TAB A

DEATH STATISTICS
STAFF EMPLOYEES AND STAFF AGENTS FOR CIA AND STAFF EMPLOYEES FOR STATE AND AGRICULTURE

1. A Comparison of death incidence with the Foreign Service, and Departmental, Department of State; and with Department of Agriculture Beneficial Association; and with U. S. mortality tables.

	1947	1948	1949	1950	1951	1952	1953	Average '51 '52 '53
CIA a/								
Total in service deaths	[redacted]							
Av. Monthly Strength								
Deaths per 1000 (physical given)								

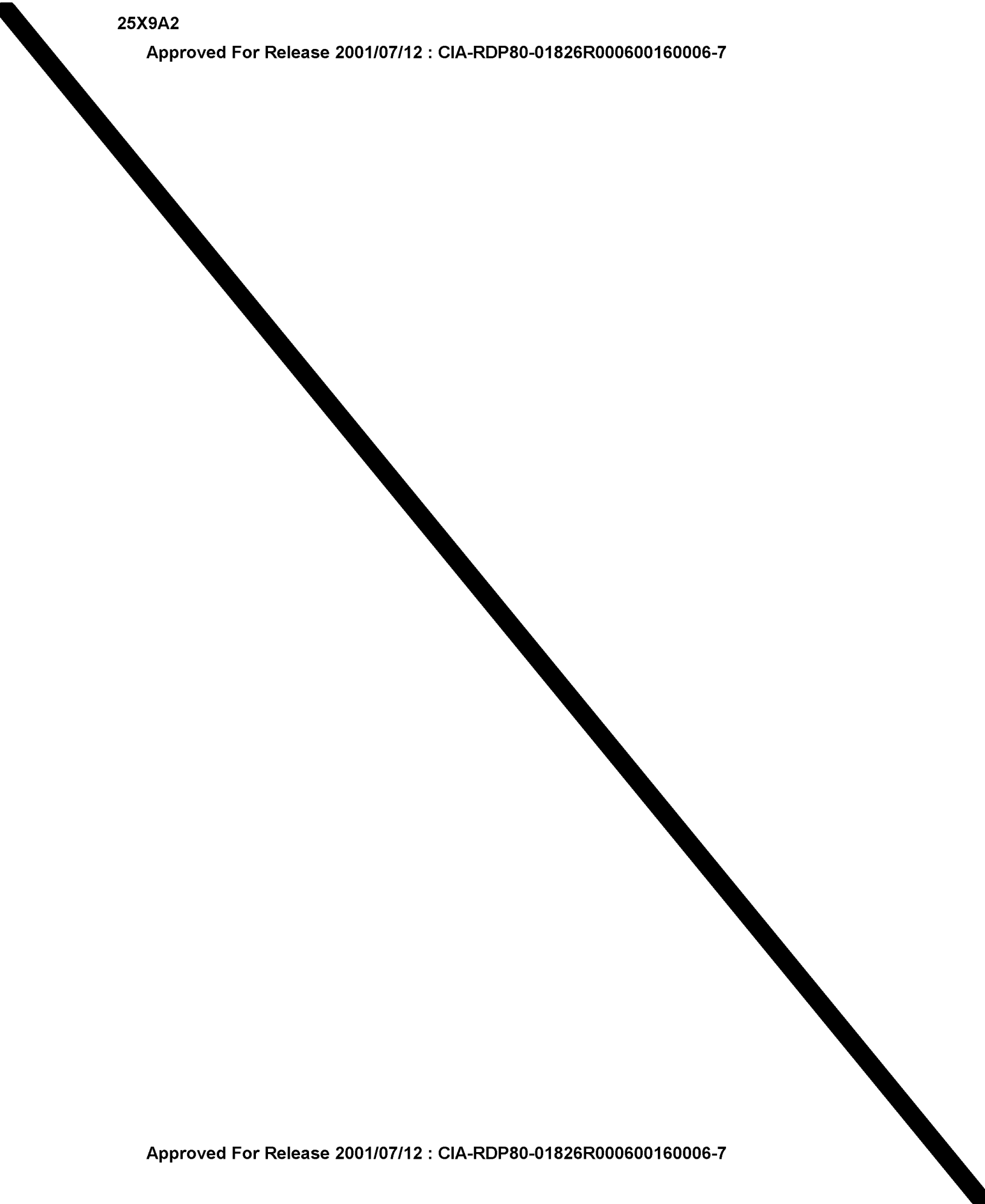
25X9

State b/ - Foreign Serv.								
Total in Service deaths	-	-	10	15	8	5	8	7
Av. Monthly Strength	-	-	5378	7898	8692	8993	7562	8416
Deaths per 1000 (physical given)	-	-	1.86	1.90	.92	.56	1.06	.83
State - Departmental								
Total in Service deaths	-	-	7	18	17d/	19	12	16
Av. monthly strength	-	-	10630	7870	9316	10046	8166	9176
Deaths per 1000 (no physical exam	-	-	.66	2.29	1.82d/ (1.29)	1.82	1.47	1.75 d/ (1.54)
Agriculture Ben. Assn. c/ (includes Retirees)								
Total deaths incl. sep'd	-	-	182	234	190	217	232	213
Strength of Ass'n.	-	-	16122	16193	16161	16045	16080	16095
Deaths per 1000 (no physical exam)	-	-	11.3	14.5	11.8	13.5	14.4	13.2

U.S. population as a whole (deaths per 1000)

(1) Estimate for 1951 by the World Almanac 9.7
(2) U.S. Public Health Service for 1952 . . . . . 9.6

a/ b/ and c/ - See Tab E for sources.
d/ Contains 5 deaths from single plane crash. If not included, the ratio is shown in ( ) above.
e/ Not separated from service.



5. Causes (CIA):

				U.S. Pop.a/
a.	Heart	25	(35%)	32.5%
b.	Cancer	11	(16%)	13.7%
c.	Suicide b/	6	(9%)	1.1%
d.	Ulcers, Obstruction, Peritonitis	6	(9%)	
e.	Polio (3) Diphtheria (1)	4		
f.	Complications following operation	2		
g.	Accident not in line of duty	5	(7%)	
	By fire while trysting 1			
	By air crash on LWOP 1			
	By mountain climbing 1			
	By auto collisions 2			
h.	Accident in performance of duty	8	(12%)	
	By explosion of gasoline 1			
	By air crash (Sched.) 3			
	By air crash (Non-Sched.) 1			
	By boom of crane 1			
	By ship sinking 1			
	By shooting (2nd party) 1			
i.	By enemy action	2		
	TOTAL	69		
	(PERFORMANCE OF DUTY TOTAL: 10 (14.7%) c/)			

6. U. S. Public Health Service 1948 Vital Statistics for U. S. Population as to death from "selected causes" (most). Rates per 1,000 of mid-year population.

All Causes	All Ages	9.885
Heart	" "	3.227
Cancer	" "	1.349
Suicide	" "	.112

Ages	15-24	25-34	35-44	45-54	55-64	65-74
All Causes	1.424	1.977	3.976	9.048	19.358	44.035
Heart	.085	.208	.854	2.918	7.259	17.908
Cancer	.056	.168	.598	1.718	3.789	7.347
Suicide	.047	.090	.147	.208	.255	.288

a/ U. S. Public Health Service 1948
b/ 5 suicides in DD/P
c/ 8 Performance of Duty in DD/P

7 CIA ages at death for all cases (49) in the years 1951, 1952, 1953

Age	Cumulative Totals	Percent of Grand Total
Under 25	4 cases	8
" 30	14	28
" 35	19	38
" 40	23	46
" 45	29	58
" 50	33	66
" 55	40	80
" 60	44	88
" 65	47	94
" 70	47	94
" 75	49	100

