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EMPLOYEE HEALTH INSURANCE COVERAGE FOR SERVICES OF PSYCHOLOGISTS AND OPTOMETRISTS

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HEARING BEFORE THE SUBCOMMITTEE ON EMPLOYMENT AND EMPLOYEE BENEFITS OF THE COMMITTEE ON OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

H.R. 9440

A BILL TO PROVIDE FOR ACCESS TO ALL DULY LICENSED
PSYCHOLOGISTS AND OPTOMETRISTS WITHOUT PRIOR
REFERRAL IN THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

JULY 24, 1973

Serial No. 93-20

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(II)

CONTENTS

Testimony of—	Page
Gravitz, Dr. Melvin A., secretary, Council for the Advancement of the Psychological Professions and Sciences, accompanied by Jack Donahue, executive director-----	34
Little, Dr. Kenneth B., executive officer, American Psychological Association, accompanied by Dr. Arthur Centor, administrative officer for professional affairs-----	30
Nilan, Patrick J., legislative director, American Postal Workers Union, AFL-CIO, accompanied by Edward L. Bowley, legislative aide, and John Dubay, director of the APWU hospital plan-----	10
Obremsky, Dr. Michael J., representing the American Optometric Association, accompanied by Dean Drulias, associate director of Federal relations, and Richard Martinez, director of Federal relations--	20
Ryan, William E., senior vice president, National Association of Blue Shield Plans, accompanied by Joseph E. Harvey, vice president, Federal employee program, Blue Cross-Blue Shield, and Gene Sibery, executive vice president, Blue Cross Association-----	2
Statement submitted by—	
Ruddock, Andrew E., Director, Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission-----	39
Additional material—	
Copy of H.R. 9440-----	IV
Communications received from—	
Donahue, Jack, executive director, Council for the Advancement of the Psychological Professions and Sciences, letter dated July 24, 1973--	40
Ruddock, Andrew E., Director, Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission-----	42

(III)

H. R. 9440

IN THE HOUSE OF REPRESENTATIVES

JULY 19, 1973

Mr. WALDIE introduced the following bill; which was referred to the Committee on Post Office and Civil Service

A BILL

To provide for access to all duly licensed psychologists and optometrists without prior referral in the Federal employee health benefits program.

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

That section 8902 of title 5, United States Code, is amended by adding at the end thereof the following:

“(J) If the contract benefits include a service or services which may be provided by a psychologist or optometrist licensed and/or certified as such under applicable State or Federal statutes, then the Federal employee beneficiary, annuitant, or family member covered by such contract shall be free to select such psychologist or optometrist of his or her choice, shall have direct access to the same, without supervision or referral by another health practitioner; and shall be entitled under such contract to have benefits paid to him or on his behalf for such service or services.”

SEC. 2. The amendment made by this Act shall become effective with respect to any contract entered into or renewed on or after the date of enactment of the Act.

EMPLOYEE HEALTH INSURANCE COVERAGE FOR SERVICES OF PSYCHOLOGISTS AND OPTOMETRISTS

TUESDAY, JULY 24, 1973

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

The subcommittee met at 10 a.m. in room 210, Cannon House Office Building, Hon. Jerome R. Waldie (chairman of the subcommittee) presiding.

Mr. WALDIE. Today the subcommittee will hear testimony on the Federal employee health benefits program. Specifically, we will consider a proposal to allow those covered under the Federal employee program direct access to the services of optometrists and psychologists.

The bill, H.R. 9440, would allow those Federal employees who are covered under the health benefits program to obtain the services of psychologists and optometrists without prior referral by a physician. And may I caution the witnesses that the testimony today should be directed to H.R. 9440, which is a change from H.R. 8057, the original bill which was introduced May 27, whereas 9440 was introduced on July 19. Under many of the Federal employee plans, psychologist services can only be provided "at the direction and supervision of a psychiatrist or an attending physician."

Access to optometric services is limited in a similar fashion. Under the Blue Cross-Blue Shield plan, for example, optometrists are not included under the definition of "doctor" and therefore cannot be reimbursed for the services they might provide. Such services could only be provided by a physician, usually an ophthalmologist.

The intent of today's hearings is to see whether these restrictions are reasonable and justified.

In the past, the Civil Service Commission has indicated that, in its view, the referral procedure for psychologists was not required for adequate mental health treatment. In testimony before the Senate Subcommittee on Compensation and Employment, Mr. Ruddock has stated that "the clinical psychologist can perform responsibly without direction and supervision of the physician." In response to the Commission's position, Aetna Life and Casualty changed their Federal employee plan to allow for a more direct access to psychologist services.

Other Federal employee plans, on the other hand, have chosen to retain their present referral procedure. They have maintained that physician supervision is necessary in order to achieve quality and cost control.

Similar questions have been raised in regard to the provision of optometric services. Presently, 42 States have provisions in their in-

insurance codes which allow optometrists to be providers of covered services. A Post Office and Civil Service Committee report has indicated that the fact that the carriers are administering a Federal contract is no reason for circumventing compliance with applicable State laws.

This subcommittee must constantly review the health benefits program, keeping in mind the need to provide quality care at a reasonable cost. H.R. 9440 is one effort in this direction and therefore deserves our serious attention.

Our first witness is Mr. Joseph E. Harvey, vice president, Federal Employee Program, Blue Cross-Blue Shield. He will be accompanied by Mr. William E. Ryan, senior vice president, National Association of Blue Shield Plans. Gentlemen, will you come forward, please?

Mr. HARVEY. Mr. Ryan will be our principal speaker today, and with us is Mr. Gene Sibery, the executive vice president of Blue Cross Association.

Mr. WALDIE. All right, would you proceed, Mr. Ryan?

STATEMENT OF WILLIAM E. RYAN, SENIOR VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, ACCOMPANIED BY JOSEPH E. HARVEY, VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAMS, BLUE CROSS-BLUE SHIELD; AND GENE SIBERY, EXECUTIVE VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. RYAN. The subcommittee has requested our views on H.R. 9440, as amended, which if enacted would require the payment of benefits by carriers participating in the Federal employee health benefits program for services specified in their contracts with the U.S. Civil Service Commission that are performed by psychologists and optometrists within the scopes of their licenses or certifications.

We welcome the opportunity to provide the subcommittee with our views and comments on the proposed legislation. However, before expressing these views we believe it should be noted that the Federal Employee Health Benefits Act (chapter 89, title 5 U.S. Code) currently, and since its enactment in 1959, specifies the kinds of health benefits which may be offered by the various approved carriers, but does not designate the providers that may furnish such benefits. Under these circumstances, provider designation has, during the life of the program, been through contractual agreement between the carriers and the U.S. Civil Service Commission. Accordingly, H.R. 9440 would constitute the first departure from a principle established in the original legislation.

Mr. Chairman, may we first refer to that portion of H. R. 9440 which relates to the services of optometrists. We are somewhat reluctant to comment on the advisability of including optometric services as a benefit in the Government-wide service benefit plan administered by Blue Cross and Blue Shield plans, primarily because our experience with this type of service has been extremely limited. Our Federal employee program, for example, is intended to provide benefits required in the diagnosis and treatment of illness or injury, and does not extend to the routine prescription and fitting of eyeglasses. To the best of our knowledge, an optometrist would rarely perform a serv-

ice that is included within the scope of benefits listed in our contract with the U.S. Civil Service Commission.

Neither local Blue Cross and Blue Shield plans nor the national associations have experienced a significant volume of complaints from subscribers on this matter. In addition, if we include optometrists as eligible providers in the program with such limited benefit possibilities, there is a danger that subscribers may be misled to conclude that more routine types of eye care are eligible for benefits.

Therefore, it does not appear that legislation is needed. Should the scope of benefits be broadened at some point in the future to include additional services routinely performed by optometrists, we can determine at that time—through negotiations—the eligible providers and conditions under which these benefits would be provided.

Mr. WALDIE. May I interrupt you there? Under the language of the program, could you in fact even contract to deliver or to pay for the routine services of an optometrist?

Mr. RYAN. No, sir. I don't believe we could.

Mr. WALDIE. So the only way the optometrist, in your basic understanding of it, would be included where you have a mind to do so, would be by amendment to the basic act?

Mr. RYAN. Yes.

Mr. WALDIE. Would this bill constitute such amendment?

Mr. RYAN. Basically at the moment there are two instances where this kind of care would be covered. That has to do with the refraction and supplying of eyeglasses in surgical procedures—two procedures; either after an accident or interocular. At the present time we do pay our subscribers for these, because they are supplemental payments, when as a supplier the glasses are provided in these two instances.

Mr. WALDIE. That would seem to be well within illness or injury.

Mr. RYAN. Yes.

Mr. WALDIE. Suppose a person's eyes simply deteriorate from old age, such as mine and Mr. Hillis'. We would not be ill or injured by the definition of the statute, and therefore would not be entitled to eyeglasses?

Mr. RYAN. I guess as a general summary, if there is no illness or injury, there would not be coverage under the program.

Mr. WALDIE. The only way we can do this is by statute, and therefore my question possibly should not be asked of you, but would this legislation comply with that demand, if it was the belief of Congress that that subject should be at least within the potential of negotiation? I suppose this approach would not permit you to negotiate, this would compel you to pay?

Mr. RYAN. I think that you would then approach a change in the basic contract.

Mr. WALDIE. No question. I guess that is exactly what we would have to do, if we want to accomplish this. My question then is, Does the bill that we have introduced—does the bill do this or go beyond that? I think it may go beyond that. It changes the basic authority of the act, but it also removes it from negotiation. I think the bill, if enacted, not only changes the basic authority of the act, but compels you to in fact pay, removes it from negotiation. I think that is the intent of the bill.

Mr. RYAN. I think that was our response, Mr. Chairman, that we felt legislation rather than negotiation leaves you in a stringent position.

Mr. WALDIE. We will check that out. You have called my attention to the limitation of the act which I was not fully aware of. It is amended in terms of health benefits and illness. There is no preventative care permitted under this health benefits program?

Mr. RYAN. The program itself also deals with the diagnosis of illness, and you may remember we had discussions before, before this subcommittee, about the increase in diagnostic outpatients relating to the specific symptoms of illness and disease.

Mr. WALDIE. If my optometrist gives me an examination and says, "You have got deterioration within your eye which causes me to refer you to an ophthalmologist, would the ophthalmologist's examination be covered?

Mr. RYAN. Yes, it would. It relates to disease and it is diagnostic services because it is treatment of illness and really falls to the physician.

Mr. WALDIE. If I did not go to the optometrist, and had gone directly to the ophthalmologist, and I say, "I can't see very well. Do I need glasses?" And he diagnoses it and I get glasses; is that covered?

Mr. RYAN. Not purely for examination of glasses. If you had some symptoms of some eye disease or illness, and the ophthalmologist performed an examination, then it would be.

Mr. WALDIE. Even if he concluded that I was not in fact diseased or ill?

Mr. RYAN. Ordinarily if the symptoms are such that he believes the tests should be taken, I would presume that there would be sufficient evidence that it would justify that kind of procedure.

Mr. WALDIE. Yes. One final question. When you get a bill in from a subscriber who has gone to an ophthalmologist is there an examination of what the results of his diagnosis produced?

Mr. RYAN. Mr. Waldie, I am not sure I can answer that but it would seem to me that our local plans, particularly when we are talking about diagnosis and the emphasis put on those over a period of years, there would be an early attempt to identify the reason for the test and the results of it and that would be the prognosis of treatment.

Mr. WALDIE. Mr. Hillis?

Mr. HILLIS. No questions.

Mr. WALDIE. Please proceed, then.

Mr. RYAN. Turning to that part of the bill which deals with psychologist's services, the provision of benefits for the diagnosis and treatment of nervous and mental disease is the area in which the psychologist can be involved.

In 1962 alone, our basic coverage for Federal employees provided \$32 million for the treatment of psychiatric diagnoses, all without copayment or deductibles. Under the supplemental portion of the program, an additional \$23 million was paid, after copayment and deductibles. A total of \$55 million, representing more than 7 percent of all benefits, was paid under this very comprehensive plan. Exactly how much of the total was paid to psychologists, we do not know. Our coding structure does not permit us to identify payments to psychologists and other nonphysician providers for whose services benefits are provided under this program.

Mr. WALDIE. May I interrupt you there? Why is that so? Why do you not identify to who those payments go?

Mr. RYAN. I think it gets to be a question of internal administration. There is a very detailed reporting to the headquarters, as far as central records are concerned. They come from the 71 plans and a great deal of information is put on those cards.

Mr. WALDIE. May I ask you how that billing is done? If a subscriber has been to his physician or psychiatrist, and the psychiatrist says, "You need some treatment from a psychologist." Does the psychiatrist, then in effect bill the plan for the psychologist's services? Or does the psychologist bill directly?

Mr. RYAN. We touch portions of this as we get into our testimony.

Mr. WALDIE. All right, let's go ahead then.

Mr. RYAN. We believe it is important that the subcommittee know of the progress and precedents that the Civil Service Commission and we have made in extending and improving benefits for the diagnosis and treatment of nervous and mental disease.

In the original 1960 contract with the U.S. Civil Service Commission, our high option nervous and mental disease benefit provided 30 days of basic hospital care (10 days under low option) with benefits under supplemental (major medical) limited to 50 percent of charges (low option was limited to inpatient hospital care only). For its time, this was good coverage—and even today many health plans still restrict coverage for nervous and mental disease to levels below those provided for physical illness and injury.

In our Federal employee program, benefits for this type of illness have been expanded and improved, and today they are fully equated with benefits provided for all other illness or injury. This evolutionary process was as follows:

In 1961, low option supplemental benefits were expanded to include treatment of nervous and mental disease on an outpatient basis.

In 1961 all basic benefit limitations applicable to nervous and mental disease were lifted. Benefits for nervous and mental disease were provided on the same basis as for physical illness—120 days of in-hospital care under high option and 30 days under low option.

In 1963 basic benefits were expanded to include psychological evaluations performed for hospital inpatients (by a hospital employee) for both options.

