Section 2. Definitions

Defines terms of a technical nature which are used in the bill. Included are the following:

"Employee" is defined in subsection (a) to include the same Federal civilian employees as are covered by the Federal Employees' Group Life Insurance Act. Employees of the Tennessee Valley Authority, who are included in the life insurance program are, however, excluded from coverage under the bill because they already have a satisfactory health benefits program in effect.

"Annuitant" is defined in subsection (b) to include retired employees, members of their families who are survivor annuitants, certain compensationers and their surviving family members whose status under the Federal Employees' Compensation Act is comparable to those of retired employees and surviving members of their families. To be within the definition, an annuitant would have to be—

(1) retired on or after July 1, 1960, or

(2) retired other than voluntarily on or after the date of enactment but prior to July 1, 1960,

on an immediate annuity, with at least 12 years of service or for disability.

"Member of family" is defined in subsection (c) to include an employee's or annuitant's spouse and unmarried children to age 19. Stepchildren and natural children are included if they live with and receive more than one-half support from the employee or annuitant. Disabled dependent children over 19 are also included.

"Carrier" is defined in subsection (f) to include commercial insurance companies, nonprofit organizations of the Blue Cross/Blue Shield type, group practice prepayment organizations, and organizations which sponsor or underwrite national employee organization plans.

"Commission" is defined in subsection (g) to mean the Civil Service Commission.

"National employee organization" is defined in subsection (h) as a bona fide labor organization, national in scope, which represents only employees of one or more departments or agencies of the Government.

Section 3. Election of coverage

(a) Extends the benefits of the enacted bill to any employee who enrolls in an approved plan. Directs the Commission to prescribe regulations governing the time, manner, and conditions of eligibility for enrollment.

(b) Extends the benefits of the enacted bill to any annuitant who, at the time he becomes an annuitant, had been enrolled in an approved plan for (1) at least 5 years, or (2) substantially the full time between the date he is first eligible to enroll and the date he retires, whichever is the shorter period. Extends the benefits of the act to (survivor-) annuitants who were enrolled as family members of an employee or annuitant.

(c) Permits a husband and wife who are both employees each to enroll separately or one to enroll for himself or herself and family. No person may be enrolled both as an employee (or annuitant) and as a family member.

(d) Permits an enrollee to change from single to family coverage and vice versa, if he applies to do so within 60 days of a change in his

family status or at such other times and conditions as the Commission may by regulation prescribe.

(e) Directs that transfers from one approved plan to another must be made only at such times and under such conditions as the Commission may by regulation prescribe.

Section 4. Health benefits plans

Specifies the health benefits plans which the Commission may approve as being—

(1) One Government-wide service benefit plan of the Blue Cross/Blue Shield type.

(2) One Government-wide indemnity benefit plan of the type usually provided by commercial insurers.

(3) A number of already existing national employee organization plans whose enrollment is limited to present and former members.

(4) A number of group practice prepayment plans which, among other things, offer benefits in the form of professional medical services.

Section 5. Benefits to be provided under plans

(a) Describes the benefits to be provided, to the extent possible with the funds available, under the four types of plans specified in section 4.

(b) Permits the Commission to authorize, in lieu of the benefits described in (a) above, alternative benefits which it determines to be equally acceptable.

Section 6. Contracting authority

(a) Authorizes the Commission to negotiate contracts with qualified carriers to provide the benefits described in section 4.

Separate contracts will be negotiated for each plan approved under the act.

(b) Requires any contract entered into to specify in detail its benefits, exclusions, and limitations.

(c) Directs the Commission to prescribe regulations fixing minimum requirements which the various plans and carriers will have to meet for approval.

(d) Specifies certain requirements relating to nondiscrimination on account of race, sex, health status, and age which all plans will have to meet.

(e) Requires that enrollees be given the option to convert to individual coverage when their group coverage terminates for any reason except cancellation of enrollment.

(f) Requires that converted individual coverage be noncancelable by the carrier except for fraud, overinsurance or failure to pay premiums.

(g) Requires subscription charges for the various plans to reasonably and equitably reflect the cost of the benefits provided. It is contemplated that the Commission will actuarially determine whether the benefits offered by any plan are deficient or excessive in relation to the subscription charge for that plan.