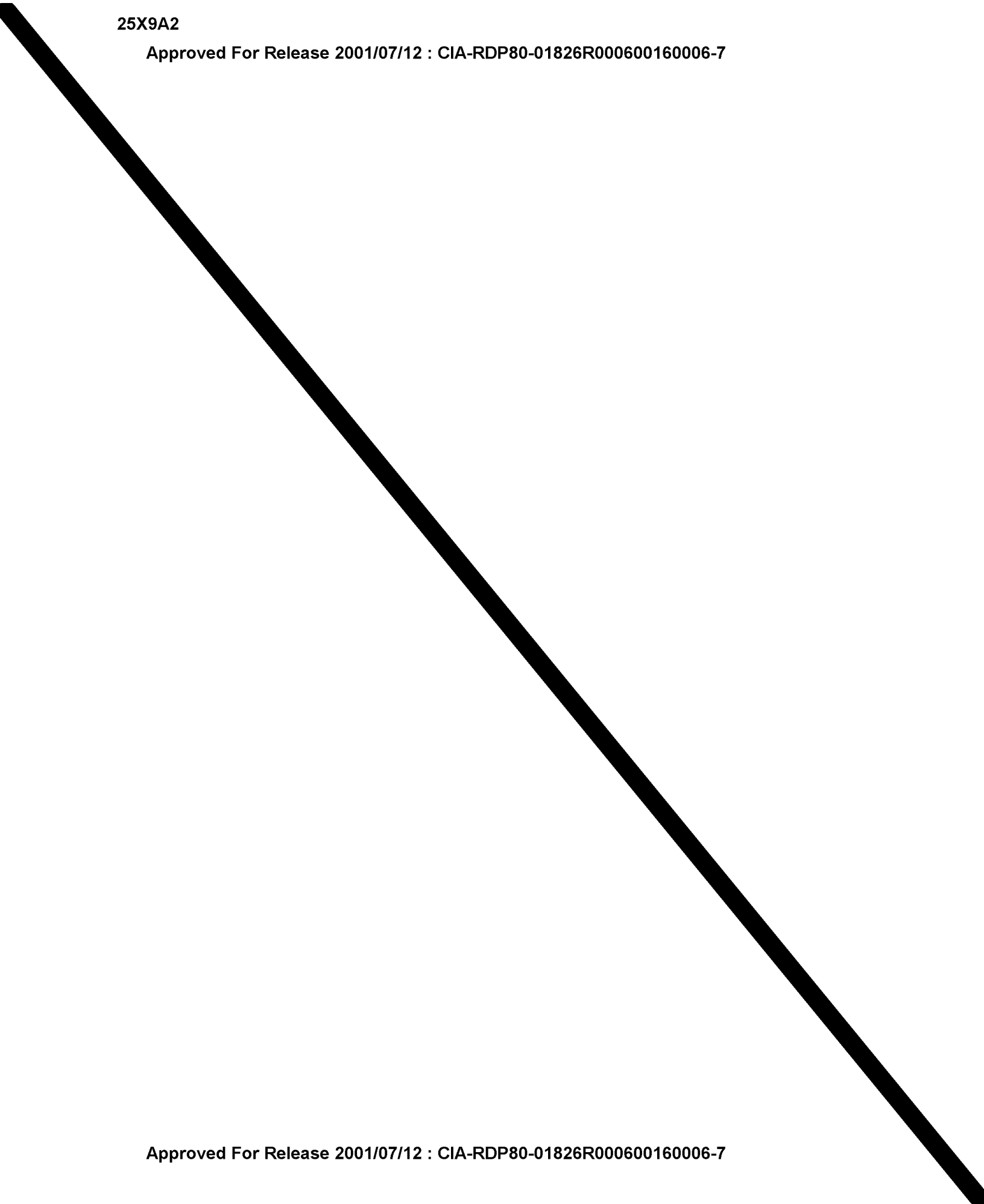
8. CIA ages related to total deaths for the same age groups (Cumulative % to total in both cases)

	Age Distribution a/	Death Distribution b/
Under 25	16%	8%
" 30	42%	28%
" 35	64%	38%
" 40	79%	46%
" 45	89%	58%
" 50	95%	66%
" 55	97%	80%
" 60	99%	88%

a/ As of 30 June 1953 (no significant change as of Jan. '54)
b/ 3-year totals - 1951, 1952, 1953.

9. Ages at death in 3 categories (Total Agency S.E. & S.A. '47-'53, incl.)

Note: Total of 42 in these 3 categories is 62% of grand total)	Heart (25)	Cancer (11)	Suicide (6)	- (Location)
24		1		
25				
26				
27			1	[redacted]
28		25X1A6a		
29			1	
30	1			
31				
32				
33	1		1	FE US
34		25X1A		
35			1	[redacted]
36	1			
37				
38	1			
39	11			
40	1	11		
41			1	OTR US
42		1		
43			1	FE US
44	1	1		
45		1		
46	11			
47				
48		1		
49	1	1		
50	1			
51	111			
52				
53	1			
54	1			
55				
56				
57	1			
58		1		
59	1 1			
60				
61	1			
62				
63		1		
64	1			
65	1			
66				
67				
68				
69				
70		1		
71	1			
72	1			



TAB B

1. Facts in respect to death - as to existing available protective features in beneficiary coverage. These are:

a. Commercial Ordinary Life policies*

(1) Most importantly for us is the matter of exclusions from coverage - and here the policies vary considerably. However, some aspects which are generally common are these:

(a) The incontestibility period for all features of the policy is 2 years (all of those listed except New York Life, which is 1 year).

(b) The Basic (Face amount) Policy contains airflight exclusion as follows:

Any flight operated for military purposes or where the insured individual acts as a crew member, has duties aboard, parachutes or participates in a flight having testing, experimental or training purposes.

Non-Scheduled Airlines are not dealt with explicitly as such except by Prudential which won't cover any such flight.

(c) Invariably, all flights as a passenger in commercial scheduled airlines of any country are covered risks today. **

(d) The Basic (Face amount) Policy contains war exclusions (declared or undeclared war) as follows:

Death arising from an act of war while in either military or civilian service outside the Home Areas or within 6 months after return to Home Areas. ***

* Examination was made of sample policies from: Acacia, John Hancock, N. Y. Life, Omaha Un. Ben. Life, Guardian, Prudential, Travelers, Lincoln Nat'l., Penn Mutual.

** "Scheduled Airlines" are commonly defined as follows: "Aircraft operated on schedule for commercial purposes by an incorporated and governmentally certified Scheduled Commercial Air Carrier over an established route between specified airports."

*** The Home Areas are commonly defined as the U.S., Canada, Panama, D. C., T.H., Puerto Rico and Virgin Islands.

(e) The Double Indemnity (twice the Face Amount) accidental death feature contains all the foregoing exclusions plus self-inflicted cause, illness or disease, gas or fumes, assault or felony, war, insurrection, riot, military service during time of war, and air flight in non-scheduled airlines.

(2) The risks of Agency hazardous and semi-hazardous duty not covered by Ordinary Life policies are:

(a) In respect to the Basic (Face Amount) policy:

1. Air flight in military or non-scheduled planes for the purpose of testing or training (TSS and TRS), for military purposes (OPS), acting as a crew member or with duties aboard, parachuting (OPS), and in some cases as a passenger in non-scheds (TRS, TSS, OPS).

2. Exposure to an act of war (declared or not), military or civilians while outside home areas or during six months after return.

(b) In respect to the Double Indemnity Accidental Death feature:

1. All of the above plus exposure to disease, illness, gas or fumes, assault, felony, riot, insurrection, military service, and air flight in non-scheds as a passenger.

(3) It is to be noted that in addition to the above listed risks, there are 16 hazardous duty risks which, if revealed in the candidate's application for insurance or ferreted out by the agent, would probably either exclude acceptance or provide coverage, in some cases, at an excessive premium. However, given acceptance of the candidate on a non-hazardous occupation description, the policy is insecure for two years (the contestibility period). The insurance companies are already suspicious of us.

b. National Service Life Insurance or U. S. Government Life Insurance

(1) Both of these policies are GI - the latter available in World War I, and since, to that veteran if in active service, and NSLI during and since World War II without previous service. The only difference is that U. S. Government Life has a double ability feature for a small additional premium - NSLI does not.

(2) Both of these policies are incontestible from date of issue for any cause except fraud, in both death and disability features. i.e., NO exclusions.

c. Federal Employees Compensation Act

(1) This act provides compensation for disability, death and medical care (including hospitalization) resulting from injuries suffered in performance of duties or from diseases proximately caused by employment. Exclusions from coverage are disabilities or death resulting from willful misconduct, self-inflicted action, or intoxication.

(2) FECA - as to death benefits *

(a) Burial expenses up to $400.00 plus transportation of remains to home.

(b) Widow, no other dependents. 45% of pay ** not to exceed $525.00 monthly until her death or remarriage.

(c) Widow with 2 unmarried children under 18 years of age. 40% of pay to widow plus 15% for each child (total 70%) not to exceed (75% of pay in any case) $525.00 total per month until death or remarriage of widow and until children marry, die, or reach 18 years of age as to their part.

(d) No widow, 2 unmarried children under 18 years of age. 35% of pay for one child, 15% for the other not to exceed (75% of pay in any case) total of $525.00 per month until children marry, die, or reach 18 years of age.

(3) In summary, continuing death benefits to beneficiaries arising from injuries suffered in performance of duty or from disease proximately caused by employment are these - for the situations illustrated:

* The statement of benefits below is translated later here with chosen examples.

** The pay or salary rate for this purpose includes all amounts withheld for tax and retirement purposes plus value of subistence, quarters and other considerations as part of pay.

Beneficiary	GS-11 Employee dies in U. S.	GS-11 Employee dies in [redacted]
(a) Widow only	$222.75	$256.50 (monthly)
(b) Widow and 2 children	328.16	399.00 (monthly)
(c) 2 children only	239.16	285.00 (monthly)

25X1A6a

(4) This act is an exclusive remedy, but does not prevent the beneficiary from electing to receive the benefits of the Civil Service Retirement Act if she so desires, but she cannot receive such benefits concurrently with those under FECA.