Again in 1963, the supplemental benefits limitation on prescription drugs for treatment of nervous and mental disease was increased from 50 to 80 percent of cost under the high option and 75 percent under low option, which equated this benefit with that for drugs related to physical illness.

In November 1964, basic benefits for hospital inpatient care for nervous and mental disease were increased to 365 days under the high option, which equated this benefit with that related to other illness or injury.

In 1967, supplemental benefits for nervous and mental disease (in addition to drugs) were fully equated with those for physical illness. This change increased benefit payments to 80 percent of charges (high option) and 75 percent (low option).

In 1967 a new supplemental benefit was added specifically for the treatment of nervous and mental disease. It included day/night care in hospitals, collateral visits with members of the patient's immediate family, group therapy, and the services of members of a mental health team when performed under the direction and supervision of a physician. (A mental health team was defined to include a physician as the head of the team and one or more of the following: a psychologist, a psychiatric nurse, or a psychiatric social worker.)

In several steps the supplemental benefits dollar maximum was increased from \$20,000 (high option) and \$5,000 (low option) in 1960 to the present \$50,000 (high option) and \$25,000 (low option)—these maximums being fully applicable for treatment of nervous and mental disease as well as to charges related to physical illness.

The principle of fully equating benefits for treatment of mental and physical illness is extremely important. However, Mr. Chairman, equating benefits means what it implies. It is the intent of the Federal employee program to pay for services to subscribers who are sick or injured. We expect to pay for establishing a diagnosis and for the ongoing treatment and evaluation of the condition that has been diagnosed. We do not expect to pay for—and our rates do not contemplate coverage of—professional services, however competent or helpful, that do not either constitute or assist in the practice of medicine. This is the basic reason for our insistence on evidence of the continuing supervision and responsibility of a medical practitioner whatever the condition being treated.

Blue Cross and Blue Shield coverage is consistent on this point. As an example, consider the coverage offered by our three largest national accounts other than FEP which retain highly sophisticated staff and consultants, both for management and for labor, to assist in designing and controlling the flow of their health benefits dollars. Of these, one limits benefits for psychologists to testing procedures. A second also provides this "testing" benefit and will provide benefits for services rendered by a clinical psychologist when billed for by an approved institution. The third does not cover the services of psychologists on an outpatient basis. In these very large accounts, outpatient benefits for services rendered by a full mental health team are unique to FEP. We do not know the exact extent of benefits similar to FEP in the local contracts of our member plans, but it is not extensive.

The provision in the Blue Cross and Blue Shield system's contract for Federal employees limiting benefits for services of a clinical psychologist to those performed under the direction and supervision of a physician is not new. It has been in the contract (and stated clearly in the explanatory brochure) since the mental health team benefit was added in 1967. Services of clinical psychologists are treated exactly as the services of any nonphysician. (Dentists and podiatrists, both licensed to perform surgery, are defined as physicians within the scopes of those licenses.) This requirement applies equally to nurses (including psychiatric nurses), physical therapists, nurse anesthetists, and psychiatric social workers, as well as to clinical psychologists.

One very practical problem is the difficulty in defining clinical psychologists, and particularly in distinguishing him from the nonclinical psychologist. According to the latest information we have avail-

able, only 26 States and the District of Columbia license clinical psychologists—and some of these have only recently initiated licensing. In addition, 21 States require “certification”—a procedure usually involving standards established by a private association rather than by a State agency. Four States have no requirements at all.

All but one of the States requiring either licensing or certification specifically prohibit the “practice of medicine” by clinical psychologists. We consider this particularly relevant in view of the intent of the program to pay for the diagnosis and treatment of illness. While we recognize the strides made by the American Psychological Association in recent years in upgrading the professional level of clinical psychologists, the level of training and scope of practice of psychologists still do not appear to us to be constant throughout the country.

Clinical psychologists are not the only professional group requesting recognition to provide psychotherapy and other psychiatrically related services directly to patients without the supervision of a physician. We currently have the same request from the psychiatric social workers, and have had it from other sources, including various religious and educational groups. Making an exception for clinical psychologists would, in our opinion, result in immediate demands from other groups for similar exceptions, which would cumulatively impact on the premiums the Federal employees and the Government must pay.

Mr. Chairman, I want to emphasize that we recognize the valid and useful contribution the clinical psychologist makes to the care and treatment of the mentally ill. We have made every effort to include his services within the benefit structure, to the extent that this can be done within the intent to cover the costs of illness. To this purpose, we have not insisted on the formal or classic mental health team arrangement (which current contract language would permit and where all members work as a unit, usually as salaried employees of a mental health facility). Neither have we required that the attending physician be a psychiatrist. Recognizing both the shortage of psychiatrists and the desirability of great flexibility in the treatment process, the program does provide benefits for informal mental health team arrangements.

However, the contract specifies physician direction and supervision, regardless of specialty, and in the interest of all of the parties, we administer it accordingly. To assure supervision, we required patients receiving services from nonphysician members of a mental health team to consult with the physician “head” of the team at least every 30 days. Experience indicated that this procedure was unnecessarily time consuming and accordingly, we altered it. Currently, supervision and direction may be accomplished by a consultation between the non-physician therapist and the physician “head” of the team at least every 90 days—with a direct evaluation of the patient by the physician at least once a year. This does not appear to impose a hardship on the patient, and is consistent with the intent of the program.

There are several needs which should be met in the further development of a mental and nervous disease benefit. These include better definition and identification of the clinical psychologist; the development of peer review mechanisms to monitor charges and utilization; further development of our own capacity for precise administration of

nonphysician professional services; and further clarification of the costs and utilization implications of such an expansion of benefits. These developments, in conjunction with the continuing efforts of the American Psychological Association to upgrade and standardize the qualifications of clinical psychologists, may make it possible to modify our present position. However, this is a decision we are not prepared to make independently of these other factors.

Mr. Chairman, we appreciate the concern of the committee. Both the evolution of clinical psychology as a profession and the evolution of our ability to administer nonphysician professional benefits in strict compliance with medical necessity are continuing. We have had informative discussions with the American Psychological Association on these points, and expect to continue them. In no way do we impugn the professionalism of the representatives of the association or of its membership. However, our position with respect to providing benefits for clinical psychologists' services, independent of medical direction and supervision, has not changed from that expressed in prior correspondence with the association and the Civil Service Commission.

For these reasons, the National Association of Blue Shield Plans and the Blue Cross Association are opposed to the enactment of H.R. 9440, as amended.

Thank you for the privilege of appearing before you today.

Mr. WALDIE. Thank you, Mr. Ryan. Mr. Hillis?

Mr. HILLIS. Thank you, Mr. Chairman.

Mr. Ryan, I appreciate your statement very much. I found it enlightening, and I certainly compliment the organization that you represent with the going forward and expansion of this very needed care in the area of mental health and nervous diseases. But do I understand that what you are saying here is basically the reason you oppose the bill is because you don't have enough experience in what the ramifications of this step proposed in legislation might bring about?

Mr. RYAN. I think that is one. There are others.

Mr. HILLIS. How do we gain that experience? Are you making any studies in this area?

Mr. RYAN. We attempt to through our programs. We are paying for a good deal of this care. The main factor is we are paying for it when it is under the supervision of the physician, because it is an illness.

Mr. HILLIS. I know in my own area we have these so-called regional mental health centers which are staffed by a psychiatrist and then a team of resident psychologists, and so forth. Would this be covered under your plan?

Mr. RYAN. Yes. The problem we had, Mr. Hillis, is with the 5 million subscribers spread across 50 States, there are a number of States and localities where that kind of team is not available to our subscribers. At this point, we feel for equity we should relax somewhat and allow physicians and an informal mental health team to operate just as the more formal team is operated. What we wanted to do is get the benefit to the people, but we still attempted to maintain supervision and direction.

Mr. HILLIS. It is my understanding that through the center, cure or rehabilitation is brought about much more rapidly than institutionalization, and often institutionalization is not even used at all. So a real step forward in the field of mental health is the development of these centers and utilization of these personnel. Are you doing some research in this area to see what the next step may be and perhaps that service can be further expanded through the use of psychiatrists?

Mr. RYAN. We are and have been continually interested in expanding our mental health benefits, because we see the need, as does anyone else. There are some points of resistance though, because these are expensive and rather undiscovered fields. In the commercial accounts, I think we have gained a good deal of experience from having the broad concept that we have experienced in the FEP program.

Mr. HILLIS. This is what I congratulate you for. I think it has been very good. I think the whole society gains by keeping the person on the job, treating him on a part-time or outpatient basis. And we all gain thereby, especially the taxpayer.

I think that is all the questions I have.

Mr. WALDIE. Thank you, Mr. Hillis. Mr. Hogan?

Mr. HOGAN. I have no questions.

Mr. WALDIE. Under the present contract, it is my understanding if the optometrist did tonography, measuring the eye pressure for glaucoma that his services would be covered for the subscriber in your present contract?

Mr. RYAN. No, sir.

Mr. WALDIE. That is not correct?

Mr. RYAN. I am sorry, he is not an eligible provider of medical services, and what we are dealing with now, as far as optometrists are concerned, is only supplying of eyeglasses in those procedures we mentioned before. We are getting into diagnostic services which are leading toward disease.

Mr. WALDIE. I know he performs the glaucoma test. I had it performed, and it is a personal inquiry.

Mr. HOGAN. In some States, the optometrist is prohibited from putting any medicine in your eye.

Mr. RYAN. Not in all instances.

Mr. WALDIE. No, they put a probe in your eye.

Mr. RYAN. I am not eminently qualified to talk on this, but I do believe many of these types of tests are uniform screening tests which are performed on all patients. This is the kind of thing that we in Blue Cross/Blue Shield have to try to make a judgment on.

Mr. WALDIE. Do you ever pay for a subscriber a bill from an optometrist that has not been a referral from a physician?

Mr. RYAN. No.

Mr. WALDIE. There is no authority in your view under the present contract to do that?

Mr. RYAN. That is right.

Mr. WALDIE. Fine. Well, so there is no question that with this bill passed you would be permitted to do—or is it your view that you would be ordered to do it? From the present language?

Mr. RYAN. I think we then would have to make the judgment on individual procedures as to whether or not they qualified as diagnostic procedures, which would be covered for eligible subscribers; and then we get into whether or not there are symptoms that lead to disease when in fact this provider cannot treat illness or disease. It seems a very difficult problem as far as claims adjudication would be concerned.

Mr. WALDIE. Well, gentlemen, are there any further questions?

Mr. HILLIS. No questions.

Mr. HOGAN. No.

Mr. WALDIE. Well, we appreciate it, Mr. Ryan and Mr. Harvey and Mr. Sibery. Thank you.

Our next witness is Mr. Patrick J. Nilan, legislative director, American Postal Workers Union (AFL-CIO).

**STATEMENT OF PATRICK J. NILAN, LEGISLATIVE DIRECTOR,
AMERICAN POSTAL WORKERS UNION, AFL-CIO, ACCOMPANIED
BY EDWARD L. BOWLEY, LEGISLATIVE AIDE; AND JOHN R.
DUBAY, DIRECTOR OF THE APWU HOSPITAL PLAN**

Mr. NILAN. Thank you, Mr. Chairman. I would like to introduce my colleagues that are with me, and also as you will note, we have referred to H.R. 8057 on our statement and we will appreciate the stenographer striking that bill number and add substituting H.R. 9440.

For the record, I am Patrick J. Nilan, legislative director of the American Postal Workers Union (AFL-CIO). I am very pleased to appear before the committee this morning with our legislative aide, Edward L. Bowley; and our director of the APWU hospital plan, John R. Dubay. And we are sorry that Ben Evans could not be with us, but the Civil Service Commission auditors are visiting our hospital plan today.

Mr. WALDIE. May I interrupt for a moment? When was the last time they audited your experiences?

Mr. DUBAY. Last year.

Mr. WALDIE. They audit you every year?

Mr. DUBAY. Yes, they get around to it every year, and because of the merger of the plans, they are doing the final 1972 audit.

Mr. WALDIE. What is the audit designed to do?

Mr. DUBAY. Go over the complete records of our operations.

Mr. WALDIE. To determine if you are providing adequate medical care for the premiums you receive?

Mr. DUBAY. Yes, Mr. Congressman, and also the auditors review our operations to see that we are following the contract. Also to make sure we are following our contract with the Civil Service Commission, as far as the expenditure and payment of benefits to our members.

Mr. WALDIE. How long has the annual review and audit been occurring?

Mr. DUBAY. We have been audited every year for the past 5 years.

Mr. WALDIE. I see. I didn't mean to digress, but that has always been an interesting area of inquiry for this committee; namely, how carefully the plans are being monitored by the Civil Service Commission. You seem to be monitored more excessively than most, and I am going

to pursue it a little further. I think it is good, by the way. You may proceed.

Mr. NILAN. We speak in behalf of more than 350,000 postal employees for whom we are the exclusive national representative for labor-management relations and collective bargaining with the U.S. Postal Service. Our membership is employed in post offices in all 50 States, the District of Columbia, Puerto Rico, Virgin Islands, and Guam.

We desire to thank the chairman and members of the committee for giving the American Postal Workers Union the opportunity to express our view on this particular bill and on similar bills introduced in the House. The legislation is concerned with providing payment of benefits for services performed by a psychologist and/or an optometrist—"If the contract benefits include a service or services which may be provided by a licensed, and/or certified as such, psychologist or optometrist, under applicable State or Federal statutes, and such practitioners' training meets Federal, State, and national standards of accreditation, then the Federal employee beneficiary, annuitant, or family member covered by such contract shall be free to select such psychologist or optometrist of his or her choice, and shall have direct access to the same, without supervision or referral by another health practitioner, and shall be entitled under such."

Mr. Chairman, the American Postal Workers Union opposes this legislation for the following reasons:

1. We would require considerable time to have an actuarial study and report on cost made available to us. There is no question in our mind the cost would be prohibitive. The APWU health plan is an experience-rated plan and our premium is based on covered expenses submitted to the plan for benefits and services received by our enrollees.

2. If enacted, it is our opinion H.R. 9440 would open the door to every State-licensed practitioner and our files are full of "services" performed that were not medically required.

