

June 24, 1996

MEMORANDUM

From: Dave Bonfili

To: Bruce Reed

Subj: OPENING FEHBP TO PUBLIC WOULD REQUIRE LEGISLATION

1. The Federal Employees Health Benefits Program (FEHBP) was established by Public Law 86-382. Eligibility guidelines were modified by the Civil Service Retirement Spouse Equity Act of 1984 (PL 98-615) and the Federal Employees Health Benefits Amendments Act of 1988 (PL 100-654).
2. According to definitions supplied in these three acts, FEHBP eligibility is limited to civilian federal employees, spouses, certain former spouses of civil service employees, former employees, and annuitants, unmarried dependent children under the age of 22 (including legally adopted children, children born out of wedlock but recognized, and both foster children and stepchildren under certain circumstances), unmarried children aged 22 or over who are incapable of self-support because of a physical or mental incapacity which existed before their 22nd birthday, and temporary employees who have completed one year of current continuous employment, excluding any break in service of five days or less (this last group must, however, pay the entire cost of coverage).
3. Applicable legislation is as follows.
 - PL 86-382, Section 2, Paragraphs (a)-(e).
 - PL 98-615, Section 3, Paragraphs (1)-(5).
 - PL 100-654, Section 301, Paragraph (a).
4. Modifying the FEHBP eligibility pool would require legislative amendment.

HEALTH INSURANCE (FEHBP)

GENERAL FEATURES

The Federal Employees Health Benefits Program (FEHBP) was established by Public Law 86-382 and became effective on July 1, 1960. FEHBP helps to protect eligible employees and their families from the costs of illness or accidents. It provides guaranteed protection which cannot be cancelled by the health plan which the employee selects under FEHBP; it also provides coverage without medical examination or restrictions because of age or physical condition. The government makes a substantial contribution for the cost of FEHBP insurance, while the employee pays the rest through payroll withholding.

The Program offers virtually immediate coverage with no set waiting period; the only wait involves the processing of the employee's Standard Form 2809, "Health Benefits Registration Form"; coverage takes effect on the first day of the pay period that begins after the employing office receives the employee's completed SF 2809, following a pay period during any part of which the employee was in pay status.

Continued coverage extends for up to a year while the employee is in a non-pay status on account of illness or other reason. However, employees must pay their share of the premiums for each pay period in which coverage continues. When the employee is in non-pay status on account of military duty of more than 30 days, coverage can extend up to 18 months, provided the employee pays both the employee and the government share of the premium during the last six months. Temporary protection for 31 days without cost after enrollment or coverage of an eligible family member ends (except for voluntary cancellation) is also available as part of the FEHBP program, as is continued protection after retirement.

PARTICIPATION AND ELIGIBILITY

Enrollment. Participation in the Federal Employees Health Benefits Program is voluntary, but employees are encouraged to enroll for the protection it provides. New employees have 31 days from the date of appointment or from date of eligibility to enroll. Employees who choose not to enroll at their first opportunity may enroll during the annual open season periods announced by the Office of Personnel Management, or upon the occurrence of an event that would permit enrollment (See Table of Permissible Changes in Enrollment in this Guide.) Upon enrollment, employees select and sign up for an individual plan that best suits their health needs from among the many plans offered under FEHBP.

Eligible Family Members. Enrollment may be for the employee alone, or for the employee along with family members, including spouse and unmarried dependent children under the age of 22—the latter including legally adopted children, children born out of wedlock but recognized, and both foster children and stepchildren under certain circumstances. Unmarried children aged 22 or over who are incapable of self-support because of a physical or mental incapacity which existed before their 22nd birthday may also be covered.

With a Self and Family Enrollment, any new eligible family member, such as a new child or spouse automatically becomes covered. Self Only Enrollments may be changed to a Self and Family Enrollment within a limited time period following the event or during an open season.

Former Spouses. Under the Civil Service Retirement Spouse Equity Act of 1984 (Public Law 98-615) and similar statutes, certain former spouses of civil service employees, former employees, and annuitants may qualify to enroll in a health benefits plan under FEHBP. Former spouses whose divorce occurred during the spouse's federal service should contact the agency that employed the spouse at the time that the divorce occurred; those whose divorce occurred after retirement should contact: Office of Personnel Management, Retirement & Insurance Service, Office of Retirement Programs, PO Box 17, Washington, DC 20044.

Ineligible Family Members. The employee's parents, or others who are not considered "eligible" family members (such as a grandchild, unless the grandchild qualifies as a foster child), cannot be covered, even though they live with or are supported by the employee.

Loss of Eligibility. If a family member loses eligibility for coverage under a Self and Family Enrollment (for example, when a child reaches the age of 22, or in case of a divorce), then that family member is entitled to convert to a non-group contract with the applicable plan within 31 days. However, the family member will not be notified either by employing agency or by OPM when such eligibility is lost; but must apply within the 31 days after coverage ends.

Temporary Employees. As a result of P.L. 100-654, enacted November 14, 1988, FEHBP coverage is available to temporary employees who have completed one year of current continuous employment, excluding any break in service of five days or less. Temporary employees must pay the entire cost of this coverage, however.

Plans. Some of the FEHBP plans offered under the program are open to all employees. However, many plans require the employee to obtain health care through designated providers in a particular geographic location; to work for a particular agency; or to join a particular union. The brochures describing the plans offered give more details, but in some cases it will be necessary to call the plan to find out if a particular employee is eligible to opt for a particular plan. This chapter includes the telephone numbers of all the plans offered nationwide under FEHBP. Some of the federal employee union plans are open to all federal employees who hold full or associate membership in the sponsoring organization; others are restricted to employees in certain occupational groups and/or agencies.

SF 2809. Employees may enroll in FEHBP by completing Standard Form 2809, "Health Benefits Registration Form," and turning it in to their employing office.

However, employees normally may *not* enroll or be enrolled as employees if they are covered as family members under someone else's existing enrollment in the FEHBP. However, such dual enrollments are sometimes permitted under certain circumstances in order (a) to protect the interests of children who otherwise would lose coverage as family members; or (b) to enable an employee who is under age 22 and covered under a parent's enrollment, and who becomes the parent of a child, to enroll for Self and Family coverage. However, no person (employee or family member) is entitled to receive benefits under more than one enrollment in the FEHBP.

TYPES OF PLANS

Two basic types of health benefits plans are available to you under the Federal Employees Health Benefits Program:

Fee-for-Service Plans. Fee-for-service plans reimburse you or the health care provider for covered services. If you enroll in one of these plans, you may choose your own physician, hospital, and other health care providers. There are two general types of fee-for-service plans:

1. **Service Benefit Plan.** This is a governmentwide plan available to every eligible employee no matter where located. The service benefit plan is offered by Blue Cross/Blue Shield and provides benefits either to you or, through direct payment, to doctors and hospitals.

2. **Employee Organization Plans.** Some employee organization plans are open to all federal employees through full or associate memberships in the organizations that sponsor the plans; others are restricted to employees in certain occupational groups and/or agencies. These plans generally provide benefits either directly to the member or, at the member's option, to doctors or hospitals. (It is generally necessary to consult the individual plan brochures for information about membership, as well as about possible membership/associate member-

ship fees, which are in addition to the monthly premiums for the plans themselves.)

Effective in January, Section 11003 of PL 103-66, the Omnibus Budget Reconciliation Act of 1993, requires that the charges and FEHBP fee-for-service plan benefit payments for certain physician services furnished retired enrollees who do not have Medicare Part B not exceed the limits on charges and payments established under the Medicare fee schedule for physician services.

Prepaid Plans. These are the Comprehensive Medical Plans (CMP)/Health Maintenance Organization (HMO) options that provide or arrange for health care by designated physicians, hospitals, and other providers in particular locations. CMP/HMOs can be either Group Practice Plans, Individual Practice Plans, or a combination of both, called Mixed Model Plans.

Group Practice Plans provide care through a group of physicians practicing at medical centers operated by the plans. Individual Practice Plans provide care through participating physicians practicing usually in their own offices.

Each CMP/HMO offered under FEHBP is open to all federal employees who live within the plan's enrollment area. It is very important for you to be sure you live within the plan's enrollment area before you enroll in one of these plans. The enrollment area is described in the plan's brochure. Contact the plan if you have any doubt.

Beginning with the November, 1994, open season, some plans began to accept enrollments also from persons who only work in the enrollment area, along with those who live in the enrollment area. Specific requirements will vary with each plan and will be stated in the plan's brochure.

Preadmission Certification. Enrollees should be aware that all plans require preadmission certification for all hospital admissions of a non-emergency nature. The employee is responsible for seeing that this requirement is met, and the plan may not cover some hospital costs otherwise coverable if the preadmission is not certified. For information on emergency admissions, it is necessary to consult the brochure for the particular plan.

FEHBP COSTS

The government normally pays 60 percent of the average high option premium of six of the largest health benefits plans, but not more than 75 percent of the premium for any individual plan. However, this formula has been modified through 1992 because of the departure from the Program of the Aetna Indemnity Benefit Plan, whose high option premium previously had been used in computing the amount of the government's share.

The government contribution is the same for most federal employees, except for employees who are appointed under the Federal Employees Part-Time Career Act of 1978, and temporary employees eligible under provisions of 5 USC #906a. Also, the Postal Service contributes an additional amount towards the cost of Postal Service employees' enrollment.

The remainder of the FEHBP premium is paid by the enrollee and is withheld from the biweekly pay check. An employee is also responsible for the employee share of the cost of the enrollment while on any non-pay status. The cost of each plan differs and may change at the end of each contract year. A schedule of current costs for the different fee-for-service plans is included in this chapter of the *Guide*.

CONTINUATIONS OR TERMINATIONS

Transfers/Non-Pay Status. Eligibility for coverage under the health benefits program will continue if the employee transfers to or is re-employed by another federal agency without a break in service of more than three days.

Enrollment may also be continued for up to one year if the employee is in a non-pay status because of illness or other reason; however,

employees must pay the employee's share of the premiums for each pay period that coverage is extended. In the case of military duty of more than 30 days, enrollment can be continued up to eighteen months, although the employee must pay both the employee's and the government's share of the premiums for the last six months of this period. Employees who enter the military service for periods of 30 days or less are also continued in the program. However, if the period of service is more than 30 days and the employee elects to have the enrollment terminated, the enrollment will be reinstated if the employee returns to the job by exercising reemployment rights. An employee who returns from military service not in the exercise of re-employment rights must register for health benefits participation within 31 days, the same as a new employee.

Retirement. Ordinarily, enrollment continues for covered employees upon retirement from the government with the same benefits and costs as when on active status, provided that the enrollee is retired under a retirement system for civilian employees of the government on an immediate annuity. The retiree must have been enrolled under the program for the five years of service immediately preceding retirement; or, if less than five years, for all service since having the opportunity to enroll in a plan under the program. An annuitant may not normally enroll after retirement.

Survivors. Survivors of deceased employees or annuitants remain covered by the plan if a family member is entitled to a survivor's annuity which is sufficient to cover the survivor's share of the cost. Survivors and annuitants may pay premiums directly to OPM if the annuity is insufficient to cover the premium.

Cancellations. Enrollees may voluntarily cancel their enrollment at any time. Termination will generally be effective on the last day of the pay period in which the request to cancel is received by the employing office.

Temporary Continuation of Coverage. Temporary continuation of coverage (TCC) is available to employees who are voluntarily or involuntarily separated from government service (except for gross misconduct) and who would not otherwise be eligible for continued coverage. Included is separation for retirement when the employee is unable to meet the five-year enrollment requirement for continued enrollment after retirement.

This temporary coverage continues for up to 18 months after separation from service. In such a TCC situation, the former employee must pay the total premium (both the employee and the government contributions) plus a charge of 2 percent of the total premium for administrative expenses. Even when this temporary continuation ends (except by cancellation or nonpayment of premium), the former employee is still entitled to a 31-day extension of coverage and an opportunity to convert to a non-group health benefits contract. There is no cost to the separated employee for this 31-day extension. However, a change of enrollment may take place except for a change from a Self Only to a Family Enrollment if the employee or spouse is pregnant to cover costs of a child born during the extension period.

In certain cases, TCC is also available for up to 36 months for a covered child or a former spouse who would otherwise lose FEHBP coverage as a result of changes in family member status. Former spouses may lose such coverage because of divorce or annulment. Children may lose such coverage as a result of marriage, reaching age 22, recovery from an inability to support oneself, or loss of status as a stepchild, foster child, or recognized natural child. The total premium plus the 2 percent administrative charge must also be paid in the case of such extensions as these. The employing agency must be notified within 60 days when a child or former spouse becomes eligible for TCC.

CLAIMS AND APPEALS

Claims. If a plan denies a claim by an FEHBP enrollee for a payment or service, the carrier must reconsider its decision if it receives a written request from an employee within one year citing the reasons why the

claim should have been honored. Within 30 days the plan must either pay the claim or provide the service, reaffirm its original denial, or request further valid information to enable it to make a determination. If the plan affirms its denial or fails to respond to the claim, the employee may request an OPM review of the plan's compliance with its FEHBP contract. Write to OPM Retirement and Insurance Service, P.O. Box 436, Washington, D.C. 20044.

Appeals for Reconsideration. Procedures for appeals for reconsideration of agency and OPM decisions under the Federal Employees Health Benefits Program are the same as they are for FEGLI and Retirement; hence they are discussed in one single place in this *Guide*: see Section 17 of the CSRS Retirement chapter for this discussion.

CHANGES IN ENROLLMENT

Ordinarily changes in enrollment may be made only during the annual open season announced by OPM each year. This rule applies to annuitants as well as to active employees. However, changes in coverage from Self and Family to Self Only can be made at any time. For all the enrollment changes that are allowed, see the Table of Permissible Changes in Enrollment which follows in this *Guide*.

FEHBP FRAUD HOTLINE

Call (703) 908-8662 if a health plan provider has billed you for services which you did not receive.

TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT EMPLOYEES, ANNUITANTS, AND FORMER SPOUSES Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

No.	Events That Permit Enrollment or Change	Changes Permitted			Time Limit in Which Registration Form Electing Changes Must be Filed With Employing Office**
		From Not Enrolled to Enrolled	From Self Only to Family	From one Plan or Option to Another	
1	Open Season	Yes†	Yes	Yes	As announced by the Office of Personnel Management.
2	Change in marital status. (Marriage, divorce, annulment, death of spouse.)	Yes†	Yes (Except former spouses)	Yes (Except former spouses)	From 31 days before to 60 days after change in marital status.
3	Other change in family status. (For example, birth of a child, legal separation, discharge from military service of a spouse or a child under age 22.)	No	Yes	No	Within 60 days after change in family status.
4	Enrollee or family member moves from an area served by a prepaid plan (CMP/NMCO) in which enrolled at time of move.	Does not apply	Yes	Yes	At any time after presenting written notice to the employing office of the move.
5	Termination of enrollment by employee organization plan because of termination of membership in organization.	Does not apply	No	Yes	Within 31 days after termination of enrollment in plan.
6	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage other than by cancellation or change to Self Only of the covering enrollment, or employee, covered under another federally sponsored health benefits program, loses such coverage for any reason.	Yes*	Does not apply	Does not apply	Within 31 days after termination (except, for employees, within 60 days after the death of the enrollee). Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.
7	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage because of change of the covering enrollment from Family to Self Only.	Yes, for Self Only*	Does not apply	Does not apply	Within 31 days after change of covering enrollment has been filed. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.
8	Employee transfers to overseas post of duty from the United States, or reverses.	Yes†	Yes	Yes	Within 31 days before or after move.
9	Employee returns to active civilian duty or annuitant separates from military service which was not limited to 30 days or less.	Yes†	Yes	Yes	Within 31 days after return to active civilian duty or separation from military service.
10	Your plan stops participating in the FEHB program.	Does not apply	Yes	Yes	As set by the Office of Personnel Management.
11	Self Only enrollment under this Program of employee's or annuitant's spouse terminated as a result of change in spouse's Federal employment status or 365 days' nonpay status.	No	Yes	No	Within 31 days after termination of spouse's enrollment. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.
12	Employee who is not enrolled loses coverage under parent's non-federal health plan.	Yes†	Does not apply	Does not apply	Within 31 days after loss of coverage, except within 60 days after the death of the parent.
13	Enrolled employee retires from overseas post of duty and is eligible to continue enrollment as annuitant.	Does not apply	Yes	Yes	Within 60 days after retirement.
14	Enrollee becomes eligible for Medicare.	Does not apply	No	Yes	At any time beginning 30 days before becoming eligible for Medicare.

Events That Permit Enrollment or Change		Changes Permitted			Time Limit in Which Registration Form Electing Changes Must be Filed With Employing Office**
No.	Event	From Not Enrolled to Enrolled	From Self Only to Family	From one Plan or Option to Another	
15	Employee's eligible child (or children) loses coverage under another's FEHB enrollment.	No	Yes	No	Within 31 days after child's (children's) loss of coverage. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.
16	Employee or an eligible family member loses coverage under Medicaid (State program of medical assistance for the needy).	Yes* employee loses	Yes family mem. loses	Does not apply	Within 31 days after termination of Medicaid or loss of Medicaid coverage by family member.
17	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage due to cancellation of the covering enrollment.	Yes*	Does not apply		You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan, within 31 days after cancellation of the covering enrollment. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day period. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the cancellation was filed, there will be a break in coverage.
18	Enrolled employee's employment status changes from full-time to part-time (career employment) as defined in the Federal Employees Part-Time Career Employment Act of 1976.	No	No	Yes	Within 31 days after the change in employment status.
19	Employee or employee's spouse loses coverage under spouse's non-Federal health plan when spouse terminates employment to accompany employee who accepts a position out of commuting area.	Yes*	Yes	No	Within 31 days before or 180 days after the move.
20	Employee's or annuitant's spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents; or employee's or annuitant's eligible child (or children) loses non-Federal coverage under the other parent's health plan because the other parent involuntarily loses coverage for his or her dependents.	Yes**	Yes	No	Within 31 days before or after spouse's or dependent's loss of coverage; or within 31 days before or after child's (or children's) loss of coverage.
21	Former spouse who is eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1988 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes*	Does not apply	Does not apply	Generally, within 60 days after divorce or within 60 days after the date of OPM's notice of eligibility to enroll.
22	Temporary employee completes one year of service in accordance with 5 U.S.C. 8906a.	Yes*	Does not apply	Does not apply	Within 31 days after becoming eligible.
23	Temporary employee, eligible under 5 U.S.C. 8906a, changes to a non-temporary appointment.	Yes*	Yes	Yes	Within 31 days after changing to non-temporary appointment.
24	Employee separated from service and eligible for temporary continuation of coverage.	Does not apply	Yes	Yes	Within 60 days after the later of: separation; or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.
25	Child of employee, former employee or annuitant stops meeting the requirements for unmarried dependent children.	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; or the child's receiving notice of the opportunity to elect temporary continuation of coverage (based on the annuitant's notification to the employing office of the child's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.
26	Former spouse meets the requirement in 5 U.S.C. 8901(10) of having been enrolled in an FEHB plan as a covered family member at some time during the 18 months before the marriage ended, but does not meet one or both of the other two requirements of 5 U.S.C. 8901(10).	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; the date coverage under Subpart H of 5 CFR Part 890 was lost, if the loss occurred within 36 months of the qualifying event; or the former spouse's receiving notice of the opportunity to elect temporary continuation of coverage (based on the annuitant's or former spouse's notification to the employing office of the former spouse's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage; or the date of the qualifying event, including the 31-day extension of coverage; or the date of the qualifying event, if later. If election is made after the end of the 31-day extension of coverage or the date of the qualifying event, the effective date will be retroactive.
27	Former employee, former spouse or child whose temporary continuation of coverage under 5 CFR Part 890 Subpart H terminates due to other FEHB coverage, loses the other FEHB coverage.	Yes*	Does not apply		You must re-enroll in the same plan and option as that in which you were enrolled prior to obtaining the other FEHB coverage... if eligible to enroll in that plan, within 31 days after the other coverage ends, but not later than the expiration of the period of eligibility for the temporary continuation of coverage. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day time limit.

*Individuals must be otherwise eligible to enroll.

**Employees only.

**Also selected effective date information.

EMPLOYEES HEALTH BENEFITS ACT

Except for clerical and conforming amendments, the conference substitute is substantially the same as the House bill, except as follows:

The House bill provided for a membership of 25 members on the Advisory Commission on Intergovernmental Relations; the Senate amendment provided for a membership of 27 members. The conference substitute provides for a membership of 26 members on the Commission.

The House bill provided that two members of the Commission were to be appointed from a panel of at least four elected county officers submitted by the National Association of County Officials; the Senate amendment provided that four members were to be appointed from a panel of at least eight elected county officers so submitted. The conference substitute provides that three members of the Commission are to be appointed from a panel of at least six elected county officers submitted by such association. Under the conference substitute, not more than two of the three members appointed from such panel may be from any one political party.

The conferees express the hope that in selecting a panel of county officers for submission to the President, the National Association of County Officials will give consideration to all qualified county officers, regardless of whether or not they are affiliated with the association.

L. H. FOUNTAIN,
OVERTON BROOKS,
FLORENCE P. DWYER,

Managers on the Part of the House.

FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF 1959

For text of Act see p. 862

Senate Report No. 468, July 2, 1959 [To accompany S. 2162]

House Report No. 957, Aug. 20, 1959 [To accompany S. 2162]

The House Report is set out.

House Report No. 957

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 amendment proposed by the committee to S. 2162 strikes out all after the enacting clause and inserts in lieu thereof a substitute text which appears in italic type in S. 2162, as reported by the committee of the House. A discussion of the effect of this proposed amendment is contained in the explanation of the bill, as reported.

LEGISLATIVE HISTORY

STATEMENT

PURPOSE

The general purpose of this legislation is to facilitate and strengthen the administration of the activities of the Government generally and to improve personnel administration in the Government by providing a measure of protection for civilian Government employees, against the high, un-budgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents, the costs of which will be shared by the Government, as employer, and its employees.

At the present time, a wide gap exists between the Government, in its capacity of employer, and employers in private enterprise, with respect to health benefits for employees. Enlightened, progressive private enterprise almost universally has been establishing and operating contributory health benefit programs for its employees. Until now, the Government has made scant progress in this area.

This bill is designed to close the gap which now exists and bring the Government abreast of most private employers. It will enable Government employees to purchase protection, at a cost which is within their means, from the unanticipated and usually oppressive costs of medical care and treatment in the event of sickness or injury, as well as the often crushing expense of so-called catastrophic illness or serious injury. Availability of this health protection program to Government employees will be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel so urgently needed to assist in maintaining and improving our strong national defense and in the operation of other essential Government programs.

The addition of the health insurance program provided by the bill to the existing fringe benefits package for Government employees—which currently includes retirement and survivor annuities, group life insurance, annual and sick leave, compensation for job-connected injury or death, and other benefits—will fill a long, keenly felt need and will place the Government on a substantially equal level with progressive industry in respect to employee fringe benefits.

Legislation to establish a health benefits program for Federal employees has been before the Post Office and Civil Service Committee in each Congress beginning with the 83d. Hearings were held in 1956 on an administration proposal to provide Federal employees protection against the bankrupting expenses of extended catastrophic illness or injury, with the Government sharing the cost. The reported bill incorporates the outstanding feature of that plan—"major medical" protection against the expense of catastrophic illness or injury—and, in addition, provides protection for basic health needs. Thus the bill affords Federal employees an opportunity to obtain comprehensive insurance for health services at moderate cost.