Section 7. Contributions

(a) Directs that an enrollee contribute, through withholding from salary or annuity, an amount not to exceed—

(1) $1.75 biweekly for a single enrollment, and a matching contribution from the Government.

(2) $4.25 biweekly for a family enrollment, and a matching contribution from the Government.

(3) $6 biweekly for a family (which includes a nondependent husband) enrollment if the enrollee is female and a not-to-exceed $2.50 biweekly contribution from the Government.

(b) Permits an employee to continue his group coverage without contribution for as long as 1 year while he is on leave without pay.

(c) Directs that the Government's matching contribution on account of active employees be made from funds used to pay their salaries.

Directs that the Government's matching contribution on account of annuitants be annually appropriated for this purpose. It is contemplated that the Commission would determine the amount required to be appropriated and that the Congress would appropriate the required amount in advance of the year for which it is to be used.

(d) Provides for the conversion of contribution rates for enrollees paid on other than a biweekly basis.

Section 8. Health benefits fund

Creates a Federal employees' health benefits fund into which all contributions, premium refunds, and any interest earned are to be deposited and out of which all premiums or subscription charges are to be paid. It is contemplated that in addition to the 1 percent maximum mentioned in the next paragraph, an amount not in excess of approximately 3 percent of any 1 year's contributions or in excess of approximately 10 percent as an accumulative total may be retained in the fund at any one time as part of the special reserve for adverse fluctuations in future charges, referred to below.

Directs 1 percent of all deposits to the fund to be set aside for the payment of the Commission's administrative expenses in administering the enacted bill.

Requires balances allocable to each plan and remaining in the fund to be used, as the Commission may determine, for or as a special reserve for adverse fluctuations in future charges, reducing contribution rates, or increasing benefits of the plan.

Authorizes the Secretary of the Treasury to invest the fund in interest-bearing obligations of the United States and to sell such obligations. Directs that earned interest and proceeds from sales become part of the fund.

Section 9. Administrative expenses

(a) Authorizes the Commission to draw its administrative expenses for fiscal years 1960 and 1961 from the reserves in the employees' life insurance fund.

Directs reimbursement for the amounts so drawn to be made from the Federal employees health benefits fund to the employees' life insurance fund.

The Commission will incur administrative expenses in implementing the enacted bill before health benefit contributions become effective. Drawing on the employees' life insurance fund in this manner is not intended as a precedent. It is the simplest expedient for providing funds for the Commission's necessary administrative expenses. Reimbursement to the life insurance fund is required, since the "borrowed" money is not surplus but constitutes reserves already earmarked for the payment of life insurance premiums.

(b) Makes the Federal employees health benefits fund available for payment of the Commission's administrative expenses for fiscal year 1961 and subsequent fiscal years.

Section 10. Regulations

Gives the Commission general authorization to promulgate such regulations as may be necessary to carry out the provisions of the act. Specifically, it directs the Commission to prescribe regulations concerning—

beginning and ending dates of coverage;
employees who are reinstated after suspension or removal;
making information about the various plans available to employees and annuitants;
issuance of certificates describing benefits.

Section 11. Studies by Commission

(a) Directs the Commission to make studies, surveys, and reports on the operation and administration of the enacted bill.

(b) Requires the carriers to—

(1) Furnish reports which would enable the Commission to complete the studies, surveys and reports mentioned in (a), above.

(2) Permit the Commission and General Accounting Office to examine their pertinent records.

(c) Requires employing agencies to keep all necessary records and furnish the Commission with needed information and reports.

Section 12. Advisory Council

(a) Creates an 11-member Federal Employees Health Benefits Advisory Council composed of, ex-officio,

the Secretary of Labor;
the Director of the Bureau of the Budget;
the Surgeon General of the Public Health Service;
the Chief of the Bureau of Medicine and Surgery of the Veterans' Administration,

and, to be appointed by the President,

a representative of the public;
three representatives of national employee organizations;
a representative of a university school of medicine;
a representative of a university school of hospital administration;
a representative of a university school of public health.

