FEDERAL EMPLOYEES' HEALTH BENEFITS [FEHB] PROGRAM OVERSIGHT

HEARING

BEFORE THE

SUBCOMMITTEE ON THE
CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT
REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

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FEDERAL EMPLOYEES' HEALTH BENEFITS [FEHB] PROGRAM OVERSIGHT

THURSDAY, SEPTEMBER 5, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 2154, Rayburn House Office Building, Hon. John Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Gilman, Bass, Burton, Morella, and Moran.

Staff present: George Nesterczuk, staff director; Daniel R. Moll, senior policy director; Caroline Fiel, clerk; Cedric Hendricks and Mike Kirby, minority professional staff members; and Ellen Rayner, minority chief clerk.

Mr. MICA. Good morning. I would like to call this meeting of the Subcommittee on the Civil Service to order. I apologize for the delay. This morning we are going to be conducting an oversight hearing on the Federal Employees' Health Benefits Program. I am going to open now with a few comments, and will be joined by our ranking member and some other members in just a few minutes, but we want to keep the hearing on schedule.

The hearing this morning on the Federal Employees' Health Benefits Program will be an oversight hearing, and we are going to hear from several panels. My opening remarks will talk about the hearing, some of the history of the FEHBP, and the folks who will testify this morning.

The FEHB Program is the largest employer sponsored health insurance system in the country. In 1996, the $16 billion FEHB Program will insure more than 9 million Federal employees, retirees, and their dependents. Partial portability, no preexisting condition limitation, and an annual open enrollment period are facets of the FEHBP that make it an extremely attractive health care system. The free enterprise based program has effectively contained costs through private sector competition with limited governmental intervention.

The program is administered by fewer than 150 employees and it serves over 9 million enrollees. The FEHBP is often cited as a model of efficiency and effectiveness that the private sector and the public sector should seek to replicate.

However, it is necessary from time to time to give consideration to proposals that can improve the program and its performance.

But any changes we promote must be consistent with the market principles which have been a key to the program's success.

Over the past year, a number of FEHB related issues have arisen. Some affect coverage and benefits provided to Federal employees; others affect the cost borne by employees and the Government. One of the bigger cost issues coming before us concerns the manner in which the Government computes the cost of sharing of premiums with the employee.

On average, the Government finances now about 71 percent of the cost of the FEHBP premiums. Participants finance the remaining 29 percent. The Government share is computed by taking 60 percent of the average of the high option premiums among six plans representative of the various insurers in the program. This is known as the "big six" formula.

In 1999, the current formula will expire and the Clinton administration has indicated that the Government's contribution will be calculated using a "big five" formula, which is more representative of current carriers. However, this could result in a significant shifting of the cost burden to the employees. OPM has informed the subcommittee that had the "big five" been in place in 1996, Federal employees and retirees would have had to pay more than $1 billion in additional out-of-pocket costs for health care costs.

During the last year's reconciliation process, I proposed moving to a fixed dollar formula to establish the Government share of the premium. My proposal would have given all FEHBP enrollees more Government money to purchase the health care plan of their choice. The decision not to enact that proposal cost enrollees $434 million in additional out-of-pocket health care expenses this year alone. I expect to explore this issue further in the course of OPM's testimony today.

We will also examine the January 1996 change in the prescription drug benefit for enrollees of Blue Cross and Blue Shield standard option who are eligible for Medicare part B coverage. The cost-sharing requirement makes Blue Cross and Blue Shield prescription drug program more closely resemble most other FEHBP drug benefit plans.

But the benefit change resulted in initial confusion among Federal annuitants and that situation was exacerbated by delays in the processing of mail order prescriptions. We will hear today from the GAO on their findings in response to an inquiry from myself, Mr. Gilman, and Mr. Moran on this issue.

The Blue Cross and Blue Shield Association, Merck-Medco, and the National Association of Chain Drug Stores and the National Association of Retail Druggists will also have an opportunity to offer their perspectives on this issue.

During the 104th Congress, a number of bills have been introduced either mandating that health insurance carriers provide coverage for certain benefits or that they provide direct reimbursement for certain health care providers. The American Academy of Audiology, the International Hearing Society, and the American Academy of Otolaryngology, Head and Neck Surgery, will comment on H.R. 1057, introduced by Mr. Gilman, to mandate that audiologists be given direct reimbursement by FEHBP carriers.

Next we will hear from the director of nutrition and aging at Florida International University regarding H.R. 2009, which would add medical foods as an item for which coverage may be provided. The American Association of Pastoral Counselors will testify regarding the possible direct reimbursement of their members by carriers.

The issue of mental health parity will be discussed by the American Psychiatric Association. The National Acupuncture Foundation will testify on legislation proposed to mandate coverage of qualified acupuncturist services.

The Office of Personnel Management has been asked to comment on all of these issues consistent with its role as the FEHBP manager. OPM provides qualified health plans for participation in the program, negotiates annually with carriers on benefits and premiums, manages premium payments, and publishes information concerning plan options.

I welcome all of our witnesses and those who have agreed to participate with the subcommittee today. And now what I would like to do is call our first panel, if they could come forward, please.

Our first panel is Sarah Jaggar, Director of Health Services, Quality and Public Health Issues for GAO; John C. Hansen, Assistant Director of Health Services, Quality and Public Health Issues of GAO; Alan P. Spielman, senior vice president of Federal programs for Blue Cross and Blue Shield Association; Terry Latanich, senior vice president of Merck-Medco Managed Care, Inc.; and Carlos Ortiz, director of government relations, CVS, National Association of Chain Drug Stores and National Association of Retail Druggists.

If you would come forward and remain standing, this is an investigations and oversight subcommittee and we do swear in all of our witnesses.

[Witnesses sworn.]

Mr. MICA. The witnesses answered in the affirmative. I would again welcome the panel and we look forward to hearing your perspectives on some of these issues. We are going to start with Sarah Jaggar, Director of Health Services, Quality and Public Health Issues of GAO.

Ladies and gentlemen of the panel, we will make your lengthy prepared statements part of the record, but, if you would, please summarize your remarks as best possible, and we will limit you to a 5-minute presentation, and will withhold questions until that point.

So, we will proceed with Ms. Jaggar. Welcome, and you are recognized.

Ms. JAGGAR. Thank you, sir.

Mr. MICA. Excuse me. Before we hear from you, we have been joined by Mr. Gilman, and Mr. Gilman wanted to make a statement.

Mr. GILMAN. Thank you, Mr. Chairman. I want to thank you for holding this hearing on the Federal Employees' Health Benefits Program. All three panels, I guess, will be examining important aspects of the Federal Health Benefits Program.

The first panel will be focusing in on the Blue Cross/Blue Shield prescription drug copayment issue, and the copay change caused a

major disruption in the relationships that Federal retirees have had with their local community pharmacists. As we all know, most Federal retirees cannot afford paying 20 percent of the cost of their prescriptions at the local pharmacy and most use the mail order program.

However, more important is the quality-of-care issue. Due to the copay change, many retirees with multiple drug prescriptions are not now afforded the opportunity of care by a local pharmacist. There is no substitute for one-on-one interaction to help monitor whether retirees are taking their medications properly or if they are having any other problems.

And I am particularly grateful to Chairman Mica for the inclusion of H.R. 1057 in the second panel. As my colleagues may know, on February 27, 1995, I introduced H.R. 1057, legislation which would cover audiology services for Federal employees. That legislation is an attempt to require Federal health benefit insurance carriers to guarantee direct access toward reimbursement for audiologist-provided hearing care services when hearing care is covered under a Federal health benefit plan.

We already allow direct access to services provided by optometrists, clinical psychologists, and nurse midwives, yet we fail to allow direct access to services provided by audiologists in Federal health benefit plans covering hearing care services.

At no point was it my intention upon introduction of this measure to expand the services which can be provided by audiologists; my legislation would simply allow audiologists to provide what they are already licensed to do under State law and no more. Instead, what H.R. 1057 does is to provide freedom of choice to the patient of providing swift and timely access to hearing care.

I am confident today's hearing will prove to the subcommittee the need for such legislation and I look forward to working with Chairman Mica and moving this bill forward and onto the House floor before adjournment. I look forward to both hearing from all of our panelists and participating in the discussions to follow.

Thank you, Mr. Chairman.

Mr. MICA. I thank the gentleman from New York, and I will return to our first witness. Ms. Jaggar, you are recognized.

STATEMENTS OF SARAH JAGGAR, DIRECTOR, HEALTH SERVICES, QUALITY AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JOHN C. HANSEN, ASSISTANT DIRECTOR, HEALTH SERVICES, QUALITY AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE; ALAN P. SPIELMAN, SENIOR VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION; TERRY LATANICH, SENIOR VICE PRESIDENT, MERCK-MEDCO MANAGED CARE, INC.; AND CARLOS ORTIZ, DIRECTOR, GOVERNMENT RELATIONS, CVS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES AND NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Ms. JAGGAR. Thank you, sir. Good morning, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the Blue Cross and Blue Shield Association's recent change in prescription drug benefits covered by its Federal employees health

plan. With me is John Hansen, Assistant Director in charge of this work.

The Blue Cross and Blue Shield Association's plan is the largest of about 400 health plans available to Federal employees, covering almost 42 percent of about 4 million Federal enrollees.

As of January 1, 1996, the association began requiring enrollees insured under the plan's standard option and also covered by Medicare part B to pay 20 percent of the price of prescriptions purchased at participating retail pharmacies. Before this change, these Federal enrollees did not have to pay anything for retail prescription drugs. The enrollees may continue to receive drugs free of charge, however, if they purchase them through the plan's mail order program.

The benefit change gave enrollees an incentive to use the plan's mail order program. It also raised concerns, however, about the quality of mail order services and the change's effect on the business of retail pharmacies that serves the plan's enrollees.

To provide pharmacy services to its Federal employee health plan, the association contracts with two pharmacy benefit managers, or PBM's: PCS, which has provided the plan's retail services since 1993; and Merck-Medco Managed Care, Inc., which has provided mail order drug services since 1987.

As part of our ongoing study of the Federal employee health plan's use of PBM's, we are looking at several issues concerning this benefit change and the performance of the PBM's with which the association contracts. Today, I would like briefly to discuss the association's reasons for the benefit change, how it was implemented, the change's effect on retail pharmacies. Then I will touch upon the extent to which PCS and Medco have met their contract requirements for the association.

The association made the benefit change to help control its Federal health plan's increasing drug costs. In recent years, prescription drug costs have accounted for an increasing share of the total benefits paid by the association, totaling $1.4 billion in 1995. As you can see in chart 1, which is over here on my left, these payments have risen from about 13 percent in 1988 to about 23 percent in 1995 of the association's total benefit payments. These increases appear to reflect mainly increases in the number of prescriptions per enrollees and the price of prescriptions.

The benefit change was intended to encourage enrollees to use the less expensive mail order program. Without the change, the association contended that it would have had to increase monthly premiums for all of its Federal enrollees for standard option coverage.

In early 1996, when the change was implemented, the volume of prescriptions the mail order pharmacy received was much greater and occurred more quickly than Medco or the association had anticipated. As you can see in chart 2, during the last week of January, for example, prescriptions reached 233,000, 66 percent greater than anticipated.

As you look at the chart, you can see what we call the spike there at approximately the fourth bar over. The dotted line across the bars indicates what the expected rate of receipt of prescriptions was anticipated to be. About 9 percent of the Medicare part B en-

rollees' prescriptions were purchased through the mail order program in 1995, but about 38 percent by February 1996.

Medco could not initially process this rapid increase. The number of pharmacists was insufficient and many enrollees did not get their prescriptions filled promptly. For example, although Medco's contract requires that it dispense or return 99 percent of the prescriptions it receives within 5 business days, Medco met this goal about 87 percent of the time in January and about 94 percent of the time in February. In addition, many customer calls were delayed or went unanswered during this time.

Medco, PCS, and the association collaborated to respond to this increased volume and, by mid-March, 1996, Medco was meeting its customer service performance measures. Medco officials expanded operations at the company's Florida and New Jersey pharmacies, reassigned pharmacists to confirm phone and fax prescription orders, and brought pharmacists and support personnel from across the country to its Tampa pharmacy to increase processing capacity.

Further, OPM and the association agreed that Medco would send medications by overnight mail to customers who would not otherwise receive their prescriptions within 5 business days. They also agreed to arrange for mail order customers who needed medications which would have otherwise been delayed to get up to a 21-day supply from PCS network retail pharmacies without paying the 20 percent copayment. This ad hoc arrangement required PCS to respond quickly and, indeed, over 5,000 enrollees used this service.

Although the association and Medco appear to have corrected the startup problems, NACDS and other critics of the change are concerned about its economic effect on retail pharmacies. Federal enrollees' shift to the association's mail order program has been substantial. Chart 3 shows that between January and May 1995—these are the blocks that are not shaded in—total prescription payments to retail pharmacists for prescriptions dispensed to enrollees affected by the benefit change were about $260 million, compared with about $165 million between January and May 1996, a decrease of about 36 percent that is reflected in the shaded-in bars.

Let me shift gears briefly and slightly. In addition to assessing Medco's performance related to the 1996 benefit change, the Association reviewed both PCS's and Medco's overall performance in meeting their contract requirements in 1995. According to the association, the PBM saved the plan about $505 million. Chart 4 shows that retail and mail order pharmacy discounts accounted for about $264 million in savings, about one-half of the savings. Manufacturer rebates accounted for about $107 million in savings.

The association also indicated that PBM's met most customer service performance measures in 1995. For instance, Medco dispensed prescriptions and answered customer calls within the specific timeframes and its pharmacy dispensed all of its prescriptions with less than a 0.005 percent error rate. In addition, in 1995 and as of April 1996, PCS met its contract guarantee that a network pharmacy be located within 5 miles of 98 percent of the enrollees.

Mr. Chairman, this concludes my prepared statement. We will be pleased to answer any questions you may have.

[The prepared statement of Ms. Jaggar follows:]

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the Blue Cross and Blue Shield Association's recent change in prescription drug benefits covered by its federal employee health plan. Of the approximately 400 health plans available to federal employees, the Blue Cross and Blue Shield Association's plan is the largest, covering almost 42 percent of about 4 million federal enrollees.

In recent years, prescription drug costs have accounted for an increasing share of the total benefits paid by the Association's federal employee health plan. To help control the plan's drug costs, as of January 1, 1996, the Association began requiring enrollees insured under the plan's Standard Option and covered by Medicare part B[1] to pay 20 percent of the price of prescriptions purchased at participating retail pharmacies. Before this change, these federal enrollees, like those in some other federal health plans, did not have to pay anything for retail prescription drugs. The enrollees may continue to receive drugs free of charge, however, if they purchase them through the plan's mail order program.

The benefit change gave enrollees an incentive to use the plan's mail order program. It also raised concerns, however, from Members of Congress and retail pharmacies about the quality of mail order services and the change's effect on the business of retail pharmacies that serve the plan's enrollees. To provide pharmacy services to its federal employee health plan (referred to as the Blue Cross and Blue Shield Service Benefit Plan), the Association contracts with two pharmacy benefit managers (PBM): PCS Health Systems, Inc., provides the plan's retail prescription drug services, and Merck-Medco Managed Care, Inc. (referred to as "Medco"), provides mail order drug services.

As part of an ongoing study of federal employee health plans' use of PBMs, we are looking at several issues concerning this benefit change and the performance of the PBMs that serve the Blue Cross and Blue Shield Service Benefit Plan.[2] Today, I would like to discuss the Association's reasons for the benefit change, how it was implemented, the change's effect on retail pharmacies, and the extent to which PCS and Medco have met their contract requirements for all services they provide to the Association's federal health plan.

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[1]Medicare part B is a voluntary program financed by enrollee premiums and general federal revenues. It covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services.

[2]Blue Cross FEHBP Pharmacy Benefits (GAO/HEHS-96-182R, July 19, 1996).

To obtain information on the benefit change, we met with representatives of the Office of Personnel Management (OPM), Blue Cross and Blue Shield Association, Medco, PCS, National Association of Chain Drug Stores (NACDS), and American Pharmaceutical Association. Regarding the potential effect of the benefit change on retail pharmacies, we reviewed PCS data on recent changes in payments to retail pharmacies for prescriptions dispensed to the Association's federal enrollees. To determine the extent to which Medco and PCS met their contract requirements, we reviewed the Association's contracts with the PBMs and analyzed reports submitted to the Association on their performance in meeting contract requirements.

In summary, the Blue Cross and Blue Shield Association made the benefit change to try to control an average annual 21-percent increase in its federal health plan's drug costs and, as a result, hold down enrollees' premiums. At the inception of the change in early 1996, however, the volume of prescriptions the mail order pharmacy received was much greater and occurred more quickly than Medco or the Association had anticipated. During the last week of January, for example, prescriptions reached 233,000--an amount about 66 percent greater than anticipated. As a result, Medco could not meet its customer-service performance measure for prompt dispensing and delivery of prescriptions to enrollees for several weeks during the benefit change's implementation. Medco, PCS, and the Association collaborated, however, to respond to this increased volume, and, by mid-March 1996, Medco was meeting its customer-service performance measure.

Although the Association and Medco appear to have corrected the problems experienced in implementing the benefit change, NACDS and other critics of the change are concerned about its economic effect on retail pharmacies. Federal enrollees' shift to the Association's mail order program has been substantial. During the first 5 months of 1996, the total amount paid retail pharmacies for prescriptions dispensed to the enrollees affected by the benefit change decreased by about 36 percent, or about $95 million, from the amount paid during the same period in 1995.

In addition to assessing Medco's performance related to the benefit change, the Association reviewed both PBMs' overall performance in meeting their contract requirements in 1995. According to the Association, the PBMs saved the Blue Cross and Blue Shield Service Benefit Plan about $505 million. The Association also indicated that the PBMs met most customer-service performance measures, such as dispensing prescriptions or answering customer calls within specific time frames.

BACKGROUND

OPM contracts with almost 400 health plans, including fee-for-service plans and health maintenance organizations, to operate the Federal Employees Health Benefits Program (FEHBP). The Blue Cross and Blue Shield Association's plan is the largest, covering almost 42 percent of about 4 million FEHBP enrollees in 1994. The Association's contract with PCS for retail prescription drug services began in 1993; its contract with Medco for mail order drug services began in 1987.

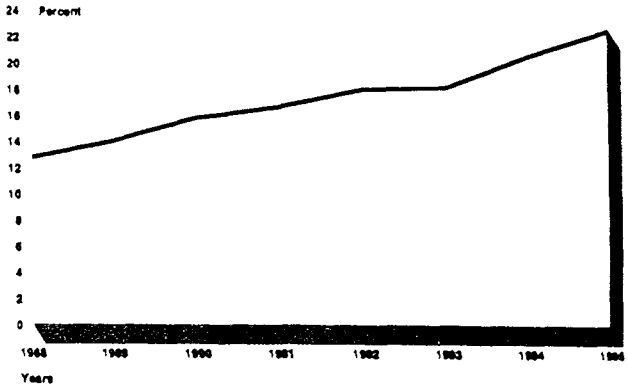
In operating the retail drug program, PCS contracts with a network of pharmacies to provide the Association's federal employee health plan prescriptions at discounted prices. In 1996, this network included 44,751 pharmacies, about 60 percent of which were chain drug stores; the remaining 40 percent were independently owned. In operating the mail order program, Medco provides the plan prescriptions also at discounted prices. Medco receives and dispenses prescriptions from pharmacies in Florida, New Jersey, Ohio, and Texas.

Under its FEHBP contract, the Association must submit to OPM any proposal to change its federal employee health plan benefits. OPM reviews such proposals to assess their cost-effectiveness to the program and potential effect on the delivery of benefits to federal enrollees. In addition, the Association oversees the activities of Medco and PCS and must report to OPM any significant problems that could affect the delivery of benefits to enrollees, such as those Medco initially experienced in implementing the benefit change.

BENEFIT CHANGE INTENDED
TO HELP CONTROL DRUG COSTS

The Association submitted its benefit change proposal to OPM on May 31, 1995, citing the need to control the Blue Cross and Blue Shield Service Benefit Plan's rising prescription drug costs while maintaining quality service for enrollees. Between 1988 and 1995, the Association's payments for the plan's prescription drugs increased at an average annual rate of about 21 percent, compared with an average annual rate of about 12 percent for total benefit payments. Moreover, prescription drug payments have constituted an increasingly greater share of total benefit payments, rising from about 13 percent in 1988 to about 23 percent in 1995 (see fig. 1). These payment increases appear to result mainly from increases in the number of prescriptions per enrollee and the price of prescriptions.

Figure 1: Prescription Payments as a Percentage of Total Benefit Payments, 1988 to 1995



Source: Blue Cross and Blue Shield Association.

Before the benefit change, the approximately 800,000 people[3] insured under the Association's Standard Option Plan who also had Medicare part B coverage did not pay anything for prescription drugs purchased at network retail pharmacies or through the mail order program. These people must now pay 20 percent of the price of prescriptions purchased at network retail pharmacies.[4] Copayments for retail prescriptions were already required of other enrollees and are similar to those required in several other federal employee health plans. Without the benefit change, the Association contended that it would have had to increase monthly premiums for all of its federal enrollees with Standard Option coverage.

[3]This number includes federal enrollees and their dependents.

[4]In 1995, federal enrollees with Medicare part B coverage paid 20 percent in copayments for prescriptions purchased at retail pharmacies not included in the plan's network of pharmacies. In 1996, this amount increased to 40 percent.

PLAN DEVELOPED TO MEET INCREASE IN MAIL ORDER PRESCRIPTIONS

To review Medco's strategy for managing the anticipated increase in prescriptions and calls about them, Association staff met with Medco representatives on August 24, 1995. According to Medco officials, they estimated the size and timing of the increase by relying primarily on their own claims experience in managing pharmacy benefits for about 50 million people as well as data from a comparable benefit change made by Massachusetts Blue Cross and Blue Shield.

The resulting Medco forecast estimated a gradual 64-percent growth in 1996 mail order prescriptions. Using this data, Medco planned to gradually increase its capacity to handle prescriptions from about 110,000 a week during the last quarter of 1995 to 180,000 a week during the last quarter of 1996. Medco also planned to handle occasional surges in demand of up to 13 percent more than the forecasted number and increase its telephone capacity to respond to greater demand for customer service. More immediate growth in mail order prescriptions could have been expected from this cost-conscious group of enrollees, however, according to our actuarial consultant's review of this forecast.

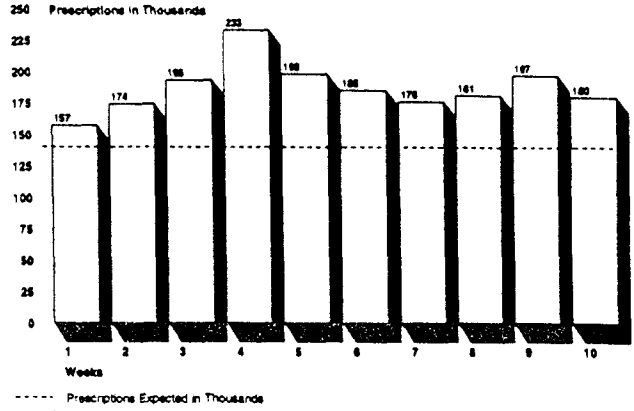
OPM notified the Association that the benefit change had been approved in September 1995. Both OPM and Association officials contended that the change would promote more cost-effective use of the prescription drug benefit by encouraging enrollees to use the less expensive mail order program. According to the Association's actuarial analysis, which included Medco savings estimates related to its contract, the benefit change would save the plan about $193 million in 1996. OPM's actuarial analysis supported this estimated level of savings. Although these analyses did not include an audit of Medco's estimates or related supporting documentation, our actuarial consultant's review of the Association and OPM analyses indicated that the overall savings estimates were reasonable, though possibly understated.

Demand for Mail Order Service Surpassed Expectations

The number of prescriptions received by Medco quickly surpassed Medco and Association expectations. During the first week of January 1996, the number of prescriptions rose to 157,000, and during the week ending January 27, 1996, they reached 233,000--an amount about 66 percent greater than expected. By the week ending March 9, 1996, and continuing through the week ending April 6, 1996, the number of weekly prescriptions received ranged between 175,000 and 187,000. Enrollees with Medicare part B benefits accounted for most of the increase in prescriptions. About 9 percent of these enrollees' prescriptions were purchased through the mail order program in 1995, a percentage that increased to

about 38 percent by February 1996. Figure 2 shows the increase in mail order prescriptions contrasted with the number of forecasted prescriptions.

Figure 2: Weekly Number of Mail Order Prescriptions Received, Week Ending January 6, 1996, to Week Ending March 9, 1996



Source: Medco.

Medco's processing capacity could not absorb this rapid increase. The number of pharmacists was insufficient to handle prescription orders, and many enrollees did not get their prescriptions filled promptly. For example, although Medco's contract requires that it dispense or return 99 percent of the prescriptions it receives daily within 5 business days, Medco reported that this performance measure was met about 87 percent of the time in January 1996 and about 94 percent of the time in February 1996. In addition, many customer calls were delayed or went unanswered during January and February 1996. Medco's contract specifies that no more than 2 percent of customer calls a week receive a busy signal, known as call blockage. Although the call blockage rate averaged 1.8 percent a week for the 2-month period, about 8 percent, or 11,000 calls, received a busy signal during the week ending January 20, 1996.

During the last week of January 1996, OPM informed Association officials of its disappointment with the customer service being provided to enrollees using the mail order program and indicated that corrective measures should be taken.

Actions Restored Service

Medco responded to the unanticipated demand and associated service problems by moving quickly to increase processing capacity. For example, during the week ending January 20, 1996, Medco officials expanded operations at the company's Florida and New Jersey pharmacies from a 5-1/2-day schedule to 7 days a week, with operating hours expanded from 15 hours to 19 hours daily. Medco also reassigned pharmacists who normally performed other Medco jobs to confirm phone and fax prescription orders. Medco officials also brought pharmacists and support personnel from pharmacies across the country to one Tampa pharmacy to increase processing capacity.

OPM and the Association agreed that Medco would send medications by overnight mail to customers who would not otherwise receive their prescriptions within 5 business days. Between the weeks ending January 6, 1996, and April 27, 1996, Medco sent approximately 160,000 prescription packages by overnight mail at a cost of almost $1 million.[5] In February 1996, OPM also indicated that the Association should arrange for mail order customers who needed delayed medications to get up to a 21-day supply from PCS network retail pharmacies without paying the 20-percent copayment. This ad hoc arrangement required PCS to respond quickly to the needs of the Association and over 5,000 enrollees who used this service.[6] The copayments for over 10,000 retail prescriptions dispensed to these enrollees cost the plan approximately $291,000.

Although Medco continued to use extra means to deliver prescriptions to enrollees through the last week of April 1996, Association data show that the mail order program began to meet performance expectations for turning around prescriptions within 5 days the week ending March 16, 1996. Medco had already begun to consistently meet performance expectations for customer service calls the week ending February 10, 1996.

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[5]As of August 28, 1996, Blue Cross and Medco had not resolved which company would pay these overnight mail costs under their contract. A Medco official estimated the actual cost to be about $542,000, considering the cost Medco would have incurred by using the regular mail service.

[6]PCS officials said that although PCS was not contractually required to implement this policy change, the company developed procedures for it and implemented it within 1 week of learning of the problem.

Customer Service Surveys Reflect Difficulties

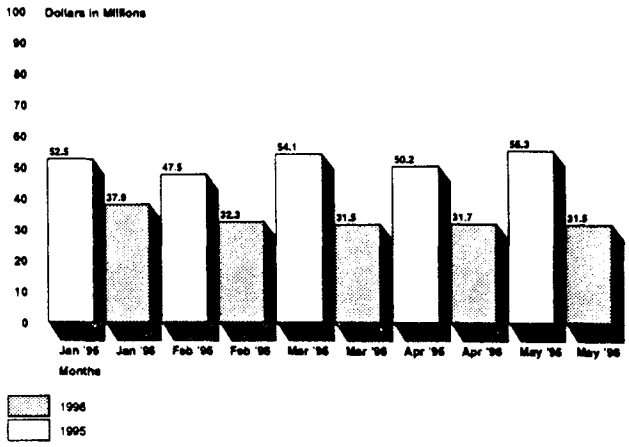
The difficulties enrollees had with the mail order program during early 1996 were reflected in an Association's customer satisfaction survey of mail order customers. During the first quarter of 1996, about 81 percent of those surveyed indicated that they were satisfied with services. Enrollee responses indicated that they were most concerned about the time it took to fill prescriptions. About 75 percent responded that their prescriptions were filled promptly, down from quarterly averages of 94 percent in 1994 and 92 percent in 1995.

CONCERN ABOUT THE EFFECT OF THE BENEFIT CHANGE ON RETAIL PHARMACIES

NACDS and many chain and independent pharmacies foresee the benefit change shifting millions of dollars in prescription drug sales to the mail order program. Because the benefit change is recent, we could not determine how many federal enrollees affected by the change will continue to shift prescriptions to the mail order program. Therefore, determining the benefit change's effect on retail pharmacies' sales is difficult. Nevertheless, payments to retail pharmacies for prescriptions dispensed to enrollees affected by the benefit change decreased substantially from 1995 to 1996, according to our analysis of PCS payments to retail pharmacies.[7] (See fig. 3.)

[7]All analyses of payments to retail pharmacies included copayments and deductibles paid by enrollees.

Figure 3: Payments to Retail Pharmacies for Prescriptions Dispensed to Enrollees With Standard Option and Medicare Part B Coverage, January to May, 1995 and 1996



Source: PCS.

Figure 3 shows that between January and May 1995, total prescription payments to retail pharmacies for prescriptions dispensed to enrollees affected by the benefit change were about $259.6 million, compared with about $164.9 million between January and May 1996--a decrease of about 36 percent.

Retail pharmacies serving the largest percentages of the federal enrollees affected by the benefit change experienced similar percentage decreases in prescription payments, according to PCS data. Between 1995 and 1996, Walgreens, Rite Aid, CVS, Revco, and Wal-Mart had, on average, a 41-percent decrease in total retail payments for prescriptions dispensed to the enrollees with Medicare part B coverage and a 14-percent decrease in total payments for prescriptions dispensed to all plan enrollees.

Total payments to all retail pharmacies for prescriptions dispensed to enrollees in the Association's federal employee health plan also decreased between 1995 and 1996. This total includes payments to enrollees affected by the benefit change. PCS data indicate that between January and May 1995, total payments were about $473.3 million, compared with about $439.8 million between January and May 1996--a decrease of about 7 percent.

PBMS MET MOST BLUE CROSS
1995 PERFORMANCE MEASURES

The Blue Cross and Blue Shield Association contracts with Medco and PCS include annual performance measures that focus on savings and customer service. The contracts provide financial incentives for exceeding certain performance measures and penalties for not meeting them. According to information from Association officials, in 1995, Medco and PCS met most of their savings and customer service measures for the Blue Cross and Blue Shield Service Benefit Plan.

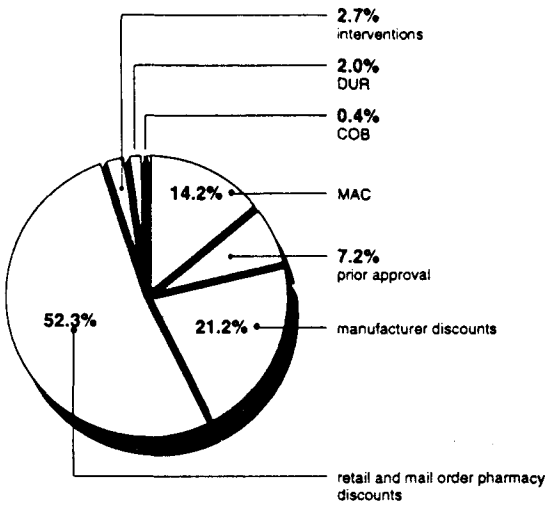
PBM Performance Produced
Savings in 1995

The Blue Cross and Blue Shield Association estimated that its two PBMs saved the plan about $505 million in 1995. Association officials indicated that these savings are used to support the pharmacy benefit program, as well as to contain enrollee premiums, deductibles, and copayments.

Savings in 1995 resulted from seven categories of PBM services, according to Association estimates. These estimated savings were based on what the Association projected it would have paid for prescription drugs and related services had it not contracted with the PBMs. The Association developed this methodology, which represents one way to determine potential savings from PBM services. We plan to evaluate the soundness of this methodology and compare it with those developed by other federal health plans for our final report.

Figure 4 shows the percentage of total savings each of seven service categories represents.

Figure 4: 1995 Blue Cross FEHBP Pharmacy Savings



Source: Blue Cross and Blue Shield Association.

-- Retail and mail order pharmacy discounts accounted for about $264 million in savings. For retail, the savings represent the discounts PCS achieved from negotiating with individual pharmacies the amount PCS would reimburse them for prescriptions.[8] Mail order savings were derived from discounts that the Association negotiated with Medco.

-- Maximum allowable cost (MAC) savings accounted for approximately $72 million in savings. MAC refers to the maximum price that retail pharmacies in PCS' network may be paid for certain generic drugs. Savings resulted from the difference between drugs' MAC prices and their usual and customary prices.

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[8]Total retail savings resulted from the difference between the reimbursement amount PCS paid pharmacies for all individual prescriptions and the drugs' usual and customary prices. The usual and customary price is what each pharmacy charges its cash-paying customers whose prescriptions are not covered by health plans.

-- Manufacturer rebates accounted for about $107 million in savings and represent the guaranteed discounts that PCS and Medco negotiated with drug manufacturers. The plan received 90 percent of the total rebates, and the PBMs retained 10 percent as an administrative fee and incentive to increase the amount of discounts. PCS did not meet its rebate guarantee in 1995 and as a result incurred a penalty.

-- Concurrent and retrospective drug utilization review (DUR) accounted for about $10 million in savings that resulted from clinical activities the PBMS performed. Concurrent DUR is performed before dispensing a drug to prevent problems such as drug interactions and therapeutic duplications. Retrospective DUR is a program PCS conducts to encourage physicians and enrollees to use the most cost-effective drugs and regimens to optimize drug therapies.

-- Medco's intervention program accounted for about $13.5 million in savings. The program encourages patients to use, and physicians to prescribe, less expensive brand-name drugs considered as safe and effective[9] as other, more expensive brand-name drugs.

-- The prior approval program accounted for about $36.5 million in savings. This program covers 13 drugs that require Association approval before dispensing and derived savings from prescriptions denied reimbursement or never filled.[10]

-- The coordination of benefits (COB) program accounted for about $2 million in savings. COB is an industrywide method used to avoid paying duplicate benefits to an individual covered by another insurer.

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[9]Medco uses an independent group of health care professionals, known as a Pharmacy and Therapeutics Committee, to evaluate drugs in all therapeutic categories on the basis of safety, efficacy, and substitutability.

[10]Prior approval is required for medications that may be used to treat conditions or illnesses that are not covered by the Association, are outside the Food and Drug Administration or manufacturer guidelines, and have a high potential for abuse.

Performance Measures Focus on Providing Quality Customer Service

The Association's contracts with its PBMs also specify performance measures for the quality of customer service provided to the federal plan and its enrollees. For example, as previously discussed, Medco's contract requires dispensing prescriptions and answering customer calls within specific time frames. Medco's contract also requires that its pharmacy dispense all of its prescriptions annually with less than a .005-percent error rate. In addition, PCS' contract has several guarantees for the accuracy and timeliness of prescription claims submitted by enrollees for reimbursement. In two instances, PCS did not meet claims timeliness guarantees and therefore paid the Association minor penalties.[11]

PCS' contract also guarantees that it provide plan enrollees convenient access to its network pharmacies. The guarantee states that a network pharmacy be located within 5 miles of 98 percent of the enrollees. PCS data indicate that this guarantee was met in 1995 and as of April 1996.

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Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions.

For more information on this testimony, please call John Hansen, Assistant Director, at (202) 512-7105. Other major contributors included Joel Hamilton, Jennifer Arns, and Mary Freeman.

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[11]According to PCS officials, neither instance disrupted service to enrollees, and the company was within 4 days of meeting the performance measure.

Mr. GILMAN [presiding]. Thank you, and we will hold questions until all of the panelists are finished. Our next witness is Alan Spielman, senior vice president, Federal Programs, Blue Cross and Blue Shield Association.

Mr. SPIELMAN. Thank you, Mr. Chairman. In the interest of the committee's time, I will highlight a few key points in my written statement, which I understand will be included in the record.

First, the satisfaction of our enrollees with their Blue Cross and Blue Shield Benefit Plan is very important to us, and we devote a lot of attention to customer feedback. Enrollees are highly satisfied with their Blue Cross and Blue Shield Standard Option Plan. A recent satisfaction survey by OPM shows that 95 percent of our enrollees with Medicare B coverage are satisfied with their overall plan and, importantly, 93 percent are satisfied with their last mail service pharmacy experience.

Quality of care is a key element of our prescription drug programs, and the pharmacists in both our retail and mail order programs play a critical role supported by state-of-the-art information systems. Both our retail and mail service programs provide for online drug utilization review, computerized patient profiles, and intervention techniques to prevent potentially harmful drug interactions.

Our 1996 prescription drug benefit change, applying the same drug coinsurance at retail to all standard option enrollees, was part of a comprehensive strategy to help contain rising prescription drug benefit costs and improve quality. The benefit change gives all enrollees a choice on whether to fill a prescription at retail or at mail but does, like other preferred provider benefit designs, provide an incentive to enrollees in the form of lower cost sharing to encourage prudent purchasing.

There are three levels of prescription drug cost sharing for standard option enrollees with Medicare B coverage: 40 percent for out-of-network retail pharmacies, 20 percent for network retail pharmacies, and no cost sharing for our mail service pharmacy. For those enrollees who obtain their prescription drugs from network retail pharmacies, we estimate that the 20 percent cost sharing is, on average, equivalent to about $7 for a brand name prescription and $2 for a generic prescription.

The 1996 benefit change helped to keep our premium increases down, saving all of our standard option enrollees, both active employees and retirees, over $100 annually. This benefit design is competitive with other Federal employees' health benefit plans and is much richer than that enjoyed by a majority of non-Federal retirees.

The service disruptions experienced by our mail service pharmacy early in 1996 have been eliminated.

In conclusion, I would like to make one final point. The success of the Federal Employees' Health Benefits Program, as the chairman's opening statement indicates, has been due to competition among carriers to provide the best value to the Federal employee and retiree, balancing premium costs, benefit levels, and the quality of health care and customer service.

In this environment, all health plans, including the Blue Cross and Blue Shield Service Benefit Plan, need the flexibility to achieve

the balance that best meets the needs of their enrollees without Government-mandated restrictions or involvement in the contractual arrangements between the health plan and providers of services.

This concludes my summary, Mr. Chairman. I would be pleased to answer any questions.

[The prepared statement of Mr. Spielman follows:]

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present testimony today on behalf of the Blue Cross and Blue Shield Association's Federal Employee Program. I am Alan Spielman, Senior Vice President for Federal Programs.

I understand that the primary focus of the subcommittee's invitation is to examine the facts, circumstances, and implications of our prescription drug program. Accordingly, I will proceed directly to that subject.

I. History and Description of the Blue Cross and Blue Shield Federal Employee Program Managed Pharmaceutical Activities

The Blue Cross and Blue Shield Federal Employee Program is one of over 300 health plans participating in the Federal Employees Health Benefits Program (FEHBP) and covers about 44% of all FEHBP eligibles.

The Blue Cross and Blue Shield Federal Employee Program has been a leader in managed pharmaceutical care since January 1, 1987, when we offered our enrollees the optional Mail Service Prescription Drug Program for their chronic use medications that are used to treat long-term medical conditions. To administer this program, the Blue Cross and Blue Shield Association chose Medco Containment Services, Inc. (Medco) to dispense prescriptions through the mail to our members and to contract with manufacturers for discounts.

On January 1, 1993, we moved further into managed pharmaceutical care with the implementation of our Retail Pharmacy Program, an initiative to offer our members a nationwide Preferred pharmacy network. Our goals were to improve quality, reduce and control the costs of prescription drugs, and provide members with adequate and convenient access to a network of Preferred pharmacies. To attain these goals, the Blue Cross and Blue Shield Association chose PCS Health Systems, Inc. (PCS) to administer the program. PCS contracts with pharmacies for preferred prices and with manufacturers for discounts.

As we moved to implement our managed pharmaceutical programs, we were constantly aware of the important role played by pharmacists in improving the overall quality of health care. As vital health care providers, pharmacists serve patients through dispensing necessary medications accompanied by all-important oral and written communications. We were careful to design our managed pharmaceutical program so that the valuable pharmacist interaction with patients would be maintained. Both our retail and mail service programs provide for on-line drug utilization review, computerized patient profiles, and intervention techniques to alert the pharmacists to potentially harmful drug-to-drug, or drug-to-disease interactions.

We also were acutely aware of the fact that our enrollee population, with a disproportionate share of retirees, dictated that we get a handle on the increasing costs of prescription drugs in order to maintain a cost-effective health plan for everyone.

The FEP Pharmacy programs have been successful in helping to hold down the costs of prescription medication through $500 million in program savings in 1995 achieved through a variety of initiatives. We saved about $264 million, approximately 52% of the FEP drug program savings for the year, from more favorable discounts from retail pharmacies and the mail service pharmacy provider.

In addition, FEP receives approximately 35% of total drug program savings from drug manufacturers. Approximately 21% of our 1995 program savings came directly from manufacturers through performance-based discounts on brand name products and a limited amount on generic drugs. We also achieve an additional 14% of program savings from manufacturers of generic drugs through use of a Maximum Allowable Cost (MAC) schedule which limits the cost of generic products while also providing a higher margin for retail pharmacies that substitute equally effective but less costly generic drugs for their more expensive brand name products.

FEP encourages the use of cost-effective prescription drugs through the distribution of educational material on the relative cost differences of drugs within the same therapeutic class, and through communication with physicians who prescribe costly drugs when less expensive therapies are available. This last approach results in nearly 3% of our drug program savings by encouraging physicians to prescribe a more cost-effective brand name drug than the medication initially prescribed. These activities encourage price competition in the marketplace among manufacturers by facilitating the use of equally safe and efficacious, less expensive drugs.

Although we receive discounts from select pharmacies participating in our network and encourage their use, enrollees in the Blue Cross and Blue Shield Federal Employee Program can use any pharmacy they choose. However, we do provide greater benefits for those that choose to use one of the 45,000 pharmacies nationwide (82% of all retail pharmacies) in the FEP Preferred Pharmacy network. This network includes over 17,700 independent pharmacies and nearly all chain pharmacies.

The FEP Preferred Pharmacy network provides access to at least one pharmacy within five miles to over 98% of FEP enrollees (provided that any pharmacy exists within five miles). We continually add pharmacies upon request in areas where members do not have a pharmacy conveniently located near them. Furthermore,

in 1994, the Retail Pharmacy Program established the Preferred Long-Term Care Pharmacy Network to serve members residing in long-term care facilities. The network has over 500 pharmacies participating.

The FEP Preferred pharmacy network is open to any pharmacy that agrees to follow the program guidelines and meet specified pricing arrangements that are based on prices offered by pharmacies themselves. Members may get any prescription drug covered under their Blue Cross and Blue Shield benefits, both acute (short-term) and chronic (long-term) for up to a 90 day supply through the Preferred pharmacy network.

Enrollees can also choose to use the optional mail service pharmacy benefit. This benefit is a convenient option for those that want to have their chronic use medications sent to them via the mail. We encourage use of this benefit because of the substantial savings achieved compared to the prices charged by retail pharmacies. Savings are returned to the program and help keep the cost of our prescription drug benefits competitive.