(5) All hazardous duty or semi-hazardous duty risks run by Agency employees are covered by FECA under the conditions of performance of duty or proximate cause resting in employment.

d. Civil Service Retirement Act

(1) This Act provides death and disability benefits to employees of the U. S. Government with and without performance or line of duty qualification provided the employee has acquired minimum eligibility of a total of five years of civilian service ** - intermittent or otherwise. As noted in the previous analysis of FECA, no continuing benefit under this Act can run concurrently with FECA benefits. The individual concerned (employee or beneficiary) may choose.

(2) Exclusions from coverage are common with FECA, i.e., willful misconduct, vicious habits and intemperance, with respect to disability only.

(3) The continuing benefits are annuity, in nature, computed as a percentage of the highest five-year average base salary modified by the years of creditable service. Military service can be added to the civilian years for this computation. No additions for overseas allowances are permitted as in the case of FECA.

* "Pay" includes the addition of $900.00 quarters allowance annually.

** Under 5 years of service, or more than 5 years with no widow or dependent children, the Act provides for a lump sum of amount paid-in, plus interest.

(4) As to death benefits: *

(a) Widow - no other dependents.

50 % of employee's then annuity benefit, attainable when widow reaches age 50, and terminable when she dies or remarries.

(b) Widow and 2 children. Immediately payable.

50% of employee's then annuity benefit, plus to each child 50% of the widow's annuity, not to exceed $900.00 annually, divided by the number of children, or $360.00 annually, whichever is lesser - terminable to each child on death or marriage or attainment of age 18, except that if such child is incapable of self-support, terminable on death, or marriage or recovery. Upon death of widow, recompute as in (c) below.

(c) No widow, 2 children only. Immediately payable

50% of employee's than annuity benefit to each child not to exceed $1200.00 annually divided by the number of children or $480.00 annually, whichever is lesser - terminable as above in (b) and, in case of termination to one child, recompute as if that child had not survived the annuitant, i.e., a case of one child only.

(d) In summary, as to continuing benefits to dependents.:

	Employee GS-11	Employee GS-11
Category	9 yrs. svc.	15 yrs. svc.
Widow only	$33.42	$55.69 monthly (at age 50)
Widow plus 2 children	66.84	111.39 monthly (immediately)
2 children only	66.84	80.00 monthly - max. (immediately)

* The statement of benefits below is translated later here with chosen examples.

e. Public Law 110 as to death - on PCS abroad

(1) Pay the cost of preparing and transporting the remains of an employee, or member of his family, who may die in travel status or abroad ..... to appropriate place of interment .....

f. War Agencies Employees Protective Association (WAEPA)

(1) This is a non-profit association independent of the U. S. Government, which provides death benefits only, in two (2) categories - term life insurance and accidental death, and only to civilian employees of the U. S. Government.

(2) This insurance is effective only when the individual is actively employed, not including terminal leave. Eligibility extends to age 60 and membership in the Association terminates at age 65 or upon entry into the Armed Forces of any country. Membership is open to any employee of this Agency "who may go overseas at some future time." (see Appendix II) and without a medical examination, if he applies within 60 days "after becoming eligible." If application is later than these 60 days a "statement of health" is required. Eligibility extends to any individual paid from appropriated funds of this Government (see Appendix III). On termination of government service the term life feature may be converted into one of the Underwriters standard ordinary life policies, without medical examination.

(3) The policy is effective on the date of application if the application is acceptable to the Association. There is no contestible period as in Ordinary Life policies and, in respect to the term insurance part of the policy, no exclusions of any kind. The accidental death feature has these five (5) exclusions:

(a) Bacterial infections (except pyogenic infection arising from accidental wound).

(b) Any kind of disease.

(c) Medical treatment (except from accidental injuries).

(d) Suicide

(e) Air flight in non-scheduled flight, unless under orders of the U. S. Government, and in any flight as a crew member of the plane (see WAEPA letter 15 January 1953, Appendix I herewith).

(4) Death benefits now are:

Salary*	Term Life Ins.	Accidental Death	Total
3200 or over	12,000	15,000	27,000

(5) Costs are:

Age up to 41	$8.33 per month	25.00 Quarterly	100.00 Annually
Age 41 to 51	10.42 per month	31.25 "	125.00 "
Age 51 to 65	12.50 per month	37.50 "	150.00 "

(6) The underwriters are:

(a) Equitable Life Assurance Society of the U. S. as to the term feature.

(b) American Casualty Company of Reading, Pa. as to the accidental death benefit.

(7) Our experience with WAEPA is as follows:

(a)

	Premiums Paid Total	Benefits Paid Total
1947	7,915.25	0
1948	11,630.00	0
1949	14,615.50	0
1950	20,299.43	0
1951	55,400.82	27,000.00 1 death
1952	117,437.29	12,000.00 1 death
1953	156,547.46	18,103.00 3 deaths
	383,845.75	57,103.00

(b)

	Premiums Paid Av. per month	Rate of Coverage by persons - years **
1947	791.00	79.00
1948	969.00	116.00
1949	1,218.00	146.00
1950	1,691.00	203.00
1951	4,616.00	554.00
1952	9,786.00	1,174.00
1953	13,045.00	1,565.00

* This salary is about GS-4; for salaries below this figure ($3200), the benefits and costs are approximately one-half of the amounts shown above. See rates in Brochure.

** Persons - years: assuming ages up to 41 premium is $100.00 for an individual for a year.

(c) Length of time contracts in force 1947-1953 inclusive.

	Cancelled Contracts	Existing contracts in force as of 1 Jan. 1954
Up to 3 mos.	56 (10%)	113 (7.7%)
" " 7 "	169 (30%)	201 (13.7%)
" " 13 "	119 (22%)	197 (13.5%)
" " 19 "	70 (13%)	259 (17.7%)
" " 25 "	60 (11%)	258 (17.7%)
" " 31 "	45 (8%)	201 (13.7%)
" " 37 "	20 (3.6%)	127 (8.7%)
" " 43 "	7	73 (5.0%)
" " 49 "	1	9
" " 55 "	0	4
" " 61 "	3	5
" " 67 "	2	7
" " 73 "	1	5
" " 79 "	0	1
" " 85 "	0	1
Total	553	1461

(d) Modifying factors in the above are:

1. in 1950 WAEPA added $2000 to the term coverage
2. in 1951 " addad $15,000 accidental death coverage
3. in 1953 WAEPA added eligibility liberalization to read: "... available to anyone (in CIA) who may go overseas at some future time." Previously, overseas orders had to be cut.
4. Bad Agency publicity.

(8) DDI reports no interest in risk coverage on the part of his people but a good interest in group life (term) coverage. They feel that with 99% of them not going overseas at any time, they would be straining the truth to apply for WAEPA.

(a) He also reports that they don't know the exclusions in their O. L. policies. Nor do they know anything about F.E.C.A.

g. Recapitulation as to continuing benefits after death.

(1) In order to assess practically the asset values to the beneficiary in existing available protective measures, certain assumptions as to asset (or proceeds) disposition-methods are utilized as follows:

(a) The widow's age is assumed at 30 years (because of the general youth of the Agency employees) in both examples to follow, i.e., widow is the only beneficiary in the first case, and widow and 2 children in the second - ages 5 and 6 years.

(b) As to Ordinary Life Insurance. There is assumed a policy of $10,000 face with double indemnity for accidental death.

The widow chooses to receive the proceeds immediately in the form of a monthly life income (20 years certain) in both examples. Disposal of these proceeds is illustrated by utilizing option 4, under an Ordinary Life policy written by United Benefit Life Insurance Co. of Omaha, Nebraska. The benefit is $30.50 per month for the face of policy, or $61.00 per month with the Double Indemnity feature.

1. The proceeds of this policy are not taxable as income unless left with the company at interest. Such interest is taxable.

(c) As to FECA, in the summary following here, the examples shown in the analysis heretofore are used.

1. The benefits here are not taxable as income.

(d) As to CSRA, it is seen that its value is small - is of no consideration in the case of death in performance of duty, and is applicable under line-of-duty or not, to a widow alone only when she reaches 50 years. To a widow with children benefits are applicable immediately but are small.

1. The benefits here are taxable as income under the annuity rule. (3% of total salary deduction until tax equals deduction, then all taxable.)

(e) As to WAEPA in the term feature, it is assumed that the employee chose proceeds disposal on the basis of monthly installments payable immediately on his death for the 15-year period. This pays $6.53 per month per $1,000 of policy face ($12,000 now), i.e., a total of $78.36.

1. The proceeds here are not taxable as income, in the same way as Ordinary Life.

(f) As to WAEPA, in the accidental death feature, which must be paid in a lump sum ($15,000 now), it is assumed that the single beneficiary (wife only, age 30) is better served by her purchase of a single premium Deferred,

Refunding Life Annuity payable in 20 years at her then age of 50 years (or earlier for less amount if she chooses or needs). On this basis, Guardian Life of N.Y.C. will, in 20 years, accumulate a cash value for her of $24,135 and then pay her $94.13 monthly for life and also refund the unused balance to her specified beneficiaries.