The urgent need for a joint Government-employee health benefits program is emphasized by the fact that there is widespread and increasing

EMPLOYEES HEALTH BENEFITS ACT

recognition on the part of the public that both basic health and major medical insurance coverages are essential to protect wage-earners and their families. In 1940, approximately 4 million individuals were enrolled in basic hospital plans; at the beginning of 1959 the number of individuals who had this protection had skyrocketed to 123 million—70 percent of the population. Similar spectacular increases have been recorded in surgical and regular medical programs. In the comparatively new field of major medical insurance, participation in plans offering this protection has virtually exploded from 700,000 in 1952 to 17 million in 1959. It is a source of concern to this committee that no more than a relative handful of Federal employees now have such major medical coverage. This extremely important protection will be made available by the reported bill, along with the more generally prevalent basic coverage which now is held by approximately 70 percent of Federal employees.

COMMITTEE REVIEW OF PROGRAM

The committee emphasizes that the health benefits program provided by this legislation represents an entirely new area of Federal employees' fringe benefits in which the Government is without previous experience, and that extreme care will be necessary, particularly in the initial stages, to protect both the Government and its employees. The committee intends to conduct a continuing review of the operation of the program in order to carry out its responsibilities under section 136 of the Legislative Reorganization Act of 1946.

SUMMARY OF MAJOR PROVISIONS

The reported bill makes basic and catastrophic health protection available to approximately 2 million Federal employees and their dependents. Employees will have free choice among health benefits plans in four major categories, including (1) a Government-wide service benefit plan, such as is offered by Blue Cross-Blue Shield, (2) a Government-wide indemnity benefit plan, such as is currently offered by several insurance companies, (3) one of several employee organization plans, such as the present health plans of the National Association of Letter Carriers and the National Federation of Post Office Clerks, and (4) a comprehensive medical plan, which may be either a group-practice prepayment plan (such as the Kaiser Foundation plan in California and the Group Health Association plan in Washington, D. C.) or an individual-practice prepayment plan (such as the Group Health Insurance plan in New York). The Government-wide service benefit plan and the Government-wide indemnity benefit plan each will include at least two levels of benefits.

The reported bill retains the provisions of the Senate-passed bill (1) providing for 50 percent contribution by the Government to subscription charges and (2) establishing biweekly maximum contributions of \$1.75 for an individual employee, \$4.25 for an employee and family, and \$2.50 for a female employee and family including a non-dependent husband.

Employees will be eligible for enrollment in health benefits plans without having to pass any physical examination and, in the event of their separation from Government service, may convert their coverage to a private health benefits plan without undergoing any physical examination. It is

LEGISLATIVE HISTORY

intended that each of the foregoing plans will provide a wide range of hospital, surgical, medical, and related benefits designed to afford the employees full or substantially full protection against expenses of both common and catastrophic illness or injury.

Responsibility and authority for administration of the health benefits program in the interest of both the employees and the Government is vested in the U. S. Civil Service Commission. The Commission will execute contracts with the Government-wide service plan carrier and the Government-wide indemnity plan carrier and will make suitable arrangements to place the other types of plans in effect through appropriate contracts or agreements.

Provision is made for the prime insurer under the Government-wide indemnity benefit plan to reinsure with such other qualified companies as may elect to participate, in accordance with an equitable formula. Similar provision is made for the prime carrier under the Government-wide service benefit plan to allocate its rights and obligations under its contract among such of its affiliates as may elect to participate.

No person will be excluded from participation in the health benefits program because of race, sex, health status, or (at the time of first opportunity to enroll) age.

With respect to the service benefit plan and the indemnity benefit plan, the reported bill requires the Commission to enter into contracts which call for premium rates that are competitive with those generally charged for a new group health insurance sold to large employers. For the premiums agreed upon, the Commission is charged with negotiating the best possible basic health and major medical benefits. These provisions are designed to assure maximum health benefits for employees at the lowest possible cost to themselves and to the Government.

The Government will contribute 50 percent to the subscription charge for each enrolled employee, but not more than certain amounts which the Commission may prescribe from time to time subject to (1) biweekly minimums of \$1.25 for an individual employee or annuitant, \$3 for an employee or annuitant and family, and \$1.75 for a female employee and family including a nondependent husband, and (2) biweekly maximums of \$1.75 for an individual employee, \$4.25 for an employee or annuitant and family, and \$2.50 for a female employee and family including a nondependent husband. The provisions for contributions are related to the service benefit plan and the indemnity benefit plan authorized by section 4 of the bill, thus permitting each employee to exercise independent judgment and obtain the plan which best suits his or her individual needs or family circumstances.

The bill provides for setting aside portions of total contributions (1) not exceeding 1 percent for administrative expenses, and (2) not exceeding 3 percent to provide a contingency reserve or margin for adjustment based on experience without seeking further legislation.

The Commission will make available to each employee eligible to enroll in a health benefits plan information which will enable the employee to exercise an informed choice among the various plans. Each employee will be issued an appropriate certificate summarizing the benefits under the plan selected.

The bill authorizes the Chairman of the Civil Service Commission to appoint an advisory committee of five members, comprising employees en-

EMPLOYEES HEALTH BENEFITS ACT

rolled under the act and elected officers of employee organizations. This committee (which will perform a solely advisory function) replaces the Advisory Council which would have been provided by the Senate bill.

The bill omits those parts of the Senate bill which would have (1) established a Bureau of Retirement and Insurance in the Civil Service Commission to administer the health benefits program along with the retirement and life insurance programs, and (2) required prior submission of health benefits contracts to the Post Office and Civil Service Committees of the Senate and the House of Representatives. In the judgment of the committee, the assignment of duties in connection with administration of the program should be left to the discretion of the Civil Service Commission, which is responsible for success of the program. The committee is convinced that the prior submission of contracts would have tended to impede and interfere with progress in the establishment and operation of the program.

COST

On the basis of the formula, provided by section 7 of the reported bill, for a 50 percent Government contribution subject to certain limitations, the cost of the program for the first year of operation is estimated at \$214 million, of which approximately one-half will be paid by the Government.

ADMINISTRATIVE REPORTS

The reports of the Director of the Bureau of the Budget and the Chairman of the U. S. Civil Service Commission (directed to S. 2162 as passed by the Senate and submitted before the committee amendment was drafted) recommend approval of a health benefits program identical in principle to the program which will be established by the bill, as reported by this committee, except that such reports favor a Government contribution of 33 $\frac{1}{3}$ percent in lieu of 50 percent as authorized by the reported bill. The Post Office Department, the Department of Health, Education, and Welfare, the Department of Defense, and the Comptroller General of the United States also submitted reports favorable to the principles of the reported bill.

The committee points out that the Civil Service Commission, the Bureau of the Budget, major employee organizations, and leading companies and associations which now provide health benefits and will participate in this program, have agreed to the terms of the reported bill, in a spirit of compromise and cooperation, in order that an effective and financially sound Government employees health benefits program may become a reality at the earliest possible time. The committee desires to express its appreciation for this cooperation and joint endeavor to bring about a result in the general interest of the Government and all parties concerned. It is believed that the final agreement represented by the reported bill will receive overwhelming approval by Federal employees, full cooperation by the companies and associations which expect to participate, and support of the Government departments and agencies concerned.

The text of the reports of the Bureau of the Budget, the Civil Service Commission, the Department of Defense, the Department of Health, Education, and Welfare, and the General Accounting Office appear immediately following the explanation of the bill, as reported.

LEGISLATIVE HISTORY

EXPLANATION OF THE BILL, AS REPORTED

SHORT TITLE

The first section of the bill creates a short title which permits the provisions of this legislation to be conveniently cited as the "Federal Employees Health Benefits Act of 1959."

DEFINITIONS

Section 2 defines the technical terms used throughout the act, as follows:

Subsection (a) defines the term "employee" to include an appointive or elective officer or employee in or under the executive, judicial, or legislative branches of the U. S. Government and an employee of the District of Columbia government. Included within the definition are Members of Congress, the Official Reporters of Debates of the Senate and their employees, and employees of Gallaudet College. The definition of the term "employee" does not include members of the Armed Forces ("uniformed services") and noncitizen employees whose permanent duty stations are located outside the United States. Also excluded are employees of certain corporations which are under the supervision of the Farm Credit Administration, of which corporations any member of the board of directors is elected or appointed by private interests.

This definition will operate to provide coverage under the bill to the same groups of employees who are covered under the Federal Employees' Group Life Insurance Act of 1954, as amended, except that employees of the Tennessee Valley Authority, who have been specifically excluded from the definition, will not be covered. This exclusion was made at the request of the Tennessee Valley Authority because employees of the Authority have their own contributory health benefits program which has been operating successfully.

Subsection (b) defines the term "Government" as meaning the Government of the United States of America to distinguish it from State and local governments.

Subsection (c) defines the term "annuitant" to include—

(1) an employee who retires on or after the effective date (July 1, 1960), mentioned in section 15, under the Civil Service Retirement Act or other retirement system for civilian employees, on an immediate annuity after 12 or more years of service or for disability;

(2) a member of a family who receives an immediate annuity as the survivor of a retired employee described in paragraph (1), or an employee who dies after completing 5 or more years of service;

(3) an employee who receives benefits under the Federal Employees' Compensation Act as a result of illness or injury to himself and who because of the illness or injury is determined by the Secretary of Labor to be unable to return to duty; and

(4) a member of a family who receives monthly compensation as the surviving beneficiary of—

(A) an employee who dies of an illness or injury compensable under the Federal Employees' Compensation Act after 5 or more years of service, or

EMPLOYEES HEALTH BENEFITS ACT

(B) a former employee who dies while receiving compensation benefits and is held by the Secretary of Labor to have been unable to return to duty.

Subsection (d) defines the term "member of family" to include—
an employee's or annuitant's spouse;
his unmarried children under age 19, including—

- (A) an adopted child, and
- (B) a stepchild or recognized natural child who lives with him in a regular parent-child relationship; and
- (C) his unmarried children, regardless of age, who are incapable of self-support because of a disability that existed prior to their reaching the age of 19.

Subsection (e) defines the term "dependent husband" to mean a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than 1 year.

Subsection (f) defines the term "health benefits plan" as meaning essentially a group insurance policy, contract, agreement, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

Subsection (g) defines the term "carrier" to include a voluntary association, corporation, partnership, or other nongovernmental organization which provides, pays for, or reimburses the cost of health services under group insurance contracts, agreements, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition includes a health benefits plan, duly sponsored or underwritten by an employee organization.

Subsection (h) defines the term "Commission" as meaning the U. S. Civil Service Commission, to which is assigned the responsibility of administering this legislation.

Subsection (i) defines the term "employee organization" to include an association or other organization of employees which—

- (A) is national in scope or
- (B) in which membership is open to all employees of a department or agency of the Government who are eligible to enroll in a health benefits plan

and which on or before December 31, 1959, applies to the Commission for approval of a plan which it sponsors or underwrites.

In addition to the health benefits plans provided by national employee labor organizations, this language would include employee organization-sponsored plans such as those of the Federal Bureau of Investigation, the National Security Agency, the U. S. citizen employees of the Panama Canal, the Foreign Service, the Central Intelligence Agency, and the Postal Hospital Association of St. Louis.

ELECTION OF COVERAGE

Section 3 provides generally for election of health benefits plans by employees.

Subsection (a) permits an eligible employee to enroll, either as an individual or for self and family, in a health benefits plan approved by the Civil Service Commission. This subsection authorizes the Commission

LEGISLATIVE HISTORY

(1), to prescribe regulations fixing the time, manner, and conditions of eligibility for enrollment and (2) to exclude employees from enrolling on the basis of the nature and type of their employment or conditions pertaining thereto such as, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of like nature. However, no employee may be excluded by the Commission's regulations solely on the basis of the hazardous nature of his job.

Subsection (b) permits an annuitant to continue his coverage after he retires if he was enrolled in a health benefits plan under the act for a period of not less than (A) the 5 years of service immediately preceding retirement or (B) the full period or periods of service between the date he first becomes eligible to enroll in a plan and the date on which he becomes an annuitant, whichever is shorter. This subsection also permits the survivor of a deceased employee or annuitant to continue his coverage if the survivor was enrolled as a member of the family at the time of the employee's or annuitant's death.

Where a husband and wife are both Federal employees, subsection (c) permits either one to enroll individually or to enroll for self and family and prohibits any person from enrolling both as an employee or annuitant and as a member of the family.

Subsection (d) permits an employee or annuitant to change from individual to family coverage or vice versa at such time and under such conditions as the Commission may prescribe.

Subsection (e) permits an employee or annuitant to transfer his enrollment from one health benefits plan to another at such time and under such conditions as the Commission may prescribe.

HEALTH BENEFITS PLANS

Section 4 authorizes the Commission to contract for or approve the following health benefits plans:

(1) One Government-wide service benefit plan of the type commonly provided by Blue Cross-Blue Shield under which payment for medical services is made, insofar as possible, under contracts with hospitals, physicians, and other vendors of medical services. Where such payment is impracticable, it will be made directly to the employee.

(2) One Government-wide indemnity benefit plan such as is commonly provided by commercial insurance companies. Under this type of plan payment for medical services may be made directly to the employee or directly to the vendor of the medical services.

(3) Employee organization plans which are sponsored or underwritten by employee organizations. To be eligible under the bill, the organization which sponsors or underwrites the plan must have had in operation a plan which provided health benefits to its members on July 1, 1959. Employees will be able to enroll in these employee organization plans only if at the time of enrollment they are members of the organization.

(4) Two types of comprehensive medical plans—(A) group-practice prepayment plans and (B) individual-practice prepayment plans.

The Government-wide service benefit plan and the Government-wide indemnity benefit plan will each offer two options providing varying levels of benefits at varying subscription charges so that every employee will

EMPLOYEES HEALTH BENEFITS ACT

have an unrestricted choice between the service type plan and the indemnity type plan and, within each plan, between benefits and subscription charges which best suit his family circumstances and his ability to pay.

An employee who belongs to an association which sponsors an employee organization plan will have the additional choice of enrolling in his association's plan. Employees who are located in areas in which a group-practice prepayment plan or an individual-practice prepayment plan operates will have the further choice of enrolling in such a comprehensive medical plan.

TYPES OF BENEFITS

Section 5 stipulates that the benefits to be provided under the plans described in section 4 may be of the following types:

- (1) Service benefit plan—
 - (A) hospital benefits.
 - (B) surgical benefits.
 - (C) in-hospital medical benefits.
 - (D) ambulatory patient benefits.
 - (E) supplemental benefits.
 - (F) obstetrical benefits.
- (2) Indemnity benefit plan—
 - (A) hospital care.
 - (B) surgical care and treatment.
 - (C) medical care and treatment.
 - (D) obstetrical benefits.
 - (E) prescribed drugs, medicines, and prosthetic devices.
 - (F) other medical supplies and services.
- (3) Employee organization plans—
Benefits of the types described in paragraph (1) or (2) or both.
- (4) Comprehensive medical plans—
Benefits of the types described in paragraph (1) or (2) or both.

The general effect of section 6 is to authorize and require the Civil Service Commission to take appropriate action to contract, or to make other arrangements, for health-benefits plans.

CONTRACTING AUTHORITY

Subsection (a) authorizes the Civil Service Commission to negotiate contracts with qualified carriers offering plans described in section 4. The subsection requires each such contract to be for a uniform term of at least 1 year and permits the contract to be made automatically renewable from term to term in the absence of notice of termination by either party.

Paragraph (1) of subsection (b) requires the prime carrier for the indemnity benefit plan to be a company which is licensed to issue group health insurance in all the States and the District of Columbia.

Under the related authority to prescribe minimum standards for carriers, vested in the Civil Service Commission by subsection (d), it is expected that one of the standards for the prime indemnity carrier will be

LEGISLATIVE HISTORY

the volume of group health insurance business it has handled in the past. The Commission is expected to choose as a prime carrier a company that has by the volume of its operations demonstrated the experience and capacity necessary to handle what will undoubtedly be the largest policy of its kind in the world. In addition to requiring licensing in all the States and the District of Columbia, the Commission will presumably apply some volume-of-business test, such as requiring that the carrier selected shall, in the most recent year for which data are available, have made at least 1 percent of all group health insurance benefit payments in the United States.

Paragraph (2) of subsection (b) requires the prime carrier of the indemnity benefit plan to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance payments in the United States during the latest year for which such information is available. The reinsurance formula is to be determined by the carrier and approved by the Commission. Under paragraph (2) the prime carrier for the service benefit plan is similarly required to allocate its rights and obligations among such of its affiliates as may elect to participate, in accordance with an equitable formula which the carrier and its affiliates will determine and which the Commission will approve.

This practice of reinsuring and allocating rights and obligations follows closely the policy laid down by the Congress in the Federal Employees' Group Life Insurance Act of 1954 and ensures that all qualified companies and organizations which are engaged in providing protection against the cost of health services will share equitably in the contracts to be negotiated under this act, if they desire to do so.

Subsection (c) requires that any contract negotiated by the Civil Service Commission shall contain a detailed statement of benefits offered and include such maximums, limitations, exclusions and other definition of benefits as the Commission may deem necessary or desirable.

Subsection (d) authorizes the Civil Service Commission to prescribe regulations fixing minimum standards for participating health benefits plans and for carriers offering such plans.

Subsection (e) prohibits the Civil Service Commission from entering into any contract or approving any plan which excludes employees or annuitants, or members of their families, because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

Subsection (f) requires each plan approved by the Commission to permit an employee or annuitant whose enrollment in the plan is terminated, other than by his voluntary cancellation of enrollment, to convert from group coverage to individual coverage. It is expected that when the group coverage of an employee or annuitant terminates, he will have continued temporary protection for 31 days without current contributions so that he may have reasonable opportunity to convert to individual coverage and thus avoid an interruption in his protection against the cost of health services. The terms or conditions under which the employee or annuitant may convert will be prescribed by the carrier and approved by the Civil Service Commission and the employee will have to pay the periodic charges of the converted coverage directly to the carrier.

EMPLOYEES HEALTH BENEFITS ACT

Subsection (g) requires that the converted coverage shall, at the option of the employee or annuitant, be noncancellable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

Subsection (h) stipulates that the premiums to be charged by the carriers for approved health benefits plans shall reasonably and equitably reflect the cost of the benefits provided. The subsection requires that the premiums for the service benefit plan and the indemnity benefit plan be determined on a basis which, in the judgment of the Civil Service Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefits plans issued to large employers. This subsection further requires that premium rates determined for the first contract term shall be continued for subsequent contract terms except that they may be readjusted for any subsequent term based on past experience and benefit adjustments under the subsequent contract. Any readjustment in rates is required to be made in advance of the contract term in which the new rates will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health benefits plans to large employers.

The effect of subsection (h) is to make certain that the premiums which the Government will have to pay for the service benefit plan and the indemnity benefit plan will not be more costly than those charged by the industry to other large employers.

CONTRIBUTIONS

Section 7 provides for contributions by the Government and by employees to subscription charges.

Paragraph (1) of subsection (a) specifies the Government's contributions to the subscription charge for each enrolled employee and annuitant as the lesser of (A) 50 percent of the subscription charge or (B) such other amounts as the Commission prescribes.

The amounts which the Commission may prescribe, in accordance with clause (B), above, must not (i) be less than \$1.25 or more than \$1.75 biweekly for an individual who is enrolled for self alone, (ii) be less than \$3 or more than \$4.25 biweekly for an individual who is enrolled for self and family, or (iii) be less than \$1.75 or more than \$2.50 biweekly for a female employee who enrolls for self and family if the family includes a nondependent husband.

Paragraph (2) of subsection (a) authorizes the withholding from an individual's salary or annuity of the difference between the total subscription charge of the plan in which he is enrolled and the Government's contribution to the subscription charge. The employees' contributions will be made through payroll deductions, as is the case with respect to employees' contributions under the Civil Service Retirement Act and the Federal Employees' Group Life Insurance Act of 1954.

(3) Paragraph authorizes the Civil Service Commission to adjust the contributions of the Government and of the employees and annuitants to a particular plan whenever past experience indicates that such an adjustment is warranted or whenever there is a change in benefits offered by the plan. Any such adjustment must preserve the same ratio between the Government's and employee's or annuitant's contribution as existed originally,

LEGISLATIVE HISTORY

with the one exception that the Government's contribution cannot be adjusted to a biweekly amount which is more than the \$1.75, \$4.25, or \$2.50 specified in subsection (a) (1).

The net effect of this provision is that the Commission will prescribe the maximum contribution which the Government will make to each approved health benefits plan and so be able to control the total cost of the program to the Government.

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.

There may be some plans or options within 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.

Any adjustment in contribution rates must, within the specified limits, preserve the ratio which originally existed between the employee's or annuitant's contribution and the Government's contribution. If in the future an adjustment will (because of the maximums imposed on the Government's contribution) result in destroying this ratio, it is contemplated that the Civil Service Commission will call the matter to the attention of the Congress in advance so that the legislation can be amended to increase the maximum Government contributions if the Congress wishes.

Subsection (b) authorizes the Civil Service Commission to continue an employee's coverage for a period of up to 1 year (exclusive of any temporary extension of coverage) while he is in a leave-without-pay status. Because the employee will not be drawing any pay during this period, no contributions can be withheld from his salary and, therefore, the Commission is authorized to waive both the employee's and the Government's contributions while the employee is in a leave-without-pay status.

Subsection (c) directs that the Government's contribution toward the cost of the program be paid from the following sources:

(1) For most employees, from the appropriation or fund which is used for the payment of their salaries.

(2) In the case of an elected official, from the appropriation or fund which is available for payment of other salaries of the same office or establishment.

(3) In the case of an employee in the legislative branch whose salary is paid by the Clerk of the House of Representatives, from the contingent fund of the House.

Subsection (d) directs the Civil Service Commission to provide for the conversion of the biweekly contribution rates to weekly, monthly or other rates in the case of individuals who are paid on other than a biweekly basis and permits the converted rate to be adjusted to the nearest cent.

EMPLOYEES HEALTH BENEFITS ACT

EMPLOYEES' HEALTH BENEFITS FUND

Subsection (a) of section 8 creates an employees health benefits fund, to be administered by the Civil Service Commission, which is made available without fiscal year limitation for the payment of all premiums to approved health benefits plans and into which all contributions of employees, annuitants, and the Government shall be paid.

Subsection (b) requires that portions of the contributions made by employees, annuitants, and the Government shall be regularly set aside in the fund as follows:

(1) A percentage, not to exceed 1 percent of all such contributions, determined by the Commission as reasonably adequate to pay its administrative expenses under this bill.

(2) For each health benefits plan a percentage, not to exceed 3 percent of the contributions for such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. It is expected that these contingency reserves will be available to defray anticipated increases in future premiums and it is hoped that their use in this manner will postpone for a reasonable period of time the necessity of increases in contribution rates. Authorization is also contained in this subsection for applying the contingency reserves to reduce the contributions of employees and the Government or to increase the benefits provided by the plan from which the reserves are derived. It is required that the contingency reserves set aside for each plan will be used for the purposes mentioned above with respect to that plan only.

Subsection (c) authorizes the Secretary of the Treasury to invest any of the moneys in the employees health benefits fund in interest-bearing obligations of the United States and to sell such obligations for the purposes of the fund. All interest derived from these investments and the proceeds from the sale of obligations will become a part of the fund.