In addition to achieving cost savings that surpass those available through retail pharmacies, the FEP mail service pharmacy provides members access to Registered pharmacists for counseling via a toll-free number twenty four hours a day, reviews prescriptions for drug interactions (including those dispensed from retail pharmacies that are reimbursed through our program), and provides patients with information on their medication that are similar to those provided by many retail pharmacies. We are expanding this service by instituting a special program designed to enhance drug utilization review for our senior population.

The FEP continues to be a leader in managed prescription drug delivery. For example,

- In 1994, FEP increased the dispensing of generic alternative medications through generic performance incentives paid to pharmacies; and

- In 1996, we created a new incentive payment system to reward cost-effective pharmacies;

- As a result of these two incentives, we expect to pay retail pharmacies an additional $6 million this year above the payments for FEPs share of the prescription drug cost and dispensing fee.

To improve dispensing of therapeutically equivalent but lower cost medications, we began a program in August 1996 whereby we pay pharmacists for recommending

to physicians and patients therapeutically similar, lower-cost products as alternatives to the higher cost, originally-prescribed drug.

FEP is also working to improve overall pharmaceutical care by participating in demonstration projects regarding patient compliance and disease management, as follows:

- Patient Compliance. One of four PCS demonstration projects studying various interventions and pharmacy payment methodologies for incentivizing pharmacies to improve patient compliance with drug therapies.

- Disease Management. Two demonstration projects on improving the treatment of diseases and patient outcomes.

II. Specifics Regarding the 1996 Prescription Drug Changes

Each year, as part of the annual benefit negotiation cycle with the Office of Personnel Management (OPM), the Blue Cross and Blue Shield Association (BCBSA) reviews options for potential benefit changes. The review involves balancing a number of competing pressures in order to achieve our overall objective of offering a product that will have a broad market appeal at a competitive rate.

As we entered the negotiations for the 1996 benefit year, we were operating under a set of assumptions that influenced our decisions concerning the benefit proposal. The significant assumptions included:

- Competition would increase among the carriers of the FEHBP.

- Many competitors would again lower premiums.

- The government contribution to the premium would decrease which would result in federal employees and retirees paying more for our coverage even if our premium remained unchanged.

- Underlying health care costs were increasing and our premium would have to increase.

We were concerned that a scenario of significantly higher employee out-of-pocket premiums for our product and significantly lower employee out-of-pocket premiums for our competitors would result in dramatic changes in enrollment across the program. As a result, one of our principal goals in our benefit development process was to modify our benefits in areas where we could make a change that would permit the FEP to continue to be an overall "best value" FEHBP plan. We wanted

to minimize the premium increase that would have been required so that our enrollees could continue enjoying a high quality benefit plan

We also faced the following scenario concerning our prescription drug benefits:

- Costs for our prescription drug benefit have been increasing rapidly in recent years.
- Drug costs for our retiree population, including those members covered by Medicare Part B, have been increasing much faster than drug costs for our active population.
- Many carriers in the FEHBP require some level of cost sharing from subscribers with Medicare Part B for drug benefits while our product did not have cost sharing.

In developing our proposal we wanted to ensure that the drug benefit change would be acceptable to our enrollees. We conducted considerable research on retiree perceptions of our prescription drug programs (both retail and mail) and on their likely reaction to various benefit changes that might be made. A principal research mechanism was a series of focus groups held around the country. We convened groups of retirees in Baltimore, Maryland, San Antonio, Texas, Tampa, Florida, Tulsa, Oklahoma, Des Moines, Iowa, and Washington, D.C. to discuss the FEP prescription drug benefit.

These focus groups confirmed that enrollees in the Blue Cross and Blue Shield plan who also were covered by Medicare Part B were very knowledgeable about their coverage and benefits. An overwhelming majority of focus group participants were aware that they did not pay anything out-of-pocket for prescription drugs and most felt very fortunate to have such a generous drug benefit. Thus, not surprisingly, we learned that while they would have preferred to retain a free benefit, they were receptive to some cost-sharing, to increased voluntary use of generics, and to increased use of mail service.

We sought to design the 1996 prescription drug benefit so our members with Medicare Part B would experience very little in increased out-of-pocket expenses (our projections indicated that the majority of these enrollees would pay less than $7 on average, per brand-name prescription and about $2, on average, per generic prescription.

The benefit change we implemented for 1996 offered a good balance and allowed us to (1) project savings of approximately $200 million dollars from increased generic utilization, mail service discounts, and member cost sharing, and (2) avoid

additional enrollee out-of-pocket premiums of over $100 annually for actively employed and retired Standard Option family and single enrollees.

Your letter of invitation asked "what are the savings to enrollees and to the overall program costs as a result of the prescription drug program instituted in 1996?" Because 1996 is not yet over, we cannot provide the precise dollar amount of program savings. We know – based on claims paid through June – that the change brought about a number of desirable shifts in utilization including increase in the use of lower-cost generic drugs. At the same time, we have observed an increase in the total number of days of supply which we are examining.

The savings to enrollees, of course, can be measured in the difference in premiums established for 1996 over what they would have been had the benefit change not been made. The change saves 757,000 Standard Option single contract holders $110 annually and saves 960,000 Standard Option family contract holders over $124 annually.

III. Description of FEP Prescription Drug Benefit for Medicare-eligible Enrollees

The Blue Cross and Blue Shield Standard Option product for members also covered by Medicare Part B continues to be a very valuable benefit by any measure, and especially when the benefit is compared to the cost and drug coverage typically purchased by retired Americans who do not have access to the FEHBP.

Generally, Medicare does not pay for prescription drugs. Consequently, many Americans purchase supplemental coverage to assist in providing reimbursement for the cost of their prescriptions. This supplemental coverage is commonly referred to as "Medigap" policies. Although by law there are 10 standardized Medigap policies (labeled Plan A through J) only the three most expensive (Plans H, I, and J) provide any reimbursement for prescription drugs. The maximum drug benefit is $1250 for Plans H and I, and $3000 for Plan J. And, before coverage for drugs begins, a policyholder must satisfy a $250 deductible and there is a 50% coinsurance, so the Medigap policies pay only half the cost up to the maximum.

Following is a comparison of the out of pocket cost and drug benefits of our Standard Option product with a Medigap Plan provided by AARP.

Blue Cross and Blue Shield Standard Option (For enrollees covered by Medicare Part B)

- Self-only members pay $46.50 each month for their coverage.

- Members pay no deductible for drugs and are responsible for 20% coinsurance for prescriptions filled in one of our network pharmacies.

- Annual catastrophic protection maximum of $2,000 in out-of-pocket expenses for all covered expenses (when member uses Preferred providers).

- After the annual catastrophic protection maximum is reached, Standard Option would be responsible for 100% of the cost of drugs filled in one of our network pharmacies.

- Member pays nothing for prescriptions filled through the mail service pharmacy.

AARP Medigap Policy (highest level of drug coverage)

- Self-only members pay over $100 each month (District of Columbia).

- Policy holders pay a $250 deductible for drugs and are responsible for 50% coinsurance for prescription drugs.

- Annual prescription drug maximum of $3,000 in benefits per year.

- After the annual maximum is reached, the member would be responsible for 100% of the costs of their drugs.

Your invitation requested that we describe the difference between the benefit for enrollees that are Medicare - eligible and the benefit for other FEP enrollees and explain the reason for the difference.

The FEP Standard Option prescription drug benefit is the same for enrollees with Medicare - B coverage and those who do not have such coverage – with two exceptions: 1.) The $50 per person/$100 per family deductible for prescriptions filled at retail pharmacies is waived for enrollees who also have Medicare Part B coverage; and 2.) The $12 co-payment for up to a 90 day supply of drugs obtained through the mail service program is waived for enrollees who also have Medicare Part B coverage. Medicare is the primary payor for most other medical services for enrollees who are also covered by Medicare. As a result, we annually evaluate our benefits to determine how best to add value for these enrollees. Our decision to provide enhanced drug benefits was made early in FEP's history when drug coverage was part of a "major medical" benefit. Since adding the separate retail drug benefit in 1993, we have made several changes. In 1994, we instituted a 20% coinsurance for out-of-network pharmacies to encourage use of the preferred

network by enrollees with Medicare Part B coverage. In 1995, we limited number of days per prescription through the retail pharmacy to 90 days, and in 1996, we made the benefit change that is the subject of today's hearing.

You have also asked if the 1996 benefit change is more or less generous than the practices of most other FEHBP fee-for-service plans which require cost sharing. The benefit designs vary considerably so the answer to your question depends on the plan selected. Overall, we believe our benefit is competitive with that of other carriers. And, of course, we think it is always important to look at the total benefit package when attempting to assess relative values.

One key indicator of the value enrollees assign to the Blue Cross and Blue Shield Plan is their loyalty. Each year, despite the many choices available to them, more than 98.5 percent of all enrollees and 99.6 percent of retirees, choose to remain with Blue Cross and Blue Shield.

IV. Implementation Issues

BCBSA, of course, expected an increase in demand in the mail service program as a result of the benefit change. We also anticipated an increase in telephone calls and customer inquiries. We did not expect a concentrated lobbying effort by the community pharmacists which included direct mailings to enrollees designed to create anxiety about the benefit change.

As members with Medicare Part B became more aware of the costs of their drugs, and as they responded to the pharmacists' campaign -- which in some instances advised that they could no longer use their retail pharmacies -- they turned to the mail order program in numbers beyond expectations. For example (as the General Accounting Office has noted), during the first week of January 1996, weekly prescriptions rose to 157,000 and by the week ending January 27, 1996, rose to 233,000, or about 66% higher than the expected 140,000.

In response to the volumes of prescriptions received at the Mail Service Program, we:

- Added additional pharmacies and pharmacists.
- Implemented procedures to notify members whose prescriptions were delayed at mail.
- Expedited delayed medications by overnight delivery to ensure that members received them as quickly as possible.

- Ensured that therapies would not be interrupted by initiating procedures for members waiting for their medications to get them at a Preferred retail pharmacy at no cost.

- Contacted members who experienced delays during the first month of the year and reimbursed them for any coinsurance they paid to purchase medications that were delayed at the mail service pharmacy.

By March of 1996, the mail service pharmacy performance was back to normal. Currently, members are receiving their prescriptions within approximately two weeks from mailing the prescription to the pharmacy. Prescriptions that are called-in or faxed-in by physicians are being received by the members within approximately one week.

V. Enrollee Satisfaction

Your letter of invitation asked specifically about the level of enrollee satisfaction with our mail order program. Customer satisfaction with the mail service has been consistently rated high by our members. More recently, the Office of Personnel Management has surveyed enrollee satisfaction with various plan benefits. In that survey, we understand that 95% of our enrollees with Medicare are satisfied with the Blue Cross and Blue Shield Plan overall, and 93% were satisfied with their last mail service experience.

VI. Quality Control

The use of mail order drug programs is widespread in the FEHBP and in the private sector. Since the start of our mail service program back in 1987, we have been very pleased with the quality of the pharmaceutical services provided by Medco, our mail service pharmacy provider. Each mail service pharmacy is subject to the same degree of regulation and scrutiny as a retail pharmacy. The federal regulations include those from the Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the Federal Trade Commission (FTC). At the state level, each state has statutes which regulate pharmacies located within their borders. These statutes are typically enforced by a board of pharmacy which is empowered to impose sanctions for noncompliance.

In addition, we believe that our mail service pharmacy further ensures quality by having:

- At least two different pharmacists check each prescription;

- A system that automatically checks all prescriptions and refills for drug-to drug, drug-to-medical condition, and drug-to-allergy condition interactions, duplicate prescriptions, refills requested too soon, and concomitant therapy - and their system includes checking against drugs paid for through Preferred network pharmacies in our Retail Pharmacy Program; and

- Potential problem situations evaluated by a registered pharmacist who calls the prescriber, if necessary, to resolve the problem.

In addition to computer-assisted review of all prescriptions, the Medco mail service pharmacy allows members to call and speak directly to a pharmacist about their medication and maintains an emergency number for after hours. This is protection around the clock.

Medco enhances their commitment to quality through two unique programs:

1. The GateKeeper Program

   This is a program coordinated with the National Association of State Units on Aging.

   Medco trains all customer service representatives and pharmacists to be "GateKeepers." The representatives are taught to recognize signs of confusion, depression or distress in an enrollee who writes or telephones the pharmacy. They listen for signals that a patient may need assistance, and, if so, a referral is made to Medco's GateKeeper Coordinator. The coordinator contacts the Division on Aging in the appropriate community of each state. The agency makes contact with the patient and, when appropriate, provides social services. These often include the assignment of homemakers, nursing aides, financial planners, "Meals on Wheels," or volunteers who assume responsibility for a variety of tasks such as running errands and driving individuals to and from doctor appointments.

2. Partners for Healthy Aging

   Partners for Healthy Aging is a program specifically designed to improve the quality of health care for seniors while reducing inappropriate drug therapy commonly prescribed for seniors.

   This program includes special certification of Medco's pharmacists in senior care, drug utilization edits tuned especially to the risks that medications can

pose for older patients and, an expanded patient profile that augments the drug utilization alerts to Medco's clinical pharmacists.

We are pleased to work with Medco in enhancing the quality of care of our senior members who purchase maintenance drugs through the mail service pharmacy. Quality of care is the top priority of the pharmacy programs.

VII. BCBSA Response to Criticisms of Our Prescription Drug Program

The community pharmacists have severely criticized the way in which Blue Cross and Blue Shield Federal Employee Program (FEP) has achieved significant savings on prescription drugs provided to federal employees, retirees, and their families. Basically, the community pharmacists do not agree with the necessary and justifiable measures increasingly being taken to control costs and improve quality by prudent purchasers of health care products and services. In this instance, the crux of their argument is that the government should intervene in the health care marketplace and restructure the contractual arrangements between private sector entities so as to mitigate the economic consequences of reasonable competition.

With respect to the Blue Cross and Blue Shield FEP, the pharmacists' arguments have been based on a number of false assumptions and apparent misunderstandings. First, we do not restrict the pharmacies available to federal employees and retirees. Our managed pharmaceutical programs allow enrollees to use any pharmacy they choose. However, we do provide greater benefits for those that choose one of the 45,000 pharmacies nationwide in the FEP Preferred Pharmacy Network or the Mail Service Prescription Drug Program. The Preferred Pharmacy Network represents 82 percent of all retail pharmacies in the country.

Second, the pharmacists, at one point, called for the government (i.e., the Office of Personnel Management) to renegotiate the contractual arrangement between the Blue Cross and Blue Shield Association and our retail and mail service pharmacy benefit managers (PBMs). The Office of Personnel Management is not a party to these private sector contractual arrangements. The Blue Cross and Blue Shield FEP is confident of its ability to negotiate a good deal for federal enrollees.

We would oppose any move to legislate specified manufacturers' rebates in the Federal Employees Health Benefits Program. We prefer using our leverage to negotiate the best rebates available in the marketplace on a case-by-case basis rather than accepting a rebate amount determined by legislative fiat, which may be less than a rebate we could negotiate ourselves. Of course, the drug manufacturers are in a better position to explain the adverse implications of legislated rebates in their industry.

Finally, we would disagree strongly with the pharmacists' assertion that our pharmaceutical programs are draining millions of dollars from local communities. The savings we have been able to achieve represent direct and tangible benefits to American taxpayers and our enrollees. The dollars saved are still available in the community; they simply can be spent for commodities other than prescription drugs that may be priced higher than those available through our pharmacy programs.

We are proud of the savings we have been able to achieve while providing high quality prescription drug coverage to our enrollees. We have an obligation to continue seeking and providing innovative and cost-effective pharmaceutical services.

We also are proud of our record on participation in the FEHBP for nearly 36 years. Nearly 2 million federal employees and retirees are enrolled in the Blue Cross and Blue Shield Service Benefit Plan, representing coverage of more than 3.5 million individuals. Blue Cross and Blue Shield, and the FEHBP, have successfully restrained premium costs while providing superior coverage to millions of people. The FEHBP is the nation's largest existing model of unrestricted access, consumer choice, competition and managed care, and we are proud of our significant role in this success.

I hope my testimony adequately addresses any concerns the Subcommittee may have about our prescription drug programs. I will be pleased to answer your questions.

Mr. GILMAN. Thank you very much, Mr. Spielman. Our next witness is Terry Latanich, senior vice president of Merck-Medco Managed Care Co. Mr. Latanich.

Mr. LATANICH. Mr. Chairman, members of the committee, my name is Terry Latanich, and my position is senior vice president for Merck-Medco Managed Care, which is a part of Merck & Co. My responsibilities include our contract with the Blue Cross and Blue Shield Association's Federal Employee Program [FEB], as it is known.

We manage pharmaceutical benefits for 47 million Americans and about 2,000 health plans across the country. These health plans are sponsored by private companies, Blue Cross and Blue Shield plans, labor unions, and other Government agencies. We are proud that several other Federal Employees' Health Benefits Program offerors have selected us to manage some or all of their prescription drug benefits. The Federal plans we serve include the FEP, GEHA, NALC, APWU, and BACE.

In my remarks, I would like to briefly comment on FEP's 1996 benefit change, our efforts to implement that change, and FEP member satisfaction with our services. As Alan Spielman noted, FEP's 1996 benefit change included two key features.

First, FEP stopped waiving the 20 percent coinsurance for retirees. While this was new for FEP, it is certainly not new for other Federal carriers. Several Federal carriers require some form of cost sharing for retirees for prescription drugs. In addition, retirees in almost all of the private sector programs we administer require some cost sharing through deductibles, copayments, and coinsurance.

Second, by continuing to waive the coinsurance for prescriptions filled through the mail service, FEP created a financial incentive for retirees to use the mail service option. Most of our 2,000 health plans, including others within the Federal Employees' Health Benefits Program, provide a financial incentive to use the mail service.

Let me talk briefly about the steps we took to implement the change. As GAO reports, we have significant experience in managing the prescription drug benefit for clients, which include significant populations of retirees. That analysis suggested that we would experience a substantial increase in utilization in the first quarter, continuing on through the fourth quarter.

While we accurately forecast the ultimate volume of prescriptions we would receive, it was the speed with which the prescriptions were received that was unanticipated. Within 1 month, prescriptions nearly tripled and customer service calls more than tripled.

Merck-Medco took swift and decisive action to address this unexpected surge in demand, making every possible resource in our organization available to FEP and OPM. We increased our operations from 5 days to 7 days a week for the first 9 consecutive weeks in 1996, beginning with the first week in January. We extended our hours of operation in our pharmacies from 12 hours a day to 18 or more on a daily basis, and we extended those hours on Saturdays and Sundays as well.

We expanded our capacity at our Tampa and New Jersey pharmacies, which are primarily dedicated to the FEP. We added three additional pharmacies to begin servicing the Federal employee pro-

gram. As was noted earlier, we brought pharmacists, pharmacy technicians, data entry operators, and other support staff from across the country into Tampa to assist us in dispensing prescriptions. We added customer service representatives and increased the number of pharmacists on duty to answer questions for enrollees and physicians.

Even at the height of the utilization spike that was noted earlier, the time it took us to fill prescriptions lagged only slightly, and by mid-March we were back up to our 99 percent on-time standard. And I would note, Mr. Chairman, that while our standard is 99 percent in 5 days, in reality, about 90 percent of those go out in the first day or 3 and it's the next 2 days where the balance of that is achieved.

At no time did we reduce Merck-Medco's high quality of care or professional standards. At no time during this process did we relax our vigilant checks for drug interactions and other possible drug use complications. At no time did we diminish Merck-Medco's accuracy in filling prescriptions. There simply is no safer dispensing environment than exists as Merck-Medco.

And at no time did we lag in providing convenient and confidential patient counseling. Merck-Medco's pharmacists are available to FEP's enrollees on a 24-hour-a-day, 7-day-a-week basis through a combination of toll free telephone lines and an after hours on-call system to answer questions for enrollees about their medications.

We are proud that FEP enrollees are satisfied with our mail service program. In quarterly surveys conducted by the Gallup organization for FEP, FEP's enrollees have identified the mail service benefit as one of the most highly rated benefits that is offered. In a survey conducted by OPM in June of this year, nearly 95 percent of those surveyed described their most recent experience with Merck-Medco's mail service program as excellent, very good, or good.

Mr. Chairman, we believe the FEHBP and its oversight by OPM should not be about the impact on retail pharmacies or the impact on mail service pharmacies. It should be about providing the best, most cost efficient care for Federal employees, retirees, and their families. And it is these employees and retirees who will decide on the merits of our service and FEP's benefit design choices through their choice of plan.

We appreciate this opportunity to present our views, Mr. Chairman and members of the committee, and I would be pleased to answer any questions that you have. Thank you.

[The prepared statement of Mr. Latanich follows:]

PREPARED STATEMENT OF

TERRY LATANICH, SENIOR VICE PRESIDENT MERCK-MEDCO MANAGED CARE, INC.

BEFORE THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,

SUBCOMMITTEE ON CIVIL SERVICE

SEPTEMBER 5, 1996

Mr. Chairman, members of the Committee, my name is Terry Latanich and my position is Senior Vice President for Merck-Medco Managed Care, Inc., a part of Merck & Co., Inc. My responsibilities include our contract with the Blue Cross and Blue Shield Association's Service Benefit Plan, or Federal Employee Program as it is known, and the oversight of Merck-Medco's relationship with the Office of Personnel Management for the other FEHBP plans we serve.

Merck-Medco manages pharmaceutical benefits for more than 47 million Americans in more than 2,000 health plans. The health plans are sponsored by private companies, Blue Cross and Blue Shield Plans, labor unions and government agencies. Merck-Medco works to improve health outcomes while reducing the overall costs of pharmaceuticals. Merck-Medco is especially proud that several FEHBP plans have selected us to provide some or all of their prescription drug benefits including FEP, GEHA, NALC, APWU, and BACE. For some of these carriers, Merck-Medco provides a full range of managed pharmaceutical care services. For others, such as the FEP, Merck-Medco provides the mail service pharmacy benefit and administers various health management programs, such as a program to help diabetics.

Merck-Medco appreciates the opportunity to testify today on the role that pharmaceutical benefit managers such as Merck-Medco play in ensuring that Federal employees, retirees and dependents receive high quality, low cost care. In my remarks, I would like to comment briefly on FEP's 1996 benefit change; Merck-Medco's efforts to implement that change; FEP member satisfaction with Merck-Medco's services; and the role that manufacturer rebates and the use of generic drugs play in controlling plan costs and premiums.

FEP's 1996 Benefit Change

FEP's 1996 benefit change included two new features:

- First, FEP stopped waiving the 20 percent coinsurance for retirees who filled their prescriptions through the retail pharmacy program. While this was new for Medicare Part B eligible FEP enrollees, it is not new for FEP or within other FEHBP plans. FEP requires a coinsurance for active employees and several of the carriers within the FEHBP require some form of cost sharing from retirees for prescription drugs. In addition, retirees share the cost of

prescription drugs in almost all of our private sector programs through deductibles, copayments, or coinsurance.

- Second, by continuing to waive the copayment for prescriptions filled through mail service, FEP created a financial incentive for retirees to use the mail service option. Again, while this is new for retiree enrollees in FEP, it is common for other carriers within the FEHBP and is the norm for private sector and other public sector health plans. Most of Merck-Medco's 2,000 employee and retiree plans provide a financial incentive to use mail service. They do this in order to share with their members the savings the plan receives when they use mail service.

Implementing FEP's 1996 Benefit Change

Let me now describe the implementation of the benefit change. As the GAO reports, Merck-Medco's experience in managing the prescription drug benefit for other clients, including some clients with significant populations of retirees, suggested that there would be a substantial first quarter utilization increase, from 93,000 prescriptions per week to 140,000. We also estimated that we would end 1996 with an average weekly volume of 180,000. The Company was precisely accurate in forecasting the ultimate volume of prescriptions, but the speed with which the increased volume came was far faster than forecast.

As the GAO notes, weekly prescription volumes peaked at 237,000 in January, before falling back to the anticipated level of 180,000. Customer service calls more than tripled from 35,000 a week in 1995 to nearly 125,000 a week in January and February of 1996. The retail pharmacy community mounted an aggressive communications campaign highlighting the benefit change. Merck-Medco fielded thousands of calls from FEP enrollees who thought that the FEP had eliminated the retail benefit or that their pharmacy was no longer eligible to participate. In many cases, enrollees had their physicians phone in all their prescriptions to our pharmacies, overloading our telephone and fax capabilities for receiving phone-in prescriptions.

Merck-Medco took swift and decisive steps to address this surge in demand, making every possible resource in our organization available to FEP and OPM.

Merck-Medco increased our operations from five to seven days a week for nine weeks beginning in the first week in January. We extended our hours of operation from 12 hours to 18 or more daily. We expanded our capacity at Merck-Medco's Tampa and New Jersey pharmacies, which are primarily dedicated to FEP. We brought on-line three more of our pharmacies to serve the FEP -- Ohio, Texas, and our other Tampa pharmacy. We also readied a fourth pharmacy to serve as a reserve. We brought pharmacists, technicians and support staff from across our system to Tampa to assist in dispensing. On the customer service side, we added telephone lines and increased the number of pharmacists on duty to answer questions from enrollees and physicians. We were able to accomplish these steps through the extraordinary professionalism and dedication of our staff and the cooperation of our union.

Even at the height of the utilization spike, the time it took us to fill prescriptions lagged only slightly. Our negotiated standard for FEP is a five day turn around for 99 percent of all

prescriptions. In January, 87 percent of all prescriptions met this standard. In February, 94 percent met the five day standard and, by mid-March we had that number up to the 99 percent standard. As noted by the GAO, Merck-Medco has fully satisfied FEP's standards for timely dispensing since mid-March. Moreover, our compliance with FEP's customer service standards has been excellent throughout 1996, including the January/February time period.

At no time did Merck-Medco reduce our high quality of care or professional standards.

At no time did we relax our vigilant checks for drug interactions and other possible drug use complications.

At no time did we diminish Merck-Medco's accuracy in filling prescriptions. Merck-Medco's mail service pharmacies have an accuracy rate of .99995. That means fewer than one in 20,000 prescriptions have any error, whether significant or not. There is simply no safer dispensing environment than exists at Merck-Medco.

And at no time did we lag in providing convenient and confidential patient counseling. Merck-Medco's pharmacists are available 24 hours a day, seven days a week through a toll-free number to answer questions from enrollees about their medicines.

Role of Rebates and the Use of Generic Drugs in the Mail Service Program

It is important to recognize that the benefit change made by FEP was in addition to -- and not a substitute for -- other strategies to control costs. FEP's programs include aggressive efforts to increase the use of generic drugs and negotiate rebates with drug manufacturers. Each of these avenues is an integral part of FEP's overall program.

Working with plan sponsors, Merck-Medco encourages the use of quality generic drugs. These generic medications are a key element of FEP's overall cost savings initiatives because, in most cases, their use results in significant savings. Consistent with a physician's instructions, State law and the preference of the enrollees, Merck-Medco uses generics to fill about 35 percent of all prescriptions dispensed to FEP eligibles. When a generic drug is substituted for a brand name medication, a special label is attached to the vial informing the patient of the substitution. Patient package inserts, prepared by the United States Pharmacopoeia, provide the patient with the name of both the generic and the brand.

Negotiated rebates with pharmaceutical manufacturers are another key part of Merck-Medco's contract with FEP and a key part of FEP's program to keep down their prescription drug costs. Cooperatively with FEP, Merck-Medco works with an independent, expert medical panel to identify a list of preferred drugs within certain therapeutic categories of medications. Merck-Medco negotiates rebate agreements with the manufacturers of these preferred medications. Merck-Medco's mail service pharmacies implement programs that alert physicians to these prescribing alternatives. We are proud to have pioneered the use of these types of programs outside of hospital and staff model HMO settings. As the GAO noted, virtually all of the rebates we earn are ultimately passed on to FEP.

Merck-Medco opposes suggestions to legislate a manufacturer drug rebate for the FEHBP. Such rebates would simply be a form of arbitrary price controls. Merck-Medco supports the current system that enables FEHBP plans and enrollees to benefit from pharmaceutical rebates that are freely negotiated in the marketplace. These rebates reflect market competition among and within various pharmaceutical product categories. Our experience in the FEHBP over many years is that Merck-Medco can negotiate aggressive rebates with drug manufacturers that provide the FEHBP with cost-effective pharmaceutical benefit programs that are among the best available in America.

FEP Member Satisfaction with the Mail Service Pharmacy Benefit

Merck-Medco is proud that the level of FEP enrollee satisfaction with Merck-Medco's mail service program has always been high. In most of the quarterly surveys conducted by the Gallup Organization for FEP, enrollees have identified the mail service benefit as one of the most highly rated benefits offered by FEP. In a survey conducted by OPM in June of this year, nearly 95 percent of those surveyed described their most recent experience with Merck-Medco's mail service program as excellent, very good, or good. This outstanding level of satisfaction was recorded even after the prescription delays that occurred during the first weeks after the benefit change.

Merck-Medco maintains this outstanding record of service because of the professionalism and integrity of our more than 1,200 licensed pharmacists and the thousands of Merck-Medco employees who support them. Merck-Medco is also proud to work with 52,000 retail pharmacies to manage more than 130 million prescriptions for our health plan sponsors. These pharmacies play an important role in caring for all our plan enrollees, including FEHBP beneficiaries.

Mr. Chairman, the FEHBP and its oversight by OPM is not about the impact on retail pharmacies or mail service pharmacies. It is about providing the best, most cost-efficient care for Federal employees, retirees and their families. And it is these employees and retirees who will provide the final verdict on our service and FEP's benefit design choices through their choice of plan during the upcoming open season enrollment period.

Each year, Federal workers and retirees are presented with a large menu of health care choices and the opportunity to change plans. Quality pharmaceutical benefits are a primary concern among all enrollees and especially senior retirees who are significant users of pharmaceuticals. Each FEHBP carrier designs its pharmaceutical benefit carefully to ensure quality, value, and choice for current and prospective enrollees. We hope that your Committee and others in the Congress will continue to do what's best to ensure that the FEHBP continues to offer the highest quality choices of pharmaceutical care to Federal workers and retirees.

We appreciate this opportunity to present our views and welcome your questions.

Mr. GILMAN. Thank you, Mr. Latanich. Our next witness is Carlos Ortiz, director of government relations of CVS, who is representing the National Association of Chain Drug Stores and National Association of Retail Druggists. Mr. Ortiz.

Mr. ORTIZ. Thank you, Mr. Chairman. My name is Carlos Ortiz and I am director of professional and government relations for CVS Pharmacy. I am a pharmacist. CVS Pharmacy operates 1,200 pharmacies in approximately 13 States and the District of Columbia.

I am here representing the Coalition for Retail Pharmacy Community Retail Pharmacy which, as we stated earlier, consists of the National Association of Retail Druggists, which is mainly independent pharmacies, and the National Association of Chain Drug Stores. They represent together 125,000 community pharmacists in the United States, approximately 53,000 community pharmacies, and they fill approximately 90 percent of the 28 billion outpatient prescription drug market in the United States.

The Blue Cross and Blue Shield Federal employees program Medicare part B, which impacts approximately 1 million Federal retirees, implemented this change in their benefit design with 20 percent copay for the retail community pharmacy and 0 percent for mail order.

We believe that this economically coerces retirees to utilize the mail order pharmacy. This policy sends hundreds of jobs and millions of dollars out of our community. CVS, for example, employs 2,700 people in the State of Maryland and CVS and its employees paid $27 million in taxes in the State of Maryland. In New York, we employ over 5,000 employees and paid—and CVS, again, and its employees paid $56 million in taxes. Virginia, it's over 3,300 employees and $29 million in taxes. These jobs from CVS and other community pharmacies and these dollars are being exported out of our community.

I was asked to address four questions. What is the impact of the benefit change on enrollees' access to prescription drugs and pharmacy services? We believe that this is poor health policy. In the fragmented health care delivery system, the pharmacy and the pharmacist are one of the few areas where all of the prescription medication histories and drug utilization review can come together. When we fill a prescription at CVS Pharmacy, we don't know what might have been filled at Medco and do the proper drug utilization review necessary to ensure the safety of that medication.

OPM's own study indicates that 63 percent of the savings from this plan came from the retirees' copays and not necessarily from mail order efficiencies. I would also contend that percentage copays are very difficult for the recipient to understand and administer.

We are asking them to triage their own acute medication needs, to decide whether they can wait until they can obtain this from a mail order pharmacy and pay zero or go to the local community pharmacy and have to pay 20 percent. And 20 percent of what? Is it 20 percent of three $50 brand name prescriptions or 20 percent of three $12 generic prescriptions? They don't even know if they have enough money in their pocket to pay that 20 percent.

What is the impact of this benefit change on the community retail pharmacies? As stated before, a GAO study said that $95 mil-

lion in revenue was lost to community retail pharmacies in the first 5 months of this year. Annualized, that comes to $230 million.

Out of a $70 billion industry, that doesn't seem like a heck of a lot of money; however, mail order was never intended as the primary vehicle for delivering pharmacy services in the United States. I think that even the mail order operators will agree that mail order can only exist as long as the safety net of the community pharmacy infrastructure remains intact. If that safety net goes away, then mail order cannot become the primary vehicle for delivering pharmacy services. We believe that this is a very dangerous precedent; that, if it snowballs, that pharmacy infrastructure will be in serious jeopardy.

What is the relationship between PBM's and drug manufacturers? Well, the two PBM's that are administering this program for the Federal Employees' Health Benefits Plan are both owned by major drug manufacturers. We believe that that's an inherent conflict of interest; that, in fact, there is very little incentive to control drug costs by these PBM's and there is very little incentive to explore cheaper, equally, or more effective therapeutic alternatives.

As we stated before and as was stated by the GAO study, 53 percent of the savings in 1995 came from reimbursement to pharmacy and only 21 percent came from product cost control and, yet, the overall cost of the program, 75 percent is for product cost and only 25 percent is for pharmacy cost. This is totally skewed and out of line.

What is the percent of pharmacies that are in the Blue Cross and Blue Shield network? Blue Cross and Blue Shield has indicated that approximately 44,751 pharmacies are in their network and, of that, 60 percent are chains and 40 percent are independents. Eighty-five percent of the 53,000 pharmacies in the United States participate in this network.

We also believe that the OPM is losing millions of dollars in drug rebates. Medicaid, which is another Federal program, achieves 18 percent rebate under drug product costs while the Federal employees program only gets approximately 7.6 percent.

Generic percentage is also very low for the Federal employees program. And we believe that compared with other similar programs, the industry average between a generic product and its equivalent brand name prescription is approximately $20 to $25. To increase and maximize the generic utilization would save millions and millions of dollars.

I would ask that all of my testimony be put in the record. I notice that the red light is on, Mr. Chairman.

[The prepared statement of Mr. Ortiz follows:]

THE IMPACT OF PRESCRIPTION DRUG COPAYMENT CHANGES IN THE BLUE CROSS/BLUE SHIELD FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) ON FEDERAL RETIREES AND COMMUNITY RETAIL PHARMACY

Mr. Chairman and members of the Committee. My name is Carlos Ortiz, Director of Professional and Government Relations for CVS Pharmacies, based in Woonsocket, Rhode Island. We operate approximately 1200 pharmacies in 13 states, primarily on the East Coast. We appreciate the opportunity to testify before the Subcommittee today on recent changes in the Blue Cross/Blue Shield (BC/BS) Federal Employees Health Benefits (FEHBP) Prescription Drug Program.

I am representing the Community Retail Pharmacy Coalition. The Coalition consists of the National Association of Retail Druggists (NARD), representing independent retail pharmacy, and the National Association of Chain Drug Stores (NACDS), which together represent 125,000 community pharmacists in more than 53,000 pharmacies. Community retail pharmacies employ more than one million people, and our pharmacists fill over two billion, or nearly 90 percent, of all outpatient prescriptions each year.

The recent change made in the prescription drug program is well known to this Committee. In the name of cost savings, BC/BS FEHBP now requires almost one million Federal retirees with Medicare Part B/Standard Option coverage to pay 20 percent of the cost of their prescription if it is obtained at the local pharmacy. There is no copay if the prescription is filled at a mail order pharmacy. As a result of this change, the use of mail order has increased from 9 percent to 38 percent in the first five months of this year.

Community retail pharmacy opposes this change. In sum, we believe that Federal retirees should not be economically coerced to use the mail order pharmacy. In addition, we believe that this copay precludes retirees, many of whom take multiple prescriptions at the same time, from having their drug therapy monitored face-to-face by their local pharmacists. The copay sends hundreds of millions of dollars in business away from local pharmacies, many of which are small businesses, to out-of-state entities, taking with it local jobs and tax dollars. Finally, OPM's own numbers indicate that 63 percent of the savings resulting from this change are not from mail order efficiencies, rather, they are a result of increased out of pocket retiree prescription copays.

Many Members of the Committee have expressed similar concerns to the Office of Personnel Management (OPM) about the negative impact of this copay on Federal retirees and local pharmacies. We appreciate the support that we have received from the Members of this Committee and from many other Members of Congress. You have specifically asked that I address four issues in my testimony:

What is the impact of the benefit change on enrollees' access to prescription drugs and pharmacy services?

We firmly believe that this copay is poor health policy and poor public policy. This copay does nothing more than increase the book of business of a particular mail order firm at the expense of Federal retirees and retail pharmacy. This imposition of the 20 percent copayment for retail pharmacy prescriptions has forced many Federal retirees to decide that they could no longer financially afford to purchase their prescriptions at their local pharmacies, which they have patronized for many years.

This has disrupted long standing professional relationships, and has created an unfortunate disruption in a continuum of pharmacy care that has been established for retirees. Effective pharmacy care cannot be provided through the mail. Face-to-face interaction by the local pharmacist is the best way to monitor a Federal retiree taking multiple medications.

Moreover, this copay has made it financially difficult for retirees to fill their acute-care prescriptions, since the retail copay is not waived for these medications. A person taking a long-term medication may be able to wait a few days to obtain their prescription through the mail and, as a result, will forego the copay. However, retirees having to obtain acute care medications immediately cannot wait to obtain them through the mail and have no choice but to pay the copay. Some may try to wait for the acute care prescription through the mail order program in order to avoid the copay, with the result that they become sicker.

Finally, the early implementation of this expanded mail order program created havoc for Federal retirees who rely on life-saving medications. These problems resulting from the "gross underestimation" of the volume of prescriptions that would be filled through the mail resulted in many delayed and lost prescriptions. OPM turned to local community pharmacies to fill the gap when these problems occurred.

What is the impact of this benefit change on community retail pharmacies?

Community retail pharmacy's strong opposition to this copayment has been cast by proponents of the copay as nothing more than "sour-grapes" frustration because it takes business away from our pharmacies. The recent GAO report documents, however, that this copay has had a negative impact on community pharmacy revenues derived from this particular book of business.

Compared with the same period of time in 1995, from January through May of 1996, BC/BS FEHBP prescription payments to all community pharmacies decreased by $95 million, from $260 million to $165 million (Chart 1). In the overall scheme of a $70 billion industry, the loss of $95 million may seem to be somewhat insignificant. However, this lost revenue, as well as the loss of revenue to other mail order operations, undermines the strength of the retail pharmacy infrastructure which helps to serve all Americans in all communities throughout the country.

What is the nature of the relationship between retail and mail service pharmacy benefit managers (PBMs) and drug manufacturers? Does the FTC impose any conditions on the drug manufacturers to prevent them from engaging in unfair trade practices?

The Coalition believes that contracting this prescription drug program to two drug manufacturer-owned pharmacy benefit management companies (PBMs) creates serious conflicts of interest, and should be reviewed by OPM and thoroughly examined by this Committee. For all practical purposes, asking drug manufacturers to manage pharmaceutical costs is like "putting the fox in charge of the hen house." These arrangements give manufacturers an incentive to use their own products over potentially more-effective, less-costly competing pharmaceutical products. There are few incentives for the manufacturer to impose meaningful cost containment mechanisms on the drug product side of the expenditure equation. The data from the new GAO report indicate that this concern is more than well demonstrated in this particular program. Over half of the program's cuts result from reduced payments to pharmacy providers, while only 21 percent come from drug manufacturer costs (Charts 2 and 3).

The Federal Trade Commission (FTC) has imposed various conditions on the Eli Lilly/PCS merger to prevent anti-competitive behavior. However, the FTC has not imposed any conditions on the other two vertically-integrated PBMs: Merck/Medco and Smith Kline/DPS. Merck/Medco is the administrator of the expanded mail order program. A November 1995 study by the GAO found that, just prior to Merck's acquisition of Medco, the number of Merck drugs on the Medco formulary increased from one to eight. Merck recently indicated that it increased its sales of drugs through Medco from 10 percent to 13 percent. By contracting with these two drug manufacturer owned PBMs, the Federal government is helping these companies achieve their self-serving goals of attaining market dominance and expanding sales of their products at the expense of Federal taxpayers and retirees.

How many and what percentages of pharmacies are in the BC/BS network nationwide? Has BC/BS instituted any programs to serve as an incentive for pharmacies (network) to dispense more generic drugs?

According to the GAO report, 44,751 pharmacies participate in the BC/BS FEHBP prescription drug program. About 60 percent of these are chains, and 40 percent are independents. This means that about 85 percent of the 53,000 pharmacies in the country participate in this program.

We believe that this Committee should be concerned about the cost containment structure in this program. According to OPM, most of the $200 million savings being achieved through this new copay, about 63 percent, result from increased out of pocket costs for Federal retirees, not from efficiencies resulting from mail order. BC/BS and OPM could have and should have instituted other cost management mechanisms in the FEHBP prescription drug program before additional cost sharing requirements were placed on Federal retirees. For example, hundreds of millions of dollars in savings are being lost because the program lacks aggressive generic substitution and drug manufacturer rebate cost management mechanisms.

No data have been presented to date which indicate that the mail order firm, in fact, purchases prescription drugs at lower costs that retail pharmacies. OPM and this Committee should be told what percentage of the $200 million savings result directly from the ability of mail order to purchase drugs at discriminatory lower prices than retail pharmacies. Until such data are presented, we must conclude that the bulk of the savings result from increased out of pocket retiree copays and fewer dispensing fees paid to pharmacies. This is unfair to retirees and pharmacies.

PCS, the retail pharmacy network administrator for the program, does provide some incentives for pharmacies to provide generic drugs in this program. According to the GAO report, about 14 percent of total program savings result from generic usage. The imposition of a 20 percent copay on retail pharmacy prescriptions is, in fact, an inherent incentive for generic drug usage, since generic drug prescription prices are usually less than brand name drugs. As a result, the patient pays a lower copay when a generic prescription is obtained. However, because there is no mail order copay, retirees have no economic incentive to obtain generics through the mail order program. For this very reason, it makes sense to also impose a copay on the mail order program.

BC/BS FEHBP Losing Millions in Drug Manufacturer Rebate Collections

In contrast to the Medicaid program, which receives about 17.8 percent of total program expenditures back from drug manufacturers in the form of rebates, BC/BS FEHP only receives about 7.6 percent (Chart 4). All other Federal health care programs - VA, DOD, Medicaid and PHS - have strong drug manufacturer cost management programs and are receiving billions of dollars in rebates from drug manufacturers each year. FEHBP should be, but is not, achieving similar results.

Generic Usage in BC/BS FEHBP/Mail Order Programs Lower than Retail Pharmacy

Data indicate that generic drug usage in the FEHBP program and in mail order programs in general is lower than generic usage in other third party prescription drug programs.

According to PCS, in 1995 the generic substitution rate in the overall BC/BS FEHBP program was 34 percent, but the rate in the Standard Option/Medicare Part B program was only 29 percent. This is far lower than the average generic substitution rate of 40-41 percent which is commonplace in other third party plans, according to the 1995 Ciba/Geneva Managed Care Report. A simple increase of 3 percent in the generic substitution rate in the FEHBP program would likely have generated the $200 million in savings that was needed.

CVS data indicate that there is a lower rate of generic substitution in the BC/BS FEHBP program compared with our overall store-wide generic substitution rate. For example, for the 12-month period ending July, 1996, the CVS generic substitution rate for the FEHBP prescription drug program was about 74 percent.