However, under this feature, in respect to the second example (the employee's beneficiaries are wife and 2 children, ages 5 and 6), it is deemed the part of wisdom for her to use the principal as she chooses under a Trust Fund arrangement, for a minimum of 12 years (until the children are 18 years old). The trusts now pay about 4% average on the investment and charge 5% on the fund earnings. This will net the beneficiary additional earnings over 12 years of about $3,000 total, or an average earning of about $250 per year. She takes out $125.00 per month average for 12 years and uses up the principal.

1. The proceeds under WAEPA accidental death feature are not taxable as income, except as to interest or earnings.

(g) As to CSRA (Civil Service Retirement Act) benefits, even though the beneficiary can choose as between CSRA and FECA, there is really no competition between the two. Each was designed for a different purpose. However, outside of performance of duty death, the sole beneficiary (widow only) waits until she is 50 years of age to benefit in a small way under CSRA. The widow with 2 children secures somewhat larger, though relatively small, benefits immediately following death, under CSRA. Here again there's no competition with FECA, hence the great importance of interpretation as to "performance of duty." The two cases used in the analysis proper are again utilized in the following summary.

1. The proceeds are taxable as income under the annuity rule.

(h) In respect to National Service Life Insurance (veteran), the 15-year installment method of paying proceeds is choosen @ $6.11 monthly per $1000 of policy face. This is $61.10 monthly.

1. These proceeds are not taxable as income.

SECRET

SUMMARY OF EXISTING AVAILABLE PROTECTIVE ASSETS IN TERMS OF THE PROCEEDS - DISPOSAL PLANS CHOSEN
(MONTHLY PAYMENTS)

ASSUMPTIONS:

1. DEATH OF A GS-11 WITH 9 YEARS SERVICE
2. BENEFICIARY - AGE 30

BENEFICIARY	ASSET	PERFORMANCE OF DUTY WITH ORDINARY LIFE		PERFORMANCE OF DUTY WITHOUT ORDINARY LIFE		LINE OF DUTY OR NOT* WITH ORD. LIFE	LINE OF DUTY OR NOT* WITHOUT ORD. LIFE	
WIFE ONLY	ORDINARY LIFE INSURANCE (FACE)	30.50				30.50		
	" " " (D.I.)	30.50				30.50		
	FECA 25X1A6a	222.75	(+ 34.00)	222.75	(+ 34.00)			
	CSRA							+ 33.42 AT AGE 50
	WAEPA (TERM)	78.36		78.36		78.36	78.36	+ 94.19 AT AGE 50
	" (ACCIDENTAL DEATH)							+127.55 AT AGE 50
	TOTAL 25X1A6a	362.11	(+ 34.00)	301.11	(+ 34.00)	139.36	78.36	
	NSLI	61.10		61.10		61.10	61.10	
	TOTAL 25X1A6a	423.21	(+ 34.00)	362.21	(+ 34.00)	200.46	139.46	+127.55 AT AGE 50
WIFE AND TWO CHILDREN	ORDINARY LIFE INSURANCE (FACE)	30.50				30.50		
	" " " (D.I.)	30.50				30.50		
	FECA 25X1A6a	328.16	(+ 71.00)	328.16	(+ 71.00)			
	CSRA					66.84	66.84	IMMEDIATELY AT DEATH
	WAEPA (TERM)	78.36		78.36		78.36	78.36	
	" (ACCIDENTAL DEATH)	125.00		125.00		125.00	125.00	TRUST FUND
	TOTAL 25X1A6a	592.52	(+ 71.00)	591.52	(+ 71.00)	331.20	270.20	
	NSLI	61.10		61.10		61.10	61.10	
	TOTAL 25X1A6a	653.62	(+ 71.00)	592.62	(+ 71.00)	392.30	331.30	

* ANY DEATH OUTSIDE OF PERFORMANCE OF DUTY

SECRET

APPENDICES

Approved For Release 2001/07/12 : CIA-RDP80-01826R000600160006-7

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APPENDIX III

WAR AGENCIES EMPLOYEES
PROTECTIVE ASSOCIATION

Room 1040-1043 Washington Bldg.
15th & New York Ave., N.W.
Washington 5, D. C.

Address Communications to Stacey K. Beebe, Manager

November 29, 1950

The Central Intelligence Agency

Gentlemen:

You have inquired about the definition of eligibility relating to the term "employee." The question is raised, we believe, because there are certain personnel connected with your agency which do not clear through the normal procedures of Government employment. I am therefore quoting an excerpt from an amendment to War Agencies Employees' Protective Association contract No. 7671, dated July 21, 1949, as follows:

"The term 'employee' as used herein shall mean an individual whose compensation or expenses are derived in whole or in part directly from the United States Government for services performed directly for the United States Government in any capacity."

We believe this definition is broad enough to cover all of the questions which you have posed to us.

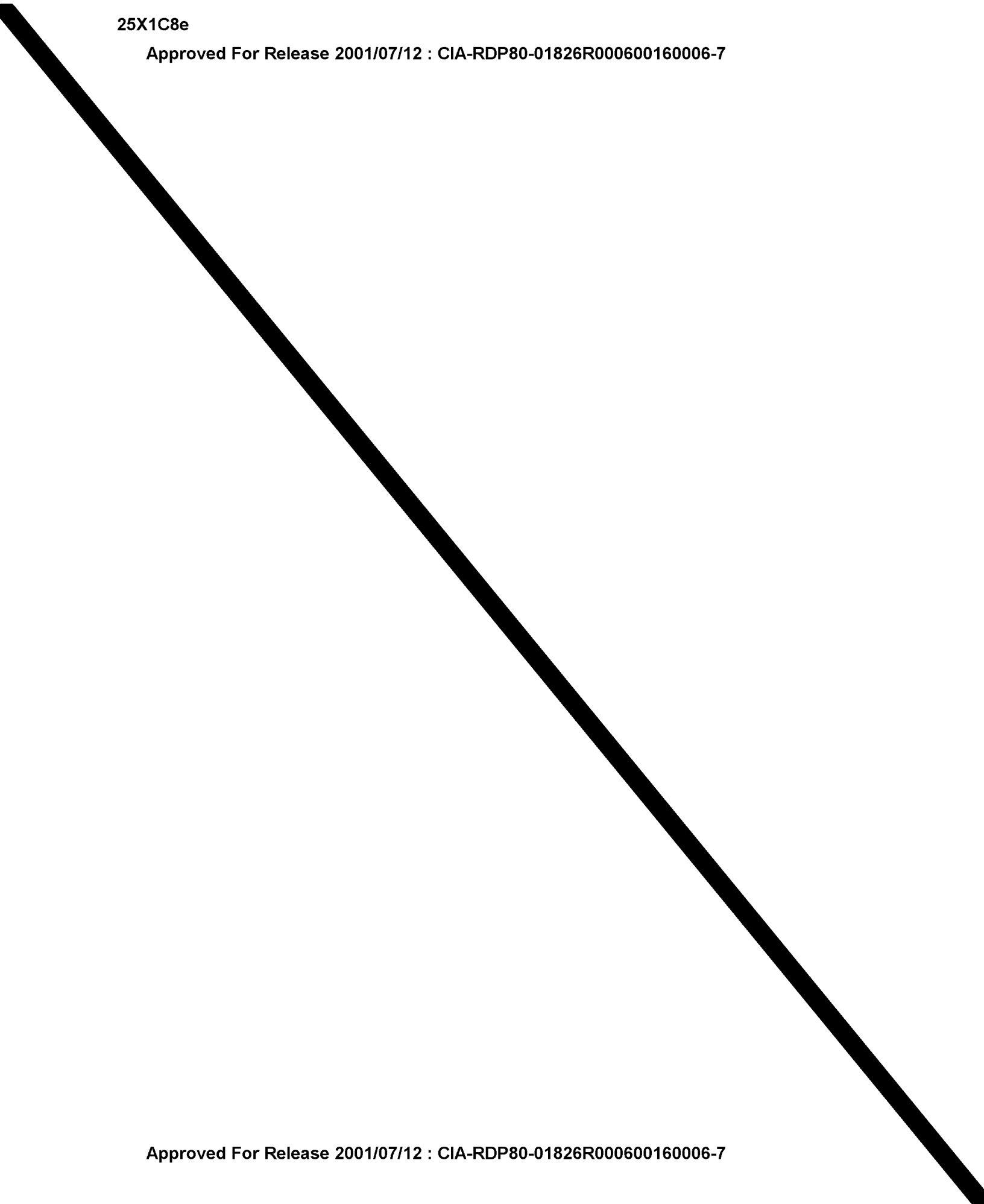
Very truly yours,

/s/

STACEY K. BEEBE
General Manager

COPY

SKB/es



APPENDIX V

EMPLOYEE GROUPS

DEFINITION: By CIA regulation [redacted] 25X1A the following four categories of employment are employees of the U. S. Government, and no employee rights as specified in legislation can be denied them.

1. Staff Employees

2. Staff Agents

3. Career Agents

4. Contract Employees

The Contract Agent is not an employee unless control of his activities is close and continous in which case he might be able to prove qualification.