ADMINISTRATIVE EXPENSES

Subsection (a) of section 9 authorizes the expenditure from the employees' life insurance fund for the fiscal years 1960 and 1961, without regard to limitations on that fund, of such sums as may be necessary to pay the administrative expenses of the Civil Service Commission in carrying out the provisions of the Federal Employees Health Benefits Act of 1959. The subsection requires that reimbursement for sums so expended be made from the employees' health benefits fund to the employees' life insurance fund, together with interest at a rate to be determined by the Secretary of the Treasury.

Subsection (b) makes the employees' health benefits fund available (1) to reimburse the employees' life insurance fund, as indicated and (2), within such limitations as may be specified annually by the Congress, to pay the expenses of the Commission in administering this legislation for the fiscal year 1962 and subsequent years.

LEGISLATIVE HISTORY

ADMINISTRATION

Subsection (a) of section 10 authorizes the Civil Service Commission to promulgate such regulations as may be necessary to give effect to the intent and purposes of the Federal Employees Health Benefits Act of 1959.

Subsection (b) requires the Civil Service Commission to specify in its regulations the beginning and ending dates of coverage of employees and annuitants and members of their families. The subsection permits the Commission, by regulation, to grant a temporary extension of coverage upon cancellation (other than voluntary cancellation) of enrollment. Where the cancellation is for reasons other than the death of the employee or annuitant, it is expected that the temporary extension of coverage will continue for 31 days. Where the cancellation is on account of the death of the employee or annuitant, this subsection permits a temporary extension of coverage for members of the family for as long as 90 days after the end of the pay period or month in which the death of the employee or annuitant occurred. In any case, it is intended that the temporary extension of coverage will be without current contributions by the employee or annuitant, or members of his family, and by the Government.

Subsection (c) provides that an employee enrolled under this legislation who is removed or suspended without pay and later reinstated or restored to duty because the removal or suspension was unjustified or unwarranted shall have his coverage restored so that he may enjoy the same benefits as if removal or suspension had not occurred.

Subsection (d) requires that the Civil Service Commission shall make available to each employee such information as may be necessary to enable him to exercise an informed choice among the various plans available. This information with respect to the Government-wide service benefit plan and the Government-wide indemnity benefit plan must be in a form acceptable to the Commission and will be developed by the Commission after consultation with the carriers. It is expected that information with respect to the employee organization plans and the comprehensive medical plans will be prepared and distributed by the respective carriers; however, this information must also be approved by the Commission. Each employee who enrolls in a health benefits plan will be issued an appropriate certificate summarizing the services or benefits provided by the plan. These certificates will also have to be approved by the Commission.

STUDIES, REPORTS, AND AUDITS

Subsection (a) of section 11 stipulates that the Civil Service Commission shall make a continuing study of the operation and administration of this legislation, including surveys and reports on health benefits plans available to employees and on the experience of such plans. It is expected that in making this study the Commission will include any instances of apparent overutilization of hospital facilities and any instances of apparently excessive charges by purveyors of health services.

Subsection (b) requires carriers to furnish such reports as the Civil Service Commission determines to be necessary to enable it to carry out its functions under this legislation and permits the Commission and representatives of the General Accounting Office to examine any records of

EMPLOYEES HEALTH BENEFITS ACT

the carriers which either the Commission or the General Accounting Office deem to be pertinent to the purposes of this legislation.

Subsection (c) requires Government departments, agencies, and independent establishments to keep such records, make such certifications, and furnish the Civil Service Commission such information and reports as may be necessary to enable the Commission to carry out its functions under the legislation.

REPORTS TO CONGRESS

Section 12 requires the Commission to transmit to the Congress an annual report concerning the operation of the Federal Employees Health Benefits Act of 1959.

ADVISORY COMMITTEE

Section 13 requires the Chairman of the Civil Service Commission to appoint a committee composed of five members, who will serve without compensation, to advise the Commission regarding matters of concern to employees under this legislation. Each member of the committee will be an employee enrolled under this legislation, or an elected officer of a national employee organization.

JURISDICTION OF COURTS

Section 14 gives the district courts of the United States original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this legislation.

EFFECTIVE DATE

Section 15 makes the benefit and contributions provisions of this legislation effective on the first day of the first pay period which begins on or after July 1, 1960, and, by implication, makes the other provisions of the legislation effective upon enactment.

ADMINISTRATIVE REPORTS

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., August 3, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D. C.

MY DEAR MR. CHAIRMAN: Reference is made to your letter of July 8, 1959, requesting the views of the Bureau of the Budget on S. 2162, to provide a health benefits program for Government employees, presently before your committee.

Since 1954 this administration has advocated, and now continues to advocate, the establishment of a voluntary health insurance program for Federal employees. Specific programs were proposed in 1954, 1955, 1956, and 1957, each proposal being an attempt to formulate a better program. In 1958 the administration gave priority to pay increase legislation and recommended that action on employee health insurance legislation be postponed. It should be noted that during these years Government annual expenditures for Federal employee pay and benefits have been increased by substantial amounts due to increases in pay rates under both the statutory

LEGISLATIVE HISTORY

and prevailing wage systems. Increases in annuities under employee retirement systems, the liberalization of the premium pay benefits system, the liberalization of the civil service retirement system and the establishment of such new benefits as the allowances for uniforms and the group life insurance and unemployment compensation systems.

Following this administration's basic policy that the Federal employee should be compensated for the services he renders to the Government under a pay and benefit system that is reasonably comparable in structure and level with the compensation provided by progressive private employers, the Bureau of the Budget favors legislation authorizing a Federal employee health insurance program with benefits providing financial protection against the cost of health care reasonably comparable with those benefits provided in private employment. Although the existing Federal employee fringe benefit system has been reported to be already more liberal than the typical private business fringe benefit system, it does not include a program of health insurance benefits. Adding these benefits to the existing system will further increase the total value of the Federal employee fringe benefit package. Under these circumstances it is essential that the value added by the new health insurance benefit program be kept in line with private industry health benefits.

The new health insurance benefits should be made available only to employees who earn them by rendering services to the Government under the new program after it becomes effective. Compensation in the form of pay and benefits is paid to employees for services rendered. Former employees who rendered service under a compensation system which did not include these health insurance benefits have already been paid in full for their services in the form of pay and benefits already received or in vested rights to payment of future benefits already earned. Whenever salary or benefits are adjusted an effective date must be selected. It may be unfortunate that some former employees must miss eligibility by narrow margins, and a retroactive approach is often suggested. However, a retroactive approach actually creates an inequity where none would otherwise exist. For while prospective entitlement is firmly linked to services rendered under a compensation agreement, retroactive entitlement is pure gratuity. If any former employee is granted this special gift, then any other former employees who are excluded by the particular retroactive date selected will feel they merit equal consideration. The new health insurance benefits should, therefore, be provided only to employees who render service to the Government after a prospective effective date.

S. 2152, now before your committee, while including several desirable features, falls short of providing an acceptable employee health insurance program in two major respects: the cost to the Government is higher than justifiable in establishing a health insurance benefits program reasonably comparable with existing private business programs, and the organization and administrative system is defective.

The cost-sharing feature of the bill would require the Government to pay one-half of the premiums rather than one-third, as established for the Federal employee group life insurance program in 1954. The first-year cost of the bill to the Government is estimated in the Senate committee report to be \$145.3 million, which must be increased by \$2.5 million in the first year and \$25 million in the fifth year to include the Government share of the cost of annuitant coverage. This amount is substantially higher than the \$80 million figure which is actually needed as one-third of the cost, including the cost of annuitant coverage, of a sound program providing a benefit level in line with private industry plans, and providing a sound experience basis for accumulating the facts on which an appropriate Federal employee health benefits program can evolve for the future. It would be prudent for the Government to seek the patterns and level of health benefit protection best suited to the problems of the Federal employee, the benefits that will yield the most effective return for the premium dollar. Experience elsewhere strongly suggests that an effective program will evolve best from a conservative base. Sound development can occur as the genuine

EMPLOYEES HEALTH BENEFITS ACT

needs of the covered employees are clearly defined through experience, and a pattern of effective health care benefits grows up to meet these needs. The bill should be modified to clearly provide this sound, conservative beginning.

The organization and administrative provisions of S. 2162 should be modified. The Civil Service Commission will advise you in full detail concerning these modifications. This report will comment only on three organization provisions: the advisory council, the Civil Service Commission reorganization, and the submittal of proposed contracts and regulations.

The functions and membership of the proposed advisory council are not designed to aid sound administration. The council's assigned functions include making investigations of the administration of the program, and receiving reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relations with carriers, employing agencies, and employees. The Civil Service Commission should be unmistakably responsible for the success of this program. The council's functions should be advisory only. The council's membership should reflect its character as an element of a Federal employee benefit program, and should include appropriate Government officials, *ex officio*, together with employees, or their representatives, who are contributing and participating in the health insurance system. There is no need to create a statutory organization based on an assumption that the Civil Service Commission may refuse to seek the advice of responsible experts in the health insurance field. Neither is there basis for assuming that the Commission may foster a program which will be deleterious to the public generally, nor that the Commission will fail to give adequate consideration to all parties, including all qualified prospective carriers. The Government's lack of experience in administering a health insurance program for its employees and the asserted absence of facts upon which to base decisions does not argue for splitting responsibility in this program between the Civil Service Commission and the advisory council. Rather, it requires placing a special responsibility on the Commission to proceed prudently, to develop factual experience as rapidly as feasible, and to build soundly, and it places a special responsibility on those who contribute to the design of the authorizing statute to provide the clear-cut authority and proper organization that will be so essential. Section 12 should be modified accordingly.

The proposed statutory reorganization of the Civil Service Commission would interfere, to no defined purpose, with the existing statutory power and responsibility of the Chairman of the Civil Service Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. It is especially important in this new program to avoid a rigid organization prescription that could hamper the proper adjustment of administration with experience. Section 13 should be deleted from the bill.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is unnecessary to assure energetic administration by the Commission and is clearly improper if it is intended to provide the committees with a power of prior review of executive action. Subsection (a) of section 16 should be deleted from the bill.

S. 2162, as passed by the Senate, includes several features which are desirable in a program of Federal employee health benefits, but it seeks to provide a level of benefits at an unnecessarily high cost, and it provides an unsound system and organization for administration. Unless S. 2162 is modified as to cost and administrative provisions, as above noted, the Bureau of the Budget would not favor enactment of the bill.

Sincerely yours,

MAURICE H. STANS, *Director*.

LEGISLATIVE HISTORY

CIVIL SERVICE COMMISSION,
August 3, 1959.

Hon. Tom MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR Mr. MURRAY: In response to your letter of July 3, 1959, I am forwarding the Commission's views on the bill S. 2162, to provide a health benefits program for Government employees, as the bill has been amended by the Senate Post Office and Civil Service Committee and reported to the Senate. These views would also apply to H.R. 8210 and H.R. 8211, which are identical to S. 2162.

In the interest of brevity we are not here including a section analysis of S. 2162. The Senate committee's report of July 2, 1959, (No. 463) contains an explanation of the bill by sections. Except as noted hereinafter, the Commission construes the bill as stated in that explanation.

As the central personnel agency of the executive branch, the Commission considers enactment of a health insurance program for Federal employees highly desirable. Such a program would fill the one remaining major gap in employee fringe benefits and be of inestimable value in attracting and retaining Federal personnel.

We are in complete agreement with the fundamental concepts underlying S. 2162. Very briefly, these would—

(1) Permit employees a free choice among a Government-wide service benefit plan, a Government-wide indemnity benefit plan, a local group practice prepayment plan, and an employee organization plan.

(2) Require contributions from the employee and from the Government.

(3) Make the Commission responsible for the overall administration of the program while sharing the day-to-day operating responsibilities with the employing agencies and the insurance carriers.

(4) Create a central fund into which all receipts would be deposited and out of which all disbursements would be paid.

The soundness of these same concepts (except for the first, which is pertinent only to health insurance) has been solidly established by the efficient operation of the Federal employees' group life insurance program.

The Commission does not, however, altogether favor the manner in which S. 2162 applies these four general principles. We also have serious reservations about several other provisions of the bill. Under the circumstances, we find S. 2162 sufficiently objectionable to compel us to report unfavorably. If the objectionable features were corrected, we would find the bill acceptable and a good basis for a successful, enduring health benefits program.

There follows a discussion of what we consider to be the objectionable features of the bill, together with suggestions for rectifying them.

RETROACTIVITY

Regardless of how long before July 1, 1960, S. 2162 were enacted, it would become generally effective no earlier than that date. Section 2(b) (2), however, contains a proviso which would extend the benefits of the bill to certain employees and certain survivors who qualify for annuity between the time the bill is enacted and the time it becomes generally effective.

We appreciate and are not unsympathetic with the purpose of this proviso which is to protect those people who would otherwise be denied the benefits of the bill because, owing to circumstances beyond their control, they are separated before its effective date.

The situation which the proviso in section 2(b) (2) seeks to cure is not new. It occurs each time beneficial legislation is enacted and on each such occasion it appears that numbers of people have been denied benefits because they were prematurely separated. Depending largely on the value

EMPLOYEES HEALTH BENEFITS ACT

of the benefit, the group which considers itself aggrieved by having been denied the benefits ranges all the way from those who were separated as little as 1 day too early to those who were separated as much as 5 or even 10 years too early.

It is unfortunate that any person has to be denied a benefit because he has been prematurely separated, but we know from long experience that the proviso in section 2(b) (2), although it may slightly lessen the number of persons who will feel aggrieved, will not appreciably remedy the situation. The proviso in section 2(b) (2) would extend health benefits to certain employees who retire involuntarily or for disability during the interval between the enactment and effective date of the bill and to survivors of certain employees who die during this interval. The number of people whom the proviso will affect will depend on how long this interval may be, but in any event the proviso will not affect the large number of employees who, for example, will voluntarily retire during the interval and later claim they had no knowledge of the fact that, had they waited, they could have qualified. Nor, for another example, will it affect the even larger number of employees who retired (or died) 1 day, 1 week, 1 year before the enactment date.

A line of demarcation must be drawn somewhere. The fairest and firmest place to draw the line is at the date the enacted bill becomes effective. Any retroactively, unless it were complete, would be discriminatory and would intensify the aggrievement the excluded groups would feel and the representations they would make for having the benefits extended to them. The Commission, therefore, recommends that the following text be deleted from the bill:

(1) Subsection 2(b) (2) on page 23, beginning in line 13 and ending in line 18.

(2) Subsection 3(b) (2) beginning on page 26, line 25, and ending on page 27, line 11.

BENEFITS AND CONTRIBUTIONS

There are at least two aspects of the bill's benefit-contribution structure which, in the Commission's view, are so objectionable as to make S. 2162 unsatisfactory. These aspects are as follows:

(1) Government contributions:

At the maximum rates specified in section 7(a), the total contribution required of the Government has been estimated by the Senate committee at \$145.3 million annually. We would make two observations concerning this estimate: First, it does not include the sums which the Government would have to contribute annually toward insuring annuitants; second, the administration's frequently stated position is that it cannot at this time acquiesce in spending more than \$80 million a year on this program.

(2) Contributions versus benefits:

It can be contended that under section 7(a) contributions of employees and Government may be kept low by setting the rate at a figure less than the maximum authorized amount. But, we are not aware that any carrier has submitted a firm offer to underwrite, at a price less than the maximum contribution rates, the ultrarich benefits which are described in section 5(a) (1) and which are further implied in the Senate committee's report on S. 2162.

In the absence of such firm offer, we have reservations as to whether the implied benefits can be contracted for even at the maximum contribution rates. To the extent that they cannot, or to the extent that Government fiscal policy requires the contribution rates to be set lower than the maximum, the implied ultrarich benefits will have to be curtailed. Any such curtailment in benefits will, like the too-high contribution rates, result in employee disaffection with the program.

We discern other weaknesses in the benefit-contribution structure of S. 2162 but those mentioned above are considered sufficient to justify our recommendation against enactment.

LEGISLATIVE HISTORY

In the absence of a written commitment from a reputable carrier containing detailed specifications of benefits and subscription charges, we believe it wiser not to mislead employees into believing that they will receive ultrarich benefits. It would be infinitely better to delete section 5 of the bill in its entirety and rely on the Commission to negotiate contracts which will provide employees with generally better benefits than they now can get, at a cost to them which, depending on the geographic area, may be less than or about the same as they now pay.

We believe that, to assure enactment of a program, section 7(a) should limit the Government's total contribution to an amount which is acceptable to the administration. And, further, to permit employees who may be so inclined to enroll in plans offering very rich benefits (e. g., some existing group-practice plans) at a subscription charge greater than the maximum contribution rate stipulated in section 7(a), no limit on the employee's contribution rate should be specified. Suggested language to accomplish both these points follows:

"Sec. 7(a) (1) The Government's contribution to the subscription charge for each enrolled employee or annuitant shall be 33 $\frac{1}{3}$ per centum of the subscription charge but may not exceed (i) 95 cents biweekly if he is enrolled for himself alone, or (ii) \$2.30 biweekly if he is enrolled for himself and members of his family, or (iii) \$1.35 biweekly in the case of a female employee or annuitant who is enrolled for herself and members of her family, including a nondependent husband.

"(2) There shall be withheld from the salary of each employee or annuity of each annuitant enrolled in a health benefits plan under this Act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment."

CONTRACTING AUTHORITY

Section 6 authorizes the Commission to negotiate contracts with qualified carriers. It enumerates some of the items to be specified in the contracts but offers no guidance—nor does the Senate committee's report on S. 2162—on what we regard as a critical issue: Should each carrier of a Government-wide plan assume the total risk under his contract or should he be required to share his rights and obligations with other insurers?

For several reasons, but primarily to simplify negotiations with prospective carriers, the Commission considers it highly desirable that the prime carriers' rights and obligations under the two Government-wide plans be shared in much the same manner as the Congress has provided under the Federal Employees' Group Life Insurance Act. While the Commission, in contract negotiations, would probably insist on such sharing even if section 6 were enacted in its present form, it would be preferable to have the Congress express its intent in this regard by including language along the following lines in section 6, perhaps as a new subsection (b):

"(b) (1) The contract for the Government-wide service benefit plan shall require the carrier to allocate its rights and obligations under the contract among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates and approved by the Commission.

"(2) To be eligible as the carrier for the Government-wide indemnity benefit plan, a company must be licensed to issue group health insurance in all the States and the District of Columbia. The policy for such plan shall require the carrier to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission."

The Commission assumes, of course, that the national Blue Cross-Blue Shield organization will be the prime carrier for the Government-wide service benefit plan. To eliminate all but a dozen or so of the largest, most re-

EMPLOYEES HEALTH BENEFITS ACT

sponsible insurance companies from consideration as prime carrier of the indemnity benefit plan, and to avoid diversity of citizenship difficulties in the event of a court action by an employee, the suggested language requires the prime carrier to be licensed in all the States and the District of Columbia. All other companies which write group health insurance would, of course, be eligible to acquire their fair share of reinsurance from the prime carrier.

HEALTH BENEFITS FUND

I am sure your committee is aware that increasing use of hospital and other health services and the continuing rise in the cost of these services has required many insuring organizations to raise their subscription or premium rates. Some organizations have had to raise their rates several times within the last few years. The current situation in New York City, where the Blue Cross has very recently announced a substantial increase in its rates for the second time in less than 2 years, is characteristic of the trend toward higher insurance costs. Also characteristic is the reported widespread dissatisfaction with the rate increases among subscribers.

Informed opinion is to the effect that steady increases in the cost of providing health services are inevitable. To avoid the necessity of having to increase contribution rates under the Government-sponsored program with unnecessary frequency and, incidentally, to avoid the employee dissatisfaction and the administrative difficulties entailed in each such rate increase, the Commission believes that an adequate contingency reserve should be set aside which could be drawn upon to stave off frequent contribution rate increases. Section 8 of S. 2162 makes no provision for setting aside funds for this purpose other than those derived from "dividends, premium rate credits or other refunds." These refunds (and there is nothing to guarantee that any will be made by the carriers) are completely inadequate for use as a contingency reserve.

The Senate committee, in page 13 of its report on S. 2162, seems to have recognized the need to stabilize contributions by setting aside a portion of contributions as a reserve. It indicates that the reserve shall "not * * * exceed approximately 3 percent of any one year's contributions or [exceed] an accumulative total of approximately 10 percent." However there is no language in section 8 which would authorize retention of any portion of the contributions as a reserve, much less the specific percentages indicated in the Senate committee's report. In view of the explicit authorization in section 8 to set aside a 1 percent reserve for administrative expenses, we question the propriety of setting aside a larger contingency reserve without explicit authorization.

Increases in the cost of health services cannot, of course, be forecast with precision over a long period of years. The Commission feels rather strongly, however, that a contingency reserve should be accumulated which will be adequate to stave off increases in contribution rates for at least the first 5 years of the program's existence and, if possible, longer. To the best of our ability, we have estimated that to do this, it will be necessary to set aside moneys up to a maximum of 10 percent of all contributions paid into the fund. Suggested language for amending section 8 to permit the setting aside of an adequate reserve follows:

Sec. 8(a) There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the "Fund," which is hereby made available without fiscal year limitation for the payment of all subscription charges or premiums under contracts or policies entered into or purchased under section 6. The contributions of employees, annuitants, and the Government toward the subscription charges shall be paid into the Fund.

"(b) Portions of the subscription charges contributed by employees, annuitants, and the Government shall regularly be set aside as follows: (1) a percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made available in section 9; (2) for each plan, a per-

LEGISLATIVE HISTORY

centage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

"(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund."

ADVISORY COUNCIL

The Commission believes that an advisory council can be a valuable adjunct to the health insurance program. Conversely, a council could operate to hamper administration of the program.

In our considered opinion, two features of section 12 will seriously impair efficient operation of the program.

(1) Composition:

The 11-member Council called for by S. 2162 is so large as to inhibit unified and timely action which may be required of it.

Of the members mentioned in clauses (1) through (7) of section 12(a) only the Director of the Bureau of the Budget, because he is concerned with Government fiscal policy, and the three representatives of employee organizations have a continuing intrinsic interest in the program. We do not see that the other members mentioned (the Secretary of Labor, the Surgeon General, the Chief of the Bureau of Medicine and Surgery, a representative of the public, and three representatives of universities) have more than a casual interest in or concern with the program nor what long-range purpose would be served by their permanent membership on the Council. In any event, the services and advice of any or all these persons could be readily obtained when, in a particular situation, it was considered desirable.

We would suggest that section 12 be amended to create a smaller, more efficient Council whose membership would be representative of the vital interests affected by the program. This membership should, in our opinion, consist of the Director of the Bureau of the Budget, the Secretary of the Treasury, because he is charged by S. 2162 with the management of the health benefits fund, the Secretary of Health, Education, and Welfare, because he is officially concerned with public health and health benefits and, finally, to represent employees' interests, two elected officers of employee organizations and two insured employees at large.

(2) Duties:

Three of the Council's duties prescribed by section 12(b) are sufficiently inappropriate for an advisory council to repeat and comment on here:

(a) "to make studies from time to time of the operation and administration of this Act."

This prescribed duty is sheer duplication of what the Commission is required to do by section 11(a)—"[to] make a continuing study of the operation and administration of this Act."

(b) "to receive reports and information with respect [to this Act] from the Commission, carriers and employees and their representatives."