3. If Federal health plans were compelled to pay for the services of any type of "doctors" that may be State licensed or certified, there would be no possible control over cost, which would reflect in premiums already too excessive.

Mr. Chairman, and members of the committee, for purposes of the APWU health plan, a "doctor" is defined as a "licensed doctor of medicine (M.D.) or a duly licensed doctor of osteopathy (D.O.); and, for specified services covered under this plan, a licensed dentist or podiatrist operating within the scope of his license."

The APWU plan broadens the above by including that "doctors' services" include services of a member of a mental health team (i.e., physician, psychologist, psychiatric nurse, psychiatric social worker) operating under the supervision of the attending physician.

However, we do not consider the services of an optometrist to be "medically required." We do provide for treatment of eye illnesses or injuries and disease by M.D.'s who are eye specialists and are educated and trained in the field of medicine.

In other words, Mr. Chairman, the American Postal Workers Union strongly supports any proposition that benefits its members in

particular, and workers in general. But, we believe that the services of the practitioners included in H.R. 9440 when "medically required" are sufficiently covered through the present benefits of our plan. We also feel just as strongly that H.R. 9440 will give our members nothing more than excessive premium cost.

If I may add, at this point, I don't have it in the statement and I should have included it, namely, that national conventions of our organizations which direct our program to a large extent, have had similar resolutions presented to them over the past years and they have consistently rejected them in view of the projected costs, and also indicating that the services of our present plan are adequate.

Mr. Chairman, we know that when you introduce legislation, it is your intent that it be beneficial to all those concerned. However, in this instance, we see no benefit to our membership and therefore, appreciate the opportunity to express our opposition to H.R. 9440. We would be happy to respond to any questions or make available to the committee any information in our possession that you may deem pertinent.

I also had one other thought. Our APWU plan, Mr. Chairman, and members of the committee, does provide benefits throughout the entire world. And if one of our people is traveling abroad and becomes ill or needs medical services, we provide those benefits for him on the same basis as we do in the United States. And as a result we do have a question as far as this bill is concerned. Would they be entitled to the psychologist services or other services provided in foreign countries that might not meet the same high standards that psychologists and optometrists do in the United States?

Thank you, Mr. Chairman.

Mr. WALDIE. Thank you, Mr. Nilan. Mr. Hillis?

Mr. HILLIS. Thank you, Mr. Chairman. That is a very good statement, Mr. Nilan, and as I understand it, your concern here is an attempt to control the escalating costs of medical treatment. So, basically, you favor a plan that provides for the treatment of illness and provides medical care, rather than more or less routine services such as furnishing of eyeglasses, and this sort of thing. I suppose one could say dentists could be included under this legislation, as well, or orthodontists, or this sort of thing, could they not?

Mr. DUBAY. Yes, they could. If we are going to take this step, we might as well go the full way, because orthodontist treatment is very expensive, because of the long series of treatments.

Mr. NILAN. One of the dangers we see in it, and correct me if I am wrong, but it would appear that the hospital plans would be required to provide a service which is presently available through the underwriter itself, with the approval of the Commission, and we feel it would be dangerous to our plan to have such services required to be made available by law.

Mr. HILLIS. I don't know the answer. Perhaps you do, Mr. Dubay. In private industry, is there a thrust in this direction under the so-called negotiated settlements? In the private sector are they leaning in this direction through labor-management negotiations? Large companies?

Mr. DUBAY. The only one I am sure of is dental care, which is definitely negotiable today. But as far as other services, I don't know.

Mr. WALDIE. I note you define doctor as "a licensed dentist for specified services." In your contract, what are the specific services for which your subscribers are permitted to be reimbursed for dental expenditures?

Mr. DUBAY. If there is injury or accident and you went to the dentist, and you had repair to your natural teeth, as a dental surgeon for oral surgery, those services are covered under our plan.

Mr. WALDIE. What about just a plain licensed dentist?

Mr. DUBAY. Yes, if he does work due to an accident on the natural teeth.

Mr. WALDIE. Suppose he has pyorrhea and loses all his teeth due to illness?

Mr. DUBAY. No, not oral surgery of that kind.

Mr. WALDIE. Have the Blue Cross/Blue Shield people left?

Mr. HARVEY. No.

Mr. WALDIE. Mr. Harvey, if a subscriber has pyorrhea or some other disease of the gums, and if he loses all his teeth, is he covered under your policy?

Mr. HARVEY. No, our policy is quite similar to the one just described.

Mr. WALDIE. So certain illnesses then are not covered?

Mr. HARVEY. The routine services of dentists are not covered under the Blue Cross/Blue Shield.

Mr. WALDIE. Are diseases of the gum considered routine services of dentists?

Mr. HARVEY. It is considered routine dental care.

Mr. WALDIE. You apparently have never had that. [Laughter.]

Strange how all my afflictions are not covered by anybody's policy. All right, Mr. Hillis?

Mr. HILLIS. I have no further questions.

Mr. WALDIE. Mr. Hogan?

Mr. HOGAN. No questions, Mr. Chairman.

Mr. WALDIE. Mr. Brasco?

Mr. BRASCO. I am sorry I am late, Mr. Chairman, but I had another meeting. One of the things, and I suppose maybe Mr. Dubay can answer it, that I didn't understand in Mr. Nilan's statement when he talks about increased costs, H.R. 9440, talks about allowing an employee who receives benefits under an existing health contract in the area of visiting a psychologist or an optometrist. The opportunity of visiting one without first consulting a physician. Now it doesn't say anything about enlarging his ability to visit either one or two of those practitioners. It just says he has a right to go to one of his choice without first being medically referred. I would assume that the limits would always prevail and are not changed. So how does the question of cost come into that? It seems to me more a question of choice than a question of cost.

Maybe I am missing something. I am wondering if—

Mr. DUBAY. Yes, Congressman. We have the records—I do not have them with me—where we have received bills for services which have not been done under the supervision of the physician, or under the mental health team concept. We would have no control over such

services being performed because the services were not medically required under the mental health team concept and therefore such bills are not paid but could be required to be paid under this bill.

Mr. BRASCO. I understand what you mean, then. So that what you are basically saying is that the contract says very specifically that a man or woman is not covered unless first the determination is made that the visits to these two practitioners are medically required; is that right?

Mr. DUBAY. Yes.

Mr. BRASCO. Therefore, if there is no determination of any illness, you feel there might be increased cost because this privilege might be abused?

Mr. DUBAY. There would be no control over medical requirement. If a physician says it is required, say within a month it would be over with, that would be the end of it.

Mr. BRASCO. That raises an interesting point, because these are two areas that I don't feel that one would go to for assistance unless they individually had those problems.

Mr. WALDIE. I think the answer, if the gentleman will yield, is in my own case.

Mr. BRASCO. Yes, of course.

Mr. WALDIE. I have to have my gums surgically pulled back and scraped. The dentist says I will lose my teeth if I don't. If Blue Cross/Blue Shield were paying for it under the policy, that would add to their output. They don't pay for it. I had to get my eyes checked for new eyeglasses, and in the process the optometrist decided I should have a glaucoma test performed. They don't pay for these tests because a doctor did not refer me. If the Blue Cross/Blue Shield people were paying for these services, it would increase their expenses and I presume that is what they are saying. If you are entitled as a subscriber to get these bills paid, it would cost them more.

Mr. BRASCO. The point I am making is it seems to me we don't enlarge the contract benefits; that they would have a right to go to these two practitioners in the first place.

Mr. WALDIE. Apparently not unless the physician refers you.

Mr. HOGAN. If my understanding is correct, if the chairman had gone to an ophthalmologist, who is a medical doctor, and he did these things, it still would not be covered because that is not one of the things under the plan that is covered.

Mr. DUBAY. We would pay for the treatment, if there were symptoms or diagnosis by a medical doctor.

Mr. HOGAN. I am not talking about symptoms. He is not seeing as well as he used to, and he needs new glasses, so he goes to have a check made to see if he—

Mr. DUBAY. Yes, we would pay with the exclusion of the first visit.

Mr. HOGAN. I am not talking about treatment. I am talking about examination to see if—

Mr. DUBAY. Not a routine eye examination.

Mr. HOGAN. Suppose during the routine eye examination they decide he needs new—

Mr. DUBAY. Optometrists are not being discriminated against, because it wouldn't be covered if you went to an ophthalmologist.

Mr. NILAN. Let me give you an example, if I may.

Mr. BRASCO. I appreciate the comments that my colleagues made, but that is not what I was driving at. The point that I was making, it appears that under the contract employees can be covered in these instances for services supplied by a psychologist or optometrist up to a certain limit. Because the bill doesn't say anything about providing additional benefits. The way the bill is worded, it would appear to me that the issue is that these people are covered. However, it goes on further to say that they would not have to go to the M.D. first to say that the M.D. refers them. What they would be doing is consulting the psychologist or optometrist on their own.

Mr. DUBAY. Right, Mr. Brasco.

Mr. BRASCO. Then what you are basically saying is because he can do that on his own, and not go to an M.D. first, that this may be something that he doesn't need, or he may be abusing it. And therefore there would be increased costs. Now is that basically what you are saying?

Mr. DUBAY. We provide treatment for illness or injury and in order to provide these services under the mental health team concept, it has to be under supervision of a physician.

Mr. BRASCO. That is the point of contention. If you are saying if the doctor does not refer this employee first, then he may not be ill in either area.

Mr. DUBAY. Well, I wouldn't know, but a medical doctor should.

Mr. WALDIE. That is essentially correct.

Mr. BRASCO. But it does not necessarily increase the costs.

Mr. WALDIE. What the present plan says is that the doctors make the determination as to whether a person needs treatment of any kind.

Mr. BRASCO. But the point is, it doesn't increase the cost unless we build on the premise that the employee, unless he goes to the doctor first may be feigning illness or it may be psychosomatic and he doesn't need consultation in the first place.

Mr. WALDIE. I think the assumption is that the M.D.'s are less prone to find a person in need of service and treatment than would be the psychologist or the optometrist; is that a fair—

Mr. NILAN. I think it is fair. I think what we are trying to say here is that if he goes to a doctor for a physical ailment or complaint. However, the employee, if he has an option, may go to a psychologist and his ailment or complaint may be something that is completely foreign to the skills or knowledge of the psychologist. In our opinion the medical doctor should first make the determination of what is wrong with a person.

Mr. WALDIE. Suppose he is mentally ill and he goes to an M.D.?

Mr. NILAN. The M.D. has a right to referral.

Mr. WALDIE. Suppose the M.D. doesn't have the slightest understanding of mental illness?

Mr. NILAN. I would hope he would be able to make that much of a determination, that a person was mentally ill.

Mr. BRASCO. I think it would be easier in the case of the optometrist, but not necessarily in the case of the psychologist.

Mr. HOGAN. What type of illness would an individual go to an optometrist for?

Mr. WALDIE. Because he can't see well.

Mr. HOGAN. That is not an illness. As I understand it, the optometrist is not licensed to diagnose illness.

Mr. WALDIE. He is. He is licensed to diagnose glaucoma. He has a test called tonography, measurement of the pressure behind the eyeball. It happened to me two blocks off the Hill last week.

Mr. NILAN. Maybe I could cite a similar example. Suppose I went to my physician because I had a slight dizziness. I went to him to get some idea what was causing it. He checked me out and he wasn't sure, so he referred me to a doctor of osteopathy, and the doctor checked my eyes to see if I had any problem with my eyes, then he reported back to my own physician as to what the situation was. And I think personally, as a member of the plan, I would prefer it this way, because I did not know what it was that was causing the condition and I would go to a physician first.

Mr. WALDIE. May I ask a question on one that is not included, and it may be the most important of all. The dentist. Under the basic law, if you are so inclined, could you contract with your subscribers to provide full dental care?

Mr. NILAN. We could.

Mr. WALDIE. It is your understanding that you would not be precluded from contracting and negotiating with your subscribers for this?

Mr. DUBAY. Yes; we could, Mr. Chairman.

Mr. WALDIE. Mr. Harvey of Blue Cross, do you concur with that answer?

Mr. HARVEY. Yes.

Mr. WALDIE. That startles me. I gathered you could only cover illness or injury. Full dental care is beyond illness or injury. Filling a cavity, is that illness under your understanding?

Mr. BOWLEY. There are health plans under the Federal Government program that provide dental care, as the Laborers International Union of North America, which is the mail handlers representative, as far as postal people are concerned, have provided dental care, extraction of teeth, filling of teeth, so apparently it is not precluded.

Mr. WALDIE. I appreciate that.

Mr. NILAN. I think what we are talking about on our plans, though, and we are all aware of the tremendous increased cost of hospitalization and medical care. It is really a judgment question.

When we go to national conventions of our union each 2 years we have a special committee that considers all resolutions in the area of health benefits, and the committee brings the resolutions to the convention floor for delegate consideration. Now all of us would like to get as much as we can without paying more, but when we reported to the delegates the projected cost for some of these programs, as against the present health plan benefits coverage, they have repeatedly rejected such new proposals on the basis of cost, because there are only so many dollars available for health benefit costs. I believe generally myself and my two colleagues would agree that under the contract we have with the Civil Service Commission and the law, that if our members demonstrated overwhelming interest in some additional new services or benefits we would provide them.

We feel that is where the choice should lie and not necessarily with being required to provide certain services by law.

Mr. BRASCO. I am going to quit with this, but in terms of finding out for myself and obviously for everybody else what we are really talking about, my point was basically that this bill need not incur any additional costs, provided that all of the practitioners involved are doing their job and not giving treatment when it is not necessary.

However, if we build upon the premise that you need the M.D. first to ascertain whether or not the employee is sick, that is not added cost but a system of checks and balances. I would assume that if that same employee went first to the psychologist and optometrist and nothing was wrong with him, they would send him back home and he would be back where he started.

But I would assume the projection in terms of increased costs is based upon the fact that the plan would rather have the M.D. make the determination, as opposed to the optometrist or psychologist.

Mr. NILAN. Often illnesses are so closely related between a physical or mental condition or any combination of them, that our plan just believes that a licensed or medical doctor is more qualified in the broad range of treatment to make this decision. And we are confident that if the doctor feels there is need for a psychologist or mental health team or some other service, he will make that decision and we will be bound by it.