In respect to Career Agents [redacted] 25X1A - deductions from salary are made for Civil Service Retirement Act and ...the Career Agent ....."will automatically come under the coverage of FECA and PL 110. Benefits of the Missing Persons Act may also be granted, and where compatible with security and operational standards, career agents may subscribe, if eligible, to hospitalization and life insurance plans which are available to Agency employees." * 1

In respect to the Contract Employee, [redacted] 25X1A - no deductions will be made from salary under the Civil Service Retirement Act...however, "such periods of service would be available as creditable service for retirement purposes upon deposit by the individual of a sum equalling the deductions based upon salary paid during that period." Also, (the Contract Employee) "will be entitled to the benefits of FECA and PL 110, and his contract shall so state. Benefits of the Missing Persons Act may also be granted and, where compatible with security and operational standards, the Contract Employee may subscribe, if eligible, to hospitalization and life insurance plans which are available to Agency employees." * 1

*1 Per COPS - DD/P January '54, all four categories eligible for life insurance; only Staff Employees and Staff Agents eligible for Agency hospitalization.

Next 3 Page(s) In Document Exempt

25X1C4e

[redacted]

c. It is most important that U. S. Contract Agents should be covered by such a policy. In their case the risks are frequently greater and insurance coverage available to them is less.

d. I mentioned to you in our conversation that it might be advantageous to provide that the decision of the Agency regarding the date of death should be final if this can be legally achieved.

/S/ [redacted] 25X1A9a

Deputy Chief, FE

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APPENDIX IX

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October 1953

Miscellaneous Expressions of Interest in Insurance from Random Selection of DD/P Officers

1. Good hospital and surgical benefits plans for overseas dependents - this inclusive of proprietary companies. [redacted] 25X1A9a

25X1A9a 2. Raise WAEPA basic limits of group insurance coverage. [redacted]

25X1A9a 3. Policy to cover transportation risks per se - all kinds. [redacted]

4. Mutual type insurance group operated by Agency similar to that of Army and Navy - would be best as far as security breaches go re Covert Personnel.

5. Investigate Blue Cross, believes offers more coverage overseas than company we now subscribe to.

6. Something to cover hazardous duty. (He never heard of FECA)

7. Protection for injury or death in line of duty which would provide living expense for family in the states.

8. Something similar to Trip Insurance obtainable at Airport - at reasonable rate; would be benefit to have included in regular processing routine, sometimes forget to pick up at Airport - method to be as simple as possible.

9. Accidental death and injury in line of duty.

10. Health, physical, mental and injury coverage overseas other than in line of duty - CIA unlike the State Department does not cover employees for illness or injury incurred other than in line of duty.

11. Travel insurance, short term.

12. Transportation insurance - employees should not have to afford this.

13. Re WAEPA - Too high for short period; too long minimum period. Follow-up on return for possible interest in keeping WAEPA. Have WAEPA also cover personnel who do not anticipate travel. WAEPA requires too many forms being filled out.

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ATTACHMENT B

PROCEDURE AND SOURCES IN OBTAINING
CIA AND OTHER DEATH AND DISABILITY FIGURES

The method of arriving at the CIA figures is noted for the record as follows:

With respect to death, a clerical task force (up to 4 people) supervised full-time by a borrowed intelligence officer from PP - (Mrs. 25X1A9a [redacted] examined every card in the Inactive Service Record Card file, to spot postings of "termination by death". The name of each person so terminated was noted on an inventory sheet (sample attached) to- 25X1A gether with other personal data shown as called for by the inventory sheet. (Data called for was specified [redacted] Cause and place of death - not showing here, was sought in the individual's personnel folder (where for the most part it didn't show either). Search then went to the offices and division. The inventory sheets were all completed.

In respect to the statistics on death, in one known case the personnel file (the card file of personnel actions) showed no card at all for the employee. (This was a 1953 death). In another instance, the card showed "resignation". This, of course, raises the question of other possible missing or mis-leading cards, most especially for the earlier years. In another case the clerical task force missed the record entirely because the notation of termination by death showed on a second attached card underneath the first, in spite of plenty of posting room remaining on the upper card. Of course the task force could have missed for other reasons too.

As to disability, the same task force and supervisor examined all records of hospitalization and surgical instances as shown in the Omaha and CHI files of the Insurance Branch of the Personnel Office. Desired information as called for on a disability inventory 25X1A sheet was posted (specifications on this sheet obtained from Mr. [redacted] - each case to a separate sheet. (Sample attached) Then these sheets were coded for IBM.

All of this disability work was under the general supervision 25X1A9a of [redacted], Chief, Research Branch, Plans, Research Development Staff, Personnel Office.

With respect to Staff Agents, the records were set up properly in February 1953. Previous to that, for a little time at least, on the occasion of death, a dummy Service Record Card was supposed to have been made and sent to the Inactive Service Record file. Of four known Staff Agent deaths, only one such card was found. Then, at another time, the Service Record Card held by the Personnel Office responsible for its original creation, was sent with the individual's personnel folder to archives, hence is buried with thousands of others,

who are inactive for any cause.

For the years desired, 1947-1953 inclusive (in respect to death), dependence had to be placed on memories. Four memories from OGC were substantiated. The Agency Security Office, Medical Office and Divisions of DD/P were circularized, and brought forward no new names.

In addition, the action file of Fiscal, to the Civil Service Commission, was checked. This process produced ten fewer names than Personnel's Inactive Service file but included two new ones.

In addition, Personnel's Inactive Service file was thoroughly checked through again. Sixty-seven records of death were turned up against the original sixty-two, but this included corrections made since the first effort. One new name was turned up. (but this process missed four names caught originally!) This re-check was supervised personally [redacted]

25X1A9a

The employees' personnel folders are in generally poor shape, filled with duplicate papers, somewhat inconsistent in arrangement of material, and incomplete as to cause and place of death. In many cases the information as to cause and place of death had to be obtained from individual memories or records within the operating branches. Such memories were accepted because in each case an informant was found who could assert with complete confidence of accuracy. With due use of cryptonyms in those few cases where necessary, there is no reason why the "termination by death" record on Form 50 can't show cause and place. (This has been informally agreed to by Personnel Relations Section).

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Sources of Figures for CIA, Dept. of Agriculture and Department of State

25X1A

CIA - Average Monthly strength for the year. This method was specified by [redacted] 30 December 1953. The figures came from Research Branch, Plans, Research and Development Staff, Personnel Office.

In respect to the CIA strength reports, one can take the years 1951, 1952 and 1953 as solid and correct. For the earlier years shown, there is unquestionably some--probably small--variation as to what is included and what not and when. All figures come from official reports.

State - These figures are from Howard Macc, Chief of the Placement and Career Development Branch, Personnel Operations Division, Office of Personnel, Department of State.

The population or strength figures for the Foreign Service are averaged for the year from monthly figures except for 1949 - which year is a "budget average." The Departmental yearly averages are also "budget averages" except 1953 which is averaged from monthly postings.

Agriculture - These figures are from Mr. J. M. Kemper, Secretary-Treasurer of the Department of Agriculture Beneficial Association. The "strength" is total membership as of 15 September of each year. ("Deaths" include 10-12 cases of permanent and total disability which Kemper estimates is correct for the total in these 5 years and also include membership and deaths of retirees who kept their policies.) T. Roy Reid, Personnel Director of the Department, estimates that Agriculture has about 56,000 employees - thus making Kemper's membership 29% of the total eligible group. This fact, plus inclusion of retirees, plus the unchanging yearly level of memberships, leads to the suspicion that the age level of this membership is high. (Kemper was uncooperative when asked if he could supply age data.)

Re : Deaths (Staff Employees)

Name _____ Sex _____

Date of Employment _____

Last Office _____ Title _____

Last Assignment (nature)

When so assigned _____ How many others so assigned _____

Date of birth _____

Date of death _____

Place of death (country) _____

Cause of death _____

Approved For Release 2001/07/12 : CIA-RDP80-01826R000600160006-7

POLICY NO.

CLAIM NO.

VOUCHER NO.

Re: Hospitalization & Surgical (Staff Employees & S.A.'s)

Name _____ Sex _____

Assignment (Office)

Date of Birth _____

Nature of Illness _____

_____

Place of Illness (Country) _____

Period of Illness _____

Benefits Paid By	New	Actual Cost
Hospital		H.
Surgical		S.
Extras		E.

Appendix XI

14 January 1954

MEMORANDUM FOR: Members of the Insurance Task Force

SUBJECT : Exploratory discussion with representatives from OMAHA on 14 January 1954 by [redacted] 25X1A9a

1. In regard to OMAHA's matching GHI surgical benefits, the actuary stated that their premium rates would change as follows:

	From	To	Additional
Single Contract	$1.60	$1.76	$.16
Individual and Spouse	4.75	5.64	.89
Family	6.00	6.80	.80

2. Please note that the increase in the family rate is less than that for an individual and spouse. This is due to the fact that previous rates were incorrect, and the actuary wiped out the inconsistency in proposing us the new rates.

