UTILIZATION OF MENTAL HEALTH BENEFITS UNDER THE FEDERAL EMPLOYEES' PROGRAM

HEARINGS

BEFORE THE

COMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS

OF THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

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CONTENTS

UTILIZATION OF MENTAL HEALTH BENEFITS UNDER THE FEDERAL EMPLOYEES' PROGRAM

MONDAY, SEPTEMBER 16, 1974

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

The subcommittee met at 11:20 a.m., in room 340, Cannon House Office Building, Hon. Jerome R. Waldie (chairman of the subcommittee) presiding.

Mr. WALDIE. The subcommittee will come to order.

This subcommittee has been concerned over the past several years with both the benefit structure and cost of the Federal employees health benefit program.

In recent months there has been widespread speculation that there would be substantial reductions in the scope of mental health benefits for the Blue Cross-Blue Shield program. The Blues indicated that a combination of skyrocketing costs and lack of utilization control by mental health providers was going to force such reductions.

For their part, the mental health practitioners have denied any such claims.

Although Blue Cross-Blue Shield has evidently put aside its call for reductions for 1975, the problem certainly remains, and could well become an issue again next year.

Today we have representatives of Blue Cross-Blue Shield, Aetna, and the Civil Service Commission prepared to testify on this subject of great concern to the more than 8 million Federal employees and their dependents who are insured under this program.

The first witness we have is Mr. Robert Laur, vice president, Blue Cross-Blue Shield. Mr. Laur, will you come forward, please. Do you have a statement you would like included in the record?

STATEMENT OF ROBERT LAUR, VICE PRESIDENT, BLUE CROSS-BLUE SHIELD

Mr. LAUR. I have a statement, Mr. Chairman.

Mr. WALDIE. Fine. We will include it in its entirety in the record, Mr. Laur, and you may proceed as you desire.

[Complete statement follows:]

A STATEMENT BY THE BLUE CROSS ASSOCIATION AND NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. Chairman, I am Robert J. Laur, Vice President of the Blue Cross Association and the National Association of Blue Shield Plans. In that capacity I serve as the Director of the Federal Employee Program jointly administered by the two Associations.

I am grateful for the opportunity to appear before the Subcommittee today, since the question of how to provide financial coverage to Federal employees

for mental health services—as well as other types of health care—is a very important one. The Federal Government and its employees are certainly to be congratulated for the support that has been given to the inclusion of mental health benefits in the Federal Employee Health Benefits Program.

Since the inception of the Federal Employee Program in 1960, through 1973, Blue Cross and Blue Shield have paid a total of $337 million in claims for mental health services to Federal employees. We are certain that this financial coverage has helped to assure that employees needing help receive it promptly, and as an ordinary or normal part of medical care. Thus the stigma and fear of mental illness that was so prevalent in former years has been diminished.

We are all aware that mental illness can strike any Federal employee—it can occur to any of us, regardless of our income, the type of work we do, or any other demographic characteristic by which people can be classified. We are also aware of the advances that have been and are being made in medical science and practice concerning the diagnosis and treatment of mental illness. Surely it is the proper function of third-party payment plans to devise pre-payment approaches that will continue to assure that Federal employees have financial access to needed mental health benefits.

In doing so, however, several requirements must be faced. These are the same requirements that affect coverage for all other forms of health services as well, namely:

1. The coverage must be available at subscription rates which subscribers are able and willing to pay.

2. The services to be covered must be capable of definition, so that subscribers, providers and carriers will have a reasonable understanding of what will be paid for.

3. Providers of services must be able to provide documentation of what services were received by a patient, the amount of such services and, in certain circumstances at least, the appropriateness of the service to the patient's illness. Furthermore, this must be accomplished in a manner which preserves the confidentiality of the physician-patient relationship.

4. So far as possible, health benefits should provide financial incentives which contribute to:

   a. Development and use of the most effective medical techniques and patterns of service delivery;

   b. Maximum awareness by providers and consumers alike that health care resources are limited and must be used efficiently.

What, then, has been the experience of Blue Cross and Blue Shield in providing mental health coverage for Federal employees in light of these requirements?

First, we believe it has been demonstrated that mental health benefits *can* be covered by pre-payment and that employees and the Government have been willing to pay for this coverage. As I will point out later, we do see signs that greater efforts at utilization and cost control need to be made, but at this time we believe mental health benefits are still an affordable part of a total pre-payment plan.

Secondly, more work is needed to permit clearer definitions of mental health services and their appropriateness for a given illness. To a considerable degree, these problems are inherent in the still-developing nature of mental health disciplines. Much is yet to be learned in these sciences, and once learned, must then be translated into professionally responsible patterns of practice.

Thirdly, in light of the foregoing, it is obvious that, at the present time, it is very difficult to assess the effect which methods of insurance coverage and reimbursement have on the promotion of efficiency and effectiveness of care.

We have some expert advice which causes us to believe that more encouragement should be given to partial hospitalization, day and night care centers, community mental health centers, clinics, and other patterns of ambulatory services.

We also sense a need for improved patient and public education about mental health services, their timely and appropriate use, and the need to avoid over-use of costly—and often very scarce—resources.

Mr. Chairman, I would like to now briefly discuss some of the statistical data which the Subcommittee has requested. I would like to summarize the data we have and submit, as an addendum to my testimony today, our detailed response.

USE OF MENTAL HEALTH BENEFITS

For several years now, about one percent of the Federal employees and their families enrolled with Blue Cross and Blue Shield received at least one covered

mental health benefit each year. We do not collect information about the educational backgrounds or income levels of this group, so we are unable to comply with the Subcommittee's request on those two items. Regarding the age and sex composition of the subscribers who receive mental health benefits, 58 percent of the benefits are for female subscribers; 42 percent of the benefits are for male subscribers; 50 percent of the benefits are for subscribers below age 35, with 32 percent of the benefits concentrated in the age 19 through 34 category; and 50 percent of the benefits are paid for subscribers age 35 and over.

For hospitalization claims paid under Basic Blue Cross and Blue Shield coverage, the average length of hospital stay for all types of conditions (excluding obstetrics) was 7.8 days in 1973. For covered mental health benefits, the average length of hospital stay was 17.8 days. Regarding the total time span for treatment of mental illness, we recently furnished a large volume of raw data to the Civil Service Commission and we are hopeful that the answers to questions such as this will be found in the analysis of that data.

Concerning the use of inpatient versus outpatient services, our data show that for Basic (paid-in-full) hospital and doctor coverage, almost 100 percent of the claims paid are for inpatient services.

For services covered by the major medical or Supplemental portion of the Blue Cross and Blue Shield plan, we are unable to differentiate between inpatient and outpatient services from our statistics. Of all mental benefits paid in 1973, 57 percent were paid under Basic coverage, 43 percent under Supplemental. We are able to report, again for 1973, that of mental benefits paid under Supplemental, 65 percent were paid for physicians' services, 19 percent for hospital services, and 16 percent for other services (such as non-physician services and drugs).

THE COST OF MENTAL HEALTH BENEFITS

In 1967, the benefits for mental health services were broadened considerably by Blue Cross and Blue Shield, so that they were essentially equal to benefits for physical illness. As we have shown, a constant proportion of one percent of subscribers use these benefits. If we look at cost trends since 1967 (so we are comparing the same benefit package), we see that mental benefits are absorbing an increasing share of total benefit dollars. In 1967, 5.4 percent of total benefits were for mental health services; by 1973 the mental benefits had increased to 7.3 percent, and we estimate that for 1974 they will reach 7.5 to 8.0 percent of total benefits. On an annual basis over the past six years, mental benefit costs have increased at an average rate of 22.3 percent each year.

Such a rate of increase is significant, we believe, and suggests that the causes for the increases need to be carefully examined. If a stable and very small fraction of subscribers absorb a growing portion of available benefit dollars, it is possible at some point that the majority of subscribers may feel they are unnecessarily subsidizing the few. Conversely, of course, the very concept of risk-sharing is that by many people pooling a few dollars each, the few suffering large expenses each year can be reimbursed.

UTILIZATION AND QUALITY CONTROL

In a service benefit plan, such as Blue Cross and Blue Shield provides, it is important that the carrier work closely with providers of services to be sure that unnecessary usage of services is controlled and that services provided are of suitable quality.

We believe there is now a growing recognition on the part of providers of mental services that peer review, utilization review and other forms of quality assurance must be improved for mental services. These same problems exist in other branches of medicine, of course, but more progress has been made in solving them than has been true in mental health. In part, of course, this is due to the complex nature of mental illness and its treatment—standards of care and methods of measurement are extraordinarily difficult to develop. Nonetheless, if claims are to be paid in a manner which protects the interest of all enrolled Federal employees and the Government, ways must be found to carry out competent screening of claims. We feel a good beginning has been made in several local Blue Cross and Blue Shield Plans, and these prototype efforts are being disseminated to all Plans which service Federal employees. In addition, we are heartened by the steps recently taken by the American Psychiatric Association on a national level to foster peer review. We have pledged our cooperation to them, and stand ready to work with similar professional groups who share our sense of the imperative need for meaningful action. If action is not taken, and claims costs continue to rise without assurance that utilization and quality are being

controlled, then finally the subscribers and patients will have to bear the burden of higher premiums or alternatively, reduced benefits.

We believe that conscientious action started now by providers and insurers should go far to assure that benefit restrictions will be unnecessary in the future, and that employees receive a full measure of service for their premium dollars.

Finally, the Subcommittee has asked us to comment on the reasons for higher utilization of psychiatric services in the Washington, D.C. area. In the Blue Cross and Blue Shield plan, 23.2 percent of all benefits paid in 1973 were paid for claims in the District of Columbia, Maryland and Virginia. Mental benefit claims for this same area, however, accounted for 33.3 percent of all mental benefits. Thus, there does appear to be a disproportionate amount of claims dollars expended in the Washington area.

The data we have readily at hand does not enable us to determine which factors contribute to this claims experience, but some obvious possibilities are:

That on a per capita basis, Federal employees in the Washington area use mental health benefits more intensively than elsewhere. Mental health experts have informed us that there is a positive correlation between education and income levels of a population group and their tendency to use mental health services. If Federal employees in the Washington area happen to be, as a group, at higher education levels or at higher pay levels than employees elsewhere, this may account for some of the differential in claims experience. Similarly, an unusually high proportion of Federal employees in the Washington area who are at the younger age levels, female, or who have young families would help to account for higher utilization rates.

That a greater proportion of Federal employees in the Washington area seek care. In part, this too could be explained by the correlation with education and income, but another reason could be that a greater array of psychiatric services exists in the Washington area than in many comparable areas. Some experts have suggested to us that the comparatively comprehensive coverage available to Federal employees has encouraged psychiatrists and other providers of mental health services to locate in this area. As the American Psychiatric Association has pointed out, the Washington area has an above-average number of psychiatrists, compared to national norms.

That *prices* for mental health services are higher in the Washington area than elsewhere. If this were true, then a disproportionate amount of claims dollars would be spent here, even if the actual use of services were the same as elsewhere. However, the information available does not seem to suggest the existence of any important price differential between Washington and comparable metropolitan areas.

Thus, we conclude that in general, the Washington area claims experience is attributable to the nature of the covered population, and the greater availability of mental health resources.

Mr. Chairman, this concludes my statement, and I would be pleased to answer any questions you and the other Subcommittee members would care to ask.

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS,
Washington, D.C., August 28, 1974.

Mr. JOSEPH E. HARVEY,
Vice President, Federal Employee Programs,
Blue Cross-Blue Shield,
Washington, D.C.

DEAR MR. HARVEY: The Subcommittee is aware that both Blue Cross-Blue Shield and Aetna have proposed reductions in benefits for mental and nervous disorders under the Federal Employees' Health Benefits Program for the 1975 contract year. The Subcommittee is interested in particular factors such as utilization and cost control which have reportedly precipitated these reduction proposals.

Therefore, we ask for your participation in a hearing to be held on September 17, 1974, at 10:00 A.M., in room 340 Cannon House Office Building. In your official remarks, please include whatever reponses you are capable of making to the questions attached on the following page.

We hope you will welcome this opportunity to enter your views into the record of our inquiry.

Sincerely,

JEROME R. WALDIE, *Chairman.*

Question 1(a) "Do you have information as to the age, sex, educational background or income of Federal employees receiving psychiatric benefits?"

Response: Our claims history records contain age and sex information on the claimant; we do not have data on the educational background or income of Federal Employees. The attached Table 1(a) shows the distribution of benefits dollars paid in 1973 by age category and sex of employee and annuitant claimants and dependent claimants separately.

TABLE 1(a)—BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM DISTRIBUTION OF NERVOUS AND MENTAL BENEFITS[1] PAID IN 1973 BY AGE CATEGORY AND SEX OF CLAIMANT

Age category and sex of claimant	Employees and annuitants	Dependents	Total
Under age 19	$32, 920	$10, 889, 436	$10, 922, 356
Male	20, 425	5, 868, 898	5, 889, 323
Female	12, 495	5, 020, 538	5, 033, 033
Ages 19 to 34	8, 163, 290	11, 697, 809	19, 861, 099
Male	4, 331, 347	4, 031, 576	8, 362, 923
Female	3, 831, 943	7, 666, 233	11, 498, 176
Ages 35 to 44	5, 376, 847	5, 761, 704	11, 138, 551
Male	3, 634, 331	452, 846	4, 087, 177
Female	1, 742, 516	5, 308, 858	7, 051, 374
Ages 45 to 54	6, 275, 461	5, 823, 362	12, 098, 823
Male	4, 078, 345	476, 900	4, 555, 245
Female	2, 197, 116	5, 346, 462	7, 543, 578
Ages 55 to 59	2, 308, 822	1, 626, 008	3, 934, 830
Male	1, 468, 625	220, 066	1, 688, 691
Female	840, 197	1, 405, 942	2, 246, 139
Ages 60 to 61	798, 134	392, 187	1, 190, 321
Male	470, 232	40, 091	510, 323
Female	327, 902	352, 096	679, 998
Ages 62 to 64	880, 223	480, 601	1, 360, 824
Male	487, 479	63, 271	550, 750
Female	392, 744	417, 330	810, 074
Ages 65 to 69	511, 011	273, 613	784, 624
Male	277, 264	35, 197	312, 461
Female	233, 747	283, 416	472, 163
Ages 70 and over	381, 658	107, 198	488, 856
Male	196, 979	8, 405	205, 384
Female	184, 679	98, 793	283, 472
All ages	24, 728, 366	37, 051, 918	61, 780, 284
Male	14, 965, 027	11, 197, 250	26, 162, 277
Female	9, 763, 339	25, 854, 668	35, 618, 007

[1] Includes Basic Blue Shield related anesthesia.

Question 1(b): "What percent of total claims paid out went for psychiatric benefits each year for the last five years?"

Response: Our claims history records contain inpatient and outpatient information on the Basic Blue Cross and Basic Blue Shield benefits but not on Supplemental benefits. Basic benefits for mental disorders accounted for between 55 and 60 percent of total mental disorder benefits from 1969 through 1973. The attached table 1(b) shows the data as requested on an inpatient and outpatient basis for Basic benefits only; and on a combined basis for total mental disorder benefits for the last five years.

TABLE 1(b)—BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM NERVOUS AND MENTAL BENEFITS [1] VERSUS ALL BENEFITS PAID 1969 THROUGH 1973

Year	All benefits			Nervous and mental benefits [1]					
				Inpatient [2]		Outpatient [2]		Combined [3]	
	Inpatient [2]	Outpatient [2]	Combined [3]	Amount	Percent of all inpatient benefits	Amount	Percent of all outpatient benefits	Amount	Percent of all benefits
1969	$381, 875, 441	$55, 313, 033	$480, 930, 105	$17, 211, 515	4. 5	$157, 089	0. 3	$31, 045, 834	6. 5
1970	495, 141, 117	75, 952, 499	601, 926, 299	23, 442, 945	4. 7	175, 228	. 2	41, 801, 830	6. 9
1971	548, 926, 094	93, 768, 459	698, 851, 584	28, 886, 368	5. 3	189, 181	. 2	49, 806, 559	7. 1
1972	592, 724, 140	106, 760, 921	760, 372, 332	31, 417, 403	5. 3	165, 018	. 2	54, 514, 206	7. 2
1973	652, 403, 612	124, 905, 067	848, 212, 495	35, 241, 956	5. 4	166, 375	. 1	61, 703, 933	7. 3

[1] Excludes Basic Blue Shield related anesthesia.
[2] Includes Basic Blue Cross and Basic Blue Shield benefits only.
[3] Includes Basic Blue Cross, Basic Blue Shield and Supplemental benefits.

Question 1(c): "What is the rate of cost increase for psychiatric benefits over the last ten years?"

Response: See response for question 1(b) regarding limitations within our data on inpatient and outpatient breakdowns. The attached table 1(c) shows the data requested on an inpatient and outpatient basis for Basic benefits only; and on a combined basis for total mental disorder benefits over the last ten years.

TABLE 1(c).—BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM NERVOUS AND MENTAL BENEFITS[1] PAID PER AVERAGE COVERED POPULATION 1964 THROUGH 1973

Period	Average covered population	Basic Blue Cross and Blue Shield only				Combined[2]	
		Inpatient		Outpatient			
		Amount	Percent covered population	Amount	Percent covered population	Amount	Percent covered population
1964[3]	3,745,800	$5,451,007	$1.46	$57,388	$.02	$9,951,996	$2.66
1965[4]	3,883,000	$8,167,471	[5] $1.80	$77,650	[5] .02	$14,075,626	[5] 3.11
Percent change over 1964	4	50	23	35	N/C	41	17
1966	4,068,000	$8,278,796	$2.04	$84,197	.02	$13,644,507	$3.35
Percent change over 1965	5	1	13	8	N/C	(3)	8
1967	4,417,200	$11,040,170	$2.50	$86,659	.02	$18,369,835	$4.16
Percent change over 1966	9	33	23	3	N/C	35	24
1968	4,548,600	$14,297,509	$3.14	$126,701	.03	$25,030,590	$5.50
Percent change over 1967	3	30	26	46	50	36	32
1969	4,672,100	$17,211,515	$3.68	$157,089	.03	$31,045,834	$6.64
Percent change over 1968	3	20	17	24	N/C	24	21
1970	5,015,400	$23,442,945	$4.67	$175,228	.03	$41,801,830	$8.33
Percent change over 1969	7	36	27	12	N/C	35	25
1971	5,092,800	$28,886,368	$5.67	$189,181	.04	$49,806,559	$9.78
Percent change over 1970	2	23	21	8	33	19	17
1972	5,043,100	$31,417,403	$6.23	$165,018	.03	$54,514,206	$10.81
Percent change over 1971	(1)	9	10	(13)	(25)	9	11
1973	5,330,100	$35,241,956	$6.61	$166,375	.03	$61,703,933	$11.58
Percent change over 1972	6	12	6	1	N/C	13	7
Percent change over 1964	42	547	353	190	50	520	353
Average rate of cost change 1964 to 1973		21	19	10	5	20	18

[1] Excludes Basic Blue Shield related anesthesia.
[2] Includes Basic Blue Cross, Basic Blue Shield, and supplemental benefits.
[3] Data shown is for the 12 month period Nov. 1, 1963 through Oct. 31, 1964.
[4] Data shown is for the 14 month period Nov. 1, 1964 through Dec. 31, 1965.
[5] Adjusted to 12 month average.

Note: Caution should be exercised in evaluating the above data due to benefit changes that have occurred from 1964 through 1973.

Question 1(d): "How many people are actually receiving psychiatric benefits at present in your Plan?"

Response: This information is not readily available on an inpatient and outpatient basis separately. The attached table 1(d) shows the data requested in total for the last four years.

TABLE 1(d)—BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM ANALYSIS OF SUBSCRIBERS RECEIVING NERVOUS AND MENTAL BENEFITS 1970 THROUGH 1973

Year	Number of subscribers receiving any kind of a benefit		Number of subscribers receiving a nervous and mental benefit		
	Number	Percent of covered population	Number	Percent of subscribers receiving any benefit	Percent of covered population
1970	1,919,536	38	44,625	2.3	0.9
1971	2,044,805	40	48,206	2.4	.9
1972	2,128,250	42	52,404	2.5	1.0
1973	2,289,731	43	[1] 59,500	2.6	1.1

[1] Estimated.

Question 1(f): "What is the present average length of hospital stay and length of outpatient treatment for which benefits were paid?"