Mr. BOWLEY. If I may, Mr. Chairman.

Mr. WALDIE. Sure.

Mr. BOWLEY. Having administered the old plan for 7 years prior to our merger, one of the biggest problems we had, Congressman Brasco, was that convention after convention, or union meeting after union meeting the members' cry was to include chiropractors, dental treatment, and optometrists, all of these people in our plan. And we have found there are some, certainly not but a few, but we do find that we have received bills, bills that come to the plan, and I am certain John Dubay could tell you the same thing in operating the plan now that we get bills for services for which certain practitioners are not licensed to perform. Would you believe such things as a bill for maternity from a chiropractor? And things of that nature?

We have taken the position first of all, if you are going to just open the door and let the membership go to whomever they please, maybe the lady next door would be a good midwife and she could put in a bill and probably perform as well as some M.D.'s. But you will lose the control, and I think the important thing is control factor. I think if we are going to provide services for any illness or injury which is what the act states, then it has to be from someone licensed to perform the service and the illness has to be—the treatment has to be medically required. And in order to determine whether it was medically required, there has to be a control, and we feel that the licensed physician is the control.

Mr. BRASCO. Mr. Bowley, I understand exactly what you are saying, and I don't want to play the devil's advocate, but it still says, "a psychologist or optometrist licensed and/or certified as such under applicable State or Federal statutes * * *" so we are not talking about someone who is not a licensed practitioner. What you are talk-

ing about is who has the better judgment in the question involved. Does the psychologist have better judgment than the M.D. has as to whether or not an employee covered is ill in that particular area? And I think, all things being equal, the optometrist should be superior in his determinations in his area, the psychologist should be superior in his area, and the M.D. in his general area. The conflict obviously is, that we are simply saying maybe the psychologist and optometrist may be more prone to explore something and submit a bill when the man or woman is not ill than the M.D. who would refer him.

Let me ask you, the M.D.'s who do the referring, are they paid under the plan?

Mr. BOWLEY. They are paid.

Mr. BRASCO. It is no additional cost for going to the M.D.? They are paid whether the employee goes to them or not?

Mr. BOWLEY. If you are referring to the two practitioners in this instance—for example, if our membership goes to a psychiatrist—it is covered. If the psychiatrist refers him to a psychologist, it is covered.

Mr. BRASCO. Let me ask it this way. I am an employee, Mr. Jones, and I am not feeling well. I have some kind of problem. I go to the M.D. Does the M.D. submit a bill to the plan?

Mr. BOWLEY. There are times, surely, that he will submit a bill. When you walk into his office, he will submit a bill.

Mr. BRASCO. Are we talking about house M.D.'s who are paid whether they see 10 or 30 people? Or do they get paid for each visit?

Mr. NILAN. The employee goes to the doctor; he has a complaint. Our plan does not cover that first visit. The employee pays for that first visit. The doctor then may refer him to the psychiatrist or whatever other approved services are available, and then that second referral, that would be the one that would be paid for the first time. So the doctor may be paid by the employee when he first sees him, before he ever gets the services that he has been referred to and subsequently paid for.

Mr. BRASCO. Supposing Mr. Jones goes to the doctor and the doctor says, "That is an interesting case you have got, Mr. Jones. Come back next week."

You don't pay for the first visit, but you pay for the second?

Mr. NILAN. That is correct.

Mr. BRASCO. Then the doctor decides after two more visits, and you have paid three doctor's bills, that he should go to the optometrist. It would seem to me you might save money if he went to the optometrist first.

Mr. DUBAY. We would not pay for the optometrist in any case.

Mr. NILAN. I think we are getting involved—

Mr. BRASCO. To the extent that it is covered under the bill, and again I assume from the language in reading the bill that we are not broadening the contract provisions over how many medical bills should be paid. Then I don't see how you could be losing money. Because if he went to the optometrist first, you wouldn't have to pay any bill but this. If he went to the M.D. first, you would have to pay three bills just to get to the optometrist. So that would cost more money doing it that way.

I understand your objection, and I assume it is based on the integrity of the different practitioners.

Mr. NILAN. No, not at all.

Mr. BRASCO. Why would you be saving anything in the case I just described? If he went to the doctor three times and the doctor says go to the optometrist, but you don't pay—

Mr. NILAN. Two reasons, really. No. 1, we could say he went to the doctor six times or seven times as well as three times. While it is perfectly all right to suggest that, the way our plans operate is to protect the general membership that belong to our plan, and we have a control. A control insofar as validating the need for the services. And I believe that most of the health plans have that position, and the control is the medical doctor.

Mr. BRASCO. Well, would you agree then that the control would be more costly under the case I just described?

Mr. NILAN. I doubt it frankly, because I think what you are talking about is somewhat unusual. If I went to a doctor three times and finally he tells me to see the optometrist, I think it would be the last time I went to see that particular doctor.

Mr. WALDIE. I suppose you could equally go to the optometrist three or four times, and he could tell you go see the physician.

Mr. BOWLEY. It might be similar to if you said to your youngsters to come to me for your allowances, and I will give you so much, or if you told them to go to the bank and draw it out themselves. I suggest that would cost you more. [Laughter.]

Mr. WALDIE. Shall we proceed?

Mr. BRASCO. Yes.

Mr. WALDIE. Do you have any further comment?

Mr. NILAN. I want to conclude by stating emphatically that we have no question about the services, the creditability, or the professionalism of the psychologist or the optometrist. They provide very important beneficial services, but again our position is locked in, as we explained in our testimony, and must oppose this bill.

Mr. WALDIE. Essentially, your position is that the medical doctor is the person who ought to be making the essential decision as to what care the subscriber should receive.

Mr. NILAN. Actually, the medical doctor should certify that there is an illness existing which he may treat or requires the attention of someone other than himself. And if the employee has the opportunity to go to the optometrist or psychologist, the question again of illness is not previously medically defined or determined.

Mr. WALDIE. All right, fine. Thank you gentlemen very much. I appreciate that.

Mr. NILAN. Thank you, Mr. Chairman.

Mr. WALDIE. Now, the next three witnesses will be presenting another view on this legislation. The first one is Dr. Michael J. Obremsky who represents American Optometric Association. He will be accompanied by Mr. Dean Drulias, who is associate director of Federal relations, and apparently a third person whom I do not know. Would you introduce him, Dr. Obremsky?

Dr. OBREMSKY. Yes, sir. Mr. Waldie, we have with us Mr. Richard Martinez, director of Federal relations, American Optometric Association.

Mr. WALDIE. You may proceed.

STATEMENT OF DR. MICHAEL J. OBREMSKY, AMERICAN OPTOMETRIC ASSOCIATION, ACCOMPANIED BY DEAN DRULIAS, ASSOCIATE DIRECTOR OF FEDERAL RELATIONS; AND RICHARD MARTINEZ, DIRECTOR OF FEDERAL RELATIONS, AMERICAN OPTOMETRIC ASSOCIATION

Dr. OBREMSKY. The American Optometric Association must applaud the chairman and the members of this subcommittee for their decision to probe the limitations of Federal employee health benefits. This bill is a sorely needed piece of legislation, due to the inequities which persist in Federal insurance as practiced by private carriers.

Vision is a basic need for every person. It affects the learning capabilities of the young, the safety of the worker, the peace of mind of the retired. Vision problems requiring correction affect 43 percent of the general population in the United States. As one of our most precious gifts, vision is a necessary tool to implement a full and satisfying life. Early disease detection and vision treatment are vital to combat the threat of blindness.

Aetna Insurance, one of the three largest insurers for the U.S. Civil Service Commission, has recently recognized the position of optometrists and the professional value of optometric services.

The Aetna Indemnity Benefit Plan for Federal employees revised as of January 1, 1973, lists as reimbursable "tests that reveal need for treatment or are made because of definite symptoms of disease or injury." Benefits include artificial eyes, as well as "eyeglasses and examinations therefor, if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery and obtained within 1 year thereof."

After much deliberation, Aetna further has changed its definition of doctor. It now defines as a doctor, for the purpose of the indemnity benefits plan, "a duly licensed optometrist for eye care covered by the plan."

This redefinition and inclusion of optometrists is in agreement with State laws regarding licensure of insurance carriers. Forty-two States have specific language in their insurance codes regarding the patient's freedom of choice in selecting his vision care practitioner.

May I insert a list of these States for the record?

Mr. WALDIE. Yes. They will be included without objection.

Dr. OBREMSKY. Thank you.

[The list follows:]

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wyoming.

Dr. OBREMSKY. Similar legislation is pending in Illinois, Iowa, and Wisconsin.

Group Health Association of Washington, D.C., a major prepaid health plan under this program, provides for vision care services as

performed by optometrists. Group Health Association utilizes the services of optometrists on its staff; there are five full-time optometric staff members, supervised by an optometric chief.

Mr. WALDIE. May I interrupt you there?

Dr. OBREMSKY. Yes, sir.

Mr. WALDIE. I am still hung up on the sentence in the paragraph above that, "The Group Health Association of Washington, D.C., a major prepaid health plan under this program." To what does that program refer?

Dr. OBREMSKY. Federal employees are eligible to join the Group Health Association as well as Aetna and as well as Blue Cross and Blue Shield. It is an eligibility health program.

Mr. WALDIE. Now, how about medical practitioners that supervise the services rendered by the optometrists?

Dr. OBREMSKY. No. The optometrist is the primary vision care service.

Mr. WALDIE. And so that he pays for the cost of the vision care rendered by the optometrist? How is that?

Dr. OBREMSKY. Well, the appropriate relationship between the patient is he pays so much monthly.

Mr. WALDIE. But there is no requirement that there be medical supervision or referral to the optometrist?

Dr. OBREMSKY. No, sir.

Mr. WALDIE. And there is no protest? The plan does not permit that, the basic legislation authorizing the Federal employee program does not permit that?

Dr. OBREMSKY. It does not, no.

Mr. WALDIE. Well, it does. There has been no such protest?

Dr. OBREMSKY. Oh, yes. That is correct.

Mr. WALDIE. All right, you may proceed.

Dr. OBREMSKY. These health care professionals perform within the full scope of their optometric practice. In addition to routine eye examinations, they provide visual field studies, tonographic evaluation, fundus photography, and low-vision treatment.

Optometrists are included in various State and Federal programs. It is inconsistent that they are not included totally in the programs offered to the 2,780,591 Federal employees and their 5.8 million dependents through the contracture of private insurance carriers by the Civil Service Commission.

The private insurance carriers for the Civil Service Commission should reflect the intent of Congress and of legislation that has been enacted into law. In various Federal statutes, Congress has expressed the intent of freedom of choice so that the individual can himself decide the type of health care practitioner.

Specific Federal statutes provide for freedom of choice. Titles 16, 18, and 19 of the Social Security Act specifically call for provision of services by an optometrist or by a physician skilled in the diseases of the eye.

Title III, section 324(b) of the public health laws recognizes an optometrist as a qualified eye care professional in order to provide care for public health personnel in remote locations:

The Secretary is authorized to provide medical, surgical and dental treatment and hospitalization and optometric care for federal employees on remote facilities.

The Department of Defense, further, has recognized the scope of practice of the optometrist in its programs. In 1969, Louis M. Rousset, M.D., Deputy Assistant Secretary of Health Affairs, DOD, directed payment of optometrists under the Civilian Health and Medical Programs for the Uniformed Services (CHAMPUS):

It is requested that you modify your publications and those of CHAMPUS so that, henceforth, a qualified doctor of optometry who is practicing within the scope of his license may be compensated under CHAMPUS for authorized care provided an eligible beneficiary without the necessity of having his patients referred to him by a physician.

Mr. WALDIE. Do you have any idea since 1969 whether or not there was, as a result of that direction, an increase in the cost of CHAMPUS that could be attributed to that direction?

Dr. OBREMSKY. I will have Mr. Martinez answer that.

Mr. MARTINEZ. Mr. Chairman, to date, we know of no specific survey by CHAMPUS but as far as we know, it is not an increase in cost but an increase in providers—

Mr. WALDIE. Well, you see, this would address itself right to the core of everything that we have been hearing. The greatest protest against the inclusion of optometrists is that it will cost the clients too much. They cannot afford it.

They all say they are quite professional and have respect for their capabilities but it costs too much.

It would be interesting and I think helpful to the committee if we would inquire of CHAMPUS to determine whether, since 1969, when they have under their program provided precisely which means under this bill it is to provide, whether the fears of the subscribers, or the carriers that have been expressed today would be warranted by that experience, and I would ask staff to prepare necessary letters of inquiry of CHAMPUS so as to make that determination.

Dr. OBREMSKY. Many other laws specify inclusion of the professional services of optometrists.

As it concerns the Federal Employee Health Benefits Act, Congress has previously addressed itself to this problem of private insurance carriers differing from the intent of Federal law. The full Committee on Post Office and Civil Service of the House of Representatives, in its Report No. 91-1084, May 13, 1970, indicated that the committee would not at that time recommend additional legislation on the subject. However, in that report, the committee did state that—

It is of the opinion that a federal employee should not be denied benefits for a covered service because he chooses to have it performed by an optometrist, rather than a physician. It is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact they are administering a federal contract is no reason for circumventing compliance with applicable state laws.

Mr. WALDIE. I am not sure I understand that either. If this were a contract entered into, wholly within the borders of a State that has such a law, is it your opinion that the contract could not exclude optometrists by virtue of a negotiation?

Dr. OBREMSKY. Mr. Drulias?

Mr. DRULIAS. I can answer that, Mr. Chairman. It is our opinion that were the contract to be entered into within the boundaries of the

State which provides for freedom of choice as to a practitioner, that those services which are covered under the contract and could be provided by either an optometrist or ophthalmologist, would allow the patient the freedom of choice to receive those services from whichever practitioner he chose.

Mr. WALDIE. And that the carrier could not negotiate a more restrictive contract than that law provided?

Mr. DRULIAS. He could not negotiate any stricter definition that provides for those services. It is our understanding that it would not in any way affect the scope of it.