This duty will (1) interpose the Council between the Commission and the carriers and impair the carriers' accountability to the Commission and (2) make the Council a forum for air-

EMPLOYEES HEALTH BENEFITS ACT

ing employee grievances. Even if S. 2162 did not require it, the Commission would, as a matter of course, furnish reports and information to the Council and otherwise keep it current with developments so that it would have a basis on which to furnish advice and make recommendations.

(c) "to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances and reserves."

The Commission, as trustee of the fund, would do just this on a continuing basis and its efforts in this regard would automatically be audited by the General Accounting Office.

We cannot help but feel that, especially at the outset of the program, the Advisory Council as constituted by section 12 would have to be in virtually continuous session, would divert the energies and resources of the Commission, and, in general, would impede efficient administration. We urge that section 12 be amended so that it provides for a council whose function will be to advise and to recommend rather than to monitor the Commission. Language which would do this follows:

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

"(1) The Director of the Bureau of the Budget or his representative;

"(2) The Secretary of the Treasury or his representative;

"(3) The Secretary of Health, Education, and Welfare or his representative;

"(4) Four members, to be appointed by the Chairman of the Commission, of whom two shall be elected officers of national employee organizations and two shall be employees enrolled under this Act.

"(b) It shall be the duty of the Advisory Council (1) to consult with and advise the Commission in regard to the administration of this Act, and (2) to make recommendations to the Commission, with respect to the amendment of this Act or improvements in its administration.

"(c) Members of the Council who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at a rate to be fixed by the Commission, but not exceeding \$50 per diem, while away from their homes or regular places of business.

"(d) The Advisory Council shall be convened once yearly or oftener on the call of the Chairman of the Commission or on request of any three members of the Advisory Council."

STATUTORY BUREAU OF RETIREMENT AND INSURANCE

The only reasons we know of for the inclusion of section 13 in S. 2162 are the ones advanced in page 19 of the Senate committee's report on the bill. To put it briefly, the Commission does not find these reasons persuasive.

It is quite possible that the Commission may find it advisable to organize a bureau to handle its retirement and insurance functions. This possibility exists whether S. 2162 is enacted or not. The Chairman of the Commission is already empowered by law to reorganize the Commission and if considerations of economy and efficiency should in the future so dictate, he would do this. But his right, among other things, to choose a propitious time for the reorganization, to assign a name to a newly created bureau, to delegate responsibility, and to determine, in accordance with position classification standards, the grade of a bureau director should not be invaded by a statute which is not germane to these matters.

We must strongly urge that section 13 be deleted entirely from S. 2162.

CONTRACTS AND REGULATIONS

The last feature to which the Commission feels obliged to object is the directive in section 19(a) which would require the Commission to

LEGISLATIVE HISTORY

transmit by May 1, 1960, to the House and Senate Committees on Post Office and Civil Service, copies of the contracts it proposes to enter into and the regulations it proposes to promulgate.

We cannot perceive nor have we been able to ascertain the purpose of this directive unless it is to assure that the Commission takes timely action to implement the enacted bill. If this is its purpose, its inclusion in the bill is superfluous since section 16(b) directs that the enacted bill become effective July 1, 1960. If the bill is enacted, we will of course deploy all our resources to have implementation completed by that date. We feel, in this connection, that it is necessary only to call attention to the very prompt action the Commission took in August of 1954 to make the Group Life Insurance Act effective—and this with no effective date specified in the statute.

In addition to being superfluous, section 16(a) would leave the Commission in a quandary in at least two respects.

(1) Prudence would seem to dictate that the Commission, having transmitted copies of the contracts and the regulations, postpone their signing and promulgation while it awaited some formal acknowledgment from both the Senate and House Committees that they had objections to or that they approved of the proposed contracts and regulations. The wait could of course result in significant delay but any action, either negative or affirmative, on the part of either committee, could be construed as an infringement upon the Executive's powers.

(2) If between the time copies of the contracts and the regulations were transmitted and the time they were signed and promulgated, changes were made in either or both, the Commission would presumably have to notify the committees of the changes and again await acknowledgments. Such last minute changes could easily occur after May 1, 1960, in which case the Commission could, involuntarily, be in violation of section 16(a).

Viewed in the most favorable light, section 16(a) is superfluous and enigmatic. It should be deleted from the bill.

We are not in this statement of our views suggesting language to perfect a number of relatively minor items in S. 2162 which we think can (and should) be easily improved. Mostly, these improvements would facilitate administration of the program.

I would be glad to have a representative of my office meet with your staff to work out these perfecting changes and, if you wish, to provide such other technical assistance as your committee may want.

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

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

OFFICE OF THE POSTMASTER GENERAL,
Washington, D. C., July 28, 1959.

Hon. TOM MURRAY,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D. C.*

DEAR MR. CHAIRMAN: Reference is made to your request for the views of this Department on S. 2162, as amended and reported in the Senate. S. 2162 is a bill to provide a health benefits program for Government employees.

In previous years the Post Office Department has favored in principle health insurance for Federal employees, provided such insurance could be obtained at a reasonable cost and meets the needs of employees for protection against catastrophic illness. This Department continues to favor such health insurance for Federal employees.

EMPLOYEES HEALTH BENEFITS ACT

S. 2162 as reported in the U. S. Senate is based on a committee print. The position of the administration on this legislation has been set forth in reports by the Civil Service Commission and by the Bureau of the Budget (pp. 24-28 of S. Rept. 468 to accompany S. 2162). These reports have been brought to the attention of this Department and this Department concurs therein.

It is understood that the U. S. Civil Service Commission and the Bureau of the Budget will file reports with your committee with respect to S. 2162 as reported to the Senate. In the circumstances, this Department has no comments or recommendations to submit with respect to this legislation.

The Bureau of the Budget has advised that there would be no objection to the submission of this report to the committee.

Sincerely yours,

E. O. SESSIONS,
Acting Postmaster General.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.

August 12, 1959.

Hon. TOM MURRAY,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D. C.*

DEAR MR. CHAIRMAN: This is in reply to your request of July 8 for our comments on S. 2162, as passed by the Senate, a bill to provide a health benefits program for Government employees.

Our comments on S. 2162 are also applicable to H.R. 8210 and H.R. 8211, pending before your committee, which appear to be identical with S. 2162.

In view of the detailed explanation of S. 2162 in the report of the Senate Committee on Post Office and Civil Service, we refrain from burdening this report with a summary of the bill.

The pattern of health insurance coverage for Federal employees proposed by this bill is one which this Department considers appropriate and essential, both to meet the health insurance needs of Federal employees and to assure the competition among plans necessary for expansion of voluntary health insurance in the Nation. In this connection, we should like to mention the following basic points:

1. The employee options permit a real choice of coverage by the employee in terms of what he considers best suited to his needs and those of his family, and also provide an opportunity for the development of enrollment procedures which will yield the kind of educational efforts required to promote restraint and responsibility in the use of health insurance benefits. Carriers have found such efforts necessary with regard to both the insured and the providers of services.

Employee choices call for reasonable opportunity for changing from one plan to another. If the rules regarding transfer from one plan to another are unduly restrictive, a valuable gauge of employee satisfaction and carrier performance can be lost. Since the bill forbids restrictions which would exclude or limit coverage for preexisting diseases or conditions, the main problems in working out reasonable transfer arrangements will be adjustments for premium payments and benefits already availed of during the previous part of the benefit year.

2. The alternative types of plans set forth in the bill permit the development of benefits which could provide full scope of protection for Federal employees. It should be the responsibility of the Commission to see that each of the plans for which it contracts or gives approval offers protection which is substantially equivalent to some desirable level established by the Commission as a yardstick. Important, too, is the opportunity provided under the bill for women employees to gain coverage for their families.

LEGISLATIVE HISTORY

3. The bill accepts the principle of uniform contributions for both active employees and retirees and uniform benefits for these groups. The continuation of protection for retired employees without reduction—with premiums to continue at the same level, and their cost to be shared by the annuitant and the Government in the same proportion, as for active employees—follows a desirable pattern of coverage in health insurance plans generally.

4. The bill permits the setting aside of a portion of the health benefits fund as a special reserve against adverse fluctuations in future charges. A reserve of this type appears wholly appropriate in view of the nature of health benefits risk and the rising trend in medical care costs.

On such matters as the desirable distribution of premium costs as between the Government and employees, the composition and functions of the Advisory Council, and the proposed establishment of a Bureau of Retirement and Insurance within the Commission, we defer to the views of the Civil Service Commission. We suggest, however, that the Secretary of Health, Education, and Welfare be designated as a member of the Council in place of the Surgeon General of the Public Health Service. It should be noted that our Social Security Administration and the Office of the Special Assistant to the Secretary on Health and Medical Affairs, as well as the Public Health Service, are expert in and concerned with the study and encouragement of voluntary prepayment plans for hospital, medical, and other health services.

We, therefore, recommend enactment of the bill, with the modifications above suggested, and with such further modifications as are indicated by the views of the Civil Service Commission and the Bureau of the Budget, on the Federal share of the costs, on administrative organization, and on the composition and functions of the Advisory Council.

In making this recommendation, we have not overlooked the fact that the bill does not address itself to the problem of health insurance for those who are already retired, a fact that has given us much concern. We consider it essential that legislation for active employees and future retirees be supplemented in the near future by providing similar protection for those already retired. While we recognize the complexity of the problems involved in providing effective health benefit coverage to those already on annuities, the pressing health insurance needs of retired Federal employees suggest the importance of an early formulation of ways and means to meet their problems.

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

Sincerely yours,

ARTHUR S. FLEMING, *Secretary.*

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,
Washington, D. O., August 7, 1959.

Hon. TOM MURRAY,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives.*

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on S. 2162, 86th Congress, a bill to provide a health benefits program for Government employees, as reported in the Senate on July 2, 1959.

This bill would provide generally for four basic types of health insurance plans to be made available to Federal employees and annuitants, and members of their families. The bill also covers the level and pattern of benefits to be provided under the various plans; places certain responsibilities in the Civil Service Commission for overall administration; provides for payroll deductions and matching contributions by the Govern-

EMPLOYEES HEALTH BENEFITS ACT

ment; establishes a Federal Employees' Health Benefits Fund; and creates a Federal Employees Health Benefits Advisory Council and states its duties.

The Department of Defense fully recognizes the importance of group health insurance for its employees. For many years it has encouraged these employees to participate in available group health insurance programs on a voluntary basis, and large numbers are currently participating in such programs. This Department has also consistently supported recommendations for health insurance which have been included in the legislative programs of this administration.

The Department of Defense therefore endorses the basic purposes of S. 2162 and favors the enactment of legislation which will establish a Federal employee health benefits program that will provide sound protection against the high costs of illness at a price which both the employees and the Government can afford. The Department further believes that July 1, 1960, should be the goal for making such program fully effective and removing the unfortunate lag between the Federal Government and private industry in this important area.

Time has not permitted the full and detailed analysis of all the technical provisions of S. 2162 which would be necessary in order to determine whether changes in any of those provisions might produce improvements. However, the Department of Defense considers that this bill does provide the basis for a sound, well-rounded program of health insurance.

From the standpoint of assuring the most economical and efficient administration of this program, however, the Department of Defense is concerned with those provisions of S. 2162 which establish and prescribe the functions and duties of the Federal Employees Health Benefits Advisory Council.

The wording of section 12 makes this Council much more than an advisory body. It has monitoring and investigative functions, may receive reports and information from various individuals concerned with the program (which to some degree at least give it the character of a grievance committee), and may recommend legislation, presumably with or without concurrence of the Civil Service Commission which is the agency responsible for the program.

All these powers and duties of the Advisory Council will, in the opinion of the Department of Defense, tend to dilute and impair the position of the Civil Service Commission as the administrator of the program, create confusion, and make more complicated the administration of a program which will be complicated enough even, under the best of circumstances. It is the belief of the Department of Defense that the Advisory Council should be confined to those functions which the name implies—advising and making recommendations to the Civil Service Commission.

It would also seem unnecessary and undesirable to provide for membership on the Council of representatives of university schools of medicine, hospital administration, and public health. While these are undoubtedly sources from which the Civil Service Commission would desire to seek information and advice from time to time, this can be done without providing membership and votes on a statutory advisory council. Their interest in and identification with the program established by S. 2162 is not this direct.

S. 2162 provides for an equal sharing by employees and the Government of contributions under the program, which exceeds the maximum Government contribution previously recommended by the administration. It is estimated that costs to the Department of Defense from legislation of this nature will approximate one-half the costs to the Government, exclusive of costs attributable to coverage of annuitants. Since S. 2162 represents pending legislation, no provision has been made for these costs in the budget of the Department.

LEGISLATIVE HISTORY

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

Sincerely yours,

L. NIEDERLEHNER,
Deputy General Counsel.

CONTROLLER GENERAL OF THE UNITED STATES.

Washington, July 21, 1953.

HON. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. CHAIRMAN: In compliance with your request of July 8, 1953, we offer our comments on S. 2162, as passed by the Senate.

The bill provides generally that there shall be made available to Government employees health benefit plans of the currently popular types, the cost of which will be borne equally by the Government and the employees concerned. The program will generally give Government employees protection equivalent to that enjoyed by commercial and industrial employees.

While the bill involves a matter of policy upon which we offer no recommendation, the following observations are made for such consideration as they may warrant.

Section 2.—Many terms appearing in the bill, some of which are used interchangeably, are not clear. Among these are hospital care, hospital benefits, medical services, ambulatory patients, hospital services, hospital outpatient, other ambulatory patients, diagnostic and treatment services, and professional services. We assume that the Commission will include in its regulations such definitions as may be necessary.

Section 3 (general comments on subsections (a) and (b)).—Subsection (a) provides the benefits to be included in health plans but subsection (b) authorizes the Commission to substitute "alternative" benefits for any and all of the benefits specified in subsection (a). As the section is now written, the alternative benefits could be exclusive of major medical care. We suggest that subsection (b) be revised to insure that the alternative benefit shall include both basic and major medical protection at least equal to that provided under subsection (a). Also, in the event the Commission finds, in the administration of the program, that costs are being adversely affected by excessive or unjustified use of health services, there may be required some means of protecting the interests of the employees who refrain from such practices. Possibly, as an aid to the Commission, the authority to include deductibles and coinsurance should be made applicable to any benefits offered by the program.

Section 3(a) (1) (A).—While there is general provision for 120 days hospital care, the duration of care provided in cases of tuberculosis and nervous and mental conditions is limited to 30 days. We think that the supplemental benefits would apply in these cases, immediately after the expiration of 30 days. However, the relationship of this section to the major medical care provided in section 3(a) (1) (E) is not entirely clear. Therefore, we suggest the insertion of an express provision in the bill designating the point at which a tuberculosis or mental patient would be covered by major medical care.

Section 3(a) (1) (B) and 3(a) (1) (C).—The language "to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes" apparently is intended to preclude graduated medical and surgical fees to Federal employees with incomes less than those in the one-quarter group of employees that earn the highest incomes. However, enactment of the language would constitute congressional recognition of the practice of graduated medical and surgical fees to personnel with incomes in the "one-quarter of Federal employees earning

EMPLOYEES HEALTH BENEFITS ACT

the highest incomes." We doubt that congressional recognition should be given to the practice of graduating medical and surgical fees upon the basis of income. Therefore, you may wish to delete the language in the section relating to graduated fees.

Section 5(a) (1) (D).—Benefits for ambulatory patients should be clarified. As the subsection now reads, it is not clear whether it was the intention to require that each of the four plans specified in section 4 include provisions for protection against medical costs for ambulatory patients, or whether care for this class of patients would be restricted to service benefit plans. Further, it is not clear whether the contemplated medical costs would apply to visits of patients to the physician's office when the patient had not been previously hospitalized for the condition subsequently treated at the office. It is likewise not clear whether the section contemplates the payment for house calls made by physicians.

Section 5(a) (1) (E).—The section provides for a sharing of the first \$1,500 of expenses and that the carrier shall pay all costs in excess of \$1,500 subject to maximums determined by the Commission. Your committee may wish to consider the desirability of prescribing in the law itself maximum and minimum amounts that would be payable in addition to the first \$1,500. This point would be of particular significance if the cost of benefits provided under a plan should increase to a point where it may be necessary for the Commission to reduce certain of such benefits to stay within the limit of available funds.

Also, we suggest the addition of the following language to be inserted after the word "subparagraph" appearing on line 10, page 31; "shall include any and all diseases but".

Section 5(a) (1) (F).—Apparently under this paragraph no supplemental benefits would be provided for any normal delivery even though complications may develop prior to the patients' complete recovery.

Section 5(a) (2).—We do not have the details of the benefits which may be offered under the indemnity plan. We recommend, however, that the bill require or, at least, that the committee report specify that the value of benefits under the indemnity plan generally coincide with the value of the services furnished under the service plan, including coverage of all diseases.

Section 6.—The bill specifies that the Commission shall approve two nationwide plans, one of the service type and one of the indemnity type, and authorizes the Commission to enter into nationwide contracts for benefits provided by the two plans. Under such conditions the question arises as to what recognition is to be given to the variations in hospital room rates, medical services, and surgical fees between various localities. Since schedules of benefits will be applicable nationwide, there will be a tendency for those hospitals and surgeons heretofore charging less than the stated maximum to increase their rates and fees until they reach the maximum levels specified. This result would add to the cost of the program for both the employee and the Government. In our opinion the bill should specify that the nationwide contracts contain language assigning to the carrier responsibility for maintaining costs at prevailing local levels. We suggest language similar to the following be added to section 6(b) "Any nationwide prime contract shall include a requirement that the carrier's subcontracts or other arrangements with corporations, associations, groups, doctors, hospitals, and other providers of health services shall be stated at cost levels no higher than the (1) charges to the general public, or (2) schedules of health benefit costs in local health benefit plans."

We suggest that this section be amended to authorize the Commission to require reinsurance if it deems such action is necessary to protect the interests of the Government. Similar reinsurance is required under the Government Employees Life Insurance Act.

Section 7(b).—This section covers employees who are on leave without pay and would vest in the Commission discretion to regulate the coverage

LEGISLATIVE HISTORY

to be granted. Presumably, this discretion is necessary to enable consideration of the circumstances involved in individual cases concerning authorized or unauthorized leave without pay. Consideration might be given to providing the Commission guidelines for its administration of this section in your committee's report.

Section 8.—We recommend a technical revision in this section. After the word "Fund" on page 36, line 14, insert the language "which shall be administered by the Commission and". Also, on page 37, after the word "Fund" appearing on line 15, insert the language "when directed by the Commission."

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, August 17, 1952.

R-119031.

Hon. TOM MURRAY,
*Chairman, Committee on Post Office and Civil Service,
House of Representatives.*

DEAR MR. CHAIRMAN: As a result of a number of conferences between members of our respective staffs we have been requested to report on the version of the bill S. 2162 presently under consideration by your committee. We are pleased to offer the following comments on the bill as presently revised by the committee.

Health benefit plans (sec. 4, p. 30)

Section 4 of the bill provides that there shall be one Government-wide service benefit plan and one Government-wide indemnity plan. Testimony before the committee has disclosed clearly that in order to provide a health plan within the reach of the employees in the lower grades, and for basic fiscal policy reasons, a benefits plan with relatively low or "thin" benefits will be acquired. Under the requirement that only one service and one indemnity plan may be operative, such plans may and probably will not provide a benefit level desired by the majority of employees in the middle or upper grades, nor will the new uniform medium or low benefit plan compare favorably with broader coverage now carried by many employees. We suggest that the committee consider revising this section of the bill to require the providing of at least two levels of benefits for each of the two primary plans created by sections 4(1) and 4(2). Two levels of benefits would provide a more flexible choice to the employees, enabling them to consider local cost conditions, and would also recognize the employees' ability to pay. In our opinion the option for two levels of benefits under each major plan could be included within a single contract with the respective carriers. While the cost of administration will necessarily be increased by additional options, we believe that the matter can be worked out by the Commission to assure a minimum of increased costs. The following language, or some modification thereof, added to sections 4(1) and 4(2) would provide a basis for the Commission to develop two levels of benefits and two levels of cost under each of the two nationwide plans:

"Provided, That any such plan shall include two levels of benefits and two related levels of subscription or premium charges."

Contracting authority (sec. 8, p. 33)

The committee has received testimony that experience under many health plans indicates they are subject to costly abuses. Published material indicates a rather significant overutilization of hospital services when the individuals are insured for hospital services only. Some published data has indicated that unnecessary hospitalization under insurance or service plans runs as high as 20 percent.

EMPLOYEES HEALTH BENEFITS ACT

If abuses occur, then costs borne by the employee and the Government will be correspondingly higher. Conversely, if the unnecessary services and the related costs are curtailed, then more funds will be available to provide the necessary benefits. The unnecessary use of hospital room and board in order to obtain other needed services not available unless the patient is hospitalized, is an example of abuse. The insurance industry and the large employers have devised contract provisions designed to curtail nonessential utilization of health services, and it would seem that where appropriate the Government should apply similar and other effective provisions. Coverage of all medical services, coupled with coinsurance and deductibles are among the corrective devices used. The committee may wish to state in the bill an expression of policy for the guidance of the Commission in framing contracts to provide to the extent possible for the curtailment of abuses of the Government health plans by the users of the services or benefits. This could be accomplished by adding a provision to section 6 of the bill, reading substantially as follows:

"Regulations of the Commission shall require that all plans or contracts include benefits, in specified categories of health services, and at such levels, as the Commission determines necessary to restrict excessive utilization or abuse of any service. The standards shall include such other provisions, including coinsurance and deductible provisions, determined by the Commission to be necessary to prevent abuses of the program."

Contributions (sec. 7(a) (1), p. 30)

We wish to point out that section 7(a) (1) as written, permits the Commission full discretion regarding the level of benefits that may be acquired. The benefits may be set very low—substantially below the amounts stated in subparagraphs (i) and (ii)—and in such cases the Government would pay 50 percent of the costs. If the benefits acquired are liberal and the costs higher, then the Government may pay less than 50 percent of the costs.

Also, we note that the minimums and maximums between which the Commission must set the "prescribed" amounts are apparently intended to be applicable uniformly to all plans. However, it is possible to interpret the language of this section as authorizing variable "prescribed" amounts, within the three categories of minimum and maximum limits stated in the bill. We believe this would be inequitable to employees who were members of the plans assigned low "prescribed" amounts. We suggest the following change on line 7, page 36:

"The amounts so prescribed, which shall be uniform for all plans, shall not—"

Subscription charges and premiums

The bill contains numerous references to "subscription charges" and "premiums." However, the manner in which the terms are used indicates that in some instances these terms refer to the combined amount represented by payroll deductions from employees and the Government's transfer to the fund, and in other instances one or both of the terms refer to the payment from the fund to the carriers. These amounts paid into the fund will not necessarily be the same as the amounts paid out to carriers, as the bill is now written. The difference in the amounts is due to allowances for expenses and credits to the reserve. It is suggested that the use of these terms throughout the bill be reviewed and their specific use clarified by editorial change.

We will be pleased to provide any further information or assistance in connection with this proposed legislation that the committee desires.

Sincerely yours,

FRANK H. WETZEL,
Assistant Comptroller General of the United States.

**FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF
 1959**

For Legislative History of Act, see p. 2913

PUBLIC LAW 86-382; 73 STAT. 708

[S. 2162]

An Act to provide a health benefits program for Government employees.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That:

This Act may be cited as the "Federal Employees Health Benefits Act of 1959".

DEFINITIONS

Sec. 2. As used in this Act—

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

(b) "Government" means the Government of the United States of America (including the municipal government of the District of Columbia).