3. In regard to OMAHA's complete matching of GHI, they need certain dependency figures for overseas, now in process of preparation by Research Branch, PRDS. This information will be given in percentages only (approved by the Director of Security personally.)

[redacted] 25X1A9a

Dr. George Baehr, Medical Director of the Health Insurance Plan of Greater New York, Testifies Before the House Interstate and Foreign Commerce Committee

EXTENSION OF REMARKS
OF

HON. CHARLES A. WOLVERTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, January 14, 1954

Mr. WOLVERTON. Mr. Speaker, the testimony of Dr. George Baehr before the Committee on Interstate and Foreign Commerce at its hearing to develop a health program is very important. Dr. Baehr was chief of medical service and director of clinical research at Mt. Sinai Hospital in New York City. He was chairman of the technical advisory committee, Department of Health, New York City, 1933–41, and consultant, Department of Hospitals, New York City, 1933–45. He has been a member of the public health council of the State of New York since 1935 and is past president of the New York Academy of Medicine.

Dr. Baehr made the following statement on prepaid medical care plans and the health-insurance plan of Greater New York:

TESTIMONY PRESENTED BEFORE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON JANUARY 14, 1954, BY GEORGE BAEHER, M. D., PRESIDENT AND MEDICAL DIRECTOR, HEALTH INSURANCE PLAN OF GREATER NEW YORK

In all considerations of health insurance, the basic and interrelated issues are (1) the method of providing medical services to the insured, (2) the scope and quality of the services, and (3) the method of payment to physicians.

LIMITED COVERAGE BY MEDICAL EXPENSE INDEMNITY INSURANCE

Medical expense indemnity plans pay individual physicians on a fee-for-service basis. For this reason, they must limit the scope of their benefit coverage for the most part to diseases requiring admission to a hospital, the frequency of which is predictable within reasonable limits. Benefits outside of a hospital are generally excluded because the number of professional and laboratory services which physicians may choose to render outside of a hospital is unpredictable when physicians are paid a fee for each service by a third party. Even when some medical benefits outside of a hospital are included under medical expense indemnity contracts, they are sharply limited in amount and leave the insured families widely exposed to additional medical bills. Comprehensive benefit coverage is impossible under these indemnity, fee-for-service plans because it inevitably results in a rapid increase in medical bills and the progressive pyramiding of costs to the insurance company.

The inadequacy of in-hospital medical coverage as a means of protecting the family budget is revealed by the experience of such comprehensive programs of medical care as the health-insurance plan of Greater New York, which find that only 10.7 percent of all professional services are rendered to such insured persons in hospitals and 89 percent in their homes and doctor's offices. With fees for home and office visits and for X-rays, technical laboratory work, and other diagnostic and therapeutic procedures now rising to the point that care even for ambulatory patients may cost a week's wages, there is a growing need for prepayment insurance for ambulatory as well as hospital care. Extra-hospital medical care is continually being needed by all families; hospital care is often not required for 20 or 30 years.

COMPREHENSIVE MEDICAL CARE THROUGH PREPAID GROUP PRACTICE

During the past 25 years, local plans for providing comprehensive medical care on a prepaid basis have been established in various parts of the country under the sponsorship of medical groups, industrial organizations, labor unions, farm cooperatives, and other local agencies. These independent plans are able to provide medical care of comprehensive scope in return for the collective per capita premium income only because the services are rendered to the insured by physicians engaged in organized group practice, who together comprise all the required professional, laboratory, X-ray, and other specialty branches of medicine and surgery. Under this system of completely prepaid group practice, financial barriers to prompt utilization of the needed medical, laboratory, and X-ray services can be eliminated and the insured families are able to enjoy all the major benefits of modern medicine, including prevention and early disease detection. In our aging population, disease prevention and early disease detection as well as medical care during chronic illness must be included in a medical-insurance program if it is to meet the needs of the public.

In this age of highly specialized professional skills and medical technology, the total medical needs of an insured population can best be met by such balanced teams of physicians, specialists, and technicians trained in the the great variety of skills and technics which today constitute modern medicine. The comprehensive-prepayment plans combine these medical skills and technics in the form of group practice and place them freely at the disposal of people of moderate means in return for the per capita income derived from insurance premiums. Each insured family has a family doctor who has been selected by the subscriber from the family physicians on the staff of a medical group. The clinical laboratory, X-ray diagnosis and therapy services, pathology, physical therapy, and visiting nurse services of the group are freely at the disposal of the family physicians as are all the consulting services of the group's specialists in the various branches of medicine and surgery without financial deterrents to their full use.

An argument commonly advanced by opponents of prepaid group practice is that it does not give subscribers free choice of any licensed physician in the community. From the standpoint of a subscriber, this has absolutely no validity, for he exercises his choice when he decides to join the plan as a member of his enrolled group of insurees and he is at liberty to drop out of the plan at any time. He is also at liberty to consult any other physician at any time that he wishes. It is certainly desirable that families of low and moderate income be given the opportunity to enjoy the benefits of comprehensive-medical care through prepaid group practice if they prefer it to so-called free choice of individual physicians and specialists whose services they cannot afford on a fee-for-service basis.

Families that receive all their medical services from a prepaid medical group can completely budget the costs of their total medical care throughout the year. If satisfied with the full scope and quality of the care provided for them by the medical group, the insured population has no need to purchase medical care from any other physician. Therein lies the cause of complaint and resistance by the opponents of prepaid group practice in every part of the country in which it has been established.

Local medical societies consist largely of [illegible] resent the economic and professional competition of

group practice and will tolerate only a fee-for-service method of solo medical practice in insurance plans. Medical societies are therefore prevented by their membership from taking any part in modernizing the organization of medical care into group practice even though it is required by the high degree of specialization characteristic of the times in which we live. Because of local resistance to progress, programs of comprehensive medical care through prepaid medical group practice have grown very slowly and have as yet reached only 4 million people.

At the national level, the American Medical Association has accepted the principle that independent groups of physicians and community leaders should be permitted to experiment with newer patterns of prepaid medical care and group practice. State and county medical societies cannot or will not initiate or operate such experiments because of their political composition. A widespread spirit of intolerance to change pervades the thinking and actions of their leaders and in some States laws have been enacted at the instigation of medical societies which actually prohibit prepaid group practice. Some local physicians are even now seeking to alter or reinterpret the Code of Professional Ethics for the purpose of obstructing the development of the only form of voluntary health insurance which has thus far been able to provide comprehensive medical care at a cost which people of low and moderate income can afford on a prepaid basis.

On July 16, 1946, an editorial in the Journal of the American Medical Association warned that such obstructive behavior by physicians may itself be unethical.[1] In spite of these pronouncements, the conflict at the local level remains unchanged and now calls for more positive action by national authorities within the profession itself or else intervention by Government in the public interest.

ORIGIN OF HIP

In 1947, after a 4-year study of the problems of medical care, the New York Academy of Medicine concluded that prepaid group practice is the logical and evolutionary development of medicine in the changing order. In 1942 and 1944, the mayor of the city of New York, the Honorable Fiorello H. LaGuardia, announced that the city would pay half the premiums of nonprofit group health insurance for municipal employees and their families if insurance coverage could be made truly comprehensive and employees and their families would be protected against additional medical bills. In order to make it possible for the city to pay half the premium cost, permissive legislation was enacted by the State legislature in 1946. Following a prolonged study of nonprofit medical insurance plans in various parts of the country, the founders of the health-insurance plan of Greater New York were convinced that medical society sponsored plans, because of the current political structure of the societies, could not change the current pattern of medical practice so as to provide the public with an opportunity to purchase comprehensive medical care. HIP was therefore established on March 1, 1947, as an independent nonprofit medical insurance plan under a board of directors composed of representative community leaders from labor, business and industry, Government, and the medical profession. It was designed to serve wage earners employed in private business and industry as well as governmental employees. The board of directors operates the plan as a community trusteeship. As in the case of voluntary hospitals, the entire responsibility for medical matters and the determination of all professional standards are delegated to a medical board and the medical aspects of the program are supervised by a medical director and his staff.

Working capital was required during its formative period and the first year of operation. As this was the first experimental demonstration of comprehensive medical care under community-wide sponsorship, several philanthropic foundations supplied loans, which are being rapidly repaid out of premium income. From our experience it is evident that similar projects cannot be established without financial aid in the form of grants or loans either from industry, labor groups, consumer, or farm cooperatives, or, if it is to be under community sponsorship, from government. The role of government in the promotion of plans for comprerensive medical care through prepaid group practice was suggested in the 1947 Report on Medicine in the Changing Order of the New York Academy of Medicine.[2] Once established, such plans can become self-supporting, paying adequate remuneration to their physicians and repaying the initial loans.