Permits the ex-officio members to designate alternates to act in their stead and fixes the terms of the appointed members at 3 years.

(b) Stipulates the duties of the Council as to—

(1) Make studies on the operation and administration of the enacted bill.

(2) Receive reports and information from the Commission, carriers, and employees and their representatives.

(3) Ascertain the status of the health benefits fund.

(4) Consult with and advise the Commission.

(5) Make recommendations.

Requires that before any contract with a carrier can be made, renewed, or terminated, copies of the proposed draft of the contract must be furnished the Council. Drafts of proposed regulations must be similarly furnished before they can be promulgated.

(c) Provides for payment of travel expenses and compensation for members who are not Federal employees.

(d) Requires the Commission to convene the Council within 30 days after its representative members are appointed and, thereafter, that the Council meet not less often than quarterly.

Section 13. Bureau of Retirement and Insurance

Creates a Bureau of Retirement and Insurance in the Commission to perform such functions and duties as the Commission prescribes with respect to retirement, life insurance, and health insurance. Requires the Bureau to be headed by a Director in grade GS–18 and makes the Director responsible to the Chairman of the Commission.

Section 14. Jurisdiction of the courts

Gives the district courts of the United States and the Court of Claims original, concurrent jurisdiction of suits against the United States under the enacted bill.

Section 15. Reports to Congress

Requires the Commission to submit annual reports to the Congress on the operation of the enacted bill.

Section 16. Effective date

(a) Requires the Commission, by May 1, 1960, to submit to the House and Senate Post Office and Civil Service Committees copies of any proposed contracts with the carriers and regulations proposed to be promulgated. The language of this section is unmistakably clear and does not authorize the committee to disapprove the proposed contracts without further legislative action on the part of the Congress.

(b) Makes benefit and contribution provisions effective July 1, 1960, and by implication, other provisions effective upon enactment.

CONCLUSION

The bill as reported is a compromise by the committee with the wishes of the administration in many respects. Many amendments to the original bill have been adopted by the committee at the suggestion of the Civil Service Commission and the Bureau of the Budget. It would be unfortunate indeed if the few remaining points insisted upon by the administration which the committee did not accept should cause the bill not to be enacted into law.

AGENCY VIEWS

Following are letters from the Bureau of the Budget and the Civil Service Commission on the bill as reported:

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., June 30, 1959.

Hon. OLIN D. JOHNSTON,
Chairman, Committee on Post Office and Civil Service,
U.S. Senate, New Senate Office Building, Washington, D.C.

MY DEAR MR. CHAIRMAN: Reference is made to Mr. Kerlin's request of June 26, 1959, for the Bureau of the Budget's views on the June 24, 1959, committee print which, if approved, would modify

S. 2162 as introduced June 12, 1959, a bill to provide a health benefits program for Government employees.

The major policy provisions of this committee print are generally without objection, except in two important respects: Government cost and organization specification. In the interest of making the prompt report requested, these objections will be discussed briefly.

The total first year cost of the committee print is estimated by your staff to be about $304 million for active employees and we are informed that about $5 million will also be required in the first year for annuitants. The annuitant cost would increase yearly for several years thereafter. The proposed Government share of this program is approximately one-half. It is our view that the Government share of the cost of the Federal employees' group life insurance program, which is one-third, is a more appropriate division, and that this Government share should not exceed $80 million. It seems clear that the Government cost of the committee print far exceeds this amount and that the excess is unjustified.

Two organization specifications contained in the committee print are not only unnecessary for effective administration of the program, but could become obstacles since they violate important fundamental precepts of organization of the Government. These items relate to the proposed Advisory Council and the proposed establishment of a Bureau of Retirement and Insurance within the Civil Service Commission.

The proposed Advisory Council is objectionable as to both the proposed functions and the proposed membership. The functions include not only advising the Civil Service Commission, but also making studies of operation and administration of the act, ascertaining status of the health fund including balances and reserves, receiving reports from carriers, and recommending amendments of the act. Prior to awarding, amending, or terminating a contract, or issuing a regulation, proposed drafts must be furnished to the council by the Commission. These monitoring and investigating functions would divide responsibility for the program and impair accountability of the carriers under contract with the Commission. No advantage to the program as a whole is perceived in departing from the norm of assigning clear-cut executive responsibilities to the administering agency, in this case the Civil Service Commission. However, there would be no objection to an Advisory Council with functions only of advising the Commission, receiving reports and information from the Commission and making recommendations to the Commission. All other functions proposed in the bill should be eliminated.