Mr. WALDIE. Well, can you give us any information then as to contracts that have been enacted for health care in those States as to the difference in costs attributable to the inclusion of this, provided by the optometrists for eye care, and then as to the situation prior to the inclusion?

Mr. DRULIAS. The only comment I can make on that is that the State of California has recently renegotiated some of its insurance contracts and we have received word from our affiliate California Optometric Association that information is forthcoming, and I can provide it to you, but I do not have it at this time.

Mr. WALDIE. Well, I wish you would provide it to the committee when you receive it. It seems to me we are focusing in on the essential part of this hearing.

Does the inclusion of other providers then—the medical doctor—in fact, increase costs astronomically or even noticeably?

Mr. DRULIAS. Well, if I could make one further comment, the scope of benefits that we are talking about, as relates to Blue Cross, Blue Shield, is so minuscule as compared to their total scope of benefits that I feel, actually, it would be very difficult to compute the cost of the increase in benefits that would rise from the inclusion of optometric services.

Mr. WALDIE. Mr. Hillis.

Mr. HILLIS. Do I understand—by answer to the question of the chairman—that these are the State employees of the State of California?

Mr. DRULIAS. This is correct.

Mr. HILLIS. And is this about to take place?

Mr. DRULIAS. No; it has taken place. California is 1 of the 42 States which require freedom of choice of a vision care practitioner, and they have recently renegotiated a contract, as I understand it.

Mr. HILLIS. So within a reasonable period of time, there might be some information available as to costs?

Mr. DRULIAS. Yes.

Mr. HILLIS. Do you have any other suggestions on how we may gain experience in these costs? I agree with the chairman in that I think this is one of the essential points of all the hearings.

Mr. DRULIAS. Well, in your question directed to Mr. Harvey, I think it is imperative that Blue Cross, Blue Shield, undertake some of the surveys. However, the Civil Service Commission has been requesting, specifically Blue Cross, Blue Shield, but the health care providers of the Federal employees program, in general, to look into including optometric services and have been since 1965.

Mr. WALDIE. I guess now that there is no representative left of Blue Cross, Blue Shield—Mr. Harvey seems to have gone—it seems to me we should address that to Blue Cross, Blue Shield. I will ask them this inquiry. They must have some of their legal points on inclusion with their optometrists.

If the laws that you have stated were in existence, all plans within those States must require that the provider include optometrists, am I correct on that?

Mr. MARTINEZ. Mr. Chairman, I received word yesterday, for example, in the State of Washington that, effective August 1, Blue Cross, Blue Shield will provide that freedom of choice to the beneficiary.

Mr. WALDIE. Well, there ought to be States where they would be required, prior to August 1, to do it, as these laws have been in existence.

Mr. MARTINEZ. Well, it is in direct violation of—

Mr. WALDIE. But are there States that have been required to provide this freedom of choice in contracts entered into in those States, to your knowledge?

Mr. MARTINEZ. No.

Mr. WALDIE. There have not not been? Then what do those laws mean then? Is it still up to the carrier as to whether to include them?

Mr. DRULIAS. Apparently, the Civil Service Commission with whom we have had considerable discussion on this matter has had no word as to whether or not—they feel it is up to the patients to test the applicability of the State laws and, to their knowledge and our knowledge, we have received no word of such a test of State law.

Mr. WALDIE. I see. So the law you have cited as the freedom of choice, in fact, is only thus far rhetoric? Nobody has followed it?

Mr. DRULIAS. To our knowledge, yes, sir.

Mr. WALDIE. That is fascinating Mr. Hillis.

Mr. HILLIS. Do you have any knowledge in the so-called private sector where there are negotiations with health benefits, where this has been included through labor negotiations as a part of an employee package of health benefits?

Dr. OBREMSKY. Yes, sir. That is through an organization called Vision Care Service of America which provides vision care to a large part of the population as a result of private sector contracts.

Mr. HILLIS. Is this one particular labor group? Can you cite how they provide the care or how they came about?

Dr. OBREMSKY. Most of these contracts were individually contracted out. In the Washington metropolitan area, I believe, this year there are some 250,000 to 300,000 eligible persons for these services. This is more or less preventative optometric care in which the patient will be reimbursed; the service pays for the examination.

Mr. WALDIE. Please continue.

Dr. OBREMSKY. The committee also stated that "it is the committee's understanding that the laws of many States already require insurance carriers to pay for the services of optometrists who are not physicians, when these services would be covered if provided by a physician."

Mr. WALDIE. But apparently that is not the case, so the committee's understanding is wrong.

Dr. OBREMSKY. It is my understanding, Mr. Chairman, that one of the difficulties is that in the case of Blue Cross, Blue Shield, in this relationship, the contracts are signed in the District of Columbia and, in that sense, the District of Columbia—

Mr. WALDIE. Well, I understand Blue Cross, Blue Shield. But what about the other States, in the State in California, in the States where there is freedom of choice; in fact, those laws are in force, correct?

Mr. DRULIAS. Well, in the State of California—

Mr. WALDIE. It is negotiated, isn't it?

Mr. DRULIAS. The scope of benefits has been renegotiated; yes.

Mr. WALDIE. The payment of optometrists has been negotiated to provide it, has it not?

Mr. DRULIAS. Kaiser has, for a long time, recognized this.

Mr. WALDIE. I know, but the law does not compel them to do it.

Dr. OBREMSKY. I do know of one example, Mr. Chairman. In the State of Virginia where I practice, they passed freedom-of-choice legislation just this year and since the Governor has signed the bill, it has been brought to the attention of carriers when they are in violation of the statute.

Mr. WALDIE. Have they responded?

Dr. OBREMSKY. I think it is too early. It was this past month that it was just brought to their attention. I do not know where it is at this time.

Mr. WALDIE. But it is that part that the committee is in error on. The law requires it but nobody is following the law, is that a fair statement?

Dr. OBREMSKY. Yes.

Mr. DRULIAS. Yes.

Mr. WALDIE. Please continue.

Dr. OBREMSKY. Federal policy indicates that provision for eye care, as specified under Federal legislation, be implemented either by an optometrist or by a physician skilled in the diseases of the eye, whichever the patient, of his own free will, may select.

This policy coincides with State licensure of health care professionals, including optometrists. All 50 States, as well as the District of Columbia, recognize, license and regulate the practice of optometry—as is the case for medicine, osteopathy, dentistry and podiatry.

Further, all 12 optometry schools and colleges are federally funded under health manpower legislation through the Department of Health, Education and Welfare, along with the other direct patient professions. Accrediting bodies such as the National Commission on Accrediting fully recognize these educational facilities.

I know that you, Mr. Chairman, are well familiar with the educational excellence of the University of California at Berkeley, where one of our schools is located.

At all optometry schools, students are required to have completed 2 years of undergraduate work prior to entrance into the optometric curriculum. The majority of these students have completed 4 years of undergraduate training before entering such a course.

The optometric course of study entails 4 years of highly structured specialized training in the field of vision care to include intensive emphasis with or without hospital settings. May I include a list of the 12 schools in the record at this time?

Mr. WALDIE. Yes.

Dr. OBREMSKY. Thank you.

[The list follows:]

1. Illinois College of Optometry; Chicago, Illinois.
2. Indiana University, Bloomington, Indiana.
3. Massachusetts College of Optometry, Boston, Massachusetts.
4. Pacific University, Forest Grove, Oregon.
5. Pennsylvania College of Optometry, Philadelphia, Pennsylvania.
6. Southern California College of Optometry, Fullerton, California.
7. Southern College of Optometry, Memphis, Tennessee.
8. State University of New York, New York, New York.
9. The Ohio State University, Columbus, Ohio.
10. University of Alabama in Birmingham, Birmingham, Alabama.
11. University of California, Berkeley, California.
12. University of Houston, Houston, Texas.

Dr. OBREMSKY. Federal employees who opt for the insurance policies which deny the right to freedom of choice are placed in an inequitable position, as compared to those who opt for Aetna coverage or Group Health Association or those Federal employees covered under the Champus program.

Optometrists provide the majority of eye care in the United States, approximately 70 percent. They are located in nearly 7,000 municipalities, ranging from the metropolitan areas to smaller, more rural communities where there is perhaps no other type of professional eye care available.

The ability of the insured to utilize the professional vision care practitioners of their choice should be one of the major goals of any private insurance carrier under contract to the Federal Government.

Your bill will surely implement such full coverage for the Federal employee. The American Optometric Association fully supports the legislation and acknowledges the perseverance and concern displayed by the members of this subcommittee in this area.

We welcome any questions from the subcommittee at this time.

Mr. WALDIE. Mr. Hillis.

Mr. HILLIS. Thank you, Mr. Chairman. Dr. Obremsky, it is nice to have you with us this morning and we appreciate your statement and we have learned a great deal from it.

I wonder, for the record, if there are available contracts in the private sector where negotiation of this type has been done. It might be good to have it in the record. It might provide a source of experience.

The group that you referred to earlier in answer to a question—is this similar to what is referred to as an HMO, Health Maintenance Organization?

Dr. OBREMSKY. Group Health, in fact, originated in 1937 or thereabouts and has been held as an example of the initial HMO concept, yes, sir.

Mr. HILLIS. This is for vision care?

Dr. OBREMSKY. It covers the entire scope of health services.

Mr. HILLIS. And this is through private subscription or small employees, large employees?

Dr. OBREMSKY. Any Federal Government contracts.

Mr. HILLIS. So it is included in there, and perhaps that might be a source of experience for us, as well, as to cost.

Dr. OBREMSKY. Yes, sir. But I should call to your attention that a patient who goes to Group Health, as Mr. Waldie, would qualify 100 percent for services rendered as a Group Health patient because they cover the full scope of services.

Mr. HILLIS. They take care of the dental problems as well?

Dr. OBREMSKY. Dental problems, eye problems, and others.

Mr. WALDIE. It would.

Mr. HILLIS. Are there similar plans throughout the country?

Dr. OBREMSKY. Yes, sir. There is a similar Puget Sound plan in the Seattle area. Kaiser, I think, has a number of hospitals not only in California but I believe in Cleveland. Also, there are union eye care programs in New York City affiliated with the State University of New York School of Optometry.

Mr. HILLIS. That is all very interesting. I think those are all the questions I have right now.

Mr. WALDIE. Mr. BRASCO.

Mr. BRASCO. Yes. Let us see if I am beginning to get this straight now. Dr. Obremsky, you are a practicing optometrist?

Dr. OBREMSKY. Yes, sir.

Mr. BRASCO. Now, under the plan as it exists, an ophthalmologist is covered, is that correct?

Dr. OBREMSKY. Yes, sir. For specified services.

Mr. BRASCO. Now, on page 2, you describe, I suppose, basically what type of services an optometrist can give to a patient: tonographic, evaluation, fundus photography and low-vision treatment, is that correct?

Dr. OBREMSKY. Yes, sir.

Mr. BRASCO. Can an ophthalmologist give those services also?

Dr. OBREMSKY. Oh, yes, sir.

Mr. BRASCO. And if I am wrong, you stop me. But an ophthalmologist then can do this plus has the benefit of a medical evaluation which an optometrist cannot do, is that correct?

Dr. OBREMSKY. No; I do not think so, sir. I make judgments of this nature in my office daily as to the integrity of the patient's eyes on optometric evaluation.

Mr. BRASCO. My point is very simply this. If an optometrist is not included in the plan this morning but an ophthalmologist is, and an ophthalmologist, as you agreed, can do all these things plus has the background of the medical evaluation, which you say you can do, too, but notwithstanding that, what would be the purposes of the optometrist?

Dr. OBREMSKY. One certain advantage is availability. Two is utilizing professions to their highest levels and skills.

Mr. BRASCO. Well, wouldn't the ophthalmologist be able to do that, too? I mean, assume that the difference between the two categories of practitioners is that the ophthalmologist has a different course of study than the optometrist, is that correct?

Dr. OBREMSKY. An ophthalmologist gets his M.D. degree first and goes into 3 years of surgical residency.

Mr. BRASCO. This is what I mean, but there is a difference between the two?

Dr. OBREMSKY. Yes.

Mr. BRASCO. In fact, it is safe to say there is a vast difference between the two?

Dr. OBREMSKY. In terms of services, yes.

Mr. BRASCO. OK. What I am saying is that the ophthalmologist can do everything that the optometrist can do and more, is that right?

Dr. OBREMSKY. I would not say that it is that clear and concise. I think an optometrist provides services that an ophthalmologist does not provide.

Mr. BRASCO. Well, what I am trying to get at, Mr. Obrensky, is whether or not we are indeed, as we go along, duplicating services, or is there a special need for both of them? That is what I am trying to ask you.

Dr. OBREMSKY. I think the American people have demonstrated their need for both the specialty of optometry and ophthalmology.

Mr. BRASCO. What is the difference? I do not understand. Assume that I had the kind of eye problem that we are talking about and I had a choice to go to an ophthalmologist or an optometrist.

Why should I go to an optometrist when the other individual can do surgery, has 4 years of medical school plus 3 years of optometric school? Why would I go to an optometrist if both of the services or men are available?

Dr. OBREMSKY. First of all, I would hope that you would have the freedom of choice to go to either.

Mr. BRASCO. Well, I do have the freedom of choice.

But tell me why I would go to one as opposed to the other?

Dr. OBREMSKY. Again, it is my contention that we should utilize the specialties to their highest level. An ophthalmologist is a wonderful eye surgeon, and I provide wonderful eye care, other than surgery and treatment of disease.

So I would say to you in busy practices where the high emphasis is on eye surgery, there is less emphasis on routine eye care. I think it is very appropriate for an optometrist to perform these services. He is a unique and qualified professional in the field to provide the care and he is specifically licensed and trained very abundantly to provide eye care.

Mr. DRULIAS. Mr. Brasco, I would like to comment on that area. You are very fortunate in living in a metropolitan area where the services that you may have need of are readily available to you.

However, a great portion of this country lives in much more rural areas where highly skilled professionals such as ophthalmologists are not found. A great many of the people needing the services of the ophthalmologist would have to travel great distances, in some cases, hundreds of miles to locate a hospital where most ophthalmologists establish their residency once they have completed their schooling.

Mr. WALDIE. Would the gentleman yield?