That is, CVS substituted a generic in 74 percent of the cases when one was available. Our overall storewide generic substitution rate was 88 percent, 14 percentage points higher than FEHBP (Chart 5).

Interestingly enough, the CVS generic substitution rate for the overall PCS program is 86 percent. PCS administers the retail pharmacy network portion of the FEHBP prescription drug program. So, this 74 percent generic substitution rate is even lower than our overall PCS rate. The FEHBP program clearly does not have the built-in incentives for physicians to prescribe, pharmacists to dispense, and retirees to ask for, lower-cost generic drugs. The bottom line is that there is significant room for growth in generic substitution in this program, which can generate substantial cost savings.

Moreover, the rate of generic substitution in mail order programs in general is remarkably low. According to a recent edition of *Chain Drug Review, f*or the top ten drugs most commonly provided by retail pharmacies, which represent 66 percent of their total prescriptions, the retail pharmacy generic substitution rate is 64.6 percent. The mail order firm generic dispensing rate is only 35.5 percent for this same set of drugs. Remarkably, for the top ten drugs that are most commonly provided by mail order, which represent 75 percent of their total prescriptions, the generic substitution rate is only 28.6 percent. Retail pharmacies have a higher rate of generic substitution for these drugs, 33.4 percent.

Community retail pharmacy is in an excellent position to help BC/BS and other Federal carriers manage their drug program costs, and we would have appreciated the opportunity to do so before this copay policy was implemented. Ironically, the lack of any copay on the mail order program only contributes to cost escalation, since the Federal retiree has no economic incentive to ask for, and the mail order firm has no incentive to provide, less expensive generic drugs.

Community Pharmacy Supports Legislative Efforts to Address Issue

What is the solution to this issue? We believe that Federal retirees should have a real and fair choice of determining where they want to obtain their prescription services. For example, if a retail copay is retained next year, an equivalent copayment should be placed on the mail order component. We believe that copayments are an effective way to promote generic substitution and control overall prescription drug utilization. Given that most of the savings from this change are being generated from copays anyway, OPM should be indifferent whether it obtains these savings from mail order copays or retail copays.

We support the report language included in the FY 97 House Treasury Appropriations bill by Congressman Hoyer that would direct OPM and its carriers to "consider other commonly-used cost management options such as full utilization of drug manufacturer rebates and generic substitution."

In addition, community retail pharmacy supports the bipartisan bill introduced by Congressman Cardin, H.R. 3462, **the Federal Health Program Benefit Change Accountability Act**. This bill, which currently has 34 House cosponsors, would require OPM to provide advance notice to Congress, Federal retirees, and other affected parties about changes that OPM is making for the upcoming calendar year to Federal retiree health benefit plans.

The copayment initiated this year represents a case in point. In spite of repeated requests from Members of Congress last year and earlier this year, OPM could not provide basic background data and information concerning the rationale for this prescription drug copayment change, other than to say that it saved "money".

Many in our industry first learned about this change when retirees themselves came into our stores upon receiving their annual open enrollment information. Many were perplexed as to why they would have to pay a copay to have their prescriptions obtained at the local pharmacy. We did not have the answers for them. Providers that have faithfully served Federal employees and retirees for many years deserve better treatment.

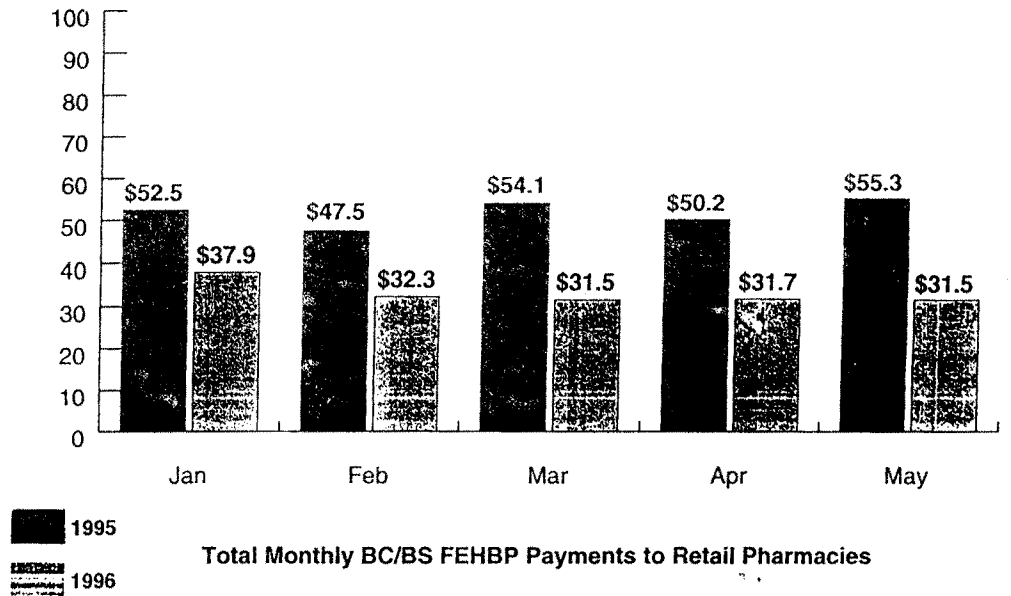
Finally, the early implementation of this mail order program was problematic, with many Federal retirees receiving the wrong prescription through the mail, no prescription at all, or a damaged medication container. It is unclear whether OPM assessed the ability of the mail order firm to meet the increased demand for prescriptions before the decision was made to implement the retail copay.

Taken together, these factors support the need for H.R. 3462, since the public scrutiny given to such changes would require that they be more thoroughly thought through before they are implemented. Accountability and justification in government is good, and should be promoted and encouraged.

Mr. Chairman, we appreciate your calling this hearing and thank you for your interest in this issue. We hope that OPM will recognize the negative impact that this copayment change has had on Federal retirees and community pharmacies, and that the agency will rectify the situation for 1997.

Chart 1

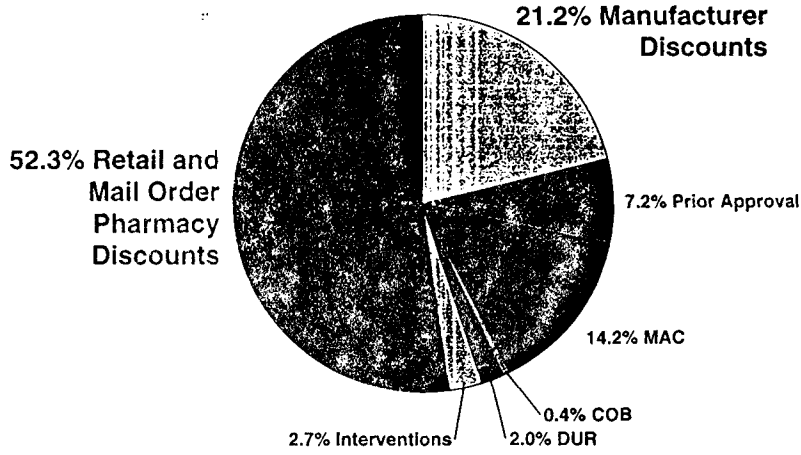
Retail Pharmacies Lost $95 million in Payments from BC/BS FEHBP Copay Change (Jan-May 1996)



Total Monthly BC/BS FEHBP Payments to Retail Pharmacies

Source: GAO, July 1996

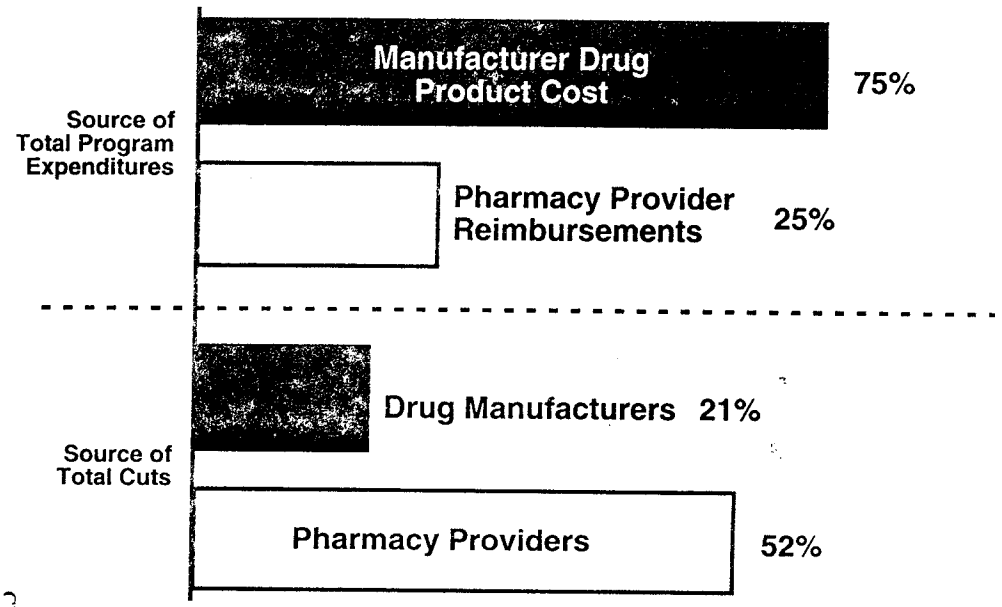
BC/BS Focuses Disproportionate Reductions on Pharmacy Providers



Source: Blue Cross and Blue Shield Association, GAO, July 1996

Chart 2

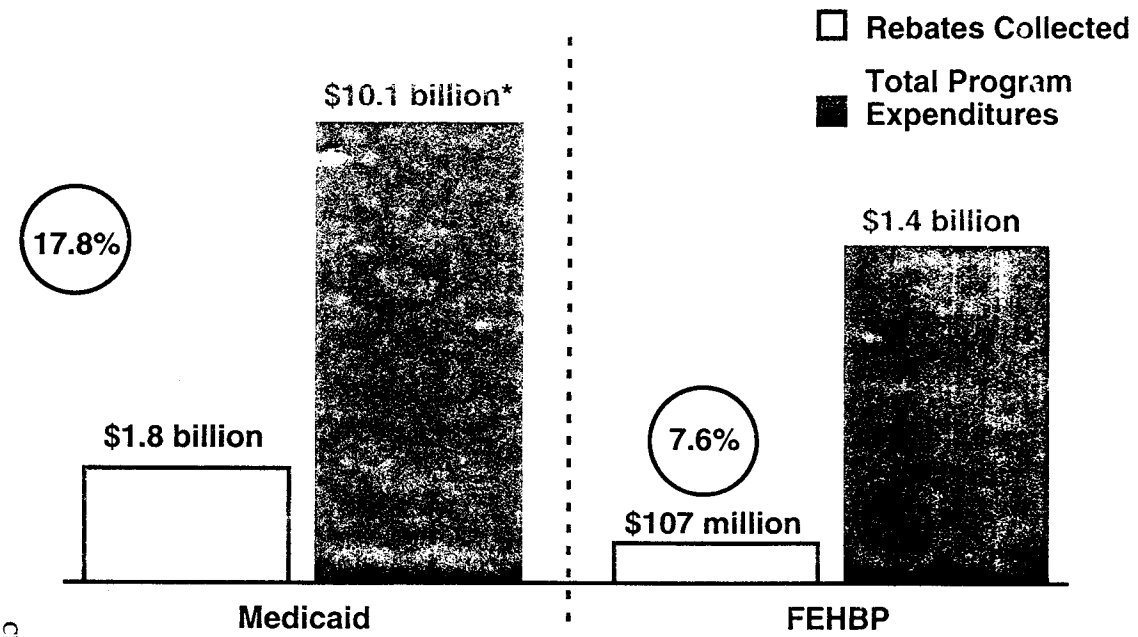
Cost Containment Is Skewed in BS/BC FEHBP Prescription Drug Program (1995)



Source: NACDS, based on GAO data, July 1996

8/96

Drug Manufacturer Rebates Collected as Percent of Total Programs Expenditures Much Higher in Medicaid vs BC/BS FEHBP (1995)

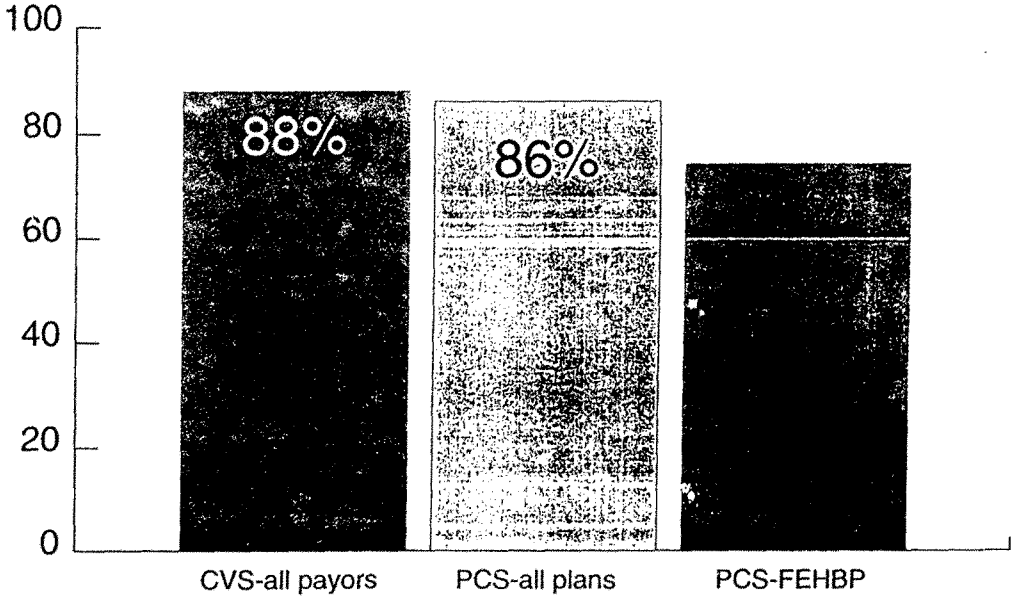


Source: NACDS, based on data from HCFA & GAO, July 1996

8/96

Chart

Use of Generics Should be Higher in BC/BS FEHBP Program



(Indicates the percentage of prescriptions that were dispensed with a generic drug when one was available)

Mr. MICA. Without objection, we will make your complete statement a part of the record. We have finished with our witnesses and I see that our distinguished member from Maryland has arrived; I believe she has an opening statement. I would like to recognize Mrs. Morella either for an opening statement or whatever questions she may have at this point.

Mrs. MORELLA. Thank you, Mr. Chairman. I appreciate the opportunity to kind of abbreviate an opening statement that I had prepared for what I consider to be a very important hearing. I want to thank you for holding the hearing.

I am a big fan of the FEHBP and every year during open season, like some of my colleagues in this region, I have several forums with the experts, to apprise my constituents about what the changes are. They have a chance to examine their options, voice their concerns. I hear both their praise of FEHBP and the problems that they encounter.

And as has been alluded to, there is high customer satisfaction. Over 85 percent of participants in fee-for-service plans and HMO's are satisfied with their FEHBP health plan. And as the Congress debated health insurance reform, FEHBP was most often discussed as a model program, so it is critical that we ensure that it continues to deliver high quality health care at a reasonable cost.

The Federal Employees Health Benefits Act of 1959 established FEHBP. It is the country's largest employer based health insurance program, serving the health care needs of almost 10 million Federal employees, retirees, and their families. Many are my constituents. And I am very pleased that today's hearing is focusing on many aspects of the FEHB Program. And the first panel that we have heard examined what is very critical to my constituents, the January 1996 change in the prescription drug benefit for Federal retirees enrolled in Blue Cross and Blue Shield.

I have been concerned about the 20 percent copayment waived if obtained by mail order for prescription drugs since it was announced last year. Many seniors depend on counsel and personal attention from their local pharmacist and they believe that this change compromises the quality of their health care.

They also believe the mail service program is an unacceptable option for prescriptions needing immediate attention. Local drug stores agree. Their customer profiles enable them to identify potentially dangerous drug interactions, a benefit that is lost through the mail order prescription drug program.

And in the beginning, I heard from many of my constituents experiencing delivery and quality problems and I do appreciate the steps that have been taken to remedy those problems. I also expressed my concern that this policy was implemented before the GAO study was complete. Now the study has been completed and we did hear from Ms. Jaggar about that particular study and the best course of action we can discuss that should be taken from here on.

I agree that we must keep premiums down, control costs, but it is critical that we explore many options and ensure quality health care for Federal retirees. Furthermore, no matter where you stand on the issue of copayments, I think that everybody agrees that retirees were not well informed of the changes before them.

The second panel will examine coverage for a range of different benefits and I look forward to hearing from one of my constituents, Dr. Harold Eist, president of the American Psychiatric Association, who will discuss FEHBP coverage of mental health benefits.

I am also an original cosponsor of legislation being introduced in the House today to require that annual and lifetime caps imposed on coverage for treatment of mental illnesses are no more restrictive, or should be no more restrictive, than such limits imposed on other medical conditions. This legislation would apply to FEHBP and I applaud OPM for eliminating the lifetime coverage maximum in 1995. I hope that the annual cap will be lifted as well, as it was from 1961 to 1973.

I look forward to hearing from witnesses discussing additional medical foods as a specific item covered by FEHBP, as I am a cosponsor of H.R. 2009. Medical foods can both save health care dollars, improve the health of patients facing a variety of illnesses and diseases. I am also a cosponsor of H.R. 1057 to provide for hearing care services by audiologists through FEHBP.

Another issue before us is a calculation of the Government's FEHBP contribution using the "big five" formula. Today, the Government share is derived using the "big six" calculation. Had the "big five" been in place in 1996, the total annual increase in costs for enrollees would have exceeded $1 billion. Now, I have, obviously, serious concerns about moving to a "big five" calculation in 1999. It would place an unfair burden on our employees and disrupt the stability that FEHBP has enjoyed.

Mr. Chairman, thank you for allowing me the opportunity to present that statement for the record and orally, and I will wait for my turn to ask any appropriate questions. Thank you. I yield back.

[The prepared statement of Hon. Constance A. Morella follows:]

Statement of the Honorable Constance A. Morella
Subcommittee on Civil Service
Federal Employee Health Benefits Program
September 5, 1996

Mr. Chairman, I want to thank you for holding today's hearing on the Federal Employees Health Benefits Program. I'm a big fan of FEHBP. Every year during open season, I hold two forums for the tens of thousands of my constituents insured by FEHBP. They have a chance to examine their options and voice their concerns. I hear both their praise of FEHBP and the problems they encounter. FEHBP enjoys high customer satisfaction -- over 85 percent of participants in fee-for-service plans and HMOs are satisfied with their FEHBP health plan. As the Congress debated health insurance reform, FEHBP was often discussed as a model program. It is critical that we ensure it continues to deliver high quality health care at a reasonable cost.

The Federal Employee Health Benefits Act of 1959 established FEHBP. It is the country's largest employer-based health insurance program, serving the

health care needs of almost 10 million federal employees, retirees and their families.

Today's hearing will focus on many aspects of the FEHB program. The first panel will examine the January 1996 change in the prescription drug benefit for federal retirees enrolled in Blue Cross / Blue Shield.

I have been concerned about the 20% copayment -- waived if obtained by mail order -- for prescription drugs since it was announced last year. Many seniors depend on counsel and personal attention from their local pharmacists, and they believe this change compromises the quality of their health care. They also believe the mail service program is an unacceptable option for prescriptions needing immediate attention. Local drug stores agree; their customer profiles enable them to identify potentially dangerous drug interactions -- a benefit that is lost through the Mail Order Prescription Drug Program. In the beginning, I heard from many of my constituents experiencing delivery and

quality problems, and I do appreciate the steps taken to remedy these problems.

I also expressed my concern that this policy was implemented before a GAO study was complete. Now that GAO has completed its study, I look forward to hearing from all of our witnesses on Panel I who will discuss the best course of action to take from here. I agree that we must keep premiums down and control costs, but it is critical that we explore many options and insure quality health care for federal retirees. Furthermore, no matter where you stand on the issue of copayments, I think everyone would agree that retirees were not well-informed of the changes before them.

Our second panel will examine coverage for a range of different benefits. I look forward to hearing from one of my constituents, Dr. Harold Eist, President of the American Psychiatric Association, who will discuss FEHBP coverage of mental health benefits. I am an original cosponsor of legislation being introduced in

the House today to require that annual and lifetime caps imposed on coverage for treatment of mental illnesses are no more restrictive than such limits imposed on other medical conditions. This legislation would also apply to FEHBP. I applaud OPM for eliminating the lifetime coverage maximum in 1995; I hope that the annual cap will be lifted as well, as it was from 1961 to 1973. I look forward to hearing from witnesses discussing adding medical foods as a specific item covered by FEHBP, as I am a cosponsor of H.R. 2009. Medical foods can both save health care dollars and improve the health of patients facing a variety of illnesses and diseases. I am also a cosponsor of H.R. 1057 to provide for hearing care services by audiologists through FEHBP.

Another issue before us today is the calculation of the government's FEHBP contribution using the "Big 5" formula. Today the government's share is derived using the "Big 6" calculation. Had the "Big 5" been in place in 1996, the total annual increase in costs for

enrollees would have exceeded one billion dollars. I have serious concerns about moving to a "Big 5" calculation in 1999. It would place an unfair burden on our employees and disrupt the stability that FEHBP has enjoyed.

Mr. MICA. I thank the gentlelady and will now recognize the ranking member of our subcommittee, the gentleman from Virginia, Mr. Moran, either for an opening statement or questions.

Mr. MORAN. Well, thank you very much, Mr. Chairman, and it is nice to welcome my colleagues back. Congresswoman Woolsey has a statement as well she would like to submit for the record. She is, as well, a cosponsor of H.R. 2009, the medical foods bill.

Mr. MICA. And I know she has been very active on this issue. Without objection, her complete statement will be made a part of the record.

[The prepared statement of Hon. Lynn C. Woolsey follows:]

REP. LYNN C. WOOLSEY
STATEMENT TO THE
SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM
September 5, 1996

Chairman Mica and Ranking Member Moran, thank you for this opportunity to submit my statement on behalf of H.R. 2009, which the Subcommittee is considering today.

I introduced H.R. 2009 to guarantee patients in fee-for-service Federal Employees Health Benefits Plans (FEHBP) the right to have medical foods covered by their health plans. Currently, FEHBP fee-for-service plans give insurance companies the choice of covering medical foods. My bill adds medical foods as a specific covered item in the plan. This will allow the patient and his or her doctor, rather than the insurance company, to make the choice of using medical foods instead of intravenous feedings.

Medical foods are a liquid formula chosen and used under the supervision of a physician to provide particular nutrients to a patient. For patients who suffer from illnesses such as diabetes, AIDS, cancer and others, medical foods reduce the risk of malnutrition and its potentially serious consequences.

In addition to their medical effectiveness, medical foods save health care dollars and provide a dignified alternative to intravenous feedings for many patients. Patients can use medical foods in a variety of settings, including the home, thereby reducing the stress and expense of a hospital stay. A recent study by the Barents Group of Peat Marwick on the cost effectiveness of using medical foods as a part of medical nutrition therapy found that federal outlays for FEHBP would be $250 million less over a seven-year period if medical foods were fully integrated into all plans participating in FEHBP.

The Office of Personnel Management which, as you know, administers the Federal Employees Health Benefits Plan, encouraged insurance carriers to provide coverage for medical foods in two recent letters to their program carriers. While this encouragement is a good first step, enactment of H.R. 2009 would ensure that the decision to use medical foods rests with patients and their doctors, not insurance companies.

H.R. 2009 has 28 bipartisan cosponsors in the House, and has been introduced in the Senate by Sen. Mike DeWine because the use of medical foods when medically appropriate is both cost effective and in the best interest of patients. Its something we can all support.

Mr. MORAN. Thank you, Mr. Chairman. While this may not be a particularly sexy topic, it is a terribly important one. The Federal Government has the best health insurance program in the Nation. Its premiums are fair, its management is superb.

It shows what you can do when you have a large enough pool and can negotiate the best deal for the subscribers to the plan, but when you are also dealing with responsible corporations who take their line of business seriously and are in it to do more than simply make a profit. We have some very fine health insurers in the program.

But while it is the best, it is not perfect. And we have run into situations where many members have felt that there were deficiencies in terms of the scope and the breadth of coverage. We have also run into situations where many of our constituents were concerned about changes that took place.

I think it is appropriate that we ask a question particularly about the change to mail order purchases of drugs today because that was an issue that certainly got the attention of a great many of my constituents. I am sure in Maryland and New Hampshire it was the same and particularly so it must have been a concern in Florida.

So let's ask a few questions. Did you suggest we get right into questions, Mr. Chairman?

Mr. MICA. Sure.

Mr. MORAN. OK; let me ask GAO, to begin with. We had $264 million as the figure that was saved through discounts. Blue Cross and Blue Shield say they saved $264 million through the discount program in 1995.

Now, in 1996 we initiated this mail order program, but yet I haven't seen actual dollar savings for that program. The last time we asked, I think they said it was premature to give an estimate. Does GAO have any estimates at this point?

Ms. JAGGAR. It is still a little early to know what the estimates are for the beginning of the year. We do not have an estimate yet.

Mr. MORAN. You can't project estimates of it at this point? You simply don't have any figures?

Ms. JAGGAR. Correct; yes, sir.

Mr. MORAN. Well, fair enough. The volume of mail order prescriptions increased by 66 percent. That was an enormous increase in the first few weeks since the copayment requirement was initiated. And I know that the National Association of Chain Drug Stores was keenly aware of that, the fall-off in business.

But now we hear from our Merck-Medco representative that that volume has fallen off. Why do you think that it has fallen off? Let me ask GAO first. There has been kind of a jagged trend there. Initially, people rushed to the mail order, I understand, but now many have gone back to using their local drug store and paying the 20 percent copay in the way that your other subscribers do, other Blue Cross and Blue Shield subscribers do.

Do you have any analysis of that?

Ms. JAGGAR. What we have focused on so far, Mr. Moran, is what the increase has been and what kind of level that has been attained at this point. Indeed, you are correct that the peak, or the

spike as we called it, in late January was 233,000 prescriptions in a 1-week period.

Now what the average is has leveled off, more in the 170,000 to 180,000 prescriptions a week range. Previous to the switch over in January, the average number of prescriptions a week—I'm sorry, the average weekly prescription rate was around 110,000, so this does represent a substantial increase that has flattened out and sustained itself.

As to the actual reason that the spike itself was not maintained, I don't believe that we have definitive information. The customer survey and satisfaction results that are in indicate that many people did notice that there was a problem in having the response times meet their expectations and, indeed, meet the standards that had been set for the program in the early days.

And their satisfaction level has leveled off and not retained to the original high rate that they had had before overall with the program. So consumer behavior does tend to take time to shake out when there is an initial rocky beginning to something, and we suspect that is the case.

Mr. MORAN. And you would expect that this level will plateau, that there are patterns that are now being established?

Ms. JAGGAR. Certainly it has, roughly speaking, leveled off at this point. Whether over time confidence will be regained and there will be an increase, further increase, we don't know. The percentage of prescriptions that are now filled by mail order is roughly around 40 percent, so about 60 percent are still filled at the retail pharmacies. Whether that will shift and change remains to be seen and depends upon the continued performance of the program.

Mr. MORAN. OK. I know it is certainly not a statistically valid sample, but a number of people have told me that they simply miss their pharmacist. They had established a pattern and they decided that the 20 percent wasn't that much more to pay and they preferred the face-to-face contact and the discussions that they used to have with their pharmacist.

I want to ask OPM this, but OPM had estimated about $200 million in savings. Mr. Spielman, do you have any estimate yourself? GAO says it is too early. Do you have any estimate on how much is being saved through this mail order, new mail order program, that was put in this year?

Mr. SPIELMAN. Well, Mr. Moran, when we designed this benefit change last year, we too were projecting savings on the order of $200 million. As I indicated in our statement, it is only halfway through the year so any estimates at this time would be very preliminary. So that was our original estimate.

Mr. MORAN. OK. I want to ask some questions of the coalition, but I do think since I have three colleagues here, including the chairman, that let me give you all an opportunity to ask some questions now and then I will come back to other questions.

Thank you, Mr. Chairman.

Mr. MICA. I am going to ask the vice chairman, Mr. Bass, if he would like to question at this time.

Mr. BASS. Thank you very much, Mr. Chairman. Boy, we are in sort of a magnanimous mood today. Thank you very much for the

opportunity to ask a couple questions. I have a brief question, I guess of Ms. Jaggar. I think she is the right one to ask.

What percentage of Federal employees, Federal retired employees, are utilizing the mail order option?

Ms. JAGGAR. Let's see, I'm trying to do the calculation. The number of people enrolled overall in Blue Cross is about 4 million. Of that number, about 800,000 people are Medicare part B enrollees. Of the Medicare part B enrollees, it looks like about 40 percent of the prescriptions that were filled were filled by mail order.

But I am sorry that I can't tell you exactly if that is 40 percent of the 800,000 enrollees. That would be of those people who did get prescriptions during 1996, about 40 percent of them.

Mr. BASS. I guess my question is: Has this been a popular program for Federal retirees?

Ms. JAGGAR. It was about 10 percent beforehand and 90 percent using the retail pharmacies, so it does look like the shift has been a fairly popular one thus far.

Mr. BASS. I think you testified that the impact on the retail pharmacies was about a 36 percent drop or something like that in business. Is there a difference in the impact on chain drug stores versus the sort of neighborhood or family drug stores, or not?

Ms. JAGGAR. We didn't look at that separately. The relationship that PCS has with the pharmacies that are within its network includes about 80 to 85 percent of the pharmacies in the country and across the country, some 44,000 pharmacies. And the impact will be different depending more on the location of the Federal retirees.

In other words, if it is in the Washington area where there may be more Federal retirees, it may have a greater impact. So it would depend upon the concentration of the different chains versus local stores.

Mr. BASS. I think that is a good answer. Do you think—maybe this isn't appropriate to GAO, I don't know who else I could ask it to though—that there is a way in which we can reconcile the different objectives, or apparently conflicting objectives, of providing savings, economy, efficiency, and service for the enrollees versus maintaining the important services, in my opinion, that local drug stores perform, that we don't end up with one or the other? Is there a way to resolve that conflict, in your opinion?

Ms. JAGGAR. I don't know. The benefit of obtaining cost savings for enrollees, of course, is what is behind OPM and Blue Cross' move, at least as they have explained it to us, in terms of trying to put in this benefit that would encourage more people to go to mail order. In other words, they have thereby not had to raise premiums and have realized some savings for the program, which they say benefits all enrollees in the plan.

The companies that fill the prescriptions are trying to offer services through telephone call-ins and so on that would replicate those services that are offered in a chain drug store or at a local level. But whether that has the same effect for individuals, the same efficacy, I think is a matter of personal preference.

Mr. BASS. Mr. Spielman, I have one question for you that may be difficult for you to answer. If you were Mr. Ortiz, what would you do to deal with the question of how you attempt to regain some foothold in this market that is made unavailable to you, or poten-

tially unavailable to you, through the creation of this somewhat artificial differential in reimbursement rates? What would you do if you were he over the long term to deal with this problem?

Mr. SPIELMAN. Well, Mr. Bass, I guess I would take issue with the premise here about regaining a foothold because, as GAO has testified, even with this benefit change, the majority of our Federal employee program prescription drug dollars are going into retail, 60 percent.

And, certainly, the Federal employee program is not the only payor. We looked at statistics the other day. PCS, of course, has other clients other than the Federal employee program and, on average, as a percent of PCS's payments to retail pharmacy, our Blue Cross and Blue Shield Federal employee program represents about 10 or 11 percent of the average payments to a pharmacy, recognizing that PCS is but one payor.

So when you add that up, coupled with GAO's broader analysis which suggests a 7-percent decline in payments, I don't know that the situation is quite as severe as you paint it.

Nevertheless, we don't believe that there is a Hobson's choice here. We believe that there is an important role for retail pharmacy. The mail order is not intended, as Mrs. Morella indicated, for prescriptions needing immediate attention if your daughter has an ear infection or what have you.

We have adopted a number of programs and are introducing some new programs which I identified in my statement intended to provide some innovations and incentives. In fact, one of our exciting programs is a pilot at the retail level to determine the feasibility of engaging the retail pharmacy in patient compliance activities and paying them for their counseling and effectiveness in counseling patients on proper drug use. In addition we have, as I indicated, disease management programs.

So I don't think it's an either/or. I think that there is a very important role for retail pharmacy, an important role for mail. And we are constantly on the lookout for ways of making both programs more effective.

Mr. BASS. Thank you. I have one last question, Mr. Chairman, if that is OK. Mr. Ortiz, why can't you form a mail order company and compete with Mr. Latanich and get Mr. Spielman to give you a contract?

Mr. ORTIZ. Well, some of the members of NACDS do, in fact, have mail order operations and significant mail order operations. I don't know whether they, in fact, bid for the Blue Cross and Blue Shield Federal employees program. At CVS, we analyzed the business, and we felt that we could deliver the services at a reasonable cost to the prescription benefit managers and to the employers through the community retail pharmacy and still maintain all of the benefits and service that face-to-face interaction between the pharmacist and the patient allows. And we think we can do that, and we think that we can do that economically.

Additionally, we talked to employers who asked for mail order options, and we explained to them other cost containment alternatives that are available to them. They, in fact, choose to maintain the community retail pharmacy network for their prescription

services and avail themselves of some of those other cost containment alternatives.

And we would be willing to discuss those with Blue Cross and Blue Shield and OPM to explore those other cost containment possibilities.

Mr. BASS. Thank you very much, Mr. Ortiz. Thank you, Mr. Chairman. That completes my questions for now.

Mr. MICA. I thank the gentleman and now recognize the gentlelady from Maryland.

Mrs. MORELLA. Thanks, Mr. Chairman. For GAO, Ms. Jagger, in your study, could you find any data that indicates that Medco is able to buy drugs at lower prices than retail pharmacies?

Mr. HANSEN. Mrs. Morella, as part of the work we did looking at the benefit change, we did not look at the prices that Medco was able to purchase drugs for.

In a study that we issued in November 1995 that focused in on pharmacy benefit managers like Medco, we did look somewhat at what prices companies were having to charge Medco for prices, and they do get good prices. That is one of the reasons that more and more employers and HMO's have turned to pharmacy benefit managers to manage their prescription drug benefits. We haven't actually looked at the specific prices. It is very proprietary data.

Mrs. MORELLA. As I ask these questions, if there is anyone else on the panel that ever feels, you know, an urge to comment, they are certainly welcome to do that.

I would also direct to GAO the question of are there other potential savings in the program that could save money for retirees?

Ms. JAGGAR. Mrs. Morella, in the course of this study, we weren't looking more broadly than at this particular benefit change. We will be, in subsequent work, looking at other issues associated with PBM's and FEHPB, if you will excuse the alphabet soup, but at this point we haven't looked more broadly than this.

Mrs. MORELLA. So it's another possibility that could be a challenge.

To Mr. Spielman, I might kind of rework that question and ask you what other cost savings measures did Blue Cross and Blue Shield consider and then why did you decide on the copay, and did you consider using generic drugs?

Mr. SPIELMAN. Well, certainly generic drug use and encouraging their use further was very much a part of our consideration in making this change. The 20-percent cost sharing does make the purchaser more sensitive to the cost and, indeed, you know, we are seeing a higher rate of generics as a result of that.

We have not wanted to go the route of mandatory generics, as some health plans do. We are continuing to pursue a number of avenues for savings. As I indicated in my testimony, disease management, we think that there are important savings in improving the patient management.

We have two projects underway for asthma treatment, as well as ulcers. We think that there is tremendous savings to be had by better educating our enrollees that are taking long-term medications for ulcers, recognizing the new research that shows that, in fact, it can be treated more effectively because of the H. Pylori situation.

So there are a number of things that we are doing to try to help contain benefit costs and it is a constant review from our perspective working with both our mail order and retail pharmacy program.

The alternatives that are available, you know, we had early on in this program looked at the option of having specified dollar copayments and that continues to be something that we look at. The 20 percent, as I indicate, has built into it an incentive for generic prescribing, but that is something we are constantly looking at.

Mrs. MORELLA. But you decided on the copay because of the money?

Mr. SPIELMAN. We decided on co-insurance when we adopted the retail pharmacy program in terms of benefit design, as opposed to a flat copay because of the effect on encouraging generic prescriptions. The reasons for the particular change in 1996 were spelled out, I think in detail, in GAO's statement, as well as my statement. It was a combination of a number of factors.

Mrs. MORELLA. Do you feel, in all candor, that you adequately informed retirees of the changes?

Mr. SPIELMAN. Yes, and I think that our efforts to do so last year at this time—shortly after the benefits were announced, we did a mailing to all of our retirees explaining it well before the beginning of the year.

I think, quite frankly, there was a lot of misinformation conveyed by folks who opposed the changes, leading our enrollees to believe that they had no option; that, in fact, they had to go to mail order. And I think that complicated the communications effort substantially.

I think the satisfaction numbers that we are getting recently bear out the issue that people are getting adjusted and more familiar with it. But any change of this magnitude, particularly with a population of high users of prescription drugs, is going to be difficult to communicate.

Mrs. MORELLA. It appeared to be done very hastily. I know that I personally felt, and I think other Members of Congress felt, that, first of all, it was premature since we didn't have the GAO report; second, we really were not that apprised of it. We found out, you know, during the open season that this, in fact, was going to be the case.

I just wondered if because of this experience whether or not you have any plans for a better way of publicizing.

Mr. SPIELMAN. Well, in publicizing these things, these benefit changes are, of course, part of the annual cycle of benefit changes that are announced as part of open season. We do, as you know quite well from your own seminars, participate in a lot of seminars and educational forums, and we have been doing that very vigorously.

We do have educational campaigns with the pharmacy community and we have periodic newsletters to all of our enrollees. I think that you really have to pursue all of those avenues of change and I believe that you can't communicate too much.

Mrs. MORELLA. I would like to also then, and I know you want to respond to this, Mr. Ortiz, and I want to give you a chance to because I thought I should certainly ask you a question. And

maybe in your response you might also comment on—I know you did in your testimony—what are some of the problems you see with the mail order program.

Mr. ORTIZ. First of all, with regard to the generic incentive, when you have a zero percent copay at the mail order level, there is no incentive for the recipient with regard to utilizing generics. Zero percent is zero percent, regardless of what the cost of the prescription medication is.

Second, percentage copays are very difficult for people to understand. We had a percentage copay for our own pharmacy program for a while and we quickly converted it to a straight dollar copay with a strong generic incentive.

As Mr. Spielman has testified earlier, the percentage copay on brand name products for his program is approximately $7 and for generics it is approximately $2. It would be much simpler for the recipient to make the conscious decision to use generics or the brand name if the copays were simply $2 and $7, instead of this 20 percent. That would be the second thing.

The other thing with regard to the communication, I know how much confusion existed with the patients that came into our pharmacies about the change, and the lack of communication to the provider community, the pharmacy provider community, of any kind was absolutely abysmal.

Second, when, in fact, Medco had problems delivering services in the first part of the year, again there was no communication to the community retail pharmacy providers of the fact that they were allowing recipients to receive a 21-day supply. It was only when those recipients brought the letters into the pharmacies that we knew that we could, in fact, fill their prescriptions at the community retail level and they would not be charged the copay. That lack of communication, I think, did not serve anyone well.

Mrs. MORELLA. Very good point, and I think there should be strategies to remedy that for any changes in the future. I wonder, Mr. Ortiz, picking up on something that you said in response, I think, to Mr. Moran's point, would the community pharmacy be willing to work with OPM and Blue Cross and Blue Shield to find additional savings? Would you like to comment on that?

Mr. ORTIZ. Absolutely. We do work with employers and other managed care organizations. I am speaking for CVS now, but I know that the other community retail pharmacies do too in designing prescription benefits. And they clearly have the same cost containment pressures that the Federal employees program has and we work with them very well to identify other cost containment alternatives. And I can volunteer here on behalf of the entire coalition that we would be very willing to work with both of them.

Mrs. MORELLA. Fine, thank you. I think this is something we should bear in mind and that everybody should bear in mind, particularly on this first panel. In the interest of time, Mr. Chairman, I yield back and thank you.

Mr. MICA. I thank the gentlelady. And now we recognize the gentleman from New York, Mr. Gilman, for questions.

Mr. GILMAN. Thank you, Mr. Chairman. I would like to ask all the panelists is there any way to reconcile the need to achieve savings for the enrollees and the economic interests of community

pharmacists? Any way we can reconcile those differences? Would any of the panelists like to respond to that, please?

[No response.]

Mr. GILMAN. Don't all volunteer at once.

Mr. ORTIZ. Mr. Gilman, just one: cost containment. We know that the generic utilization rate for the entire Federal employees program is much lower than it is for other PCS programs in general and compared to our company average. We know that there is a lot of opportunity there with regard to increasing the generic utilization of this program.

That is just simply one and we could work with Blue Cross and Blue Shield and OPM to identify ways of increasing that generic drug utilization to bring it up to the average with other similar plans.

Mr. LATANICH. Mr. Gilman, if I can comment, our experience at mail service with respect to generics, I think is different than the picture Mr. Ortiz portrays. As I indicated in my testimony, about 35 percent of the prescriptions we fill are filled generically. Only about 5 percent of the prescriptions are dispensed as brands where there is a generic available.

So the percentage of prescriptions, the percentage of opportunity being realized in the mail service program dispensing generically is very, very high and it is consistent with what we see in other programs across the country.

So while I can't speak to the retail portion of this business, I can certainly indicate that with respect to the mail service piece of the business, there is a very ongoing and sustained effort to encourage the use of generics. But it is a program that does honor the intent of the doctor and honor the intent of the patient if they choose not to receive a generic.

Mr. GILMAN. Getting back to the reconciliation, are you saying then that the pharmacists go toward generics that we would be able to solve the problem? Is that what you are saying to us?

Mr. ORTIZ. I am saying that we would be able to offer substantial savings. Just running the CVS figures for the Federal employees program, we know that if we could bring it up to the company average, it would save the program approximately $2 million.

Mr. GILMAN. Anyone else care to comment?

Mr. SPIELMAN. I would just say we agree and have developed a generic incentive program to incentivize pharmacies and provide some financial benefit for pharmacies that do a good job at that at retail. And we are always looking for ways of improving those programs, so I do think that that is a productive line of work.

Mr. GILMAN. Let me ask, Ms. Jaggar, in your analysis you indicate that the PBM's are now meeting their performance measures after there were serious problems earlier in the year. How much emphasis do these standards place on quality of care rather than just meeting some overall cost reduction standards?

Ms. JAGGAR. The standards that are in place in the contract between Blue Cross and Blue Shield and Merck and also the Medco contracts include a variety of items that are designed to get at quality. They include also information about access to pharmacists when individuals call in. They include standards for the speed with which the prescriptions are filled.

They include standards for the error rate. This error rate, for example, is 0.005 percent. Some have said that that is approximately 1 in 20,000 prescriptions being filled that would be in error. These different things are surrogates or proxies that have been agreed to between the contractor and the purchaser as indicators of quality.

In addition, there are various quality standards and checks that are in place at Merck in, for example, their Tampa pharmacy where we visited, designed to assure that those standards are met. The consumer satisfaction surveys that are conducted quarterly by the Gallup organization are designed to get at from the perspective of the beneficiaries whether or not these standards really are getting quality services to them.

In the end, of course, there is the open enrollment period annually where consumers and enrollees can vote with their feet if they are dissatisfied.

Mr. GILMAN. Thank you. And, Mr. Ortiz, what sort of an impact has this change had on the quality of care that your pharmacies have been able to provide to Federal retirees?

Mr. ORTIZ. I think, first of all, and I can't overemphasize the fact that we are asking people to triage their own health care needs, whether they can wait for a prescription and pay zero percent or whether to get it filled immediately and pay the 20 percent.