The proposed membership of the council is inappropriate for an executive branch advisory council. We believe your committee will agree that congressional membership raises unnecessary questions about division of legislative and executive powers. We believe there would be obvious advantage in including ex officio the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health, Education, and Welfare, and the Director of the Bureau of the Budget. We believe there are also obvious advantages in including at least one, perhaps more, representatives of Federal employees who contribute to the program. Such five- or six-member councils would, moreover, combine the general purposes of the Commission's two advisory committees under the Federal employees' group life insurance pro-

gram. It would guarantee knowledge of current technical developments and experience of health benefits and insurance programs in the country in general. It would be of suitable size to consult directly and expeditiously with the administering agency. We recognize, as does your committee, that the provision of a system of financial protection to Federal employees for the cost of health care is a highly complex and technical matter. We recognize, too, that new methods and new protections are constantly developing. The Commission will wish to keep in close direct touch with such developments so that the program once begun is kept abreast of the times, and should be free to seek advice from the best sources. Within the Government a properly organized advisory council should be able to give sound advice in the Federal setting as to proposed practices and objectives to be adopted or recommended by the Commission.

The proposed establishment of a statutory Bureau of Retirement and Insurance within the Civil Service Commission is not only unnecessary to the effective administration of the affected programs but is contrary to the eminently sound assignment now given by law to the Chairman of the Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. Continuation of this authority is essential for the effective administration of the Commission's programs. The Chairman's existing authority for internal organization and administration should be left unimpaired and this provision of a statutory bureau should be omitted from the bill.

In addition to these major issues of cost and organization, several administrative improvements, some technical, are desirable, three of which we would like to bring to your committee's attention. First, the provision added by the committee print in section 8 restricting the investment discretion of the Secretary of the Treasury will divide authority and would be out of keeping with the Secretary's normal functions in such matters. This restriction should not be adopted. Second, the authority given in section 9 to the Commission to borrow administrative expense money from the employees' life insurance fund should be recognized by the Congress as a temporary advance from reserves necessarily maintained for foreseeable future group life insurance program costs, to be reimbursed by the health program as soon as funds are available, preferably within 3 years. The balance in the life insurance fund is a necessary reserve, not a surplus, and its use in getting the health benefits program started is in no sense to be regarded as a precedent. Third, the requirement that the Commission transmit copies of proposed contracts, policies and regulations to the Post Office and Civil Service Committees of the Senate and House appears to be intended to assure that the Commission will take timely action and is quite unnecessary. If, as has been suggested, the requirement is intended to provide the committees with some power of prior review or, even prior approval, of Executive action, it is clearly improper. This provision should be eliminated.

Provided S. 2162 is further modified as above noted, favorable consideration of the bill would be recommended by the Bureau of the Budget as being in accord with the program of the President.

Sincerely yours,

(Signed) ELMER B. STAATS,
Deputy Director.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., June 30, 1959.

Hon. OLIN D. JOHNSTON,
Chairman, Committee on Post Office and Civil Service,
U.S. Senate.

DEAR SENATOR JOHNSTON: This is the Commission's report on the committee print of S. 2162, dated June 24, 1959, furnished in response to a telephone request of June 29, 1959.

This bill is much improved over the original bill introduced on June 12, especially with respect to section 4, which now specifies that there be one governmentwide service benefit plan and one governmentwide indemnity benefit plan. Many of the other features in the original bill which we considered to be unacceptable have been deleted or corrected.

As the history of the past 5 years will show, the Commission is sincerely impressed with the urgency of enacting sound health insurance legislation for Federal employees. We are, for this reason, passing over a number of matters of lesser importance to concentrate, in this report, on the few remaining provisions of the bill which are unacceptable to the Commission. These are discussed below.