After 7 years of operation, the health-insurance plan of Greater New York is providing comprehensive medical care to almost 400,000 insured persons. As a nonprofit agency established under the State's insurance law, it is operated in the black and has accumulated ample financial reserves as required by the State's superintendent of insurance. The services are provided by 30 medical groups, 29 of which are located in various sections of the city and 1 in an adjacent county. The medical groups are autonomous and are independent contractors. Each group includes an adequate number of family physicians proportionate to its enrollment size and a complete roster of qualified specialists representing the 12 basic specialties of medicine and surgery. They comprise altogether about 1,000 physicans, of whom about 450 are family doctors and about 550 are qualified specialists. The required professional qualifications for membership in a group are determined by an impartial medical control board of 15 representative physicians. The quality of medical care is supervised by the medical department of HIP.

Under a family-type contract, the cost for an individual subscriber without dependents is $42.72 a year, for a couple $85.44 a year, and for a family of any size $128.16 a year.[3] A family with 12 children pays no more than a family with 1 child. Allowing for large families, the average cost per individual is $36.36 a year. Employers are required to pay at least half the premium so that the weekly contribution of a single employee is $0.41, of a couple $0.82, and of a family of 3 or more, $1.23.

For providing all the care which may be needed by the insured families, HIP pays each medical group a capitation of $29.40 per annum for all persons on its rolls. After deduction of the cost of operating its medical group center and of retirement benefits, the remainder of the capitation income is available to a group for the payment of salaries of its participating physicians, most of whom are partners in the group. When a group reaches an average enrollment (14,000), the remuneration of its physicians is at least as high as the average reported incomes of other physicians and specialists in the community and the physicians enjoy added benefits of security not possible for the solo practitioner.

There are no deterring extra charges for any medical services which the insured may require in their homes,[4] in physicians' offices, medical group centers, or in hospitals. Every kind of medical and surgical service is available to them, including X-ray diagnosis and therapy, radium and radio-isotope therapy, diagnostic laboratory services, physical therapy, visiting nurse services, and even ambulance transportation without extra charge.

The plan erects no barriers by reason of age, sex, or preexisting illness, injury, physical defect, or pregnancy, either to admission to its rolls or to utilization of services thereafter. There are no waiting periods for medical care for preexisting illness or pregnancy. Reliance is placed solely upon group enrollment to protect the plan against the adverse experience to which unguarded individual enrollment would expose it.

Since the first day of operation of the plan, a division of research and statistics in HIP has recorded every medical service to every enrollee. By means of modern statistical machinery, these data can be thoroughly recorded, analyzed, and evaluated. The utilization rates of medical, surgical, and laboratory services by all age groups and especially the plan's experience with old people and with maternal and infant care will provide valuable data for future programs of medical care. An intensive study of the experience of the plan during its first 5 years is now being made by a special committee of impartial experts under the chairmanship of Dr. Lowell Reed, president of Johns Hopkins University, which is being financed jointly by the commonwealth fund and the Rockefeller Foundation. In addition to a longitudinal study of the plan's experience with its insured population, the special research project conducted by Dr. Reed's committee has included an investigation of the sickness and medical-care experience of large and representative samples of households in New York City and in the HIP population, totaling more than 25,000 persons. The publications emanating from the research division are available to you as well as all of the plan's recorded experience.

HIP also maintains a division of preventive medicine and health education as one of its important activities. It is the responsibility of the expert staff of this division to promote adequate utilization of medical services by the insured population, especially preventive services and those concerned with early disease detection. The objective is to have every family select a family doctor and use him and the specialists and laboratories of their medical group for the prevention and the early detection and treatment of illness. The effect of this wide exposure of the insured population to medical care can be measured by the fact that at least 74 percent of the enrolled members of the insured families are now using their physicians' services within a year and this rate is rising as our health education program takes hold. The average rate of utilization of physicians' services by the entire insured population is 5.3 services per year per person. The lack of financial barriers to complete medical care has not led to any significant amount of needless use of the services by the insured. Subscriber abuse is minimal and easily corrected.

The experience of HIP and of many similar plans throughout the country is now sufficiently voluminous to demonstrate that comprehensive medical care through prepaid group practice is professionally feasible and financially practical from the standpoint of both the doctors and the public. There can also be no question of the importance of prepaid comprehensive medical care to public health.

To facilitate its growth, two things are necessary: (1) Elimination of interference by local professional societies with prepaid group practice; (2) financial assistance by Government through loans to encourage the wider extension of prepaid comprehensive medical care throughout the country under local community sponsorship.

Government at all levels may also help through the purchase of prepaid medical care for its own employees and wards. It should follow the accepted practice of purchasing medical care under group contract from the prepayment organization which

Footnotes at end of speech.

Footnotes at end of speech.

produces the best values for the price charged.

ROLE OF FEDERAL GOVERNMENT

The role which the Federal Government should take in promoting and extending adequate medical care to the insurable population of the country might well follow that which it has already taken to promote and extend adequate hospital care under the Hill-Burton Hospital Survey and Construction Act. Federal assistance to the States might first be limited to grants-in-aid to encourage the States to survey existing deficiencies in medical care within the State and to determine:

1. The extent to which the insurable population is not covered by prepayment for medical and for hospital care.

2. The gaps in benefit provisions under existing prepayment programs.

3. The means whereby the gaps in population coverage and the gaps in benefit provisions under existing programs may be eliminated.

4. The availability of voluntary insurance plans which provide comprehensive benefits for medical care in the homes, in doctors' offices, in diagnostic laboratories and X-ray services, as well as in hospitals.

5. The desire of the public for prepayment plans which will provide comprehensive medical services.

6. The existence of State laws which prohibit or make it impossible for physicians to provide such comprehensive medical care through prepaid group practice of medicine.

The State surveys should also include:

1. A determination of the nonwage and low-income group in the population which cannot afford to prepay their medical care through the purchase of voluntary health insurance.

2. The possibilities of experimentation by State and local governments with coverage of some or all of this group by voluntary medical-insurance plans.

3. The degree to which Federal assistance might be required to enable State and local governments to provide medical and hospital care to persons in the nonwage and low-income groups (the medically indigent) through prepayment.

4. The possibilities of experimentation by State unemployment funds or other State agencies with the provision of medical care for temporarily unemployed persons and their dependents through continuing the prepayment of premiums for the unemployed for care which may be needed during periods of temporary unemployment.

Small Federal grants could be employed most effectively to assist States in carrying out experimental programs designed to extend prepayment plans and comprehensive coverage under these plans to the part of the population within the State which is at present not covered or inadequately covered under such plans. In recognition of the fact that comprehensive medical service coverage under any voluntary prepayment plan requires economies and increased efficiency in operation which can be achieved only by organization of medical services as group practice, Federal aid to State and local communities is needed to encourage the establishment of prepaid group practice of medicine under local community sponsorship.

The organization of medical practice along such modern and more efficient lines requires loans to medical groups for the construction of the required physical facilities, to be repaid by them out of future earnings. Such loans for the purpose of encouraging local prepayment programs for comprehensive medical care should be limited to the acquisition of medical group centers, the purchase of X-ray, laboratory, and other professional equipment required for group practice, and the administrative expenses of the medical group center during the first year of its operation. The annual appropriations for this purpose need not be large nor would they be needed for more than 5 or 10 years, for as the loans are repaid they may be used as a revolving fund.

It can be predicted that rapid progress in the extension of prepaid comprehensive medical care will not be made until (1) such loans are made available, (2) hampering State laws are repealed wherever they exist, and (3) effective steps are taken by higher professional authorities to eliminate interference by members of the local medical profession in restraint of change from the present costly and disorganized methods of medical practice to a more modern and more economical pattern.

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[1] "Instances have occurred in which physicians, for political, commercial, or emotional reasons, have endeavored to utilize the principles of medical ethics as a means of producing embarrassment, distress, or loss of reputation of other physicians whom they envy or whose open competition they fear. The principles of medical ethics were not designed for any such purpose, and the attempt to utilize the principles of ethics for such purposes may well be in itself unethical." Editorial, JAMA July 16, 1949 (vol. 140, No. 11), p. 960.

[2] "The committee recommends that comprehensive medical services be extended by the use of voluntary, nonprofit insurance, using group practice units wherever feasible, and Government subsidy wherever necessary." Medicine in the Changing Order, Commonwealth Fund, 1947, p. 56.

[3] Subscribers to the health insurance plan must also have Blue Cross or other hospital insurance.

[4] Except a permissible $2 charge for night calls requested and made between 10 p. m. and 7 a. m.

COPY

APPENDIX XIII

Excerpt from Today's Woman, 1953 (Fawcett Publications, Inc.)
Written by Jack Harrison Pollack

"Perhaps the most satisfactory health insurance today is found in the seventy odd comprehensive non-profit plans throughout the United States. Usually sponsored by co-operatives and built around the group-medical-practice idea which made the Mayo Clinic famous, they furnish in a single package virtually all of the medical and surgical care you and your family may require. When held along with Blue Cross they offer nearly complete health coverage.

'From the patient's point of view they're better because they emphasize preventive medicine,' a top doctor told me.