I know when I go to the doctor, by the time I come out of there I am confused. If a patient receives three or four prescriptions, they say, all right, did he say to wait on this one and get this one filled right away, or was it vice versa? And asking them to triage that kind of need is beyond the capability of most people. If they delay therapy, often they can get into serious medical consequences. That is an issue that has not been addressed with this 20-percent copay and zero. The second thing is, when I fill a prescription at CVS pharmacy, I don't have—I send it out to PCS. I don't know whether PCS, in fact, has all of the other drug information for prescriptions filled at Medco and whether the drug utilization review messages that I am getting back from PCS, in fact, encompass all of that person's medication profile. If it doesn't, then there is a serious gap that I cannot resolve.

Mr. LATANICH. Mr. Gilman, if I could comment just for a second. Since the inception of the PCS contract with the Blue Cross organization, the data from the mail service program and the data from the retail program have been integrated so that any drug interaction alerts, any drug warnings pertaining to drug use in that program, go across the combined data set. And it has been that way since day one.

I would also note that the issue of are we asking people to triage themselves, let's step back and recognize that many Federal carriers and most private sector carriers have co-insurance for retirees. This is the exception. This is not the norm, in the sense that, you know, previously drugs were not subject to a coinsurance. The step that Blue Cross took, in essence, put them in step with where health care is today in the United States. It's not the exception.

Mr. GILMAN. Any other comments by any of the panelists?

[No response.]

Mr. GILMAN. Just one more question. Mr. Ortiz, many pharmacy chains already have mail order programs, yet your own organiza-

tion has been opposing the mail order program. Is there some difference between the way your chain operates and some of the others?

Mr. ORTIZ. No; I think even the mail order companies that are within NACDS's membership would agree that mail order has a secondary role at best for providing medical services. The reason that CVS and the community retail pharmacy is so opposed to this program is that this, in some ways, despite the 60/40 percent split of 60-percent community pharmacy/40-percent mail order, for some people it is making mail order the primary prescription source. And that is contrary to the whole way that mail order was supposed to be utilized.

It also creates the first step in perhaps seriously jeopardizing the safety net and the infrastructure of community pharmacy. If the Federal employees program is next followed by the entire Federal employee program, which is next followed by Medicaid or Medicare, the entire community pharmacy infrastructure and the safety net that provides prescriptions is going to be in jeopardy. And that is why we are so concerned about what is going on.

Mr. GILMAN. Thank you. And thank you, Mr. Chairman.

Mr. MICA. Thank you. I have a couple of questions. First, Mr. Latanich, you stated that Merck-Medco's mail service pharmacists have an accuracy rate of 0.995. I guess the error rate would be 0.005. I have heard it referred to that way, also. This means less than 1 error in 10,000 prescriptions.

How many pharmacists check each prescription at your pharmacies or in your pharmaceutical procedure?

Mr. LATANICH. In general, the answer to that, Mr. Chairman, is at least two and, in many cases, it can be as many as three or four. Unlike the model that you are used to where in many cases there is a single pharmacist in a community that takes the prescription from beginning to end, in our environment, with significant use of highly sophisticated computers and the use of bar coding technology, essentially we have broken down the dispensing process so that multiple pairs of eyes look at every prescription, which provides the advantage of catching internally anything that may have happened inappropriately.

Mr. MICA. So you're saying there is a difference in your quality assurance, as opposed to that that might be practiced in a retail pharmacy?

Mr. LATANICH. Well, I think it is a combination of both having more sets of eyes looking at it, but also a much, much higher level of technology that is applied to insuring that the drug has been selected correctly.

Mr. MICA. Mr. Ortiz, would you want to respond? How do you insure that same quality and oversight?

Mr. ORTIZ. First of all, we have many of the same checks and balances. We have multiple eyes in most of our pharmacies. Not all of our pharmacies warrant the staffing necessary to have multiple eyes. But certainly even in those that don't, there are double, triple checks. We don't question the accuracy rate of mail order and we don't question the accuracy or the quality assurance rate of retail. We think they are both extremely high and that that is not the issue in question here.

Mr. MICA. Thank you. Ms. Jaggar, Blue Cross and Blue Shield enrollees not eligible for Medicare part B have a substantially less generous prescription drug benefit than those eligible for part B; however, both groups pay an identical premium. Have you compared the utilization rates of the drug benefits for these two groups?

Ms. JAGGAR. No, sir, we have not.

Mr. MICA. Would there be any justification for a difference in benefits among participants paying the same premium?

Ms. JAGGAR. I think that that, in fact, is a policy decision that is determined by OPM working with Blue Cross as a basis for its contract at this point. We haven't looked into that area.

Mr. MICA. Would you like to respond, Mr. Spielman?

Mr. SPIELMAN. The other factor to take into account here is that for those individuals, with Medicare B, Medicare is their primary payor for their hospital and physician and other payments. The Federal employees program is not paying primary benefits there with, of course, the major exception of the drug benefit. So there is a different set on the liability side of the equation, also.

Mr. MICA. You testified, Ms. Jaggar, that the Blue Cross and Blue Shield contract with Medco requires that its pharmacies dispense all of its prescriptions annually with less than a 0.005 error rate. Have you reviewed the average error rates at any of the retail pharmacies?

Ms. JAGGAR. No, sir; we have not looked at that.

Mr. MICA. Can you tell us how the filling of a prescription at a mail order facility would differ from a retail pharmacy?

Ms. JAGGAR. We did do a site visit at the Merck location in Tampa, FL, and we observed firsthand what the procedures are that are gone through in filling the prescriptions. We have not gone to look at retail pharmacies to see what their procedures are; however, there are no standards that are in place for that industry. And, to the best of my knowledge, there is no data that is used to measure the industry's performance in that regard.

Mr. MICA. Are you aware of any specific safeguards or checks that are built into the mail order systems that aren't replicated at the local pharmacies?

Mr. HANSEN. Well, Mr. Chairman, I'm not sure that most community pharmacies would have the sort of sophisticated bar coding and computer technology that Mr. Latanich described at the Medco facility in Tampa.

I think that certainly the checks are rather extensive, right up until you put the address label on the prescription to go to the patient. Also, I would doubt very seriously if many community pharmacies had that sophisticated technology to insure that the pills that were in that particular bottle were what the prescription was written for and that it was going to the patient that it was supposed to go to.

Mr. MICA. But you don't have any specific evidence that there are any safeguards or checks then?

Mr. HANSEN. No. We did talk to the American Pharmaceutical Association to try and determine whether there were standards for quality in terms of error rates at community pharmacies, and learned that there are no standards.

Mr. MICA. Mr. Spielman, the GAO has testified that when the benefit change went into effect, Medco's processing capacity could not absorb the rapid increase. The number of pharmacists they found was insufficient to handle the prescriptions orders and many enrollees did not get their prescriptions filled promptly.

What actions did you take to remedy this situation and meet standards acceptable for customer service?

Mr. SPIELMAN. Well, Mr. Chairman, those actions are detailed in my written statement. We worked with the vendor to bring up additional capacity, to extend hours, and to provide for overnight delivery of prescriptions. We also initiated a special program for those whose prescriptions could not get filled on time on a limited basis to get them filled at retail with a waiver of the ordinary 20-percent coinsurance. So we did take a number of steps, beginning in early January to help rectify the situation and, as we have testified, by mid-March that problem had been eliminated and the standards were being exceeded.

Mr. MICA. Were there additional costs associated with the corrective actions, and who absorbed these: Blue Cross and Blue Shield or Medco?

Mr. SPIELMAN. The particular costs involved and how they fit in the contracts are still under review, but the bottom line is that the costs were very small in relationship to our savings and will not result in any increases in Blue Cross and Blue Shield premiums.

Mr. MICA. Thank you. I don't have any further questions at this time. I will yield to Mr. Moran and see if he has any final questions.

Mr. MORAN. Thanks, Mr. Chairman. Mr. Ortiz, you testified that about 63 percent of the savings from this mail order program is attributable to the copayments. How did you calculate that?

Mr. ORTIZ. One moment, because Mr. Coster helped me with this. I think it was out of the GAO study. This is an April 10, 1996, letter to the chairman, the Honorable John Mica, from OPM. And in this letter, they state, "The combined effects of copayment and a slight decrease in utilization of retail pharmacies is expected to account for savings of approximately $125 million, or 62.5 percent of the total savings."

Mr. MORAN. I see. That doesn't necessarily mean that it is the copayments itself; it is really the imposition of the copayments causing people to use the lower cost mail order that makes the savings, that achieves the savings?

Mr. ORTIZ. That analysis and that interpretation might, in fact, be accurate, yes.

Mr. MORAN. OK; thank you, Mr. Ortiz. In the past, retail pharmacies have suggested that to keep business, they would be willing to price drugs competitively with any of the mail order firms. Now, is that still an option? I mean, is that a challenge that is still out there? Why don't you address that?

Mr. ORTIZ. Well, first of all, I am here testifying on behalf of the coalition, but I can only answer that question on behalf of CVS because, obviously, individual companies would have to make that decision and individual pharmacies would have to make that decision.

On behalf of CVS, I can say I don't know because I don't know what the mail order reimbursement rate is. I don't know whether,

in fact, that reimbursement rate reflects an ability to buy differentially than we can because of pricing practices of manufacturers. I don't know whether that reimbursement rate reflects a strategy by Merck-Medco to use Medco as a marketing tool for their products.

I don't know what the reimbursement rate is so I can't accurately answer that question. We would certainly take a hard look at it if that opportunity were available to us and seriously consider whether it would be the right business decision or not.

Mr. MORAN. So if Blue Cross and Blue Shield came to you with a pricing structure that was competitive, you would be more than happy to attempt to meet it?

Mr. ORTIZ. Yes.

Mr. MORAN. At least speaking for CVS?

Mr. ORTIZ. Yes.

Mr. MORAN. Now let me ask the other three organizations to respond for the record to the concern that some have expressed that the pharmacy providing the drugs is owned by the manufacturer of the drugs themselves and that, in the long term, that creates a potential conflict of interest monopolistic situation; whereas, with retail independent pharmacies, there is a built-in balance that the market is going to insure that the consumers' interests are better served than if you have this kind of vertical structure.

Perhaps Mr. Latanich.

Mr. LATANICH. Latanich.

Mr. MORAN. Latanich. I'm sorry. You know, I was trying to figure out is it Latanich or Latanich, and I guessed wrong. Mr. Latanich, and we appreciate your being here today, would you address that concern that has been expressed?

Mr. LATANICH. Sure. I think that since our merger occurred in November 1993, obviously it created a new delivery structure within the industry and there have been a lot of questions about how our customers would be ensured that we were always acting in their interest.

And I think that, No. 1, if you look at what has happened since November 1993, I think our clients have been exceedingly happy with the steps that we have taken to make sure that our decisions are always made independently and in their interests. We have constructed with our parent essentially a form of firewall in which we make our decisions for our clients independently of our parent.

We do do certain interventions on behalf of a number of manufacturers with whom we have contracts that afford rebates or discounts to the Blue Cross plan. We do that for Merck. We do it for many, many, non-Merck products. The number of drugs at any given time that we are making phone calls on, it may exceed 50 or more.

So we do a number of things which are always in the client's interest and, in this case, our contract with Blue Cross insures that any intervention initiative that we propose, they have the right to sign off on. And there are a number of contractual commitments that insure that everything we do is in the client's best interest, not in our best interest.

Mr. MORAN. Thank you, Mr. Latanich. Mr. Spielman.

Mr. SPIELMAN. I would just say that Blue Cross and Blue Shield is very cognizant of the issue you raise, Mr. Moran, and we have

approached that through effective management of both our retail and mail order pharmacy programs. We do have our own pharmacists on staff and a number of other contract managers. We also have built into both contracts a number of provisions designed to give us the necessary approvals.

As we have described, there is ongoing oversight of both of these programs and, indeed, there are a number of steps we have taken such as the aggregation into an FEP formulary to address the issue that you raise. We are constantly monitoring our drug programs and constantly developing new approaches to provide a better program and more effective delivery system for our enrollees. It is an issue we are aware of.

Mr. MORAN. Thank you. Mr. Hansen, Ms. Jaggar, do you have anything to add to that?

Mr. HANSEN. Mr. Moran, last November we issued a rather detailed report on this specific question, the acquisition of pharmacy benefit managers by major drug companies. In that report, we go to great length to point out that the Federal Trade Commission has established certain requirements on these PBM's to insure independence along the lines that Mr. Latanich mentioned.

We are aware that FTC continues to monitor that situation. We certainly encourage them to continue monitoring them based on our analysis of those changes. So it is an area that is still under review and still being examined, not just by the Federal Trade Commission but by purchasers of those services, much like Blue Cross is monitoring it.

Mr. MORAN. Thank you. And thank you, Mr. Chairman.

Mr. MICA. Does the gentlelady have any additional questions?

Mrs. MORELLA. No, thank you.

Mr. MICA. No additional questions at this time. I would like to thank our panelists for joining us and for their testimony and participation today, and excuse you at this time.

I would like to now call our second panel. Our second panel of witnesses include Barry A. Freeman. Dr. Freeman is president of the American Academy of Audiology; Alan L. Lowell, who is president of the International Hearing Society; Michael D. Maves, executive vice president of the American Academy of Otolaryngology; and Nancy S. Wellman. Dr. Wellman is professor and director of the National Policy and Resource Center on Nutrition and Aging at the Florida International University. And then Rev. C. Roy Woodruff. Dr. Woodruff is executive director of the American Association of Pastoral Counselors. And Dr. Eist is president of the American Psychiatric Association. And, finally, James S. Turner, president of the National Acupuncture Foundation.

And if I could ask you to please take your places and stand. As I mentioned to our first panel, this is an investigations and oversight subcommittee of Congress and we do have the custom and tradition of swearing our witnesses in. So if you would stand please.

[Witnesses sworn.]

Mr. MICA. I would like to welcome our panelists and witnesses at this time, and I will also advise you that if you have a long statement that exceeds 5 minutes, it will be made a part of the record. We would like you to summarize. We do have a rather large

panel and we would like to hear from all of you and then leave some time for questions.

With those comments, I will now recognize Dr. Barry Freeman, president of the American Academy of Audiology.

STATEMENTS OF BARRY A. FREEMAN, PRESIDENT, AMERICAN ACADEMY OF AUDIOLOGY; ALAN L. LOWELL, PRESIDENT, INTERNATIONAL HEARING SOCIETY; MICHAEL D. MAVES, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF OTOLARYNGOLOGY; NANCY S. WELLMAN, PROFESSOR AND DIRECTOR OF THE NATIONAL POLICY AND RESOURCE CENTER ON NUTRITION AND AGING AT THE FLORIDA INTERNATIONAL UNIVERSITY; REV. C. ROY WOODRUFF, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF PASTORAL COUNSELORS; HAROLD I. EIST, PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION; AND JAMES S. TURNER, PRESIDENT, NATIONAL ACUPUNCTURE FOUNDATION

Mr. FREEMAN. Thank you, Mr. Chairman, and good morning. I would like to thank Chairman Gilman for his leadership on this bill and appreciate his comments, as well as thank Mr. Moran and Mrs. Morella for cosponsoring this bill.

I currently serve as president of the American Academy of Audiology and I am testifying on their behalf, as well as a number of allied national professional organizations, including the American Speech-Language Hearing Association, ASHA. And, together, we represent the vast majority of audiologists from diverse practice settings throughout the United States.

Mr. Chairman, I am an audiologist in a private independent practice in Clarksville, TN, and my small staff and I try to serve the hearing care needs of the 1 in 10 persons with hearing loss in our community, many of whom because of my proximity to Fort Campbell are covered by the Federal employees benefits plan.

My practice is like a lot of other audiologists throughout the country that are trying to serve the needs of the more than 28 million persons with hearing loss. Today, we have an opportunity with your help to make a positive difference in the delivery of hearing care services for persons with hearing loss.

I know that you, Mr. Chairman, as well as many members of this committee, have met with my colleagues, audiologists and consumers from across the country who have expressed our frustration with the policy that currently is in place that says that Federal employee benefit plans cover audiology services but will not pay the providers of those services when they directly bill for them.

When Chairman Gilman introduced H.R. 1057, he noted the probable cost effectiveness of this legislation and alluded to many other facts during his statement here today. We don't know for a fact that this bill is going to save a lot of money, but there are some facts that we do know.

For example, we know that 3 percent of all people in this country will seek audiologist services every single year. We also know that 80 percent of those individuals that seek those services will not—80 percent of those people will not have a medical or surgical condition that will be treatable or correctable.

If you apply these numbers to the Federal employee benefit program, then we note that 216,000 of the 270,000 people seeking services in the next year will be required to visit a physician, probably an ear, nose, and throat specialist, for a hearing problem that is not medically or surgically correctable.

We know that this has been studied by other Federal programs, like the Veterans' Administration, who wanted to look at access for veterans and the cost effectiveness of services for veterans. The Veterans' Administration has adopted a policy that states,

> An ENT examination is not routinely required before an audiologic assessment, only when medical management is necessary. Patients with evidence of ear disease should be referred by the audiologist for a complete ENT examination.

Mr. Chairman, what we are really asking for today is for the Federal Government to be consistent and to let Federal employees have the same benefits as veterans.

I also note the frustration that is being expressed, especially in these days of changing to managed care, where a lot of physicians, primary care doctors, pediatricians, are trying to refer their patients to independent audiologists, and I note the frustration of these doctors who are not able to have direct access for their patients to an audiologist.

I have put into my testimony a letter today from Dr. Amy Gordon, professor of internal medicine at Johns Hopkins University, who expressed dismay at the claim denials from Blue Cross and Blue Shield that have been received by her patients that she has referred to independent audiologists in the Baltimore area.

I also have a letter in the packet today regarding H.R. 1057 from the executive vice president of the Florida Academy of Family Physicians, who stated that they believe family physicians should have the option of directly referring their patients to audiologists.

Mr. Chairman, it is almost 2 years ago to the day that I met with OPM and they recommended to me and to my staff that we take the legislative route to have audiology services added to the FEHBP plans. Since Chairman Gilman introduced H.R. 1057, it has gained the bipartisan support of the majority of this subcommittee. It has gained support from the larger Government Reform and Oversight Committee. We have 26 cosponsors in the House.

There has been a companion bill introduced by Senator Thad Cochran, cosponsored by Senator David Pryor and my own Senator, Dr. Bill Frist, and Senator Tom Harkin. We know that you cannot be responsible for the actions of the House, for the larger committee, or for the Senate, but what we are asking for today is a chance.

What we would like to do is to have you bring this to a vote for the benefit of the 28 million persons with hearing impairment that will benefit from this change in the law.

Thank you for the opportunity to speak before this subcommittee, and I will be pleased to answer questions.

[The prepared statement of Dr. Freeman follows:]

AMERICAN ACADEMY OF AUDIOLOGY

8201 Greensboro Drive, Suite 300, McLean, VA 22102

TESTIMONY OF BARRY A. FREEMAN, PH.D., PRESIDENT, AMERICAN ACADEMY OF AUDIOLOGY, BEFORE THE CIVIL SERVICE SUBCOMMITTEE, COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

September 5, 1996

Mr. Chairman, my name is Barry Freeman. I am an audiologist in private practice in Clarksville, Tennessee. I also currently serve as President of the American Academy of Audiology (AAA). I am testifying today on behalf of AAA, and also a variety of allied national professional organizations, including the American Speech-Language-Hearing Association, the Academy of Dispensing Audiologists, the Academy of Rehabilitative Audiology, the Educational Audiology Association, and the Audiology Resource Association. Together we represent the vast majority of audiologists, from diverse practice settings, throughout the United States. Also accompanying me today are Marshall Matz and Chris Markus, from the law firm of Olsson, Frank and Weeda.

Audiologists are highly-skilled, academically-trained, licensed health care providers, who are dedicated to the care of the hearing system and related functions, such as the balance system. Audiologists complete a rigorous, graduate-level education program that focuses on applied sciences and clinical training. Currently, audiologists must possess at least a masters-level degree, although many audiologists continue through the doctoral level. In fact, to take into account the

modern scope and sophistication of the profession, efforts are underway to establish the new Doctor of Audiology (Au.D.) degree as the minimum credential for the practice of audiology. Following the completion of academic training, audiologists must pass a national, standardized professional examination. They must also complete a post-graduate clinical practice experience under a supervising audiologist.

Audiologists are licensed (or subject to similar state regulation) in 46 of the 50 states. Over half of these states impose continuing education/professional development requirements, as a criterion for maintaining licensure.

Audiology services encompass a broad range of diagnostic and rehabilitative services designed to assist people of all ages, from newborn babies through adulthood. This includes the assessment of hearing in newborn babies and young children; the evaluation of the auditory system for inner ear or higher level dysfunction, such as an acoustic nerve tumor; developing hearing conservation programs for industries with workplace noise; assessing hearing loss and auditory learning disabilities of school-age children; initiating and participating in clinical and theoretical research on the auditory system; and managing hearing loss through amplification systems for children and adults. It is our mission to provide quality hearing care to the public.

The consumers of audiology services are people with hearing loss and related conditions. There are an estimated 28 million people in the United States today -- about one in every 10 -- who are affected by hearing loss. This number is expected to increase to over 40 million people during the next 10 to 20 years, as our national population continues to age.

Hearing loss generally is a non-medical problem -- meaning that, in the majority of cases, medical or surgical treatment will not provide relief to patients. Published studies conducted by audiologists at the Vanderbilt University School of Medicine, the Department of Veterans Affairs,

and in private independent clinical practices, and by ear, nose, and throat (ENT) physicians at the Henry Ford Hospital in Detroit have confirmed that approximately 80 percent of patients with complaints of hearing loss cannot benefit from medical or surgical treatment. A very large percentage of patients with hearing loss, therefore, can be fully and appropriately served by audiologists.

With this background in mind, I would like to discuss H.R. 1057 -- the "Hearing Care for Federal Employees Act" -- which is pending before this Subcommittee, and which would facilitate the provision of audiology services under the Federal Employees Health Benefits Program (FEHBP). Specifically, H.R. 1057 would amend 5 U.S.C. § 8902(k)(1) -- part of the law governing the FEHBP -- by adding the word "audiologist" to the list of non-physician health care providers that appears in that section. Under the FEHBP law, federal employees and their families may go directly to the listed providers for services covered under their insurance plans. For example, optometrists are listed in § 8902. Therefore, if an FEHBP health plan covers vision examinations, a federal beneficiary may go to his optometrist and have that service paid for under the insurance plan. Psychologists and nurse-midwives are two other commonly-used, non-physician providers recognized in § 8902(k)(1). Other providers also are recognized.

In terms of professional status, audiologists are peers of the providers currently listed in the FEHBP law. In addition, audiology services commonly are covered under FEHBP insurance plans, but not directly. Examinations for identifying hearing loss in children with recurrent ear infections, for example, or assessment of the integrity of the inner ear of persons with vertigo, traditionally have been reimbursable services for federal employees. However, the current structure generally requires that audiology services be billed through a physician to be

reimbursable under the FEHBP -- even though the actual services are performed by an audiologist.

It is important to emphasize, then, that H.R. 1057 would not mandate new benefits or otherwise change current coverage under the FEHBP. Rather, H.R. 1057 would permit FEHBP beneficiaries who have a hearing or related problem to go -- if they choose to do so -- directly or through their primary care physician, to an audiologist for evaluative and rehabilitative services. H.R. 1057 would not increase or simply reallocate costs. Instead, by eliminating the requirement for patients to see a surgeon before a diagnostic audiologic evaluation is even done, there may be a direct cost-savings to the FEHBP program.

The inclusion of audiologists under § 8902(k)(1) will have an important, direct impact for the more than 9 million federal employees, annuitants, and their dependents receiving health insurance coverage under the FEHBP program. It should make it easier, faster, and less expensive to obtain quality hearing care services, by enabling patients to go directly to the professionals who actually perform audiologic evaluations, and eliminating a large number of the multiple health care visits that currently is the practice. Based on commercial utilization data, approximately 3 percent of federal employees under the FEHBP -- that is 270,000 people -- will seek audiology services each year. Of these people, 80 percent -- or 216,000 people -- do not have a medically- or surgically-correctable disorder.

H.R. 1057 would also provide important indirect benefits to millions of Americans with hearing loss, who are not federal employees. As the Subcommittee undoubtedly is aware, many private health insurers model their benefits packages after the FEHBP. Following this precedent, audiologists are prejudiced and discriminated against compared to the providers listed in § 8902. By recognizing that it is appropriate for federal employees to go directly to audiologists for

audiology services, H.R. 1057 would establish an important precedent for many millions of Americans to obtain prompt, cost-effective hearing care.

I note that the federal Department of Veterans Affairs (VA) recognizes the value of prompt and direct access to audiologists. In the directives governing its national network of audiology clinics, which provide extensive evaluative and rehabilitative services, the VA states:

> Appointments for audiological assessments . . . should not be delayed until an ENT examination is completed. An ENT examination is not routinely required before an audiologic assessment . . . only when medical management is necessary. ***Patients with otoscopic or audiologic evidence of ear disease must be referred for a complete otologic (ENT) examination.

For many years, the VA has found this approach to hearing care to result in timely, quality services for veterans. In short, H.R. 1057 only asks that federal civilian employees be treated the same way as veterans!

Mr. Chairman, audiologists appreciate that some Subcommittee members may be concerned about expanding the list of health care providers in § 8902(k)(1). The fact is, however, that the list of covered, non-physician providers already exists, and not being part of the list sends a negative signal to insurers concerning the appropriateness of direct access to audiologists. AAA has discussed this matter with the Office of Personnel Management, and we were advised that an amendment of § 8902 was the appropriate route to pursue.

H.R. 1057 enjoys the very strong support of groups that are interested in hearing care. Self Help for Hard of Hearing People, Inc. (SHHH); the Alexander Graham Bell Association for the Deaf; and Auditory-Verbal International represent tens of thousands of consumers who are hard of hearing. I would like to submit letters of support from these organizations as part of my testimony. In addition to AAA and the allied organizations on whose behalf I speak today, other

groups representing hearing care providers also support the legislation. I am aware, for example, that Florida audiology representatives met with you, Mr. Chairman, earlier this summer; that the Pennsylvania Academy of Audiology has written to Chairman Clinger in support of H.R. 1057; and that the Indiana Academy of Audiology has had positive interaction with Representative Burton's office regarding this legislation.

I am pleased that a representative of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) is a member of the panel today. Their membership includes many of our ENT physician colleagues, as well as many of our own members who are audiologists that prepare ENT residents in the audiologic components of their training. I would like to emphasize that H.R. 1057 does not, in any way, call into question the unique qualifications of ear, nose, and throat physicians to diagnose and treat medically-related hearing loss. Audiologists understand that they are not medical doctors, and we routinely refer patients for medical or surgical attention when symptoms suggest disease conditions may be present. We are trained and licensed to make these referrals.

It also is important to emphasize that H.R. 1057 would not affect the ability of ear, nose, and throat doctors or other physicians to see patients. The legislation simply would make audiologists an entry point, an option, not the sole entry point, into the hearing care system. Patient choice for already covered services would not be limited. Therefore, just as a patient can now choose between going to an optometrist or going to an ophthalmologist for a vision test, a patient with hearing loss would be able to choose between going to an audiologist or going first to an otolaryngologist for hearing care.

Audiologists have worked closely with ear, nose, and throat physicians for many years to promote the hearing health of the U.S. population. H.R. 1057 will help our two professions

better serve patients, by increasing access to hearing care, potentially lowering costs, and producing greater consumer satisfaction. As noted above, a strong, cost-efficient hearing care system will be ever-more-important in the coming years, as the demand for hearing care grows rapidly.

Also on the panel today is a representative of the International Hearing Society. Hearing aid dispensers are licensed to fit and sell hearing aids and to test hearing for this purpose. H.R. 1057 seeks to have audiologists recognized for diagnostic and rehabilitative services already included in the FEHBP program, services we already provide. To our knowledge, hearing aids and testing for their fitting and sale are not included in the FEHBP plans. Hearing aid dealers are not trained or licensed to provide comprehensive audiological assessments for diagnostic purposes. Therefore, H.R. 1057 is properly limited to recognizing audiologists under § 8902(k)(1).

Mr. Chairman, Chairman Gilman introduced H.R. 1057 in February 1995. Since that time, the legislation has gained significant bipartisan support among the majority of the Members of this Subcommittee, among the larger Government Reform and Oversight Committee, and in the House in general. A Senate companion bill (S. 800) has been introduced by Senator Thad Cochran, who serves on the authorizing Senate Subcommittee. That bill is co-sponsored by Senator David Pryor, the Ranking Member of the authorizing Subcommittee; by my own Senator, Dr. Bill Frist of Tennessee, who chairs the Disability Policy Subcommittee in the Senate; and Senator Tom Harkin of Iowa, the Ranking Democrat on the Disability Policy Subcommittee.

I urge the Civil Service Subcommittee to report H.R. 1057 favorably. Thank you for the opportunity to speak before the Subcommittee. I will be pleased to answer any questions the Members may have.

Mr. MICA. Thank you for your testimony and we will defer questions till we have finished all the panelists. I would now like to recognize Alan Lowell, president of the International Hearing Society. You are recognized, sir.

Mr. LOWELL. Thank you. Good morning, Mr. Chairman and distinguished members. My name is Alan Lowell. I am a State-licensed, board-certified hearing instrument specialist and vice president of Professional Hearing Aid Centers in Hollywood, FL. I am here today in my capacity as president of the International Hearing Society and am pleased to present IHS' views on H.R. 1057.

IHS represents the vast majority of traditional hearing aid specialists in the United States. Hearing aid specialists are the Nation's most experienced health care providers in the testing, the selection, and the fitting of hearing aids. Hearing aid specialists are a vital point of entry in the hearing health care system.

As you know, the act would add qualified audiologists to the list of providers to whom FEHBP must provide direct access upon provision of covered services. As currently drafted, this bill would undermine the hearing health care delivery system.

First, the bill fails to recognize that hearing aid specialists are integral members of the hearing health care team who provide hearing aid related services.

Second, the bill inappropriately equates audiologists with physicians. Indeed, H.R. 1057 authorizes direct access to audiologists not just for hearing aid related services but also for certain audiologic testing procedures that should only be provided upon a physician's order.

Consequently, it is IHS' recommendation that if any direct access to nonphysician hearing health care professionals is granted through FEHBP, this access should be limited to nonmedical hearing aid related services and qualified hearing aid specialists also should be included as eligible providers.

In considering H.R. 1057, Congress must take note that the hearing health care delivery system has been the subject of Food and Drug Administration regulation for 19 years and reevaluation for the last 3 years. The FDA is presently preparing to issue a new proposed rule governing the sale of hearing aids.

Two essential premises have emerged from FDA's review that are crucial in considering H.R. 1057. One is the importance of preserving hearing aid specialists as an entry point into the hearing health care system and the other relates to the recognition that only physicians can diagnose and treat medical conditions with respect to hearing assessments to determine the need for an appropriate type of hearing aid.

Testimony to the FDA clearly demonstrates that hearing aid specialists, as well as audiologists and physicians, are qualified to be a point of entry into the hearing health care system.

Hearing aid specialists are licensed in 46 States and registered in 2 others specifically to provide hearing assessments and hearing aid related services. Many hearing aid specialists also are certified by the National Board for Certification in Hearing Instrument Sciences, the only national certification in hearing instrument testing, fitting, and followup care.

The FDA is revisiting whether to continue to require a medical examination for all prospective hearing aid users. The American Academy of Otolaryngology, Head and Neck Surgery [AAO] has stated its view that all prospective hearing aid purchasers should continue to first be examined by a physician; however, the physicians also have indicated that they would accept a change in the current FDA rule to authorize evaluations by hearing aid specialists or audiologists without medical exam or a waiver thereof, provided that strict regulatory requirements that continue to protect patients are in place.

What is salient is that the AAO does not differentiate between hearing aid specialists and audiologists with respect to their qualifications to be a point of entry into the hearing health care system and to identify those conditions which require medical referral.

Hearing aid specialists geographically are the most accessible hearing health providers, located in both urban and rural communities, and are the most cost-effective hearing aid professionals. By excluding State-licensed and/or certified hearing aid specialists as a point of entry, H.R. 1057 would do a gross disservice to the hearing impaired population.

Indeed, providing exclusive status to the audiologist directly contravenes the direction of the evolving health care system. Testimony submitted to the FDA also does not support direct access to audiologists other than for hearing aid related services.

Audiologists' scope of practice includes the provision of certain audiologic testing procedures that assist physicians in evaluating the need for or appropriate type of medical or surgical treatment for a hearing aid deficit or related medical problem.

IHS concurs with the AAO that the integrity of the hearing health care delivery system is threatened by authorizing direct access to audiologists for these audiologic procedures which should only be provided under a physician's direction.

IHS strongly urges Chairman Mica and other members of this subcommittee to recognize that H.R. 1057, as currently drafted, is inconsistent with and would undermine the viability of the federally mandated hearing health care system.

If this subcommittee should choose to provide direct access through FEHBP to hearing health care professionals, then IHS strongly urges that, No. 1, access be limited to hearing aid related services and, No. 2, qualified hearing aid specialists be included as eligible providers.

Thank you for this opportunity to submit our views, and I would be pleased to answer any questions.

[The prepared statement of Mr. Lowell follows:]

TESTIMONY
OF
ALAN L. LOWELL, BC-HIS, A.C.A.
PRESIDENT
INTERNATIONAL HEARING SOCIETY

ON H.R. 1057
THE HEARING CARE FOR FEDERAL EMPLOYEES ACT

BEFORE THE
HOUSE GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON CIVIL SERVICE

SEPTEMBER 5, 1996

I. INTRODUCTION

Good afternoon. My name is Alan Lowell. I am a state-licensed, Board-certified hearing instrument specialist and Vice President of Professional Hearing Aid Centers in Hollywood, Florida. I am here today in my capacity as President of the International Hearing Society ("IHS") and am pleased to present IHS's views on H.R. 1057, the Hearing Care for Federal Employees Act.

IHS represents the vast majority of traditional hearing aid specialists in the United States. Hearing aid specialists are the nation's most experienced health care providers in the testing, selection, and fitting of hearing aids. Hearing aid specialists are a vital point of entry into the hearing health care system.

Our members are small business men and women strategically located and accessible to the hearing-impaired public throughout the United States. A large number of IHS members are second and third generation hearing aid specialists, whose small businesses are significant contributing forces in their communities.

II. OVERVIEW OF IHS POSITION ON H.R. 1057

As you know, the Hearing Care for Federal Employees Act would add qualified audiologists to the list of providers to whom Federal Employees Health Benefits Plans ("FEHBP") must provide direct access upon provision of covered services.

As currently drafted, this bill would, for two reasons, undermine the hearing health care delivery system.

First, the bill fails to recognize that hearing aid specialists are integral members of the hearing health care team who provide hearing aid related services.

Second, the bill inappropriately equates audiologists with physicians. Indeed, H.R. 1057 authorizes direct access to audiologists not just for hearing aid related services but also for certain audiologic testing procedures that should only be provided upon a physician's order.

Consequently, it is IHS's recommendation that, if any direct access to non-physician hearing health care professionals is granted through FEHBP, this access should be limited to non-medical, hearing aid related services **and** qualified hearing aid specialists also should be included as eligible providers.

III. REGULATORY CONTEXT

In considering enactment of H.R. 1057, Congress must take note that the hearing health care delivery system has been the subject of Food and Drug Administration ("FDA") regulation for 19 years and reevaluation for the last three years.

The FDA is presently preparing to issue a new proposed rule governing the sale of hearing aids. Essential premises have emerged from FDA's review that are crucial in considering H.R. 1057. These premises fall into two themes. One relates to the importance of preserving hearing aid specialists as an entry point into the hearing health care system and the other relates to the recognition that only physicians can diagnose and treat medical conditions.

A. IMPORTANCE OF PRESERVING HEARING AID SPECIALISTS AS A POINT OF ENTRY INTO THE HEARING HEALTH SYSTEM

With respect to hearing assessments to determine the need for and appropriate type of hearing aid, testimony to the FDA clearly demonstrates that hearing aid specialists, as well as audiologists and physicians, are qualified to be a point of entry into the hearing health care system. Hearing aid specialists are licensed in 46 states (and registered in two other states) specifically to provide hearing assessments and hearing aid-related services. Many hearing aid specialists also are certified by the National Board for Certification in

Hearing Instrument Sciences, the only national certification program in hearing instrumentation testing, fitting and follow-up care. Audiologists and otolaryngologists also are eligible for this certification.

The FDA is revisiting whether to continue to require a medical examination for all prospective hearing aid users. The American Academy of Otolaryngology - Head and Neck Surgery ("AAO") has stated its view that all prospective hearing aid purchases should continue to first be examined by a physician. However, the physicians also have indicated that they would accept a change in current FDA rules to authorize evaluations by hearing aid specialists or audiologists without medical exam or a waiver thereof, provided that a medical exam is required upon identification of certain symptoms; that patients be clearly informed that it continues to be in their best health interest to first be examined by a physician; and that the broad regulatory framework is protective of patients' health. What is salient in the context of consideration of H.R. 1057 is that AAO does not differentiate between hearing aid specialists and audiologists with respect to their qualifications to be a point of entry into the hearing health care system and to identify those conditions which require medical referral.

From access, quality, and cost viewpoints, qualified hearing aid specialists should remain a point of entry for determining the need for a hearing aid. With regard to access, hearing aid specialists geographically are the most accessible hearing health providers, located in both urban and rural communities. With regard to cost and quality, hearing aid specialists are the most cost-effective hearing aid professional, as documented in surveys conducted by the Hearing Journal.

These surveys revealed that audiologists' hearing aid-related services are typically more expensive than those provided by hearing aid specialists. Approximately 90% of hearing aid specialists include the cost of testing, fitting, instruction, follow-up care, and counseling in a bundled price along with the price of the hearing aid. By contrast, testing and fitting fees are included in the price of the hearing aid in only 55% of the hearing aid sales by dispensing audiologists in private practice. Dispensing audiologists in clinics and doctors' offices include testing and fitting fees in a mere 24.5% of hearing aid sales. Charging separately for the "standard" audiometric test fees can cost approximately $110 above the cost of the hearing aid, which averages around $670.

By excluding state-licensed and/or certified hearing aid specialists as a point of entry, H.R. 1057 would do a gross disservice to the hearing-impaired population. Indeed, providing exclusive status to the audiologists directly contravenes the direction of the evolving health care system.

B. INAPPROPRIATENESS OF AUTHORIZING DIRECT ACCESS TO AUDIOLOGISTS FOR DIAGNOSTIC AUDIOLOGIC SERVICES

Testimony submitted to the FDA also does not support direct access to audiologists other than for hearing aid-related services. Audiologists' scope of practice includes the

provision of certain audiologic testing procedures that assist physicians in evaluating the need for or appropriate type of medical or surgical treatment for a hearing deficit or related medical problem.

IHS concurs with AAO that the integrity of the hearing health care delivery system is threatened by authorizing direct access to audiologists for these audiologic procedures which should only be provided under a physician's direction. These tests are quite costly and may be medically unnecessary when not ordered by a physician.

IV. CONCLUSION

IHS strongly urges Chairman Mica and other Members of this Subcommittee to recognize that H.R. 1057, as currently drafted, is inconsistent with and would undermine the viability of the federally mandated hearing health care system. If this Subcommittee should choose to provide direct access through FEHBP to hearing health care professionals, then IHS strongly urges that:

1. access be limited to hearing aid related services and

2. qualified hearing aid specialists be included as eligible providers.

Thank you for this opportunity to submit our views. I would be pleased to answer any questions.

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Mr. MICA. I thank you for your testimony, and we will now turn to Michael D. Maves. Dr. Maves is the executive vice president of the American Academy of Otolaryngology, Head and Neck Surgery. Welcome, and you are recognized, sir, for 5 minutes.

Dr. MAVES. Thank you, Mr. Chairman and members of the committee. My name is Dr. Michael Maves and I am here today representing the more than 10,000 otolaryngologists, head and neck surgeons. As the chairman indicated, I am the executive vice president of the American Academy of Otolaryngology, Head and Neck Surgery, and a practicing head and neck surgeon at Georgetown University Medical Center.

The academy is the national medical specialty society for physicians dedicated to the care of patients with disorders of the ears, nose, throat, and related structures of the head and neck. We are more commonly referred to as ear, nose, and throat specialists or ENT specialists.

The membership of this academy opposes H.R. 1057, the Hearing Care for Federal Employees Act of 1995. This bill would mandate direct patient access to audiological services for enrollees in the Federal Employees' Health Benefits Program by mandating direct reimbursement to audiologists.

On the surface, this bill appears supportive of patient choice and access issues but, upon closer analysis, we are concerned that this is a mechanism to encourage direct payments for services that may not be medically necessary.

In the current FEHB Program, employees have access to audiologists and audiological services as medically indicated. Under this legislation, enrollees would have direct access to audiological services without the oversight of a referring physician. We believe this is bad health policy, as well as bad fiscal policy.

If implemented, H.R. 1057 would undermine what we believe is the strongest element of the Federal Employees' Health Benefits Program by undermining the cost and quality control mechanisms afforded to the individual health plans that are offered to enrollees.

Audiologists are our professional colleagues and we hold them in high esteem; however, it remains unconvincing that symptoms referable to the human ear will be better diagnosed by individuals with lesser medical education than physicians. Hearing loss and ear disease, by definition, are medical problems.

It is in the best interest of an individual with hearing loss to first see a physician to have the cause of their condition medically diagnosed. This is a longstanding opinion of the Federal Government, as discussed in FDA regulations concerning the sale and dispensing of hearing aids.

Audiological services are supportive of the medical component of diagnosis and treatment for hearing imbalance disorders. There are numerous major medical conditions that can cause hearing imbalance problems, including cancers of the head and neck and diseases of the brain and cerebellum. Hearing loss can also occur as the result of the side effects of certain ototoxic medications that a patient may be taking for other unrelated medical reasons.

Most of these problems are not detectable even by highly trained audiologists, as such detection usually requires a complete medical system review, history, and physical examination, as well as knowl-

edge of drug pharmacology. These components can only be fully appreciated through medical school training and subsequent experience.

Services of audiologists, such as the administration of diagnostic hearing imbalance tests, hearing aid fittings, which also may be provided by hearing aid specialists, would be ordered and utilized by the otolaryngologist, head and neck surgeon, in rendering the medical diagnosis or in supporting the treatment options recommended by the physician. This process of medical evaluation and treatment is in the best interest of the patient.

And I might add parenthetically, this typically occurs in a single office visit, single office setting, where the audiologist is in the office under the employment of the otolaryngologist, head and neck surgeon. We feel this remains the most cost-effective method of delivering hearing health care.

Audiologists that support this legislation may indicate to you that 90, 80 or 75 percent of hearing loss is not medically or surgically treatable, thus diminishing the importance of a medical evaluation. We have heard this figure quoted on more than one occasion and during debate on this issue in the past have yet found no evidence based on a published, scientific, peer-reviewed study to suggest any such amount. Hearing loss can be both medically and surgically treated in many cases. If there is a medical problem, only a physician is in the position to diagnose and treat it.

The Food and Drug Administration has long regulated the sale and dispensing of hearing aids. Under current regulation, first time purchasers of hearing aids must be medically evaluated by a physician prior to the sale of the device. Adults can waive this requirement, but this requirement is mandatory for children.

The FEHBP should be consistent with FDA regulations on hearing aid sales and dispensing. Under the current FEHBP, plans are required, like all others, to comply with FDA rules. For all other audiological services, FEHBP should stay the course and not open up direct access to an entirely new group of health providers whose education, training, and experience does not lend itself to an independent medical practice outside of a hearing health care team led by an otolaryngologist head and neck surgeon.