Response: The attached table 1(f) shows the data requested for availability are data on the average length of inpatient stay for Supplemental hospital benefits. Also not available from our claims data base is the average length of outpatient treatment.

TABLE 1(F)—BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM, AVERAGE LENGTH OF INPATIENT HOSPITAL STAY FOR NERVOUS AND MENTAL ILLNESS VERSUS ALL TYPES OF ILLNESS [1] (HIGH OPTION ONLY) BASED ON 1973 CLAIMS PAID [2]

Nervous and Mental Illness: 17.6 days.
All Types of Illness [1]: 7.8 days.

Mr. LAUR. In view of the hour and the other people scheduled to appear, perhaps it would be helpful if I simply tried to summarize it, Mr. Chairman.

Mr. WALDIE. That would be helpful.

Mr. LAUR. There are a number of responses to questions that the subcommittee has posed to us and those are included or attached to the testimony. I won't go over those.

Perhaps I could simply say that Blue Cross and Blue Shield coverage for Federal employees has been quite comprehensive since 1967. The benefits for mental health have been essentially comparable to those for physical health. We have been impressed with the results of that coverage. We think it has made mental health services more widely available and more readily acceptable to Federal employees and we believe that's an important contribution.

I have pointed out in the testimony, Mr. Chairman, that there are several requirements that must be met to provide coverage for any health service. These are that the coverage must be available at rates subscribers are able and willing to pay; the services must be capable of clear definition so that subscribers, the providers of those services and the carriers will have a reasonable understanding of what it is that is to be paid for; the providers of service must be able to provide

[1] Excludes maternity.
[2] Includes Basic Blue Cross data only; does not include data based on claims paid for supplemental hospital benefits.

documentation of what services were received by a patient, the amount of such services and in certain circumstances at least the appropriateness of that service to the patient's illness; and this must all be done while preserving confidentiality of the doctor-patient relationship; and we believe also that health insurance benefits should provide financial incentives which help assure that the most effective means of treatment are employed and that efficiency in care is encouraged as well.

In light of those, it might be useful to briefly comment on the experience of Blue Cross and Blue Shield in the Federal employees program against those requirements.

We think it's been clearly demonstrated that mental health benefits can be offered in a prepayment plan that the employees and the Government have been willing to pay for. We do see some signs that greater efforts at utilization and cost control need to be made, but we continue to believe that mental health benefits are still an affordable part of a total prepayment plan.

Second, we believe that more work is needed to provide clearer definitions of mental health services and the conditions under which they are appropriate to be rendered for a given illness. This is a difficulty that is inherent in a developing field such as mental health, but it is an important one. To the extent that these definitions can be more clearly developed, the services become more readily covered under prepayment.

I think we are still learning what effect prepayment coverage has on the effectiveness and efficiency of the delivery of services. That's a topic requiring continued study.

We have received testimony and advice from experts which have indicated that more encouragement under prepayment should be given to partial hospitalization, day and night care centers, community mental health centers and other forms of ambulatory service.

There is certainly a need expressed by the President's Committee on Health Education of the Public and by other groups for continued efforts at educating the consumers as to the nature of mental illness, why they should seek care and what forms of care are appropriate.

Well, I think, Mr. Chairman, we could summarize by saying we have seen a constructive result from the offering of mental health benefits. People have become used to receiving care for that illness in the same manner as physical illness and it has lost its stigma and people have lost their fear of the illness. We have found it to be a service which requires more careful definition so that the insurance contract can be more readily administered and more fairly administered and we do believe that utilization controls must be improved if the costs of this service are to be kept at a level which permits full coverage for all employees.

Perhaps I could conclude the statement at this point and answer any questions the chairman has.

Mr. WALDIE. I appreciate your summarizing it as rapidly as you have done.

What financial incentives have been set forth that contribute to the development and use of the most effective medical techniques and patterns of service delivery ?

Mr. LAUR. Well, as an example, in the coverage offered by Blue Cross and Blue Shield, under our basic benefits (the paid-in-full

benefits), services in hospitals are covered. We believe that acute care rendered in a general community hospital for psychiatric emergencies or acute episodes of psychiatric illness is very important. It's much more appropriate, we believe, if a family member can be admitted to the same local community hospital with no stigmatization attached to that for a psychiatric episode than for any other kind of illness. That would be an example that the contract provides which we think moves in the right direction.

Similarly, the adding of the benefit for mental health team; that is, that coverage of care rendered by psychologists, psychiatric social workers, psychiatric nurses, as well as physicians was an important contribution.

Mr. WALDIE. What has occurred in the field to meet the third criterion, documentation of the services of providers?

Mr. LAUR. Well, a number of things. First, some credit should be given I believe to the medicare and medicaid programs which as a general impact on hospitals and providers encouraged them to keep and maintain better records. Similarly, in our own relationships with hospitals—by "our own," I mean Blue Cross and Blue Shield's local plans with hospitals and doctors—we have established a relationship whereby when a claim is questioned the records can be supplied, if necessary, to an impartial medical review panel and they make an analysis of the necessity and appropriateness of the care.

Mr. WALDIE. Does that exist in every area of the country?

Mr. LAUR. In general form, it does. It happens somewhat differently—the techniques are different in some parts of the country.

Mr. WALDIE. For the committee's information, which area of the country has the best peer review? I presume that's what we're talking about, are we not?

Mr. LAUR. Peer review is one element in what I've said. There are other elements as well.

Mr. WALDIE. Which would be the most important element of this documentation problem?

Mr. LAUR. Well, the most important element in documentation is good recordkeeping by the physician and his staff and the hospital.

Mr. WALDIE. There are other elements other than peer review you said. What are they?

Mr. LAUR. For example, in our own plan's operation, we must engage in a claims administration process that includes reviewing a claim to see whether or not it is covered by the contract, which is different than the process of peer review which looks at the adequacy of the care rendered.

Mr. WALDIE. Who looks at overutilization?

Mr. LAUR. That would be a peer review process.

Mr. WALDIE. Isn't that your alleged problem, at least in the Washington area?

Mr. LAUR. It is one.

Mr. WALDIE. Is it the major one?

Mr. LAUR. No, I don't believe I would say so.

Mr. WALDIE. What's the major one?

Mr. LAUR. I don't know that I can say. I think to put it differently, I would say that in the Washington area—and I'm now one step removed from that process since we rely upon the local Blue Cross and

Blue Shield plans in each locality—but in the Washington area, I believe, and in several other areas, we have the problem of an insufficient review process that enables us to judge both utilization and quality of services or appropriateness of services.

Mr. WALDIE. Now review process is not the same concept as peer review?

Mr. LAUR. No, because I would suggest there is more—peer review implies that a committee of colleagues expert in that discipline would review one another's work.

Mr. WALDIE. Isn't that necessarily a part, though, of the review process?

Mr. LAUR. Yes, it is a part.

Mr. WALDIE. And I gather you said that review process is deficient in this area?

Mr. LAUR. Yes.

Mr. WALDIE. Is it deficient in the peer review aspect of the review process?

Mr. LAUR. Based on my understanding of what is accomplished here, it is.

Mr. WALDIE. Where else is it deficient?

Mr. LAUR. There is a general lack of standards, agreed upon standards, for the provision of mental health services which makes it difficult for peer review groups to function in the first place.

Mr. WALDIE. Is that a general lack throughout the country?

Mr. LAUR. To my knowledge, it is.

Mr. WALDIE. All right. If I were to ask you for your best information as to where the review process was working out most satisfactorily for the patient, as well as for the doctor and as well as for the carrier, where would you refer me?

Mr. LAUR. In the experience of the Federal employee plan of Blue Cross and Blue Shield, I believe we have found the most successful programs in the State of Wisconsin, in Oakland, Calif. in the Oakland Blue Cross plan, in the Connecticut Blue Cross and Blue Shield activties, and in Florida would be some examples. Maryland has one of the more exemplary programs.

Mr. WALDIE. There is no way, I gather, that Blue Cross and Blue Shield can take the most effective review process and demand that process in all of the areas that it serves?

Mr. LAUR. The operative word there, I guess, is "demand."

Mr. WALDIE. Surely.

Mr. LAUR. We have engaged now in an activity of trying to take from exemplary plans around the country the best of what we see there and make it available in an educational way to all plans. To demand it, I think is not practical.

Mr. WALDIE. Why?

Mr. LAUR. Because in order for these approaches to work the providers themselves must truly believe in them and be committed to making them work. They rely upon that basic provider decisionmaking process. Hence, demanding that people operate in a certain way just doesn't work.

Mr. WALDIE. Can you use your point No. 4 by providing financial incentives to push them into the direction that you believe they should go?

Mr. LAUR. A number of plans, as the chairman knows, around the country do help support the development of PSRO's or medical review foundations or other utilization or peer review processes as part of their distribution, so in that sense there is. And a financial incentive must be weighed carefully in the sense that one would not want to engage in a process which penalizes the patient or the subscriber for the failure of the provider or insurer to perform.

Mr. WALDIE. If you don't engage in that process and you approach the problem in the way you were contemplating to approach it, by reducing the amount of coverage, you end up penalizing the patient anyway. Your solution to the problem we're both dealing with was to cut back benefits because you couldn't afford them. Now that's damaging to the patient and the question, I suppose is, which course of action would be most damaging to the patient: by imposing from the outside a standard that made sense or by cutting back benefits because you said, "I can't control how they're going to be delivered and we can't afford to pay them the way they are being delivered." The patient is damaged in either instance I suspect.

Mr. LAUR. Well, not if one is covering—if one is paying for what is covered in the contract and it is medically necessary.

Mr. WALDIE. Yes, but if you reduce what is covered in the contract next year you have damaged those patients who were receiving what was covered in last year's contracts. Your proposal, which you did not follow through, would have damaged the patient, would it not, if you assume that services were required, if the patient couldn't afford to buy them independently?

Mr. LAUR. I think the chairman is making an assumption about what our proposal was, first of all; and second, if all that you assume is correct, then it would be so. It seems to me a number of things need to be said. One, we would only propose to reduce benefits as a last resort. Second, one may propose alternative benefits which are more constructive, so in a sense there might be a reduction of one benefit but a replacement of it by some other benefit that appeared to meet more fully those requirements I stated earlier, in which case I'm not prepared to call that a reduction of benefits. It's a modification.

Mr. WALDIE. What was published in the paper as to your proposal, are you prepared to call that a reduction in benefits?

Mr. LAUR. What was in the paper would have been a reduction of benefits.

Mr. WALDIE. Would that have been damaging to the patient?

Mr. LAUR. I think, then, it depends upon a number of factors. One is, is it done abruptly or are those patients who had some sense of what the contract was and were in care covered while you moved to a new level. It seems to me that it is not necessarily damaging to people—I'll say this differently, if I may. No health insurance plan of which I am aware covers all possible medical services. Invariably, there are limits, and in one sense the imposition of those limits damage people. Something that they could have had paid for by the prepayment plan was not covered. If all things were covered, the cost of having that kind of a plan would be very expensive which causes many people not to have it at all; and you thereby impose a far more serious disadvantage on people.

So it's the difficult process of weighing what is an adequate benefit to cover most things that become affordable. Now that's the kind of

decision that must be weighed, not the black and white case of cutting a benefit and thereby hurting someone.

Mr. WALDIE. If the committee determined that Wisconsin's plan, whatever that might be, the process of review was really by far and away the best and ought to be imposed countrywide for the Federal employee health benefits, I suppose we could legislatively do that. We have written terms into your contract already legislatively and we can probably do that. I gather you would recommend against that?

Mr. LAUR. Heartily.

Mr. WALDIE. All right. Thank you, Mr. Laur.

Mr. LAUR. Thank you, Mr. Chairman.

Mr. WALDIE. I appreciate your consideration of the committee and your statement.

Our next witness is Mr. Malcolm McIntyre, manager, Government relations, Aetna Life & Casualty.

STATEMENT OF MALCOLM McINTYRE, MANAGER, GOVERNMENT RELATIONS, AETNA LIFE & CASUALTY, ACCOMPANIED BY PETER CONNELL, WASHINGTON COUNSEL

Mr. MCINTYRE. Good morning Mr. Chairman and members of the subcommittee. I am Malcolm McIntyre, manager of Government relations of the Group Division of Aetna Life & Casualty. I am accompanied by Peter Connell, Washington counsel for our company.

In your letter asking us to attend this meeting today, you asked to address ourselves to a number of specific questions on the utilization and cost control of benefits for mental and nervous disorders under the Federal employees' health benefits program. I will address myself to those questions in the order in which they appeared in your letter.

You requested information as to the age, sex, educational background or income of Federal employees receiving psychiatric benefits. A sample of claims which we conducted indicates that mental and nervous claimants are definitely skewed toward the younger ages for both employees and spouses. That sample also indicates that dependents use more mental and nervous benefits than employees. I have attached a table to my testimony which demonstrates some of the results of that sample. You will notice from the table that whereas 6 percent of the insured employees are under 35, 12 percent of the total number of mental and nervous claimants are in this age bracket. For dependent spouses under age 35, the insured percentage is 4.1 percent while the mental and nervous claimants percentage is 10 percent. This disparity reverses itself after age 55. For example, 10.5 percent of all the insured employees fall in the 55 to 64 age bracket while only 4.9 percent of the employee claimants do so.

The sample study was not designed to determine claim data by sex. As I have already mentioned, dependent spouses, who are primarily female, do tend to use more mental and nervous benefits than employees, since 27.9 percent of all insured persons are dependent spouses while 37.2 percent of all mental and nervous claimants are dependent spouses. Whether this is the result of sex or marital status is not known.

Information is not available which would allow us to break out the utilization of mental and nervous benefits according to income and education characteristics.

You asked what percent of total claims paid out went for psychiatric benefits each year in the last 5 years. We estimate that there has been a steady increase in the percentage of mental and nervous benefits, starting with 7 percent of total claims in 1969 and increasing to 8 percent in 1970, 9 percent in 1971, 10 percent in 1972 and 12 percent of total claims in 1973.

You also requested information regarding the cost increase for psychiatric benefits over the last 10 years. We do not have that cost information but we would hope that the appropriate professional associations might be able to make that information available to you.

You asked how many people presently covered by our plan were receiving psychiatric benefits. We estimate that 1 percent of the enrolled population in our plan received psychiatric benefits in 1973. Note that this 1 percent utilized 12 percent of the total benefits under our plan.

Question 1(e) asked how many psychiatric claims were denied in each of the past 5 years by our plan. While we do not have precise data, we estimate that between 1 and 2 percent of all mental and nervous claims were completely denied in each of the past 5 years.

You requested the average length of hospital stay and length of outpatient treatment for which benefits were paid under our plan. The indemnity benefit plan averaged 43 days of hospital confinement and 37 office visits per year. These figures represent the average length of mental and nervous treatment for the indemnity benefit plan. We would point out that these averages are about twice as great as the corresponding averages for our other group business.

Your third question is perhaps the most difficult for us to answer. You ask for our recommendations on peer review, its role and the obstacles we foresee in a peer review system. The claim review system that we have established ouselves for mental and nervous claims has convinced us of the need for special peer review committees in this area. We have worked with and still are working with the American Psychiatric Association and the American Psychological Association, not only to have such committees established, but also to assist them in the slow process of educating all their respective members regarding the efficacy of peer review. We see peer review as being currently helpful in eliminating abuses such as the use of unreasonably large groups in group therapy or the billing for individual treatments when the actual treatment rendered was on a group basis. We must admit, however, that the present effectiveness of peer review regarding proper diagnosis and proper mode of treatment is not as pronounced as similar peer review in other medical fields. We believe that further refinement of this peer review process is needed and we will continue to work with the professionals in this regard.

Your last question asks the reasons for higher utilization of psychiatric services in the Washington, D.C. area. I think we would all agree that, in general, the use of psychiatric services has lost much of the social stigma that it used to have many years ago, and properly so. We believe the utilization to be particularly higher in the Washington, D.C. area because of the greater availability of psychiatrists and psychologists and also because of the high level of insurance coverage available.

In closing, I would point out that Aetna Life & Casualty has long recognized the necessity of making available to the American people

as comprehensive coverage for the cost of health care as practical. In particular, we have tried to treat mental and nervous conditions just as we treat any physical illness. We try to structure our plans so as to provide what we consider to be an appropriate set of benefits for an appropriate premium for the particular group of employees to be covered.

Thank you for this opportunity to appear before you, and I shall be happy to attempt to answer any qeustions which you may have.

[The table referred to follows:]

COMPARISON, BY TYPE OF CLAIMANT, OF THE AGE DISTRIBUTION OF A SAMPLE OF 1973 MENTAL AND NERVOUS CLAIMANTS WITH THE AGE [1] DISTRIBUTION OF ALL PERSONS INSURED AS OF MAY 1973

Age	Employees		Dependent spouses		All	
	Percent of total mental and nervous claimants	Percent of total persons insured	Percent of total mental and nervous claimants	Percent of total persons insured	Percent of total mental and nervous claimants	Percent of total persons insured
Children					23.7	31.4
Under 35	12.0	6.0	10.0	4.1	22.0	10.3
35 to 44	9.9	6.2	9.3	5.2	19.2	11.9
45 to 54	11.0	10.1	11.4	7.8	22.4	17.9
55 to 64	4.9	10.5	5.8	6.7	10.7	17.2
65 and over	1.3	8.0	.7	4.1	2.0	12.1
All ages	39.1	40.8	37.2	27.9	100.0	100.0

[1] Spouses were included at the age of the insured employee for purposes of the "insured persons" age distribution, but at their own age for the "claimant" age distribution.

Mr. WALDIE. Thank you, Mr. McIntyre, and I have no questions. If you have nothing further to offer, we will take your testimony in its entirety.

Mr. MCINTYRE. Thank you, Mr. Chairman.

Mr. WALDIE. Our last witness is Mr. Thomas Tinsley, Director of the Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission.

STATEMENT OF THOMAS TINSLEY, DIRECTOR OF THE BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, U.S. CIVIL SERVICE COMMISSION

Mr. WALDIE. Mr. Tinsley, we will include your statement in the record in its entirety and you may proceed as you desire.

[Complete statement follows:]

STATEMENT OF THOMAS A. TINSLEY, DIRECTOR, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, U.S. CIVIL SERVICE COMMISSION

Mr. Chairman and members of the committee, I appreciate this opportunity to appear before your Subcommittee to discuss coverage of nervous and mental illness by plans that participate in the Federal Employees Health Benefits Program.

Before addressing myself to the basic subject matter of this hearing I would greatly appreciate you, Mr. Chairman and Members of the Committee, permitting me to take a few minutes to clarify for the record what appears to be widespread public misunderstanding concerning certain aspects of the administration of the Federal Employees Health Benefit Law. I have also found in recent weeks that a number of your colleagues although very familiar with the Program did not fully understand all that is involved and the reasons for certain matters relating to the development of the benefit package and premium rates being treated and

handled in a confidential manner. You and the other members of the Committee are thoroughly familiar with the policies, practices, and procedures we follow and the reasons for them. They have been discussed on a number of occasions during the course of hearings before the Committee.

During the past month or so a number of newspaper stories have appeared reporting that negotiations were taking place between Blue Cross/Blue Shield and the Civil Service Commission on a proposal made by Blue Cross/Blue Shield to drastically reduce health insurance coverage and benefits for mental and nervous illnesses. These stories as well as letters and other written materials that were distributed and made public stated or indicated that this was taking place in secret; that the individuals or groups that would be adversely affected were not permitted to participate in the negotiations and decision making process; and it was implied or inferred that there was something sly, sneaky or underhanded taking place.

The Federal Employees Health Benefits Program is not only the largest employee sponsored plan in the world but is also the most unique in terms of the number and variety of benefit "packages" and premium rates offered. At present we are negotiating contracts with 46 different carriers on 120 benefit plans. In contrast employee Health Insurance benefits in private industry are usually determined through labor management negotiations, two parties; concerning one and in a few instances two types of plans. They are then contracted for and administered by one or two carriers. The Federal Program is much different and more comple in terms of benefit structure and administration.

Early each year, we issue guidelines and instructions to all carriers and ask them to submit their proposals for changes in benefits and premium rates for the following year. We evaluate these proposals and submit our counter-proposals to the carriers. We and carrier representatives then engage in a series of benefit and premium negotiating sessions and in an exchange of correspondence about our respective proposals. Carriers are asked to justify the need for any changes they propose. The back-up data they submit is thoroughly evaluated by our contract and actuarial staffs. Agreements are reached with the carriers at various points in time and not later than the end of September. At present we have reached agreement with all but 3 carriers for 1975.