Mr. BRASCO. Certainly.

Mr. WALDIE. Am I correct in assuming that if I went to the ophthalmologist rather than to the optometrist that I would pay more?

Mr. DRULIAS. If you went to the ophthalmologist?

Mr. WALDIE. For an eye examination. I do not know what is wrong with me, say; I do not see words well anymore so I know I have got

something wrong with my eyes, so I have got a choice of an ophthalmologist or optometrist. Which is the least expensive?

Dr. OBREMSKY. I would say the fees of the optometrist would be the least expensive.

Mr. WALDIE. I would say so, too. Which goes, in essence, to one of the questions you were asking earlier.

Mr. BRASCO. Yes.

Mr. WALDIE. Why force the subscribers to the ophthalmologist when they might be served by a lower level, by the optometrist? Surgery, the optometrist can make that decision, referring him to the ophthalmologist, if required.

It would seem it might be more costly by providing the optometrist—it might be least costly to the clients. But in thinking straight, I would have gone to the ophthalmologist rather than the optometrist. The subscriber—or the plan would force me to opt where I would get reimbursed.

Mr. DRULIAS. I think the question is a little deeper than that, Mr. Chairman. It goes to the question of the right of the patient to choose his providers of care.

Mr. WALDIE. Before you go into that, let me go on further.

So in this devious thought of mind, where I am looking for reimbursement, not care, I would go to the ophthalmologist and the ophthalmologist would say, "Well, there's nothing wrong in the way of disease or illness. You just getting old. Therefore, you need eyeglasses."

Then I would have to pay; not Blue Cross, Blue Shield, and I would have been forced into it. But I had to pay for it myself if I had gone to the optometrist.

Mr. BRASCO. Well, let me ask you this because it is an interesting point of inquiry. In terms of your professional point of view, if you have any experience, any of you gentlemen, what would be the better procedure in terms of what Mr. Waldie was talking about, saving money? Would one who has an eye problem go to an ophthalmologist first so he could get a full range of alternatives in terms of something that may necessitate surgery, something which an ophthalmologist is uniquely qualified to take care of? And then if there is none of these things wrong in terms of his area of practice, the individual patient may be referred to an optometrist, or would the reverse procedure be less expensive?

Of course, that would be based on any information you might have in terms of incidence of eye care which necessitates surgery or the needed services of an ophthalmologist as opposed to routine services or less complicated services of an optometrist.

Dr. OBREMSKY. I would be best interested to reply to that, sir. I think the Department of Defense, where optometrists are commissioned to provide eye care services within eye clinics throughout the world, provides a study as to the entry points for eye care. It is the optometrist who makes the determination of, "Can I provide the services required for this patient, or should this patient be treated by someone with perhaps surgery"?—in this case, by the ophthalmologist. This is care where the optometrist is utilized to his highest level of skill and the surgeon is used at his highest level of skill with no dupli-

cation of effort and, so, better dealing with the manpower shortages that exist in the country.

Mr. BRASCO. Following up on what Mr. Waldie asked you a moment ago in terms of the carrier costs for each of the individual practitioners.

I suppose that varies from State to State, from area to area, and, of course, from individual practitioner to individual practitioner, but what would be the difference between, say, an average fee that an ophthalmologist would charge and one that an optometrist would charge, if you know?

Dr. OBREMSKY. Well, I assume there is. I certainly know what I charge. I could not say what anybody else charges. My fee is not determined by other people.

Mr. BRASCO. No. I thought you might have an idea of the average optometrist's fee as opposed to the average ophthalmologist's fee.

Dr. OBREMSKY. I would be more than happy to investigate that for you, sir.

Mr. BRASCO. Thank you very much.

Dr. OBREMSKY. Could I call to the attention of this subcommittee one experience which I had which is germane to the problem?

Mr. WALDIE. Let me interrupt you just a minute. I do not want to rush you but we have two witnesses, so would you give us your experience.

Dr. OBREMSKY. Yes, sir. I had a patient who had what is called keratoconus. It is a general disease that may lead to blindness, and does, if not properly cared for.

This patient had been to an ophthalmologist and they suggested therapeutic contact lenses which is the treatment of choice. Also, an optometrist had suggested the same thing.

And after several visits to different practitioners, ophthalmologists and optometrists, the patient came to me, at which time I explained the condition. He—the patient—had the confidence, enough confidence for me to go ahead and do the services.

The problem developed when we put in our claim to Blue Cross-Blue Shield. The services which I rendered, which were the same as an ophthalmologist's, were not reimbursable to the patient.

So the patient, when he came to me and I provided preventive eye care in terms of preventing blindness, had to pay for it out of his pocket; whereas, if he went to the ophthalmologist, Blue Cross-Blue Shield would have paid for it.

Mr. BRASCO. I have no further questions.

Mr. WALDIE. Thank you.

The next witness is Dr. Kenneth B. Little, the executive officer of the American Psychological Association.

**STATEMENT OF KENNETH B. LITTLE, PH. D., EXECUTIVE OFFICER,
AMERICAN PSYCHOLOGICAL ASSOCIATION, ACCOMPANIED BY
DR. ARTHUR CENTOR, ADMINISTRATIVE OFFICER FOR PROFESSIONAL AFFAIRS**

Dr. LITTLE. The American Psychological Association is pleased to be able to present its views on H.R. 9440 to the Subcommittee on Retirement and Employee Benefits of the House Post Office and Civil Service Committee.

I am Dr. Kenneth B. Little, executive officer of our association. I am accompanied by Dr. Arthur Centor, our administrative officer for professional affairs, and I speak in behalf of approximately 35,000 member psychologists.

The American Psychological Association strongly supports H.R. 9440 and recommends its passage. The bill succinctly states what we consider to be an essential principle in prepaid health services; those insured should be guaranteed the right to choice of recognized practitioner.

The public interest is safeguarded in this process by the requirements that all practitioners meet necessary standards both of training accreditation and statutes governing their practice.

In securing this "freedom of choice" or "equal access" principle, such legislation would also:

1. Eliminate restrictive control by one health profession over the practice of another, thereby avoiding monopoly control of health service delivery.
2. Prevent a profession or an insurer from establishing extralegal controls over treatment and health care delivery;
3. Facilitate more optimum use of a broader range of scarce health manpower.
4. Avoid the extra "featherbedded" costs and loss of employee time incurred due to unnecessary conditions of referral and supervision.
5. Avoid an imposed or artificial intrusion into the treatment process.

These, the American Psychological Association sees as significant. There is reason and a history behind the concern of professional psychologists in this matter. The report of the Senate Committee on Post Office and Civil Service (No. 92-861, June 14, 1972) concluded in part.

... the evidence disclosed at our hearing seems to indicate that there is little if any benefit derived from the practice of supervision of such psychological service other than the earning of money by doctors of medicine and the avoidance of payment by Blue Cross-Blue Shield.

Several members of our association testified at that hearing. As noted then, the restrictive conditions imposed upon Federal employees, annuitants and their dependents seeking the service of psychologists are not present in the Aetna Government-wide indemnity plan.

A major supportive Federal precedent for the recognition of the services of psychologists was established by memorandum June 1970 from the Deputy Assistant Secretary for Defense in regard to the civilian health and medical program of the uniformed services (CHAMPUS). This issued notice that a qualified psychologist may be compensated under the CHAMPUS for authorized care provided to eligible beneficiaries, without the requirement of having patients referred by a physician.

At the State level, freedom of choice legislation has now been adopted by 12 States (California, Colorado, Kentucky, Maryland, Michigan, Montana, New Jersey, New York, Oklahoma, Utah, Virginia and the State of Washington) States which include nearly 50 percent of all psychologists in this country.

Comparable legislation is under consideration by other States. Furthermore, the Health Insurance Association of America, following

careful review of changing health care practices, adopted the January 1972 recommendation of its legislative committee, to not oppose legislation or regulation requiring recognition of certain practitioners, including psychologists.

The intent of Congressman Waldie's bill (H.R. 9440) is to assure that the advantages of freedom of choice of practitioners apply to all plans under the Federal Employees Health Benefits Act by amending section 8902 of title 5, United States Code. We support this bill and its objective.

We will be happy to respond to any questions members of the subcommittee may have.

Mr. WALDIE. Dr. Little, this freedom of choice legislation, can you shed any light on the inquiry that I made to representatives of the optometrists? Has it been enforced or compelled to have the result that you see?

Dr. CENTOR. Yes.

Mr. WALDIE. And in what States?

Dr. CENTOR. Maryland.

Mr. WALDIE. And how recently?

Dr. CENTOR. Blue Cross-Blue Shield has just been added to the list of insurers who must comply with the freedom of choice legislation in Maryland. Other States will have it in several years.

Mr. WALDIE. How does that choice go? Who has them?

Dr. CENTOR. It is when the psychologist submits a bill.

Mr. WALDIE. You say Blue Cross has just been added.

Dr. CENTOR. Added to the legislation for freedom of choice. They were excluded before.

Mr. WALDIE. Why were they excluded?

Dr. CENTOR. Because of the different laws, Blue Cross-Blue Shield was excluded.

Mr. WALDIE. There was a specific exclusion of Blue Cross-Blue Shield?

Dr. CENTOR. Yes, up to this past year. Blue Cross-Blue Shield, under most State codes, has a special status.

Mr. WALDIE. I see. That is, I think, probably true in California, now that you mention it.

If the legislation were amended, rather than referring as it does to two disciplines, two professions, to provide a general proposal that all deliverers of medical care licensed by the respective dates must be recognized as providers, would that comply with freedom of choice?

Dr. LITTLE. Yes. That would comply with freedom of choice. It would depend on the terms of the contract, of course. For example, if mental health coverage were not in it, a subscriber could not choose a psychologist and be reimbursed.

Mr. WALDIE. Oh, sure, or dentistry or anything.

Dr. LITTLE. Yes.

Mr. WALDIE. They could exclude the entire field of medical care. But if they include it, mental health and all licensed deliverers of mental health care must be recognized as providers.

Dr. LITTLE. Yes. That would be our position.

Mr. WALDIE. Is that your understanding of the present freedom of choice laws in respective States?

Dr. LITTLE. Yes.

Mr. WALDIE. I want to go back and refer to a committee hearing that was quoted by the statement of representatives of the optometrists.

We said:

The committee views the recognition of various practitioners of the healing arts for licensing and insurance purposes has fallen within local or State, rather than Federal, jurisdiction and leaves it inappropriate for Congress to legislate concerning this matter.

Taken in and of itself, in 1970, that would be a statement against the passage of this bill. The committee further stated:

It is the committee's understanding that the laws of many States already require insurance carriers to pay for the services of optometrists who are not physicians when the services would be covered, if provided by a physician.

Although the committee is not, for the reasons indicated, recommending legislation on this point, it is of the opinion that a Federal employee should not be denied benefits for a covered service because he chooses to have it performed by an optometrist rather than a physician.

It is recommended the Civil Service Commission take appropriate action to inform the carriers of the fact that they are administering a Federal contract—no reason for Federal compliance applicable to State laws.

According to my understanding of that statement by the committee in 1970, in all these States where there is this freedom of choice legislation, if the Civil Service Commission, in fact, insisted upon compliance with the State law in the areas in which the Federal contract is being administered, your services would be reimbursable as an authorized provider, is that correct?

Dr. LITTLE. Yes, that would be my understanding.

Mr. WALDIE. Mr. BRASCO.

Mr. BRASCO. I assume the difference between psychiatrists and the psychologists is one is an M.D. and the other is—

Dr. LITTLE. They have two different degrees; one the M.D. and the other, the Ph. D.

Mr. BRASCO. Right. Then I assume that following the line of inquiry with the optometrist, ophthalmologist, that there might be a difference in fee that the psychiatrist could charge and the psychologist would charge, is that correct?

Dr. LITTLE. Yes, that is probably correct. We have with us today a booklet from the American Psychiatric Association that quotes figures that say on inpatient treatment by a psychiatrist, the average fee is \$40 for a 50-minute psychotherapeutic session and \$30 an hour for a psychologist. A psychiatric social worker is \$25 or something like that.

Mr. BRASCO. So there is a difference in the question of cost then.

Dr. LITTLE. Yes, sir.

Mr. BRASCO. Would you have any experience that you are aware of in this area as to where the point of entry is? Would one go to a psychiatrist first and then be referred possibly to a psychologist, or would the reverse procedure be true, if you have any statistical information or knowledge about how that would operate?

Dr. LITTLE. I presume if an individual went to a psychiatrist first and the evaluation or diagnosis was that of some form of mental or emotional disorder, the psychiatrist would either treat him, himself, or if his schedule was too full, he would refer him either to a psychologist or to another psychiatrist.

Mr. BRASCO. What would be the point of entry in the two areas? In other words, where would services of a psychiatrist be necessary and different, as opposed to services of a psychologist? What would be the point of departure, in other words, in terms of treatment?

Dr. LITTLE. Psychiatrists, as physicians, are licensed to practice medicine and to administer drugs. If the treatment of choice were to require drugs, for example, and the disorder was such that it required drugs to alleviate it, obviously a psychiatrist or some other physician would have to prescribe them.

Mr. BRASCO. Is that the only difference in terms of the treatment in question of drugs?

Dr. LITTLE. No. There are questions of organic involvement. There are mental disorders that are associated with organic disorders, as psychosis associated with syphilis, not so frequent now, but whose last stages used to involve it. Straightforward brain damage can produce psychotic effects and that sort of thing.

Mr. BRASCO. Any other areas?

Dr. CENTOR. Well, where electric shock for one would be required, it would be a treatment procedure similar to prescribing drugs.

Mr. BRASCO. Maybe, as the hour is growing late, I will reword the question so I can get what I am looking for. What would be the typical patient, say, that a psychologist would treat?

Dr. LITTLE. He would be one that has an emotional or behavioral disorder that was not significantly associated with an organic disorder or based on organic causes. Given that situation, probably the treatment by a psychiatrist or a psychologist, would be remarkably similar.

Mr. BRASCO. Except, obviously, with the exclusion of electric shock and drugs.

Dr. LITTLE. Yes.

Mr. BRASCO. Thank you. I have no further questions.