Individuals with hearing loss should see a physician to have their medical condition diagnosed and treated. Audiologists are otolaryngologist's valued colleagues. They have training and expertise in audiometric testing, as well as in the evaluation for and enhancement of hearing aid fitting and cochlear implant rehabilitation.

On the other hand, otolaryngologists are medical physicians who undergo more than 10 years of training after undergraduate school, including medical school, internship, residency and, in some instances, fellowship. This training is capped by a rigorous 2-day oral and written examination administered by the American Board of Otolaryngology.

Collaboration of otolaryngologists, audiologists, and hearing aid specialists is in the best interest of the patient and remains the most cost-effective method of delivering hearing health care. On behalf of the ear, nose, and throat physicians and the patients that we treat, I would urge you to oppose H.R. 1057.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to testify before you today and would be happy to answer any questions that you have. Thank you, sir.

[The prepared statement of Dr. Maves follows:]

American Academy of
Otolaryngology—Head and Neck Surgery, Inc.
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Testimony of
Michael D. Maves, MD, MBA
Executive Vice President
American Academy of Otolaryngology - Head and Neck Surgery
Before the
Committee on Government Reform and Oversight
Subcommittee on Civil Service
Re: The Federal Employees Health Benefits Program;
Proposed Mandates for Direct Access to Audiologists
September 5, 1996

Mr. Chairman, members of the committee: My name is Dr. Michael Maves and I am here today representing more than 10,000 otolaryngologist - head and neck surgeons. I am the Executive Vice President of the American Academy of Otolaryngology - Head and Neck Surgery and a practicing head and neck surgeon at Georgetown University Medical Center.

The Academy is the national medical specialty society for physicians dedicated to the care of patients with disorders of the ears, nose, throat and related structures of the head and neck. We are more commonly known as ENT specialists.

The membership of this Academy strongly opposes HR 1057, the Hearing Care for Federal Employees Act of 1995. The bill would mandate direct patient access to audiological services for enrollees in the Federal Employees Health Benefits Program (FEHBP) by mandating direct reimbursement to audiologists.

On the surface, this bill appears supportive of patient choice and access issues, but upon closer analysis, we are concerned that this is a mechanism to encourage direct payments for services that may not be medically necessary. **In the current FEHB program, enrollees have access to audiologists and audiological services as medically indicated. Under this legislation, enrollees would have direct access to audiological services without oversight or referral by a physician.** We believe that this is bad health policy as well as bad fiscal policy.

If implemented, HR 1057 would undermine the strongest element of the Federal Employees Health Benefits Program by undermining the cost and quality control mechanisms afforded to the individual health plans that are offered to enrollees.

Audiologists are our professional colleagues and we hold them in high esteem. However, it remains unconvincing that symptoms referable to the human ear will be better diagnosed and treated by individuals with lesser medical education than physicians. It is in the best interest of an individual with hearing loss to first see a physician to have the cause of their condition medically diagnosed. This is a long-standing opinion of the federal government as discussed in FDA regulations governing the sale and dispensing of hearing aids.

Audiological services are supportive of the medical component of diagnosis and treatment for hearing and balance disorders. There are numerous major medical conditions that can cause hearing and balance problems, including head and neck cancers and diseases of the cerebellum. Hearing loss can also result as a side effect of certain ototoxic medications that a patient may be taking for other medical conditions. Most of these problems are not detectable even by highly trained audiologists as

such detection usually requires a complete medical system review, history and physical examination as well as knowledge of pharmacology. These components can only be fully appreciated through medical school training and subsequent experience.

The services of audiologists, such as the administration of diagnostic hearing and balance tests, or hearing aid fittings, which may also be provided by hearing aid specialists, would be ordered and utilized by the otolaryngologist-head and neck surgeon in rendering the medical diagnosis or in supporting the treatment options recommended by the physician. This process of medical evaluation and treatment is in the best interest of the patient and remains the most cost-effective method of delivering hearing health care.

Audiologists that support this legislation may tell you that more than 90 percent of hearing loss is not medically or surgically treatable, thus diminishing the importance of a medical evaluation. We have heard this figure quoted on more than one occasion, during debate on this issue in the past, yet we have found no evidence based on any published, scientific, peer reviewed study to suggest any such amount. Hearing loss can be both medically and or surgically treated in many instances. If there is a medical problem, only a physician is in a position to diagnose it.

The Food and Drug Administration (FDA) has long regulated the sale and dispensing of hearing aids. Under current regulations, first time purchasers of hearing aids must be medically evaluated by a physician prior to the sale of the device. Adults can waive this requirement, but must be told that it is in their best interest to see a physician. Children must see a physician in all cases.

The FEHBP should be consistent with FDA regulations on hearing aid sales and dispensing. Under the current FEHBP, plans are required, like all others, to comply with the FDA rules. For all other audiological services, FEHBP should stay the course and not open up direct access to an entirely new group of health providers whose education, training, and experience does not lend itself to independent medical practice outside of a hearing health care team led by an otolaryngologist - head and neck surgeon.

Individuals with hearing loss should see a physician to have their medical condition diagnosed and treated. Audiologists are otolaryngologists' valued colleagues who have training and expertise in audiometric testing as well as in evaluation for and enhancement of hearing aid fitting and cochlear implant rehabilitation. Collaboration of otolaryngologists and audiologists is in the best interest of the patient and remains the most cost-effective method of delivering hearing health care. On behalf of the otolaryngology community nationwide, I would urge you to oppose HR 1057.

I appreciate the opportunity to testify before you today and would be happy to answer any questions you may have.

Mr. MICA. Thank you for your testimony. We will defer questions and hear now from Nancy Wellman. Dr. Wellman is professor and director of the National Policy and Resource Center on Nutrition and Aging at Florida International University. Welcome. You are recognized.

Ms. WELLMAN. Thank you, Chairman Mica and Congress committee members. Good morning. My testimony is a change of topic from the other three speakers. I am Nancy Wellman, director of the National Policy and Resource Center on Nutrition and Aging at Florida International University, and I am past president of the American Dietetic Association. I also chair the Nutrition Screening Initiative, which is a partnership led by the American Academy of Family Physicians, the American Dietetic Association, and the National Council on Aging and a partnership of 35 other national prominent organizations looking at health, nutrition, and aging.

I appreciate the opportunity to testify this morning before you in support of H.R. 2009. This legislation is intended to include the provision of medical foods as a specific item covered by FEHBP. Medical foods administered as part of medical nutrition therapy are proven to contribute to positive health outcomes while saving health dollars for people suffering from debilitating, acute, and chronic conditions.

With the growing recognition among medical experts that health care should be about preventing costly problems and truly promoting health and quality of life, medical nutrition therapy and medical foods are integral to the kind of health care our Nation's citizens need and deserve.

Mr. Chairman, we all know that health care, like all programs, has to be sensitive to special needs of our aging population and, in particular, we must address the nutrition related health problems and the malnutrition prevalent not only among today's older Americans but among those of us, myself included, getting closer to retirement and our golden years.

Nutrition status affects our quality of life, illness and injury prevention, chronic disease management, healing, and the costs associated with the treatment of diseases, illness, and injury.

For example, malnourished patients take 40 percent longer to recover from an illness and have 2 to 3 times as many complications. Hospital stays are 90 percent longer and $5,000 more costly per malnourished medical patient and $10,000 more costly per malnourished surgical patient. Malnourished patients are readmitted to hospitals earlier and more frequently.

As we all know, older Americans now make up about 13 percent of our population, but they consume triple that number in terms of health care resources, 36 percent of our health care resources. With those 78 million baby boomers moving toward their senior years, these statistics cannot remain the status quo. The provision of medical nutrition therapy and medical foods to people covered by FEHBP is part of solving the problem of escalating health care costs.

A recent study we commissioned at the Nutrition Screening Initiative was conducted by the Barents Group of Peat Marwick. It documents that medical foods administered as a specialized compo-

nent of medical nutrition therapy would yield $1.3 billion—that's with a B, billion—in Medicare savings by the year 2002.

Medical foods improve health outcomes and save health care dollars. For example, the cost of treating a patient who has pancreas or liver surgery and doesn't receive medical foods is approximately $17,000, compared to $6,500 for a patient who receives medical foods.

The Barents Group has emphasized that their estimates of cost savings are conservative in their assumptions, since savings would most likely occur for Medicare beneficiaries hospitalized for many diagnoses besides the 13 they investigated, as well as for those treated in outpatient settings. The savings to Medicare alone would possibly be many times over the projected $1.3 billion.

Furthermore, if specialized nutrition therapy was used consistently when medically appropriate for Medicaid recipients and Government workers covered under FEHBP and the same percentage of savings were assumed as for the Medicare population, the budget for Medicaid spending would be reduced by more than $650 million by the year 2002 and Federal outlays for FEHBP would be $250 million less over the same time period.

Medical foods are the most advanced development of nutrition sciences. They are specially formulated to assist in the management of specific chronic diseases and medical disorders, some very familiar to many of us such as diabetes, pulmonary or lung disease, renal or liver diseases, AIDS and cancer, as well as acute conditions such as hip fractures, sepsis, or pneumonia.

For patients who are not able to eat, and as a dietician, I always promote food first, or whose metabolic state makes it difficult for them to meet their nutrient needs through food alone, medical foods are clinically efficacious and cost effective, either when used in addition to food or even as a primary therapy.

Medical foods are administered orally, by mouth—you can take them by mouth—or through feeding tubes, which makes them easy and relatively inexpensive to provide to patients in a variety of care settings, including the home.

The term medical foods was first defined by Congress in 1988 in the orphan drug amendments. The term medical foods means a food which is formulated to be consumed or administered enterally, that is, orally or by feeding tubes, under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements based on recognized scientific principles are established by medical evaluation. The same definition for medical foods was then used by Congress as part of the Nutrition Labeling and Education Act of 1990.

Mr. Chairman, I almost hesitate to mention congressional action related to the ill-fated Health Securities Act in 1994; however, I will since medical foods was one of the few issues of health care reform to receive bipartisan support. Both the House Education and Labor Committee and the full Senate included language in the passage of the Health Security Act that specifically covered medical foods when prescribed by a physician. Both actions were taken on a unanimous, bipartisan basis.

In the 104th Congress, Congresswoman Lynn Woolsey introduced H.R. 2009, along with Congresswoman Deborah Price and 28 cosponsors, including Congresswoman Morella. We thank you. A companion bill, S. 1881, has been introduced by Senator Mike DeWine.

And House bill 2009, without mandating any additional benefits, would amend FEHBP statute to specifically recognize medical foods and make it clear that medical foods may be provided to civilian employees and their families under Federal health plans when their physicians deem it medically appropriate.

Its passage reinforces two recent OPM call letters sent to program carriers. I quote from the March 1996 letter.

> We continue to encourage carriers to utilize their authority under the flexible options services option to identify and offer medically appropriate, cost-effective alternatives to traditional care whenever appropriate that is not exclusively for large case management and when the provision of services not otherwise covered by the carrier's existing benefit structures, such as medical foods or medical nutrition therapies in the treatment of AIDS or other diseases, is medically appropriate, cost-effective, and in the best interest of the patients.

We acknowledge the significance of the OPM letters; however, we do not believe that they alone will draw the attention of FEHBP carriers, who undoubtedly receive numerous OPM letters.

H.R. 2009 would bolster the visibility and credibility of medical foods in the eyes of FEHBP carriers. Unfortunately, medical foods are not currently provided to all patients who might benefit for a variety of reasons, including the still relatively low awareness among health providers and insurers about their contributions to quality, cost-effective care.

In closing, Mr. Chairman, H.R. 2009 is a step in the right direction. People covered by FEHBP will benefit, as will all of us who ultimately pay for the decisions made about health care. Not only will the 9 million civilian employees and their families be more likely to get the appropriate nutrition care, but the example set sends an important message to private carriers and insurers who look to FEHBP as a model.

Certainly, the Federal Government should bring the benefits of medical foods to the attention of health care providers, especially those who participate in Medicare and Medicaid programs, as well as FEHBP. I, therefore, urge the committee to give prompt approval to H.R. 2009 and would be happy to answer questions. Thank you.

[The prepared statement of Ms. Wellman follows:]

Statement of Nancy S. Wellman, Ph.D., R.D.
before the
Civil Service Subcommittee
Government Reform and Oversight Committee
U.S. House of Representatives
September 5, 1996

Chairman Mica, Congressman Moran, Members of the Committee, good morning.

I am Nancy Wellman, Director of the National Policy and Resource Center on Nutrition and Aging at Florida International University and Past President of the American Dietetic Association. I am also the chair of the Nutrition Screening Initiative -- a partnership of the American Academy of Family Physicians, the American Dietetic Association and the National Council on Aging dedicated to the incorporation of nutrition screening and interventions into this nation's health care delivery system.

I appreciate the opportunity to testify before you this morning in support of H.R. 2009. This legislation is intended to include the provision of medical foods as a specific item covered by the Federal Employees Health Benefits Program (FEHBP). Medical foods, administered as a component of medical nutrition therapy, are proven to contribute to positive health outcomes while saving health care dollars for people suffering from debilitating acute and chronic conditions. With the growing recognition among medical experts that health care should be about preventing costly problems and truly promoting health and quality of life, medical nutrition therapy and medical foods are seen as integral to the kind of health care our nation's citizens need and deserve.

Mr. Chairman, we know that health care, like all programs, has to be sensitive to the particular needs of an aging population and in particular, must address the nutrition-related health problems and the malnutrition prevalent not only among today's older Americans but among those of us getting closer to retirement and our golden years.

Nutritional status affects quality of life, illness and injury prevention, chronic disease management, healing, and, the costs associated with the treatment of disease, illness and injury. Malnourished people get more infections and diseases; their injuries take longer to heal; surgery on them is riskier; and their hospital stays are longer and more expensive than well-nourished patients. Malnourished patients take 40% longer to recover from an illness; have two to three times more complications; have hospital stays that are 90% longer and $5,000 more costly per medical patient and $10,000 more costly per surgical patient; and are readmitted to hospitals earlier and more frequently.

Older Americans now make up 13% of the population but consume 36% of health care resources. With 78 million baby boomers moving toward their senior years, these statistics cannot remain the status quo. The provision of medical nutrition therapy and medical foods to those people covered by the FEHBP is part of solving the problem of escalating health care costs.

A recent study commissioned by the Nutrition Screening Initiative and conducted by the Barents Group of Peat Marwick documents that medical foods, administered as a specialized component of medical nutrition therapy, could yield $1.3 billion in Medicare savings by the year 2002. Medical foods improve health outcomes and save health care dollars because patients receiving them have less medical complications, shorter hospital stays, fewer hospital readmissions,

improved wound healing, enhanced immune function, and faster, stronger recoveries from injury, illness and surgery. For example, the cost of treating a patient who has pancreas or liver surgery and doesn't receive medical foods is approximately $17,000 compared to $6,500 for a patient who receives medical foods.

The Barents Group has emphasized that the estimates of cost savings are conservative in their assumptions, since savings would most likely also occur for Medicare beneficiaries hospitalized for many other diagnoses as well as those treated in outpatient settings. The savings to Medicare alone could possibly be many times over the projected $1.3 billion.

Furthermore, if specialized nutrition therapy was used consistently when medically appropriate for Medicaid recipients and government workers covered under FEHBP, and the same percentage savings were assumed as for the Medicare population, the budget for Medicaid spending would be reduced by over $650 million over the period between 1996 and 2002, and federal outlays for FEHBP would be $250 million less over the same period.

Medical foods represent the most advanced development of nutrition science. Medical foods are specially formulated to assist in the management of specific chronic diseases and medical disorders such as diabetes, pulmonary diseases, renal diseases, AIDS and cancer as well as acute conditions such as a hip fracture, sepsis or pneumonia. For patients who are not able to eat, or whose metabolic state makes it difficult for them to meet their nutrient needs through food alone, the provision of medical foods is clinically efficacious and cost effective when used as a dietary supplement or as a primary therapy. Medical foods are administered orally or through feeding tubes, which makes them easy and relatively inexpensive to provide to patients in a variety of care settings, including the home.

Just recently, on April 26, 1996, the Presidential Advisory Council on HIV/AIDS adopted the following recommendation: "The Administration should issue an Executive Directive to the Director of Personnel Management to add medical foods to those medical expenses covered under the Federal Employees Health Benefits Program." This recommendation was inspired by the testimony of Mr. Ken Wolf, a delegate to the White House Conference on AIDS from the State of Florida. Additionally, Mr. Gordon Nary, President of the International Association of Physicians in AIDS Care, has stated that "Medical foods, as defined by Congress, and prescribed by physicians may significantly influence the containment of costs in the treatment of a variety of chronic and life-compromising diseases that affect millions of Americans including those with HIV/AIDS. Since the wasting syndrome is often associated with late stage HIV disease, proper use of medical foods in HIV/AIDS patients could prevent and often reverse this deadly medical complication."

The term "medical food" was first defined by the Congress as part of the Orphan Drug Amendments of 1988, Pub.L. 100-290 Sec.3(b)(2), 21 U.S.C. Sec.360ee(b)(3). "The term 'medical food' means a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." The same definition was then used by Congress as part of the Nutrition Labeling and Education Act of 1990. Pub.L. 101-535 Sec.2(a).

Mr. Chairman, I almost hesitate to mention any Congressional actions related to the ill-fated Health Security Act in 1994, however, since medical foods was one of the few issues of health care reform receiving bi-partisan support, I will. Both the House Education and Labor Committee and the full Senate included language in their passage of the Health Security Act that specifically covered medical foods when prescribed by a physician. Both actions were taken on a unanimous, bi-partisan basis.

In the 104th Congress, Congresswoman Lynn Woolsey (D-CA) introduced H.R. 2009 along with Congresswoman Deborah Pryce (R-OH) and 28 co-sponsors. A companion bill, S. 1882, has been introduced in the Senate, by Senator Mike DeWine (R-OH).

H.R. 2009, without mandating any additional benefits, would amend the FEHBP statute to specifically recognize medical foods and make it clear that medical foods may be provided to civilian employees and their families under federal health plans when their physicians deem it medically appropriate. Its passage reinforces two recent OPM "call letters" sent to program carriers. I quote from the March 1996 letter:

> We continue to encourage carriers to utilize their authority under the "Flexible Services Option," to identify and offer medically appropriate, cost effective alternatives to traditional care... whenever appropriate (that is, not exclusively for "large case management"), when the provision of services not otherwise covered by the carriers' existing benefit structure (such as medical foods and nutrition therapies in the treatment of AIDS and other diseases) is medically appropriate, cost effective, and in the best interests of the patient.

We acknowledge the significance of the OPM letters, however, we do not believe that they alone will draw the attention of FEHBP carriers who undoubtedly

receive numerous OPM letters.

H.R. 2009 would bolster the visibility and credibility of medical foods in the eyes of the FEHBP carriers. Unfortunately, medical foods are not currently provided to all patients who might benefit from their use for a variety of reasons, including the still relatively low awareness among health care providers and insurers about their value as contributing to quality, cost effective care.

Mr. Chairman, H.R. 2009 is a step in the right direction. People covered by FEHBP will benefit as will all of us who ultimately pay for the decisions made about health care. Not only will the nine million civilian employees and their families be more likely to get appropriate nutrition care but the example set sends an important message to private insurers who look to the FEHBP as a model. Certainly, the federal government should bring the benefits of medical foods to the attention of all health care providers, especially those who participate in the Medicare and Medicaid programs, as well as the FEHBP. I urge the Committee to give prompt approval to H.R. 2009.

Thank you.

Mr. MICA. Thank you for your testimony. Now I will recognize for 5 minutes Rev. C. Roy Woodruff. Dr. Woodruff is executive director of the American Association of Pastoral Counselors. Welcome, and you are recognized, sir.

Reverend WOODRUFF. Thank you very much, Mr. Chairman and members of the subcommittee. My name is Dr. Roy Woodruff and as executive director of the American Association of Pastoral Counselors, AAPC, we represent over 3,000 certified pastoral counselors and more than 100 accredited pastoral counseling centers in the United States.

Pastoral counselors are ministers or persons otherwise endorsed by a religious faith group who are also mental health professionals. Pastoral counselors have received specialized training in both religion and the behavioral sciences and practice the integrated discipline of pastoral counseling. AAPC pastoral counselors relate to more than 80 faith groups, including the full spectrum of Protestant, Catholic, and Jewish faiths.

I am here to urge that qualified pastoral counselors be included as direct reimbursement providers in the Federal Employee's Health Benefits Program.

There are a number of pastoral counseling centers in the greater Washington metropolitan area and it has come to our attention that a significant number of Federal Government employees who subscribe to the FEHB Program have requested the services of pastoral counselors, expressing a need for the spiritual dimension to be incorporated into their counseling and psychotherapy. Similarly, we have heard from pastoral counselors and centers around the country that FEHBP subscribers have requested the services of pastoral counselors but have been unable to receive them.

Now, this demand is not surprising since a recent Gallup poll indicated that 66 percent preferred a professional counselor who represented spiritual values and beliefs, and 81 percent preferred to have their own values and beliefs integrated into the counseling process. Unfortunately, pastoral counselors who are most qualified to do just this are not included as providers in this important program, while physicians, clinical psychologists, clinical social workers, and psychiatric nurses are.

In recent years, a strong trend has appeared which shows the ever-increasing need for the spiritual dimension among those being treated for mental and emotional illness and the efficacy of this treatment. Those in the mental health professions have recognized this need as they try to develop the religious dimensions in their own work. They are recognizing as never before the power of spiritual commitment creatively used in the healing process.

However, not being trained in this work imposes limitations in applying spiritual dimension to behavioral science. Pastoral counseling has now become a major provider of mental health services, accounting for over 3.5 million hours of treatment annually in both institutional and private settings, offering individual, group, marital, and family therapy.

AAPC-certified pastoral counselors have been recognized as qualified providers by CHAMPUS for over 20 years and have functioned with distinction in that Federal program. Pastoral counselors have recently been credentialed by a number of managed

care organizations to provide service to their subscribers. These include Value Behavioral Health and U.S. Behavioral Health.

At the request of a major managed behavioral health organization, AAPC sponsored an independent study comparing the educational and clinical training requirements of fellow level pastoral counselors and that of our respected mental health colleagues in clinical social work. The study clearly documents that pastoral counselors certified at the fellow level by the American Association of Pastoral Counselors receive more education, clinical training, and supervision than do licensed clinical social workers, who are providers under FEHBP.

Mr. Chairman, I respectfully request that a comparison study of the training of AAPC-certified fellow pastoral counselors and licensed clinical social workers be included in the record.

Mr. MICA. Without objection, so ordered.

[The information referred to follows:]

PURPOSE

Over the centuries, the role of the minister has included several important functions - preaching, teaching, administering sacraments, and being a care-giver to the people. Within the role of care-giver, the minister or pastor visits the sick and homebound, participates in church gatherings and counsels people who are in crises, going through personal or familial difficulties, or embarking on a new stage of life. Short-term, situational, and crisis pastoral counseling has always been an important part of the care-giving function of the minister or pastor. Personal, familial and social difficulties have been brought before religious leaders for guidance for as long as there have been religious leaders. With the development of the study of human behavior, society has gained additional resources to help with human problems and concerns. The mental health professions - psychiatry, psychology, and social work - have enabled many people to lead better, more productive lives. The field of mental health has developed to the point of becoming a whole new industry, and its dominance in the culture has drawn attention away from the resources that continue to be available through churches and church related organizations.

For both clergy and mental health professionals, the term "pastoral counseling" has often been and continues to be associated with short term work done by ministers in churches in dealing with death, marital, and family problems. The expertise of those ministers who have gone through the advanced psychological and theological training that began in the 1920's and has become increasingly available since the 40's and 50's has not been generally acknowledged by other mental health professionals either because the value of their contribution has not been recognized or it has been ignored.

During and after World War II, chaplains were confronted with psychological and theological trauma of overwhelming proportions. They went to their denominations and seminaries seeking and obtaining the training they needed to deal with massive human tragedy. Over the years after World War II, a small but growing number of ministers have been developing a high level of expertise in mastering and integrating the disciplines of psychology and theology.

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Human issues frequently touch both psychological and spiritual dynamics in people in a way that is often inseparable - what people believe affects them psychologically, and how people feel psychologically affects their beliefs. Many people who have insurance are wanting to go to professionals trained in both disciplines, psychology and theology, to address the needs of their whole personhood, but they are prevented from doing so because of insufficient insurance coverage in this area.

Part of the problem seems to be rooted in the lack of understanding of the nature and extent of training that is required of present day AAPC accredited pastoral counselors. Whereas the titles of psychiatrist, psychologist, and social worker are associated with people who have advanced training in those fields, the title of pastoral counselor covers both the minister in his or her care-giving role in the church, and the person who has gone through extensive, additional, specialized training to learn and integrate the psychological and theological disciplines. The public, and the legislatures and insurance companies that serve the public, need to be aware of the difference between the traditional short-term counseling done by ministers in churches and the highly-skilled short and long-term therapy done by Pastoral Counselors who have achieved a high level of competence and passed through a stringent, multi-layered, evaluation process to be admitted as a Fellow in AAPC.

Another part of the problem is a result of the negative attitude toward religion, partially originating from Freud, that still influences the mental health profession by ignoring, discounting, or perceiving as unhealthy any venturing into spiritual issues. Recently, this negative perception has been shifting, as seen in a recent issue of The Family Therapy Networker (1990, Sept./Oct.) devoted to "Psychotherapy and Spirituality". In introducing the subject of spirituality in the magazine, the editor, Richard Simon, Ph.D., is suggesting, "that the rigid divorce between spirituality and psychotherapy may no longer be necessary, that the two are more compatible than we once thought," (p. 2). Ironically, pastoral counselors have been working to integrate psychology with spirituality for over half a century, and psychology is just beginning to recognize the value of the spiritual in the healing process.

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BACKGROUND AND HISTORY

In looking at the qualifications of pastoral counselors in relation to other professionals trained in the mental health field, it is first necessary to define what is meant by "pastoral counselor". Throughout history, pastoral counseling has been an integral part of the ministry and has traditionally included crises counseling, assessment and referral, and counseling in relation to functions in the domain of the church, such as weddings, baptisms, and funerals. Understanding and addressing the faith or spiritual issues has always been an integral part of the responsibility of the pastoral counselor.

Interdisciplinary training for ministers has a long history. In 1925, Charles Menninger and his sons, Karl and William, established the Menninger Clinic, now one of the world's leading psychiatric centers. Menninger was a pioneer in the integration of the psychological and theological disciplines because he believed in the inseparable nature of psychological and spiritual health.

In the 1930's awareness of the importance of integrating religion and the developing knowledge of psychology led to the collaboration of Norman Vincent Peale, a well-known minister, and Smiley Blanton, a psychiatrist, in forming the American Foundation for Religion and Psychiatry in New York City, (now known as the Institutes of Religion and Health). The purpose of the Foundation was and is to train ordained ministers in the theory and practice of psychotherapy and to relate these two disciplines to the therapeutic process.

After World War II, returning chaplains, confronted by the enormous depth of human pain caused by the war and its aftermath, went to their denominations and seminaries seeking and receiving the further training which they felt necessary to deal with these critical issues. In the late 40's and in the 50's seminary professors in Practical and Pastoral Theology responded by developing classroom courses and clinical programs that would train ministers to provide more long-term treatment with psychological knowledge integrated with concern for spiritual issues. Over the years these seminaries and clinical programs have grown in size and in their level of

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professional competence in training ministers to do in-depth theological and psychological counseling.

In 1963 seminary professors all over the nation, such as Howard Clinebell in Claremont, California; Seward Hiltner at Univerity of Chicago, and Princeton, New Jersey; and Paul Johnson in Massachusetts; Wayne Oates in Louisville, Kentucky; William Oglesby in Union Theological Seminary in Richmond, Virginia; Carol Wise at Garrett Evangelical Seminary in Evanston, Illinois; and others, along with a professional organization called Psycholanalytic Counselors, including faculty and graduates of the American Foundation for Religion and Psychiatry plus other professionals, started the American Association of Pastoral Counselors. What began then with less than 200 members, is now an internationally recognized accrediting organization with over 3000 members representing all 50 states and a number of foreign countries. AAPC sets theoretical, clinical, and ethical standards for pastoral counselors, pastoral counseling centers and training programs.

The purpose of AAPC is to promote: the ministry of pastoral counseling; the competence of pastoral counselors; the exploration, clarification and guidance of human life, both individual and corporate, at experiential and behavioral levels through a theological perspective; the relationships with ecclesiatical groups; interprofessional relationships, and increased understanding of the ministry of pastoral counseling (AAPC, 1990, pp. 1-2).

As the field of pastoral counseling developed, more ministers began earning advanced degrees, Ph.D., Th.D., (teaching degrees), S.T.D., and D.Min., (clinical degrees) and becoming interested in long term treatment that related psychological and spiritual issues. Numerous accredited AAPC training programs originially started in the 1940's and 50's continued to develop to meet this need, with rigorous courses and clinical exposure, such as found at the Virginia Institute of Pastoral Care in Richmond, and the Institutes of Religion and Health (now the Blanton-Peale Graduate Istitute) in New York City. At the same time Th.D and Ph.D programs developed in such seminaries as the University of Chicago Divinity School; Princeton Theological Seminary, Princeton, N.J.; Graduate Theological Union, Berkeley, Calif.; Emery Candler School of Religion, Atlanta, Georgia; and Louisville Southern Baptist Seminary, Louisville, Kentucky. The curricula stressed coursework in theology,

personality theory, and crises intervention, along with clinical experience in pastoral counseling centers working under close supervision with various supervisors.

In the last two to three decades these programs which were designed to serve the churches, seminaries and communities, have expanded to provide a place where people can come and relate faith/spiritual issues to the crises of life and understanding of human nature. These centers became associated with AAPC because of AAPC's consistent high standards of professionalism in this vital area that involved not only short term (6 to 10 sessions), but also long term (11 to 50 or more sessions) counseling.

The original intent of AAPC was to provide a standardized credentialling process for ordained ministers who are in good standing and have met all the criteria established by their respective faith groups, and for endorsed people from faith groups that "endorse" rather than ordain - such as Catholic sisters who cannot become priests. The people applying for admittance into AAPC, therefore, have already gone through several levels of evaluation and approval within their faith group. AAPC is organized to build upon the bases established by the major denominations, adding requirements beyond what is already demanded by the churches, so that each person in AAPC has both the broad general background required by his or her faith group, usually three years of study beyond college, and the additional specialized training required by AAPC.

A member of AAPC at any level is accountable to both his or her church leadership and to AAPC. Nationally, AAPC is divided into 10 regions to allow for closer monitoring and support of its members. Within AAPC, achieving a level of expertise that allows a person to work without direct supervision does not mean that the person has arrived and can work consistently and effectively in isolation. AAPC emphasizes to its members the importance of continuing connections with collegues and faith groups as a way to prevent personal or professional short-comings from negatively influencing the therapy. A variety of committees are designed to maintain AAPC standards in each region. For example, the Membership Committee is responsible for evaluating the competence of potential members and of people advancing within the organization; Ethics Committee is responsible for dealing with any ethical issues or problems; Theological and Social Concerns reviews and

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challenges underlying social assumptions; and Centers and Training works to build and improve services to clients and training of professionals. Regional committees have their counterpart at the national level. Problems and concerns addressed in the regional committees are also examined, supported, or censored at the national level.

In addition, the organization has several levels of membership - Pastoral Affiliate (Ordained pastor or religious leader), Pastoral Counselor-in-Training (training to become a certified pastoral counselor), Member (supervised pastoral counselor), Fellow (certified pastoral counselor), and Diplomate (pastoral counselor supervisor). An additional professional category is the Professional Affiliate which includes people who are in other professional disciplines, such as psychology and psychiatry, who identify with the need to integrate psychology and theology, and who add to the organization from their perspectives.

STATEMENT OF PROBLEM

The problem for the public, for people seeking help and for those working in insurance companies and in the legislative area, is that there is little consistency in the nation in determining which person and which profession has proven competent to help heal people's internal distress and destructive behaviors. There is a great disparity and diversity in who is qualified to be licensed in the care of people across the U.S. Each state decides who will be licensed and what the requirements for their license will be. There is little continuity from state to state. The prevalence of the medical model has meant automatic acceptance of medical doctors, psychiatrists; and in the field of psychology, Ph.D.'s in clinical psychology, and licensed social workers. While these professionals may be well-grounded in psychology, there is little evidence of any training for them in issues related either to a person's faith or spirituality, or to how faith issues may be an essential part of the healing process. In fact, many of these professionals have been taught a negative attitude toward faith issues, in accordance with Freud's work.

These groups are, however, recognized as professionals and regularly given third party payments from insurance companies without much question. Yet even within these groups, states differ as to how much training a person needs in order to be labeled a competent care-giver. Some groups are required to obtain a license, and some are allowed to practice based on the approval of their profession. Beyond that, some groups are monitored by the state through requirements for continuing education, some by a professional organization, usually in a disciplinary fashion, and some by both.

One profession, social workers, are frequently not monitored or supervised at all once they have received a license, if a license in their state is necessary. Instead, there is an expectation that the social worker will be skilled enough to be self-monitoring. A master's degree in social work is supposed to train students in "advanced analytic and practice skills sufficient for self-critical, accountable, and ultimately autonomous practice" (Council on Social Work Education, 1991, p. 31). In stark contrast, AAPC assumes that people do have "blind spots" or counter-transferential issues which by their nature are not recognized by that person but need to be pointed out by someone else; and, therefore, AAPC does not endorse

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the isolation of its members, and enforces the necessity for members to be supervised and to have peer group evaluations.

People seeking help and relying on the assistance given by their insurance coverage are directed toward professionals recognized as such by their insurance company. Frequently, people's life crises also involve a crises of faith, and often their life crises stem from spiritual issues. For those people, it becomes a necessity to address that area of their struggle, but the professional resources they are directed to utilize are either trained not to deal with faith and spiritual issues or are trained to perceive such issues in a negative way. These people would be better helped by working with a qualified pastoral counselor, but the insurance companies are not equipped with the information they need to determine if the care offered by pastoral counselors is commensurate with that of the other professional groups they endorse. Since pastoral counseling is part of the care-giving role of the minister, it is imperative that a distinction be made between that level of pastoral counseling and the AAPC accredited pastoral counseling specialist who has received the advanced training that puts him or her on an equal or higher level of expertise than other licensed mental health workers, such as licensed social workers.

In comparing the profession of pastoral counseling to other mental health professions, the first task is to determine what level of pastoral counseling skill is being assessed and against which of the other mental health professionals is it being compared. In AAPC the level of Fellow, which requires a minimum of four years of academic work, 1625 hours of supervised work, with 250 hours of direct supervision, is the first level of membership that is recognized as competent to function without continuing direct supervision. Pastoral counselors at the Fellow level of AAPC are, in effect, certified by the Association as professional pastoral counselors. All Fellows in AAPC have either an additional master's degree beyond their M.Div., or a doctoral degree. The mental health profession that most closely resembles this level of education and training is that of clinical social workers. To be a clinical social worker requires a two-year masters' degree, and a varying amount of additional experience, but does not require a doctoral degree. With this differentiation in mind, the question arises, does a Pastoral Counselor at the level of Fellow in AAPC have theoretical and clinical training in counseling comparable to a person who is eligible for licensure as a clinical social worker?

HYPOTHESIS

Hypothesis:

It is hypothesized that the academic and clinical education and training for Fellow of AAPC is more than the education and training required for LCSW licensure.

OPERATIONAL DEFINITIONS:

Pastoral Counselor - A minister or endorsed religious person who has received specialized training in integrating religious resources and insights from the behavioral sciences, and who practices pastoral counseling at an advanced level as an AAPC Fellow or Diplomate.

Pastoral Counseling - "A process in which a pastoral counselor utilizes insights and principles derived from the disciplines of theology and the behavioral sciences in working with individuals, couples, families, groups, and social systems toward the achievement of wholeness and health." (AAPC Directory, 1991, p. iv)

Minister - "A person who has been authorized by a denomination or faith group through ordination, consecration, or equivalent means, to exercise specific religious leadership and service within and on behalf of the denomination or faith group which furthers its purpose and mission and which differs from the religious service of the laity of the denomination or faith group." (AAPC Dir., 1991, p. iv).

Member (AAPC) - "Includes ministers who can: Demonstrate competence to do limited brief or supportive pastoral counseling independently, or to do in-depth pastoral counseling under direct supervision; and integrate counseling insights into the total pastoral function." (AAPC Dir., 1991, p. iv).

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Fellow (AAPC) - "Includes pastoral counselors who can: Demonstrate ability to work as a pastoral counselor at an advanced level of competency; provide leadership in interpreting the theological dimensions of human wholeness, in utilizing the mental health resources of the congregation and community, and in interpreting the place of pastoral counseling to the other psychotherapeutic disciplines. They may be in training as supervisors and do supervision of those in pastoral counseling while being supervised themselves in that process." (AAPC Dir., 1991, p. iv). A person at Fellow level is competent, effective, and safe in working with all types of life circumstances.

Diplomate (AAPC) - "Includes pastoral counselors who can: Demonstrate ability to work as a pastoral counselor, and as a supervisor of ministers and pastoral counselors-in-training, at an advanced level of competency; teach and supervise persons for the pastoral ministry and/or pastoral counseling congregations, or in pastoral counseling centers, or in appropriate schools; and demonstrate ability to conceptualize the relationship of the psychotherapeutic disciplines to the theological interpretation and guidance of life and the communication of this understanding to others." (AAPC Dir., 1991, p. iv)

Pastoral Counselor-in-Training - Includes persons who are actively engaged in the process of completing initial requirements for membership in AAPC. (AAPC Dir., 1991, p. iv).

Social Worker - A person who has completed a master's degree in social work and fulfilled any additional requirements necessary in his or her state to practice clinical social work independently - an LCSW, Licensed Clinical Social Worker.

Supervised work - Clinical work done with a supervisor on the premises. The supervisor may monitor work being done through observation, individual or group supervision, or review of work submitted by the student.

Supervision - The direct one-on-one review and evaluation of a student's work by a supervisor, examining psychological dynamics, diagnosis, therapeutic relationship, and treatment plans. In addition, pastoral counselors also receive supervision on faith or spiritual issues involved in the therapy.

METHOD

Method:

A modified form of content-analysis is used, which examines the fundamental documents of each discipline outlining standards of training for AAPC and for social work. For AAPC, the documents examined are the American Association of Pastoral Counselors [AAPC] Handbook (1990), and the Centers and Training Committee Site Visitor's Manual (AAPC, 1991). For social work, the documents examined are Handbook of Accreditation Standards and Procedures put out by the Council on Social Work Education [CSWE] in 1991, and the 1991 Reciprocity and Endorsement Summary, compiled by the American Association of State Social Work Boards [AASSWB].

Procedures:

1. Read documents provided by AAPC and by the graduate social work departments of San Francisco State University and San Jose State University, and by the American Association of State Social Work Boards.
2. Go through documents looking for similarities and differences in purpose, amount and nature of academic training, amount and nature of clinical experience, and procedures to certify competence.
3. Outline each profession in terms of purpose, academic training, clinical experience, and certification or licensing requirements.
4. Compare:
   a. Number of degrees needed to achieve level of certified competence.
   b. Number of years required to achieve competence.
   c. Amount of supervised work required to achieve competence.
   d. Amount of individual supervision required to achieve competence.
   e. Amount of monitoring, after, certification, done by each profession.
5. Compare and contrast the two professions of social work and pastoral counseling based on items examined in #4.
6. Draw conclusions on relative education, training, and monitoring in each profession.

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Requirements for certification at Fellow level in AAPC are compared to requirements for licensure for MSWs. Clinical requirements are compared, specifically hours of clinical supervised experience and supervision required by each profession. Academic requirements past the bachelor's degree are also compared.

Clinical requirements are compared using the AAPC Membership ByLaws for potential AAPC Fellows found in the Handbook (AAPC, 1990), and for MSW's, the Handbook for Accreditation Standards and Procedures (CSWE, 1991), and the cooperative state requirements for LCSW applicants found in the Reciprocity and Endorsement Summary (AASSWB, 1991). The documents used serve each profession as general guidelines. The AAPC documents are the standard documents for the entire organization. The social work documents were very difficult to locate and it is possible that there are other policy documents for the profession of social work that state underlying standards more specifically. If such documents do exist, their existence was not known in the university graduate departments of social work at San Francisco State University and at San Jose State University. Also, the social work policy documents that were examined stated that they were purposely general and believed in letting each school of social work decide how to make the guidelines specific, "In keeping with the tradition of academic freedom, the philosophy, objectives, and organization of the social work curriculum are left to the discretion of the individual program" (CSWE, p. 105). Each school of social work builds on the general standards given, adding to them to achieve the goals of their individual program.

RESULTS

In comparing the educational and clinical training of pastoral counselors at the Fellow level in AAPC (level of certified competence) and that of social workers, the documents outlining the standards of the two professions were examined, noting both similarities and differences.

Standards for Individual Membership - AAPC

People desiring to become members of AAPC are evaluated personally and professionally. All evaluations include transcripts, written materials summarizing psychological and theological theoretical positions, and analysis of clinical audio and/or video tapes submitted for assessment by the Membership Committee.

"Evaluation of readiness for individual membership in AAPC is made based upon two kinds of judgments. The first depends upon formal and technical requirements and can be demonstrated by academic degrees, hours of supervision, experience, supervisory evaluations, etc. The second is based upon the evaluations of one's professional peers joined in a committee interview and involves assessment and affirmation of professional competence not measurable by formal requirements," (AAPC, 1990, p. 31). The second area also includes evaluation of actual counseling tapes and written analysis of clinical work.

Applicants for AAPC membership at all levels go through regional membership committees and must submit tapes and written evaluations of their work, supervisory evaluation, and transcripts from their programs. They are expected to have and are asked about their own personal therapy. They are also expected to complete at least one unit (10-12 weeks full-time) of Clinical Pastoral Education (CPE), working in a hospital or mental health facility. Evaluations by CPE supervisors offer significant observations on the potential member's therapeutic effectiveness with clients and on the health of his or her interactions with collegues.

At the regional level, prospective members seeking certification sit for 1 1/2 hours with one or two actual counseling tapes and are listened to and evaluated by the Regional Membership Committee. At Fellow level the theoretical and clinical

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evaluation lasts for 2 hours. Diplomates are reviewed by the regional committee for approximately 2 hours and then are again reviewed for the same amount of time by the Association Membership Committee which makes the final decision on granting that level of membership. There are many levels of checks and balances. For the protection of the pastoral counselor and those being counseled, lists of all prospective members are published and sent out to the whole membership so that any objection known by anybody in the nation can be aired. This procedure prevents people from changing regions to escape wrong-doing of any kind, such as insurance problems, or sexual acting out.

In assessing the educational background of a prospective member, AAPC standards consider training in the following areas important for the achievement of educational objectives:

1. Theories of Personality and Personality Development.
2. Interpersonal Relations
3. Marriage and Family Dynamics
4. Group dynamics
5. Personality and Culture
6. Psychopathology
7. The Psychology of Religious Experience
8. Theories of Counseling and Psychotherapy
9. Theories of the Pastoral Office, including the History and Theory of Pastoral Care.
10. Research Methods in the behavioral sciences and theology.
11. Orientation to the Helping Professions. (AAPC, 1990, pp. 31-32)

In addition, AAPC requires a specified number of hours of clinical work under supervision for entry at the Member level of the organization:

1. Thirty hours of individual supervision with the same supervisor and counselee, an approved Fellow or Diplomate in AAPC.
2. Thirty hours of supervision with another supervisor and variety of counselees.
3. Thirty-five hours of continuous group case supervision.

4. Thirty hours in clinical case conference, usually interdisciplinarian, including one or more members from the professions of psychiatry, psychology, or psychiatric social work.

The intent in setting up these guidelines is to insure that potential AAPC members have both breadth and depth in their supervision, and that they are exposed to a variety of clinical experiences and professional perspectives.