We have always followed a policy of not disclosing proposals or counter-proposals or confirming, denying, commenting on or otherwise discussing rumored or other reports concerning what they might or might not be. It has always been our practice to hold discussions and negotiations concerning these matters in private. We believe our reasons for doing so are valid and in the best interest of all Federal employees and the program. These reasons have been furnished and discussed in some detail on other occasions before this Committee. I do not believe it necessary to impose further on your time by discussing them again. Let me just say that I do not believe that one carrier should know what another is proposing or has proposed until after all negotiations have been completed. This would not only have an adverse effect on the competition that exists among various plans, the diversity in benefits offered, the choice an employee now has, as intended by the law, but would result in many of the smaller plans being forced to leave the program. In addition, in the light of our recent experience resulting from the newspaper stories, I would dread the thoughts of the chaos, unnecessary concern on the part of employees and their families, the disruptions in our efforts to carry on the normal operations of the program, the pressures of vested interest groups and individuals, and other consequences of making public the proposals of the 46 carriers concerning the 120 health benefit plans.

I apologize to you and the Committee for taking this time on this matter when the subject we are here to discuss is one of such major importance. I do appreciate your giving me this opportunity to do so.

I believe it is important to review our experience and the development of coverage of nervous and mental illness in the Federal Employees Health Benefits Program over the 14 years it has been in existence. When negotiating benefits for the first contracts, the Commission was cautioned not to cover treatment of nervous and mental illness at all; however we did cover such care under the two Government-wide plans. Early in the Program, those plans that covered nervous and mental illness did so with specific limitations on benefits. For example, Blue Cross and Blue Shield limited hospital care to 30 days each 12 months under high option and 10 days under low option, plus Supplemental Benefits of only 50% after the deductibles for outpatient treatment. Aetna paid 100% of the first $1,000.00 of Hospital Room and Board charges, 80% of the balance under high option and limited outpatient benefits to 50% of expenses. Their low

option paid only the first $250.00 plus 75% of the balance for in-hospital care. From the mid-sixties on, benefits of both plans were improved and they now cover treatment of nervous and mental illness the same as any other illness. Coverage of nervous and mental illness by these two plans is among the best available anywhere today. Most other plans including those under our Program do not provide coverage of nervous and mental illness that is as generous as the benefits of the Blues and Aetna Plans in the Federal Programs.

If the Chairman feels it would be helpful and would contribute to this inquiry I would be glad to furnish for the record exhibits showing the development and changes in mental and nervous coverage, year by year for these plans.

The Aetna experience with respect to treatment of nervous and mental illness shows steadily increasing benefit payments since the early days of this program. While treatment of all types of illness has also been increasing, the rate of increase for treatment of nervous and mental illness surpasses all others. The percentage of total benefit payments being used to pay for treatment of nervous and mental illness has also steadily increased over the years.

Unfortunately, Aetna data were not sufficiently refined in the earlier days of our Program to permit good comparisons with current experience. However, the Aetna reports that in 1973, 12.4% of total benefit payments were for nervous and mental treatment and was paid to 1.2% of their Federal enrollees.

The Blues experience has been somewhat similar in that benefit payments have been steadily increasing. In the years 1960–1965, 3.9% of their total benefit payments were for mental and nervous illness. Since then the ratio has increased and in 1973 was 7.3% of benefit payments. The benefits were provided to approximately 1% of their enrollees.

The Aetna data includes information that is interesting and which we believe warrants further analysis and more detailed study to determine its significance and the exact reasons for it. Let me just briefly mention these. In doing so, Mr. Chairman, I will single out the Washington area experience only because in your letter to me you expressed particular interest in this area and asked that I do so.

Chronic cases make up the major expense to the Plan, rather than the more costly diagnoses such as schizophrenia and manic depressive psychotic. Nationwide, over 50% of total benefit payments for treatment of nervous and mental illness are for the less complex diagnoses such as anxiety and depressive neuroses (60% for the Washington, D.C., area). Claimants in the Washington, D.C., area, (Maryland, and Virginia) have established utilization and treatment patterns that differ significantly from those in most other locations. Although residents in this area constituted only 16.8% of Aetna's total enrollment, they accounted for 48.5% of total nervous and mental covered expenses. Southern California, with 8.5% of the covered population accounted for 11.5% of the expenses; Pennsylvania and Texas had expenses proportionate to their populations, and all other areas had expenses proportionately less than their populations.

Expenses are also concentrated heavily among certain age and sex groups. Female employees under age 45 represented 3.1% of the covered enrollees and had 7.7% of covered expenses. Employees' wives under age 55 were 14.2% of the covered population and had 31.1% of the covered expenses. Male employees under age 45 were 9.1% of the population and had 15% of the expenses.

Enrollees and spouses under age 45 living in the Washington area were about 4% of the covered population and accounted for 24.8% of the mental and nervous expenses.

Schizophrenia showed a very low concentration in the Washington area but the rate of hospitalized schizophrenics was very high.

Psychotic depression showed a much heavier concentration in the Washington area and a high hospitalization rate.

Other conditions (anxiety, depressive, and other neuroses and transient situational disturbances) showed a heavy concentration in this area but a lower hospitalization rate.

In the Washington area, the average claim expense in 1973 was $1,700.00; schizophrenics' verage per claimant per year was about $3,700.00 and accounted for 16.6% of the total expenses; psychotic depression, with 8.4% of total expenses, had an average of about $2,300.00; the anxiety and depressive neuroses claims averaged about $1,550.00 and accounted for 46.4% of the total expenses.

Washington and other areas varied also with respect to the types of services claimed. Individual therapy represented 38.7% of all expenses outside this area and 63.6% here; group therapy represented 3.8% of total claims outside Washington and 11.2% here; psychoanalysis accounted for 5.4% outside Washington

and 3% here; in-hospital psychotherapy visits represented 9.7% outside, 2.1% in Washington; and hospital inpatient charges represented 42.4% outside Washington and 20.1% here. Most of these expenses were for psychotherapy, but because of the more liberal hospital benefit formula, hospitalization accounted for about half of the benefits.

There was also in indication that nervous and mental treatment is often concentrated in families. There were several cases in the Aetna study involving families with total expenses exceeding $25,000.00 or more during 1972 and 1973, and 20 cases with expenses of $10,000.00 or more. Over 23% of the claims involved two or more members of the same family with significant nervous and mental expenses and over 2% had four or more family members claiming benefits for nervous and mental illness.

Both Aetna's and the Blues' data showed a concentration of nervous and mental claims where there is a concentration of psychiatric practitioners.

As I indicated earlier Blue Cross/Blue Shield reports similar experience in claims for mental and nervous conditions. We have not completed our study and analysis of the data we have concerning their experience so I am unable at this time to highlight or give you the same detailed information on the specific items mentioned in connection with the Aetna study. The data we have are voluminous and in the form of computer printouts in considerable detail. We have been arranging it and placing it in formats of various types for detailed study and analysis. We should complete the study later this year at which time we will be pleased to inform the Committee concerning the results. It should be extremely valuable because of the amount of data it includes. We also plan to make the data and study available to other interested groups for their review and analysis and hopefully the results will assist us, the carriers, and all others involved and interested in the field of providing care and benefits for mental and nervous conditions.

Mr. Chairman you asked that in my official remarks I include what I consider to be the reason for the higher utilization by subscribers of psychiatric services in the Washington area. I wish I were able to give you with confidence the exact reasons why these differences exist. A number of reasons have been advanced by those in this field with whom I have discussed in detail and at some length this matter, insurance carriers, representatives of professional organizations in the mental health case cares, researchers, administrators of programs, individual psychiatrists and others. These reasons include overtreatment, unnecessary treatment and abuse of the availability of the liberal benefit provisions in the Federal Program by the Psychistrists, Psychologists, and other Professionals providing the health care; the economic and social make-up of the population; the liberal benefits and the fact that insurance money is paying for it; when a benefit is provided greater utilization, better and more expensive care will and can be expected to result; the manner of practice and the theary followed by psychistrists and others. I am sure you will hear from the other witnesses many of the other reasons advanced so I will not extend my statement on this point at this time.

You also asked that I include what I consider to be the reasons that compel a reduction in mental and nervous disorder contract benefits, if in fact I do believe they are necessary.

As I indicated earlier we have not completed our negotiations and in keeping with our policy I do not feel free to discuss the specifics of our current benefit and rate situation.

I can tell you this that insofar as the Commission is concerned (and as far as I personally am concerned) as the legally responsible administrator of the Program, in the absence of any legislative or other similar act or direction, benefits which now are provided in the Program, whether they be mental or nervous or any other type benefit, will not be reduced unless there has been demonstrated a clear, convincing, and very compelling need to do so which is in the best interest of all Federal employees, participants in the Plan, the Government and the Program.

Thank you Mr. Chairman. I will be pleased to try to answer any questions you or the Committee might have or furnish any additional data or information you may be interested in on this subject.

Mr. TINSLEY. Thank you, Mr. Chairman. I might just briefly summarize the statement.

The first part of the statement deals with some procedural matters

that appear, at least from a reading of my mail, to have been completely misunderstood. That is the method of negotiating contracts under the Federal program and the reasons why the negotiations are conducted in a confidential manner. Your committee and you, Mr. Chairman, are familiar with these reasons.

Mr. WALDIE. No, I'm not, as a matter of fact. I'd like you to explain. I have never understood why we have to be kept in the dark until the last moment and then all of a sudden a staggering premium increase might be announced and we are told it's too late to do anything about it. So, to be perfectly frank, I have never understood why we have been denied participation in that process since we, the Government, representatives of the principal, and you, the Civil Service Commission, are acting as our agent—how you can keep the principal out of those negotiations is something that has never been made clear to me. So make it clear.

Mr. TINSLEY. One of the basic reasons, Mr. Chairman, is that we are dealing with 46 different contracts, 46 different carriers, if you will. We negotiate approximately 120 different benefit plans when you consider self and self-only, high and low option. We do not believe the best interest of the employees or anyone else would be served if one carrier were to know right from the beginning what the other carriers were proposing.

There's a great deal of diversity in the Federal program as it exists now. The employees have a choice. In most areas this choice involves at least seven different types of benefit plans and a variety of premium rates. The employee, in part, I think, would be adversely affected if that selection was reduced to the point where he was a captive of one carrier or one set of benefits were available.

The difficulty in ever resolving the issues and reaching agreement on the benefits and on the premiums would be compounded. Our recent experience, because of the newspaper stories, diverted a great deal of staff resources through——

Mr. WALDIE. But is it at all possible for us to conclude that because of the newspaper stories that you did not succumb to their requests for an increase in these premium costs for this service, this benefit?

Mr. TINSLEY. Well, Mr. Chairman, you're aware of our policy of not commenting, denying, confirming——

Mr. WALDIE. I am very much aware of it, but all I say is those newspaper stories said that you were planning on agreeing to a massive reduction in benefits in this field and after the newspaper stories continued and Congress reacted the ultimate result was no such massive decrease occurred. Now it may be there was never a massive decrease in the mill, but it may equally be there was, and the fact that publicity was given to it caused you to back off from agreeing with the carriers that such a decrease was warranted and we will never know because you will never tell us. Right? You can't, according to your theory. Right?

Mr. TINSLEY. At some point in time I would think you would be informed—Mr. Chairman, the temptation here is very great to violate the rules we have followed for years.

Mr. WALDIE. Well, you won't tell us?

Mr. TINSLEY. If you will read the last part of my statement——

Mr. WALDIE. We'll mark the record confidential.

Mr. TINSLEY. If you will read the last part of my statement, there

is a statement of our position in there, where I tell you that insofar as the Commission is concerned and as far as I am personally concerned, in the absence of any legislative or other similar act or direction, benefits which now are provided in the program, whether they be mental or nervous or any other type benefit, will not be reduced unless there's been demonstrated a clear, convincing and very compelling need to do so which is in the best interest of all Federal employes, participants in the plan, the Government and the program.

Now it was subsequently stated in the press that they withdrew the purported proposal that they had made. When we entered the negotiations the statement I just made was the policy of the Commission. It will continue to be the policy of the Commission and until a carrier convinces us that a reduction in benefits is necessary and it's going to have to be very convincing, we are not going to entertain any proposals to reduce benefits. This was our position last February. It's our position today and as far as I can foresee it's going to be our position next year.

You can interpret what I have just said any way you want to in connection with the negotiations.

Mr. WALDIE. Well, that's a good position and I commend you on it and encourage you to hold fast.

Okay. Please proceed, Mr. Tinsley.

Mr. TINSLEY. In connection with the balance of my statement, it contains a great deal of the data that you and your staff expressed an interest in. It concerns the mental and nervous area, particularly as the Washington, D.C. area compares to the rest of the country. There are a great deal of interesting statistics cited in there. As I point out, they are cited not to imply that we know that there is something wrong in Washington, D.C. They do show that the Washington, D.C. area in almost every respect is much higher than what occurs in the rest of the country. We are continuing to analyze the data that we have.

We have recently obtained rather voluminous data on the Blue Cross and Blue Shield program right down practically to having a case run, which we intend and have started to put in formats to analyze and study and see what we can learn from them. I have also promised to give this to other groups that are interested in this area to see what they can learn from it, including the professional organizations.

So, at the moment, while there are great differences that exist, I don't purport to know the reasons for them. I have been told by various groups and organizations that I have talked to, individuals that I have talked to in the professions, a variety of reasons why these things could exist. I'm not at all convinced that the reasons that they have given me are really the reasons that I would have confidence in. It may be a mix of reasons.

You asked me about the reasons that compel reduction in mental and nervous contract benefits if in fact I do believe they are necessary. I think I just answered that question.

That basically covers the statement.

Mr. WALDIE. What does the Commission do to fulfill its responsibility to the subscribers of the contract that the Commission monitors so that the subscribers are in fact receiving high quality care and that it is being delivered to them efficiently?

Mr. TINSLEY. The Commission's role here is relatively limited in terms of the impact we have. We do consult with the various professional groups and others interested in various aspects of the program, whether it be mental or nervous or any other field. We do press the carriers, because the carriers are concerned about costs and they are concerned about premiums. Despite what many people think, they do not come by their premium requests easily. Those are two areas.

Another area that we have been moving in, is that we have been encouraging the establishment of peer review groups.

Mr. WALDIE. Let me interrupt a minute, Mr. Tinsley. How can you really judge their premium requests if you're not aware of how efficient they are in the delivery of their services or whether they are over or under utilizing? How can you tell that that carrier is in fact monitoring the providers? You don't monitor providers at all, do you?

Mr. TINSLEY. No, Mr. Chairman, we do not.

Mr. WALDIE. You don't monitor carriers at all, do you?

Mr. TINSLEY. To some extent, yes. We review claims.

Mr. WALDIE. But very limited?

Mr. TINSLEY. Very limited, yes, Mr. Chairman.

Mr. WALDIE. You don't monitor anything except you negotiate the contract.

Mr. TINSLEY. Administratively, we have expanded the scope of our audits to go far beyond——

Mr. WALDIE. But that's just the last couple years?

Mr. TINSLEY. That's correct, Mr. Chairman.

Mr. WALDIE. When the heat started coming on.

Mr. TINSLEY. For one reason or another. You were very helpful in moving us in that direction.

Mr. WALDIE. All I'm really pointing out is—and I think we all learned from this, carriers, providers and Commission—but it doesn't seem to me that the role of the Commission has been very aggressive in monitoring either carriers or providers and I suspect you should be monitoring carriers. I'm troubled by some of the allegations of the carriers that there has been unwise utilization in the Washington area of these services. I don't know if that's true and they are limited apparently in their conclusions because of the statistical problems they have, but we have no statistics that are independent, do we? As a Commission, where do you get the statistics?

Mr. TINSLEY. You mean independent statistics in the Federal program?

Mr. WALDIE. Well, the statistics you have quoted in your statement, where did they come from?

Mr. TINSLEY. No, we don't have any independent statistics.

Mr. WALDIE. They come from the carriers?

Mr. TINSLEY. That is correct, Mr. Chairman. They come from the carriers.

Mr. WALDIE. So we could really have not bothered calling you today. This information that you have provided us would have been provided by the carriers?

Mr. TINSLEY. We do review what they provide. We do question what they provide and in many instances they have revised what they have provided on the basis of our analysis and what we have brought to their attention. To that extent there has been some benefit.

Mr. WALDIE. But you see, the problem we have representing the subscribers, and that's really what this committee represents—we don't represent the carriers; we don't represent the providers; we represent only the subscribers—the carriers tell us that the providers are not delivering the service honestly. They don't put it that bluntly, but that's how it seems to me to boil down. Overutilization may be negligence, but probably is dishonesty. Clearly, billing for an individual visit when you have a group visit is dishonest. If the carrier monitors that they would seem to me to have a natural bias to be interested mostly in the dollar. They know what their contract price is, premium price, and if they could keep the money that went out less than the money that came in they will walk off with a profit. So their inclination is to keep prices down and that's a healthy inclination, but who is there in this field that looks out for the subscriber? The carrier doesn't really and the provider doesn't really. Who monitors the provider when they are acting contrary to the best interests of the subscriber? Can you tell me that?

Mr. TINSLEY. I don't know today that in any area of medical care there's any effective monitoring of providers in any area, whether it be mental or nervous or other areas. Now it's much easier in other areas than it is in mental and nervous.

Mr. WALDIE. Or the carrier. Let's stay out of mental and nervous. Let's go into surgical which should be the easiest of all. Who protects, in terms of the provider, his interests? Does the carrier?

Mr. TINSLEY. The provider or the subscriber?

Mr. WALDIE. I'm sorry. I meant the subscriber. Does the carrier in the surgical case? Who makes certain the provider does not get an unnecessary appendectomy?

Mr. TINSLEY. Today, only those in the medical profession.

Mr. WALDIE. Well, the carrier I guess tries to because he has to pay for it.

Mr. TINSLEY. That's right. He will question certain claims and refer them to peer review groups for review.

Mr. WALDIE. But you have no role, do you?

Mr. TINSLEY. No role other than to encourage the establishment of such groups.

Mr. WALDIE. How do you encourage that?

Mr. TINSLEY. In two ways. One, since the carriers are dealing with the professions directly, since the impact is there and since today third-party payees are the custom rather than the exception, that they use whatever pressure they can bring to bear, particularly where you have an organization like Blue Cross and Blue Shield with hospital contracts and participating physicians.

Mr. WALDIE. How do you encourage them to do that?

Mr. TINSLEY. Obviously, by keeping pressure on them in terms of——

Mr. WALDIE. How do you keep pressure on them?

Mr. TINSLEY. In terms of the premium negotiations. In terms of the complaints we receive.

Mr. WALDIE. But what do you tell them in terms of premium negotiation? How is that a point of pressure in premium negotiation? Do you tell them unless they're satisfied there's an adequate monitor on the part of the providers that you will not concede a certain premium increase?

Mr. TINSLEY. At that—we are at that point now, Mr. Chairman.

Mr. WALDIE. That's the pressure?

Mr. TINSLEY. Yes.

Mr. WALDIE. If you're convinced that they are adequately monitoring you'd be more prone to agree with the premium increase?

Mr. TINSLEY. To some extent, yes. At the same time——

Mr. WALDIE. When you say you're at that point now, what do you mean by that?

Mr. TINSLEY. I don't think that has been done in the past.

Mr. WALDIE. No, I don't think it has either. That's why I'm curious.

Mr. TINSLEY. Another thing that's been instituted is we have started a series of meetings with the various groups—providers, professional organizations——

Mr. WALDIE. You mean the Commission has?

Mr. TINSLEY. Yes. In order to bring them closer to the program to present to them the problems that we see that might exist and to enlist their support with their own peers to do something in this particular area because it's quite obvious that costs, the way they are increasing for the American public, not just the Federal employees as well as utilization of medical care, something has to be done, if we are to maintain the type of a system that the country now has for providing and paying for it.

Mr. WALDIE. Well, I don't think we want to maintain that kind of system. We want to change the system.

Mr. TINSLEY. Well, I don't mean that the present system isn't in need of some change. I'm talking now in terms of, if you want to maintain insurance carriers that are insurance carriers rather than intermediaries.If you want to have the medical profession establish their own standards and establish their own prices without having the Federal Government or some other outside source establish them for them.

Mr. WALDIE. Well, we establish them, don't we. When you're negotiating down there with the carriers, aren't you establishing their prices?

Mr. TINSLEY. Their prices, yes, but I'm not establishing the doctors' charges or the hospital charges or any other charges.