(c) "Annuitant" means—

(1) an employee who on or after the effective date of the provisions referred to in section 15 retires on an immediate annuity, under the Civil Service Retirement Act or other retirement system for civilian employees of the Government, after twelve or more years of service or for disability,

(2) a member of a family who receives an immediate annuity as the survivor of a retired employee described in clause (1) or of an employee who dies after completing five or more years of service,

(3) an employee who receives monthly compensation under the Federal Employees' Compensation Act as a result of injury sustained or illness contracted on or after such date of enactment and who is determined by the Secretary of Labor to be unable to return to duty, and

(4) a member of a family who receives monthly compensation under the Federal Employees' Compensation Act as the surviving beneficiary of (A) an employee who, having completed five or more years of service, dies as a result of illness or injury compensable under such Act or (B) a former employee who is separated after having completed five or more years of service and who dies while receiving monthly compensation under such Act on account of injury sustained or illness contracted on or after such date of enactment and has been held by the Secretary of Labor to have been unable to return to duty.

For the purpose of this subsection, "service" means service which is creditable for the purposes of the Civil Service Retirement Act.

4 (d) "Member of family" means an employee's or annuitant's spouse and any unmarried child (1) under the age of nineteen years (including (A) an adopted child, and (B) a stepchild or recognized natural child who lives with the employee or annuitant in a regular parent-child relationship), or (2) regardless of age who is incapable of self-support because of mental or physical incapacity that existed prior to his reaching the age of nineteen years.

5 (e) "Dependent husband" means a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than one year.

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

7 (g) "Carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization.

8 (h) "Commission" means the United States Civil Service Commission.

9 (i) "Employee organization" means an association or other organization of employees which—

(1) is national in scope or

(2) in which membership is open to all employees of a Government department, agency, or independent establishment who are eligible to enroll in a health benefits plan under this Act, and which on or before December 31, 1959, applies to the Commission for approval of a plan provided for by section 4(3) of this Act.

ELECTION OF COVERAGE

Sec. 3. (a) Any employee may, at such time, in such manner, and under such conditions of eligibility as the Commission may by regulation prescribe, enroll in an approved health benefits plan described

in section 4 either as an individual or for self and family. Such regulations may provide for the exclusion of employees on the basis of the nature and type of their employment or conditions pertaining thereto, such as, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of like nature, but no employee or group of employees shall be excluded solely on the basis of the hazardous nature of their employment.

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

(1) for a period not less than (A) the five years of service immediately preceding retirement or (B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Commission, in which he is eligible to enroll in such a plan and the date on which he becomes an annuitant, whichever is shorter, or

(2) as a member of the family of an employee or annuitant may continue his enrollment under such conditions of eligibility as may be prescribed by regulations of the Commission.

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

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

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

HEALTH BENEFITS PLANS

Sec. 4. The Commission may contract for or approve the following health benefits plans:

(1) **Service benefit plan.**—One Government-wide plan (offering two levels of benefits) under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described in section 5(1) rendered to employees or annuitants, or members of their families, or, under certain conditions, payment is made by a carrier to the employee or annuitant or member of his family.

(2) **Indemnity benefit plan.**—One Government-wide plan (offering two levels of benefits), under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described in section 5(2).

(3) **Employee organization plans.**—Employee organization plans which offer benefits of the types referred to in section 5(3), which

are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations, which are available only to persons (and members of their families) who at the time of enrollment are members of the organization, and which on July 1, 1959, provided health benefits to members of the organization.

(4) **Comprehensive medical plans.**—

(A) **Group-practice prepayment plans.**—Group-practice prepayment plans which offer health benefits of the types referred to in section 5(4), in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. Such a group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(B) **Individual-practice prepayment plans.**—Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Commission, to accept the payments provided by the plans as full payment for covered services rendered by them including, in addition to in-hospital services, general care rendered in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated such plans prior to approval by the Commission of the plan in which employees may enroll.

TYPES OF BENEFITS

Sec. 5. The benefits to be provided under plans described in section 4 may be of the following types:

(1) **Service benefit plan.**—

- (A) Hospital benefits.
- (B) Surgical benefits.
- (C) In-hospital medical benefits.
- (D) Ambulatory patient benefits.
- (E) Supplemental benefits.
- (F) Obstetrical benefits.

(2) **Indemnity benefit plan.**—

- (A) Hospital care.
- (B) Surgical care and treatment.
- (C) Medical care and treatment.
- (D) Obstetrical benefits.
- (E) Prescribed drugs, medicines, and prosthetic devices.
- (F) Other medical supplies and services.

(3) **Employee organization plans.**—Benefits of the types specified in this section under paragraph (1) or (2) or both.

(4) **Comprehensive medical plans.**—Benefits of the types specified in this section under paragraph (1) or (2) or both.

All plans contracted for under paragraphs (1) and (2) shall include benefits both for costs associated with care in a general hospital and for other health service costs of a catastrophic nature.

CONTRACTING AUTHORITY

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

(b) (1) To be eligible as the carrier for the plan described in section 4(2), a company must be licensed to issue group health insurance in all the States of the United States and the District of Columbia.

(2) Each contract for a plan described in paragraph (1) or (2) of section 4 shall require the carrier—

(A) to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission, or

(B) to allocate its rights and obligations under the contract among such of its affiliates as may elect to participate, in accordance with an equitable formula to be determined by the carrier and such affiliates and approved by the Commission.

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

(d) The Commission is authorized to prescribe regulations fixing reasonable minimum standards for health benefits plans described in section 4 and for carriers offering such plans. Approval of such a plan shall not be withdrawn except after notice, and opportunity for hearing without regard to the Administrative Procedure Act, to the carrier or carriers concerned.

(e) No contract shall be made or plan approved which excludes any person because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(f) No contract shall be made or plan approved which does not offer to each employee and annuitant whose enrollment in the plan is terminated, other than by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee or annuitant who exercises this option shall pay the full periodic charges of the nongroup contract, on such terms or conditions as are prescribed by the carrier and approved by the Commission.

(g) The benefits and coverage made available pursuant to the provisions of subsection (f) shall, at the option of the employee or

annuitant, be noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(h) Rates charged under health benefits plans described in section 4 shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described in section 4(1) and (2) shall be determined on a basis which, in the judgment of the Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers; rates determined for the first contract term shall be continued for subsequent contract terms, except that they may be readjusted for any subsequent term, based on past experience and benefit adjustments under the subsequent contract; any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

CONTRIBUTIONS

Sec. 7. (a) (1) Except as provided in paragraph (2) of this subsection, the Government contribution for health benefits for employees or annuitants enrolled in health benefits plans under this Act, in addition to the contributions required by paragraph (3), shall be 50 per centum of the lowest rates charged by a carrier for a level of benefits offered by a plan under paragraph (1) or paragraph (2) of section 4, but (A) not less than \$1.25 or more than \$1.75 biweekly for an employee or annuitant who is enrolled for self alone, (B) not less than \$3 or more than \$4.25 biweekly for an employee or annuitant who is enrolled for self and family (other than as provided in clause (C) of this paragraph), and (C) not less than \$1.75 or more than \$2.50 biweekly for a female employee or annuitant enrolled for self and family including a nondependent husband.

(2) For an employee or annuitant enrolled in a plan described under section 4(3) or (4) for which the biweekly subscription charge is less than \$2.50 for an employee or annuitant enrolled for self alone or \$6 for an employee or annuitant enrolled for self and family, the contribution of the Government shall be 50 per centum of such subscription charge, except that if a nondependent husband is a member of the family of a female employee or annuitant who is enrolled for herself and family the contribution of the Government shall be 30 per centum of such subscription charge.

(3) There shall be withheld from the salary of each enrolled employee and the annuity of each enrolled annuitant, and there shall be contributed by the Government, amounts (in the same ratio as the contributions of such employee or annuitant and the Government under paragraphs (1) and (2)) which are necessary for the administrative costs and the reserves provided for by section 8(b).

(4) There shall be withheld from the salary of each enrolled employee or annuity of each enrolled annuitant so much as is necessary, after deducting the contribution of the Government, to pay the total charge for his enrollment. The amount withheld from the annuity

of an annuitant shall be equal to the amount withheld from the salary of an employee when both are enrolled in the same plan providing the same health benefits.

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

(c) The sums authorized to be contributed by the Government with respect to any employee shall be paid from—

(1) the appropriation or fund which is used for payment of the salary, wage, or other compensation of such employee.

(2) in the case of an elected official, from such appropriation or fund as may be available for payment of other salaries of the same office or establishment,

(3) in the case of an employee in the legislative branch whose salary, wage, or other compensation is disbursed 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 appropriation or fund which would be used for the payment of the salary of such employee if he were in a pay status.

The sums authorized by subsection (a) (1) to be contributed by the Government with respect to any annuitant shall be paid from any appropriations which are hereby authorized to be made for such purpose.

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

EMPLOYEES HEALTH BENEFITS FUND

Sec. 8. (a) There is hereby created an Employees Health Benefits Fund, hereinafter referred to as the "Fund", to be administered by the Commission, which is hereby made available without fiscal year limitation for all payments to approved health benefits plans. The contributions of employees, annuitants, and the Government described in section 7 shall be paid into the Fund.

(b) Portions of the contributions made by employees, annuitants, and the Government shall be regularly set aside in the Fund as follows: (1) a percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made available by section 9; (2) for each health benefits plan, a percentage, not to exceed 3 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, rate adjustments,

or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund.

ADMINISTRATIVE EXPENSES

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

(b) The Employees Health Benefits Fund is hereby made available (1) to reimburse the Employees' Life Insurance Fund for sums expended by the Commission in administering the provisions of this Act for the fiscal years 1960 and 1961 and (2), within such limitations as may be specified annually by the Congress, to pay such expenses for subsequent fiscal years.

ADMINISTRATION

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

(b) Regulations of the Commission shall include regulations with respect to the beginning and ending dates of coverage of employees and annuitants and members of their families under health benefits plans, and for such purpose may permit such coverage to continue, exclusive of the temporary extension of coverage described in section 6(f), until the end of the pay period in which an employee is separated from service or until the end of the month in which an annuitant ceases to be entitled to annuity, and in case of the death of such employee or annuitant may permit a temporary extension of the coverage of the members of his family for a period not to exceed ninety days.

(c) Any employee enrolled in a plan under this Act who is removed or suspended without pay and later reinstated or restored to duty on the ground that such removal or suspension was unjustified or unwarranted shall not be deprived of coverage or benefits for the interim but shall have his coverage restored to the same extent and effect as though such removal or suspension had not taken place, and

appropriate adjustments shall be made in premiums, subscription charges, contributions, and claims.

(d) The Commission shall make available to each employee eligible to enroll in a health benefits plan under this Act such information, in a form acceptable to the Commission after consultation with the carrier, as may be necessary to enable such employee to exercise an informed choice among the types of plans referred to in section 4. Each employee enrolled in such a health benefits plan shall be issued an appropriate document setting forth (or summarizing the services or benefits (including maximums, limitations, and exclusions), to which the employee, or the employee and members of his family, are entitled thereunder, the procedure for obtaining benefits, and the principal provisions of the plan affecting the employee or members of his family.

STUDIES, REPORTS, AND AUDITS

Sec. 11. (a) The Commission shall make a continuing study of the operation and administration of this Act, including surveys and reports on health benefits plans available to employees and on the experience of such plans.

(b) The Commission shall include provisions in contracts with carriers which would require carriers to (1) furnish such reasonable reports as the Commission determines to be necessary to enable it to carry out its functions under this Act, and (2) permit the Commission and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this Act.

(c) Each Government department, agency, and independent establishment shall keep such records, make such certifications, and furnish the Commission with such information and reports as may be necessary to enable the Commission to carry out its functions under this Act.

REPORTS TO CONGRESS

Sec. 12. The Commission shall transmit to the Congress annually a report concerning the operation of this Act.

ADVISORY COMMITTEE

Sec. 13. The Chairman of the Commission shall appoint a committee composed of five members who shall serve without compensation, to advise the Commission regarding matters of concern to employees under this Act. Each member of such committee shall be an employee enrolled under this Act or an elected officer of an employee organization.

Sec. 14. (a) The Chairman of the Commission is authorized to appoint in grade 18 of the General Schedule of the Classification Act of 1949, as amended, an officer who shall have such functions and duties with respect to retirement, life insurance, and health benefits programs as the Commission shall prescribe. Such positions shall

be in addition to the number of positions otherwise authorized by law to be placed in such grade.

(b) The rate of basic compensation of the Executive Director of the United States Civil Service Commission shall be \$19,000 per annum.

JURISDICTION OF COURTS

Sec. 15. The district courts of the United States shall have original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this Act.

EFFECTIVE DATE

Sec. 16. The provisions of this Act relating to the enrollment of employees and annuitants in health benefits plans and the withholding and payment of contributions shall take effect on the first day of the first pay period which begins on or after July 1, 1960.

Approved September 28, 1959.

MUTUAL SECURITY APPROPRIATION ACT, 1960

PUBLIC LAW 86-383; 73 STAT. 717

[H. R. 8355]

An Act making appropriations for Mutual Security and related agencies for the fiscal year ending June 30, 1960, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That:

The following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1960, namely:

TITLE I—MUTUAL SECURITY

FUNDS APPROPRIATED TO THE PRESIDENT

For expenses necessary to enable the President to carry out the provisions of the Mutual Security Act of 1954, as amended, to remain available until June 30, 1960, unless otherwise specified herein, as follows:

Military assistance: For assistance authorized by section 103(a) to carry out the purposes of chapter I (including administrative expenses as authorized by section 103(b)), which shall not exceed \$25,000,000 for the fiscal year 1960, and purchase for replacement only of passenger motor vehicles for use abroad), \$1,300,000,000;

Defense support: For assistance authorized by section 131(b), \$650,000,000, and in addition for Defense support for Spain, authorized by section 131(b), \$45,000,000, exclusive of technical cooperation;

Development Loan Fund: For advances to the Development Loan Fund as authorized by section 203, \$550,000,000, to remain available until expended;

Technical cooperation, general authorization: For assistance authorized by section 304, \$150,000,000;

United Nations expanded program of technical assistance and related fund: For contributions authorized by section 306(a), \$30,000,000;

Technical cooperation programs of the Organization of American States: For contributions authorized by section 306(b), \$1,200,000;

Special assistance, general authorization: For assistance authorized by section 400(a), \$245,000,000;

Special assistance, special authorization: For assistance authorized by section 400(c) in the planning for construction of the American Research Hospital

PUBLIC LAW 98-615 [H.R. 2300]; November 8, 1984

**CIVIL SERVICE RETIREMENT SPOUSE EQUITY ACT OF
1984—PERFORMANCE MANAGEMENT AND RECOGNITION
SYSTEM**

For Legislative History of Act, see p. 5540

An Act to provide retirement equity for former spouses of civil service retirees, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Civil Service Retirement Spouse Equity Act of 1984".

Civil Service
Retirement
Spouse Equity
Act of 1984.
5 USC 8331 note.
5 USC 8331.

Sec. 2. Chapter 83 of title 5, United States Code, is amended—

(1) in section 8331—

(A) by striking out "and" at the end of paragraph (21);

(B) by striking out the period at the end of paragraph (22) and inserting in lieu thereof a semicolon; and

(C) by adding at the end thereof the following new paragraphs:

"(23) 'former spouse' means a former spouse of an individual—

"(A) if such individual performed at least 18 months of civilian service covered under this subchapter as an employee or Member, and

"(B) if the former spouse was married to such individual for at least 9 months; and

"(24) 'Indian court' means an Indian court as defined by section 201(3) of the Act entitled 'An Act to prescribe penalties for certain acts of violence or intimidation, and for other purposes', approved April 11, 1968 (25 U.S.C. 1301(3); 82 Stat. 77).";

(2) by amending section 8334(h) to read as follows:

5 USC 8334.

"(h) For the purpose of survivor annuities, deposits authorized by subsections (c), (d), and (j) of this section and by section 8339(j)(5)(C) and the last sentence of section 8339(k)(2) of this title may also be made by a survivor of an employee or Member.";

Infra.
Infra.

(3) in section 8339—

(A) by amending subsection (j) to read as follows:

"(j)(1) The annuity computed under subsections (a)-(i) and (n) of this section (or a portion of the annuity, if jointly designated for this purpose by the employee or Member and the spouse of the employee or Member under procedures prescribed by the Office of Personnel Management) for an employee or Member who is married at the time of retiring under this subchapter is reduced as provided in paragraph (4) of this subsection in order to provide a survivor annuity for the spouse under section 8341(b) of this title, unless the employee or Member and the spouse jointly waive the spouse's right to a survivor annuity in a written election filed with the Office at the time that the employee or Member retires. Each such election shall be made in accordance with such requirements as the Office shall, by regulation, prescribe, and shall be irrevocable. The Office shall provide, by regulation, that an employee or Member may waive the survivor annuity without the spouse's consent if the employee or Member establishes to the satisfaction of the Office—

Post, p. 3199.

Regulations.
Waiver.

"(A) that the spouse's whereabouts cannot be determined, or
"(B) that, due to exceptional circumstances, requiring the
employee or Member to seek the spouse's consent would other-
wise be inappropriate.

Post, p. 3199.

"(2) If an employee or Member has a former spouse who is entitled to a survivor annuity as provided in section 8341(h) of this title, the annuity of the employee or Member computed under subsections (a)-(i) and (n) of this section (or any designated portion of the annuity, in the event that the former spouse is entitled to less than 55 percent of the employee or Member's annuity) is reduced as provided in paragraph (4) of this subsection.

"(3) An employee or Member who has a former spouse may elect, under procedures prescribed by the Office, to have the annuity computed under subsections (a)-(i) and (n) of this section or a portion thereof reduced as provided in paragraph (4) of this subsection in order to provide a survivor annuity for such former spouse under section 8341(n) of this title. An election under this paragraph shall be made at the time of retirement or, if later, within 2 years after the date on which the marriage of the former spouse to the employee or Member is dissolved, subject to a deposit in the Fund by the retired employee or Member, within such 2-year period, of an amount determined by the Office, as nearly as may be administratively feasible, to reflect the amount by which the annuity of such employee or Member would have been reduced if the election had been continuously in effect since the date the annuity commenced, plus interest. For the purposes of the preceding sentence, the annual rate of interest for each year during which the annuity would have been reduced if the election had been in effect since the date the annuity commenced shall be 6 percent. If the employee or Member does not make such a deposit, the Office shall collect the amount of the deposit by offset against the employee or Member's annuity, up to a maximum of 25 percent of the net annuity otherwise payable to the employee or Member, and the employee or Member is deemed to consent to such offset. An election under this paragraph—

"(A) shall not be effective to the extent that it—

"(i) conflicts with—

Post, p. 3199.

"(I) any court order or decree referred to in subsection (h)(1) of section 8341 of this title; which was issued before the date of such election; or

"(II) any agreement referred to in such subsection which was entered into before such date; or

Post, p. 3199.

"(ii) would cause the total of survivor annuities payable under subsections (b), (d), (f), and (h) of section 8341 of this title based on the service of the employee or Member to exceed 55 percent of the annuity to which the employee or Member is entitled under subsections (a)-(i) and (n) of this section; and

"(B) shall not be effective, in the case of an employee or Member who is then married, unless it is made with the spouse's written consent.

Regulations.
Waiver.

The Office shall provide by regulation that subparagraph (B) of this paragraph may be waived for either of the reasons set forth in the last sentence of paragraph (1) of this subsection. In the case of a retired employee or Member whose annuity is being reduced in order to provide a survivor annuity for a former spouse, an election to provide or increase a survivor annuity for any other former spouse (and to continue an appropriate reduction) may be made

within the same period that, and subject to the same conditions under which, an election could be made under paragraph (5)(B) of this subsection for a current spouse (subject to the provisions of this paragraph relating to consent of a current spouse, if the retired employee or Member is then married). The opportunity to make an election under the preceding sentence is in addition to any opportunity otherwise afforded under this paragraph.

"(4) In order to provide a survivor annuity or combination of survivor annuities under subsections (b), (d), (f), and (h) of section 8341 of this title, the annuity of an employee or Member (or any designated portion or portions thereof) is reduced by 2½ percent of the first \$3,600 thereof plus 10 percent of so much thereof as exceeds \$3,600.

Post, p. 3199

"(5)(A) Any reduction in an annuity for the purpose of providing a survivor annuity for the current spouse of a retired employee or Member shall be terminated for each full month—

Termination dates.

"(i) after the death of the spouse, or

"(ii) after the dissolution of the spouse's marriage to the employee or Member, except that an appropriate reduction shall be made thereafter if the spouse is entitled, as a former spouse, to a survivor annuity under section 8341(h) of this title.

Post, p. 3199.

"(B)(i) Any reduction in an annuity for the purpose of providing a survivor annuity for a former spouse of a retired employee or Member shall be terminated for each full month after the former spouse remarries before reaching age 55 or dies, unless the employee or Member elects, within 2 years after the former spouse's death or remarriage, to continue the reduction in order to provide a survivor annuity or increase the survivor annuity for the current spouse of the retired employee or Member.

"(ii) Notwithstanding clause (i) of this subparagraph—

"(I) a reduction in an annuity shall not be terminated under such clause, and

"(II) an election made under such clause with respect to a current spouse after a remarriage before age 55 or the death of a former spouse shall not be effective,

if, and to the extent that, continuation of the reduction is necessary in order to provide for any survivor annuity, or any increase in a survivor annuity, which becomes payable under section 8341(h)(2) of this title to any other former spouse as a result of such remarriage or death.

"(C)(i) Upon remarriage, a retired employee or Member who was married at the time of retirement (including an employee or Member whose annuity was not reduced to provide a survivor annuity for the employee or Member's spouse or former spouse as of the time of retirement) may irrevocably elect during such marriage, in a signed writing received by the Office within 2 years after such remarriage or, if later, within 2 years after the death or remarriage of any former spouse of such employee or Member who was entitled to a survivor annuity under section 8341(h) of this title (or of the last such surviving former spouse, if there was more than one), a reduction in the employee or Member's annuity under paragraph (4) of this subsection for the purpose of providing an annuity for such employee or Member's spouse in the event such spouse survives the employee or Member.

"(ii) Such election and reduction shall be effective the first day of the second month after the election is received by the Office, but not less than 9 months after the date of the remarriage, and the retired

Effective date.

employee or Member shall, within 2 years after the date of the remarriage or, if later, the death or remarriage of the former spouse (or of the last such surviving former spouse), deposit in the Fund an amount determined by the Office of Personnel Management; as nearly as may be administratively feasible, to reflect the amount by which the annuity of such retired employee or Member would have been reduced if the election had been in effect since the date of retirement or, if later, the date the previous reduction in such retired employee or Member's annuity was terminated under subparagraph (A) or (B) of this paragraph, plus interest. For the purposes of the preceding sentence, the annual rate of interest for each year during which an annuity would have been reduced if the election had been in effect on and after the applicable date referred to in such sentence shall be 6 percent.

"(iii) If the employee or Member does not make such deposit, the Office shall collect such amount by offset against the employee or Member's annuity, up to a maximum of 25 percent of the net annuity otherwise payable to the employee or Member, and the employee or Member is deemed to consent to such offset.