There are also requirements for personal therapeutic experience. "For membership one shall have undergone sufficient psychic therapeutic investigation of one's own intrapsychic processes so that one is able to protect the counselee from one's own problems and to deploy oneself to the maximum benefit of the counselee," (AAPC, 1990, p. 32). AAPC assumes that all people view reality through the lens of their own experience, and that it is essential for the professional counselor to be able to identify and monitor his or her own beliefs and emotional states and separate them from the client so that accurate assessment and treatment of the client can be achieved.

In the assessment of professional competence, "All candidates have their qualifications reviewed in a personal interview with the Membership Committee which evaluates:

1. Personal identity and interpersonal competence.
2. Academic and theoretical competence.
3. Pastoral identity.
4. Therapeutic competence.
5. Ethical commitment." (AAPC, 1990, p. 33)

Member level in AAPC is, however, seen as a temporary step on the way to Fellow level, at which point the person achieves acknowledgement of competence adequate to work without constant direct supervision.

To qualify for membership at the Fellow level in AAPC, an applicant must:

1. Hold a baccalaureate degree from an accredited college.

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2. Hold a Masters of Divinity degree from a school of theology accrdited by the Association of Theological Schools or its equivalent.
3. Hold an advanced degree (M.A., S.T.M, D.Min, etc.) in pastoral counseling or its equivalent, which requires one year of academic work beyond the first professional degree.
4. Hold membership in good standing in a recognized religious endorsing body which certifies the applicant as a minister as defined by the Association.
5. Hold a continuing responsible relationship in one's local religious community.
6. Give evidence of satisfactory completion of one unit of Clinical Pastoral Education in an accredited center or its equivalent.
7. Give evidence of three years as a minister, demonstrating growing maturity in one's identity and roles as a professional religious leader.
8. Have done at least 1375 hours of counseling and 250 hours of interdisciplinary supervision (total 1625 hours) from professionals such as psychiatrists, psychologists, and psychiatric social workers.
9. Give evidence of having recieved at least one-third of one's required pastoral counseling training, both academic and supervision, with an Institutional Member of the Association approved as a Center for Training in Pastoral Counseling or in an academic program related to an approved Center for Training in Pastoral Counseling.
10. Give evidence of having undergone sufficient theological and psychotherapeutic investigation of one's own intrapsychic and interpersonal processes so that one is able to protect the counselee from the pastoral couselor's problems and to deploy oneself to the maximum benefit of the counselee.
11. Give evidence of:
    a. an understanding of the counseling and psychotherapeutic process,
    b. an ability to develop a counseling or psychotherapeutic relationship,
    c. an ability to perform a leadership role in the context of the religious community
    d. an ability to integrate one's professional role and personal identity;
    e. be elected to membership and certified as a Fellow by the Regional Membership Committee. (AAPC, 1990, pp. 7-9)

The person who achieves Fellow level in AAPC has, therefore, undergone extensive theoretical, clinical, and intrapsychic training, guided by others who have

either achieved Fellow or Diplomate level in AAPC and assisted by those who have achieved an advanced level of competency in another mental health profession such as psychiatry or psychology. The result is a professional who has integrated the fields of psychology and theology, has addressed and come to grips with his or her own psychological and theological character and attributes, and has learned the skills necessary to intervene in a client's troubled system in a psychologically and spiritually health-producing manner.

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Standards for Clinical Social Workers

"The fundamental objectives of social work concern are the relationships between individuals and individuals and social institutions. Historically, social work has contributed to the development of these relationships in such a way as to promote social and economic justice and protect the opportunities for people to live with dignity and freedom." (CSWE, 1991, p. 108).

Professional practice of social work "focuses on the transctions between people and their environments that affect their ability to accomplish life tasks, alleviate distress, and realize individual and collective aspirations. Within this general scope of concern, social work, as it is practiced in a wide range of settings, has four related purposes:

1. "The promotion, restoration, maintenance, or enhancement of the functioning of individuals, families, households, social groups, organizations, and communities by helping them to prevent distress and utilize resources. These resources may be found in people's intrapersonal or interpersonal capacities or abilities and in social services, institutions, and other opportunities available in the environment."
2. "The planning, development, and implementation of the social policies, services and programs required to meet basic needs and support the development of capacities and abilities."
3. "The pursuit of such policies, services, and programs through legislative advocacy, lobbying, and other forms of social and political action, including providing expert testimony, particpation in local and national coalitions and gaining public office."
4. "The development and testing of professional knowledge and skills related to these purposes." (CSWE, p. 107).

Professional Context:

"Social work is a self-regulating profession with sanction from public and voluntary auspices. Through all its roles and functions and multiple settings, social work is based on knowledge and guided by professional values and ethics. With its central focus on the transactions between people and their environments, social work uses research and theory from social, behavioral, and biological sciences as well as

from social work practice itself, developing a unique perspective on the human condition." (CSWE, p. 107)

"Social workers are responsibile for their own ethical conduct, for the quality of their practice, and for maintaining continuous growth in the knowledge and skills of their profession." (CSWE, p. 108)

The social work profession trains and sends people out into the public realm with no structure set up to monitor them after they have graduated and, if necessary, been credentialled or licensed. There is an enormous trust put in the individual's desire and ability to monitor him or herself and seek help when appropriate. The social work field does not seem to recognize the human being's ability to be blind to his or her shortcomings.

Advance Social Work Curriculum - Master's Program:

The master's program in social work is built on a liberal arts perspective and must include the professional foundation and one or more concentrations. "Students who graduate from MSW programs are to have advanced analytic and practical skills sufficient for self-critical, accountable, and utlimately autonomous practice." (CSWE, p. 110)

There are five professional foundation areas to be covered in every masters of social work program:

1. Human behavior and the social environment. Includes knowledge of individuals development and membership in families, groups, organizations, and communities; and knowledge of the relationships among human biological, social, psychological, and cultural systems as they effect and are affected by human behavior.

2. Social welfare policy and services. Includes analysis and developement of social welfare policies and services, and of the political process as a means to further the achievement of social work goals and purposes. (CSWE, p. 112)

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3. Social work practice. Includes theory, research - exploration and data gathering, differential assessement and planning, intervention, and evaluation relevent to social work practice.

4. Research. Includes scientific thinking and systematic approaches to acquisition of knowledge, quantitative and qualitative, preparing student to evaluate their own practice systematically.

5. Field Practicum. Includes "supervised direct service activities, providing practical experience in the application of the theory and skills acquired in all foundation areas. The objectve of the practicum is to produce a professionally reflective, self-evaluating, knowledgeable, and developing social worker." (CSWE, p. 113). Individual programs are organized differently. Each program establishes standards for the field practicum consistent with the purposes of the professional foundation curriculum. At the masters level, each student should have a minimum of 900 hours of field practicum experience.

In addition to the basic foundation areas, each masters program offers areas of concentration, and each student must choose at least one area of concentration. "A concentration should involve the student in the application of the professional foundation content to the specialized focus of concentration." (CSWE, p. 114) Possible frameworks for concentration include:

I. Fields of practice: Service to families, children and youth; services to the elderly; health; mental health; developmental disabilities; education; business & industry; neighborhood and community development; the justice system; and income assistence and employment.

2. Population groups: Children, youth, middle-aged adults, the aged, women, men, families, ethnic populations, groups defined by income levels, migrants.

3. Problem areas: Crime and delinquency, substance abuse, developmental disabilities, illness, family violence, neighborhood deterioration, poverty, racism, sexism.

4. Practice roles and Intervention Modes: Practice with individuals, families and groups, consultation, training, community organization, social planning, program planning and development, administration, policy formulation, implimentation and analysis, and research.

The field of social work, then, is extremely broad in its scope. Social workers can be specialized to be organizational leaders or individual counselors. It would stand to reason that the guidelines for social workers are not specific because they must encompass so much diversity.

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COMPARISON CHART

AAPC Fellow Pastoral Counselor	LCSW
Length of Programs	
Three-year M.Div., plus an addition professional degree (M.A., D.Min., Ph.D., etc.)	Two year master's degree. Average 2.4 yrs. additional experience for license
Common Educational Background (Neither discipline specifies hours or credit units)	
Theories of personality development	Human behavior, individual development
Interpersonal relations Marriage & Family Dynamics Group Dynamics Personality & Culture	Membership in families, groups, organizations and communities; biological, social, psychological, & cultural systems.
Research Methods	Research
Clinical Work under Supervision	Field Practicum
Beginning Specialization in Each Field	
Theories of the Pastoral Office History & Theory of Pastoral Care	Social Welfare Policies
Theories of Counseling and Psychotherpay	Social Work Practice, theory, research, planning & intervention
Study Not Directly Comparable	
Psychopathology Psychology of Religious Experience Orientation to Helping Professions	Areas of concentration: (student picks at least one) field of practice, population group, problem areas, practice roles & intervention modes
Nature and Extent of Clinical Experience	
Fellow level AAPC minimum: 1625 hours supervised experience including 250 hours direct supervision	Field practicum minimum: 900 hours superivsed experience Licensing beyond degree: requirements vary according to state

After the training, graduates in both pastoral counseling and social work face the next step of seeking admittance to the professional level in their field, attaining Fellow level in AAPC or being licensed as an LCSW. For pastoral counselors, the requirements for their next step are clear and consistent nationwide. For those MSW's seeking licensing in various states, the only thing the states hold in common is the need for the graduate degree and clinical experience. There is a great disparity from state to state in how and when experience is to be obtained and how it is to be supervised.

States list their requirements for social workers in varying ways, some in terms of years, some in terms of hours, and some include both year and hour requirements. Many states require that a certain proportion of the experience take place after the degree program has been completed, while some do not make that specification. In addition, supervision requirements vary and are stated in years, hours, hours per week, years or hours of direct supervision or supervised experience.

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SUMMARY OF STATE REQUIREMENTS - LCSW's

KEY:

Yrs. - Years of experience required.
Hrs. - Hours of experience required.
Post-M - Years or percentage of experience required to be post-masters.
S-Yr. - Years of supervised work experience required.
S-Hr. - Hours of supervised work experiece required.
DS-Hr. Hours of direct supervision required.

STATE	Yrs.	Hrs.	Post-M.	S-Yr.	S.Hr.	DS-Hr.
Alabama	3		2	3		
Arizona			2	1		
Arkansas	3		2	3		
California	2	3000				1/wk
Colorado			2	2		
Delaware	3		2	3		
Florida	3		2	2		
Georgia			4	1		
Idaho					1000	
Kansas			3	3		
Louisiana		3000	2			
Maine			2		+2000	
Maryland			2	3		
Massachusetts			2		100	50
Michigan			2	2		
Mississippi			1	2		
Missouri			1	2		
Montana			50%		2000	
Nebraska			3			
North Carolina			2	2		
North Dakota				2		
Ohio			2	3		
Oklahoma			3		3000	
Oregon			3			
Rhode Island		2000	2		100	
South Carolina			2			150
South Dakota			50%		1800	
Tennessee			2			
Texas	2				or 2000	
Vermont			2			100
Virginia			2	2	4000	200
Washington			2			100
West Virginia			1	2		
Wyoming		3000	100%			100

An examination of these requirements for the 30 states for licensure as an LCSW reveals the following averages:

Total years of clinical experience required - 2.4.

Total hours of clinical experience required - 2,333

Amount of total years of clinical experience required to be post-masters degree - 2.12

Amount of total hours of clinical experience required to be post-masters degree - 1,975

Amount of years of supervised work - 2.33

Amount of hours of supervised work - 1,483

Amount of hours of supervision - 112.5

In addition to the degree and clinical experience, states offer a variety of standardized tests, and some also require an oral exam. Again, each state sets its own standard. After a person has been granted a license or certificate, some states will require mandatory regulation, in the form of required continuing education, and some have voluntary regulation; some states also require continuing education, some do not.

AAPC has standardized procedures to review both theoretical and clinical competence of all applicants. Once people are accepted at any certified level in AAPC, the Association requires that they be continually accountable to their faith group and to AAPC.

CONCLUSIONS

In comparing the training for LCSW's and pastoral counselors who have attained AAPC Fellow level, an LCSW needs to complete a masters degree in social work which consists of two years of academic work while an AAPC Fellow needs to complete an M.Div. which takes three years of academic work plus an additional degree or equivalent beyond the M.Div. which takes another year or more. There is a similarity in the core psychological curricula for pastoral counselors and social workers. However, Pastoral Counselors study theology in addition to and interrelated with the study of psychology, so they are trained in two disciplines instead of one.

To become a licensed social worker, a person needs to meet additional requirements for experience, which vary widely from state to state. AAPC requirements are nationally consistent. To become a Fellow of AAPC, a person has to have the additional year of study in counseling past their M.Div. degree, plus 1,625 hours of supervised work, which includes 250 hours of direct supervision. It is possible, but difficult, to complete AAPC Fellow requirements within four years. If a person could complete the requirements in four years of study, including clinical work, then becoming an AAPC Fellow would be roughly equivalent in time to the two years of academic and average of two years of clinical work required for the LCSW - such a process would be like comparing minimal standards (AAPC) and average standards (LCSW).

The academic training for pastoral counselors who attain Fellow level in AAPC, (mimimal of a year past the master's degree), is greater than that required to become a licensed social worker in all the surveyed states (none surveyed required more than the masters degree).

Clinically, comparing AAPC standards with those of the surveyed states for MSW's is a little more complex due to the diverse ways in which clinical experience is assessed by the states. AAPC's requirements are stated in terms of hours of supervised work and hours of direct supervision. In these areas, AAPC with 1375 hours of supervised work, comes out slighlty below the average of 1483 hours for LCSW's in the states surveyed. However, many of the states do not specify how

many hours for LCSW's are to be spent in direct supervision. AAPC Fellows add to the 1375 hours of supervised work the hours required in the area of direct supervision. The sum of the hours of supervised work and direct supervision for AAPC Fellows is 1625 hours, well above the average hours required for LCSW's. The requirement of 250 hours of supervision for application to Fellow level in AAPC is 50 hours over the highest requirement in the 30 states that were surveyed, and 137.5 hours over the average of those states. Fellows in AAPC have far more hours of personal one-on-one supervision than do social workers in any of the states surveyed (AASSWB, 1991).

It is possible in some states for a person with a graduate degree in social work to be licensed with as little as 1000 hours of supervision (pre- or post-degree not specified) ie., Idaho; or 2 years of supervision (pre- or post-masters not specified), ie., North Dakota. In contrast, some states require substantially more, such as California which requires 2 years (3000 hours) of experience with 1 hour of direct supervision per week; or Georgia which requires 4 years post-master's with 1 year supervised experience.

There is no such discrepancy in AAPC. AAPC is nationally consistent. There is continuity across the nation, levels and requirements for membership are the same regardless of states.

Another major difference between social work and pastoral counseling professions is that social work training is set up to produce self-regulating, autonomous professionals, while pastoral counseling training prohibits professional isolation. Again, there are discrepancies among the states regarding mandatory or voluntary regulation of title or practice and requirements for continuing education for social workers. There is no such discrepancy in AAPC. All members of AAPC at all levels are required to be accountable to AAPC and to their individual faith groups. In order to continue as a member of AAPC, a person needs to: maintain an active pastoral counseling practice, participate in a responsible program of professional education and development, and maintain appropriate supervisory and consultative relationships; maintain a responsible and mutually accountable relationship to his or her denomination or faith group; and participate in a local congregation or religious community. (AAPC, 1990, p. 14)

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A series of checks and balances exists throughout the entire organization of AAPC. There are also checks and balances within the faith groups in addition to those within AAPC. In some faith groups, such as in the Presbyterian Church, an ordained person who moves to a new job in the church has to sign a form stating that he or she has not been involved in any sexual acting out, and the person is asked to sign a release to allow the church to check his or her history. In AAPC regions, people are also asked if they have been involved in any acting out. The concern of the church and AAPC is for the protection and effective care for the people coming for help and for the caregiver.

A third major difference between the licensing of social workers and the acceptance of pastoral counselors to Fellow level in AAPC is the inclusion in the assessment of competence of actual tapes of the counselor's work. Both professions have procedures to assess theoretical understanding and competence, and some states do require oral or situational testing as part of the LCSW licensing process. However, AAPC requires the examination of actual counseling tapes by a committee to ascertain if theoretical understanding has been integrated with practical application.

The nature and intensity of supervision required of a person preparing for Fellow level in AAPC is substantially higher then that required for licensure as a social worker. The AAPC standards are explicit in the number and type of supervision that is required, and in the amount of exposure to different supervisors. There is a depth in the training of a pastoral counselor that is not required for the social worker. The pastoral counselor has to explore his or her own psyche as part of the educational process. Awareness of personal dynamics and their impact on the therapeutic relationship is an integral part of a pastoral counselor's training. The counselor's personal theology is also examined, both for its integrity and for its integration into the counselor's theoretical basis for counseling. The pastoral counselor needs to be clear in his or her beliefs, while open and respectful of the varying beliefs of those coming for help. Faith and spiritual issues, potentially deeply significant parts of the counselee's life, are not addressed at this depth in social work training, and the title "pastoral counselor" conveys to the person seeking help that spiritual difficulties can be part of the process. Thus, the pastoral counselor is able to address the person at both the psychological and the theological level in

ways not available to the social worker. The integration of the psychological and theological allows more breadth and depth in the healing process.

FUTURE RESEARCH

The evidence clearly shows that a person at Fellow level in AAPC has a greater level of training with checks and balances than does a Licensed Clinical Social Worker. Having made this distinction, the question arises, are people at Diplomate level of AAPC with a Ph.D or Th.D. comparable in terms of clinical competence with licensed Ph.D.'s in Clinical Psychology, and M.D. psychiatrists? As in this comparison between AAPC Fellow Pastoral Counselors and LCSW's, the three disciplines, AAPC Diplomates, clinical psychologists, and psychiatrists, will most likely share some common theoretical and technical training in regard to learning to do effective therapy, and diverge in other areas of professional expertise. Further study is indicated and encouraged in this area.

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Reverend WOODRUFF. Thank you. And I also request inclusion in the record of the document called "Pastoral Counseling, a National Mental Health Resource," which describes the work of pastoral counseling.

Mr. MICA. Without objection, so ordered.

[NOTE.—The document entitled, "Pastoral Counseling, a National Mental Health Resource," can be found in subcommittee files.]

Reverend WOODRUFF. Thank you. The right of consumers to select providers of their choice in any health care system is a universally articulated desire, and those consumers who would choose a provider equipped to understand and value the consumer's personal faith orientation and commitment should not be denied this right.

It is equally important to stay the continuing escalating health care costs, and the desire and need to curb spending is an essential element which cannot be overlooked. The pastoral counseling community appreciates and shares these concerns and we have always striven to keep costs affordable.

Speedy referral by clergy to pastoral counselors, psychotherapists, can catch mental and emotional illnesses in their early stages, very often avoiding long-term treatment. Early intervention and treatment is one of the keynotes of pastoral counseling.

Treatment through a pastoral counseling center or a private practice pastoral counselor also mitigates the stigma often associated with the treatment of mental and emotional illness. In such a familiar and nonthreatening setting and with the complete assurance of confidentiality, the client is not inhibited from seeking treatment at an early stage of illness before the condition becomes chronic and/or resistant to treatment.

For these reasons, we urge this committee to work with us to fully examine the inclusion of pastoral counselors for direct reimbursement of services under the FEHB Program. With this, and in the interest of the time, I will conclude my testimony with appreciation. I will be happy to answer any questions at the appropriate time.

[The prepared statement of Reverend Woodruff follows:]

Mr. Chairman and members of this Subcommittee, my name is Dr. Roy Woodruff. I am Executive Director of the American Association of Pastoral Counselors, which represents over 3,000 Pastoral Counselors and more than 100 Pastoral Counseling Centers in the United States.

Pastoral Counselors are ministers or persons endorsed by a religious faith group who are also mental health professionals. Pastoral Counselors have received specialized training in both religion and the behavioral sciences and practice the integrated discipline of pastoral counseling.

AAPC Pastoral Counselors relate to more than 80 faith groups including the Protestant, Catholic, and Jewish faiths.

I am here to urge that qualified Pastoral Counselors be included as direct reimbursement providers in the Federal Employees Health Benefits program.

There are a number of Pastoral Counseling Centers in the greater Washington metropolitan area, and it has come to our attention that a significant number of Federal Government employees who subscribe to the FEHB program have requested the services of Pastoral Counselors, expressing a need for the spiritual dimension to be incorporated into their psychotherapy. Similarly, we have heard from Pastoral Counselors and Centers around the country that FEHB subscribers have requested the services of Pastoral Counselors, but have been unable to receive them.

This demand is not surprising since a recent Gallup Poll indicated that sixty-six percent preferred a professional counselor who represented spiritual values and beliefs, and eighty-one percent preferred to have their own values and beliefs integrated into the counseling process.

Unfortunately, Pastoral Counselors are not included as providers in this important program, while physicians, clinical psychologists, clinical social workers, and psychiatric nurses are.

In recent years a strong trend has appeared which shows the ever increasing need for the spiritual dimension among those being treated for mental and emotional illness, and the efficacy of this treatment. Those in the mental health professions have recognized this need as they try to develop the religious dimensions in their own work. They are recognizing as never before the power of spiritual commitment creatively used in the healing process. However, not being trained in this work imposes serious limitations in applying the spiritual dimension to behavioral science.

Pastoral Counseling has now become a major provider of mental health services, accounting for over 3.5 million hours of treatment annually in both institutional and private settings, offering individual, group, marital, and family therapy.

Pastoral Counselors have been recently certified by a number of managed care organizations to provide service to their subscribers. These include Value Behavioral Health and U.S. Behavioral Health.

Pastoral Counselors certified at the Fellow level by the American Association of Pastoral Counselors receive more education, clinical training, and continued supervision than do licensed clinical social workers, who are providers under FEHB.

Mr. Chairman, I respectfully request that a comparison study of the training of AAPC Fellow accredited Pastoral Counselors and Licensed Clinical Social Workers be included in the record. I also request inclusion in the record of the document, "Pastoral Counseling: A National Mental Health Resource" which describes the work of Pastoral Counseling.

The right of consumers to select providers of their choice in any health care system is a universally articulated desire.

It is equally important to state that continuing escalating health care costs and the desire and need to curb spending is an essential element which cannot be overlooked. The Pastoral Counseling community appreciates and shares these concerns.

Speedy referral by clergy to pastoral psychotherapists can catch mental and emotional illnesses in their early stages, very often avoiding long-term treatment. Early intervention and treatment is one of the keynotes of Pastoral Counseling.

Treatment through a pastoral counseling center or a private practice Pastoral Counselor also mitigates the stigma often associated with the treatment of mental and emotional illness. In such a familiar and non-threatening setting, and with the complete assurance of confidentiality, the client is not inhibited from seeking treatment at an early state of illness, before the condition becomes chronic and/or resistant to treatment.

For these reasons, we urge this Committee to work with us to fully examine the inclusion of Pastoral Counselors for direct reimbursement of services under the FEHB program.

With this, and in the interest of time, I will conclude my testimony, and will be happy to answer any questions you may have.

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Mr. MICA. Thank you for your testimony, and I will recognize Harold Eist. Dr. Eist is president of the American Psychiatric Association. You are recognized, sir, and welcome.

Dr. EIST. Thank you, Mr. Chairman and members of the subcommittee. I am Dr. Harold Eist, president of the American Psychiatric Association, a medical specialty organization representing more than 40,000 psychiatrists nationwide, and we want to thank you for inviting me to appear at this testimony.

I am a local private practice psychiatrist, happy that I live in Representative Morella's district. I am pleased to be here this morning. I am on the faculty of Howard University, the Washington School of Psychiatry, and I am the medical director of the Montgomery Child and Family Health Services.

Mr. Chairman, I know life isn't fair. I see the effects of this in treating my patients every day. But isn't that why we are all here today, to make it more fair? Fair and equal coverage for mental illness in the FEHBP would simply, once and for all, end a fiscally insupportable, publicly deplorable discrimination that denies FEHBP recipients the advantages of the finest psychiatric care the world has ever known. This inexpensive care—the cost of not providing it is vastly higher than its price—would provide constitutional fair equality of opportunity for the mentally ill which my patients have been consistently denied.

For instance, the indirect costs of untreated depression are in excess of $40 billion, $40 billion with a B, copying my colleague here today, $40 billion. Mental disease or dysfunction obstructs access to life's opportunities. Adequate care preserves the range of opportunities we would have were we not disabled, given our talents and skills.

We see daily unnecessary tragedies, frustration, and suffering by our patients because though we have the skills, the modest means to provide treatments for the mentally ill have been denied them. When people feel sick, they go to the doctor. Going to the wrong doctor increases costs and puts patients at increased risk. Parity would provide the opportunity for the mentally ill to go to the right doctor. This has been documented to save enormous sums.

Fair and equal coverage has been irrationally denied, despite the expressed will of the people, the President of the United States, the Senate of this great country and, in my view, the majority of Members of the House. And I am pleased to say that Congresswoman Morella is currently pushing for parity legislation in the House. We are so grateful to you, Congresswoman Morella, and as are the mentally ill of America who have been waiting in line for 200 years.

I have personally met with OPM staff on numerous occasions over the years and presented them with mounds of data. They fully accept this benefit is affordable, predictable, stable, reliable and cost efficient. They have stated, "We agree there should be true parity for the mentally ill, but the issue is political." Senator Simpson was correct in his recent Wall Street Journal statement: "We don't need any more data. We need parity now." The great pathologist, Rudolph Veerkow, stated, "Politics is just medicine on a grand scale."

With the stroke of a pen, you can do more good for the American people, Mr. Chairman, than armies of physicians working for their lifetimes. Today, Mr. Chairman, it is time to strike a blow for what is right, for what is fair, for our people.

Thank you.

[The prepared statement of Dr. Eist follows:]

Mr. Chairman and members of the subcommittee, I am Harold I. Eist, M.D., President of the American Psychiatric Association (APA), a medical specialty society representing more than 40,000 psychiatric physicians nationwide, and we want to thank you for inviting me to appear before you this morning. I am a local private-practice psychiatrist in the Washington, D.C. metro area, the Medical Director of the Montgomery Child and Family Health Services, Inc., and on the faculty of Howard University and the Washington School of Psychiatry. I am pleased to share with the committee on behalf of my patients, many of whom are the nation's federal employees, retirees, and their families, my first-hand experience with the mental illness and substance abuse benefit under the Federal Employee Health Benefits Program (FEHBP) that provides their medical care.

When the Federal Employee Health Benefits system was first established in 1960, the initial FEHBP mental illness benefits were limited (high option mental benefit provided 30 days of basic hospital care/low option 10 days and benefits under major medical were limited to 50 percent of charges/low option was limited to inpatient care only). Recognizing that mental illnesses are diagnosable and treatable, there was an immediate impetus for expansion of FEHBP coverage when President Kennedy called on the U.S. Civil Service Commission to modify FEHBP so that psychiatric illness would be covered the same as other medical conditions and illnesses (Supplementary Report on Mental Health and Substance Abuse Benefits Under the FEHBP, 1993). During the years from 1961 to 1973, the FEHBP coverage limitations on mental illnesses were eliminated, resulting in mental benefits being fully equated with those for all other medical illness or injury.

In stark disregard to the accumulating evidence that the cost of covering mental illness was stable and predictable, a horrible injustice to Federal employees with psychiatric illness occurred first in 1975 and again in 1980. It was based on stigma, rooted in fear and ignorance. At that time, two government-wide health plans (Blue Cross Blue Shield & Aetna) reduced their mental illness benefits. Later, during the mid 1980's coverage for mental illness in FEHBP became much less than that provided in the private sector (Hustead, et. al, 1985). At that time APA testified in opposition to FEHBP's movement toward arbitrary limits for treatment of mental illness and provided evidence that the Office of Personnel Management (OPM) and the FEHB carriers failed to recognize the cost "offset" from providing access to necessary psychiatric care. In fact, Blue Cross of Western Pennsylvania data indicated that FEHB subscribers who utilized an outpatient psychotherapy benefit actually experienced a significant reduction in medical surgical utilization rates -- dropping from $16.47 to $7.06 on a monthly basis -- in comparison to a group which did not receive similar psychiatric care (McGrath, 1981).

We are very much aware of the undocumented allegations about over utilization and resulting cost increases attributable to the mental illness benefit under FEHBP. But, at no time has there been any independent evidence provided. Regrettably, personal bias and stigma never needed evidence, it preferred to discriminate against medical and psychological treatment. Despite the fact that FEHB carriers reduced the value of mental illness coverage

by as much as 60 percent between years 1980-1984, the resulting effect on the overall premium was almost negligible. Total premiums increased by 20 to 25 percent a year between 1980 and 1984. Absent the reduction in mental benefits, the increases would have averaged only one percent more a year (Hustead, 1983). Moreover, unlike today -- nearly 20 years after the FEHBP mental illness benefit was unwisely and capriciously limited -- advances in neuroscience -- such as brain imaging and a vast armamentarium of new psychoactive medications and behavioral therapies -- have substantially enhanced the nature of psychiatric practice. Our ability to appropriately diagnose and treat mental illnesses is on the threshold of a new era.

We appreciate OPM's recent well-intended steps to reduce discriminatory FEHB limits on mental illness benefits (elimination of the lifetime coverage maximum in 1995). However, as APA, the National Alliance for the Mentally Ill (NAMI), and the National Depressive and Manic Depressive Association (NDMDA) have pointed out to OPM, the action has regrettably resulted in an unintended and harmful consequence for federal workers and their families particularly in the event of a psychiatric illness requiring hospitalization. Illustrative of this: Blue Cross and Blue Shield implemented daily patient borne copayments of as much as $400 a day for inpatient treatment in a non-member hospital under the standard option and proclaiming proudly having expanded such coverage to 100 days annually; thus effectively allowing the patient to incur $40,000 ($400 x 100 days) out-of-pocket with no ordinary and customary annual stop loss protection. The Mail Handlers have also severely increased the out-of-pocket costs for enrollees for inpatient treatment as well as eliminated the catastrophic annual stop loss protection for mental illness and substance abuse (Sabshin, 1995).

While the APA applauds the Administration's 1995 removal of the lifetime maximums for treatment of mental illnesses as an important first step toward fair and equal coverage, we remain concerned about potential harmful consequences for federal workers, retirees, and their families when FEHB plans are at liberty to ratchet down on mental illness coverage elsewhere in plan design or to substantially raise beneficiary out-of-pocket costs. We strongly believe that the Administration can and should do more to correct this inequity.

As you know during the recent debate on the Kassebaum-Kennedy-Hastert health insurance reform legislation (S. 1028 and H.R. 3103), the U.S. Senate voted by an overwhelming two-thirds majority to adopt the Domenici-Wellstone amendment on mental illness parity. The amendment essentially requires private and self insured health plans (including the FEHBP) to provide the same level of coverage for mental illness as is provided for other physical illnesses. This was a historic moment for persons suffering from mental illnesses. Although the House-passed bill (H.R. 3103) did not include a mental illness parity provision in its version of the bill, there is significant support in the House of Representatives -- demonstrated by the 116 members that signed-on to a letter to the House health care conferees -- urging adoption of the Domenici-Wellstone mental illness parity amendment in the final conference agreement. Additionally, President Clinton stated to the APA led Coalition for Fairness in Mental Illness Coverage in June of this year: "I strongly

favor the amendment in the Kassebaum-Kennedy bill that requires parity for mental health services in medical insurance." We are also grateful that the Senate Majority Leader, Senator Trent Lott, also said: "...it's indefensible to say that people with mental health problems do not have the same access to coverage as people with physical health problems." (Sachs, et. al., 1996).

We understand why the final bill was limited to preexisting conditions and portability (and a demonstration MSA project to prevent stalemate), but we are deeply disappointed that the Domenici-Wellstone amendment was not included in the final conference agreement. This is a short term setback on our long journey to end "one of the last remaining injustices in America" to quote Senator Domenici. As a beginning step on this journey we look to this subcommittee along with representatives from Office of Personnel Management in this Administration to move forward on mental illness parity within the Federal Employees Health Benefits Program.

Senators Domenici and Wellstone and numerous members of the House have vowed not to let this issue go away and they have our commitment to fight for parity for our patients. They are continuing to push for financial protections for persons with mental illnesses via newly introduced legislation, "the Mental Health Parity Act of 1996," (S. 2031). Rather than requiring full parity between mental and other health coverage, S. 2031 would require that annual and lifetime caps imposed on coverage for treatment of mental illnesses are no more restrictive than such limits imposed on other medical conditions. This important legislation is a first step towards parity, and FEHBP has already taken part in moving towards the intent of S. 2031 by eliminating discriminatory lifetime coverage caps in mental illness treatment.

The U.S. Congressional Budget Office (CBO) has estimated that this proposal will increase private insurance premiums by a mere 0.4%, or $0.60 monthly, of which employers would pay only 0.16% (Lemieux, 1996). Employers could easily meet this slight increase by adjusting deductibles, copays and visit limits. For example, employers could meet this slight increase by raising their deductible by a mere $5 per year (Bachman correspondence, 1996).

Given that OPM already required FEHB carriers to eliminate the lifetime caps on its mental illness benefits, we urge the Administration to take the next step toward mental health parity by equalizing the annual plan payment limits for treatment of mental illnesses with those for other medical conditions and illnesses through Executive Order. We believe that equalization of the annual limits is a reasonable approach that should be vigorously pursued. These two strategies (equalization of annual and lifetime caps) will provide financial protection to individuals and their families that suffer from the most severe mental illnesses as these individuals often require ongoing long-term treatment and are most likely to run up against their plan's annual and lifetime plan payment limits.

The public support for fair and equitable treatment of mental illness coverage in health insurance has never been stronger. For example, a 1993 Parade Magazine survey found that, of the 2,500 people questioned, 98% said insurance should "cover medication and therapy for people with mental illnesses."

Furthermore, we have the data to demonstrate that full mental health parity can be done in a cost-effective manner. We have actuarial studies that demonstrate that mental illness parity beyond lifetime and annual coverage equalization can be accomplished through a very modest increase in premium costs. An actuarial study of the cost of parity coverage for treatment of mental illnesses for commercial health plans (including federal employee health plans) and self insured plans by the internationally recognized firm of Milliman & Robertson found that the likely effect of parity coverage of treatment for mental illness would be to increase typical plan premiums by: 2.5 percent for parity of severe mental illnesses, 3.0 percent for parity of all mental illnesses, and 3.9 percent for parity of mental illnesses and substance abuse. In addition, a Coopers & Lybrand analysis, excluding substance abuse, found a 2.6 percent premium increase for mental health parity. These estimates are borne out by the U.S. Congressional Budget Office, which projected similar (i.e., 4 percent) premium increases in its analysis of the Domenici-Wellstone amendment. According to CBO's estimate, employers would bear the cost of only 1.6 percent of the estimated premium increase. We urge this subcommittee to move forward on mental illness parity in FEHBP.

Insurers and employers could easily offset the modest premium costs associated with parity coverage of treatment of mental illness. For example, an insurance plan could reduce or largely cover the cost of the premium increase by increasing all outpatient visit and prescription drug copayments by just $5. Or the plan could impose a modest increase in the annual deductible, on the order of $30 to $60 per year (or just $2.50 to $5 per month).

Now more than ever as scientific advances have resulted in cost-effective and successful treatments for mental illness, equal and fair coverage for mental illness should by available to federal workers, retirees and all Americans. The FEHBP provided equal treatment of mental illness in its early years and we urge you to once again take the lead on providing mental illness parity. This subcommittee has the opportunity to end discrimination -- based on stigma, rooted in fear and ignorance -- in health insurance against those who suffer from mental illness. Parity coverage of mental illness is a matter of simple fairness and it is the right thing to do. We urge you to take action today, the millions of Americans suffering from mental illness can't afford to wait any longer.

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Mr. MICA. Thank you for your testimony. We will turn now to our final panelist, James S. Turner, who is president of the American National Acupuncture Foundation. Welcome.

Mr. TURNER. Thank you very much, Mr. Chairman and members of the committee. I very much appreciate this opportunity to be present and present testimony. I am an acupuncture patient and president of the National Acupuncture Foundation and vice chairman of the National Certification Commission for Acupuncturists and Oriental Medicine.

Acupuncture first burst onto the American stage in 1972 when James Reston, New York Times columnist, was in China with President Nixon and received major surgery with the assistance of acupuncture. He wrote a series of articles for the New York Times which caused acupuncture to be sought after by many Americans.

During the first 10 years of acupuncture's emergence in America, there were a number of initiatives on various State levels. States like California, Maryland, Florida, Massachusetts, and Nevada adopted legislation to license acupuncturists. In 1982, the acupuncture profession came together with the idea of establishing national standards. At that time, it established the commission that I serve as vice chair. It established a board to certify, to accredit schools of acupuncture, and it established a national acupuncturist association.

In that period of time between 1982 and now, acupuncture has grown tremendously in the United States. Our commission has certified approximately 6,000 acupuncturists. The State of California has certified or licensed a number almost equal to that.

In March of this year, the Food and Drug Administration, after a series of activities, approved acupuncture needles as being safe and effective for use in the American medical system. That particular activity by the Food and Drug Administration grew out of a joint meeting that was held at NIH and the FDA looking at various kinds of research on acupuncture.

In particular, for example, acupuncture, according to studies done by various researchers, is able to reduce the cost for stroke patients who are treated with standard stroke treatments plus acupuncture by an amount of $26,000. Similar activities have occurred and been certified in the area of asthma and other pulmonary diseases and pain and other various medical problems that affect people.

In this situation, about 15 million Americans have sought acupuncture treatments on an annual basis over the last few years. Now pending before Congress there is a bill which is H.R. 3292, the Federal Acupuncture Coverage Act, which we are here to support and urge further studies, further hearings and studies on, and hope that it will be adopted either in this session or the next session of Congress.

I very much appreciate the opportunity to testify here and suggest that we pay attention to the development of acupuncture. A significant number of Members of Congress have publicly testified that it has been useful to them or their families. We think it is a very important new resource in the American health care system that can be quite useful and helpful, not only to Federal employees but generally to the American public.

Thank you very much.

[The prepared statement of Mr. Turner follows:]

STATEMENT OF JAMES TURNER IN SUPPORT OF

THE FEDERAL ACUPUNCTURE COVERAGE ACT

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be with you this morning. My name is James Turner, and I am President of the National Acupuncture Foundation and Vice-Chairman of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). As a representative of these organizations, I greatly appreciate the opportunity to testify in favor of H.R. 3292, the Federal Acupuncture Coverage Act.

Both the National Acupuncture Foundation and NCCAOM strongly support this bill because we believe that federal employees should be allowed to access this safe, effective and inexpensive form of health care. With the spiralling costs of health care, including acupuncture as an option under the Federal Employees Health Benefits (FEHB) program would allow for an expansion of services while, at the same time, reducing the government's overall health care costs.

Acupuncture is extremely safe when performed by certified acupuncturists. In 1982, the acupuncturist profession acted to further ensure the safety of acupuncture by establishing a national commission, NCCAOM. This organization has developed and implemented nationally recognized standards of competence for the practice of acupuncture and Oriental

medicine. Since its inception, NCCAOM has certified over six thousand Diplomates in Acupuncture and is used as the basis for licensure in 90% of the states which have established standards of practice for acupuncture. Thirty-three states plus the District of Columbia license acupuncturists. Legislation has also been drafted or introduced in an additional five states.

NCCAOM maintains stringent standards for its members to be certified. Currently, there are over 40 schools of acupuncture in the United States. These schools are accredited by the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine (NACSCAOM) which is recognized by the United States Department of Education and the Council on Postsecondary Education.

The standard of training for acupuncture is a three-year masters level program. Many schools exceed this standard. Certification is based on a candidate's ability to meet eligibility standards of education and/or experience; passage of a comprehensive written and practical examination; successful completion of an NCCAOM-approved Clean Needle Technique Course; and commitment to a professional code of ethics. All Diplomates undergo a recertification process every two years.

In the last 25 years, acupuncture has been one of the fastest growing forms of health care in the United States. In 1993, a study done by Dr. C. David Lytle of the Food and Drug Administration estimated that up to 12 million Americans a year visit acupuncturists for

medical treatment, and that number continues to grow.

Increasing numbers of people are using acupuncture because it works for a variety of ailments. The use of acupuncture in fighting substance abuse, for example, is one of the fastest growing areas for acupuncture. There are over 150 chemical dependency programs that rely on acupuncture in over 20 states. Acupuncture is used to control withdrawal symptoms and the craving associated with drug addiction. Studies based on human clinical trials, animal studies and a pilot detoxification program all have demonstrated the safety and efficacy of acupuncture in the treatment of substance abuse. In some cases, it is more effective than traditional therapies.

Even the courts are beginning to utilize acupuncture as part of treatment programs for nonviolent drug offenders. A very effective and nationally recognized program in Dade County, Florida, uses acupuncture for certain drug offenders. Attorney General Janet Reno was a strong early proponent of the program when she was District Attorney of Dade County. In our nation's capitol, a model Drug Court was created which uses acupuncture in the treatment of substance abuse. The results so far have been very encouraging.

In addition, using acupuncture in treating drug addiction is extremely cost effective. Billions of dollars are spent annually by employers on substance abuse-related expenses because of the high cost of in-patient treatment facilities and the high rate of chronic relapse. Offering acupuncture as an alternative treatment for substance abuse among federal employees

would save the federal government money with lower health care costs and fewer lost employee work days.

Acupuncture is also used successfully in the treatment of paralysis due to strokes, head injuries, spinal cord injuries, multiple sclerosis and pediatric cerebral palsy. In a 1992 study done by Dr. Margaret Naeser of Boston University School of Medicine's Department of Neurology, acupuncture was found to be very effective in treating paralysis when used in conjunction with standard therapies such as physical therapy. Not only is acupuncture successful in improving neurological functions, but it also offers significant cost savings, with Dr. Naeser estimating an average of $26,000 saved per stroke patient.

These examples cover only the tip of the iceberg when looking at acupuncture's myriad benefits. Data has been compiled from studies done nationwide revealing the effectiveness of acupuncture in treating chronic ailments like migraine headaches and back pain. Many cancer patients use acupuncture as a way to reduce the nausea associated with chemotherapy. Data has also been compiled which demonstrate acupuncture's efficacy in treating pulmonary illnesses like chronic bronchitis and bronchial asthma. Individuals battling depression and other mental illnesses often use acupuncture in conjunction with other psychiatric therapies. Acupuncture has also served to alleviate the recurring symptoms of allergies.

As you can see, acupuncture is an effective tool in treating a variety of illnesses. I strongly

believe that federal employees would benefit by having acupuncture added to their health plans.

The federal government, too, would benefit with lower overall health costs. A recent survey done by Dr. Claire Cassidy of 576 patients in six acupuncture clinics across the United States supports this contention. Of those surveyed, nearly 90 percent reported favorable health results from their visits with acupuncturists. The respondents were then asked whether, with acupuncture, they had reduced office visits to medical doctors, use of prescription medicines, and claims for insurance reimbursement. Of those who answered the question, 84 percent said they had reduced doctor visits; 79 percent said that they had reduced use of prescription drugs, and 76 percent that they had reduced claims for insurance reimbursement. In addition, of those who answered, 77 percent reported reducing office visits to physical therapists, 69 percent reported reducing their visits to psychotherapists, and 71 percent reported avoiding surgery that had been recommended.

Mr. Chairman, I believe that these percentages speak for themselves. Adding acupuncture to the Federal Employees Health Benefits program would be beneficial to <u>both</u> the federal government and its employees. Workers would be able to access this safe and effective treatment for certain ailments, and the government would be able to better control health care costs. It is a win-win situation for everybody.

Millions of Americans have discovered the benefits of acupuncture. We hope that the

Congress will allow federal employees to also experience its benefits by passing H.R. 3292.