Mr. WALDIE. Well, you're establishing how much you will pay on these charges and that pretty well establishes it, doesn't it?

Mr. TINSLEY. In a broad sense, Mr. Chairman.

Mr. WALDIE. Well, I don't see anything wrong with that, by the way, and I would not feel as sensitive as your remarks indicate to me you might feel. I'd feel quite aggressive about it and I'd go in and establish the hell out of those prices if necessary, in all fields of medicine, unless they themselves start exerting some discipline that I have not noted in price and in other matters.

I think what the committee is trying to determine is who's right here. I don't know whether overutilization is taking place in portions of this country of this or any other particular medical or health service. I don't know whether the sort of services that are being delivered are essential and proper and should be delivered and that to call them overutilization is incorrect. But what troubles me is I don't know how to find out, either, and that is a big gap in the system when you have to say I don't know how to find out and you can't tell me as the Com-

mission's representative. Carriers can't tell me because their statistics are not sufficiently firm in the field, and the providers don't seem to believe it exists at all. So the system has got to provide some sort of better response than we have in problems like this so we can judge who's right. I don't yet know why the carriers backed off in their request to have this benefit diminished. I don't know whether it was because you fellows were tough down at the Commission and insisted they could not back off or whether they decided it was not politically warranted because of the flap, or whether they decided their statistics would not justify the backing off, but somebody backed off in this controversy and I really would like to know why.

And while I'm talking about it, Mr. Laur, let me ask you that question. Could you tell us why you backed off on this?

Mr. LAUR. Well, the assumption is that we did, Mr. Chairman.

Mr. WALDIE. That's right. Can you tell me if my assumption is correct?

Mr. LAUR. No, I can't.

Mr. WALDIE. You mean you can't tell me if it's correct?

Mr. LAUR. Obviously because of the——

Mr. WALDIE. Because of the confidentiality?

Mr. LAUR. That's correct.

Mr. WALDIE. That's embodied in the negotiations.

Mr. LAUR. I will say this, which I think is a partial reply at least, the Blue Cross and Blue Shield proposals to the Commission—and there's a sort of a ritual process one goes through—were prepared before I arrived on the scene as the director of that program and were submitted to the Commission shortly after I arrived. In the process of getting acquainted with a whole Federal employees program and trying to understand it, I think there was a natural reexamination of a number of things. So that we may well have concluded that it was premature to consider certain activities, principally because in my judgment Blue Cross and Blue Shield have as one of their major strengths and contributions to the Federal employee health benefits plan our ability to work with providers, and I wanted to be absolutely certain that we had done the maximum that we could in delivering a benefit before we decided it was out of control.

Now I'm not so sure but what I'll have a different conclusion once I have had the opportunity to learn fully what can and what cannot be done, but I think that was certainly a piece of the considerations that have occurred as the summer has gone along.

Mr. WALDIE. Thank you. It's possible we'll learn when we have the providers' testimony before the committee, and I don't mean to be critical of the decision because I happen to think the decision not to reduce was a wise decision, but I really feel frustrated in not being able to totally discount the possibility of overutilization in this area in this field and that maybe no system will ever be devised where you can get sufficient figures that we could come up with conclusions in that area, but I am impressed with the fact that Wisconsin has a peer review or a review process that is supposed to be much better than this area and that Wisconsin is not troubled with an overutilization in this area or with what seems to be overutilization. It would seem to me you could draw conclusions from that.

Mr. TINSLEY. Mr. Chairman, Washington, D.C. does have a peer review group in the mental and nervous area. They were one of the first to have it. Southern California is setting up peer review in this area. There are many in other areas in the country. Part of the problem with peer review in this area, of health care, even with the doctors, it's a problem, as well as for a carrier or someone knowledgeable in the field, is when you're dealing with a mental and nervous illness or condition it is not the same as dealing with appendicitis. It is not the same as dealing with other physical ailments. You know when your appendix is out it's out. You may not have known it really needed to come out except you can darn well tell by certain laboratory and other type examinations whether they should have taken it out. In the mental and nervous area it's extremely difficult. It's extremely difficult to obtain separate examinations and opinions in the mental and nervous area independent from the man who's treating it. It's an area where more than any other the professionals, the men in it, have a much greater control, much greater freedom in terms of the treatment modalities, the length of treatment, than any other area.

Mr. WALDIE. Okay. I appreciate your testimony and your appearance.

There are no more witnesses and the meeting is adjourned.

[Whereupon, at 12:15 p.m., the meeting was adjourned.]

UTILIZATION OF MENTAL HEALTH BENEFITS UNDER THE FEDERAL EMPLOYEES' PROGRAM

TUESDAY, OCTOBER 8, 1974

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

The subcommitte met at 10:10 a.m., in room 340, Cannon House Office Building, Hon. Jerome R. Waldie (chairman of the subcommittee) presiding.

Mr. WALDIE. The subcommittee will come to order.

Today the subcommittee will resume its hearings on the utilization of mental health benefits under the Federal employees' health benefits program.

In these hearings, the subcommittee has already heard from the two major insurance carriers under the Federal plan, Blue Cross-Blue Shield and Aetna, as well as the Civil Service Commission, which has responsibility for administering the plan. These witnesses have voiced their concern that an increasing share of the total benefits paid out each year is going for mental health benefits, up from 5.3 percent in 1969 to 7.3 percent in 1972 for Blue Cross-Blue Shield and from 7 percent in 1969 to 12 percent in 1973 for Aetna, while the number of subscribers being treated has remained essentially the same.

All health costs have increased greatly in recent years. Between 1969 and 1972, figures for the Blue Cross-Blue Shield high option plan indicate that average benefits paid out per covered person for all conditions have risen nearly 48 percent, while benefits paid out for mental conditions have risen about 69 percent.

Several factors contribute to the greater benefits paid out for mental health care. Between 1969 and 1972, the number of physician claims for mental care submitted under supplemental benefits of the high option Blue Cross-Blue Shield plan nearly all outpatient, increased by 39 percent as compared with 18 percent for all conditions. And, physician charges for mental conditions paid under supplemental benefits increased four times as much as did benefits paid out for all conditions.

In-patient admissions under Basic benefits increased by 19 percent for mental conditions, while admissions increased less than 1 percent for all conditions. Hospital charges per case for mental conditions increased at about the same rate as charges for all conditions; however, due to greater increases in the length of stay for mental conditions as compared with all conditions, total charges per case for mental conditions increased slightly from 1969 to 1972.

Although, clearly the health plan must provide comprehensive mental health benefits for subscribers, there is need for greater cost

control efforts in this area. The difficulty of defining the causes and full affects of mental illnes makes it more difficult to agree upon the standards of care on which to base cost control decisions. Nevertheless, procedures for determining what is helpful and necessary care need to be developed.

This is a difficult undertaking, and I look forward to having the opinions of the witnesses today as to how it can best be accomplished.

The first witness will be Dr. John Donnelly, secretary of the National Association of Private Psychiatric Hospitals. Dr. Donnelly, come forward, please.

Doctor, you may proceed as you desire.

STATEMENT OF DR. JOHN DONNELLY, SECRETARY, NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Dr. DONNELLY. It is our wish to present to the committee the following remarks with regard to the problems of the provision of psychiatric services in private psychiatric hospitals. These hospitals have, in the last year and a half, had patients who are enrolled in the Federal employees' health benefits program and who have been faced with discrimination in terms of the coverage which they believe they have have under the Blue Cross contract, but when faced with hospitalization these have been denied them.

There have been long delays in the reaching of decisions by Blue Cross as to whether or not the hospitalization is indeed covered under the contract, and then there have been retroactive denials, often after months, so that the patient is left with a bill which he in no way could anticipate nor does he have the means of paying. This in turn results in the failure of the hospital to be reimbursed for services rendered, and, of course, this has an impact in terms of the cost for other patients.

In general, these denials of benefits have been based on an arbitrary decision by Blue Cross that such patients are hospitalized only in order to control their environment or that all they were receiving is milieu therapy. Unless a patient is receiving electroshock treatment it seems that no Federal employee insured under the Blue Cross program is entitled to hospitalization in a private psychiatric hospital.

These decisions appear to have been taken for purely economic reasons in the administration of the Blue Cross program, and they are justified medically by the administrators of the Blue Cross program on the two grounds which I mentioned above. These do not take into consideration the reasons for the hospitalization of a patient nor the active treatment programs which such patients require and have received.

Now we agree that there should be strict review of the utilization of hospitalization, irrespective of the source of funding. We believe that there should be clarification of the use of the term "average length of stay" as it applies to psychiatric patients who are grouped as though the incidence of psychiatric illness is identical with the total incidence of physical disorders in the general population and as though the course of psychiatric illnesses treated in specialized psychiatric hospitals is identical with those treated in general hospitals.

Now with regard to utilization of controls, I present as an example a plan of operation of the utilization review subcommitte at the hospi-

tal which I administer in Hartford, Conn. Continuing review of patient care is undertaken by this utilization review subcommittee of the medical staff, which meets monthly, to review random cases of inpatients, and it also conducts reviews of random cases of discharged patients. This is the customary method by which selections can provide good controls.

In addition to the regular monthly meetings of the utilization review subcommittee, there are bimonthly meetings of a clinical care subcommitte composed of the senior clinical director and the chiefs of sections. This committee is concerned with reviewing and evaluating clinical programs in the hospital as they affect the care of patients, as well as reviewing any specific problems submitted to it by the utilization review subcommittee. Among the areas which it is intended to examine and study are the treatment plans as laid down in the 3-week evaluation and an examination of the followup of these plans during the hospitalization of the patient.

This 3-week evaluation conference is done for every patient admitted to the Institute of Living. The patient undergoes extensive physical, neurological, psychological, and psychiatric examinations. Treatment plans are formulated and set in motion. What we call a 3-week evaluation conference is held during the third week of the patient's hospitalization, and is attended by the personal physician of the patient, the clinical supervisor and the chief of section. A review is made of the patient's history, mental status, the findings of the various examinations, and a definitive diagnosis is established. The plan for treatment is reviewed, and the prognosis is again evaluated.

While not all hospitals follow the same intensive review process, utilization review is required in all hospitals accredited by the joint commission on accreditation of hospitals and by hospitals accepting patients under governmental sponsorship, such as medicare.

Now with regard to the term "average length of stay" as it applies to psychiatric hospital patients, this is much more complicated than it is in terms of general hospitals. Because the vast majority of patients in general hospitals suffer from acute illnesses which respond readily and rapidly to treatment, the term "average length of stay" has as significant meaning within the context of the general hospital. But even in the case of physical illnesses, there are some which begin in acute form and continue for some length of time, while others develop on a less acute basis and continue for a long time. The impact of such patients on the average length of stay in the general hospital, however, is relatively small because they are few in number compared with the mass of acute physical conditions which respond readily.

In the case of psychiatric illnesses, the term "average length of stay" is not as meaningful. There are many psychiatric illnesses which develop acutely and respond rapidly to relatively short-term hospitalization. There are psychiatric illnesses, however, which do not start as acutely and which take a considerable length of time to treat.

Thus, an acute depression responds quickly to therapeutic measures such as electroshock, whereas other illnesses such as paranoid schizophrenia take a very much longer time to bring under control.

An important element in the understanding of the duration of psychiatric illness is that the patient is responding not only to changes within his own physical body, as in the case of general physical ill-

ness, but also to environmental factors. These factors include both current stresses which contributed to the onset of the illness and the conflicts still within him as the result of stresses to which he had been subjected in his earlier years.

Much more meaningful in approaching the question of the length of stay of psychiatric patients is the use of the median length of stay which gives a much better picture of the duration of hospitalization over a large number of patients.

In order to be meaningful, the use of "average length of stay" should be applied in large measure to the different types of psychiatric illnesses and the frequently or incidence of these, rather than grouping all psychiatric illnesses together.

Now I understand that you have received or will receive the studies conducted under the auspices of the National Institute of Mental Health with regard to utilization of psychiatric services under the Federal employees' health benefits program. I am informed that these studies indicate that, for a very large number of patients, up to 90 percent have terminated the treatment process within 3 months and only a relatively small number require continued treatment over longer but varying periods of illness.

Psychiatric hospitals are increasingly utilized for patients who have already received treatment on an outpatient basis but later require hospitalization because progress has not been made or the patient fails to respond or, in fact, the patient gets worse. The psychiatric hospital is also used for patients who have not responded to short-term treatment in the psychiatric wing of the general hospital.

Optimum psychiatric treatment for these patients requires a full schedule of therapeutic activities which are just not available in the general hospital.

I want the committee to know that four of the nationally known private psychiatric hospitals in the country have embarked on a comprehensive study of the length of stay in hospital for psychiatric patients. This study is being conducted by four hospitals: The Menninger Clinic in Kansas, the McLean Hospital in Massachusetts, Sheppard & Enoch Pratt in Maryland, and the Institute of Living in Hartford.

This project, which has been ongoing for a year, is investigating factors which affect the length of stay patients in psychiatric facilities, including the particular illnesses, age of the patient and the age at onset, duration of illness prior to hospitalization, previous treatment, either on an in or outpatient basis, social and environmental factors, genetic factors, and so forth. It is hoped that this study will in time, at least insofar as the patients in those hospitals are concerned, be most revealing.

Now with regard to the private psychiatric hospital patient, we would like to make the following remarks:

With the great increase in psychiatric wards in general hospitals throughout the country over the last several years, there has been a marked shift in the emphasis of the treatment of psychiatric patients, taking into consideration the total picture.

Prior to the opening of the psychiatric wards in general hospitals, most psychiatric patients requiring inpatient services were treated in State hospitals or in private psychiatric hospitals.

With the introduction of psychiatric units in the general hospital,

which was made possible only because of the increased availability of psychiatrists in general practice, the pattern has developed that the acute psychiatric conditions tend to be treated in the general hospital. Since the duration of hospitalization in the general hospital is relatively short by administrative philosophy, those patients who do not respond to the limited programs in those hospitals and who still require in patient treatment are referred to private psychiatric hospitals or to State facilities. In very large measure the availability of third party coverage determines in which direction the patient is referred.

It should be realized, therefore, that private psychiatric hospitals have very specialized functions in dealing with the psychiatrically ill population.

I might mention that within the private psychiatric hospital group there are two subgroups, one being those private psychiatric hospitals in areas in which there are no general hospital facilities. These tend to take those patients who respond to short-term treatment, as well as those patients who need longer and somewhat different types of treatment processes. The other subgroup of psychiatric hospitals, which admit patients after hospitalization in general hospitals, tends to get the most difficult patients who have not responded to the relatively easy short-term methods of treatment, such as electroshock. Such patients, moreover, tend to have major problems within the family or in the work situation, as well as deep problems within themselves, which are all contributory to the degree of disturbance of the patient.

Nevertheless, if these patients are not to be abandoned—and I referred to the NIMH study, we are talking about 10 percent—if they are not to become chronically disabled, it is vital that intensive care be given them in a hospital setting.

With regard to State hospitals, in the last 15 years there has been a big drive to reduce the population of patients within these facilities. In large measure, this was started for two or three different reasons. Originally it was directed to eliminate the custodial care function of the State hospital, on the basis that many of these patients could live useful lives in the community. But accounts in newspapers from New York to California now indicate that many patients admitted on a short-term basis to State facilities are quickly discharged, often with continuing severe emotional illnesses, with inability to adjust in the community. Subsequently, they are readmitted to psychiatric facilities and there has evolved what is known as the "revolving door." State hospital facilities—I can speak for our own State—may show short length of stay for admissions, but the real question has to be asked: What has been done for the patient by the time he is discharged? How able is he to resume an active role in the community? And how many times will he return to the State facility?

Now with regard to the cost of psychiatric hospitalization, we would like to present the following remarks:

In studies of the cost of inpatient care in private psychiatric hospitals, two aspects must be taken into consideration: The cost per day and the total cost of hospitalization during an illness. In private psychiatric hospitals, certainly in the best of private psychiatric hospitals, treatment programs are intensive—not only the patient, but

also members of his family frequently need to be involved, and the number of personnel tend to be much higher than in a State facility.

The reasons for the lower ratio of personnel in State hospitals are the matter of economics and the inability to recruit professional personnel.

It is our opinion that not only is the cost of hospitalization in the private psychiatric hospital much less than in the general hospital on a daily basis, but also much less over the whole duration of the illness.

For your information, I would like to quote comparative costs for patients at the Institute of Living and at the general hospitals in the Hartford area.

The Connecticut State Department of Welfare reimburses the general hospitals (there are three) for welfare patients from a minimum of $151.08 to a maximum of $173.32 per day. This covers the total care of patients in a semiprivate room.

At the Institute of Living, a private, nonprofit hospital, the rates for private patients in multiple occupancy accommodations start at $71 a day (less than half the welfare rate), and the top rate for a private room with bath is $90 a day. It should be noted that these rates include the psychiatrist's therapy and all treatment programs and excludes only expenses incurred by the individual patients, such as for medications.

In spite of the fact that all or most all patients admitted to the Institute of Living have had prior treatment, the majority at other facilities, the average length of stay at discharge for 1,203 patients was 217 days. However, to illustrate how statistics distort, when one patient with the longest stay was removed from that number of 1,203, the average drops to 208 days. In actual fact, nearly 60 percent of the patients are at the institute for less than 4 months.

If one takes a curve for length of stay for psychiatric patients nationally, it is similar to that which reflects the income distribution of individuals throughout the country.

At the office of the National Association of Private Psychiatric Hospitals, a survey was done of the charges at 30 private member hospitals and the average rate for semiprivate care was $99.30 per day.

We submit that the cost in private psychiatric hospitals is indeed very much less than in general hospitals.

Mr. WALDIE. Doctor, have you ever when you have been denied payment on a Federal employee health benefits program patient—has the patient ever brought suit to your knowledge?

Dr. DONNELLY. A number of patients are taking suit, yes.

Mr. WALDIE. They are doing it. None have been thus far to your knowledge processed to completion?

Dr. DONNELLY. Not yet. I have in my case a brief with regard to retroactive denials at the Institute of Living which I prepared and presented to the Civil Service Commission, Mr. Gordon F. Brown, a year ago, with all the details of the retroactive denials the length of time, and so forth. As a matter of fact, we made the decision at the Institute of Living that all patients who were Federal employees who applied for admission were to be advised that, on the basis of the administration of the Blue Cross portion of the Federal employees' program, unless they had other insurance or other sources to fund hospitalization, they should seek alternative hospitalization, not based on the reimbursement by that Blue Cross contract.

Mr. WALDIE. Is that plan the only one you have had difficulty with?

Dr. DONNELLY. That is the only one we have had real difficulty with. We have had problems occasionally with Aetna. Where Aetna has questioned a patient's hospitalization, my personnel have sat down with Aetna representatives. Where there have been disagreements, these have been settled. Aetna does review these cases, reviews them individually, to see whether or not the hospitalization is justified. Sometimes they recognize it is; other times they say it is not.

Mr. WALDIE. Well, you are bringing somewhat of a different problem than the committee initially began to consider. We were considering a proposal to cut back coverage. Your problem is even with existing coverage they have, you believe, implemented a cutback by administrative review by denial of claims that you believe to be legitimate.

Dr. DONNELLY. I have said that, as far as psychiatric hospitalization is concerned, if they were to cut back the coverage, or whether they were to say they were giving 100 percent but administer it in the way they are presently doing, it would not make any difference as far as the patient is concerned.

I might say I have met with representatives of National Blue Cross. I have been in a number of positions in the field. I have been chairman of the Council on Mental Health of the AMA, and we invited the committee on financing of health care, a year ago, together with Blue Cross to discuss the problem. Certain statements were made at that time which indicated to me what the basic problem was. For example, Mr. Harvey at that meeting stated that, if they increased the psychiatric coverage—no, if they reimbursed more psychiatric coverage under the premiums, they would have to cut back coverage for physical and surgical illnesses, that there are only so many dollars and that, therefore, it is an administrative decision as to how they are going to be disbursed.

Mr. WALDIE. All right. Do you have anything further you would like to submit to the committee?

Dr. DONNELLY. I will submit other backup material.

Mr. WALDIE. We will be happy to receive it. Thank you very much for a well prepared statement which will be helpful in our deliberations.

[The utilization review subcommittee plan of operation referred to earlier by Dr. Donnelly follows. Also, a brief with regard to retroactive denials at the Institute of Living, submitted by Dr. Donnelly was retained in the files of the subcommittee.]