Typical of these plans are San Francisco's Permanente Health Plan; the Seattle and St. Louis Group Health Associations; the Elk City, Oklahoma, Farmers' Co-operative Plan; New York City's bustling Health Insurance Plan (HIP).

HIP is America's outstanding comprehensive prepaid medical plan. Terming it "the finest experiment of its kind," The New York Times editorialized: "For actuarial and medical soundness, HIP has no superior. It is unique, a model for the country." In 1951 HIP received the Lasker Award for distinguished public-health service.

Designed mainly for families with incomes under $6,500, HIP members never see a doctor's bill nor are they saddled with extra charges. There are no age limits or waiting periods and you can be treated for anything from a common cold to the most complicated surgery. HIP's 400,000 members include employees of the City of New York, the United Nations and over 300 business firms, unions and social agencies - and their families. Their employers pay half the cost, employees pay the rest. The total cost ranges from $42.72 a year for one person to $128.15 a year for three or more persons."

REGULATION [redacted] 25X1A

25X1A [redacted]

PERSONNEL
27 May 1954

THE CIA CAREER COUNCIL AND THE CAREER SERVICES

Rescissions: CIA Regul[redacted], 25 May 1953
25X1A Notice No[redacted]20 May 1953

CONTENTS

1. GENERAL

This Regulation establishes the overall policy and the organizational structure and responsibilities for administering the career program within the Central Intelligence Agency.

2. POLICY

The basic personnel management policy of the Central Intelligence Agency contemplates a progressive program that identifies, develops, effectively uses and rewards individuals who have qualifications required by the Agency; motivates them toward rendering maximum service to the Agency; and eliminates from the service, in an equitable manner, those who fail to perform as effective members of the Agency. This policy will be implemented through the career program which is applicable to all U. S. citizens who are Staff Employees or Staff Agents of the Agency, whether on duty in headquarters or in the field.

3. PURPOSE

The purpose of the career program is to establish personnel management practices which will develop people to the fullest extent to meet present

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Career Service	Career Service Head	Service Designation
Training	Director of Training	SD-TR
Communications	Assistant Director for Communications	SD-CO
Personnel	Assistant Director for Personnel	SD-PE
Office, Deputy Director (Plans)	Deputy Director (Plans)	SD-P
DD/P Clerical	Chief of Administration, DD/P	SD-PS
Foreign Intelligence	Chief, Foreign Intelligence Staff	SD-FI
Political and Psychological Warfare	Chief, Political and Psychological Warfare Staff	SD-PP
Paramilitary Operations	Chief, Paramilitary Operations Staff	SD-PM
Technical Services	Chief, Technical Services Staff	SD-TS
Office, Deputy Director (Intelligence)	Deputy Director (Intelligence)	SD-I
National Estimates	Assistant Director for National Estimates	SD-NE
Collection and Dissemination	Assistant Director for Collection and Dissemination	SD-CD
Research and Reports	Assistant Director for Research and Reports	SD-RR
Current Intelligence	Assistant Director for Current Intelligence	SD-CI
Scientific Intelligence	Assistant Director for Scientific Intelligence	SD-SI
Operations	Assistant Director for Operations	SD-OO
Office, Deputy Director (Administration)	Deputy Director (Administration)	SD-A
Budget and Finance	Comptroller	SD-BF
Logistics	Chief, Logistics Office	SD-LO
Medical	Chief, Medical Staff	SD-ME
Security	Director of Security	SD-SE

ATTACHMENT A

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During discussion of responsibilities of the Assistant Director for Personnel in connection with proposed changes in the administration of the Career Service Program, the Deputy Director and the Inspector General approved the following change in the statement of the responsibilities of the Assistant Director for Personnel as stated in paragraph 2f(7) of Regulation [redacted]

25X1A

From

"(7) Staff assistance to Agency officials in the administration of the Agency Career Service Program, including secretariat and other administrative services for the CIA Career Service Board."

To

"(7) Administering and monitoring the Agency Career Service Program. Developing and recommending the establishment of policies and procedures for the management of Career Boards and, through review of their activities, periodically advising the Director as to the effectiveness and accomplishments of the program."

ATTACHMENT B

~~SECRET~~

CONFIDENTIAL

and anticipated personnel needs of the Agency and to encourage their long-term service with the Agency.

4. ADMINISTRATION

a. THE ASSISTANT DIRECTOR FOR PERSONNEL

The Assistant Director for Personnel will direct the activities of such Boards and Panels as are established at the Agency level to implement the career program and will advise and assist the Heads of Career Services in carrying out all aspects of their responsibilities for personnel career management.

b. THE CIA CAREER COUNCIL

(1) Organization

Assistant Director for Personnel	- Chairman
Inspector General	- Member
Deputy Director (Administration)	- Member
Deputy Director (Intelligence)	- Member
Deputy Director (Plans)	- Member
Director of Training	- Member
Assistant Director for Communications	- Member

(2) Responsibilities and Functions

(a) General Responsibilities and Functions

The CIA Career Council will function as an advisory group to the Assistant Director for Personnel. The Chairman will seek the opinions of the Council on the feasibility and advisability of major or significant changes in, or additions to, Agency personnel policy. Members of the Council will bring to it proposals for the revision of

[redacted]

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25X1A [redacted]

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Agency personnel policy or problems which might affect basic personnel policy. The Assistant Director for Personnel will give careful consideration to such opinions in recommending changes or additions for the approval of the Director and in the implementation of approved personnel policy throughout the Agency.

(b) Specific Responsibilities and Functions

The Council will be responsible for the following tasks:

(1) Recommending to the Assistant Director for Personnel the establishment of such Agency Boards and Panels as are necessary to implement the personnel program.

(2) Furnish information and advice so that the Assistant Director for Personnel may prepare and submit periodically to the Director a summary of the operation of the Agency's personnel program.

(c) Meetings

The Council will meet at the call of the Chairman, either on his initiative or upon the request of any member. If a member cannot be present, he may be represented by his Deputy. Agenda of scheduled meetings will be distributed in advance and stenographic record of meetings will be prepared at the discretion of the Council.

SECRET

c. CAREER SERVICES

Career Services are established within CIA as listed in Attachment A, under the direction of the officials indicated. An appropriate Service Designation, as shown, will be used to identify each Staff Employee and Staff Agent with the Career Service to which he is assigned.

(1) Responsibilities of Heads of Career Services

The Heads of Career Services, as shown above, are responsible for monitoring the application and functioning of the Agency personnel program as it applies to the members of their Career Service, including:

(a) Improving and strengthening personnel administration within that Career Service;

(b) Planning the utilization and development of such individuals, including their training, assignment, rotation and advancement;

(c) Reviewing fitness reports of such individuals;

(d) Planning the rotation and reassignment of such individuals so as to enable that Career Service to meet long-range personnel requirements through orderly processes;

(e) Reviewing requests for personnel actions to reassign, promote, demote or separate such individuals and recommending appropriate action to the Assistant Director for Personnel;

(f) Reviewing proposals for the training of such individuals and recommending their participation in Agency-sponsored training.

(2) Career Boards

The Head of each Career Service will establish a Career Board to advise him on personnel management matters and, as he directs, to monitor the application and functioning of the personnel program as it affects the members of that Career Service.

(a) Organization

Each Career Board will be composed of the following officials:

(1) The Head of the Career Service ex-officio;

(2) Three or more Staff or Division Chiefs or officials of comparable responsibility;

(3) A Senior Personnel or Administrative Officer who will be responsible for providing technical advice and assistance to the Board.

d. ASSIGNMENT OF SERVICE DESIGNATIONS

The Assistant Director for Personnel will assign a basic Service Designation to each Staff Employee and Staff Agent in the Agency which will identify him with an appropriate Career Service. In so doing,

the Assistant Director for Personnel will give full consideration to the Head of the Career Service involved, the individual's desires, and to his qualifications for assignment to a particular Career Service. An individual may later hold other or additional appropriate Service Designations.

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TRAINING FOR REASSIGNMENT

1. POLICY

It shall be the policy of the Agency to afford reasonable training to any individual whose services have been satisfactory and whose reassignment within the same or to another Agency component is desirable. Specific training shall be provided when there is reasonable expectancy that such training will qualify the individual for another assignment in an allied or different line of work.

2. RESPONSIBILITIES

a. ASSISTANT DIRECTOR FOR PERSONNEL

The Assistant Director for Personnel will identify placement possibilities and desirabilities for individuals and will cause the individual to be immediately reassigned to the table of organization of the gaining component. The Assistant Director for Personnel will participate with the head of the career service and the Director of Training in establishing a training program which will be consistent with the education, experience, and estimated work potential of each individual concerned.

b. HEADS OF CAREER SERVICES

If the individual fails to perform acceptably in his new assignment, the head of that career service will take action in accordance with existing regulations either to effect a new assignment or to terminate the services of the employee.

c. DIRECTOR OF TRAINING

(1) The Director of Training will provide such formal training as is

determined to be necessary, and is determined to be feasible through training processes, in order to prepare the individual for the new assignment.

(2) At the completion of such training the Director of Training will submit an appropriate evaluation.