Thank you, Chairman Mica, and members of the Subcommittee on Civil Service for granting me the opportunity to express my views on this important issue.

Mr. MICA. Thank you for your testimony. I thank all of the witnesses. I am going to turn directly to the gentleman from New York, who has several questions.

Mr. GILMAN. Thank you, Mr. Chairman. I would like to direct a question to Dr. Freeman. What services do audiologists provide and what are the qualifications they need to provide these kind of services?

Mr. FREEMAN. Thank you, Mr. Gilman. Audiologists are licensed and trained to provide evaluation services for hearing care. We provide comprehensive diagnostic assessments. We do not pretend to be medical doctors. We parallel more closely the relationship that optometry has with ophthalmology, in the sense that we provide the evaluation for the medical community as well as the rehabilitation for individuals with hearing loss.

Our training, to be a licensed practitioner you must have a minimum of a masters degree. Many audiologists go through to the doctoral level, and as well as pass national boards that are administered through the educational testing service.

Mr. GILMAN. Currently, how are patients referred to audiologists?

Mr. FREEMAN. Audiologists receive patients directly. Direct access from patients just coming in, calling and making appointments, as well as from the medical community. In the private sector, patients are referred from otolaryngologists. They are referred from pediatricians, from primary care physicians.

The concern we have with the current legislation is that, as Dr. Maves pointed out, there is a mechanism for current FEHBP beneficiaries to receive audiology services. We are covered. Audiology services, rather, are covered under the current law. The problem is that they are covered if they are billed and the payment goes directly to an ENT physician for our services, rather than being able to receive the services or the payments directly.

Mr. GILMAN. If an audiologist has a patient and sees some medical need, how do you make that determination? What do you do?

Mr. FREEMAN. Well, there are a variety of assessments that we use, ranging from case history all the way through to examination of the ear. And our diagnostic testing assesses the function of the outer ear, the middle ear, the cochlea, and so on and so forth, without going in all the way through to the brain stem level and without going into a great detail on the actual procedures.

Mr. GILMAN. Thank you. I would like to turn to Dr. Maves. What services do neck and ear specialists provide, and what are the qualifications to provide those services?

Dr. MAVES. Otolaryngologists, head and neck surgeons, have an undergraduate degree, followed by 4 years of medical school, followed by a year of internship, followed by 4 years of residency and, for a small group, a subset of our practitioners, an additional year in fellowship training. So, in some instances, more than 10 years beyond the undergraduate level of completion of training.

At the end of that time, the certifying examination given by the American Board of Otolaryngology, one of the founding members of the ABMS, is a 3-day examination of both oral and written material which is required for that individual then to be board-certified in otolaryngology head and neck surgery.

Mr. GILMAN. As far as you know, do audiologists refer their clients to neck and ear specialists when they find a medical problem?

Dr. MAVES. Yes, sir, they do. But the more common form of practice, actually, is for the two to work together in a collaborative fashion. Typically, in both an academic and a private practice situation, the otolaryngologist will have either under his employ or in an associate capacity an audiologist or a number of audiologists with whom the patients are evaluated in conjunction.

We feel strongly that that hearing care team of the otolaryngologist and the audiologist has been an extremely successful one over the years and is the type of pattern that we feel should be continued.

Mr. GILMAN. Well, if you find that audiologists do refer clients to the physician when they find a medical problem, what are your major concerns about direct access for audiologists in the Federal Employees Health Benefits Program?

Dr. MAVES. Our concerns are two, Mr. Gilman. The first is that I think we have concern that, indeed, those medical conditions will not be recognized and realized. I think that is a concern by all of us.

Second, we do not feel that that is an effective mechanism for delivering hearing care. We are concerned that unnecessary audiological tests may be administered before the patient sees the physician for a disorder which, if the physician had seen the patient initially, appropriate diagnostic tests could have been carried out in an orderly fashion.

Mr. GILMAN. Do you see any similarities in which occurred between the ophthalmologists and the optometrists?

Dr. MAVES. It certainly is a circumstance that at first glance might seem similar; however, I believe if you examine the situation of the optometrist, you will see that they customarily require a doctorate level program, a doctorate of optometry. They have their own certifying examination, and as are physicians, licensed by each individual State. The direction and nature in duration of their training is different than that for the typical audiologist, who usually is a masters level graduate.

Mr. GILMAN. Do you think that the qualifications for being a licensed audiologist are sufficient to make certain that there is going to be quality of care by the audiologist?

Dr. MAVES. Let me say this very emphatically: We do not mean to demean our colleagues in audiology. I am, in large part, here because of the good education experience and collaborative function that I have had with audiologists throughout my training, academic career, and subsequent career. We feel that in the current capacity, the audiologists do provide quality care when part of the hearing health care team under an otolaryngologist or working with an otolaryngologist.

Mr. GILMAN. Thank you. And Alan Lowell, president of the Hearing Society, can you tell us how many Americans utilize a hearing aid?

Mr. LOWELL. Mr. Gilman, there are about 26 million Americans that suffer from a hearing loss and, unfortunately, there are only about 6 million people, or Americans, that are wearing hearing in-

struments. As you can see, it is a vastly underutilized product and service.

Mr. GILMAN. And what services do hearing aid specialists provide?

Mr. LOWELL. Well, hearing instrument specialists are qualified to provide an entire battery of services, from case history, identifying otologic red signs which would require a medical referral to a physician, testing, hearing assessment, complete evaluation, fitting of hearing instruments, post-evaluation and counseling, not only to the patients but to the family members as well.

Mr. GILMAN. Are there any licensing requirements for hearing aid specialists?

Mr. LOWELL. Mr. Gilman, indeed, in 46 States hearing instrument specialists are required to be licensed and in 2 States they are required to be registered. Beyond that, there is a certification arm known as the National Board for Certification in Hearing Instrument Sciences. There are approximately 2,500 people who are nationally board-certified.

Mr. GILMAN. And how would a hearing aid specialist determine if a patient needs some medical care or physician care?

Mr. LOWELL. In the medical case history, as it is clearly defined for the purpose of identifying these otologic red flags, if a patient has any of these signs or symptoms, then we would refer them to a physician, preferably an otolaryngologist. Also, in our testing procedures we are able to identify any type of situation that would require a referral to a physician.

Mr. GILMAN. Thank you. And thank you, Mr. Chairman.

Mr. MICA. Thank you, Mr. Gilman. Now I would like to yield to our ranking member, Mr. Moran, for questions.

Mr. MORAN. Thanks, Mr. Chairman. Since Chairman Gilman dealt with the hearing side of our panel, let me focus a little bit on the mental health.

The estimates that have been suggested in terms of the additional cost for mental health parity, many have suggested are illogically low but, apparently, there is a fairly strong calculation that goes behind those. I think the suggestion was it is only 0.6 percent of health premiums that would be required if we were to have full mental health parity.

Now, that is the biggest impediment. That is what it is all about. When we suggest mental health parity, not only the Members of the House and Senate, but the OMB particularly, say you just can't afford it. Now, tell me, Dr. Eist, where do you get your figures and how we would be able to afford it?

Dr. EIST. Mr. Moran, thank you for that question. I was hoping somebody would ask it. First of all, we just can't not afford it. Those are the facts. The CBO, Congressional Budget Office, determined that it would cost $600 million over 5 years to provide mental health parity over what we are paying today. That translates into $12 annually for a covered FEHBP beneficiary, a buck a month. That's not even a hamburger at McDonald's and it's a lot better for you. That's the CBO.

Milliman & Robertson, which is one of the most prestigious companies in the country, determines that for full parity, including the severely mentally ill and substance abusers, we are looking at 3.9

percent, which translates into an added deductible of $60 per year, or $5 per month.

And that is not even looking at cost offsets which, for instance, in a study conducted by the western Pennsylvania Blue Cross and Blue Shield, when people were given the right psychiatric care, surgical and medical utilization dropped from $16.40 to $7.06 on a monthly basis. That is why I say we can't afford not to do it. We haven't even included the cost offsets in this data.

The numbers that you have heard that have been bandied about that are high are just simply inaccurate.

Mr. MORAN. Thank you, Dr. Eist. Actually, many of us on the Democratic side particularly have suggested that argument, that you can't afford not to provide this or that and, particularly, mental health. Somehow, the budget analysts don't find that as compelling an argument as we might. But I understand what you are saying and if $600 million is the figure over 5 years, then it does work out to a very marginal additional premium cost.

Let me ask Reverend Woodruff, the concern about the inclusion of pastoral counseling, again, is a financial one, particularly given the vast number of people who have some type of pastoral experience or title or career. I mean, I must have thousands of people who call themselves reverend in my district and I am sure there is tens of millions across the country.

And so the problem would be when you grant certification reimbursement to one deliverer of pastoral counseling, how do you exclude others? And if you can't exclude them, there is just so many reverends or so many religions that we would be supporting a vast population of people, I am sure virtually all of them well-intentioned and doing a good job. But, you know, the scope of what we would be buying into seems almost infinite.

So how do you address that?

Reverend WOODRUFF. Well, thank you, Mr. Moran, for raising that question because this is a point that we want to do everything we can to clarify. We are certainly not asking for all persons who have reverend at the beginning of their name to be covered under this provision that would include pastoral counselors, although many of those do a lot of good mental health work and are very supportive to many people.

We are talking about what is really a select few of those persons who have gone beyond their pastoral studies and identity to gain other degrees in psychology, counseling, psychotherapy, and who have gone through a matter of years of intensive clinical training and supervision and who, in the process of that training, have learned to creatively and therapeutically integrate or help a client integrate that client's own faith value system along with good, competent behavioral science and psychotherapeutic methodology toward their own healing and recovery, given whatever the presenting problem is.

So, currently, in the country right now the people who are certified by our organization, and we are the standard-setting and certifying organization in the country for this, we are talking about 2,000 people. Now, they are spread all over the country. There are certain concentrations. For example, in the city of New York the Blanton Peale Institute, which is part of the Institutes of Religion

and Health, the last figures I saw on that, they were the second largest provider of outpatient mental health care in the city of New York. And most centers like that, they are one of our accredited centers, work very closely with other disciplines. Psychiatrists are on the teaching faculty of that particular training program.

Most centers operate on a sliding scale, so that part of our commitment has always been to prioritize provision of service over the amount of income and so that it is an affordable kind of process.

Now, this can make it very difficult at times for pastoral counselors economically, but the provision of service at an affordable cost has been very much our commitment.

We are talking about persons who are specifically certified, who met standards, who passed examinations, have gone through a rigorous process of certification. Many of those are also State-licensed.

States vary tremendously in how they license. In CHAMPUS, for example, if a pastoral counselor, a certified pastoral counselor, is functioning in a State that has relevant licensure—few States have licensure or regulation for pastoral counselors, while many others have other licensure that pastoral counselors qualify for—in that case, CHAMPUS says, well, we expect you to be licensed as well as to be certified as a pastoral counselor.

However, in States that do not have relevant licensure—and there are a number of those States that do not—CHAMPUS says we will accept the certification of the American Association of Pastoral Counselors, recognizing that its standards are equivalent or really higher than almost any State counselor licensure.

Mr. MORAN. Now, is the composition of this Association of Pastoral Counselors balanced between rabbis, Catholic priests, Protestant ministers, Islamic mullahs?

Reverend WOODRUFF. It is very inclusive of all of that. We don't have Islamic members at this point, although we have been in touch and some dialog with an Islamic organization called Mercy International along that line.

But, yes, we have the full range and spectrum of various Protestant Christian denominations, of Roman Catholic priests and sisters and brothers, others who are consecrated but not ordained but who are recognized as a religious vocation, and Jewish rabbis, and, again, sort of the full spectrum of those from Orthodox to Reform to Liberal.

Mr. MORAN. Thank you for testifying. Thanks to all of the panel. I had a lunch I was supposed to be at at noontime, so I am going to dismiss myself from the panel. But thanks for holding this hearing, Chairman Mica, and we thank the panelists.

Mr. MICA. Thank you, Mr. Moran. I would now like to recognize the gentlelady from Maryland, Mrs. Morella, for questions.

Mrs. MORELLA. Thanks, Mr. Chairman. I want to thank the panel for excellent testimony. It was varied and all of it was exceedingly important. We appreciate your expertise.

I wanted to perhaps direct a question to Dr. Freeman and Mr. Lowell and Dr. Maves dealing with veterans. Veterans now have direct access to audiologists, and I wonder have any problems resulted among veterans that might also affect civil servants and their families?

Mr. FREEMAN. The Veterans' Administration has recently taken a look at and has reassessed that program. There was just a study, in fact, that was published this month in a referee journal looking at direct access for audiology services, and they have found it to be very successful, cost effective. And I don't know. Is that the question?

The types of problems that veterans experience are quite similar to what you would see in the general population. They may have a little bit more noise exposure, except for an industrial population, but the general types of problems that you would see, whether it be from ear wax to infections to tumors, would be present in the veterans populations probably in an equivalent number to that of the general population.

Mr. LOWELL. Mrs. Morella, typically, hearing instrument specialists do not interface with veterans per se, other than to provide hearing health care services to those veterans who are currently wearing hearing instruments. So, other than that, we really do not get involved with that population very much at all.

However, CHAMPUS—I'm sure we're talking about two separate entities, but hearing instrument specialists are providers in many cases under the CHAMPUS program for veteran and family members.

Dr. MAVES. Congresswoman Morella, the VA is a little bit of an unusual peculiar circumstance all of its own, inasmuch as it is not unusual in the VA system to actually have an audiology department or even speech pathology, another discipline that we frequently interact with, actually as a freestanding department separate in their own right. That is a situation that in most academic medical centers is not that way. Usually those departments are either part of the department of otolaryngology or part of an umbrella of services.

Contained within that peculiarity of the VA, however, I am unaware of any problems. On the other hand, having worked in a number of veterans hospitals, even though they may well be a separate circumstance, understand that the opportunity for collaboration and referral to the otolaryngologist is almost instantaneous, inasmuch as in many locations, if not all, the two departments are very proximate to one another.

So that I think I would look at the veterans hospital certainly as an example of a way in which this might occur, but a very peculiar one given the nature of providing services to the veterans and the structure in which the Veterans' Administration hospitals typically use speech pathology, audiology, and other rehabilitative services.

Mrs. MORELLA. I was curious about the applicability. I mean, can we see some challenges or problems that civil service retirees or civil servants and their families would also face?

Dr. Wellman, I said you should probably be Dr. Wellwoman.

Ms. WELLMAN. Thank you.

Mrs. MORELLA. You mentioned the $250 million savings in the FEHB Program over 6 years if medical foods are covered. How do you arrive at that figure?

Ms. WELLMAN. Well, we had commissioned the Barents Group to do a study, and in that study we only looked at Medicare patients

with 13 diagnoses, both surgical and nonsurgical patients who were hospitalized, and looked at the difference between those who were given medical foods and those who weren't. They came up with the $1.3 billion in Medicare savings.

We went back to the Barents Group with the figures related to the population, the civilian population covered by FEHBP, and they again very conservatively came up with that $250 million savings estimate.

There has been some suggestion that perhaps the types of illnesses may be different in the Medicare population versus those in the Federal employees group, but the diagnoses are fairly similar. They are not just diagnostic problems or illnesses or injuries only seen in elders.

Mrs. MORELLA. You know, in another area, I have always felt there should be some nutritional standards for people over the age of 65 or whatever. It is like we have something up to that category and then we totally forget it. I know this is not the medical foods, but would you speak to that?

Ms. WELLMAN. I appreciate that comment because, in truth, the dietary recommendations, the RDA's which are put out periodically by the National Academy of Sciences Institute of Medicine, lumps us all together once we pass age 51. I know that my 85-year-old father who recently came to live with us is a bit different than I am, but we are still lumped together. The Food and Nutrition Board there is working on it.

I think that medical foods are really, unfortunately, one of the best kept secrets in terms of their quality of life effect, as well as their cost effectiveness. And part of that may harken back to the little attention that is paid to the value of nutrition, probably because of the crowded curriculum already in medical schools.

But I think that you are very aware that H.R. 2009 wouldn't mandate any additional benefits; it would just highlight the medical foods as a category that is allowable and would give that visibility so that more people with a variety of acute and chronic conditions would benefit from them, and the system would benefit because of the cost reductions.

Mrs. MORELLA. Probably an area, too, where more education would be very helpful.

Ms. WELLMAN. Exactly. We think that H.R. 2009 would help us. It would be a giant step there. Thank you.

Mrs. MORELLA. Thank you. Reverend Woodruff, it is a pleasure to have you here. And I know you mentioned that pastoral counseling is recognized by CHAMPUS. Have they done any evaluations about how helpful pastoral counselors have been?

Reverend WOODRUFF. The only evaluative comment I have heard directly from a CHAMPUS person was from Dr. Alex Rodriguez, who used to be the director of provider networks, I believe it was, for CHAMPUS or the medical director. And Dr. Rodriguez has made public statements that they considered among nonmedical counselors and therapists, that they considered certified pastoral counselors to be reliably among the most competent and qualified.

Mrs. MORELLA. I am sure that much can be assisted by virtue of the pastoral counseling, again, the concept of anatomy of an ill-

ness and the combination of mind and body and the kind of relationship, too, and the spiritual aspect as well, obviously.

Reverend WOODRUFF. That's right.

Mrs. MORELLA. Dr. Eist, is it again a pleasure to have you here. Thank you for your very kind comments and thanks for the leadership that you have provided. Your testimony was very persuasive and very dramatically presented, too, and we appreciate it. And, of course, representing the National Institutes of Health also where a lot of that work is being done. I value it.

I testified on behalf of the amendment that was offered by the Senate with regard to mental health parity and, at that time, I recall there was a study that had been done by Coopers & Lybrand. Maybe you want to comment on that because my remembrance is that it was just a very small, smidgeon of an increase in that insurance and in the public sector there would be a savings.

One of the things I think is that Members of Congress and citizenry have got to look at some of these figures and see how actually we do save money. So I give you an opportunity to comment on that.

Dr. EIST. Thank you, Congresswoman Morella. Maybe some of my passion comes from watching you all these years. You know, Winston Churchill once said that the American people always do the right thing, but only after they have tried everything else. And we have certainly tried everything else in mental health care. We have tried every conceivable way of ignoring it.

You are correct that Coopers & Lybrand study showed a 2.6-percent premium increase for mental illness parity. I mean, every single study shows that it is a modest amount of money, and that doesn't include the cost offsets. We haven't even addressed the cost offsets; we are just looking at the small additional, actually pennies per month, that would be necessary to provide basic fairness once and for all in America.

Mrs. MORELLA. And we haven't even looked at loss of productivity and the effect on families. It seems to me that would be an important aspect.

Dr. EIST. Right; well, that is where the $40 billion in indirect costs comes from. And that was, as you know, reported from an NIMH 1993 report to Congress which documented that lost productivity, absenteeism, problems with caretakers having to stay away from work to care for the mentally ill individual, increased firings, absenteeism, were enormous in the mentally ill population that are completely preventable.

We do a terrific job with these populations if we can just treat them. Only 1 in 10 people in America who are mentally ill are getting the treatment they need. It is better than the world where only 1 in 100 is getting the treatment they need, but it is certainly not nearly what we should be doing in America and what we can do in America. We have the ability to do this, we have the people to do this, but we are denied access to the resources. And we need the resources.

Mrs. MORELLA. And I would like to see in our Federal Employees' Health Benefit Plan that we become the models, the models for the Nation.

Dr. Turner, I was in the State legislature years ago when we first had the accreditation of acupuncturists who work with another doctor. I am trying to recall all of that. Tell me about acupressure. Is that an offshoot of acupuncture?

Mr. TURNER. Acupressure works on the same underlying scientific principles, but it is done by massaging the points rather than penetrating them with a needle. And the commission that I am the vice chair of is now in the process of also certifying what are called oriental massage therapists, and that would include acupressure and some other forms.

With regard to your first point, Maryland has now altered its laws so that acupuncturists now practice independently without reference to physicians.

Mrs. MORELLA. In how many other States is that the case?

Mr. TURNER. There are 33 States that license acupuncturists. In all of them they work without physician supervision. Also, all States recognize the physician's right to use acupuncture inside their scope of practice. Some of them require additional training of a few hundred hours of training. But 33 States and the District of Columbia license acupuncturists directly and about 5 States right now are considering legislation in their legislatures to do that same thing.

Mrs. MORELLA. Thank you. Mr. Chairman, I have no other questions. I thank the panel very much.

Mr. MICA. Thank you. I have one final question for not all the panelists, but most of them. First we will start with Mr. Freeman, and I am going to ask the same question to several others.

Are there any specific legal or regulatory obstacles that now prevent insurance carriers from offering the benefits that you are promoting today? Are there any specific legal or regulatory obstacles?

Mr. FREEMAN. Such as licensure laws, et cetera? I am not aware of any. There are other insurance programs that do pay directly to audiologists for services.

Mr. MICA. Ms. Wellman, are there any specific legal or regulatory obstacles that stand in the way of getting your service or medical foods provided?

Ms. WELLMAN. I think it's just a big lack of awareness. There are no particular obstacles except that, again, the advocacy on the part of the health practitioners isn't strong enough because of their lack of awareness.

Mr. MICA. Dr. Woodruff.

Reverend WOODRUFF. That would apply in States that have no relevant counselor licensure for which pastoral counselors would qualify.

Mr. MICA. You have a problem as far as State licensure?

Reverend WOODRUFF. Yes.

Mr. MICA. Nothing dealing with the Federal carriers in FEHBP?

Reverend WOODRUFF. No.

Mr. MICA. Dr. Eist.

Dr. EIST. Chairman Mica, the major problems that we have to deal with are ignorance and stigma.

Mr. MICA. But no regulatory or legal obstacles?

Dr. EIST. Sometimes one wonders.

Mr. MICA. Mr. Turner.

Mr. TURNER. Now that the FDA has approved acupuncture needles as a regulated device, that was the major barrier. That is removed. There are many carriers that do reimbursement acupuncturists at this point. There is work that needs to be done to move it forward, but there are no major specific legal problems.

Mr. MICA. OK. Well, I want to thank all of the panelists. Each of you have presented your case and your argument for possible coverage. I know some of you would like to legally mandate it and some of you would prefer that we do not mandate those particular services, but we want to give a fair and open hearing to this.

If you have additional statements that you would like included in the record, we will leave the record open and you may include them.

At this time, there being no further questions from the members, we will excuse this panel. And thank you again for your participation.

Mr. MICA. This afternoon we have one additional panel, and that is a single panelist, Mr. Ed Flynn, who is the associate director of the Retirement Insurance Service of the Office of Personnel Management. He is not a stranger to this panel, but we would like to welcome him. He is our last witness today.

Ed, if you wouldn't mind standing, I will swear you in.

[Witness sworn.]

Mr. MICA. Thank you. I welcome you back and will give you adequate time to respond. You can go beyond the 5 minutes, if you like. You have heard a number of witnesses today advocating inclusion, exclusion, participation, and nonparticipation, and we would like to hear your comments on behalf of OPM. You are recognized.

STATEMENT OF WILLIAM "ED" FLYNN III, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE SERVICE, U.S. OFFICE OF PERSONNEL MANAGEMENT

Mr. FLYNN. Thank you very much, Mr. Chairman. It is a pleasure for me to be here today to address you and the other members of the subcommittee. I would like to say just at the outset that it has been a while since I have had the opportunity to be here, and I just thought I would use this opening period to thank you and Mr. Moran for your support of some improvements in the debarment provisions affecting the Federal Employees' Health Benefits Program. I know that OPM and OPM's inspector general both believe that those particular provisions, if they are able to become law, will help us administer this program even more effectively than we do now.

A number of items have been discussed here this morning, Mr. Chairman, and some of the testimony that I had prepared in my opening comments actually repeats, in some cases, almost word for word some of the things that our earlier commentors have said. So I will abbreviate that a little bit and, with your willingness, Mr. Chairman, I will go through a short statement and then be happy to answer any questions that you may have for us.

Again, thank you for your invitation to come here today to discuss the Federal Employees' Health Benefits Program. In your invitation, you asked me to address the rationale for and our experience with the 1996 change in prescription drug benefits for stand-

ard option enrollees with Medicare part B in the Blue Cross and Blue Shield Health Plan. You also asked for our views on several proposals which would require health plans to include benefits for services or supplies or to allow direct access to certain providers.

Now, as I said earlier, we have heard a great deal this morning about what actually occurred as a result of the benefit change in the Blue Cross and Blue Shield program. I thought I might just add a few remarks about that change and our perspective on it.

This particular change occurred during last year's negotiations with Blue Cross and Blue Shield on benefits and premium rates for 1996. As we looked at that program, we saw drug benefits accounting for $1 in every $5 of medical costs in 1994. And despite savings from a range of initiatives, cost trends for prescription drugs were increasing at a 20-percent annual rate, well in excess of other medical cost increases. Without some action, premiums would have had to increase to cover these costs.

Further, utilization data indicated that 61 percent of the plan's cost for prescription drugs were incurred by annuitants with Medicare part B as their primary coverage.

Now, given the absence of any prescription drug coinsurance requirement, Medicare eligible enrollees used retail pharmacies for 90 percent of their prescriptions, compared to 20 percent for all other enrollees who had been, for the past several years, paying the coinsurance requirement that we applied to Medicare part B enrollees in 1996.

Based on recent prescription drug utilization data, we believe this change avoided premium increases totaling $144 yearly for a family and that program costs avoided by this drug benefit change will be approximately $200 million in 1996.

Mr. Chairman, you expressed an interest in the extent to which Merck-Medco, the mail order provider for the Blue Cross and Blue Shield Federal employee program, met its contractual obligations to Blue Cross and Blue Shield. And while that topic was covered some by Blue Cross and Blue Shield this morning, our measure of this is whether our enrollees received the benefits and levels of services described in the brochure.

We expect that enrollees will receive all of the benefits promised by their health plan. It is the plan's responsibility to make suitable arrangements to do so. When that is not the case, as was the situation here, we will direct that corrective actions be taken. In this instance, we believe that the additional costs resulting from the plan's failure to meet its service obligations should neither be borne by the enrollee nor the program.

You also had witnesses touch earlier this morning, Mr. Chairman, on a recent survey that we commissioned conducted by the Gallup organization. There is a table accompanying my statement which reflects the results of that survey, but I might just highlight a couple of items from that for the committee.

As you can see in the table, enrollees in the Blue Cross and Blue Shield who were surveyed rated their most recent prescription drug experience very highly for both retail pharmacy and mail order providers. At 93 percent, Medicare eligible respondents expressed virtually the same level of satisfaction with their most recent prescription drug experience as other members. There was no dif-

ference in member satisfaction with retail pharmacy and mail order as a means of obtaining their prescriptions.

Now, Mr. Chairman, you also expressed an interest in benefits and cost trends in the largest plans. Again, that is included in a table that I have provided the subcommittee with my prepared remarks. Those 5 plans account for 67 percent of our Federal enrollees.

As you view the chart and as other members view it, I would just note that the Mail Handler's plan is unique in that it includes no mail order drug program, while its retail pharmacy benefit features relatively high deductibles and preferred retail pharmacy network offers automated claims processing but does not waive either the deductible or the coinsurance. Thus prescription drugs represent only about 3 percent of total benefits paid in 1995, although the annual rate of increase recently has been 100 percent in that program.

And I would just ask you to bear in mind that there are several reasons that account for differing rates of change that you see in that chart, or table 2. One is benefit structure. As all of us know, a hallmark feature of this program is that it offers a variety of plans with a variety of benefit packages. In addition, changes can be influenced by such factors as demographically different enrollee populations and the relative convenience of using different claim systems.

And then, finally, also in the materials provided, Mr. Chairman, chart 3 compares, as you requested, the prescription drug benefits of Blue Cross and Blue Shield and the other four major plans in the survey.

In anticipation of this hearing, you requested our views on three bills which would affect coverage under the Federal employee health plans for particular health services or particular health care providers. H.R. 1057 and H.R. 3292, respectively, would add audiologists and acupuncturists to the list of providers in a provision of law governing the program. That provision requires fee-for-service health plans to allow enrollees direct access to certain nonphysician providers who are authorized to perform a service otherwise covered by the plan's contract.

Now, we recognize that the use of qualified health practitioners other than physicians has the potential to reduce costs and can widen the choices available to enrollees in obtaining health care; however, we are concerned that mandating access to the services of specific providers is contrary to the program's guiding philosophy of allowing flexibility for plans to respond to changing health care practices and individual enrollee needs in the most effective way. Therefore, we oppose both H.R. 1057 and H.R. 3292.

The third bill that you asked us to comment on, Mr. Chairman, would amend the portion of the law that describes the general categories of benefits health plans may offer to include coverage for the cost of medical foods. Medical foods is a specific type of treatment. You have heard the definition of that described this morning.

But I might just also point out, Mr. Chairman, that one of the enduring strengths of the Federal Employees' Health Benefits Program is that the enabling legislation has historically specified only broad program structure and has authorized OPM to contract with

qualified carriers for a variety of plans and benefit levels. In our previous report to the subcommittee on this proposal, OPM noted that current law already includes sufficient flexibility to address coverage for medical foods under existing contracting authority.

Benefits for medical foods are a very good example of our health program's capacity to respond to enrollee needs. OPM has transmitted formal guidance to participating health plans which specifically ask them to provide coverage of nonprescription medical foods in appropriate cases as part of our flexible services option. The flexible services option gives plans discretion to offer benefits for medically appropriate services not otherwise covered by the contract when this will effectively serve the best interest of a particular patient. We are confident that plans are complying with our guidance, as evidenced by the lack of complaints that medical foods benefits have been denied.

I might also add with respect to medical foods, Mr. Chairman, when Federal law requires a prescription for those medical foods, the costs of that are covered under the Federal Employees' Health Benefits Program.

OPM is strongly committed to working administratively with health plans through the annual contracting process to provide access to the most appropriate health care services at a reasonable cost. Accordingly, we recommend against enactment of H.R. 2009 because it might ultimately inhibit that flexibility.

Those constitute pretty much the substance of my prepared remarks, Mr. Chairman, and I would be happy to try and answer any particular questions that you may have.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

at an oversight hearing by the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

on

OPM RESPONSIBILITY FOR BENEFIT CHANGES UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEPTEMBER 5, 1996

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

GOOD MORNING. THANK YOU FOR YOUR INVITATION TO COME TODAY TO DISCUSS THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. YOU ASKED ME TO ADDRESS THE RATIONALE FOR, AND OUR EXPERIENCE WITH, THE 1996 CHANGE IN PRESCRIPTION DRUG BENEFITS FOR STANDARD OPTION ENROLLEES WITH MEDICARE PART B IN THE BLUE CROSS AND BLUE SHIELD HEALTH PLAN. YOU ALSO ASKED FOR OUR VIEWS ON SEVERAL PROPOSALS WHICH WOULD REQUIRE HEALTH PLANS TO INCLUDE BENEFITS FOR SPECIFIC SERVICES OR SUPPLIES, OR TO ALLOW DIRECT ACCESS TO CERTAIN PROVIDERS.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AIDS IN ENABLING THE GOVERNMENT TO COMPETE FOR WELL-QUALIFIED EMPLOYEES. IT HAS EXISTED SINCE 1960 WHEN THERE WERE 36 HEALTH PLANS. TODAY, WE CONTRACT WITH 381 HEALTH PLANS, PROVIDING COMPREHENSIVE MEDICAL CARE, AT AN AFFORDABLE PRICE, TO ALMOST 10 MILLION FEDERAL EMPLOYEES, RETIREES, AND THEIR ELIGIBLE FAMILY MEMBERS. IT IS

THE COUNTRY'S LARGEST EMPLOYER-SPONSORED HEALTH INSURANCE PROGRAM.

WE BELIEVE THAT THIS PROGRAM HAS AN ENVIABLE TRACK RECORD. AGGREGATE PREMIUM INCREASES UNDER THE PROGRAM FROM 1990 THROUGH 1995 WERE 5.2 PERCENT, COMPARED TO 9.6 PERCENT FOR PRIVATE SECTOR PLANS. MOREOVER, OUR ANNUAL SURVEYS CONFIRM HIGH RATES OF ENROLLEE SATISFACTION.

LET ME NOW TURN TO THE 1996 BENEFIT CHANGE YOU ASKED ME TO ADDRESS. IN 1996 FOR THE FIRST TIME, MEDICARE PART B ENROLLEES IN THE BLUE CROSS AND BLUE SHIELD STANDARD OPTION WERE REQUIRED TO PAY THE SAME COINSURANCE THAT ALL OTHER STANDARD OPTION ENROLLEES PAY FOR DRUGS PURCHASED AT RETAIL PHARMACIES. THE PLAN CONTINUED TO WAIVE COST SHARING ON MAIL ORDER DRUGS, AND CONTINUED TO WAIVE THE ANNUAL DEDUCTIBLE ON RETAIL DRUGS, FOR THE MEDICARE GROUP. THIS CHANGE WAS DESIGNED TO PROMOTE USE OF THE MAIL ORDER PROGRAM FOR PRESCRIPTIONS IN EXCESS OF 21 DAYS BECAUSE OF THE SIGNIFICANT DISCOUNTS ACHIEVED.

THIS BENEFIT CHANGE OCCURRED DURING BILATERAL NEGOTIATIONS ON BENEFITS AND PREMIUM RATES FOR 1996. DRUG BENEFITS ACCOUNTED FOR $1 IN EVERY $5 IN MEDICAL COSTS IN 1994. DESPITE SAVINGS FROM A RANGE OF INITIATIVES, COST TRENDS FOR PRESCRIPTION DRUGS WERE INCREASING AT A 20 PERCENT ANNUAL RATE, WELL IN EXCESS OF OTHER MEDICAL COSTS. WITHOUT SOME ACTION, PREMIUMS WOULD HAVE HAD TO

INCREASE TO COVER THESE COSTS.

UTILIZATION DATA INDICATED THAT 61 PERCENT OF THE PLAN'S COSTS FOR PRESCRIPTION DRUGS WERE INCURRED BY ANNUITANTS WITH MEDICARE PART B AS THEIR PRIMARY COVERAGE. GIVEN THE ABSENCE OF ANY PRESCRIPTION DRUG COINSURANCE REQUIREMENT, MEDICARE ELIGIBLE ENROLLEES USED RETAIL PHARMACIES FOR 90 PERCENT OF THEIR PRESCRIPTIONS, COMPARED TO 20 PERCENT FOR ALL OTHER ENROLLEES. THIS RESULTED IN SIGNIFICANTLY HIGHER COSTS TO THE PLAN.

THE CHANGE WE AGREED TO GIVES MEDICARE PART B ENROLLEES AN INCENTIVE TO MAKE COST-CONSCIOUS SELECTIONS FOR THEIR PRESCRIPTION DRUG NEEDS, JUST LIKE OTHER STANDARD OPTION ENROLLEES. IF A MEMBER CHOOSES NOT TO USE MAIL ORDER, OR IN THOSE CASES WHEN IT WOULD BE INAPPROPRIATE, THE PLAN'S NEGOTIATED PRICES ON DRUGS OBTAINED FROM THE PLAN'S PREFERRED RETAIL PHARMACIES STILL RESULT IN LOW COSTS EVEN WITH THE COINSURANCE. IN 1995, THE AVERAGE 30-DAY COINSURANCE PAID BY ENROLLEES AT PREFERRED PHARMACIES WAS $2 FOR GENERIC DRUGS AND $6.68 FOR BRAND-NAME PRODUCTS.

BASED ON RECENT PRESCRIPTION DRUG UTILIZATION DATA, WE BELIEVE THIS CHANGE AVOIDED PREMIUM INCREASES TOTALLING $144 YEARLY FOR A FAMILY AND THAT PROGRAM COSTS AVOIDED BY THIS DRUG BENEFIT CHANGE WILL BE APPROXIMATELY $200 MILLION IN 1996.

WHEN THIS CHANGE WENT INTO EFFECT, THERE WAS A HUGE AND IMMEDIATE SHIFT TO THE MAIL ORDER PROGRAM BY ENROLLEES WITH MEDICARE. THE DEMAND FOR MAIL ORDER SERVICES DOUBLED DURING JANUARY 1996, FAR EXCEEDING THE ANTICIPATED RATE OF INCREASE AND CAUSING NUMEROUS SERVICE PROBLEMS. WE DIRECTED THE PLAN TO TAKE IMMEDIATE ACTION TO REMEDY THE SITUATION AND TO REPORT WEEKLY ON THEIR PROGRESS.

AT OUR DIRECTION, BLUE CROSS AND BLUE SHIELD AND ITS MAIL ORDER PROVIDER INCREASED PROCESSING AND CUSTOMER SERVICE CAPACITY. THEY MET STANDARDS FOR ACCEPTABLE CUSTOMER SERVICE IN A MATTER OF WEEKS, AND OPERATIONS WERE ESSENTIALLY BACK TO NORMAL BY MID-MARCH. WE ALSO DIRECTED THE PLAN TO AUTHORIZE THE USE OF PREFERRED RETAIL PHARMACIES AT NO COST WHENEVER THERE IS A LIKELIHOOD THAT SERVICE STANDARDS FOR THE MAIL ORDER PROGRAM WILL NOT BE MET.

CONCERNS EXPRESSED BY ENROLLEES CONFINED TO NURSING HOMES ALSO ALERTED US TO THE FACT THAT THE MAIL ORDER PROGRAM WAS NOT A VIABLE OPTION FOR THOSE INDIVIDUALS. AGAIN, WE DIRECTED THE PLAN TO RESTORE THE COINSURANCE WAIVER WHEN THIS WAS THE CASE.

MR. CHAIRMAN, YOU EXPRESSED AN INTEREST IN THE EXTENT TO WHICH MERCK-MEDCO MET ITS CONTRACTUAL OBLIGATIONS TO BLUE CROSS AND BLUE SHIELD. WHILE BLUE CROSS AND BLUE SHIELD CAN RESPOND MORE DIRECTLY, OUR MEASURE OF THIS IS WHETHER OUR ENROLLEES RECEIVE THE BENEFITS AND LEVELS OF SERVICE DESCRIBED IN THE BROCHURE. WE

EXPECT THAT ENROLLEES WILL RECEIVE ALL OF THE BENEFITS PROMISED BY THEIR HEALTH PLAN. IT IS THE PLAN'S RESPONSIBILITY TO MAKE SUITABLE ARRANGEMENTS TO DO SO. WHEN THAT IS NOT THE CASE, AS WAS THE SITUATION HERE, WE WILL DIRECT THAT CORRECTIVE ACTIONS BE TAKEN. IN THIS INSTANCE, WE BELIEVE THAT ADDITIONAL COSTS RESULTING FROM THE PLAN'S FAILURE TO MEET ITS SERVICE OBLIGATIONS SHOULD NEITHER BE BORNE BY THE ENROLLEE NOR THE PROGRAM.

IN APPROACHING THIS ISSUE FOR 1997, WE COMMISSIONED THE GALLUP ORGANIZATION IN JUNE TO SURVEY ENROLLEES IN THE FIVE LARGEST FEE-FOR-SERVICE HEALTH PLANS WHO HAD REQUIRED PRESCRIPTION DRUGS IN THE PRECEDING 3 MONTHS. THE SURVEY'S PURPOSE WAS TO COMPARE CUSTOMER SATISFACTION WITH SERVICES PROVIDED BY RETAIL PHARMACY AND MAIL ORDER DRUG PROGRAMS. IN PARTICULAR, WE WANTED TO DETERMINE IF THE OPINIONS OF ENROLLEES COVERED BY MEDICARE PART B DIFFERED FROM OTHERS IN THIS REGARD. THE RESULTS OF THE SURVEY ARE SHOWN ON CHART NUMBER 1.

AS YOU CAN SEE, ENROLLEES IN THE BLUE CROSS AND BLUE SHIELD PLAN RATED THEIR MOST RECENT PRESCRIPTION DRUG EXPERIENCE VERY HIGHLY FOR BOTH RETAIL PHARMACY AND MAIL ORDER PROVIDERS. AT 93 PERCENT, MEDICARE ELIGIBLE RESPONDENTS EXPRESSED VIRTUALLY THE SAME LEVEL OF SATISFACTION WITH THEIR MOST RECENT PRESCRIPTION DRUG EXPERIENCE AS OTHER MEMBERS. THERE WAS NO DIFFERENCE IN MEMBERS' SATISFACTION WITH RETAIL PHARMACY AND MAIL ORDER AS A MEANS OF OBTAINING PRESCRIPTION DRUGS.

MR. CHAIRMAN, YOU ALSO EXPRESSED AN INTEREST IN BENEFITS AND COST TRENDS IN THE LARGEST PLANS. THE FIVE PLANS INCLUDED IN THE GALLUP SURVEY ACCOUNT FOR 67 PERCENT OF FEDERAL ENROLLEES. THIS INFORMATION IS SHOWN ON CHART NUMBER 2.

AS YOU VIEW THE CHART, I WOULD NOTE THAT THE MAILHANDLERS PLAN IS UNIQUE IN THAT IT INCLUDES NO MAIL ORDER DRUG PROGRAM, WHILE ITS RETAIL PHARMACY BENEFIT FEATURES RELATIVELY HIGH DEDUCTIBLES AND THE PREFERRED RETAIL PHARMACY NETWORK OFFERS AUTOMATED CLAIMS PROCESSING BUT DOES NOT WAIVE EITHER THE DEDUCTIBLE OR COINSURANCE. THUS, PRESCRIPTION DRUGS REPRESENT ONLY 2.9 PERCENT OF TOTAL BENEFITS PAID IN 1995, ALTHOUGH THE ANNUAL RATE OF INCREASE HAS RECENTLY BEEN 100 PERCENT.

ALSO, PLEASE BEAR IN MIND THAT THERE ARE SEVERAL REASONS THAT ACCOUNT FOR THESE DIFFERENT RATES OF CHANGE. ONE IS BENEFIT STRUCTURE. A HALLMARK FEATURE OF THIS PROGRAM IS THAT IT OFFERS A VARIETY OF PLANS WITH A VARIETY OF BENEFIT PACKAGES. IN ADDITION, CHANGES CAN BE INFLUENCED BY SUCH FACTORS AS DEMOGRAPHICALLY DIFFERENT ENROLLEE POPULATIONS, AND THE RELATIVE CONVENIENCE OF USING DIFFERENT CLAIMS SYSTEMS.

CHART NO. 3 COMPARES THE PRESCRIPTION DRUG BENEFITS OF BLUE CROSS AND BLUE SHIELD AND THE OTHER 4 PLANS IN THE SURVEY.

YOU ALSO REQUESTED OUR VIEWS ON THREE BILLS WHICH WOULD AFFECT

COVERAGE UNDER FEDERAL EMPLOYEE HEALTH PLANS FOR PARTICULAR HEALTH SERVICES OR HEALTH CARE PROVIDERS. H.R. 1057 AND H.R. 3292, RESPECTIVELY, WOULD ADD AUDIOLOGISTS AND ACUPUNCTURISTS TO THE LIST OF PROVIDERS IN A PROVISION OF LAW GOVERNING THE PROGRAM. THAT PROVISION REQUIRES FEE-FOR-SERVICE HEALTH PLANS TO ALLOW ENROLLEES DIRECT ACCESS TO CERTAIN NON-PHYSICIAN PROVIDERS WHO ARE AUTHORIZED TO PERFORM A SERVICE OTHERWISE COVERED BY THE PLAN'S CONTRACT.

WE RECOGNIZE THAT THE USE OF QUALIFIED HEALTH PRACTITIONERS OTHER THAN PHYSICIANS HAS THE POTENTIAL TO REDUCE COSTS AND CAN WIDEN THE CHOICES AVAILABLE TO ENROLLEES IN OBTAINING HEALTH CARE. HOWEVER, WE ARE CONCERNED THAT MANDATING ACCESS TO THE SERVICES OF SPECIFIC PROVIDERS IS CONTRARY TO THE PROGRAM'S GUIDING PHILOSOPHY OF ALLOWING FLEXIBILITY FOR PLANS TO RESPOND TO CHANGING HEALTH CARE PRACTICES AND INDIVIDUAL ENROLLEE NEEDS IN THE MOST EFFECTIVE WAY. THEREFORE, WE OPPOSE H.R. 1057 AND H.R. 3292.