INSTITUTE OF LIVING UTILIZATION REVIEW SUBCOMMITTEE OF THE QUALITY CARE COMMITTEE

PLAN OF OPERATION

I. The Utilization Review Subcommittee shall be composed of at least the Assistant Chiefs of Section of the Medical-Dental Staff, plus one representative nominated by the Director of Nursing and a representative nominated in alternate years by the Departments of Social Work Service and Clinical Psychology.

II. The objectives of the Utilization Review Subcommittee shall be:

A. Assurance of quality of comprehensive care of the total patient population and to assure effective use of hospital services,

B. Control of necessity for admission for, and duration of, hospitalization,

C. Review of those patients who qualify for admission and treatment under *Medicare*, and

D. Supervision of clinical and administrative procedures as Medicare and Medicaid regulations may require.

III. In pursuit of these objectives, the Subcommittee shall:

A. Review a sample selection of patients who:

1. have been admitted since the last meeting of the Utilization Review Subcommittee,

2. have been in the hospital for twenty days or more,

3. have been discharged since the last meeting of the Utilization Review Subcommittee.

B. Review *ALL* patients who qualify for hospitalization under *Medicare.* Where it has been decided that a hospitalization of more than twenty days will be necessary, a review will take place within seven days after the patient has been in the hospital for twenty days, and a review will be made on a monthly basis thereafter.

C. Substantiate medical care evaluation studies.

IV. The above reviews shall be made from data obtained from the patients' clinical records. This will include review of the history, mental status examinations, physical and neurological examinations, x-ray and laboratory findings, physicians' orders for drugs and other modes of therapy, as well as observations contained in the nursing reports, social service reports and psychological reports.

These reviews shall be done in order to substantiate the necessity for hospital admission, adequate diagnostic evaluation, proper diagnosis, appropriate use of consultations, prompt initiation of indicated therapy, response to therapy and need or lack of need for continued hospitalization. In the case of discharged patients, plans for after care will also be scrutinized.

No physician shall have review responsibility for any extended duration cases in which he was professionally involved.

V. Minutes of each meeting shall be kept and observations on the patients reviewed will be recorded as well as documentation of medical care evaluation studies. Copies of these reports will be made availabe to the Psychiatrist-in-Chief, the Medical Director, the Clinical Directors, the Chiefs of Section, the personal physician of each patient discussed, and the Quality Care Committee. These minutes will be presented at the regular meetings of the Executive Committee of the Medical Staff and at the monthly meeting of the Medical Staff.

VI. As a result of these reviews, comments or recommendations may be made to the personal physician of the patient under discussion, together with an exchange of opinions as to continued hospitalization.

VII. It shall be the responsibility of the hospital Administrative Staff to make available to the Utilization Review Subcommittee whatever records and material may be pertinent to the findings of the Subcommittee and its efficient operation.

VIII. The fiscal intermediary (The Aetna Life and Casualty Company, 84 Wadsworth Street, Hartford, Connecticut 06106) shall receive copies of the Utilization Review Subcommittee's reports on Medicare patients as well as progress notes, a 10-day evaluation note, certifications and recertifications.

IX. Patients' records which have been reviewed shall be tagged according to whether they come under the sample selection or whether they are records of patients who qualify for hospitalization under Medicare.

X. The Medical Records Librarian shall maintain a record of the dates when initial reviews of Medicare patients take place, and shall keep the Utilization Review Subcommittee informed of the cases due for review on the subsequent monthly intervals.

XI. In the event that the Utilization Review Subcommittee shall decide that a patient's hospitalization shall be terminated earlier than the date decided upon by the personal physician, the personal physician, the patient, the responsible party, and the fiscal intermediary shall be so notified in writing.

Mr. WALDIE. Our next witness will be a representative of the American Psychiatric Association, Dr. John Spiegel, and accompanying him will be Dr. Louis Reed and Dr. Sullivan.

Gentlemen, will you please come forward?

STATEMENT OF DR. JOHN SPIEGEL, PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION, ACCOMPANIED BY DR. LOUIS REED AND DR. FRANK SULLIVAN

Dr. SPIEGEL. Mr. Chairman, I am Dr. John Spiegel, president of the American Psychiatric Association. On my right is Dr. Frank Sullivan, who has been chairman of our task force on peer review, and on my

left is Dr. Louis Reed, who is a consultant to the association, particularly on statistical review of matters that are before us.

Dr. Reed will address himself to the committee's interrogatories relating to utilization in the Federal employees' health benefits plan, and other utilization data. And Dr. Sullivan, who has been working with the professional standards review organizations and peer review on the national level, will give you his perspective into the present progress of peer review in the field of psychiatry. I think the current progress is something that the committee will be especially interested in.

By way of introduction, I hasten to say that Blue Cross and Blue Shield, and the Civil Service Commission have taken a very forward stand by way of providing a wide range of benefits for mental and emotional illness among Federal employees. We have witnessed the fact that the Commission and the Blue wish to continue this kind of coverage, by their recent decision not to change the benefit structure.

Mr. WALDIE. May I interrupt you? Just as a layman, what is the distinction between a mental illness and an emotional illness?

Dr. SPIEGEL. They are really synonymous. But mental illness is a more precise term. Emotional illness is an informal way of referring to a mental illness.

We wish to be on record as saying that we will maintain a high level of communication and cooperation with these agencies so that we may work together to provide needed and appropriate mental health services to patients, utilizing and building effective peer review mechanisms to insure this.

It was stated to us by Blue Cross and Blue Shield that perhaps there has not existed the desired level of professional communication essential to maintaining an optimal working program for all parties concerned. As a result there may have emerged in some cases, patterns of misunderstanding, of retroactive denial of claims, and the contemplated trend toward reduction in the mental health benefit structure. We are hopeful that these experiences will help to produce the proper working relationships and correct perspective of a basically excellent program. We urge that this committee maintain its vital interest and active participation in this important program for Federal employees, and continue to act as forthrightly and effectively in the future as it has done in the past.

At the same time, we, as an association, on the national and local levels, are involved in the formulation and implementation of effective methods of peer review.

In addition, we investigate and evaluate modalities of treatment for mental and emotional illness—it sounds as if they are different things because it says mental and emotional, but I think we can just read it as mental illness. We form committees and task forces of experts in specific subject areas to determine if certain modalities of treatment have scientific validity, and public position papers on our findings. Such a position was used in the recent hearings on the CHAMPUS program to illustrate that this association did not subscribe to megavitamin therapy as a scientifically recognized modality of treatment. We are continuing and expanding our efforts in this direction.

The association recently formed a commission on standards and practice and third party payments specifically for the CHAMPUS program in order to provide a high level of professional provider input into this program.

This commission on standards and practice is also working with the Blue Cross, Blue Shield in connection with the Federal employees' program, which is a new development of collaboration and consultation between our association and the Blue Cross, Blue Shield officers, and we think this is very promising in terms of straightening out the problems in the future.

I am pleased to say that we are in general agreement with the statement made by the Blue Cross Association and the National Association of Blue Shield Plans before this committee. We particularly wish to underscore their statement that the Federal Government is to be congratulated for the support that has been given to the inclusion of mental health benefits in the Federal employee health benefits program. We hope that this comprehensive type of coverage will provide the exemplar for benefit packages that are yet to be formulated under national health insurance. We believe that the provision of mental health benefits cuts down on the utilization of general medical services. It is estimated that between 50 to 70 percent of those who go to primary physicians complaining of physical symptoms are really suffering from a component of mental and emotional illness. Appropriate mental health treatment in many of these cases will obviate costly and protracted medical services that are inappropriate.

There has been a recognition of the need for comprehensive mental health services, and we are hopeful that this will be translated into national policy in the years to come, and this program will really serve as a model for those national policies.

Higher utilization in the Washington, D.C. area should not necessarily be perceived in a pejorative sense. Mental health benefits around the country are still not developed to the extent that more than a small percentage of those requiring treatment are receiving it. It has also been demonstrated that utilization invariably follows the availability of a benefit and services, and we will hear more testimony to this effect from the others here this morning.

I wish to thank the chairman and this committee for its wisdom and judiciousness in this matter. I will now ask Dr. Louis Reed to summarize some of the data relating to his study on utilization and costs of psychiatric treatment, as well as to other data you have requested.

Mr. WALDIE. Thank you, Doctor.

Dr. Reed?

Dr. REED. I am a private consultant in the field of health economics and have done considerable work in this area for the American Psychiatric Association. I was director of its project from June 1970 to December 1972 on health insurance plans and psychiatric care, which was financed by the National Institute of Mental Health, and which resulted in publication in 1972 of the volume "Health Insurance and Psychiatric Care: Utilization and Cost."

As part of that project—which was to gather all salient available data on coverage and utilization of care for mental conditions under health insurance—I and my colleagues, Mrs. Evelyn Myers and Mrs. Patricia Scheidemandel, made an intensive study of the utilization experience in 1969 under the Blue Cross and Blue Shield plan for Federal employees. More recently, I made a special study for the American Psychiatric Association of the utilization in 1972. This was

published as an article in the September 1974 issue of the American Journal of Psychiatry and a reprint is attached, and you may wish to put that in the record.[1]

Before answering some of the specific questions on utilization which were attached to the chairman's letter to the American Psychiatric Association, let me briefly smmarize the findings from the study of the 1972 utilization experience. In this I will try and avoid going over ground that was covered by Mr. Laur of Blue Cross-Blue Shield in his testimony, and I will confine myself to utilization under the high option plan, which has 80 percent of the enrollees under both options.

Hospital admissions under the basic benefits (that is, to general hospitals and mental hospitals that are member hospitals of the local Blue Cross plans) in 1972 numbered 5.1 per 1,000 covered population—3.9 percent of all admissions. Average length of stay was 17.6 days, as against 7.6 days for all conditions. Total days for mental conditions numbered 89.2 per 1,000—9 percent of days for all conditions. Total covered charges (in effect benefits paid) amounted to $5.68 per covered person, or 6.2 percent of benefits for all conditions.

Hospital outpatient cases of mental conditions were inconsequential in number or costs.

Basic surgical-medical claims and covered charges for care of mental disorders had to be partly estimated for reasons which I shall not here go into. Briefly, there were 4.9 claims per 1,000 population for in-hospital medical care of mental conditions, involving 71.7 visit days per 1,000 and total benefit payments of $1.17 per covered person. Outpatient basic surgical-medical benefits for mental disorders were inconsequential.

Mr. WALDIE. What is a surgical treatment of a mental disorder?

Dr. REED. Well, this could be for certain operations which are very infrequently performed.

Mr. WALDIE. What are they?

Dr. REED. Dr. Spiegel could answer better than I.

Dr. SPIEGEL. Well, there are some procedures that have been used in the past.

Mr. WALDIE. Lobotomies?

Dr. SPIEGEL. Lobotomies, yes. Singlectomies.

Mr. WALDIE. Is that what they are referring to here on these statistics?

Dr. REED. No, this is not—this is really the physician visits for care in the hospital.

Mr. WALDIE. But what would be a surgical claim for mental health?

Dr. REED. What would be a surgical claim?

Mr. WALDIE. What would be a surgical claim for mental disorders, if you are not doing a lobotomy.

Dr. REED. I would think that they would be very, very few.

Dr. SPIEGEL. I would imagine this would refer to—but I'm not at all certain, I am just guessing—to associated medical or surgical illnesses that occur while a patient is in a hospital for a mental illness.

Mr. WALDIE. Okay.

Dr. REED. I am covering this because all of the benefits under the

[1] Retained in the files of the subcommittee.

Blue Cross and Blue Shield plan are either hospital benefits, basic hospital benefits or basic surgical-medical benefits or the supplementary benefits, and the in-hospital medical benefits are really physician visits for mental cases in the hospital.

Total basic surgical-medical benefits for mental disorders amounted to $1.19 per covered person, equal to 2.3 percent of all basic surgical-medical benefits for all conditions.

Under supplemental benefits there were 1.3 cases, or you might say claims, per 1,000 for reimbursement of hospital bills for mental disorders—24 percent of cases for all conditions. This in effect is for care in mental hospitals that are not Blue Cross member hospitals. Mental hospitals that are Blue Cross members are paid under basic benefits. Total charges on these cases or claims amounted to $1.26 per covered person, equal to 69 percent of such hospital claims for all conditions. Supplemental benefits pay 80 percent of covered charges in excess of a deductible of $100 per person. The percentage is high because virtually all hospital care for general conditions is paid for under basic benefits.

Cases or claims for reimbursement of physicians' charges for care of mental disorders numbered 18.5 per 1,000 population. Virtually all of this is for outpatient care (that is care in the office or hospital outpatient department) since virtually all charges for in-hospital physician service are paid under basic benefits. Total charges under such claims amounted to $4.72 per covered person.

Mr. WALDIE. Doctor, may I interrupt you just a minute? Congressman Daniels will now be presiding. Unfortunately I have a call and my presence is required somewhere else for a while. Congressman Daniels will be handling the hearing now, if you will excuse me a moment.

Mr. DANIELS. All right, Doctor, you may proceed.

Dr. REED. They constituted 47.9 percent of all physician supplemental charges. The proportion is so high partly because all charges for outpatient surgical care and all office X-rays and laboratory services are paid under basic benefits, and because much care in physicians' offices is for minor conditions or illnesses needing only a few physician visits and for which the aggregate charges do not exceed $100 so that no claim is filed.

Charges for other types of care under supplemental benefits were relatively low, 2 cents per covered person for special nursing, 48 cents for drugs, and 41 cents per covered person for other services—this last includes services of psychologists.

Total covered charges for care of mental disorders under supplemental benefits amounted to $6.88 per covered person— 34 percent of all charges for all conditions. Of these charges, $5.03 was paid by the program and $1.85 by the patient in coinsurance and deductibles.

Total benefits (under both basic and supplemental benefits) for care of mental conditions amounted to $11.92 per covered person, representing 7.3 percent of total benefits for all conditions $162.21 per covered person. Total benefits for mental conditions under the low option amounted to $3 per person covered—4.6 percent of benefits for all conditions.

Bringing together the data under basic and supplemental benefits, it appears that in 1972 under the high option there were approximately

6.4 hospital admissions for mental disorders per 1,000 population, involving approximately 109 days of care per 1,000, or 10.7 percent of the days for all conditions. About four-fifths of the days were under basic benefits. Total benefits paid for hospital care amounted to approximately $6.62 per covered person—6.7 percent of benefits for all conditions.

As regards physician services, there were 23.6 claims per 1,000 for care of mental conditions—more than three-fourths under the supplemental. Mental claims were 2 percent of all claims. Total charges for physicians' services amounted to $5.91 per covered person, and total benefits paid to $4.64 per person. These benefits amounted to 8 percent of all physician care benefits for all conditions.

It is of interest that of the total benefits paid for care of mental conditions, $7.82 per covered person, or 66 percent, was for inpatient care, that is, hospital care and physician services in the hospital, and $4.10, or 34 percent, was for outpatient care—care outside the hospital.

Over the years since the inception of the Federal employees program, the proportion of benefits paid for care of mental conditions to total benefits for all conditions has increased more or less steadily, from 3.9 percent in 1961–62, to 6.4 percent in 1969, to 7.3 percent in 1972, and, according to figures compiled by the Civil Service Commission, to 7.4 percent in 1973. I do not regard such increase as in itself indicating improper utilization, that is, provision of inappropriate or unessential service. Over this perod there has been a shift in attitudes toward mental illness—people have become more prone to seek help in cases of mental or emotional problems, the proportion of psychiatrists to all physicians has increased somewhat, and much hospitalization that used to take place at low per diem cost in State mental hospitals has been shifted to general hospitals and private mental hospitals in the community.

Mr. DANIELS. Dr. Reed, do you think it a natural condition these days that people are more prone to talk about mental illnesses than heretofore?

Dr. REED. That is my impression; very much so, I think.

I am sure Dr. Spiegel——

Dr. SPIEGEL. I agree.

Mr. DANIELS. I get the same impression, because we have a mental health association in our community which is very, very active, and I am surprised to find that over the years there is greater attendance at their affairs and people are more outspoken about their children or members of their family having some handicap with regard to mental illness. So that might be the reason for the increase in the services.

Dr. REED. I think it is certainly part of it.

I do not think that there is any specific percentage of total benefits which should go for mental illness—be it 4 or 7 percent—and which we should regard as right and proper and be disturbed when it goes up or down. I think that an increase always indicates that you should scrutinize it, but in itself such an increase I think does not indicate improper utilization.

Changes will occur in the proportion of benefit payments going for various diseases depending upon incidence of illness, demand for care or changes in medical technology. For example, benefit costs for maternities, as a proportion of the total, have gone down in recent

years because of the lowered birth rate. Benefit payments for poliomyelitis have practically disappeared as a result of the vaccine. I imagine that the proportion of benefit payments going for kidney disease has considerably increased because of dialysis; likewise the proportion of benefit payments for heart disease because of open heart surgery and other developments in that field.

I should like now to respond to some of the specific questions on utilization that were in the chairman's letter to the American Psychiatric Association. All of the data that I will give relate to the high option and are taken from the association's publication "Health Insurance and Psychiatric Care: Utilization and Cost." The data are for the year 1969—we did not develop data of these types in the 1972 study. I think that 1972 data, if it were available, would not differ significantly from that for 1969.

1. Age and sex of those receiving psychiatric benefits, inpatient and outpatient

As shown in table 1 attached—and the tables are all at the end of the testimony—admission rates for mental conditions under basic hospital benefits are much lower for children—persons under 19—than for the total population of all ages. Rates for the aged—those over 65—are also relatively low. The rates for those from 19 to 64 are all higher than the average. Average length of stay is about the same at all ages. Benefit costs are low for children and the aged, high for those in the prime and middle-age groups.

Admission rates for females are significantly higher than for males at virtually all ages. So are the days of care rates. The average length of stay is about the same; benefit costs are more than 50 percent greater for females than for males.

Hospital cases and charges under supplemental benefits—that is in table 2—are also higher for females than males. Also cases and charges are relatively low among persons under 19, and slightly lower than average for those 65 and over. The highest utilization is in the 19–34 age group.

As regards physician services, the utilization of physician in-hospital visits follows the same pattern as for hospital care under basic benefits—higher for females than males, quite low for children, low for the aged and highest for those 19–64 (table 3.)

As regards physician outpatient services, under supplemental benefits, the data in the lower part of table 2 show only slightly more cases among females than among males—13.6 as against 11.3 per 1,000 population—and only slightly higher average charges per person covered—$2.96 for females as against $2.73 for males. The case or claims rate is relatively very low among children, even lower among the aged, and relatively low in ages 55–64. The rate is highest among the ages 19–54, with the highest utilization among those 19–34. Charges per person are along the same general pattern.

Mr. DANIELS. Is there any particular reason, Doctor, why utilization by older people, our senior citizens, is less at their age than the prior age group?

Dr. REED. Dr. Spiegel, why don't you address yourself to that?

Dr. SPIEGEL. I don't think that I am the best qualified to answer that. Dr. Sullivan, do you have any——

Dr. SULLIVAN. I don't know that we know specifically other than that it is a fact statistically. I am not sure that that means that there

is less emotional problem in that age group, and I would doubt that that is the case.

Mr. DANIELS. Well, I am particularly interested in why it would fall off.

Dr. SULLIVAN. I don't think that we know. I think it is not because there's less emotional problems; or it may have to do with availability, it may have to do with financing.

Mr. DANIELS. If you obtain any data on that score you are privileged to submit a supplemental statement which will be made part of your testimony.

Dr. REED. Very good.

2. Utilization by educational and income levels

We do not have information on utilization of Federal employees by educational or income levels. However, some of the differences in regional utilization, which I will discuss below, may partly reflect differences in these factors. Utilization experiences for a considerable number of insured groups of the general population indicate strongly that the utilization of outpatient psychiatric care varies markedly with years of education and income. That is it goes up as education and income increase.

3. Duration of hospital stay

We have already indicated that the average duration of stay for mental conditions under basic hospital benefits in 1972 was 17.6 days per admission. In 1969 it was 16.3. The distribution of admissions and days of care in 1969 by duration of stay is shown in table 4. It will be seen that 51 percent of admissions in 1969 had a stay of 9 days or less, and that these cases involved 14 percent of the total days of care. On the other hand, 13.4 percent of the admissions stayed 31 days or longer and these admissions were responsible for 47 percent of the total days of care. We do not have data now on the distribution of hospitalized persons according to total days of care in a year, that is, aggregating the data for those who were hospitalized more than once in the year. We will have such data when the results of a special study undertaken by the Blue Cross-Blue Shield Plan at the instigation of the Civil Service Commission have been analyzed.