"(iv) Notwithstanding any other provision of this subparagraph, an election under this subparagraph may not be made for the purpose of providing an annuity in the case of a spouse by remarriage if such spouse was married to the employee or Member at the time of such employee or Member's retirement, and all rights to survivor benefits for such spouse under this subchapter based on marriage to such employee or Member were then waived under paragraph (1) of this subsection or a similar prior provision of law."

(B) in subsection (k)(1) by striking out "unmarried" in the first sentence thereof; and

(C) by amending subsection (k)(2) to read as follows:

"(2XA) An employee or Member, who is unmarried at the time of retiring under a provision of law which permits election of a reduced annuity with a survivor annuity payable to such employee or Member's spouse and who later marries, may irrevocably elect, in a signed writing received in the Office within 2 years after such employee or Member marries or, if later, within 2 years after the death or remarriage of any former spouse of such employee or Member who was entitled to a survivor annuity under section 8341(h) of this title (or of the last such surviving former spouse, if there was more than one), a reduction in the retired employee or Member's current annuity as provided in subsection (j) of this section.

Effective date.

"(B)(i) The election and reduction shall take effect the first day of the first month beginning 9 months after the date of marriage and shall prospectively void any election previously made under paragraph (1) of this subsection.

"(ii) Within 2 years after the date of marriage, the retired employee or Member (other than an employee or Member who made a previous election under paragraph (1) of this subsection) shall deposit in the Fund an amount determined by the Office of Personnel Management, as nearly as may be administratively feasible, to reflect the amount by which the retired employee or Member's annuity would have been reduced under subsection (j)(4) of this section since the commencing date of the annuity, if the employee or Member had been married at the time of retirement and had elected to provide a survivor annuity at that time, plus interest. For the purposes of the preceding sentence, the annual rate of interest for

each year during which the annuity would have been reduced if the election had been in effect since the date of the annuity commenced shall be 6 percent.

"(C) If the employee or Member does not make such deposit, the Office shall collect such amount by offset against the employee or Member's annuity, up to a maximum of 25 percent of the net annuity otherwise payable to the employee or Member, and the employee or Member is deemed to consent to such offset."

(4) in section 8341—

5 USC 8341.

(A) in paragraphs (1)(A) and (2)(A) of subsection (a), by striking out "1 year" and inserting in lieu thereof "9 months";

(B) in subsection (b)—

(i) by amending paragraph (1) to read as follows:
 "(b)(1) Except as provided in paragraph (2) of this subsection, if an employee or Member dies after having retired under this subchapter and is survived by a widow or widower, the widow or widower is entitled to an annuity equal to 55 percent (or 50 percent if retired before October 11, 1962) of an annuity computed under section 8339(a)-(i) and (n) of this title as may apply with respect to the annuitant, or of such portion thereof as may have been designated for this purpose under section 8339(j)(1) of this title, unless the right to a survivor annuity was waived under such section 8339(j)(1) or, in the case of remarriage, the employee or Member did not file an election under section 8339(j)(5)(C) or section 8339(k)(2) of this title, as the case may be."

5 USC 8339.

Ante. p. 3195.

Ante. p. 3195.

(ii) in the second and third sentences of paragraph (3) by striking out "spouse, widow," each place it appears and inserting in lieu thereof "widow";

(iii) by striking out "60 years of age" at the end of paragraph (3) and inserting in lieu thereof "55 years of age"; and

(iv) by adding at the end thereof the following new paragraph:

"(4) Notwithstanding the preceding provisions of this subsection, the annuity payable under this subsection to the widow or widower of a retired employee or Member may not exceed the difference between—

"(A) the amount which would otherwise be payable to such widow or widower under this subsection (determined without regard to any waiver or designation under section 8339(j)(1) of this title or a prior similar provision of law), and

"(B) the amount of the survivor annuity payable to any former spouse of such employee or Member under subsection (h) of this section."

(C) in subsection (d)—

(i) by inserting after the first sentence the following:
 "Notwithstanding the preceding sentence, the annuity payable under this subsection to the widow or widower of an employee or Member may not exceed the difference between—

"(A) the amount which would otherwise be payable to such widow or widower under this subsection, and

"(B) the amount of the survivor annuity payable to any former spouse of such employee or Member under subsection (h) of this section."; and

(ii) in the last sentence, by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively.

and by striking out "60 years of age" and inserting in lieu thereof "55 years of age";

(D) in subsection (e)—

(i) in paragraph (1), by inserting "or a former spouse who is the natural or adoptive parent of a surviving child of the employee or Member" after "survived by a spouse" each place it appears; and

(ii) by amending the last sentence of paragraph (2) to read as follows: "On the death of the surviving spouse or former spouse or termination of the annuity of a child, the annuity of any other child or children shall be recomputed and paid as though the spouse, former spouse, or child had not survived the employee or Member.";

(E) in subsection (f) by inserting after paragraph (2) the following:

"Notwithstanding the preceding sentence, an annuity payable under this subsection to the surviving spouse of a Member may not exceed the difference between—

"(A) the annuity which would otherwise be payable to such surviving spouse under this subsection, and

"(B) the amount of the survivor annuity payable to any former spouse of such Member under subsection (h) of this section."; and

(F) in subsection (g) by striking out "60 years of age" and inserting in lieu thereof "55 years of age"; and

(G) by adding at the end thereof the following new subsections:

"(h)(1) Subject to paragraphs (2) through (5) of this subsection, a former spouse of a deceased employee, Member, or annuitant is entitled to a survivor annuity under this subsection, if and to the extent expressly provided for in an election under section 8339(j)(3) of this title, or in the terms of any decree of divorce or annulment or any court order or court-approved property settlement agreement incident to such decree.

Ante, p. 3195.

"(2)(A) The annuity payable to a former spouse under this subsection may not exceed the difference between—

"(i) the amount applicable in the case of such former spouse, as determined under subparagraph (B) of this paragraph, and

"(ii) the amount of any annuity payable under this subsection to any other former spouse of the employee, Member, or annuitant, based on an election previously made under section 8339(j)(3) of this title, or a court order previously issued.

"(B) The applicable amount, for purposes of subparagraph (A)(i) of this paragraph in the case of a former spouse, is the amount which would be applicable—

"(i) under subsection (b)(4)(A) of this section in the case of a widow or widower, if the deceased was an employee or Member who died after retirement;

"(ii) under subparagraph (A) of subsection (d) of this section in the case of a widow or widower, if the deceased was an employee or Member described in the first sentence of such subsection; or

"(iii) under subparagraph (A) of subsection (f) of this section in the case of a surviving spouse, if the deceased was a Member described in the first sentence of such subsection.

"(3) The commencement and termination of an annuity payable under this subsection shall be governed by the terms of the applica-

Effective dates.
Termination
dates.

ble order, decree, agreement, or election, as the case may be, except that any such annuity—

"(A) shall not commence before—

"(i) the day after the employee, Member, or annuitant dies, or

"(ii) the first day of the second month beginning after the date on which the Office receives written notice of the order, decree, agreement, or election, as the case may be, together with such additional information or documentation as the Office may prescribe,

whichever is later, and

"(B) shall terminate—

"(i) in the case of an annuity computed by reference to clause (i) or (ii) of paragraph (2)(B) of this subsection, no later than the last day of the month before the former spouse remarries before becoming 55 years of age or dies; or

"(ii) in the case of an annuity computed by reference to clause (iii) of such paragraph, no later than the last day of the month before the former spouse remarries or dies.

"(4) For purposes of this subchapter, a modification in a decree, order, agreement, or election referred to in paragraph (1) of this subsection shall not be effective—

"(A) if such modification is made after the retirement of the employee or Member concerned, and

"(B) to the extent that such modification involves an annuity under this subsection.

"(5) For purposes of this subchapter, a decree, order, agreement, or election referred to in paragraph (1) of this subsection shall not be effective, in the case of a former spouse, to the extent that it is inconsistent with any joint designation or waiver previously executed with respect to such former spouse under section 5339(j)(1) of this title or a similar prior provision of law.

"(6) Any payment under this subsection to a person bars recovery by any other person.

"(7) As used in this subsection, 'court' means any court of any State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, or the Virgin Islands, and any Indian court.

"(i) The requirement in subsections (a)(1)(A) and (a)(2)(A) of this section that the surviving spouse of an employee or Member have been married to such employee or Member for at least 9 months immediately before the employee or Member's death in order to qualify as the widow or widower of such employee or Member shall be deemed satisfied in any case in which the employee or Member dies within the applicable 9-month period, if—

"(1) the death of the employee or Member was accidental; or

"(2) the surviving spouse of such individual had been previously married to the individual and subsequently divorced, and the aggregate time married is at least 9 months."

(5) in section 8342(a)—

(A) by striking out "An" and inserting in lieu thereof

"Subject to subsection (j) of this section, an"; and

(B) by adding at the end thereof the following new subsection:

"(j) Payment of the lump-sum credit under subsection (a) of this section—

Ante, p. 3195.

5 USC 8342.

"(A) may be made only if any current spouse and any former spouse of the employee or Member are notified of the employee or Member's application; and

"(B) in any case in which there is a former spouse, shall be subject to the terms of a court order or decree issued with respect to such former spouse if—

"(i) the order or decree expressly relates to any portion of the lump-sum credit involved, and

"(ii) payment of the lump-sum credit would extinguish entitlement of the former spouse to a survivor annuity under section 8341(h) of this title or to any portion of an annuity under section 8345(j) of this title.

Ante, p. 3199.
Infra.
Regulations.

"(2)(A) Notification of a spouse or former spouse under this subsection shall be made in accordance with such requirements as the Office shall by regulation prescribe.

Waiver.

"(B) Under the regulations, the Office may provide that paragraph (1)(A) of this subsection may be waived with respect to a spouse or former spouse if the employee or Member establishes to the satisfaction of the Office that the whereabouts of such spouse or former spouse cannot be determined.

Regulations.

"(3) The Office shall prescribe regulations under which this subsection shall be applied in any case in which the Office receives two or more such orders or decrees.":

5 USC 8345.

(6) in section 8345—

(A) in subsection (f) by adding at the end thereof the following new paragraph:

"(4) The provisions of this subsection shall not apply—

"(A) to any survivor annuity payable under subsection (h) of section 8341 of this title; or

"(B) to any survivor annuity payable under subsection (b), (d), or (f) of such section which is reduced on account of any survivor annuity referred to in subparagraph (A) of this paragraph.":

and
(B) in subsection (j)(3) by striking out "or the District of Columbia" and inserting in lieu thereof the following: ", the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, or the Virgin Islands, and any Indian court"; and

5 USC 8348.

(7) in section 8348(a)(1)(B) by striking out "this title" and inserting in lieu thereof "this title, in administering survivor annuities and elections providing therefor under sections 8339 and 8341 of this title.":

5 USC 8901.

Sec. 3. Chapter 89 of title 5, United States Code, is amended—

(1) in section 8901—

(A) by striking out "and" at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and"; and

(C) by adding at the end thereof the following new paragraph:

"(10) 'former spouse' means a former spouse of an employee, former employee, or annuitant—

"(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved.

"(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the dissolu-

tion of the marriage to the employee, former employee, or annuitant, and

"(C)(i) who is receiving any portion of an annuity under section 8345(j) of this title or a survivor annuity under section 8341(h) of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System),

Ante, p. 3202.
Ante, p. 3199.

"(ii) as to whom a court order or decree referred to in section 8341(h) or 8345(j) of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) of this title (or similar provision of law), or

Ante, p. 3195.

"(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former employee's separation from the service (other than by retirement).";

(2) in section 8902—

5 USC 8902.

(A) in subsection (g) by striking out "employee or annuitant" each place it appears and inserting in lieu thereof "employee, annuitant, family member, or former spouse"; and

(B) in subsections (j) and (k) by striking out "or family member" and inserting in lieu thereof "family member, or former spouse";

(3) in section 8903(1)—

5 USC 8903.

(A) by striking out "employees or annuitants, or members of their families" and inserting in lieu thereof "employees, annuitants, members of their families, or former spouses"; and

(B) by striking out "employee or annuitant or member of his family" and inserting in lieu thereof "employee, annuitant, family member, or former spouse";

(4) in section 8905—

5 USC 8905.

(A) by redesignating subsections (c), (d), and (e) as subsections (d), (e), and (f), respectively, and inserting after subsection (b) the following new subsection:

"(c)(1) A former spouse may—

Health.

"(A) within 60 days after the dissolution of the marriage, or

"(B) in the case of a former spouse of a former employee whose marriage was dissolved after the employee's retirement, within 60 days after the dissolution of the marriage or, if later, within 60 days after an election is made under section 8339(j)(3) of this title for such former spouse by the retired employee,

Ante, p. 3195.

enroll in an approved health benefits plan described by section 8903 of this title as an individual or for self and family as provided in paragraph (2) of this subsection, subject to agreement to pay the full subscription charge of the enrollment, including the amounts determined by the Office to be necessary for administration and reserves pursuant to section 8909(b) of this title. The former spouse shall submit an enrollment application and make premium payments to the agency which, at the time of divorce or annulment, employed the employee to whom the former spouse was married or, in the case

5 USC 8903.

Post, p. 3204.

Ante, pp. 3199,
3202.

of a former spouse who is receiving annuity payments under section 8341(h) or 8345(j) of this title, to the Office of Personnel Management.

"(2) Coverage for self and family under this subsection shall be limited to—

"(A) the former spouse; and

"(B) unmarried dependent natural or adopted children of the former spouse and the employee who are—

"(i) under 22 years of age; or

"(ii) incapable of self-support because of mental or physical disability which existed before age 22"; and

(B) in subsections (e) and (f), as so designated by subparagraph (A) of this paragraph, by striking out "An employee or annuitant" and inserting in lieu thereof "An employee, annuitant, or former spouse";

5 USC 8907.

(5) in section 8907—

(A) in subsection (a) by striking out "employee" each place it appears and inserting in lieu thereof "individual";

(B) in subsection (b)—

(i) by striking out "employee enrolled" and inserting in lieu thereof "enrollee";

(ii) in paragraph (1) by striking out "employee or the employee and members of his family" and inserting in lieu thereof "enrollee or the enrollee and any eligible family members"; and

(iii) in paragraph (3) by striking out "the employee or members of his family" and inserting in lieu thereof "the enrollee and any eligible family members"; and

(C) by amending the section heading to read as follows:

"§ 8907. Information to individuals eligible to enroll";

5 USC 8909.

(6) in section 8909—

(A) in subsections (a) and (b) by striking out "employees, annuitants," and inserting in lieu thereof "enrollees"; and

(B) in subsection (d) by striking out "Each employee or annuitant" and inserting in lieu thereof "Each employee, annuitant, or former spouse";

5 USC 8913.

(7) in section 8913(c)—

(A) in the first sentence by striking out "employees and annuitants and members of their families" and inserting in lieu thereof "employees, annuitants, members of their families, and former spouses"; and

(B) in the second sentence by inserting "or former spouse" after "in which an annuitant"; and

(8) in the chapter analysis, by striking out the item relating to section 8907 and inserting in lieu thereof the following:

"8907. Information to individuals eligible to enroll."

Effective dates.
5 USC 8341 note.

Sec. 4. (a)(1) Except as provided in subsections (b) and (c), the amendments made by section 2 of this Act shall take effect one hundred and eighty days after the date of enactment of this Act and shall apply to any individual who, on or after such effective date, is married to an employee or Member who, on or after such effective date, retires, dies, or applies for a refund of contributions under subchapter III of chapter 83 of title 5, United States Code.

5 USC 8331.

(2) Except as provided in subsection (f), the amendments made by section 3 of this Act shall take effect one hundred and eighty days

after the date of enactment of this Act and shall apply to any individual who, on or after such effective date, is married to an employee or annuitant.

(b)(1) Notwithstanding subsection (a)(1) of this section, a former spouse of an employee or Member who retired before the one hundred and eightieth day after the date of enactment of this Act is entitled to a survivor annuity under section 8341(b) of title 5, United States Code, as amended by this Act, if—

Ante, p. 3199.

(A) the retired employee or Member elects, in writing, within eighteen months after the date of enactment of this Act, according to procedures prescribed by the Office of Personnel Management, to have the annuity of such employee or Member reduced under section 8339(j) of title 5, United States Code, as amended by this Act, and, except as provided in paragraph (3) of this subsection, to deposit in the Civil Service Retirement and Disability Fund an amount determined by the Office, as nearly as may be administratively feasible, to reflect the amount by which such employee or Member's annuity would have been reduced had the reduction been in effect since such employee or Member's annuity commenced, plus interest computed at the annual rate of six percent for each year during which the annuity would have been reduced if the election had been in effect on and after the date the annuity commenced; or

Ante, p. 3195.

(B) where the retired employee or Member dies or died on or before the one hundred and eightieth day after the date of enactment of this Act or does not make the election described in subparagraph (A)—

(i) the former spouse's marriage to the employee or Member was dissolved after September 14, 1978;

(ii) the former spouse was married to the employee or Member for at least ten years during periods of creditable service under section 8332 of title 5, United States Code;

(iii) the former spouse is not entitled to any other retirement or survivor annuity (other than benefits under title II of the Social Security Act or under section 8345(j) of title 5, United States Code, as amended by this Act) based on any previous employment of the former spouse or of the employee or Member;

42 USC 201.
Ante, p. 3202.

(iv) the former spouse has not remarried before age fifty-five after September 14, 1978;

(v) the former spouse files an application for the survivor annuity with the Office within thirty months after the date of enactment of this Act; and

(vi) the former spouse is at least fifty years of age at the time of filing such application.

A survivor annuity under subparagraph (B) shall commence on the day after the employee or Member dies or the first day of the second month after the former spouse's application is received by the Office, whichever occurs later.

Commencement date.

(2) Except as provided in paragraph (3), if a retired employee or Member who makes an election under subparagraph (A) of paragraph (1) does not make the deposit required by such subparagraph, the Office shall collect the amount of the deposit by offset against the employee or Member's annuity, up to a maximum of 25 percent of the net annuity otherwise payable to the employee or Member, and the employee or Member is deemed to consent to such offset.

Ante, p. 3195.

(3) An election made by an individual under subparagraph (A) of paragraph (1) of this subsection to provide a survivor annuity for any person prospectively voids any election previously made by such individual with respect to such person under section 8339(k)(1) of title 5, United States Code, as amended by this Act, or any similar prior provision of law. Notwithstanding the provisions of such subparagraph (A), an individual who made such an election under such section 8339(k)(1) (or prior provision) shall not be required to make the deposit described in such subparagraph.

(4) A survivor annuity provided under this subsection shall be 55 per centum of the annuity of the retired employee or Member, as determined under section 8339(a)-(i) and (n) of title 5, United States Code, increased by—

5 USC 8340.

(A) the total percent increase the retired employee or Member was receiving under section 8340 of such title at death, or

(B) in the case of a retired employee or Member whose date of death precedes the one hundred and eightieth day after the date of enactment of this Act, the total percent increase the retired employee or Member would have received under such section 8340 had such individual died on the one hundred and eightieth day after such date of enactment,

Ante, p. 3199.

and shall not be subject to reduction under section 8341(b)(4) of such title, as amended by this Act.

(c) Notwithstanding subsection (a)(1) of this section, an employee or Member who retired before the one hundred and eightieth day after the date of enactment of this Act and who is married to a spouse acquired after retirement for whom such employee or Member was unable to provide a survivor annuity because—

(1) the employee or Member was married at the time of retirement and elected not to provide a survivor annuity for the employee or Member's spouse at the time of retirement, or

(2) the employee or Member failed to notify the Office of the employee or Member's post-retirement marriage within one year after the marriage,

Ante, p. 3195.

may elect in writing, within one year after the date of enactment of this Act, in accordance with procedures prescribed by the Office, to provide for a survivor annuity for such spouse under section 8341(b) of title 5, United States Code, as amended by this Act, to have the retired employee or Member's annuity reduced under section 8339(j) of such title, as so amended, and to deposit in the Civil Service Retirement and Disability Fund an amount determined by the Office, as nearly as may be administratively feasible, to reflect the amount by which such employee or Member's annuity would have been reduced had the election been continuously in effect since the annuity commenced, plus interest. For the purposes of the preceding sentence, the annual rate of interest for each year during which the annuity would have been reduced if the election had been in effect on and after the date the annuity commenced shall be 6 percent. If the retired employee or Member does not make such deposit, the Office shall collect such amount by offset against such employee or Member's annuity, up to a maximum of 25 percent of the net annuity otherwise payable to such employee or Member, and such employee or Member is deemed to consent to such offset. The Office shall provide for general public notice of the right to make an election under this subsection. In cases to which paragraph (2) of this subsection applies, the retired employee or Member shall provide the Office with such documentation as the Office shall decide is

Public notice.

appropriate, that such employee or Member attempted to elect a reduced annuity with survivor benefit for such employee or Member's current spouse and that such employee or Member's election was rejected by the Office because it was untimely filed.

(d) A deposit required by subsection (b)(1)(A) or (c) of this section may be made by the surviving former spouse or spouse, as applicable, of the retired employee or Member.

(e) The Office shall determine at the end of each fiscal year—

(1) the cost of survivor annuities provided under subsections (b) and (c) of this section, less an amount determined appropriate by the Office to reflect the value of any deposits made under subsection (b)(1)(A), (c), or (d), and

(2) the cost of administering subsections (b) and (c).

The Office shall notify the Secretary of the Treasury of the amounts so determined. The Secretary of the Treasury, before closing the account for the fiscal year in question, shall credit to the Civil Service Retirement and Disability Fund, out of any money in the Treasury not otherwise appropriated, such amounts, which shall be available in the same manner as provided under subparagraphs (A) and (B) of section 8348(a)(1) of title 5, United States Code, as amended by this Act.

(f) An individual who is entitled to a survivor annuity under subsection (b) of this section is deemed to be in receipt of annuity payments under section 8341(h) of title 5, United States Code, as amended by this Act, for the purpose of chapter 89 of such title, as so amended. Notwithstanding subsection (a)(2) of this section, any such individual who otherwise meets the definition of a former spouse under section 8901 of title 5, United States Code, as so amended, may enroll in an approved health benefits plan described by section 8903 of such title, under the conditions set forth in section 8905(c) of such title, as so amended.

(g)(1) For purposes of subsections (a) (1), (b), (c), (d), and (e), "employee", "Member", and "former spouse" each has the meaning given that term under section 8331 of title 5, United States Code, as amended by this Act.

(2) For purposes of subsection (a)(2), "employee" and "annuitant" each has the meaning given that term under section 8901 of title 5, United States Code.

(h) Section 827 of the Foreign Service Act of 1980 and section 292 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees shall not apply with respect to either the amendments made by section 2 or the preceding provisions of this section.

Ante, p. 3202.

Ante, p. 3199
Ante, p. 3202
5 USC 8901 et
seq.

Ante, p. 3195.

Ante, p. 3202.

22 USC 4067.

50 USC 403 note.

TITLE II—PERFORMANCE MANAGEMENT AND RECOGNITION SYSTEM

ESTABLISHMENT OF PERFORMANCE MANAGEMENT AND RECOGNITION SYSTEM

Sec. 201. (a) Chapter 54 of title 5, United States Code, is amended to read as follows:

“CHAPTER 54—PERFORMANCE MANAGEMENT AND RECOGNITION SYSTEM

- “Sec.
- “5401. Purpose.
- “5402. Coverage.
- “5403. General pay increases.
- “5404. Merit increases.
- “5405. Pay administration.
- “5406. Performance awards.
- “5407. Cash award program.
- “5408. Report.
- “5409. Regulations.
- “5410. Termination.