Thus far, the only overall Government cost figures which have been mentioned are those obtained from multiplying the maximum contribution rates cited in section 7(a) by the anticipated number of employees who will enroll in the program. This cost has been estimated by your committee at $145.3 million annually and does not include the additional amount required to be appropriated annually to defray part of the cost of annuitants' benefits. The amount required for the latter purpose will, of course, steadily increase as the number of annuitants entitled to health benefits increases. We estimate that $2.5 million will be required for the first year and that this will rise each year until $25 million will be needed for the fifth year.

The Government costs produced by these maximum contribution rates and the amounts required to be appropriated annually add up to a figure substantially in excess of that which your committee has already been advised the administration finds justifiable.

The Advisory Council created by section 12 precludes efficient administration of a health benefits program. As constituted, the council would have some advisory functions but also would participate in the supervision and operation of the program, functions which are incompatible with the responsibility given the Commission as the administering agency and therefore unacceptable. An Advisory Council composed of (for example) five employees covered by the act or their elected representatives and two employees experienced in the administration of health benefits programs or in the provision of health benefits services, whose duties were to advise, receive reports from, and make recommendations to the Commission would not only be considered acceptable but highly desirable.

Section 13 which creates a Bureau of Retirement and Insurance, notwithstanding that it has been amended, serves no useful purpose in our opinion, and we recommend its deletion. We recommend strongly against the inflexibility which would be created by statutory prescription of a part of the Commission's internal organization. Such action would be inconsistent with prior statutory action placing

organizational authority in the Chairman of the Commission. Furthermore, we cannot see that the section is germane to the purpose of the bill or is needed to carry on the programs elsewhere authorized in S. 2162.

I have comments on two other aspects of S. 2162 which I should like to make here. We construe the bill to permit—

(1) the setting aside of a portion (of up to, for example, 10 percent) of all contributions as a contingency reserve to defray increases in future subscription charges, and

(2) the making of contracts for each of the two government-wide plans with separate "prime" carriers—with each of the two prime carriers required to share its rights and obligations with other eligible carriers under an equitable sharing formula approved by the Commission.

If S. 2162 contemplates contingency reserve and contract arrangements substantially different from those stated, the bill would be unacceptable on these grounds also. We regard these two points as of such critical importance as to warrant their stipulation in the bill. If they are not so stipulated, but if the committee nevertheless agrees with our construction of the bill, the record should be made unmistakably clear that the intent of the Congress is as stated in (1) and (2), above.

The Bureau of the Budget advises that there is no objection to the submission of this report to your committee.

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

INDIVIDUAL VIEWS OF SENATOR FRANK CARLSON AND SENATOR THRUSTON B. MORTON

We share our colleagues' appreciation of the urgent need to enact a health insurance program for Federal employees. We know too that the administration is keenly aware of this need. This awareness is demonstrated by the fact that the President has on several occasions recommended to the Congress that a health insurance program be enacted.

Bills to provide such a program were sponsored by the administration and introduced in the Congress in 1954, 1955, 1956, and 1957. This active support on the part of the administration, particularly by the Civil Service Commission, has been furnished in recognition of the fact that health insurance is the one remaining major gap in fringe benefits for Federal employees; that enactment of a good health insurance program would restore the Federal Government to its rightful place among progressive, enlightened employers; and that a contributory health insurance program would increase efficiency by reducing costly turnover of Federal employees.

Like the administration, we support with enthusiasm enactment of a health insurance program which holds out a promise of giving employees sound protection against the high costs of illness at a price which they can afford and which the Government can afford. The bill, S. 2162, which has evolved from our hearings on S. 94, represents tremendous progress toward this goal.

One of the noteworthy features of S. 2162 is that it enables employees to choose freely the kind of health insurance—service benefits, indemnity benefits, or group practice benefits—best suited to their needs and circumstances. Our hearings on S. 94 have developed the matter of free choice as one of the most important and difficult issues: S. 2162 has commendably resolved this issue, as well as others.