4. Duration of outpatient treatment

In 1973 there were 29,541 different persons who had submitted claims under the high option supplemental benefits for reimbursement of physician charges for care of mental conditions—a rate of 6 per 1,000 covered population, or six-tenths of 1 percent. It may be assumed that virtually all of the charges were for outpatient care since inpatient care is covered under basic benefits and physicians in almost all States are paid on the basis of usual, customary and reasonable charges so there would be few extra charges which a person would be asked to be reimbursed for under supplemental benefits. The average charge per person covered came to $4.78.

Now this distribution of persons according to the amount of charges doesn't actually show number of visits, but one can infer that from data on that.

Of those who had supplemental physician charges for care of mental disorders, 20 percent had total charges during the year of less than $100—in other words, they had one or two or three visits for psychiatric care. And, of course, these data do not take account of persons

who perhaps had just one or two visits to a psychiatrist in a year and no other care of physicians in the office so that he didn't aggregate charges of more than $100 and so it wasn't worth while for him to submit a claim. Another 42 percent had charges of between $100 and $500. Assuming an average charge of $30 per visit—less than the $35 or I guess now $40 frequently charged for a 50-minute visit for psychotherapy, on the assumption that some patients had only a 20- or 30-minute visit and some had group therapy—this would mean between 3, and say, 15 or 16 visits. These two groups of patients had aggregate charges of only 15 percent of the total. Another 28 of the persons incurred charges of between $500 and $2,000—they had, it may be estimated, about 16 to 67 visits during the year and their charges were 38 percent of the total.

On the other hand, there were 9.3 percent of the patients who had charges of over $2,000—or more than about 67 visits during the year. This group of patients had 47 percent of the total charges. Included in this group of heavy users were 2 percent of the patients who had charges of from $5,000 to more than $15,000—indicating over 160 visits a year.

You will see that there was one person whose total charges were $15,572. One wonders how he had incurred such high charges, which would indicate 400 or more visits during the year. Possibly this could be because he paid during 1973 for some service that had been received in the preceding year.

These patients were probably receiving psychoanalysis. This 2 percent of the patients incurred 17 percent of the aggregate charges.

The average charge per person with supplemental physician charges for mental conditions was $757—indicating 25 or so visits during the year. The median charge was $384, indicating about 12 visits. But the distribution is highly skewed with a relatively small proportion of patients having a much higher than average number of visits.

Now these data show the average number of visits per person having some care for mental disorders during the one year. We will have data a little later which bring together the figures for the experience for 1971, 1972 and 1973. And this will show the distribution of different persons according to charges over this whole period. These data will indicate a relatively larger proportion of all patients with very high charges and therefore a large number of visits.

Now, I will introduce data from a study which is under way by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health on private psychiatric office practice. I think that this study when it is published will be very informative and very useful. It was made by sending questionnaires to 10 percent of all physicians who in the records of the American Psychiatric Association devoted more than 15 hours a week to office practice. About 660 questionnaires were sent out. A reply was received from approximately 71 percent of these physicians.

The questionnaire asked for the specialty of the physician and certain other data, and then it asked him to fill out a form for each of the last 10 patients that he had seen consecutively in the week in which he filled out the questionnaire. And these data on the patient questionnaire are quite detailed, show age and sex, marital status, when the psychiatrist first saw this patient and where, did he have any inpatient

service, approximate number of office visits of this patient during the last 12 months, the diagnosis of the patient's disorder, degree of functional impairment at the time, the services received, the duration of this patient's final visit this week, current frequency of visits, and number of visits within the past year and within the past 2 years, and expected future duration of treatment.

It is impossible to really go into that deeply here, and I might not be able to answer all of your questions on it because I have not been intimately associated with this study.

There are three tables which are at the end of the tables relating to my study that give data from this study. These show a distribution, the number of visits of all patients in the last 12 months by length of time since patients were first seen.

Then the second table shows the number of visits of analytic patients; that is patients who were receiving psychoanalysis in the past 12 months by length of time since patients were first seen.

And then the third table shows the number of visits of nonanalytic patients, that is the patients who were not receiving analysis in the past 12 months, by length of time since patients were first seen.

Now in some respect these data will understate the duration of treatment because, you see, they relate only to the past, and they do not take account of visits in the future. However, that will be dealt with in the full report of this study.

Just referring to the bottom part of each table, we can see that the number of visits in the past 12 months irrespective of when patients were first seen, the median for all patients was—the mean for all patients was 45 visits and the median was 25. For analytic patients the mean was 138 visits and the median was 145. Now analytic patients are generally seen four times a week for 48 weeks a year. And then the mean number of visits for nonanalytic patients was 51 visits in the past year and 40 was the median.

We were in some question as to whether we should bring this data to your attention now because it is incomplete. But we thought that it does help to shed some light on this and that it would be useful.

5. Variation of utilization by region

The American Psychiatric Association report on "Health Insurance and Psychiatric Care" gave data, developed by a special study, on utilization under the Blue Cross and Blue Shield plan for Federal employees, in 1969, by region with separate data for the District of Columbia, Maryland, and Virginia. The data are shown in tables 5, 6, and 7.

It will be seen from these tables that utilization of basic hospital benefits in the District of Columbia and the States of Maryland and Virginia was lower than in the South Atlantic region as a whole or nationwide. It was impossible in this study to break out data for just simply the Washington metropolitan area. The data relate to all Blue Cross, Blue Shield covered employees in the District of Columbia, and Maryland and Virginia. Now there has been much said about utilization being higher here for District of Columbia, Maryland and Virginia, but it will be seen that this is not so as regards inpatient care. It is so as regards outpatient care, which we will deal with later. Thus admissions in these three areas combined were 3.3 per 1,000 as

against 4.3 for the country as a whole, and days of care were 69.2 per 1,000 as against 70.1 for the country as a whole. Benefit payments per person were $3.45 per person in the District of Columbia, Maryland, and Virginia as against $3.25 nationally. I do not have figures on charges for hospital care under supplemental benefits (that is, for care in nonmember mental hospitals); this might change the picture.

Charges per covered person for physician services under supplemental benefits were definitely much higher in the District of Columbia, Maryland, and Virginia area than in the country generally, $8.41 as against $2.86 for the United States as a whole. Charges for other conditions were also higher, it appears.

Total benefits for mental conditions (basic and supplemental) were $12.41 per covered person in the District of Columbia, Maryland, and Virginia as against $6.94 nationally.

I think that some of the reasons for the higher utilization of physician outpatient care for mental conditions in the District of Columbia, Maryland, and Virginia jurisdictions are the following: The bulk of Federal employees in this area are in the District of Columbia metropolitan area, and this area, like other large metropolitan areas, has a relatively high ratio of psychiatrists to population—in fact, the Washington area probably leads the country in this regard. The Federal employees in the District Columbia metropolitan area include a higher proportion of persons with high levels of education and income, since such employees include more of the heads and subheads of agencies and supervisory employeees of agencies than other areas, and much data show that persons of higher income and educational levels use more psychiatric care than those of lower educational and income levels.

Mr. DANIELS. Is that a good or bad sign?

Dr. REED. Is that a good or a bad thing? Well, I don't know. Maybe it is a good thing. I think it will indicate that as the general population receives more education, the educational level goes up, that the use of care for mental conditions may increase.

Mr. DANIELS. You don't mean to tell me that we have more intellectuals here in Washington than elsewhere in the country, do you? How about the metropolitan area of New York?

Dr. REED. Well, generally the persons with higher income levels have higher educational levels. That is a fact. And I think that the people who are in the higher positions in Government service here in Washington probably do have a higher educational level than Federal employees throughout the country because they include more of the people at the top. They are the policymaker that are here.

Mr. DANIELS. How would it compare with New York City for the metropolitan area?

Dr. REED. I would say that it is probably greater here than in New York because again you have more, I believe, of the top people here in Washington.

Dr. SPIEGEL. If I may interject, Mr. Daniels, I think your question as to whether it is good or bad is related to your previous comment on stigma. As people with more education, more income, don't feel so stigmatized they are more apt to use the services. As people of lower income are stigmatized they are not so apt to use the services, but that is changing.

Mr. DANIELS. Yes, I agree the situation is changing.

All right, Doctor, anything further?

Dr. REED. I'm finished. Sorry to have burdened you with so many statistics, but that's the nature of the beast.

Mr. DANIELS. That is the type of subject we are dealing with, too, that necessitates furnishing this committee with statistics.

Doctor, I do not have any questions. We are being caught short by time. We have several other witnesses here today. Do you desire to say something further?

Dr. SULLIVAN. Could I make a brief statement?

Mr. DANIELS. Proceed.

Dr. SULLIVAN. My name is Frank Sullivan. I am chairman of the task force for peer review of the American Psychiatric Association.

The American Psychiatric Association's recommendations for peer review are set forth in its position statement establishing in each district branch a peer review committee functioning as a part of the local medical society peer review mechanism to respond to all questions relating to quality, utilization, availability and cost of medical services. Although still in the initial stages of development, these committees have shown themselves to be available and responsive to the issues presented by fiscal intermediaries. We request that this position statement, published in the March 1973 issue of the American Journal of Psychiatry be included in the record.[1]

Illnesses do not befall groups as statistical data would lead us to believe, but occur only in individuals and thereby manifest the variations of complexity, severity, and duration known to exist. Meaningful review must take into account these individual variations during, not after, the patient's treatment. Therefore, only a system such as peer review can, though a system of concurrent review methodologies, evaluate and monitor the individual's medical needs and appropriateness of the delivery of care. Benefit periods, although fiscally appealing, provide little toward the necessary concurrent utilization and quality review of care delivered to the individual striken with an illness.

Psychiatry has made major strides in establishing a local peer review mechanism and more recently devised initial hospital review criteria in response in response to Public Law 92–603. The American Psychiatric Association will continue to participate in the American Medical Association's project for revision and refinement of hospital review criteria. The APA task force on peer review has proposed a project to extend over the nevt 3 to 5 years to expand the effectiveness and expertise of the local peer review components through research, collection and exchange of data, and educational feedback.

Theoretical and operational guidelines for peer review exist through the American Medical Association, the American Psychiatric Association, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and the Department of Health, Education, and Welfare. The district branch peer review committees are available to all interested parties to render consensus opinions on issues related to the practice of psychiatry. Criteria set development for inpatients is evolving in response to the PSRO legislation and similar criteria will emerge for outpatients. We also ask that our national

[1] The article referred to was placed in the subcommittee files.

model criteria sets in inpatient care, developed by the task force on peer review be included in the record.[1] That is also attached. I might add that an addition will be made to this shortly, by the end of the year, for childhood diagnoses criteria sets which have been developed in cooperation with the American Association of Child Psychiatry. These are completed and are going into final revisions and will be added to these criteria sets.

Guildelines based on criteria are central to objective utilization review and will require continued refinement through research oriented medical audit procedures.

In response to this committee's question, there are no real obstacles to the evolution of peer review, only the realities of the gradual development of what is a complicated process if properly devised. The realities rather than the obstacles are time and research funding, and perhaps most importantly, motivational efforts and educational feedback directed toward the practicing physician.

Thank you.

Mr. DANIELS. Thank you, gentlemen.

Dr. SPIEGEL. Thank you.

[Note: A portion of the attachments referred to follow:]

[1] The publication was retained in the subcommittee files.

TABLE 1

BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1969
BASIC INPATIENT HOSPITAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX (IN GENERAL HOSPITALS AND MEMBER MENTAL HOSPITALS)

AGE	MALE	FEMALE	TOTAL
	ADMISSIONS—RATE PER 1,000		
Under 19	1.1	1.3	1.2
19–34	4.5	7.1	6.0
35–44	6.2	6.6	6.5
45–54	6.3	8.7	7.5
55–64	4.9	7.2	6.0
65 and over	3.1	4.0	3.6
All ages	3.5	5.0	4.3
	DAYS OF CARE—RATE PER 1,000		
Under 19	21.9	24.8	23.3
19–34	87.9	122.6	107.6
35–44	83.7	103.7	96.5
45–54	78.6	134.5	106.1
55–64	72.7	127.9	98.2
65 and over	53.8	81.2	67.6
All ages	54.8	83.6	69.8
	AVERAGE LENGTH OF STAY (DAYS)		
Under 19	20.6	19.3	19.9
19–34	19.7	17.3	18.0
35–44	13.4	15.6	14.8
45–54	12.4	15.4	14.2
55–64	14.8	17.7	16.4
65 and over	17.2	20.1	18.9
All ages	15.6	16.7	16.3
	AVERAGE COVERED CHARGES PER COVERED PERSON		
Under 19	$0.98	$1.18	$1.08
19–34	3.84	5.81	4.96
35–44	3.94	4.84	4.51
45–54	3.76	6.51	5.12
55–64	3.47	6.24	4.75
65 and over	1.54	1.91	1.73
All ages	$2.49	$3.90	$3.23

TABLE 2

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1969
Supplemental Benefits for Mental Disorders, by Age and Sex

Age	Males	Females	Total	Males	Females	Total
	Hospital cases per 1,000 population			Hospital charges per person covered		
Under 19	0.7	0.6	0.6	$0.58	$0.53	$0.55
19–34	2.1	2.0	2.0	1.67	1.48	1.56
35–44	0.9	1.6	1.4	0.45	0.84	0.70
45–54	0.8	2.1	1.4	0.37	1.33	0.84
55–64	1.0	1.8	1.4	0.70	1.08	0.88
65 and over	0.7	1.5	1.1	0.55	1.37	0.96
All ages	1.0	1.4	1.2	0.70	0.95	0.83
	Physician services—cases per 1,000 population			Physician charges per person covered		
Under 19	5.7	3.4	4.6	$1.19	$0.69	$0.95
19–34	25.9	29.4	27.9	7.09	7.22	7.16
35–44	22.7	18.9	20.3	5.97	4.03	4.73
45–54	10.1	17.0	13.5	2.03	3.23	2.62
55–64	5.2	10.8	7.8	1.00	1.85	1.39
65 and over	1.2	2.8	2.0	0.22	0.36	0.29
All ages	11.3	13.6	12.5	2.73	2.96	2.84

	Total supplemental benefits paid by program per person covered		
	Males	Females	Total
Under 19	$1.47	$0.97	$1.23
19–34	6.92	6.89	6.91
35–44	5.12	4.05	4.44
45–54	1.94	3.96	2.93
55–64	1.41	2.63	1.97
65 and over	0.73	1.89	1.31
All ages	2.76	3.22	3.00

TABLE 3

BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1969
BASIC SURGICAL-MEDICAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX

AGE	MALE	FEMALE	TOTAL
	IN-HOSPITAL MEDICAL CLAIMS PER 1,000		
Under 19	1.0	1.2	1.1
19–34	3.8	6.5	5.4
35–44	5.5	6.5	6.1
45–54	5.9	8.4	7.1
55–64	4.6	7.0	5.7
65 and over	3.0	3.6	3.3
All ages	3.2	4.8	4.0
	VISIT DAYS PER 1,000		
Under 19	18.9	20.0	19.4
19–34	66.6	99.3	85.2
35–44	65.0	88.5	80.0
45–54	70.6	114.5	92.2
55–64	59.1	100.8	78.4
65 and over	44.6	63.0	53.9
All ages	45.0	69.0	57.6
	BENEFITS PAID PER COVERED PERSON		
Under 19	$0.21	$0.24	$0.22
19–34	0.80	1.13	0.99
35–44	0.72	0.99	0.89
45–54	0.77	1.29	1.03
55–64	0.65	1.13	0.87
65 and over	0.29	0.34	0.32
All ages	0.50	0.77	0.64

TABLE 4

BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1969
ADMISSIONS AND DAYS OF CARE FOR MENTAL CONDITIONS BY DURATION OF STAY AND SEX

DURATION	MALE			FEMALE			TOTAL		
	NUMBER	PERCENT OF TOTAL	CUMULATIVE PERCENT	NUMBER	PERCENT OF TOTAL	CUMULATIVE PERCENT	NUMBER	PERCENT OF TOTAL	CUMULATIVE PERCENT
				ADMISSIONS					
1 day	436	6.3%	6.3%	737	6.8%	6.8%	1,173	6.6%	6.6%
2 days	476	6.7	13.2	651	6.0	12.8	1,127	6.4	13.0
3 days	525	7.8	20.7	697	6.4	19.3	1,222	6.9	19.8
4–5 days	967	14.0	34.7	1,301	12.0	31.3	2,268	12.8	32.6
6–9 days	1,314	19.0	53.6	1,882	17.4	48.7	3,196	18.0	50.6
10–14 days	1,009	14.6	68.2	1,534	14.2	62.9	2,543	14.3	65.0
15–30 days	1,362	19.7	87.9	2,476	22.9	85.8	3,838	21.6	86.6
31–70 days	669	9.7	97.5	1,247	11.5	97.3	1,916	10.8	97.4
71–120 days	111	1.6	99.1	211	2.0	99.3	322	1.8	99.2
121 and over	62	0.9	100.0	81	0.7	100.0	143	0.8	100.0
Total	6,931	100.0	100.0	10,817	100.0	100.0	17,748	100.0	100.0
				DAYS OF CARE					
1 day	435	0.4%	0.4%	736	0.4%	0.4%	1,171	0.4%	0.4%
2 days	952	0.9	1.3	1,302	0.7	1.1	2,254	0.8	1.2
3 days	1,575	1.5	2.7	2,091	1.2	2.3	3,666	1.3	2.5
4–5 days	4,317	4.0	6.7	5,821	3.2	5.5	10,138	3.5	6.0
6–9 days	9,601	8.9	15.6	13,836	7.7	13.2	23,437	8.1	14.1
10–14 days	11,894	11.0	26.7	18,157	10.1	23.2	30,051	10.4	24.5
15–30 days	29,161	27.0	53.7	52,896	29.3	52.5	82,057	28.4	53.0
31–70 days	29,286	27.1	80.8	53,332	29.5	82.1	82,618	28.6	81.6
71–120 days	9,641	8.9	89.7	18,654	10.3	92.4	28,295	9.8	91.4
121 and over	11,067	10.3	100.0	13,753	7.6	100.0	24,820	8.6	100.0
Total	107,929	100.0	100.0	180,578	100.00	100.0	288,507	100.0	100.0

TABLE 5

BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1969, BASIC HOSPITAL BENEFITS FOR ALL AND FOR MENTAL CONDITIONS, BY REGION

REGION	ALL CONDITIONS	MENTAL CONDITIONS	MENTAL AS PERCENT OF ALL
	HOSPITAL ADMISSIONS—RATE PER 1,000		
New England	113.2	2.2	1.9%
Middle Atlantic	113.0	3.1	2.7
East North Central	111.5	3.1	2.8
West North Central	152.3	6.4	4.2
South Atlantic	125.8	4.3	3.4
D.C., Md., and Va.	(110.0)	(3.3)	(3.0)
Other South Atlantic states	(162.4)	(6.7)	(4.1)
East South Central	165.1	5.8	3.5
West South Central	157.7	4.5	2.9
Mountain	149.0	6.5	4.4
Pacific	127.9	4.3	3.4
All United States	130.7	4.3	3.3
	DAYS OF CARE—RATE PER 1,000		
New England	942.3	37.6	4.0%
Middle Atlantic	1,033.7	68.0	6.6
East North Central	900.8	51.3	5.7
West North Central	1,161.9	106.5	9.2
South Atlantic	972.5	73.0	7.5
D.C., Md., and Va.	(894.5)	(69.2)	(7.7)
Other South Atlantic states	(1,151.3)	(81.4)	(7.1)
East South Central	1,184.6	90.9	7.7
West South Central	1,024.6	67.9	6.6
Mountain	950.8	92.8	9.8
Pacific	824.3	55.7	6.8
All United States	985.0	70.1	7.1

TABLE 6

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1969
All Benefits for Mental Disorders, by Region

Region (census division)	Basic hospital benefits								Basic surgical-medical benefits		Supplemental benefits		All benefits	
	Covered population (000)	Admissions		Days of care		Average length of stay (days)	Benefits							
		Number	Per 1,000 population	Number	Per 1,000 population		Amount (000)	Per covered person	Amount (000)	Per covered person	Amount (000)	Per covered person	Amount (000)	Per covered person
New England	272	592	2.2	10,232	37.6	17.3	$ 499	$1.83	$ 62	$0.23	$ 977	$3.59	$1,538	$5.65
Middle Atlantic	530	1,654	3.1	36,013	68.0	21.8	1,697	3.20	280	0.53	1,165	2.20	3,141	5.93
East North Central	512	1,603	3.1	26,245	51.3	16.4	1,325	2.59	259	0.51	465	0.91	2,049	4.00
West North Central	269	1,734	6.4	28,690	106.5	16.5	1,225	4.55	243	0.90	365	1.36	1,833	6.80
South Atlantic	1,200	5,212	4.3	87,578	73.0	16.8	4,077	3.40	794	0.66	7,335	6.11	12,206	10.17
D.C., Md. & Va.	(840)	(2,807)	(3.3)	(58,137)	(69.2)	(20.7)	(2,897)	(3.45)	(557)	(0.66)	(6,967)	(8.30)	(10,421)	(12.41)
Other South Atlantic states	(361)	(2,405)	(6.7)	(29,441)	(81.4)	(12.2)	(1,180)	(3.26)	(237)	(0.66)	(368)	(1.02)	(1,785)	(4.94)
East South Central	240	1,391	5.8	21,789	90.9	15.7	767	3.20	210	0.88	150	0.63	1,127	4.70
West South Central	398	1,796	4.5	27,005	67.9	15.0	1,105	2.78	340	0.85	684	1.72	2,128	5.35
Mountain	325	2,112	6.5	30,179	92.8	14.3	1,347	4.14	337	1.04	162	0.50	1,846	5.67
Pacific	350	1,519	4.3	19,469	55.7	12.8	1,257	3.59	203	0.58	1,034	3.10	2,543	7.27
All United States	4,096*	17,613	4.3	287,200	70.1	16.3	13,299	3.25	2,728	0.67	12,387	3.02	28,411	6.94

* Exclusive of 35,259 covered persons in U.S. territories and foreign countries.