5 USC 5401.

“§ 5401. Purpose

“It is the purpose of this chapter to provide for a performance management and recognition system which shall—

“(1) use performance appraisals as the basis for (a) determining adjustments in basic pay by general pay increases and merit increases, and (b) making performance award determinations;

“(2) within available funds, recognize and reward quality performance by varying amounts of performance and cash awards;

“(3) within available funds, provide for training to improve accuracy, objectivity, and fairness in the evaluation of performance;

“(4) regulate the costs of performance awards by establishing funding level requirements; and

“(5) provide the means to reduce or withhold certain pay increases for less than fully successful performance.

5 USC 5402

“§ 5402. Coverage

“(a) Except as provided in subsection (b) or (c) of this section, this chapter shall apply to any supervisor or management official (as defined in paragraphs (10) and (11) of section 7103(a) of this title, respectively) who is in a position within grade GS-13, GS-14, or GS-15 of the General Schedule described in section 5104 of this title.

5 USC 7103.

5 USC 5104,
5332.

Exclusions.

“(b)(1) Upon request filed under paragraph (3) of this subsection, the President may, in writing, exclude an agency, any unit of an agency, or any class of employees within any such unit, from the application of this chapter, if the President considers such exclusion to be required as a result of conditions arising from—

“(A) the recent establishment of the agency, unit, or class, or the implementation of a new program;

“(B) an emergency situation; or

“(C) any other situation or circumstance.

Effective date.
President of U.S.
Report.

“(2) Any exclusion under this subsection shall not take effect earlier than 30 calendar days after the President transmits to each House of the Congress a report describing the agency, unit, or class to be excluded and the reasons therefor.

“(3) A request for exclusion of an agency, any unit of an agency, or any class of employees within any such unit, under this subsection shall be filed by the head of the agency with the Office of Personnel Management, and shall set forth reasons why the agency, unit, or class should be excluded from the application of this chapter. The Office shall review the request and reasons therefor, undertake such

PUBLIC LAW 100-654 [H.R. 5102]; November 14, 1988

FEDERAL EMPLOYEES HEALTH BENEFITS AMENDMENTS ACT OF 1988

For Legislative History of Act, see p. 5385.

An Act to amend the provisions of title 5, United States Code, relating to the health benefits program for Federal employees and certain other individuals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Benefits Amendments Act of 1988".

Federal
Employees
Health Benefits
Amendments
Act of 1988
5 USC 8901 note.

TITLE I—PROVISIONS RELATING TO HEALTH CARE PROVIDERS

SEC. 101. AUTHORITY TO IMPOSE DEBARMENT AND OTHER SANCTIONS.

(a) IN GENERAL.—Title 5, United States Code, is amended by inserting after section 8902 the following:

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term 'provider of health care services or supplies' or 'provider' means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term 'individual covered under this chapter' or 'covered individual' means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a; and

(C) an individual or entity shall be considered to have been 'convicted' of a criminal offense if—

(i) a judgment of conviction for such offense has been entered against the individual or entity by a Federal, State, or local court;

(ii) there has been a finding of guilt against the individual or entity by a Federal, State, or local court with respect to such offense;

(iii) a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court with respect to such offense; or

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity.

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under subsection (b) or (c), a provider is barred from participating in the program under this chapter, no payment may be

Sec. 101

made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

Contracts.

"(B) Each contract under this chapter shall contain such provisions as may be necessary to carry out subparagraph (A) and the other provisions of this section.

"(b) The Office of Personnel Management may bar the following providers of health care services or supplies from participating in the program under this chapter:

Fraud.

"(1) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply.

"(2) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care service or supply.

"(3) Any provider that has been convicted, under Federal or State law, in connection with the interference with or obstruction of an investigation or prosecution of a criminal offense described in paragraph (1) or (2).

Drugs and drug abuse.

"(4) Any provider that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

"(5) Any provider—

"(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

"(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

Claims.

"(c) Whenever the Office determines—

"(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

"(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

"(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies;

"(2) that a provider of health care services or supplies has knowingly made, or caused to be made, any false statement or misrepresentation of a material fact which is reflected in a claim presented under this chapter; or

"(3) that a provider of health care services or supplies has knowingly failed to provide any information required by a carrier or by the Office to determine whether a payment or

reimbursement is payable under this chapter or the amount of any such payment or reimbursement; the Office may, in addition to any other penalties that may be prescribed by law, and after consultation with the Attorney General, impose a civil monetary penalty of not more than \$10,000 for any item or service involved. In addition, such a provider shall be subject to an assessment of not more than twice the amount claimed for each such item or service. In addition, the Office may make a determination in the same proceeding to bar such provider from participating in the program under this chapter:

"(d) The Office—

"(1) may not initiate any debarment proceeding against a provider, based on such provider's having been convicted of a criminal offense, later than 6 years after the date on which such provider is so convicted; and

"(2) may not initiate any action relating to a civil penalty, assessment, or debarment under this section, in connection with any claim, later than 6 years after the date the claim is presented, as determined under regulations prescribed by the Office. Claims.

"(e) In making a determination relating to the appropriateness of imposing or the period of any debarment under this section, or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account— Claims.

"(1) the nature of any claims involved and the circumstances under which they were presented;

"(2) the degree of culpability, history of prior offenses or improper conduct of the provider involved; and

"(3) such other matters as justice may require.

"(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.

"(2)(A) Except as provided in subparagraph (B), a debarment shall be effective with respect to any health care services or supplies furnished by a provider on or after the effective date of such provider's debarment.

"(B) A debarment shall not apply with respect to inpatient institutional services furnished to an individual who was admitted to the institution before the date the debarment would otherwise become effective until the passage of 30 days after such date, unless the Office determines that the health or safety of the individual receiving those services warrants that a shorter period, or that no such period, be afforded.

"(3) Any notice referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective.

"(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such manner as the Office may by regulation prescribe, for termination of the debarment.

"(B) The Office may—

"(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

"(I) there is no basis under subsection (b) or (c) for continuing the debarment; and

"(II) there are reasonable assurances that the types of actions which formed the basis for the original debarment have not recurred and will not recur; or

"(ii) notwithstanding any provision of subparagraph (A) terminate the debarment of a provider, pursuant to an application filed by such provider before the end of the minimum debarment period, if the Office determines that—

"(I) based on the conduct of the applicant, the requirements of subclauses (I) and (II) of clause (i) have been met, and

"(II) early termination under this clause is warranted based on the fact that the provider is the sole community provider or the sole source of essential specialized services in a community, or other similar circumstances.

State and local governments.

"(5) The Office shall—

"(A) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of a provider barred from participation in the program under this chapter of the fact of the debarment, as well as the reasons for such debarment;

"(B) request that appropriate investigations be made and sanctions invoked in accordance with applicable law and policy; and

"(C) request that the State or local agency or authority keep the Office fully and currently informed with respect to any actions taken in response to the request.

Records.

"(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.

"(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

"(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.

"(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

"(h) A civil action to recover civil monetary penalties or assessments under subsection (c) shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund.

Regulations.

"(i) The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment."

(b) CHAPTER ANALYSIS.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8902 the following:

"8902a. Debarment and other sanctions."

SEC. 102. APPLICABILITY; PRIOR CONDUCT.

5 USC 8902a
note.
Contracts.

(a) APPLICABILITY.—The amendments made by this title shall be effective with respect to any calendar year beginning, and contracts entered into or renewed for any calendar year beginning, after the date of the enactment of this Act.

(b) PRIOR CONDUCT NOT TO BE CONSIDERED.—In carrying out section 8902a of title 5, United States Code, as added by this title, no debarment, civil monetary penalty, or assessment may be imposed under such section based on any criminal or other conduct occurring before the beginning of the first calendar year which begins after the date of the enactment of this Act.

TITLE II—PROVISIONS RELATING TO TEMPORARY CONTINUATION OF COV- ERAGE FOR CERTAIN INDIVIDUALS

SEC. 201. AUTHORITY TO CONTINUE COVERAGE.

(a) AUTHORITY.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8905 the following:

"8905a. Continued coverage

"(a) Any individual described in paragraph (1) or (2) of subsection (b) may elect to continue coverage under this chapter in accordance with the provisions of this section.

"(b) This section applies with respect to—

insur. (1) any employee who—

separ. (A) is separated from service, whether voluntarily or involuntarily, except that if the separation is involuntary, this section shall not apply if the separation is for gross misconduct (as defined under regulations which the Office of Personnel Management shall prescribe); and

elig. (B) would not otherwise be eligible for any benefits under this chapter (determined without regard to any temporary extension of coverage and without regard to any benefits available under a nongroup contract); and

indiv. (2) any individual who—

unmar. (A) ceases to meet the requirements for being considered an unmarried dependent child under this chapter;

"(B) on the day before so ceasing to meet the requirements referred to in subparagraph (A), was covered under a health benefits plan under this chapter as a member of the family of an employee or annuitant; and

"(C) would not otherwise be eligible for any benefits under this chapter (determined without regard to any temporary extension of coverage and without regard to any benefits available under a nongroup contract).

Regulations.
Contracts.

"(c)(1) The Office shall prescribe regulations and provide for the inclusion of appropriate terms in contracts with carriers to provide that—

"(A) with respect to an employee who becomes (or will become) eligible for continued coverage under this section as a result of separation from service, the separating agency shall, before the end of the 30-day period beginning on the date as of which coverage (including any temporary extensions of coverage) would otherwise end, notify the individual of such individual's rights under this section; and

Children and
youth.

"(B) with respect to a child of an employee or annuitant who becomes eligible for continued coverage under this section as a result of ceasing to meet the requirements for being considered a member of the employee's or annuitant's family—

"(i) the employee or annuitant may provide written notice of the child's change in status (complete with the child's name, address, and such other information as the Office may by regulation require)—

"(I) to the employee's employing agency; or

"(II) in the case of an annuitant, to the Office; and

"(ii) if the notice referred to in clause (i) is received within 60 days after the date as of which the child involved first ceases to meet the requirements involved, the employing agency or the Office (as the case may be) must, within 14 days after receiving such notice, notify the child of such child's rights under this section.

"(2) In order to obtain continued coverage under this section, an appropriate written election (submitted in such manner as the Office by regulation prescribes) must be made—

"(A) in the case of an individual seeking continued coverage based on a separation from service, before the end of the 60-day period beginning on the later of—

"(i) the effective date of the separation; or

"(ii) the date the separated individual receives the notice required under paragraph (1)(A); or

"(B) in the case of an individual seeking continued coverage based on a change in circumstances making such individual ineligible for coverage as an unmarried dependent child, before the end of the 60-day period beginning on the later of—

"(i) the date as of which such individual first ceases to meet the requirements for being considered an unmarried dependent child; or

"(ii) the date such individual receives notice under paragraph (1)(B)(ii);

except that if a parent fails to provide the notice required under paragraph (1)(B)(i) in timely fashion, the 60-day period under this subparagraph shall be based on the date under clause (i), irrespective of whether or not any notice under paragraph (1)(B)(ii) is provided.

(d)(1)(A) An individual receiving continued coverage under this section shall be required to pay currently into the Employees Health Benefits Fund, under arrangements satisfactory to the Office, an amount equal to the sum of—

(i) the employee and agency contributions which would be required in the case of an employee enrolled in the same health benefits plan and level of benefits; and

(ii) an amount, determined under regulations prescribed by the Office, necessary for administrative expenses, but not to exceed 2 percent of the total amount under clause (i).

(B) Payments under this section to the Fund shall—

(i) in the case of an individual whose continued coverage is based on such individual's separation, be made through the agency which last employed such individual; or

(ii) in the case of an individual whose continued coverage is based on a change in circumstances referred to in subsection (c)(2)(B), be made through—

(I) the Office, if, at the time coverage would (but for this section) otherwise have been discontinued, the individual was covered as the child of an annuitant; or

(II) if, at the time referred to in subclause (I), the individual was covered as the child of an employee, the employee's employing agency as of such time.

(2) If an individual elects to continue coverage under this section before the end of the applicable period under subsection (c)(2), but after such individual's coverage under this chapter (including any temporary extensions of coverage) expires, coverage shall be restored retroactively, with appropriate contributions (determined in accordance with paragraph (1)) and claims (if any), to the same extent and effect as though no break in coverage had occurred.

(3)(A) An individual making an election under subsection (c)(2)(B) may, at such individual's option, elect coverage either as an individual or, if appropriate, for self and family.

(B) For the purpose of this paragraph, members of an individual's family shall be determined in the same way as would apply under this chapter in the case of an enrolled employee.

(C) Nothing in this paragraph shall be considered to limit an individual making an election under subsection (c)(2)(A) to coverage for self alone.

(4)(1) Continued coverage under this section may not extend beyond—

(A) in the case of an individual whose continued coverage is based on separation from service, the date which is 18 months after the effective date of the separation; or

(B) in the case of an individual whose continued coverage is based on ceasing to meet the requirements for being considered an unmarried dependent child, the date which is 36 months after the date on which the individual first ceases to meet those requirements, subject to paragraph (2).

(2) In the case of an individual who—

(A) ceases to meet the requirements for being considered an unmarried dependent child;

(B) as of the day before so ceasing to meet the requirements referred to in subparagraph (A), was covered as the child of a former employee receiving continued coverage under this section based on the former employee's separation from service; and

"(C) so ceases to meet the requirements referred to in subparagraph (A) before the end of the 18-month period beginning on the date of the former employee's separation from service,

extended coverage under this section may not extend beyond the date which is 36 months after the separation date referred to in subparagraph (C).

Regulations.

"If (1) The Office shall prescribe regulations under which, in addition to any individual otherwise eligible for continued coverage under this section, and to the extent practicable, continued coverage may also, upon appropriate written application, be afforded under this section—

"(A) to any individual who—

"(i) if subparagraphs (A) and (C) of paragraph (10) of section 8901 were disregarded, would be eligible to be considered a former spouse within the meaning of such paragraph; but

"(ii) would not, but for this subsection, be eligible to be so considered; and

"(B) to any individual whose coverage as a family member would otherwise terminate as a result of a legal separation.

"(2) The terms and conditions for coverage under the regulations shall include—

"(A) consistent with subsection (c), any necessary notification provisions, and provisions under which an election period of at least 60 days' duration is afforded;

"(B) terms and conditions identical to those under subsection (d), except that contributions to the Employees Health Benefits Fund shall be made through such agency as the Office by regulation prescribes;

"(C) provisions relating to the termination of continued coverage, except that continued coverage under this section may not (subject to paragraph (3)) extend beyond the date which is 36 months after the date on which the qualifying event under this subsection (the date of divorce, annulment, or legal separation, as the case may be) occurs; and

"(D) provisions designed to ensure that any coverage pursuant to this subsection does not adversely affect any eligibility for coverage which the individual involved might otherwise have under this chapter (including as a result of any change in personal circumstances) if this subsection had not been enacted.

"(3) In the case of an individual—

"(A) who becomes eligible for continued coverage under this subsection based on a divorce, annulment, or legal separation from a person who, as of the day before the date of the divorce, annulment, or legal separation (as the case may be) was receiving continued coverage under this section for self and family based on such person's separation from service; and

"(B) whose divorce, annulment, or legal separation (as the case may be) occurs before the end of the 18-month period beginning on the date of the separation from service referred to in subparagraph (A),

extended coverage under this section may not extend beyond the date which is 36 months after the date of the separation from service, as referred to in subparagraph (A)."

(2) TABLE OF SECTIONS.—The table of sections for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8905 the following:

"8905a. Continued coverage."

(b) OPTION TO CONVERT TO A NONGROUP CONTRACT AFTER CONTINUED COVERAGE ENDS.—Section 8902(g) of title 5, United States Code, is amended by striking "or former spouse" each place it appears and inserting "former spouse, or person having continued coverage under section 8905a of this title".

(c) CHANGE OF COVERAGE BASED ON CHANGE IN FAMILY STATUS.—Section 8905(e) of title 5, United States Code, is amended by striking "or former spouse" and inserting "former spouse, or person having continued coverage under section 8905a of this title".

(d) OPEN SEASON.—Section 8905(f) of title 5, United States Code, is amended—

(1) by striking "or former spouse" each place it appears and inserting "former spouse, or person having continued coverage under section 8905a of this title"; and

(2) by adding at the end the following:

"(3)(A) In addition to any informational requirements otherwise applicable under this chapter, the regulations shall include provisions to ensure that each employee eligible to enroll in a health benefits plan under this chapter (whether actually enrolled or not) is notified in writing as to the rights afforded under section 8905a of this title.

"(B) Notification under this paragraph shall be provided by employing agencies at an appropriate point in time before each period under paragraph (1) so that employees may be aware of their rights under section 8905a of this title when making enrollment decisions during such period."

SEC. 202. TECHNICAL AND CONFORMING AMENDMENTS.

(a) Sections 8902(j), 8902(k)(1), and 8909(d) of title 5, United States Code, are amended by striking "or former spouse" each place it appears and inserting "former spouse, or person having continued coverage under section 8905a of this title".

(b) Section 8903(1) of title 5, United States Code, is amended—

(1) by striking "or former spouses," and inserting "former spouses, or persons having continued coverage under section 8905a of this title"; and

(2) by striking "or former spouse." and inserting "former spouse, or person having continued coverage under section 8905a of this title."

(c) Section 8905(d) of title 5, United States Code, is amended to read as follows:

"(d) If an employee, annuitant, or other individual eligible to enroll in a health benefits plan under this chapter has a spouse who is also eligible to enroll, either spouse, but not both, may enroll for self and family, or each spouse may enroll as an individual. However, an individual may not be enrolled both as an employee, annuitant, or other individual eligible to enroll and as a member of the family."

SEC. 203. APPLICABILITY.

(a) IN GENERAL.—The amendments made by this title shall apply with respect to—

5 USC 8902 note.

Sec. 203

Contracts

(1) any calendar year beginning, and contracts entered into or renewed for any calendar year beginning, after the end of the 9-month period beginning on the date of the enactment of this Act; and

(2) any qualifying event occurring on or after the first day of the first calendar year beginning after the end of the 9-month period referred to in paragraph (1).

(b) DEFINITION.—For the purpose of this section, the term "qualifying event" means any of the following events:

(1) A separation from Government service.

(2) A divorce, annulment, or legal separation.

(3) Any change in circumstances which causes an individual to become ineligible to be considered an unmarried dependent child under chapter 89 of such title.

TITLE III—HEALTH INSURANCE COVER- AGE FOR TEMPORARY EMPLOYEES

SEC. 301. HEALTH INSURANCE COVERAGE FOR TEMPORARY EMPLOYEES

(a) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8906 the following new section:

Regulations.

"§ 8906a. Temporary employees

"(a)(1) The Office of Personnel Management shall prescribe regulations to provide for offering health benefits plans to temporary employees (who meet the requirements of paragraph (2)) under the provisions of this chapter.

"(2) To be eligible to participate in a health benefits plan offered under this section a temporary employee shall have completed 1 year of current continuous employment, excluding any break in service of 5 days or less.

"(b) Notwithstanding the provisions of section 8906—

"(1) any temporary employee enrolled in a health benefits plan under this section shall have an amount withheld from the pay of such employee, as determined by the Office of Personnel Management, equal to—

"(A) the amount withheld from the pay of an employee under the provisions of section 8906; and

"(B) the amount of the Government contribution for an employee under section 8906; and

"(2) the employing agency of any such temporary employee shall not pay the Government contribution under the provisions of section 8906."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8906 the following:

"8906a. Temporary employees."

(c) REGULATIONS.—Section 8913(b) of title 5, United States Code, is amended—

(1) in paragraph (2) by striking out "or" at the end thereof;

(2) in paragraph (3) by striking out the period and inserting in lieu thereof a semicolon and "or"; and

(3) by adding at the end thereof the following new paragraph:

"(4) an employee who is employed on a temporary basis and is eligible under section 8906a(a)."

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective 120 days after the date of enactment of this section.

5 USC 8906a note.

TITLE IV—PROVISIONS RELATING TO CONTRIBUTIONS BY JUSTICES AND JUDGES TO THE THRIFT SAVINGS FUND

SEC. 401. CONTRIBUTIONS BY JUSTICES AND JUDGES TO THE THRIFT SAVINGS FUND.

(a) IN GENERAL.—Subchapter III of chapter 84 of title 5, United States Code, is amended by adding at the end thereof the following new section:

§ 8440a. Justices and judges

(a)(1) A justice or judge of the United States as defined by section 451 of title 28 may elect to contribute an amount of such individual's basic pay to the Thrift Savings Fund. Basic pay does not include an annuity or salary received by a justice or judge who has retired under section 371 (a) or (b) or section 372(a) of title 28, United States Code.

(2) An election may be made under paragraph (1) only during a period provided under section 8432(b) for individuals subject to chapter 84 of this title: *Provided, however,* That a justice or judge may make the first such election within 60 days of the effective date of this section.

(b)(1) Except as otherwise provided in this subsection, the provisions of subchapters III and VII of chapter 84 of this title shall apply with respect to justices and judges making contributions to the Thrift Savings Fund.

(2) The amount contributed by a justice or judge shall not exceed 5 percent of basic pay.

(3) No contributions shall be made for the benefit of a justice or judge under section 8432(c) of this title.

(4) Section 8433(b) of this title applies with respect to elections available to any justice or judge who retires under section 371 (a) or (b) or section 372(a) of title 28. Retirement under section 371 (a) or (b) or section 372(a) of title 28 is a separation from service for the purposes of subchapters III and VII of chapter 84 of this title.

(5) Section 8433(d) of this title applies to any justice or judge who resigns without having met the age and service requirements set forth in section 371(c) of title 28.

(6) Sums contributed under this section and earnings attributable to such sums may be invested and reinvested only in the Government Securities Investment Fund established under section 8433(b)(1)(A) of this title.

(7) The provisions of section 8351(b)(7) of this title shall govern the rights of spouses of justices or judges contributing to the Thrift Savings Fund under this section."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 84 of title 5, United States Code, is amended by inserting after the item relating to section 8440 the following:

"Sec. Justices and judges."

P.L. 100-654
Sec. 402

LAWS OF 100th CONG.—2nd SESS.

Nov. 14

Tennessee.

SEC. 402. DESIGNATION OF LEWIS E. MOORE, SR., POST OFFICE BUILDING.

The United States Post Office Building located at 525 Royal Parkway in Nashville, Tennessee, is designated as the "Lewis E. Moore, Sr., Post Office Building". Any reference to such building in a law, rule, map, document, record, or other paper of the United States shall be considered to be a reference to the "Lewis E. Moore, Sr., Post Office Building".

Approved November 14, 1988.

LEGISLATIVE HISTORY—H.R. 5102:

HOUSE REPORTS: No. 100-917 (Comm. on Post Office and Civil Service).
CONGRESSIONAL RECORD, Vol. 134 (1988):

Sept. 16, considered and passed House.

Oct. 14, considered and passed Senate, amended.

Oct. 19, House concurred in Senate amendment.

'Unchecked' Research on People Raises Concern on Medical Ethics

A1

By SHERYL GAY STOLBERG

WASHINGTON, May 12 — On the outskirts of the nation's capital, tucked away on the sixth floor of a suburban office building, there is a little-known computer data base: a state-by-state accounting of the experiences of every cat, dog, hamster, guinea pig, chimpanzee, rabbit or farm animal used in a laboratory experiment.