Mr. WALDIE. I have no further questions. Thank you, gentlemen.

The last witness we have is Dr. Melvin A. Gravitz, secretary, Council for the Advancement of the Psychological Professions and Sciences.

**STATEMENT OF DR. MELVIN A. GRAVITZ, SECRETARY, COUNCIL
FOR THE ADVANCEMENT OF THE PSYCHOLOGICAL PROFESSIONS
AND SCIENCES, ACCOMPANIED BY JACK DONAHUE, EXECUTIVE
DIRECTOR**

Mr. GRAVITZ. Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear before the subcommittee today. I am Dr. Melvin A. Gravitz, National Secretary of the Council for the Advancement of the Psychological Professions and Sciences and a clinical psychologist practicing in the District of Columbia and nearby Maryland. I am accompanied today by Mr. Jack Donahue, executive director of the council.

In addition to my clinical practice which began 20 years ago, I am serving or have served as a psychological consultant to a number of Federal agencies, hospitals, and institutions of higher learning in this area. I am a former president of the Washington Society of Clinical Psychologists and a former officer of the Division of Consulting Psy-

chology of the American Psychological Association. I have served as chairman of the Maryland State Board of Examiners of Psychologists and, currently, am secretary of the District of Columbia Board of Psychologist Examiners. The latter board is charged with implementing the psychology licensure law which was enacted by the Congress of the United States and signed into law by the President in 1971.

The Council for the Advancement of the Psychological Professions and Sciences—more widely known as CAPPS—is a nonprofit corporation incorporated in the District of Columbia less than 2 years ago. One of our purposes is to bring the viewpoints of American psychology before the Congress, Federal executive agencies, and the public in general. In so doing, we have address congressional committees on a number of topics, including national health insurance, vocational rehabilitation, Social Security Act amendments, aging and the problems of the aged, and health maintenance organizations.

In each case, the viewpoint of CAPS has been focused upon advancement of the public interest.

In addition to our organization addressing the Congress on various topics, we are particularly pleased today to address the subcommittee on still another matter of obvious public interest. This is H.R. 9440 which has been introduced by the chairman of this subcommittee to benefit the many thousands of Federal employees, family members, and annuitants covered by contracts written under the Federal Employees Health Benefits Act.

Parenthetically, Mr. Chairman, the patients of psychologists may, in general, be reluctant to speak up in their own behalf in this view because of their personal nature of consultation of the psychologists.

Nearly 2 years ago, CAPPS testified on essentially the same issue before the Subcommittee on Compensation and Employment Benefits of the U.S. Senate.

I will not repeat today the findings of those proceedings, but it is appropriate to mention several important points which were developed during those hearings and which will indicate the interest and positions of some of the concerned parties.

The intent of H.R. 9440 is to provide for the Federal employee and family member the freedom to consult and have direct interference-free access to the mental health practitioner of his own choice. The 1971 hearings were also addressed to the question of free choice and direct access to psychologists in the Blue Cross-Blue Shield nationwide Federal Employees Health Benefits Plan contract.

In the 1971 hearings, the U.S. Civil Service Commission, one of the parties to the FEHB "Blues" contract, was represented by the Hon. Andrew E. Ruddock, director of its Bureau of Retirement, Insurance, and Occupational Health. Mr. Ruddock declared, "We in the Commission have become convinced that the clinical psychologist can perform responsibly without the direction and supervision of the physician." He further stated that the Civil Service Commission has urged that Blue Cross-Blue Shield grant psychologists that recognition but that this Government-wide carrier declined to do so. That was not done. Mr. Ruddock further stated that the Civil Service Commission favors inclusion of psychologists as independently qualified practi-

tioners under the terms of the Federal employees Health Benefits Plan.

Mr. Chairman, if the position of the Commission remains the same as then—and we have no reason whatsoever to believe otherwise—the question then arises, “Who does believe that medical referral and so-called supervision in the Blue Cross Federal contract is necessary?”

It does not appear that the medical profession itself considers such referral and supervision as necessary for several reason. It is generally known that supervision, as required so far by Blue Cross, may in fact be performed in the medical doctor's office by an assistant who is delegated the task of reading the necessary report form which must be filed with the insurance claim. Under these circumstances, I believe that many physicians are uncomfortable, to say the least, over the professional use of their name to certify to their supervision of members of another independent profession; namely, psychology.

I would also point out to this subcommittee that the Blue Cross Government contract does not even require that the so-called supervision be performed by a medical doctor who has specialty training or expertise in the mental health area. In fact, medical doctors of any specialty whatsoever—including those removed quite some distance from the mental health specialization, such as dermatologists and proctologists—are able to perform this function, and there are very real questions as to the efficacy of their fulfillment of the supervisory role which is demanded of them by the Blue Cross requirement.

At the national organization level, medical professions have publicly stated their attitudes toward psychologists as providers of mental health services. I quote now from the position paper of the American Psychiatric Association on Psychiatrist Relationship with Non-medical Mental Health Professionals, which was published in March 1973: “Professionals in various allied fields often elect to engage independently in health-related practices in a nonmedical setting. A person should feel free to select the practitioner of his choice from among qualified professionals. If there is a public demand for health-related services that are not normally regarded as medical or offered as part of a total medical treatment program, insurance companies may offer insurance for such health-related services as they currently do for medical treatment.”

Mr. WALDIE. I do not know that somebody would not offer health services as medical treatment. Of course they do. What do they advise that they sell?

Dr. GRAVITZ. As I understand the intent of the entire paper, Mr. Waldie, of the Psychiatric Association, what they are saying is that citizens ought to be able to consult the qualified mental health practitioner of their own choice.

Mr. WALDIE. What do they say if there is a public demand that insurance companies may offer insurance? What is that?

Mr. DONAHUE. Mr. Chairman, we thought it somewhat presumptuous of the American Psychiatric Association to phrase it just that way. But it is permissive and I think the implication is that the American Psychiatric Association has no objection to this relationship at all.

Mr. WALDIE. All right. Please continue. I think it is presumptuous, too. I think it is demeaning.

Mr. DONAHUE. I would certainly agree, Mr. Waldie.

Dr. GRAVITZ. In further reference to the position of psychiatrists on the question, I refer to a letter printed in the official newspaper of the American Psychiatric Association as a "guest editorial" on June 21, 1972. The author, Ralph S. Green, M.D., President of the Michigan Psychiatric Society, said, in part:

"I have heard of instances of what I choose to call the 'absentee therapist'. In these cases the psychiatrist lends his name as consultant to, or member of, a team of allied professionals. He is however only distantly and minimally involved in the actual therapeutic process. Yet he shares in the fees. If this is an answer to increasing our capacity to deliver services, it would appear that this social altruism finds its reward not only in the service to society but also in hard coin."

Mr. Chairman, if the U.S. Civil Service Commission and the psychiatric specialists are not in favor of the so-called "supervision" and referral which are professionally unnecessary and needlessly expensive to the Federal Government and to the taxpayers, the question still remains, "Who wants it?"

Clearly, the U.S. Senate Post Office and Civil Service Committee also does not want it. Following the hearings noted previously, the full committee report (No. 92-861 dated June 14, 1972) stated:

Testimony presented during that hearing indicated that Blue Cross-Blue Shield is the only insurance carrier of significance which does not cover mental health services without the certification of a doctor of medicine who supervises the treatment. Although the committee pretends no expertise in the practice of medicine, the evidence disclosed at our hearing seems to indicate that there is little if any benefit derived from the practice of supervision of such service other than the earning of money by doctors of medicine and the avoidance of payment by Blue Cross-Blue Shield.

The report then continues:

The Committee recommends that in its next contract negotiation with Blue Cross-Blue Shield and other carriers, the Civil Service Commission give particular attention to these two problems—correct contract interpretation by the insurance carriers, and the inclusion of mental health care by qualified clinical psychologists within the Federal employees health benefits program.

Mr. Chairman, as a practicing psychologist, I can assure you that the participants in the Federal employees insurance program do not want and do not need the restriction. The artificial so-called "supervision" and referral which Blue Cross has unilaterally required that one independent profession exercise over another independent profession may in fact create a distinct and serious interference with the unique relationship which exists between the psychologist and his client, because doubts may be created in the client as to the quality of care being provided in view of the "supervision" which the insurance carrier has imposed.

Some prospective clients of psychologists make one visit to the practitioner where they learn that their insurance plan, if it is the Blue Cross plan, will not provide reimbursement for such services without initial medical referral and continuing "supervision." This first visit then becomes the only visit.

It is impossible to determine whether these individuals then continue to bear the burden of psychological distress without the benefit of any professional help, or whether they then consult a physician

whose services are reimbursable by Blue Cross. In any event, the employees' free choice and direct access to a qualified practitioner is definitely interfered with.

I might add that research has been available for several years which demonstrates conclusively that people who utilize psychological services, utilize significantly less surgical, hospital, medicine, and related health services.

In my personal experience—verified as recently as yesterday morning—I have found that psychologists cannot even obtain a supply of Blue Cross Claims forms to be kept in their offices for the convenience of their patients. It sounds incredible, but I have been told by Blue Cross that it is necessary for the Federal employee to visit their personnel office to obtain the proper form each and every time they wish to file a claim which is frequently on a monthly basis or so.

By any reasonable and conservative reckoning, the trip of the employees from their desks to their personnel office requires approximately 15 minutes. At the personnel office, another Federal worker has to spend his time to searching for and then conveying the claims form to the employee. Then the employee returns to his own desk.

The total amount of Federal employee time which this process entails is at least an hour. It would be not only interesting but quite appropriate and relevant to calculate the number of payroll-hours needlessly consumed in this process when it is replicated thousands of times during the course of the contract year. To say the least, this is a totally irresponsible drain on the public treasury and represents, furthermore, an interference with the efficiency of the Federal Government itself.

Compounding this needless drain on the public Treasury is the cost to the taxpayer via sick leave each time the Federal employee makes a trip to his physician for referral and evaluation and other purposes as required by Blue Cross. Can this be less than a half day of sick leave each time this totally unnecessary visit has to be made?

In addition, there is also the needless expenditure of fees which develop because the current Civil Service Commission contract with Blue Cross requires that an attending physician see the patient for "evaluation" at least every 12 months, and there are mandatory "supervisory" contacts at 90-day intervals. Most of these costs, by the way, ultimately are paid by the taxpayer because the Federal employee patient may claim reimbursement for them.

While required by Blue Cross—but not by Aetna, CHAMPUS and certain other Federal health insurance programs under the FEHB—the matter of medical referral and so-called "supervision" has not been demonstrated in the least to contribute one iota either to the patient's welfare or to the Government's efficiency.

It is, in fact, completely unnecessary and needlessly expensive and time consuming.

In the interest of brevity, Mr. Chairman, I will not dwell at length at this time upon the educational, statutory, ethical, peer-review mechanisms, and other constraints operative in my profession to help assure the high quality professional services which could be made available by psychologists to these subscribers of the FEHB were the current Blue Cross referral and "supervision" restrictive terms eliminated from the contract, as proposed in H.R. 9440.

At your request, I would be pleased to supply such information to the committee, including the fact that, to date, 46 States and the District of Columbia already have statutory licensure or certification of psychologists.

I also wish to make it clear that our objection to the mandatory medical referral and "supervision" are not directed exclusively at the Blue Cross plan. There may be other FEHB contracts and plans which are equally restrictive, and we wish to declare for the record our interest eliminating all such restrictions throughout the FEBH contract program.

Mr. Chairman, we in psychology fully support H.R. 9440, and we urge its enactment.

Thank you again for the privilege of testifying today.

Mr. WALDIE. Thank you, Mr. Gravitz. The subcommittee must adjourn to answer a call of the House. Prior to adjournment though, we have a prepared statement, on a similar bill, by Andrew E. Ruddock, Director, Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission, which will be made a part of the record.

[The complete statement follows:]

STATEMENT BY ANDREW E. RUDDOCK, DIRECTOR, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, U.S. CIVIL SERVICE COMMISSION

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to appear before your Subcommittee to give the Commission's views on H.R. 8057, a bill to provide for access to all duly licensed providers of health services without prior referral in the Federal Employees Health Benefits Program.

The Commission reported its official position by letter dated July 23, 1973 addressed to Chairman Dulski of the full committee.

The purpose of H.R. 8057, among other things, is to compel all carriers under the Federal Employees Health Benefits Program to provide benefits for the services of any appropriately licensed or certified health practitioners without the necessity of prior referral or supervision by a physician.

As indicated in our report, some participating plans may now pay for or provide such services but only under certain constraints. If an employee selects a practitioner who is not covered by his plan, or if he goes to one without complying with the conditions—such as referral by a physician—specified by his plan, he gets no benefits from his plan and has to pay for it out of his own pocket. I think it is important to keep in mind that none of our plans, or for that matter any other plan I know of, is designed to cover every conceivable kind of service that a person needs or thinks he needs to maintain good health.

I am sure that if carriers had to pay for services of all kinds of practitioners of the healing arts without any control on frequency, type, or quality of care, as I think H.R. 8057 would require, the premiums would skyrocket. This is not conjecture on my part: In 1971 the Governmentwide Indemnity Benefit Plan liberalized its benefits for mental illness by eliminating the requirement that a psychologist's services had to be on referral, and under the direction and supervision, of a psychiatrist. We now have a report from Aetna which shows that allowable expenses for psychologists' services rose from \$368,015.75 in 1971 to \$631,168.35 in 1972, an increase of 71 percent from one year to the next.

This experience of sharply increased cost when controls are removed is corroborated by the testimony of Mr. Vernon McKenzie, Special Assistant to the Assistant Secretary of Defense for Health and Environment, at a November 23, 1971 hearing before the Subcommittee on Compensation and Employment Benefits of the Senate Committee on Post Office and Civil Service. In discussing coverage of psychologists under the CHAMPUS program, Mr. McKenzie stated that CHAMPUS policy had been changed in June of 1970, to compensate a qualified psychologist without the necessity of having his patients referred to him by a physician. Then, in response to a question from Senator Stevens as to what the

experience had been, Mr. McKenzie replied: "In 1970, our payments to psychologists for outpatient care amounted to \$1.3 million. For 1971, which is after the change in policy, our payments to psychologists for out-patient care amounted to \$1.9 million."