TABLE 7

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1969
Charges for Physicians' Services Under Supplemental Benefits, All and Mental Conditions, by Region

Region	Charges per person covered		
	All conditions	Mental conditions	Mental as percent of all
New England	$5.69	$2.56	45.0%
Middle Atlantic	7.37	2.20	29.9
East North Central	5.60	0.93	16.7
West North Central	5.21	1.08	20.7
South Atlantic	11.34	6.08	53.7
D.C., Maryland, and Virginia	13.63	8.41	61.7
Other South Atlantic states	5.99	0.66	11.0
East South Central	5.61	0.40	7.1
West South Central	8.81	1.58	17.9
Mountain	5.32	0.48	9.0
Pacific	10.04	2.57	25.6
Total	$8.16	$2.86	35.0

TABLE 8

Number of Visits of All Patients in Past 12 Months by Length of Time Since Patients Were First Seen

No. of visits in past 12 months	Patients first seen a year or more before		Patients first seen less than a year before		Date patients first seen unknown	Total	
	No.	Cumulative %	No.	Cumulative %	No.	No.	Cumulative %
Less than 10	267	12	791	44	11	1,069	26
10- 19	250	24	352	64	12	614	42
20- 29	205	33	226	76	10	441	52
30- 39	137	39	136	84	4	277	59
40- 49	367	56	87	89	8	462	71
50- 59	142	62	51	91	2	195	75
60- 69	46	65	31	93	1	78	77
70- 79	42	66	25	95	0	67	79
80- 89	78	70	25	96	3	106	82
90- 99	137	76	14	97	3	154	85
100-109	118	82	17	98	0	135	89
110-119	10	82	5	98	0	15	89
120-129	54	85	4	98	1	59	91
130-139	44	87	5	99	1	50	92
140-149	22	88	5	99	1	28	93
150-159	36	89	5	99	0	41	94
160-169	38	91	2	99	0	40	95
170-179	32	92	5	99	1	38	95
180-189	43	94	3	100	1	47	97
190-199	6	95	0	100	0	6	97
200-209	59	97	4	100	3	66	98
210-219	15	98	1	100	1	17	99
220-plus	44	100	2	100	1	47	100
Totals	2,192		1,796		64	4,052	

Additional data:	Mean	Median
Number of visits in past 12 months of patients first seen a year or more before	64	43
Number of visits in past 12 months of patients first seen less than a year before	22	12
Number of visits in past 12 months irrespective of when patients were first seen	45	25

TABLE 8

Number of Visits of Analytic Patients in Past 12 Months by Length of Time Since Patients Were First Seen

No. of visits in past 12 months	Patients first seen a year or more before		Patients first seen less than a year before		Date patients first seen unknown	Total	
	No.	Cumulative %	No.	Cumulative %	No.	No.	Cumulative %
Less than 10	0	-	6	5	0	6	1
10- 19	0	-	7	11	1	8	3
20- 29	4	1	8	18	0	12	5
30- 39	3	2	9	26	0	12	7
40- 49	6	3	8	33	0	14	10
50- 59	1	4	8	40	0	9	12
60- 69	1	4	9	48	0	10	14
70- 79	5	5	8	55	0	13	16
80- 89	14	9	6	60	0	20	20
90- 99	25	15	6	65	0	31	26
100-109	25	21	6	70	0	31	32
110-119	5	22	5	75	0	10	34
120-129	37	32	3	77	1	41	41
130-139	23	37	3	80	1	27	47
140-149	13	41	5	84	1	19	50
150-159	23	46	3	87	0	26	55
160-169	34	55	2	89	0	36	62
170-179	29	62	5	93	1	35	69
180-189	40	72	3	96	1	44	77
190-199	4	73	0	96	0	4	78
200-209	53	87	2	97	3	58	89
210-219	12	90	1	99	1	14	92
220-plus	41	100	2	100	1	44	100
Totals	398		116		11	524	

Additional data:	Mean	Median
Number of visits in past 12 months of patients first seen a year or more before	153	160
Number of visits in past 12 months of patients first seen less than a year before	82	70
Number of visits in past 12 months irrespective of when patients were first seen	138	146

TABLE 8

Number of Visits of Analysts' Nonanalytic Patients in Past 12 Months by Length of Time Since Patients Were First Seen

No. of visits in past 12 months	Patients first seen a year or more before		Patients first seen less than a year before		Date patients first seen unknown	Total	
	No.	Cumulative %	No.	Cumulative %	No.	No.	Cumulative %
Less than 10	27	5	90	28	2	119	14
10- 19	24	10	57	47	2	83	24
20- 29	25	15	50	62	5	80	34
30- 39	30	22	27	71	2	59	41
40- 49	124	47	27	79	2	153	60
50- 59	28	53	21	86	1	50	66
60- 69	24	57	7	88	1	32	70
70- 79	20	62	12	92	0	32	74
80- 89	33	68	9	95	3	45	79
90- 99	62	81	6	97	1	69	87
100-109	38	89	4	98	0	42	92
110-119	3	89	0	98	0	3	93
120-129	9	91	1	98	0	10	94
130-139	17	95	2	99	0	19	96
140-149	7	96	0	99	0	7	97
150-159	8	98	2	100	0	10	99
160-169	3	98	0	100	0	3	99
170-179	0	98	0	100	0	0	99
180-189	2	99	0	100	0	2	99
190-199	1	99	0	100	0	1	99
200-209	4	100	1	100	0	5	100
210-219	1	100	0	100	0	1	100
220-plus	1	100	0	100	0	1	100
Totals	491		316		19	826	

Additional data:	Mean	Median
Number of visits in past 12 months of patients first seen a year or more before	65	50
Number of visits in past 12 months of patients first seen less than a year before	29	20
Number of visits in past 12 months irrespective of when patients were first seen	51	40

Mr. DANIELS. Our next witness is Dr. Oscar Legault of the Washington Psychiatric Society.

STATEMENT OF DR. OSCAR LEGAULT, WASHINGTON PSYCHIATRIC SOCIETY

Dr. LEGAULT. I am Dr. Oscar Legault, Mr. Chairman. I am accompanied by Mr. Armin U. Kuder, who is the counsel for the Washington Psychiatric Society.

Mr. DANIELS. Welcome, gentlemen.

Dr. LEGAULT. Thank you.

Mr. Chairman, I gather that you are pressed for time, and so I will merely have submitted this statement of the Washington Psychiatric Society and try to hit some of the highlights of it in oral testimony.

Mr. DANIELS. Fine. I would appreciate it if you would do that because the House will convene at 12 o'clock, and in addition to you gentlemen we have another witness, and I would like to accommodate the other witness if at all possible.

So in the interest of time I will move that your statement be incorporated in the record in full, and you may proceed to summarize it.

Dr. LEGAULT. Thank you.

The statement of our society is directed particularly to the questions of the overutilization, so-called, of psychiatric benefits in the Washington area, by which is meant the high rate of utilization. You have heard some comments on this from Dr. Reed and Dr. Spiegel and the representatives of the American Psychiatric Association.

First of all, we wish to make the point that the high rate of utilization is not necessarily overutilization since epidemiological studies of the incidence of mental disturbance show it is very high indeed, and that incidence of 1 percent of the total subscribers to the FEHP program is not at all out of line with the rate of 30 percent, for instance, found in epidemiological studies of the incidence.

There are other reasons for the high rate of utilization in the Washington area. One of them has been commented on, and you were just talking about it with Dr. Reed, about the nature of the population in the Washington area, and you were commenting about comparing them with New York. Now we have studies in the Washington Psychiatric Society which indicate that the average income of the psychiatric patient of this area is about $14,800 in this area. What we think is that Washington abounds in not necessarily what you would call a high class intellectual population, but in a middle class, lower middle class intellectual population, who are apt to seek longer forms of treatment at a higher rate because they are sophisticated enough to know that these treatments are directed toward fundamental difficulties that they have. They do not seek shorter terms of treatment, and thus we have a weighing of that form of treatment for longer duration in the Washington area.

Also the area has attracted large numbers of psychiatrists, and we can show that the rate of development—we have appended a table here which shows the rate of growth of our society is not commensurate with the increase in insurance benefits, but is rather linked with the influx of professionals into the area, having to do with the armed services and the Public Health Service influx into the National Institutes of Health where people spend their military training and then decide to stay in the Washington area.

Also the very fact that the Federal employees have such a good insurance program is due to the establishment of the National Institutes of Health and the pressure of those psychiatrists for the establishment of such a very liberal form of insurance benefit. The courts in the area recognize this and have adjudicated that hospitalization is not to be carried out unless people have had ample try of outpatient and other forms of treatment, recognizing that long-term psychotherapy is one of these modalities.

These are the major highlights that I wish to point out.

Also one other particular thing I wish to bring to the attention of the committee is the nature of the population that is being treated in Washington. It is essentially the lower middle class.

Mr. DANIELS. The lower middle class?

Dr. LEGAULT. I think so, yes, and lower classes. We have a fair—that is the average income, but we have a large number of people who afford treatment of a sort because they have insurance that they could not afford otherwise. We have a breakdown which would establish that.

Mr. DANIELS. Well, Dr. Reed, one of the witnesses who testified in the previous panel, also gave an additional reason for the increased utilization of such services the fact that they were better educated here, higher educational level people, higher intelligentsia.

Dr. LEGAULT. I think so. I think so. I think the average education of the Federal worker is higher than one would find statistically in many areas of the country. This is a highly intellectual crowd in this town.

Mr. DANIELS. Well, that is surprising. That is a very interesting point.

Dr. LEGAULT. The Federal Government attracts very good people to work for it.

Mr. DANIELS. Well, it should. It should because, after all, the public does demand services for its money, and the Government should attract the best talent it possibly can obtain.

Dr. LEGAULT. Are there any questions.

Mr. DANIELS. I do not have any questions. I am very much surprised and interested in what you have just said here today. Thank you very much.

[Statement of Dr. Legault follows:]

STATEMENT OF THE WASHINGTON PSYCHIATRIC SOCIETY

Mr. Chairman, I am Oscar Legault, M.D., a member of the Executive Council of the Washington Psychiatric Society, the Washington metropolitan area branch of the American Psychiatric Society, representing over 800 psychiatric physicians in Maryland, Virginia and the District of Columbia. We are grateful for this opportunity to present the views of our branch with respect to some of the issues raised in these hearings. We believe that the knowledge and experience of our members will be helpful in illuminating the problem areas as well as the process of deciding what to do for the future.

Throughout the current discussion of the scope of mental health benefits to be included in the Federal Employee Health Benefits Program, whether the discussions have been before this Subcommittee, the Civil Service Commission or between our representatives and the insurers, there have been attempts to draw conclusions from evidence that there is a higher utilization of mental health benefits in the geographical area served by our members. These efforts have been made, it appears, for the purpose of finding ways to reduce costs. In other words, if we can find out why more insured patients in this area use mental health benefits and their per capita benefits are higher, then we can plan how to reduce that use and those costs.

While this approach may seem commendable, we believe that it incorrectly assumes that patient uses should be curtailed and it improperly emphasizes costs to the detriment of patient needs. Simply put, higher utilization is not necessarily over-utilization. We would like to use this time before ths Subcommittee to put before it some of the reasons for this higher utilization in the Washington, D.C., area, to show that the primary beneficiaries of this utilization are the federal employees, their wives and children, residing here, and to discuss what we do, and what can be done, to insure that this medical care is of the highest

quality and furnished at fair and reasonable prices. In doing so, we believe we shall allay any misgivings still remaining that psychiatrists, not patients, benefit from utilization of mental health benefits.

Without question a signification percentage of all human suffering is psychological in nature. Epidemiological studies of both rural and urban populations have established that approximately thirty percent of both groups of people suffer from serious psychiatric disorders—serious enough to mandate hospitalization or other substantial treatment. Mental disorders are the single most frequently encountered diagnoses among veterans receiving benefits from the Veterans Administration, comprising nearly twenty-five percent of the VA's patient load. Comparing these facts to the information on FEHB before this Subcommittee, it immediately appears that federal employees, like their non-governmental counterparts, are not using mental health benefits as much as might be expected, and that psychiatric care is still a long way from being fully accepted, without social stigma. Still, if the statistics submitted previously to this Subcommittee hold up, we can say for the people in the Washington, D.C., area, that they are doing better than others in obtaining treatment for their disorders.

There are reasons for this fortunate situation for the residents of this area. The American Psychiatric Society has established that there are higher concentrations of psychiatric professionals available in our major cities. In addition to being such a population center, the Washington area has a remarkable number of residency training programs in psychiatry, at St. Elizabeth's Hospital and other Government facilities, as well as numerous private institutions. The Uniformed and Public Health Services have brought a great number of physicians on active duty to this area, particularly during the Viet Nam war, who are or have become psychiatric professionals and have stayed. This is mirrored in our membership statistics. There has been a steady increase from 1965, when we had 384 members, to the present, with a membership of 825. As can be seen from Table One, attached hereto, this seems unrelated to the years of changes in the FEHB insurance programs.

Moreover, a survey in 1973 indicated that approximately fifty-seven percent of our members were 43 years of age or younger. This highlights the importance of the residency programs, the military and the Public Health Service in bringing younger professionals here, who then find it a desirable place to stay.

Thus, this much-discussed concentration of psychiatrists, in the judgment of the members of our Society, is not the result of the availability of benefits under FEHP (and CHAMPUS). Convenience, desirable living conditions, opportunity for further training, teaching positions, all attract and retain our members. The favorable isurance programs merely allow federal employees to take advantage of the care which is available.

As previously attested to by the insurance carriers' witnesses, it is the opinion of professionals familiar with patient populations on a comparative basis, that those in the Washington area represent a more psychologically sophisticated population than the average. In 1973, the mean income of patients of our members was found to be $14,800.00. Our members believe that in general these people are more apt to seek to accomplish fundamental changes in choosing types of treatment, rather than being satisfied with symptomatic relief as is the case when care facilities are limited in scope and patients are less well-informed and less accepting of psychiatric treatment. This helps to account for the fact that our members have reported on the average longer terms of treatment here as compared to the national average. Yet this trend is found actually embodied in legal decisions in the District of Columbia, which require both trial courts and hospitals to use all possible alternatives before allowing compulsory hospitalization. The alternatives include long-term psychotherapy, of course. Our counsel advises us that these decisions have been considered quite advanced in the legal community. They buttress our understanding of the nature of our constituency.

Much more study has to be done on the incidence of mental illness, and the results of different forms of treatment, but everything we know suggests that the people of this area have better opportunities to receive quality care and help for their suffering than is generally available. If the federal employee programs have helped in achieving this, they are to be emulated, not curtailed.

This does not mean that there should be no questioning of our medical practice. There should be. The Blue Cross and Blue Shield Plans regularly survey our fees. Invariably, these have been in line with national means and averages.

Dissatisfied patients have resort to out Ethics Committee, the D.C. Medical Society, the licensing authorities in the District of Columbia, and the much-publicized malpractice suit. We are subject to Medicaid audits. And finally, we have an active, and, we believe, effective peer review system. Attached hereto is a more detailed statement of the work of the Peer and Utilization Review Committee. As can be seen, in twenty-five months, the Committee has considered forty-three cases of insurance utilization, approving the charges in thirty-three instances, rejecting them in their entirety in five and rejecting at least part of the claim in five more. For these purposes, a case refers to one referral from an insurer, relating to the practices of one health care provider. A number of cases involved more than one patient, one case for review involving billings to sixteen patients.

Furthermore, the Committee is actively engaged in establishing standards of good practice. We expect to coordinate these efforts with the work of the American Psychiatric Association, and other involved professional organizations.

We trust it is clear that our interests are to insure quality care for patients. Limitations on benefits and coinsurance simply deter some patients from getting care, or a least limit the chance of the patient making long-term gains. Peer review and an informed public are the better method for promoting the interests of patients. To this end, it is desirable that peer review be strengthened. Our experience indicates that the most obvious deficiencies in our present structure are the lack of authority to compel participation (although this lies with the insurers who can withhold benefits), of sanctions (again, possible only through insurers), and of specific immunity for the members of the Committee who perform this service. At present our Peer Review committee functions only on the basis of complaints lodged with it; it does not initiate review, nor can it in fact, compel the appearance of a member.

Mr. Chairman, we trust the foregoing will be of assistance to the Subcommittee. If there are any questions, or if there is any information we may be able to provide, we will be happy to respond.

TABLE 1.—*Washington Psychiatric Society Membership From 1965 to Present*

	Total number of members
1965	384
1966	420
1967	484
1968	538
1969	584
1970	629
1971	703
1972	765
1973	809
1974 (plus 25 pending)	825

STATEMENT OF WASHINGTON PSYCHIATRIC SOCIETY—SUPPLEMENTAL STATEMENT OF PEER AND UTILIZATION COMMITTEE

In 1971 it became apparent to the psychiatric community of the metropolitan area of Washington, D.C. that there was a need to develop a formal mechanism for the evalution and judgment of cases in which questions had been raised by third party insurance carriers about the utilization of certain modalities of treatment and about standards of psychiatric treatment generally. Accordingly, a Task Force was appointed to develop guidelines for the operation and organization of a Peer Review and Utilization Committee. This Task Force presented a series of recommendations to the Council of The Washington Psychiatric Society. These were accepted and the Committee began operations in January 1972.

The Committee consists of a Chairman and 18 members selected to be representative both of the various geographical areas which compose the metropolitan membership of the WPA and of the various modalities and interests with which the profession of psychiatry concerns itself. The members are appointed for three year periods in a rotating fashion so that six drop out and six new ones come into the Committee each year.

The activities of the Committee are quite varied and have increased in scope since the time the Committee came into existence. However the bulk of its activities can be summarized under the following two headings.

1. REVIEW OF SPECIFIC CASES IN REGARD TO UTILIZATION AND STANDARDS OF CARE

The Committee passes judgment and makes recommendations on cases referred to it by various third party insurance carriers who have questions about certain claims for benefits. Most of these, particularly those eminating from the Medical Service of D.C. which is the local Blue Shield carrier, are routed through the Peer Review Committee of the Medical Society of the District of Columbia. Cases are also referred to the Committee by other insurance carriers either through the medical society or directly. These cases cover a wide range of practices about which guidance is sought and cover all areas of psychiatric practice including outpatient psychotherapeutic care, treatment in hospitals, somatic treatments of all kinds, group, family and couples therapy, and psychiatric treatment of children. The Committee has been asked to respond to questions about how many electric shock treatments are accepted practice during a particular time period, whether it is proper to charge for psychotherapeutic sessions during the course of electric shock treatment, at what point in-hospital treatment becomes custodial care, the size and duration of groups undergoing group therapy along with the role of co-therapists and whether cases receiving long term intensive psychotherapy can be managed with less intensive treatment. The Committee passed on its first case in February, 1972 and between that time and March 1974, decisions have been arrived at in forty-four cases—eleven in-patient and thirty-three out-patient. In thirty of these cases, full benefits were approved, partial approval was recommended in five and it was recommended that benefits be rejected in five cases.