Here in the Government's Division of Animal Care, one can discover precisely how many guinea pigs were subjected to biomedical research in 1995 (333,379). Or how many chimpanzees felt pain during research but were comforted with medication (19,712). Civil servants have compiled such numbers for 31 years, ever since Congress passed the Animal Welfare Act.

But there are no comparable figures for people. "We have better information about animal experiments than we do about human experiments," said R. Alto Charo, of the President Clinton's National Bioethics Advisory Commission.

More than two decades after the Federal Government issued regulations to protect human subjects of medical experiments, the research landscape has changed so much that many doctors and scientists are not necessarily covered by the rules. For example, an entire area of study, embryo research, has grown in the private sector over the last 20 years.

The regulations were the direct legacy of the notorious Tuskegee study, which was halted 25 years ago, amid revelations that the Government had withheld treatment for syphilis to black men in Tuskegee, Ala., without their consent.

The Federal regulations were aimed at establishing the twin pillars of ethical research for subjects of federally-financed studies: the assurance that patients would be warned of risks and that an independent panel would evaluate the experiment before it was conducted.

Continued on Page A15

Continued From Page A1

experiment before it was conducted. But as President Clinton prepares to issue a formal apology to the subjects of the Tuskegee study on Friday, there is mounting concern that the Government's protections do not go far enough.

On Capitol Hill, Representative Christopher Shays, Republican of Connecticut, convened a hearing last week to determine the scope of lapses and violations of ethics in experiments. He was startled by the testimony, including accounts of ethics panels, institutional review boards, or I.R.B.'s, set up as profit-making ventures to evaluate proposed experiments for research groups that pay them.

"I found it amazing," Mr. Shays said. "I am struck by the fact that we have I.R.B.'s that can be created by anyone, that we don't even know how many there are. I think the more we get into this the more we are going to realize how casual this process really is."

Moreover, certain privately-financed research is not bound by the rules. The loophole means some people — no one knows how many — are participating in studies that are wholly unregulated. When there are complaints, there is nothing the Government can do.

"There is unchecked human experimentation taking place," said Dr. Gary B. Ellis, director of the Federal Office for Protection from Research Risks. How much is impossible to determine. But documents obtained from the research protection agency revealed several examples of possible lapses, though the names of those making the complaints were withheld.

In one instance, the parents of a 3-year-old boy with a rare genetic disease enrolled him in an experimental bone marrow transplant program in 1990, at a state university hospital. The parents said their son emerged from the treatment with profound brain damage, unable to walk, talk or feed himself. There was no way to know if the treatment caused the damage, but in a 1991 letter to the protection agency, his parents said that the consent form they had signed had not fully explained the risks of the procedure.

"Had we been informed of this risk we would not have consented to the transplant," the couple wrote. "We are now faced with the expense and challenge of caring for a brain-damaged child who will now live a much longer life span because they corrected his disease."

In another case, an Oregon breast cancer patient complained that the hospital in which she had received chemotherapy had released information from her medical records to researchers without her consent.

In both cases the research was privately financed, so Dr. Ellis could not investigate. "We have incident after incident where we get to the point where we determine that we don't have the authority," he said. "It's very frustrating."

Senator John Glenn, Democrat of Ohio, has been seeking to close this gap. He introduced a bill, the Human Research Subject Protections Act of 1997, that would require informed consent and board review of all experiments, regardless of who paid for them. The bill also would create criminal penalties for violators — a provision that has drawn criticism from the Pharmaceutical Research and Manufacturers Association of America, which often finances private research.

"We believe in informed consent and our companies bend over backwards when we deal with patients," said Mark Grayson, the group's spokesman. But criminal penalties were unwarranted, he said.

Dr. William E. Gibbons, who directs research on genetic testing of embryos at the Jones Institute for Reproductive Medicine in Norfolk, Va., was also skeptical, saying his scientists already follow Federal guidelines.

"How bad a problem do we actually have?" Dr. Gibbons asked. Replied Senator Glenn: "One violation is too much."

Experts point out that the debate over ethics in human experiments is occurring at a time when medical research is safer than it has ever been. History is dotted with scientific horrors beyond the Tuskegee study, notably the gruesome Nazi experiments of World War II and human radiation experiments financed by the Government during the cold war.

These low points in the annals of medicine gave rise to the current system. The concept of informed consent, that patients must be told in advance about how the experiment might help or hurt them, is rooted in the Nuremberg Code by which the

Nazi experiments were judged in postwar trials. But it was not until 1974, two years after the Tuskegee study was disclosed, that the Federal Government enacted a set of comprehensive rules designed to protect volunteers for research.

Informed consent was one cornerstone of the new rules. The creation of institutional review boards was

the other. Today, these provisions are so universally accepted they are referred to as the Common Rule.

The Common Rule applies to three research categories: studies supported by 17 Federal agencies that adhere to it, including the Department of Defense; experiments to prove the efficacy of a new medicine or device and gain the Food and Drug Administration's approval, and research paid for with private money but conducted by academic researchers whose employers have signed agreements with the Government. About 450 universities now require that their scientists adhere to the Common Rule.

Although it has been updated six times in the past 23 years (there are now specific provisions for children, prisoners and pregnant women) many ethics experts say the nature of research has changed so dramatically since the Common Rule was drafted that a thorough re-examination is in order.

"The old model presumes that you would do research to find out some important new basic facts about health," said Dr. Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania. "Current research might be for a pharmaceutical company to put a new drug on the market to compete with the five ones that are already there for, say, insomnia or weight loss. The risks and benefits may be different."

In addition, Dr. Caplan said, the boom in research paid for by private industry has created a new phenomenon: commercial review boards that have generated a wave of what Dr. Caplan called "I.R.B. shopping."

At last week's Congressional hearing, Dr. Benjamin Wilfond, a pediatrician who sits on the review board at the University of Arizona, recalled how one proposal was shopped around.

Not long ago, he said, his board rejected a plan by a university researcher to test a new anti-inflammatory treatment for childhood asthma. The experiment, which was to be paid for by the company seeking approval of the new drug, called for half of the children to receive the new treatment and the other half to receive a placebo. Some of the children given the placebo were to have discontinued their current therapy; the university board thought that was unethical.

Later, Dr. Wilfond said, he learned that the same experiment was being conducted by a private doctor who had submitted the plan to an ethics panel in another state.

What, if anything, Congress can do about lapses is unclear; Government has traditionally been loath to interfere with the private practice of medicine, and no regulatory system is foolproof. "The situation that we have created is generally effective," Dr. Harold Varmus, director of the National Institutes of Health, told Representative Shays last week. "But it's not perfect."

But Ms. Charo, of the bioethics commission, said she believed that expanding the Common Rule to cover all research would be a good first step. At least, she said, regulators might then be able to gather basic statistics for humans as they do for other species. After all, she added wryly: "I'm an animal too."

The New York Times

WEDNESDAY, MAY 14, 1997

Eliz/
Tom/EK

Are we for
this?
- BR

Major Witness Sticks to Story In Bomb Trial

AI

By JO THOMAS

DENVER, May 13 — In a high-stakes assault on the Federal Government's star witness, Timothy J. McVeigh's defense lawyer today sought to portray his client's former close friend as a liar and an opportunist, motivated by the hope of avoiding many years in prison himself.

But after two days of searching cross-examination, the friend, Michael J. Fortier, stuck to his testimony that Mr. McVeigh, filled with hatred for the Government, had cased the Federal Building in Oklahoma City as part of his meticulous planning for the worst terrorist attack in United States history.

And when the lead prosecutor, Joseph H. Hartzler, led Mr. Fortier through a redirect examination, his questions resulted in a new disclosure that supported Mr. Fortier's testimony: At the very spot where Mr. Fortier said his friend had planned to park a getaway car, agents from the Federal Bureau of Investigation later found the key to the Ryder rental truck that had carried the bomb.

The testimony of Mr. Fortier comes two years after he agreed to plead guilty to four lesser bombing-related charges, and to testify against Mr. McVeigh and his co-defendant, Terry L. Nichols. Mr. McVeigh and Mr. Nichols are charged with murder and conspiracy in the April 19, 1995, blast, which killed 168 people; Mr. Nichols will be tried later.

Although the Government has said

Continued on Page A15

Continued From Page A1

it did not need Mr. Fortier's testimony to convict Mr. McVeigh, Mr. Fortier gave the most detailed account yet about Mr. McVeigh's activities and statements in the months before the bombing. But like many Government witnesses in criminal cases, Mr. Fortier presented ample opportunities for cross-examination.

Mr. Jones tried to discredit Mr. Fortier by reading from transcripts of F.B.I. wiretaps in which Mr. Fortier cursed the press and the Government and said he would like to make money by selling his account of the bombing.

"Would you agree with me, Mr. Fortier, that you have transformed yourself?" Mr. Jones asked today.

When Mr. Fortier said, "No, sir, I wouldn't agree with you," Mr. Jones replied, "Well, certainly you would agree with me that your testimony and statements today are different than the ones before, aren't they?"

Mr. Fortier answered: "Before May 17, I was lying to the F.B.I. and to the media and other people."

The answer did not suit Mr. Jones.

"That wasn't the question I asked you, Mr. Fortier," he retorted. "The question I asked you is whether your statements today are different than the ones before May 17."

Mr. Fortier said, "Yes, they are."

In his sessions with the prosecutors, Mr. Jones persisted, "Did you go over things like responding to my question by saying, 'Well, I was lying then and I'm not lying now'?"

Mr. Fortier answered, "Mr. Hartzler has never coached me on what to say."

Mr. Jones snapped back: "I didn't ask you whether he coached you. I asked you whether you had discussed those matters. And incidentally, was it suggested that you answer by saying, 'I haven't been coached'?"

Mr. Fortier replied, "No, sir, it wasn't."

Despite Mr. Jones's relentless attack on Mr. Fortier, for the moment, the witness's testimony has seemed to have helped only Mr. Nichols. Mr. Fortier, who will be sentenced when both trials are over, testified that Mr. McVeigh told him before the bombing that Mr. Nichols wanted to drop out of the plot and did not want to mix the bomb.

Mr. Jones also tried to discredit Mr. Fortier by aiming at his testimony that Mr. McVeigh had asked him to rent a locker in Kingman, Ariz., in the fall of 1994. He was unable to find one, he said, but when Mr. McVeigh and Mr. Nichols showed up at his home a few days after this request, they told him they had found one.

"Well, how did he know you hadn't been able to find one?" Mr. Jones asked.

When Mr. Fortier replied, "I don't know," Mr. Jones said, "Is it possible, Mr. Fortier, that what really happened is that you and your wife went out to find a storage shed on your own, didn't have anything to do with Tim McVeigh, you needed someplace to put this stuff that you had stolen from other people, because you didn't want to leave it in your house?"

Mr. Jones had already underscored admissions from Mr. Fortier on his direct examination that he had used and sold drugs, and had stolen items from a local National Guard Armory and a local airport.

Mr. Jones also zeroed in on testimony in which Mr. Fortier said he had sent off for a false identification kit so Mr. McVeigh could apply for credit card advances he never intended to repay. Mr. McVeigh had been asking him to give him money from his own credit cards, Mr. Fortier testified, and he did not want to do this.

"So then you decided to help him commit a crime to get a false ID?" Mr. Jones asked.

Mr. Fortier answered, "That's cor-

rect, to get him off my back."

Mr. Jones repeated, "To get him off your back."

When Mr. Fortier said, "Yes," Mr. Jones asked, "Well, what else are you willing to do to get somebody off your back, Mr. Fortier?"

Mr. Fortier replied, "I don't understand the question."

Mr. Jones persisted: "Like the F.B.I. What are you willing to do to get them off your back?"

Mr. Fortier answered, "I was willing to lie to them."

Mr. Jones retorted, "No, you were willing to cooperate with them, weren't you?"

Mr. Jones also ridiculed Mr. Fortier's admission on cross-examination that he could not remember just how he and Mr. McVeigh got from Interstate 35 to downtown Oklahoma City the day he said they cased the Federal Building. But later, Mr. Hartzler reminded Mr. Fortier that he had gotten in Mr. Hartzler's van and showed the prosecutor the route around the building and the alley where Mr. Fortier said Mr. McVeigh intended to leave the getaway car.

"So you independently on your own directed us to that alley and told us about that alley and where Mr. McVeigh was going to park?" Mr. Hartzler asked.

Mr. Fortier replied, "Absolutely."

Referring to the truck used to carry the bomb, Mr. Hartzler asked, "Did you know at that time that the F.B.I. had found the key to the Ryder truck in that alley?"

Mr. Fortier replied: "No, sir. This is the first I've heard of that."

The last witness of the day was Charles C. Edwards, design engineering manager for a company that makes ignition keys and locks for the Ford trucks bought by Ryder. Mr. Edwards said the F.B.I. had asked him to make a door and ignition lock to fit a keycode for a Ford truck. When it was made, the key found in the alley fit, he testified.

The New York Times

WEDNESDAY, MAY 14, 1997

By JEANNE CUMMINGS
AND GLENN BURKINS

Staff Reporters of THE WALL STREET JOURNAL

BOSTON—Before Al Gore's Reinventing Government project came along, Priscilla Doolittle was a manager in the vast federal bureaucracy. Working from her desk in the Hartford, Conn., office, she supervised 14 employees at the Social Security Administration.

But then the vice president stepped in with a mandate to "de-layer" federal agencies and make them more responsive to America's taxpayers. So Social Security weighed down with twice as many supervisors as Mr. Gore deemed appropriate moved to make its operations leaner. The regional headquarters in Boston reassigned Ms. Doolittle and declared her a manager no more.

Just one problem: Ms. Doolittle's new job as a "management support specialist" isn't much different from her old one. She is "treated as management," Ms. Doolittle says, and doing "most of the things" she did before.

The outcome reflects the seeds of a major debate between Mr. Gore, who trumpets Reinventing Government as a big success, and Texas Gov. George W. Bush, who scorns it as a big sham. "They haven't reinvented government bureaucracy—they've just reshuffled it," Mr. Bush says. The GOP presidential candidate last week unveiled his own plan for streamlining government, but it relies largely on expansions of such existing reform efforts as privatizing government work.

Same Desks, 'Same Responsibilities'

In the case of Ms. Doolittle's job move, it isn't Republican critics who have raised questions. An outside expert notes that she and others affected by the change have the same desks, "same responsibilities" and "virtually the same workload" as when they were called managers. The expert is the federal government's own lawyer, arguing that Ms. Doolittle shouldn't be permitted to join the union representing rank-and-file agency employees.

As Mr. Gore, the Democratic presidential candidate, attempts to bring his hazy public profile into focus, the administration's Reinventing Government initiative distills the images he would like American voters to remember this fall: experience, vision, tough-mindedness, the capacity to save taxpayer money without compromising on services ordinary people need.

To Mr. Gore's aides, who credit the project with a governmentwide savings of \$137 billion and the smallest federal work force since John F. Kennedy's administration, the issue underscores the contrast with a Republican candidate they say is ill-prepared for the presidency.

Aiming even higher, Mr. Gore identifies his initiative with "the soul and spirit of self-government," and "a new trust and faith in our people and in each other." Just last week, Mr. Gore called for "a second American revolution" as he launched the second stage of the effort with proposals to make "e-government" services available to all by 2003.

E-Government Initiative

Republicans, too, view the initiative as potent symbolism—of Mr. Gore's phony claims and unwillingness to take on powerful Democratic constituencies such as organized labor. When the vice president unveiled his e-government initiative, the Bush campaign immediately circulated criticisms of the Reinventing Government project from the axes of the General Accounting Office and former Union Chief of Staff Leon Panetta under the headline: "Gore Exaggerates Record."

Of all the issues the two candidates will argue about this fall, "REGO" will be among the most revealing. Unlike many administration initiatives, REGO has been the vice president's responsibility from the beginning. That makes it an apt test of both his ability to operate the levers of federal power and of his reputation for gilding the lily.

Some fruits of the project are beyond dispute. The U.S. government employs fewer full-time workers today than it did in 1993, when the Clinton-Gore team took office. In 1999, the federal work force was down to 2.3 million, compared with 4.8 million in 1960. Thousands of government field offices have been shut down, and dozens of programs consolidated.

The government no longer pays an employee to taste-test imported tea. Gone are rules requiring localities to certify they purchase American-made goods, including toilet paper. About 1,000 of Mr. Gore's 1,200 specific recommendations have been put into effect, administration aides say.

How much those adjustments have changed day-to-day federal operations is another question. Critics say the administration achieved many of its vaunted cuts not by force of will, but sleight of hand.

Pentagon Cutbacks

Brookings Institution scholar Paul C. Light says the reason the federal work force has declined is Defense Department reductions resulting from the end of the Cold War, not streamlining initiatives. Without Pentagon cutbacks, he notes, the government work force today would be significantly larger, not smaller, than in JFK's time. While the number of uniformed and civilian defense workers has declined to 2.2 million from 4.1 million in 1960, he says, the number of employees in domestic agencies has risen to 1.1 million from 761,000.

Others say many federal employees have simply been replaced by private contractors who now do the same work.

"Where are all the billions we are saving?" complains Bobby Harnage, president of the American Federation of Government Employees, who says taxpayers received little benefit from changes that have taken 100,000 members from AFGE's bargaining units. And last week, Mr. Bush's aides distributed a 1999 GAO finding that two-thirds of the claimed REGO savings couldn't be verified.

A look at the attempt to streamline the Social Security Administration's bureaucracy in Boston shows that the Texas governor will have plenty of fodder for assailing his Democratic rival on the issue.

Big Challenge

Mr. Gore himself set the agenda, declaring that federal agencies should slim down their supervisory force and aim for a manager-worker ratio of 1-to-15. Mandates to that effect soon went out to all government agencies. That was a big challenge at the Social Security Administration, which then had one manager for every seven workers.

Then an agency working group settled on a solution: take 1,200 operations and field office supervisors and give them jobs as "management support specialists,"

which previously didn't exist. After initially striking a go-slow posture, Boston-area SSA officials swung behind the program.

The SSA workers raised questions, their bosses defended the changes as a "high priority of the White House." But they assured participants that the reclassified workers would continue to be "key management officials" despite their new job titles.

Couldn't Discipline Staffers

The new jobs did come with changes.

As nonmanagers, the five workers couldn't discipline lower-ranking staffers, approve overtime or conduct performance reviews. But they were available to substitute for their vacationing superiors.

But legal wrangling that ensued between the AFGE and the government over Ms. Doolittle and several of her colleagues shows how limited the real-world impact of the bureaucratic shift really was. If the workers weren't managers anymore, AFGE lawyers argued, they should be eligible for the union's bargaining unit.

Not at all, government lawyers responded. "The change of job title was transparent," they argued in a brief filed in an administrative proceeding here as part of the dispute.

Keeping Parking Space

Ms. Doolittle, a 28-year Social Security employee, echoes the argument. "Our jobs are very similar to what we did before we became management support specialists," she says. She continues to attend the Thursday morning management staff meeting and has even kept her space in the managers-only parking lot.

Social Security officials defend the changes as more than cosmetic and note that the agency has received its highest customer-satisfaction marks ever since they occurred. And as upset as AFGE has been at times about REGO, that hasn't stopped the federal employees' union from swinging behind Mr. Gore's bid to win the White House.

As Mr. Harnage sat in his Washington office recently critiquing Mr. Gore's initiative, a large laminated poster with a smiling picture of the vice president lay on a table nearby. It was captioned with the words, "AFGE for Gore."

Supreme Court Shields HMOs From Lawsuits

By ROBERT S. GREENBERGER

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—The Supreme Court, in a victory for managed care companies, ruled that health maintenance organizations and others can't be sued under federal law for giving doctors financial incentives to hold down costs.

In a busy day as the high court's term nears its end, the justices also made it easier for employees to sue their employers for age discrimination; the ruling likely will be read broadly to cover other forms of workplace discrimination.

The justices widened the category of people an employee benefit plan may sue for violations of U.S. laws protecting retirement benefits.

Managed-care industry officials applauded the unanimous Supreme Court decision. Earlier this year, some industry executives claimed the very existence of their industry was threatened by the lawsuit. The case revolved around the definition of who is considered a "fiduciary" of health-care plans.

Under U.S. law, such officials may be sued if they don't act solely in the interests of plan participants.

In yesterday's decision, the justices decided that actions taken by health-care-plan physicians—such as determining whether a plan covers certain medical procedures—don't fall into that category. The decision closed one avenue of litigation against managed-care facilities, though it leaves open another through state courts.

The case involved Cynthia Herdrich,

who in March 1991 went to her managed-care facility complaining of severe abdominal pain. Although her condition worsened, Ms. Herdrich's doctor didn't schedule tests for another eight days. In the meantime, her appendix burst and she developed a life-threatening infection.

She survived and sued doctor-owned Carle Clinic Association of Urbana, Ill., charging that the tests were delayed because the plan's doctors had financial in-

centives to hold down costs. But Justice David Souter, writing for the court, said "we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes" eligibility decisions through its doctors.

The managed health-care industry, besieged by consumer and congressional complaints as well as class-action lawsuits, was relieved. In a statement, Karen

Ignagni, president of the American Association of Health Plans, called the decision "a resounding victory for maintaining affordable care."

Trial lawyers bringing class-action suits against managed-care companies found some solace in a footnote in the opinion. It suggested health-care plans could be sued if they don't disclose their activities, including incentive programs.

"From the perspective of the class actions we're involved in, we think [that's] very helpful," said Stephen Neuwirth, an attorney with Boies, Schiller & Flexner, (*Pegram vs. Herdrich*)

The age-discrimination decision involves a case brought by Roger Reeves, who was fired when he was 57 years old after 40 years of employment by Sanderson Plumbing Products Inc., a Mississippi company. In his filing, Mr. Reeves said that two months before he was fired in 1995, the director of manufacturing told him he was "too damn old to do the job."

Sanderson Plumbing, citing some work problems, offered a nondiscriminatory reason for the firing. A jury didn't buy the company's explanation and decided in Mr. Reeves' favor. That decision was reversed by an appeals court, but the Supreme Court overturned the lower court.

Writing for the court, Justice Sandra Day O'Connor said that Mr. Reeves didn't need concrete evidence of his employer's intent to discriminate; indirect evidence of bias can be enough to prove illegal age discrimination.

Stephen Bokat, senior vice president and general counsel for the U.S. Chamber

of Commerce, conceded the decision was a defeat for business. But he said the court hedged a bit. "They said a court may use [this decision] as a basis for deciding discrimination, but that it doesn't have to in all cases," he said.

Thomas Osborne, a staff attorney for the AARP Foundation Litigation, said the court's simplification of the procedure "may encourage people who have been daunted by what has gone on before to come forward and file suits."

(*Reeves vs. Sanderson*)

The high court's unanimous decision in the employee benefit plan case involves Ameritech Corp. and its pension-plan trustee, Harris Trust & Savings Bank. The ruling will permit them to try to recover about \$20 million lost in a late 1980s real-estate deal with Salomon Smith Barney Inc.'s realty unit. Ameritech now is owned by SRC Communications Inc., San Antonio, and Harris Trust is a unit of Bank of Montreal, Toronto. Salomon, which provided services to the pension plan, now is part of Citigroup Inc., New York.

It has long been established that fiduciaries, who include those who exercise discretionary control or authority over pension plans, are liable for certain transactions under the U.S. Employee Retirement Income Security Act, or ERISA. But in yesterday's decision, the high court said that an employee-benefit plan also may sue brokerage firms, insurance companies and others whose transactions violate ERISA.

(*Harris Trust vs. Salomon Smith Barney*)