This colloquy then ensued:

"Senator STEVENS. What was the normal increase in your expenditures under the program?"

"Mr. McKENZIE. The normal expenditure increase under the program during the same period for all psychiatric outpatient care was approximately 22 percent."

"Senator STEVENS. This was actually less than your overall increase, then?"

"Mr. McKENZIE. No, sir; it was more than our overall increase on a percentage basis."

"Senator STEVENS. I misunderstood the figures, then. What was the increase in this area?"

"Mr. McKENZIE. For 1970 payments were \$1.3 million; for 1971 the payments were \$1.9 million."

Then, after an off the record discussion:

"Senator STEVENS. You had a \$600,000 increase, roughly a 45 percent increase?"

"Mr. McKENZIE. Yes, sir."

I do not cite this testimony with any intention to reflect adversely on the psychologists. On the contrary, we have been convinced that they have established high standards of accreditation, peer review, and discipline within their profession. Despite the additional cost we anticipated, we agreed with Aetna to cover their independent services. We have proposed such coverage to Blue Cross-Blue Shield several times but Blue Shield, which operates primarily through contracts with medical doctors, refuses to recognize psychologists as independent practitioners.

In this connection, I understand that the Chairman's concern is especially for services of psychologists and optometrists. I would note that any employee who is interested in independent coverage of these services can join the Aetna plan. Federal employees, unlike those in private industry, do have a meaningful choice among plans with different features. For example, we have one plan which any employee may join, that provides benefits for chiropractic services. But, I think it would be a mistake to force all plans to provide identical coverage or benefits. To do so would reduce the keen competition that now exists among plans and the choices employees now have.

That the present arrangement works well is, in my opinion, evidenced by the fact that we get extremely few employee complaints concerning the subject matter of H.R. 8057. I do get letters and visitations from representatives of professional organizations such as those of the psychologists, social workers, optometrists, chiropractors, and pastoral counselors, during which they strongly and eloquently urge that we compel plans to cover their services or, if they are already covered, that any restrictions of that coverage be removed. However, we operate the Federal Employees Health Benefits Program to serve the interests of employees generally rather than to promote the interests of any group of practitioners of the healing arts.

For the reasons mentioned here and in our formal report on H.R. 8057, the Commission believes that this bill is not in the best interests of our employees, the health benefits program, or the Government and opposes its enactment.

Mr. WALDIE. This hearing is now adjourned.

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

[The letters which follow were received for the record:]

COUNCIL FOR THE ADVANCEMENT OF THE
PSYCHOLOGICAL PROFESSIONS AND SCIENCES,
Washington, D.C., July 24, 1973.

Re H.R. 9440.

Hon. JEROME R. WALDIE,

Chairman, Subcommittee on Retirement and Employee Benefits, Post Office and Civil Service Committee, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: As indicated in his statement this morning before your Subcommittee, Dr. Melvin A. Gravitz and I welcomed the opportunity to testify on H.R. 9440 on behalf of the Council for the Advancement of the Psychological Professions and Sciences.

Regrettably, the hearing was terminated after Dr. Gravitz read portions of his prepared statement and without an opportunity for questions and answers. Therefore, we are addressing ourselves via this letter to some relevant points which were not covered and we would respectfully ask that this letter be made a part of the hearing record.

With regard to existing "freedom-of-choice" legislation in the several States, we are greatly concerned over the lack of effective enforcement which was discussed in connection with the testimony of the American Optometric Association. Recently such an act became law in Virginia; however, Blue Cross-Blue Shield has declined to abide by the law with regard to services by psychologists, optometrists and other qualified providers. Pending the outcome of litigation by the "Blues" attacking this law, they have decided to put the benefits into escrow and meanwhile the beneficiaries of their contracts will not be reimbursed. Enclosed is a copy of a memorandum of May 25, 1973, from the Virginia Blue Cross-Blue Shield to psychologists which you will find of interest in this regard. In view of such conduct and in view of the experience of the optometric profession with unenforced "freedom-of-choice" acts covering optometry in 42 States, we are less than totally confident in the effectiveness of such State laws in protecting the interests of FEHB subscribers. Merely mandating the Civil Service Commission to assure compliance with such laws by FEHB contractors is inadequate.

We are greatly concerned over the nature and implications of data in the written statement of the Civil Service Commission provided for the record of today's hearings. The statement on page 2 unjustly alleges that "premiums would skyrocket" because of the Aetna 1971 experience. I believe the Aetna data deserves a great deal more analysis. For example, some 16,000 "Blues" subscribers switched to Aetna in 1971, many of these because of the availability of psychological services without medical referral/supervision. Thus, it was expectable for the Aetna experience in the next year to reflect higher utilization of psychological services, when after all many subscribers believably made the change to take advantage of the more liberal benefit pattern. Notwithstanding, the increased expense for psychological services amounted to approximately \$263,000. If this amount is spread over the 16,000 switching subscribers, it shows an average of about \$17 per subscriber. This is not an unreasonable annual expenditure for such services on the average. These figures would be lowered were there any consideration of inflationary factors, the addition of new Aetna subscribers not switching over from the "Blues," etc. Mr. Chairman, I am certain that your staff recognizes the shortcomings in the CSC statement regarding Aetna, as illustrated by the foregoing and that some effort will be made to assure the availability of a fair and balanced presentation of the psychologist expense data at an appropriate time.

On page 4 of the Commission statement, the testimony of Mr. McKenzie in the 1971 hearings is reproduced verbatim only up to the point where Senator Stevens referred to "roughly a 45 percent increase" in expenditures. My examination of the 1971 hearing record indicates that there were further exchanges intended to clarify the situation, as follows:

"Senator Stevens: You had a \$600,000 increase roughly a 45-percent increase?"

"Mr. McKenzie: Yes, sir. Perhaps it would be more meaningful if I gave you the statistics regarding our outpatient costs for psychiatric services, including those of psychologists. For those services the percentage of increase was 22 percent as opposed to a 19-percent total for the whole program."

"Senator Stevens: Have you had any comments from your CHAMPUS group or your people concerning the change?"

"Mr. McKenzie: Yes, sir; they have. The statements have all been laudatory in nature."

"Senator Stevens: Thank you very much. We appreciate that contribution a great deal."

Again, Mr. Chairman, I believe that the statement of the Civil Service Commission inadequately represents the thrust of Mr. McKenzie's declaration, i.e., the increase of expenditure for mental health services (22 percent) exceeded the over-all program expenses (19 percent) by a mere 3 percent.

Further in this connection, we would add our own endorsement to the statement of need for a thorough and complete assembly of data for CHAMPUS, the Aetna Governmentwide Indemnity Benefit Plan, the "Blues" Nationwide Service Benefit Plan, and other contracts within and without FEHB. Hopefully, the leadership of the Subcommittee on Retirement and Employee Benefits will be

effective in encouraging the generation of the data to which you and Congressman Brasco referred in the hearings.

With regard to the cost of services, we would like to underscore the points made by Congressman Brasco that H.R. 9440 is applicable only to "covered services." It seems obvious that the control of costs and utilization rests with the terms of the contract which describe the conditions which shall be covered. It is not logical to exclude qualified providers of covered services as a control on cost and utilization. Increased cost is not always a reflection of abuse or overutilization. Like optometrists, psychologists are available and represent a significant group of individuals qualified to provide the covered services and should be utilized to the maximum level of skills and to the maximum extent of available manpower.

Thank you again for the opportunity to express our viewpoints on behalf of psychology in the interest of the Federal employees beneficiaries and annuitants who can benefit by the enactment of the provisions of H.R. 9440.

Sincerely,

JACK DONAHUE, *Executive Director.*

U.S. CIVIL SERVICE COMMISSION,
BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH,
Washington, D.C., August 1, 1973.

Hon. JEROME R. WALDIE,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. WALDIE: This is in reply to your letter of July 26, 1973, in which you ask two questions. These are discussed below, under the numbered questions.

1. "How often does the Civil Service Commission audit, monitor, or otherwise evaluate each of the FEP health plans? If all the plans are not so evaluated at least once each year, why is this not done? (At the hearing, the American Postal Workers Union testified that their APWU Hospital Plan has been monitored by the Commission every year for the past 5 years.)"

Twice a year we request and receive accounting statements from all health benefit plans that we contract with. These reports are reviewed and analysed prior to selecting sites for on-site audits. Our fiscal year 1974 goal is to reach a position where we will be auditing all plans with significant FEP activity, on a 2-year average cycle. We have not reached that goal at present. When it is reached we will reassess the cost-benefit aspects of the audits to determine whether the audit cycle should be further reduced.

Regarding the APWU testimony, the APWU Plan was formed on January 1, 1972, through a merger of four other Plans with whom we previously contracted. We have never audited APWU, but have audited the four predecessor Plans; these have averaged about six audits each, in 13 years. This perhaps is more frequent than at some other FEP sites. There would be various reasons for this:

Almost 100 percent of the business of employee organizations relates to FEP, while FEP represents about 5 percent of the activity of Blue Cross and Blue Shield, and less than that in some other Plans.

Operations of the two largest of the predecessor Plans (Fed. Clerks, NPU), and the successor Plan APWU are not guaranteed (underwritten) by a third party as most other plans are. Three of these merged plans had substantial cumulative deficits for 4 or more years in a row.

The number of audits since inception, cited above, includes four termination audits. The contracts provide for a 2-year period for settling accounts, and transferring reserves to the new Plan, in merger situations.

The above points, combined with the fact that the two largest of the four merged plans (and APWU) are not supervised by State Insurance Commissioners, necessitates closer than usual audit surveillance.

Our latest 1-day visit (not an audit) to APWU, on July 24, 1973, was made at the request of the Plan.

2. What, in my view, would be the effect of legislation which would require plans to comply with State statutes concerning "freedom of choice" of health practitioners.

With regard to this question, a little background may be helpful. For many years, our position, briefly stated and communicated to all carriers, has been

that the Commission does not interpret nor enforce State statutes. However, our position statement says further that carriers should not use our Federal contract as a reason for avoiding State law and that benefit payments made to comply with State laws governing recognition of certain practitioners will, on audit by us, be allowed as a valid charge to our contract even though the contract does not require such payment.

Many of the plans continue not to recognize certain practitioners and, to my knowledge, this practice has not been tested in court. I should add that some plans have recognized certain practitioners other than M.D.'s, including podiatrists, psychologists, optometrists, and dentists for care covered by the plans so that employees have a meaningful choice among plans. For example one plan, which is open to every Federal employee recognizes psychologists and optometrists; another recognizes chiropractors.

To answer your question, I think the "freedom of choice" effect of legislation which would require plans to comply with State statutes would be inimical to the Federal employee program for the following reasons, among others:

Premiums would be substantially increased.

Because State statutes differ, a plan benefit that was available to employees in one State would not be available to employees in another State, yet all employees would be paying a premium for the benefit.

If all plans were to cover the same kinds of practitioners they would become less competitive.

Impetus would be given to lobbying efforts for State legislation requiring recognition by plans of all kinds of practitioners as well as facilities such as rehabilitation centers and nursing homes.

We get extremely few complaints from employees about nonrecognition of certain practitioners. The complaints come from the practitioners themselves or their professional organizations.

Rather than legislation which would require health plans to comply with myriad and different State laws, it is my considered opinion that we need an amendment to the Federal Employee Health Benefits law specifically exempting a plan from having to comply with State laws governing plan coverages such as practitioners, benefits, and facilities, unless it wishes to do so by offering the particular benefit to all employees enrolled in the plan, regardless of location. Such an amendment would permit a plan to offer, and the Commission to accept or counterpropose, a benefit when there was an employee need or demand for it, when there was assurance that possible abuse of the benefit could be controlled, and when premium considerations and benefit priorities permitted—in the same way that other benefits are negotiated. We would be glad to furnish technical assistance in drafting such an amendment and, while I have not discussed it with the Commissioners, I think they might be inclined to consider it favorably.

Sincerely yours,

ANDREW E. RUDDOCK, *Director.*



that the Commission does not interpret nor enforce State statutes. However, our position statement says further that certain should not use our Federal contract as a reason for avoiding State law and that benefit payments made to comply with State laws governing recognition of certain negotiations will, on the whole, not be allowed as a valid charge to our contract even though the contract has not provided such payment.

Many of the plans continue not to recognize certain practitioners and, to my knowledge, this practice has not been noted in contract. I should add that some plans have recognized certain practitioners other than M.D.s including podiatrists, psychologists, osteopaths and dentists for care covered by the plan as well as chiropractors have a recognized choice among plans. For example one plan which is open to every Federal employee recognizes psychologists and osteopaths as well as other recognized practitioners.

The answer, your question, I think, is "freedom of choice" effect of legislation which would require plans to comply with State statutes would be limited to the Federal employee program for the following reasons among others:

Because State statutes differ, a plan benefit that was available to employees in one State would not be available to employees in another State, yet all employees would be paying a premium for the benefit.

Small plans were to cover the same kinds of policies hence they would become less competitive.

Legislation would be given to lobbying efforts for State legislation regarding recognition of plans of all kinds of practitioners as well as health insurance reimbursement centers and nursing homes.

We get extremely few complaints from employees about nonrecognition of certain practitioners. The complaints come from the practitioners themselves or their professional organizations.

Rather than legislation which would require health plans to comply with certain and uniform State law it is my considered opinion that we need an amendment to the Federal Employees Health Benefits Act specifically extending a plan from having to comply with State law governing plan coverage and reimbursement amounts and facilities, etc. to do so in order to provide particular benefit to all employees enrolled in the plan regardless of location. Such an amendment would benefit a plan to insure and the Commission's position is to recommend a benefit when there was an employee need of payment for it. When there was assurance that possible abuse of the benefit could be controlled and when premium considerations and benefit preferences permitted—in the same way that other benefits are negotiated. We would be glad to furnish technical assistance in drafting such an amendment and while I have not discussed it with the Commissioners, I think they might be inclined to consider it favorably.

Sincerely yours,

Anthony H. Leopold, Director