But S. 2162, with all its good points, still contains five provisions which, in our judgment, warrant further consideration by the Senate of the bill. These have been pointed out to the committee in frequent correspondence and through personal contact by the Bureau of the Budget and the Civil Service Commission. They are:

(1) The program's cost to the Government is too high

The cost to the Government has been estimated by the committee as $145,300,000 annually. Since this figure includes only the Government's contribution for active employees, it understates the total cost by failing to include the additional sums which Congress must appropriate every year from now on as the Government's contribution toward the cost of providing benefits for retirees.

The additional sums required to be appropriated for retirees will increase each year as the number of insured retirees increases each year. We understand from the Civil Service Commission that an estimated appropriation of $2,500,000 will be required for the first year. Assuming a stable contribution rate (which is open to considerable doubt),

we are advised by the Commission that this amount will steadily increase until, for the fifth year, the appropriation required will be $25 million.

(2) S. 2162 contains no provision which would clearly permit adequate prefunding for the purpose of avoiding frequent increases in subscription rates

Continuously increasing utilization of health facilities plus the steady growth in the cost of these facilities will very soon cause the subscription charges under S. 2162 to rise. This is evidenced by the fact that plans with unlimited liability to pay for health services have had their reserves depleted and have been constantly plagued by price increases during the last few years.

To stave off frequent increases in contribution rates, S. 2162 should explicitly provide for setting aside an adequate reserve. The reserve of 3 percent of 1 year's contributions plus income derived from any dividends, premium rate credits, or other refunds which S. 2162 relies on to provide the necessary reserve is totally inadequate for the purpose.

A health insurance program cannot subsist on a hand-to-mouth basis.

(3) The Advisory Council created by section 12 is an insurmountable obstacle to efficient administration

Our committee has ample power to investigate and to seek corrective legislation of the functions of the agency if circumstances should in the future arise which make this course of action desirable. The Commission's operating responsibility should be clear and unmistakable. We are not aware of the need in this Federal employee program for participation by the various educational institutions which are named. Plainly they are numbered among the responsible sources from which the Commission would, if necessary, seek information and advice, but to give them three votes in the Advisory Council seems quite inappropriate.

The duties prescribed for the Council would require it to act not as an adviser to the Civil Service Commission but rather as a grievance committee and as a perpetual monitor with independent investigatory powers. These powers, without precedent for a council of this kind, would weaken and impair the Commission's position as administrator of the program by implicitly making it accountable to the Council and interposing the Council between it and the President, the carriers, employing agencies, and employees.

We think a small group which would serve in a truly advisory capacity is highly desirable. A large group with plenipotentiary powers such as S. 2162 would create can only serve to hamper the program and increase the cost of administration.

(4) The statutory requirement for a Bureau of Retirement and Insurance is a usurpation of the Commission Chairman's power to organize the Civil Service Commission

The underlying purpose of section 13 completely escapes us. We can only conclude that its purpose is to coerce the reorganization of the Commission. Unless and until it is demonstrated that the Commission's present or contemplated organization for administering a health

insurance program is unsatisfactory, we cannot agree to section 13 of S. 2162, and strongly recommend its deletion.

(5) The requirement that the Commission transmit copies of proposed contracts and regulations to the Senate and House Post Office and Civil Service Committees is unnecessary or improper

Again, we fail to perceive the purpose of this provision.

If section 16(a), in requiring the above-mentioned documents to be transmitted by May 1, 1960, is intended to prod the Civil Service Commission into implementing S. 2162 with alacrity, it is completely unnecessary. Based on its past spectacular performance in implementing the Federal Employees' Group Life Insurance Act, it needs no prodding and, in any event, section 16(b) would require that implementation be completed by July 1, 1960, the date recommended by the Administration.

If section 16(a) is intended to permit the committee to review the above-mentioned documents and to approve or disapprove their contents, it is an infringement of the Executive's powers and is improper.

It would be deplorable if, after 5 years of effort, retention of these few objectionable features of the bill were permitted to thwart enactment of a much-needed health insurance program for Federal employees.

The chairman of our subcommittee has publicly stated that S. 2162 represents a start on a good program, that it should be enacted, and that improvements can be made later through amendatory legislation.

We share the views of the chairman of the subcommittee and are hopeful that some of the suggestions we are offering will be adopted before final enactment of S. 2162.

FRANK CARLSON.
THRUSTON B. MORTON.

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