When cases are referred to the Chairman of the Committee through any of the routes mentioned above he then refers the cases to a sub-committee consisting of members of the over-all committees selected for their experience and expertise in that particular area. The folders containing the relevant information about these cases are sanitized by the erasure of the names of the physician and patients involved in order to protect confidentiality. The Sub-Committee discuss the case and may also ask for additional information. Generally this is sufficient for them to recommend a course of action to the full Committee which then has the options of accepting this decision and passing it on to the Medical Society and ultimately to the carrier or of rejecting the decision. In certain instances however it has been felt that interviews with the physician involved would be desirable either to clear up uncertainties about the particular case or because the standard of practice represented raised doubts in the minds of the Committee members about the qualifications of the treating physician. In the period described about there were four interviews of this kind with physicians. In one instance the Peer Review Committee became aware of enough data about a particular institution to raise doubts about its over-all standards of practice and as a result of the actions of the Committee this institution is in the process of revising and improving its operation in order to bring it up to accepted standards in the area. The Committee has also suggested that particular physicians ought to become involved in educational activities to up-grade their skills.

It should be mentioned that cases may also be submitted to the Peer Review Committee by physicians who object to certain decisions of the carriers and by patients who are dissatisfied with the care they have received or with the insurance company decisions about benefits.

At the present time, the Committee is embarking on a new and promising direction by undertaking to review certain cases from St. Elizabeths hospital referred to it by the Public Defender. If this initative proves to be successful it may lead to the expansion of the Committee's activities to include not only the private but also the public sector of mental health care practice.

2. SETTING STANDARDS AND GUIDELINES FOR PSYCHIATRIC PRACTICE

This function of the Committee is exercised to a certain extent by establishing precedents derived from individual case reviews. However it is clear that the Committee needs to go beyond this method and must establish formal standards for psychiatric treatment for various locations and modalities which characterize the practice of psychiatry. Accordingly the Peer Review Committee is

now undertaking the systematic formulation of such standards. For this purpose the members of the Committee have been divided into four sub-committees as follows:

1. Psychothrapy and psychoanalysis
2. Group psychotherapy
3. In-patient and psychosomatic treatment
4. Treatment of children, couples and families.

The above activities along with others not specified in this report are carried out by members of the Committee entirely on a voluntary basis.

Mr. DANIELS. Our next witness is Mr. Irving Chase, chairman of the Public Affairs Committee of the National Association for Mental Health.

Mr. SMUCKER. Mr. Chairman, Mr. Chase was not able to be present. In the interest of time I would simply submit this testimony for the record, if it pleases you.

Mr. DANIELS. What is your name?

Mr. SMUCKER. Bob Smucker, National Association for Mental Health.

Mr. DANIELS. You desire to submit the statement on behalf of Mr. Chase?

Mr. SMUCKER. That's right.

Mr. DANIELS. With no objection, it will be incorporated in the record at this point.

Mr. SMUCKER. All right.

[Statement of Mr. Irving Chase, chairman of the Public Affairs Committee, National Association for Mental Health, follows:]

STATEMENT OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC., BY IRVING H. CHASE, CAMBRIDGE, MASS.

Mr. Chairman and members of the committee, my name is Irving Chase. I reside in Cambridge, Massachussetts. I am appearing today in behalf of the National Association for Mental Health. I am Past-President of this Association and am chairman of its Public Affairs Committee.

The National Association for Mental Health is the national citizens' voluntary organization working toward the improved care and treatment of the mentally ill; for improved methods and services in research, prevention. detection, diagnosis and treatment of mental illness; and for the promotion of mental health.

I have been an active citizen volunteer in the field of mental health since 1958, when I became president of the Mental Health Association of Central Middlesex (Massachusetts). Since then I have served as a director and then president of the Massachuetts Association for Mental Health, from 1967–1970.

I served also as a member, representing citizen-laymen concerns and interest, on the following bodies:

The National Advisory Mental Health Council.

Advisory Committee to the Commissioner of Mental Health of the Commonwealth of Massachusetts on Construction and Utilization of Community Mental Health Centers.

Advisory Committee to the Governor of the Commonwealth of Massachusetts on Comprehensive Health Planning.

Myth Dispeled

Mr. Chairman, on October 29, 1971, we went before the House Ways and Means Committee to explode the myth that providing adequate coverage for mental illness in insurance plans causes rates to skyrocket. I am pleased to say that efforts by our group and others to educate the public to the fact that this is simply not true have been partially successful.

Intent of the Testimony

The intent of this testimony is to give information regarding the following: (1) the cost of insuring against mental illness; (2) the importance of providing

outpatient and partial hospitalization coverage for mental illness in community mental heath centers; (3) the effectiveness of community mental health centers; (4) A Plan of Coverage for the Mentally Ill in National Health Insurance.

A Proposed Cutback in Mental Health Benefits in the Federal Employees Program

Recenty a move was being considered to reduce mental health coverage under the Federal Employees Program because of indications that it was too costly to provide the present coverage.

Our Association has proposed, under our Plan of Coverage for the Mentally Ill in National Health Insurance, that there be unlimited outpatient and partial hospitalization coverage in community mental health centers, and a 20 visit limit on private outpatient care and a limitation of 45 days on inpatient care. We contend that our plan, which includes utilization review to prevent indiscriminate use, would not be costly to provide. We recommend that it be the absolute minimum coverage for the Federal Employees Program.

Response to the Chairman's Questions

Mr. Chairman, following is information in response to the questions in your letter of August 29.

WHAT IS THE AVERAGE LENGTH OF PSYCHIATRIC TREATMENT NATIONWIDE?

The average length of stay in a psychiatric unit of a general hospital is approximately 17 days. The average length of outpatient treatment for private psychiatrists is 25, including psychoanalysis. If psychoanalysis is excluded, the average number of visits is 15. The average number of outpatient visits to a community mental health center is between four and five.

INDEPENDENT UTILIZATION REVIEW BOARD

The National Association for Mental Health recommends establishing independent utilization review boards. This board shall be comprised of mental health professionals and paraprofessionals and informed laypersons. In no instance should members of the IURB be employees or Board members of the organization being reviewed. Access to information upon which judgment can be made and authority to enforce this judgment should be provided by NHI administrative regulations. Such regulations should protect the confidentiality of individual patients' records. The purpose of the utilization review process shall be as follows:

1. To determine the nature and necessity of contiued treatment;
2. To safeguard the rights of clients receiving treatment, including the rights of confidentiality;
3. To assure quality care of an active nature.

HIGH UTILIZATION IN THE WASHINGTON, D.C. AREA

It is difficult to answer the question regarding reasons for high utilization of psychiatric services in the Washington, D.C. area. One answer might be that government workers have extensive outpatient coverage under the Federal Employees Program. It is also possible for a government worker to get time off for psychiatric treatment, which encourages utilization. There are other factors that may influence utilization in Washington. The educational level of government employees is probably somewhat higher in Washington than in the general cross-section of government employees. There may be greater stress in Federal government employment than in the general population, also causing an increased utilization. In addition, there is a higher concentration of psychiatrists in Washington, D.C. than in most metropolitan communities. Utilization rates are influenced by availability of services.

A COMPARISON OF DIFFERENT METHODS OF PROVIDING PSYCHIATRIC TREATMENT, ESPECIALLY COMMUNITY MENTAL HEALTH CENTERS VERSUS PRIVATE PRACTITIONERS

The National Association for Mental Health firmly supports the concept of developing insurance coverage whether public or private, that will encourage the development of community mental health centers. Centers provide a team approach to diagnosis, treatment and evaluation. Their staff are salaried. Centers

are able to provide a wider range of services than can be obtained from a private therapist. For example, centers give more group psychotherapy than do private psychiatrists. Community mental health centers also can offer a wide range of social services to patients, such as assisting in finding employment, locating suitable housing, follow-up visits to the home and a host of other services for which psychiatric social workers are specifically trained.

Community mental health centers can provide other important services, such as testing and psychotherapy given by psychologists and home visits by a psychiatric nurse. Indigenous personnel can provide important services to patients in the community.

Statistics which compare the average number of visits to a community mental health center as opposed to the average number of visits to a private psychiatrist, clearly indicate that there is a built-in mechanism at work in the community mental health center which limits the number of visits that the average patient would make to the center. This mechanism does not appear to be present in the practice of private psychiatrists. The average number of outpatient visits to a community mental health center is 4.3 (1971 statistics). The average number of visits to a private psychiatrist are as follows: 10 or less—29%; 11 to 20—15%; 21 to 40—20%; 41 to 60—13%. Over 60 visits—23%.

In summary, we believe the foregoing information suggests that fully staffed centers provide the most effective treatment modalities and therefore deserve the support of third party payment dollars.

Utilization and Costs Of Mental Health Services

In the publication *Health Insurance and Psychiatric Care: Utilization and Cost*, information was given which shows that over-utilization and out-of-hospital psychiatric services under private insurance plans has not occurred in a wide pattern or excessive degree. In an analysis of 15 plans which included generous coverage for mental health care, it was found that the lowest annual utilization was 6.1 persons per thousand and the highest annual utilization was 21.0 persons per thousand covered. The same analysis gave information regarding the number of visits to psychiatrists as a percent of visits to all physicians. It was found that as a percent of visits to all physicians, the lowest utilization was 1.1 percent and the highest utiliztaion was 4.4 percent. The above figures hardly indicate that people are eager to see a psychiatrist with minor problems, as some have charged.

The same publication also gave information regarding the cost of mental illness benefits as compared to benefits for all illnesses under certain private health insurance plans. A comparison of the experiences of eleven major health insurance plans shows a low of one percent and a high of only 6.4 percent of total benefits were paid for mental health care. Even more striking are the data relating to the annual cost of all mental illness benefits per person covered. The lowest amount was $1.09 and the highest $7.32 annually. The cost is clearly a very modest one especially in view of the fact that coverages included *all* mental illness benefits, both inpatient and outpatient.

Importance of Supporting Community Mental Health Centers Through Insurance

Mr. Chairman, if there were sharp cuts in the Federal Employees Program for services for the mentally ill, it is very possible that those who are drafting national health insurance legislation will assume, without good evidence, that mental illness is too costly to include under NHI legislation. We would, as a result, stand to curtail drastically or perhaps lose the most important advance in the century in the mental health arena—the development of a community mental health center system.

There is no need for me at this point to outline the abuses of the state mental hospital system which community mental health centers are now supplanting. The degradation suffered by individuals over many years as a result of the lack of care given in massive custodial institutions far removed from the communities they serve, is well documented. Community mental health centers are providing a viable alternative and I think that it is important that we provide some background on just how important the community mental health center movement has become.

National Association for Mental Health National Health Insurance Proposal

As we mentioned above, the National Association for Mental Health, in our Plan of Coverage for the Mentally Ill in National Health Insurance, has called for unlimited coverage for outpatient and partial hospitalization services given

through community mental health centers or through organizations affiliated with community mental health centers. We have supported 20 visits to a private psychiatrist with the first seven consultations per each one year benefit period covered in full.

Background on Federally Funded CMHC's

There are now 592 comprehensive community mental health centers that have received federal funding. Of that number, 455 are operational. Eighty million people now reside in areas that have received federal funds for community mental health centers. That's about 40% of the U.S. population. Approximately 60 million people reside in areas where the federally funded centers are operational.

Community mental health centers are fairly evenly distributed throughout our total population. 15% of the centers are in cities of 500,000 or more. 50% are in cities of 25,000 to 500,000 and 35% are in cities of less than 25,000 population.

The average number of patients seen in each center per year has increased steadily since statistics were first taken in 1968. In 1968, the average number of patients seen per center was 1,646. In 1971, that average had increased to 2,350. The total number of patients seen has also dramatically increased since 1968. In that year, 271,590 patients were seen by all centers. By 1971, that figure had increased to 693,260, more than double.

And, Mr. Chairman, 77% of all services in CMHC's are outpatient and another 5% are partial hospitalization services. In other words, only 18% of the patients seen at community mental health centers are seen on an inpatient basis. This is further indication of the growing trend toward ambulatory treatment of the mentally ill.

Impact of Federally Assisted Community Mental Health Centers on State Mental Hospital Utilization

In community mental health centers in operation for three years or more, the inpatient rate of catchment area residents in state hospitals is significantly lower (by 30%) than that for the United States as a whole. Some have reduced the number to zero. Since 1955, there has been a dramatic reduction in the number of patients in state mental hospitals. In 1955, that number was 559,000. As of June 30, 1973, there were 250,000 resident patients in state mental hospitals.

The reduction in census has important financial implications. From 1950 to 1955, the state hospital census increased from 513,000 to 559,000 or 9%. If it had continued to increase at that pace through 1973, it would have gone up by 181,000 and would now total 740,000. Instead, as noted above, there are now 250,000 resident patients in state mental hospitals. That's still too many, more than some of our major cities, but far less than would have been the case without community mental health centers, medications and improved treatment methods.

Our Plan of Coverage For the Mentally Ill In National Health Insurance

The NAMH Plan of Coverage for the Mentally Ill in National Health Insurance calls for the structuring of national health insurance to encourage outpatient care and to stimulate the growth and development of comprehensive community mental health centers. It would provide for unlimited outpatient and partial hospitalization services in these settings, with limits placed on other outpatient and all inpatient services, except for children, for whom we believe inpatient services should be unlimited. All would be subject to a strict utilization review process.

We are not unaware that there are limitations on the amount employees are willing to pay in insurance premiums, however, we are acutely concerned that severe or inappropriate curtailment of mental health coverage or drastically increased requirements for co-payment that apply only to mental health services are especially detrimental to families in moderate low income brackets. And careful consideration should be given to the fact that some kind of mental health services will be needed by perhaps at least 10% of the enrollees covered by the Federal Employees benefit program.

Mr. Chairman, we were pleased to learn that the Federal Employees Program will not be cut. We urge you, and the members of this committee to take our proposal into serious consideration when future decisions are made that would affect the Federal Employees Program, private insurance plans, and NHI.

Mr. DANIELS. That concludes the hearing. Thank you all for having appeared here today.

[Whereupon, at 11:35 a.m., the subcommittee adjourned.]

[The statement which follows was received for inclusion in the record.]

JOINT PREPARED STATEMENT BY THE AMERICAN ACADEMY OF CHILD PSYCHIATRY, AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, AMERICAN MEDICAL ASSOCIATION, AMERICAN NURSES ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, ASSOCIATION OF MENTAL HEALTH ADMINISTRATORS, COUNCIL FOR THE ADVANCEMENT OF PSYCHOLOGICAL PROFESSIONS AND SCIENCES, NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS, AND THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Thirteen major national organizations interested and involved in mental health wish to express their deep concern over the recent action taken by the Aetna Life Insurance Co. and the Civil Service Commission to reduce mental health benefits under the Aetna Plan for Federal Employees Health Benefits. The announcement was made on October 21, 1974, and will become effective the first pay period of January 1975.

The extent of these cutbacks in mental health benefits is enumerated in the U.S. Civil Service Commission publication "Government-wide Indemnity Benefit Plan 1975," appended for the record.

Under the Aetna plan for Federal employees for 1975, mental health benefits are limited to a total of 20 sessions or visits by physicians, clinical psychologists, psychiatric social workers or psychiatric nurses. For purposes of this provision, two outpatient sessions or visits at a qualified Community Mental Health Center count as one session or visit.

This action will have a number of adverse effects on the beneficiaries of this plan. While it is true that beneficiaries had the option of transferring to the Blue Cross and Blue Shield Plan for Federal employees, which has no such restrictions for mental health services (although widows or widowers of beneficiaries of this plan did not have this transfer option), it is predictable that those who are presently receiving mental health benefits will constitute the bulk of those transferring. Many others who are not receiving such treatment probably have not transferred to Blue Cross and Blue Shield. Should some of these beneficiaries subsequently have need of mental health services, they would be severely restricted in their treatment program under the new Aetna benefit package.

Another adverse effect will be the distortion of utilization figures for mental health in the Blue Cross and Blue Shield plan for Federal employees. For example, if a wide range of mental health benefits is available in only one plan, which draws high utilizers of mental health services, mental health utilization data in that plan will not represent a true picture. The organizations presenting this statement have every intention of closely monitoring these data that may result from the new Aetna contract, and of keeping this committee informed of any marked changes in mental health utilization data in the Blue Cross and Blue Shield plan.

During this past summer there was abundant speculation that Blue Cross and Blue Shield and the Civil Service Commission were considering the introduction of a reduced mental health benefit package in that plan for Federal employees. The principal rationale was that mental health benefits were absorbing an increasing share of total benefit dollars in the plan. Since that time, it has been demonstrated that the data were in error, and the percentage of total benefits being utilized by mental health services has, in fact, remained rather stable in the 7 percent range during the past 3 years, rising at the modest level of about 0.1 percent each year. Utilization did rise during the first few years following the expansion of the mental health benefit by Blue Cross and Blue Shield, but this would have been considered inevitable in any specific health service area, and even beneficial since it demonstrated a need for expanded mental health services. It would appear from the experience of the past 3 years that the utilization of mental health services in these programs has reached a natural balance in relation to the utilization of other health services. The statistics have indicated that mental health services may have approached a plateau, thus mitigating against a reduction at this time. These associations have been reiterating through the years the positive effect of wide mental health benefits in the health care delivery system in lowering utilization in other medical services.

The policies that Blue Cross/Blue Shield, Aetna, and the Civil Service Commission instituted in providing a range of mental health benefits for Federal employees are indeed commendable. The decision not to reduce these benefits in the Blue Cross/Blue Shield plan represented an extension of this positive approach in providing mental and emotional health care.

In the testimony of September 16, 1974, presented by Aetna Life & Casualty on FEHB before this committee, it was stated, "In particular, we tried to treat mental and nervous conditions just as we treat any physical illness." Moreover, Aetna noted that it tries "to structure our plans so as to provide what we consider to be an appropriate set of benefits for an appropriate premium for the particular group of employees to be covered." The issue being considered in that testimony was the Blue Cross and Blue Shield benefit package for mental and emotional health care. During that testimony, Aetna gave no indication to the committee of its intent to reduce mental health benefits. Statistics were cited of steady increases in the percentage of mental and nervous benefits in its plan, but the committee was not made privy to Aetna's intent while the entire general matter was being reviewed by the Congress and the public sector. A posture of greater mutual cooperation and attempts at program improvement in the future can avert such unilateral action.

It is, therefore, difficult to understand this completed action by Aetna and the Civil Service Commission. One might speculate that this decision moved along in a manner that made it difficult to stop. Perhaps the most recent expression by Aetna officials that they would hope to restore the mental health benefit of last year is an indication that their action will be reversed in next year's negotiations with the Civil Service Commission.

The rationale for the reduction of mental health benefits based on the asserted need for "cost control" does not in all fairness represent a compelling argument, since the cost factor is nominal and feasible.

The need for regulation and review has already come before this committee which called on the Civil Service Commission to oversee the FEHB plan more effectively. This directive was made in a formal report on its extensive hearings on FEHB.

This group of national organizations in the past few months has vigorously protested any trend toward the diminution of mental health benefits in Federal programs. These associations feel that the Federal Government has demonstrated effective leadership in this direction. Moreover, the possibility of retrogressive policies in cutting mental health benefits have been staunchly resisted by Congress. It has been amply demonstrated through these plans that the provision of mental health benefits is economically feasible. At a time when we are on the threshold of a plan for national health insurance, it would be counter to the public need to reduce mental health benefit packages in existing plans.

At the same time, national associations stated in their testimony before the Senate Permanent Subcommittee on Investigations on the CHAMPUS program mental health benefits on July 23, 1974, that it is important to institute the necessary administrative and supervisory controls in such programs, which should include accreditation and utilization and peer review procedures to eliminate any questionable practice. We stated that the action to curtail benefits for one disease category is inappropriate and harmful to those who are receiving proper and responsible health care.

Our associations wish to help strengthen such programs through the effective use of peer review. Many such efforts have already been demonstrated to officials of the Blue Cross and Blue Shield programs, and to the CHAMPUS program of the Department of Defense. Much work needs to be done, but we feel that substantial progress has been made in developing effective peer and utilization review systems for mental and emotional health care.

It is essential that there be consumer representation in the negotiating process that determines the benefit. Closer ties and cooperation between the carriers and the providers will insure that when problems come up that mechanisms to propose solutions will be used by all parties working together.