THE THIRD BILL WOULD AMEND THE PORTION OF THE LAW THAT DESCRIBES THE GENERAL CATEGORIES OF BENEFITS HEALTH PLANS MAY OFFER TO INCLUDE COVERAGE FOR THE COST OF MEDICAL FOODS. MEDICAL FOODS ARE LIQUID NUTRIENTS WHICH MAY OR MAY NOT REQUIRE A PRESCRIPTION AND ARE ADMINISTERED UNDER A DOCTOR'S SUPERVISION FOR THE SPECIFIC DIETARY MANAGEMENT OF A MEDICAL DISORDER OR DISEASE. WHEN FEDERAL LAW REQUIRES A PRESCRIPTION, THESE FOODS ARE COVERED

LIKE OTHER MEDICATIONS.

ONE OF THE ENDURING STRENGTHS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM IS THAT THE ENABLING LEGISLATION HAS HISTORICALLY SPECIFIED ONLY BROAD PROGRAM STRUCTURE AND HAS AUTHORIZED OPM TO CONTRACT WITH QUALIFIED CARRIERS FOR A VARIETY OF PLANS AND BENEFIT LEVELS. IN OUR PREVIOUS REPORT TO THE SUBCOMMITTEE ON THIS PROPOSAL, OPM NOTED THAT CURRENT LAW ALREADY INCLUDES SUFFICIENT FLEXIBILITY TO ADDRESS COVERAGE FOR MEDICAL FOODS UNDER EXISTING CONTRACTING AUTHORITY.

BENEFITS FOR MEDICAL FOODS ARE A VERY GOOD EXAMPLE OF OUR HEALTH PROGRAM'S CAPACITY TO RESPOND TO ENROLLEE NEEDS. OPM HAS TRANSMITTED FORMAL GUIDANCE TO PARTICIPATING HEALTH PLANS WHICH SPECIFICALLY ASKED THEM TO PROVIDE COVERAGE OF NON-PRESCRIPTION MEDICAL FOODS IN APPROPRIATE CASES AS PART OF OUR FLEXIBLE SERVICES OPTION. THE FLEXIBLE SERVICES OPTION GIVES PLANS DISCRETION TO OFFER BENEFITS FOR MEDICALLY APPROPRIATE SERVICES NOT OTHERWISE COVERED BY THE CONTRACT WHEN THIS WILL EFFECTIVELY SERVE THE BEST INTERESTS OF A PARTICULAR PATIENT. WE ARE CONFIDENT THAT PLANS ARE COMPLYING WITH OUR GUIDANCE, AS EVIDENCED BY THE LACK OF COMPLAINTS THAT MEDICAL FOODS BENEFITS HAVE BEEN DENIED.

OPM IS STRONGLY COMMITTED TO WORKING ADMINISTRATIVELY WITH HEALTH PLANS THROUGH THE ANNUAL CONTRACTING PROCESS TO PROVIDE ACCESS TO

THE MOST APPROPRIATE HEALTH CARE SERVICES AT A REASONABLE COST. ACCORDINGLY, WE RECOMMEND AGAINST ENACTMENT OF H.R. 2009 BECAUSE IT MIGHT ULTIMATELY INHIBIT THAT FLEXIBILITY.

I WOULD BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE FOR ME NOW.

SURVEY RESULTS

HEALTH PLAN	PERCENT SATISFIED WITH...* PRESCRIPTION DRUG BENEFIT	LAST RETAIL EXPERIENCE	LAST MAIL EXPERIENCE
Blue Cross/Blue Shield			
All enrollees	88	94	93
Medicare B	88	93	93
APWU (American Postal Workers Union)			
All enrollees	95	94	97
Medicare B	98	97	99
GEHA (Government Employees Hospital Association)			
All enrollees	90	95	96
Medicare B	93	97	97
Mail Handlers			
All enrollees	54	88	NA
Medicare B	69	89	NA
NALC (National Association of Letter Carriers)			
All enrollees	93	95	95
Medicare B	95	96	96
All Respondents			
All enrollees	**86**	**94**	**94**
Medicare B	**89**	**93**	**93**

* Results are percent responding "Excellent," "Very Good," or "Good" as of June 1996
Survey has confidence level of 95%

Chart No. 1

PRESCRIPTION DRUG BENEFITS			
Five Largest FEHBP Plans	Prescription Drugs As Percentage of Total Benefits Paid -- 1995	1994 - 1995 Rate of Cost Increase	
		Retail	Mail Order
Blue Cross/Blue Shield	22%	22%	-10%
GEHA (Government Employees Hospital Association)	18%	15%	23%
NALC (National Association of Letter Carriers)	17%	44%	25%
APWU (American Postal Workers Union)	22%	14%	-7%
Mail Handlers	2.9%	100%	*N.A.*

Chart No. 2.

Comparison of Prescription Drug Benefits of the Five Largest FEHB Plans

--Mail Order vs. Retail--

Five Largest FEHBP Plans		Mail Order Benefits - Copay -		Retail Pharmacy Benefits - Coinsurance - Deductible -		
		Brand	Generic	**PREFERRED** Brand	Generic	**REGULAR** Brand and Generic
Blue Cross/ Blue Shield	HIGH Option	$8	$8	15% after $50 deductible	(same)	35% after $50 deductible
	STD Option	$12	$12	20% after $50 deductible	(same)	40% after $50 deductible
GEHA (Government Employees Hospital Association)		$20	$5	Greater of $15 or 50% of Preferred charge	Greater of $5 or 50% of Preferred charge	Greater of $15/5 or 50% of Preferred charge
NALC (National Association of Letter Carriers)		$12	$12	20% after $25 deductible	(same)	40% after $25 deductible
APWU (American Postal Workers Union)		15%	(no copay)	15% after $25 deductible	(same)	30% after $25 deductible
Mail Handlers	HIGH Option	*N.A.*	*N.A.*	25% after $300 deductible *(no claim filing)*	(same)	25% after $300 deductible *(must file claims)*
	STD Option	*N.A.*	*N.A.*	30% after $600 deductible *(no claim filing)*	(same)	30% after $600 deductible *(must file claims)*

Chart No. 3

Mr. MICA. Let me ask, if I may, you have heard a request today again for the inclusion of certain coverages and OPM does oppose mandating those coverages. What specific steps do you take in working with some of these different folks that want to provide these services in coordinating or requesting that the carriers give them a fair hearing or fair access?

Mr. FLYNN. We undertake a number of activities, Mr. Chairman. I might perhaps do this in sort of at one end of the continuum and at another, recognizing that any number of activities in between are possible. And while it is not a health care provider, but we are often approached by particular organizations or companies who are desirous of perhaps entering into a subcontract or similar kind of arrangement with one of our health plans or any number of our health plans in the Federal Employees' Health Benefits Program.

And in those situations, we can meet with that particular group of individuals, suggest who they might be in touch with and, in fact, provide them with a list of contacts so that they can then go to the plans, make the plans aware of the services they provide. And if a subcontracting or similar kind of arrangement makes sense, they are free to engage in that.

On the other end of the continuum, I guess I might just talk a little bit about the intensive and exhaustive pattern of consultation or discussion that occurred after we accepted Blue Cross and Blue Shield's benefit change for Medicare part B enrollees last year. We heard immediately from many of the same people that testified here earlier this morning late last November and in early December. And over the course of the 8 or 10 months that have gone on since then, we have met on a number of occasions with other representatives of the retail pharmacy, community pharmacy, industry.

We have had working sessions with some of their experts in benefit design. We have sponsored meetings with those organizations with our carriers. Earlier this spring, I was asked to address a legislative meeting of the National Association of Retail Druggists. So we have spent a great deal of time consulting individually and in a collective capacity with people who have an interest in this program.

In addition, we consulted with the National Association of Retired Federal Employees, who came to us on behalf of Medicare part B retirees who are also members there. And we spent a great deal of time with others in the industry in the area of public health and in terms of benefit design.

All this is by way of saying that the types of activities we can engage in to make carriers aware of the specific types of services that providers might be able to provide and how that fits into a health benefits program can take on a range of activities.

And we are more than willing to make sure that the carriers who go to make up this program are made aware of advances in health care, health care techniques, health care delivery, and consider in appropriate circumstances how their particular programs can be structured in ways that take advantage of those advances.

Mr. MICA. Well, today we have heard some testimony and the audiologists testified they think that they can deliver services directly and more cost effectively. The medical foods representative

testified that, in fact, that they could save money in the long term. Dr. Eist from the American Psychiatric Association talked about the loss of job performance, the cost of lost wages and productivity, et cetera. Even the acupuncturist representative and pastoral counselor felt that they could save money by providing their service.

Does OPM conduct any specific studies or take any initiatives to determine whether there, in fact, can be cost savings and then act accordingly to see that those services are provided, or there is some type of requirement for their insurance providers to look at those services?

Mr. FLYNN. I guess the best way to answer that, Mr. Chairman, is it depends on the issue. We have in some cases, but we largely rely on the carriers who go to make up the health benefits program and on others within the executive branch who have particular expertise in these areas.

As you have pointed out earlier this morning, we have just under 150 people who run the Federal Employees' Health Benefits Program and that administration of the program is largely contractual in nature. So we have to rely largely on the work of others and assess that work and make a judgment about whether or not that work is of such a nature and such a degree of persuasion as would cause us to change the benefit structure of the program.

Mr. MICA. When we went to the 20-percent copayment and eliminating that in the mail order, was that initiated by the carrier or did you all have any part or role or study that you played in encouraging that type of approach?

Mr. FLYNN. Well, Mr. Chairman, we certainly encourage approaches that provide quality care, access to care, at an affordable price. But to answer your specific question, the imposition of the copayment on Medicare part B enrollees in the Blue Cross and Blue Shield standard option program was brought to us by Blue Cross and Blue Shield as their initiative. It is one that we then studied, made sure we understood its impact and understood its financial implications, and then negotiated that benefit with them. But it did come initially from the Blue Cross and Blue Shield plan.

Mr. MICA. The Congress has been reluctant in mandating specific types of coverage. Is there anything else or any other approach that we should take that would require OPM to look at some of these services or something that we could do to encourage the carriers to adopt more cost-effective services being provided?

Mr. FLYNN. Mr. Chairman, I cannot think of anything specific offhand. I think on the basis particularly of the testimony that we heard from the second panel, you have seen that we have engaged with some of the interests represented and, in some cases, we have moved in a direction that seems appropriate or that accommodates some of their interests, though perhaps not all the way in terms of where they would like to be

The one thing that I hear and take back in terms of that particular interest is that we need to think about, I believe, ways of making sure that there is regular and systematic exposure of our health benefit carriers to these kinds of interests and regular and systematic analysis of whether or not those types of things make sense in the benefit structure that we are trying to achieve from 1 year to the next.

And I think we can be of some help in that regard and I know that you have encouraged us to do that in the past. And I would want to give some thought to how we do that, but that is something that we are clearly able to do.

Mr. MICA. I thank you. I want to change the subject, and that is your 5-minute warning. I will self-destruct in 5 minutes. Saved by the bell.

But I want to change the subject for a few minutes here and ask about the FEHBP premium calculation. The Clinton administration has consistently submitted budgets which assert that the Government's contribution to FEHBP premiums will be calculated using a so-called "big five" formula upon the expiration of the current Aetna proxy formula.

In June of this year, Director King advised me that this "big five" formula would have increased the cost to enrollees by over $1 billion if it had been in effect for 1996. He also noted that, and this is a quote from him, "The administration has not offered an alternative to change what is presently scheduled to occur under current law."

For the record, could you please explain the current formula for calculating premiums and how the "big five" differs?

Mr. FLYNN. Yes, sir, Mr. Chairman, I will attempt to do that. One point that I might add is that the expiration of the current formula for determining the Government contribution is actually a provision of the Omnibus Budget Reconciliation Act of 1993, a portion of which affecting the contribution formula goes into effect in 1997 for a small portion, another small portion in 1998, and then the complete expiration of the phantom formula, or the "big six" formula in 1999.

The "big six" formula, Mr. Chairman, was established in the early years of the FEHBP. It essentially provides a mechanism for determining the maximum amount that the Government will contribute toward the cost of any particular individual's health insurance. And it is the average of the six largest plans in the program, fee-for-service employee organizations and health maintenance organizations.

It became no longer six plans in 1989 when Aetna, which had been one of the insurers in the program, ceased to participate in the program. And it was at that time that this phantom formula came into place, which essentially preserved the basic features of the "big six" formula and provided a mechanism to automatically calculate what the Aetna premium would have been had they continued to participate in the program.

I might also add that once the formula has been calculated, the Government will pay 60 percent of that weighted average in a plan, no more than 75 percent of an individual premium in an individual plan. And that has resulted, as you said earlier, Mr. Chairman, in a split on average in the program where the Government pays about 71 percent of the total premium and the employee pays about 29 percent.

In 1997, there is a slight adjustment to that formula that will result in employees, on average, paying about 38 cents more per month than they otherwise would have. That figure will double the

next year so that employees will pay about 76 cents per month more than they would have under the phantom formula.

But when the formula expires and we move to a "big five" formula, there is a cost shift that occurs as the result of the application of that formula against the five largest plans that would take the Government's contribution from its current level at about 71 or 72 percent and it would shift over a large proportion of that. So that, whereas, employees are now paying about 29 percent, they would be paying about 36 percent. In dollar terms for the average enrollee, that is about $20 a month, or $240 a year in increased premium costs based on 1996 rates, all other things being equal.

Mr. MICA. Will OPM be taking any steps to reduce the cost impact on people enrolled in the program?

Mr. FLYNN. Both the Office of Personnel Management and, of course, the administration are aware of the statutory expiration of the current formula in 1999. There are no particular plans at the present to change that formulation and, as you know, the savings to the Government that are associated with that have been included in the 5-year projections of costs and savings to the Government.

I suspect because of that impact that there will likely be proposals from a variety of sources and, of course, all of them will have to be considered in light of the expiration of the formula.

Mr. MICA. In 1995, I proposed instituting a fixed dollar Government contribution. This would have strengthened the hand of beneficiaries and created additional incentives for plans to limit cost increases. Director King informed me that this proposal would have saved $434 million in fiscal year 1996.

Why did the administration oppose this innovative effort?

Mr. FLYNN. Well, Mr. Chairman, and I have not seen the actual calculation of the annual savings in terms of 1996—is that correct—but a lot of this depends upon what period of time you measure the impact of the proposal and how it might occur.

If I were to take 10 years of experience in this program, which would reflect some of the cyclical patterns that we have seen in the program and perhaps be more reflective of our experience in general, I could also take that particular proposal and see the Government share going down over that period by about 37 percent, resulting in an increase, on the average, to the enrollee of about $80 a month in terms of cost.

Those are the kinds of things that we need to take into account. And that is driven largely, Mr. Chairman, by the fact that even though we have had several recent years of very good experience in terms of premium increases, the underlying rate of increase in medical cost in the economy is still there and it will affect this program, as it does affect health care programs of other employer purchasers.

So we would approach that particular proposal with a lot of caution and want to make sure we understood fully what its implications would be and what the impact might be over a broader period of time.

Mr. MICA. I have additional questions, Mr. Flynn, that I am going to submit. We have run out of time. Some deal with the pre-

mium increase forecasts. I didn't get into the prescription drug program questions that I wanted to also ask.

I will ask unanimous consent that those questions be submitted to you along with questions from Mrs. Morella, and I also have questions submitted related to silent PPO's from Mr. Burton, and a unanimous-consent request to accept Representative Burton's opening statement for the record. I also have a unanimous-consent request from the ranking member, Mr. Moran, so we will submit those questions.

Without objection, all of those questions will be forwarded to you and other appropriate witnesses and be made a part of the record.

[The prepared statement of Hon. Dan Burton follows:]

OPENING STATEMENT
THE HONORABLE DAN BURTON
SEPTEMBER 5, 1996

MR. CHAIRMAN, I FIRST WANT TO THANK YOU FOR HOLDING THIS HEARING TODAY. THE FEDERAL EMPLOYEES HEALTH BENEFIT (FEHB) PROGRAM IS VERY IMPORTANT TO THOSE OF MY CONSTITUENTS WHO ARE FEDERAL EMPLOYEES OR RETIREES AND TO THE HEALTH CARE PROVIDERS THAT SERVE THEM.

THE FEHB PROGRAM HAS MANY STRENGTHS. IT OFFERS FEDERAL EMPLOYEES AND RETIREES A WIDE RANGE OF HEALTH PLAN CHOICES, INCLUDING HMOs AND FEE-FOR-SERVICE PLANS. IT PROVIDES COVERAGE FOR PREEXISTING CONDITIONS. THIS SUBCOMMITTEE HAS LOOKED AT THE POSSIBILITY OF INCLUDING OUR NATION'S MILITARY FAMILIES, RETIREES, AND THEIR DEPENDENTS IN THE FEHB PROGRAM, AND I SUPPORT THE CHAIRMAN'S INITIATIVE IN THIS AREA.

MANY FEDERAL RETIREES AND PHARMACISTS IN MY DISTRICT HAVE EXPRESSED TO ME THEIR CONCERNS REGARDING THE MAIL ORDER PRESCRIPTION DRUG PROGRAM AND THE 20% CO-PAYMENT FOR OBTAINING PRESCRIPTION DRUGS FROM LOCAL PHARMACIES. HOWEVER, THE OFFICE OF PERSONNEL MANAGEMENT HAS STATED THAT WITHOUT THIS BENEFIT CHANGE, PREMIUMS FOR ALL BLUE CROSS AND BLUE SHIELD STANDARD OPTION ENROLLEES WOULD HAVE INCREASED BY $5.42 PER MONTH FOR INDIVIDUALS AND BY $12.03 PER MONTH FOR FAMILIES.

WHILE CONGRESS DID NOT LEGISLATE THESE CHANGES, WE HAVE A RESPONSIBILITY TO CAREFULLY REVIEW THE BLUE CROSS AND BLUE SHIELD PRESCRIPTION DRUG PROGRAM AND ENSURE THAT FEDERAL RETIREES RECEIVE QUALITY HEALTH CARE AT A REASONABLE PRICE.

A NUMBER OF BILLS WHICH WOULD EITHER MANDATE THAT THE FEHB PROGRAM COVER CERTAIN BENEFITS OR REQUIRE THAT HEALTH CARE PROVIDERS RECEIVE DIRECT REIMBURSEMENT FOR SERVICES HAVE BEEN REFERRED TO THIS SUBCOMMITTEE. ONE OF THESE IS H.R. 1057, INTRODUCED BY MY FRIEND AND COLLEAGUE FROM NEW YORK, CONGRESSMAN BEN GILMAN. H.R. 1057 WOULD PROVIDE FOR DIRECT COVERAGE OF HEARING CARE SERVICES BY AUDIOLOGISTS UNDER THE FEHB PROGRAM.

AUDIOLOGISTS IN MY DISTRICT ARE IN VERY STRONG SUPPORT OF H.R. 1057. I AM PLEASED THAT THE AMERICAN ACADEMY OF AUDIOLOGY AND A NUMBER OF OTHER ORGANIZATIONS THAT ARE CONCERNED ABOUT THIS ISSUE ARE HERE TO TESTIFY TODAY, AND I LOOK FORWARD TO HEARING THEIR PERSPECTIVES ON H.R. 1057.

AGAIN, MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS HEARING. I LOOK FORWARD TO THE TESTIMONY FROM OUR WITNESSES AND THE DISCUSSION TO FOLLOW.

Mr. MICA. There being no further business to come before the subcommittee, I want to thank you for your participation. Again, we will be asking you written questions. I do hereby declare this meeting of the Subcommittee on the Civil Service adjourned. Thank you.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Rep. Ben Gilman

Opening Statement
Civil Service Subcommittee
September 5, 199

I WANT TO THANK CHAIRMAN MICA FOR HOLDING THIS HEARING ON THE FEDERAL EMPLOYEE HEALTH BENEFIT (FEHB) PROGRAM. ALL THREE PANELS WILL EXAMINE IMPORTANT ASPECTS OF THE FEDERAL HEALTH BENEFIT PROGRAM.

THE FIRST PANEL WILL FOCUS IN ON THE BLUE CROSS/BLUE SHIELD PRESCRIPTION DRUG COPAYMENT ISSUE. THE COPAY CHANGE CAUSED A MAJOR DISRUPTION IN THE RELATIONSHIPS THAT FEDERAL RETIREES HAVE WITH THEIR LOCAL COMMUNITY PHARMACIST.

AS WE ALL KNOW, MOST FEDERAL RETIREES CANNOT AFFORD PAYING 100 PERCENT OF THE COST OF THEIR PRESCRIPTIONS AT THE LOCAL PHARMACY AND MUST USE THE MAIL ORDER PROGRAM.

HOWEVER MORE IMPORTANTLY, IS THE QUALITY OF CARE ISSUE. DUE TO THE COPAY CHANGE MANY RETIREES WITH MULTIPLE DRUG PRESCRIPTIONS ARE NOT NOW AFFORDED THE OPPORTUNITY OF CARE BY A LOCAL PHARMACIST. THERE IS NO SUBSTITUTE FOR ONE-ON-ONE INTERACTION TO HELP MONITOR WHETHER A RETIREE IS TAKING THEIR MEDICATIONS CORRECTLY OR IF THEY ARE HAVING ANY PROBLEMS.

I AM PARTICULARLY GRATEFUL TO THE CHAIRMAN FOR THE INCLUSION OF H.R. 1057 IN THE SECOND PANEL. AS MY COLLEAGUES MAY KNOW, ON FEBRUARY 27, 1995, I INTRODUCED H.R. 1057, LEGISLATION WHICH WOULD COVER AUDIOLOGY SERVICES FOR FEDERAL EMPLOYEES. THIS LEGISLATION IS AN ATTEMPT TO REQUIRE FEDERAL HEALTH BENEFIT INSURANCE CARRIERS TO GUARANTEE DIRECT ACCESS TO, AND REIMBURSEMENT FOR, AUDIOLOGIST-PROVIDED HEARING CARE SERVICES WHEN HEARING CARE IS COVERED UNDER A FEDERAL HEALTH BENEFIT PLAN.

WE ALREADY ALLOW DIRECT ACCESS TO SERVICES PROVIDED BY OPTOMETRISTS, CLINICAL PSYCHOLOGISTS AND NURSE MIDWIVES, YET FAIL TO ALLOW DIRECT ACCESS TO SERVICES PROVIDED BY AUDIOLOGISTS IN FEDERAL HEALTH BENEFIT PLANS COVERING HEARING CARE

SERVICES.

AT NO POINT WAS IT MY INTENTION, UPON INTRODUCING H.R. 1057, TO EXPAND THE SERVICES WHICH CAN BE PROVIDED BY AUDIOLOGISTS. MY LEGISLATION WILL ONLY ALLOW AUDIOLOGISTS TO PROVIDE WHAT THEY ARE ALREADY LICENSED TO DO UNDER STATE LAW -- AND NO MORE.

INSTEAD, WHAT H.R. 1057 DOES IS PROVIDE FREEDOM OF CHOICE TO THE PATIENT WHILE PROVIDING SWIFT AND TIMELY ACCESS TO HEARING CARE.

I AM CONFIDENT THAT TODAY'S HEARING WILL PROVE TO THE SUBCOMMITTEE THE NEED FOR H.R. 1057, AND I LOOK FORWARD TO WORKING WITH CHAIRMAN MICA IN MOVING THIS BILL FORWARD AND ON TO THE HOUSE FLOOR

BEFORE ADJOURNMENT.

I LOOK FORWARD TO BOTH HEARING FROM ALL OF OUR PANELS AND PARTICIPATING IN THE DISCUSSIONS TO FOLLOW.

Representative Bernard Sanders
September 1996
House Civil Service Subcommittee Hearing on BC/BS FEHBP
Prescription Drug Program

Mr. Chairman,.

I am pleased that you called this hearing to address the findings of the GAO report on the impact of the recent imposition of the 20 percent community retail pharmacy copay on retirees and pharmacies. I have been contacted by constituents from all over the state of Vermont, including Poultney, Richford, Derby Line, and Burlington, expressing real concern over OPM decision to switch to mail order services and impose copays for retirees wishing to obtain prescriptions locally.

I believe very strongly, and the GAO report confirms my suspicion, that the 20 percent co-payment charged for prescriptions filled at local pharmacies "penalizes" Federal retirees who purchase their prescription drugs in their communities. The quality of health care for enrollees is jeopardized when they must choose between buying locally and treating an illness immediately, or sending away for the drugs by mail order to save 20 percent. Retirees, many of whom have multiple prescriptions, receive better care by a local pharmacist - there is no substitute for the personal interaction that occurs between a pharmacists and a retiree with questions about how to appropriately take their medicine. This is simply not fair, and it is not in the best interest of our Federal retirees.

This plan has also been bad for local economies. Long term relationships with local pharmacists are being replaced by impersonal mail order forms. Between January and May 1995, total average monthly prescription payments to retail pharmacies dropped by $95 million, or $228 million loss over a year's time, which clearly has an adverse impact on locally owned, community-based pharmacies and franchises.

The decision to implement this new policy was made as a cost-savings measure. I never believed that this particular measure would produce cost-savings for the enrollees, but rather, would reduce the quality of coverage and

access to health care. This is why in December I joined with other Members of Congress to ask OPM to delay the implementation of the new plan.

When OPM did not reverse this decision, I joined numerous other Members of Congress and sent another letter to OPM expressing concern. We asked OPM to explain the rationale behind implementing this plan, along with OPM's anticipated costs savings; to analyze the impacts of the plan on Federal retirees and locally owned pharmacies; and, to explain whether OPM considered the ramifications of this plan on Federal retirees and local pharmacies.

I have also cosponsored the Federal Health Program Benefits Change Accountability Act (HR 3462), which would require OPM to report to Congress regarding any proposed changes to Federal health plans in the future. This bill would require OPM to demonstrate to Congress how cost-savings are expected to be achieved and how the proposal will affect the quality and cost of enrollees' health care.

The GAO interim report confirms that OPM's policy change has resulted in late and misdirected prescriptions for beneficiaries. The report also details that the cost-savings were produced, not from the mail order program, but from increased out-of-pocket costs paid by retirees. Of the $200 million in savings that were generated from this copay change, almost 65 percent are from retiree copays paid at local pharmacies, not mail order efficiencies. Cost savings should come from reductions in prescription drug costs, not from the pockets of our retirees. Instead, OPM has tried to control costs by turning the management of the program over to drug manufacturer-owned pharmacy benefit managers. These firms have real incentives to sell their prescription drugs, not necessarily manage this program for the benefit of retirees. We also have to be concerned about reports that the managers of the mail order program were actually switching patient's drugs from the one prescribed by the doctor to the one that the drug manufacturer produces and sells.

Not only does this appear to be an obvious conflict of interest, but it is certainly poor management practices by OPM. OPM should have tried to save money by working with retirees and pharmacies by increasing the rate of lower-cost generic use before they put in place an anti-consumer mail order program. Other Federal agencies appear to receive far greater drug discounts

than FEHBP. It seems like OPM could have looked into this approach to cost savings as well.

Mr. Chairman,

To close, let me thank you again for calling this hearing. I hope the initial GAO report and this hearing will lead Congress to reverse the decision by OPM to switch to mail order prescriptions for retirees. Let me end by encouraging OPM to look to other, more consumer-friendly approaches to cost savings in the future.

TESTIMONY OF CONGRESSMAN MIKE DOYLE (PA-18)

BEFORE THE CIVIL SERVICE SUBCOMMITTEE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

September 5, 1996

Direct access to hearing services provided by clinical audiologists would dramatically improve the quality of life for approximately 28 million people in our country who are affected by hearing loss, streamline current insurance procedures, and in the long run will result in cost-savings for our health care system and its consumers.

The Health Care for Federal Employees Act, H.R. 1057, would amend the Federal Employees Health Benefits Program (FEHBP) to include audiologists as a recognized non-physician provider and thus allow federal employees to go directly to the health care professional who has the skills to address their hearing loss. Currently, an individual who is affected by hearing loss is required to jump through unnecessary hoops to receive the care they need. These hoops translate into added overall costs to our health care system, and inconvenience for individuals, by demanding an additional charge of a physician's office visit and by forcing them to make inefficient use of their time. It is also important to note that these "gate-keeping" initial visits often do not result in proper medical recommendations. For example, a scarce 18% of individuals are initially examined for vision problems. I'm sure all of us have had numerous visits to the eye doctor, but how many of us have had our hearing checked even once?

As a cosponsor of H.R. 1057, I strongly believe that providing direct access to audiology services is necessary if we are truly committed to finding ways to both improve the delivery of health care services and responsibly contain costs. Just as direct access to psychologists and optometrists is included by the FEHBP, we should now move forward to include audiology services. I am confident that H.R. 1057 will not only benefit the 270,000 people who currently seek audiological services each year under the FEHBP, but would encourage the individual experiencing hearing difficulties to seek the quality care they need to live a more productive life.

Hearing loss profoundly shapes our abilities and behavior. It is important to recognize that hearing loss is a significant health care issue that should be addressed by highly trained professionals, not "one-size-fits-all" pitches on our television sets. Hearing loss is not the same for everyone, and is not a cosmetic issue. A hearing aid's effectiveness is not determined by how small it is. Rather than having individuals make a phone call with their credit card in hand, we should encourage them to seek the services of an audiologist.

Hearing loss is no less difficult to deal with than other physical or psychological conditions. An inability to interact with others will quickly lead to a host of other problems. A proper audiological exam is the most effective way to address hearing loss. The Hearing Care for Federal Employees Act will enable individuals struggling with hearing loss to receive the health care they require directly.

I encourage the Committee on Government Reform and Oversight to expeditiously move this bill forward during the limited time left in the 104th Congress.

MORAN

Federal Employees' Health Benefits Program

Hearing before the Subcommittee on Civil Service

September 5, 1996

Issue: Coordination of Medicare and FEHB for married federal retirees age 65 and over.

Background: When a federal retiree enrolled in the FEHB program reaches age 65, eligibility for Medicare "Part A" coverage for in-patient hospital care begins automatically. In addition, the retiree has the option to enroll in, and pay premiums for, Medicare "Part B" for outpatient service coverage. (Part B monthly premiums are currently $42.50 per month, per person.) For federal *retirees* age 65 an over, Medicare pays first, and FEHB pays second, picking up costs not covered by Medicare. When FEHB pays second after Medicare, the FEHB plans generally waive their own copayments and deductibles. Thus, a federal retiree age 65 or over participating in FEHB and Medicare Part A would have no out-of-pocket costs for in-patient hospital care, and, if he or she participates in Medicare Part B, would have no out-of-pocket costs for outpatient doctor visits or, in most cases, prescription drugs.

However, if the retiree is married to a spouse who is still working, these rules do not apply. Most federal retirees are unaware of this exception for married retirees.

Questions for Witnesses for the U.S. Office of Personnel Management

I am concerned about coordination of medicare and FEHB benefits for married couples, both of whom are eligible for FEHB participation because one spouse is working for the government and the other is a federal retiree age 65 or over. In my district, there are many couples who both work for the federal government who may, at some time, find themselves in this situation. I understand that, under FEHB, the usual rule is that, for federal retirees, Medicare pays first, and FEHB pays second (thereby paying costs not paid by Medicare), *and* the FEHB plan usually waives its own copayments and deductibles. Thus, most federal employees and retirees are under the impression that, once they turn 65 and are covered by Medicare *and* FEHB, they will have virtually full coverage for medical costs and will not pay copayments and deductibles.

However, if a couple both of whom are eligible for FEHB, were to elect a *family policy* under FEHB while one spouse is still working, Medicare will not pay first for the retiree's medical care, and the FEHB plan will not waive copayments and deductibles for the retiree. I would like your answer to four questions:

First, please explain the difference between OPM's and HCFA's interpretation of Section 1862(b) of the Social Security Act regarding Medicare as second payer when a couple is

eligible for group health insurance like FEHB. What are the effects on married retirees of this difference of opinion and how is the issue going to be resolved?[1]

Second, regardless of the current law, what do you think the policy should be regarding coordination of benefits for Medicare and FEHB when both spouses of a couple are eligible for FEHB? Do you think this committee should consider clarification or modification of the law?

Third, if OPM's interpretation of Medicare secondary payer rules prevails, I am concerned that OPM's literature should adequately alert FEHB-eligible couples, one of whom is retired and Medicare eligible, to the consequences of which spouse's name is on a FEHB family policy. Would you be willing to address this concern and how might you go about it?

I would also like to know what kind of guidance is available for retirees when they turn age 65 and must make a decision about participating in Medicare Part B in addition to FEHB.

---

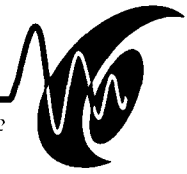
[1]OPM's interpretation is that if the retiree's name is on the family policy, Medicare will be first payer for the retiree's health care, regardless of the employment status of the spouse. HCFA's interpretation is that regardless of which spouse's name is on a family policy, Medicare will pay second as long as one spouse is still working.

QUESTIONS FOR PANEL 3
OFFICE OF PERSONNEL MANAGEMENT

Mr. Flynn, your statement did not address the issue of "Silent Preferred Provider Organizations (PPO's)." However, I believe you are the right person to ask. The Office of Personnel Management's structure for the Federal Employee Health Benefit Plan allows for Silent PPO's, as sort of entrepreneurs in the reimbursement part of the health care system. I have heard assertions about the potential of savings resulting from these broker/middlemen, although not how these savings devolve to either the federal government or the beneficiaries. I have also heard assertions of the potential damage which could be wrought by what might be seen as predatory practices by those who have no role in health care delivery. Could you give me your view of this practice and whether it might be worthwhile to have the General Accounting Office take a look at this issue.

AMERICAN ACADEMY OF AUDIOLOGY

8201 Greensboro Drive, Suite 300, McLean, VA 22102



September 10, 1996

BY HAND DELIVERY

The Honorable John L. Mica
Chairman
Civil Service Subcommittee
U.S. House of Representatives
B-371C Rayburn House Office Building
Washington, D.C. 20515

Re: Federal Employees Health Benefits Program Oversight Hearing -- Supplement To Hearing Record

Dear Mr. Chairman:

This letter supplements my written and oral testimony, presented on September 5, 1996, in support of H.R. 1057 -- the "Hearing Care for Federal Employees Act" -- sponsored by Chairman Gilman of New York.

Mr. Chairman, your last question asked whether there is any legal or regulatory impediment to audiologists being recognized as direct access providers under the Federal Employees Health Benefits Program (FEHBP). As I indicated on September 5, the answer technically is no. As a practical matter, however, upon reflection, the answer may be yes.

There is no legal restriction on the ability of the Office of Personnel Management (OPM) to provide direct access to audiologists under the FEHBP. As a matter of regulatory policy, however, there is a clear impediment. In September 1994, representatives of the American Academy of Audiology (AAA) met with the Chief of OPM's Program Planning and Evaluation Division, Office of Insurance Policy, to discuss the possibility of enabling direct access to audiologists. We were expressly informed by OPM that, in order to obtain FEHBP recognition of audiologists as direct access providers, AAA needed to pursue amendment of 5 U.S.C. § 8902(k)(1) and a Congressional mandate to OPM that audiologists be recognized. OPM has clearly demonstrated that, although it is not legally prevented from recognizing audiologists as direct access providers, it will not do so administratively.

Further, even if OPM were to authorize direct access to audiologists on an administrative level, AAA believes audiologists would still be prejudiced vis-a-vis the other non-physician health care providers currently listed in the FEHBP statute. As you know, the FEHBP law provides the

model framework for many private health care plans in the U.S. By not being in the statute with the currently listed providers, such as optometrists, audiologists may (improperly) be viewed as lesser qualified professionals.

I note that, at the state and regional levels, individual audiologists have over time attempted to obtain direct coverage for audiology services by specific FEHBP carriers. These attempts have largely been in vain, however. If desired, AAA can provide the Subcommittee with evidence of these efforts at recognition, and related rejections.

Thank you again for providing a hearing on H.R. 1057. It is good legislation that will significantly improve the ability of millions of Americans with hearing loss to obtain hearing health care.

We hope you will schedule a mark-up and move H.R. 1057 before the 104th Congress adjourns. Thank you.

Sincerely,

Barry Freeman

Barry A. Freeman, Ph.D.
President

BAF:cmm

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

JAN 15 1997

Honorable John L. Mica
Chairman, Subcommittee
On Civil Service
Committee On Government Reform
And Oversight
U.S. House of Representatives
Washington, DC 20515-6143

Dear Mr. Chairman:

I am pleased to enclose responses to the Subcommittee's questions for the record of the September 5, 1996, oversight hearing on the Office of Personnel Management's administration of the Federal Employees Health Benefits Program. As you suggested, I am also forwarding individual responses directly to each of the other Subcommittee members who submitted questions.

Thank you again for the opportunity to discuss our views with respect to FEHB benefit structure and for your support of our efforts to keep this a model group health program.

Sincerely,

James B. King
Director

Enclosure

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

HEARING OF SEPTEMBER 5, 1996 ON

OPM RESPONSIBILITY FOR BENEFIT CHANGES UNDER THE
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

QUESTIONS FOR THE RECORD FOR

MR. WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

Questions Submitted by Chairman John L. Mica

FEHBP Cost Increases

In OPM's testimony before this Subcommittee, Mr. Flynn, you extolled the enviable track record of the FEHB Program and stated that aggregate premium increases under the program from 1990 through 1995 were 5.2 percent.

The Subcommittee would like additional details concerning this point. Provide answers to the following specific questions.

[**Note:** For purposes of responding to the questions on FEHB Program cost experience, the following tables show data for 1990 through 1997, rather than for 1990 through 1995, pursuant to the request at the conclusion of the questions to extend all calculations.]

Question: What was the percentage increase or decrease in premiums for each year that is included in the aggregate 5.2% increase?

Answer: The written statement comparing premium increases from 1990 through 1995 for the FEHB Program and private sector plans mistakenly reads "aggregate premium increases...were 5.2 percent compared to 9.6 percent" when, in fact, it should read "average" premium increases. The aggregate FEHB premium increase for the 6-year period was 31 percent.

Accordingly, the following table shows both the annual percentage change and the aggregate percentage change in FEHB premiums from 1990 through 1997.

Year	FEHB Annual Premium *	Annual Percent Change	Aggregate Premium Increase
1989	$2,831	--	--
1990	3,078	8.7%	8.7%
1991	3,222	4.7%	13.8%
1992	3,459	7.4%	22.2%
1993	3,746	8.3%	32.3%
1994	3,852	2.8%	36.1%
1995	3,709	-3.7%	31.0%
1996	3,699	-0.3%	30.7%
1997	3,791	2.5%	33.9%

* PROGRAMWIDE WEIGHTED AVERAGE TOTAL PREMIUM.

Question: What was the aggregate percentage increase or decrease in the Government contribution formula for each of these years?

Answer: The following table contains both the annual and aggregate changes in the FEHB Government contribution formula.

Year	Annual Self Only Change	Annual Self & Family Change	Aggregate Self Only Change	Aggregate Self & Family Change
1990	15.2%	13.1%	12.5%	13.1%
1991	11.8%	11.8%	28.7%	26.5%
1992	3.4%	3.8%	33.1%	31.3%
1993	6.5%	6.9%	41.2%	40.3%
1994	2.7%	1.3%	45.6%	42.2%
1995	-7.3%	-5.1%	35.1%	34.9%
1996	0.2%	-1.6%	35.4%	32.7%
1997	2.1%	2.2%	38.3%	35.6%

NOTE: REFLECTS CHANGE IN NON-POSTAL CONTRIBUTION FORMULA.

Question: What was the percentage increase or decrease in the Government contribution for each of these years?

Answer: The following table shows the average monthly Government contribution for each FEHB enrollee, and both the yearly and aggregate percent changes.

Year	Monthly Government Contribution	Annual Percent Change	Aggregate Percent Change
1989	156.16	--	--
1990	176.50	13.0%	13.0%
1991	186.18	5.5%	19.2%
1992	201.51	8.2%	29.0%
1993	219.63	9.0%	40.6%
1994	226.38	3.1%	45.0%
1995	216.13	-4.5%	38.4%
1996	213.96	-1.0%	37.0%
1997	218.50	2.1%	39.9%

NOTE: DOES NOT INCLUDE POSTAL SERVICE EMPLOYEES. 1997 FIGURE IS WEIGHTED ON 1996 POPULATIONS.

Question: What was the aggregate increase in the CPI for these years? What was the percentage increase in CPI for each of these years?

Answer: The following table shows the annual and aggregate increases in the CPI.

Year	Annual Increase	Aggregate Increase
1989	--	--
1990	6.1%	6.1%
1991	3.1%	9.4%
1992	2.9%	12.6%
1993	3.0%	15.9%
1994	3.0%	19.4%
1995	2.6%	22.5%
1996	3.3%	26.6%
1997	2.8%	30.1%

NOTE: 1996 AND 1997 DATA REFLECT CURRENT OMB ESTIMATES.

Question: What was the maximum biweekly Government contribution (dollars) for each of these years?

Answer: The following table shows the maximum biweekly Government contribution (dollars) for Self and Self & Family.

Year	Self Only	Self & Family
1989	45.44	99.48
1990	52.33	112.54
1991	58.49	125.80
1992	60.50	130.58
1993	64.43	139.60
1994	66.20	141.42
1995	61.38	134.18
1996	61.51	132.01
1997	62.83	134.94

NOTE: DATA REFLECTS NON-POSTAL CONTRIBUTION FORMULA.

Question: How many enrollees did not receive the maximum contribution by virtue of the 75 percent limitation?

Answer: The following table shows the number of enrollees whose maximum Government contribution was based on the 75 percent limitation.

Year	Enrollees at 75%	Percent of Total
1989	2,177,901	65.6%
1990	2,387,889	71.3%
1991	2,753,439	81.2%
1992	2,452,117	71.4%
1993	2,413,447	69.7%
1994	2,537,919	73.4%
1995	1,535,685	44.7%
1996	1,120,084	32.3%
1997	1,297,765	37.8%

NOTE: DATA DOES NOT INCLUDE POSTAL SERVICE EMPLOYEES.

Non-Directed PPOs

Question: Mr. Flynn, your statement did not address the issue of "Silent Preferred Provider Organizations (PPOs)." However, I believe you are the right person to ask. The Office of Personnel Management's structure for the Federal Employees Health Benefit Plan allows for Silent PPOs, as sort of entrepreneurs in the reimbursement part of the health care system. I have heard assertions about the potential of savings resulting from these broker/middlemen, although not how these savings devolve to either the federal government or the beneficiaries. I have also heard assertions of the potential damage which could be wrought by what might be seen as predatory practices by those who have no role in health care delivery. Could you give me your view of this practice and whether it might be worthwhile to have the General Accounting Office take a look at this issue.

Answer: Organizations which provide savings through non-directed PPO networks are not a part of the FEHB structure per se. In our administration of the Program, though, we strongly communicate the expectation that each carrier will seek savings in all areas of activity in accordance with sound business practices and strategy. Given the size and highly competitive character of the FEHB Program, carriers also have a keen interest in keeping health plan costs down to attract and retain subscribers. Each carrier exercises its judgement about how to obtain the lowest available price for covered goods and services, but OPM certainly expects carriers to operate in a lawful and ethical manner.

Savings in the FEHB Program

Fee-for-service (FFS) carriers in the Program use a variety of means to control benefit costs, such as, Preferred Provider Organization (PPO) networks, post-audits of hospital bills, negotiated prompt payment discounts, and non-directed PPO networks. By far, the greatest money saver to date has been traditional PPO networks that offer enrollees incentives to use network providers. The overwhelming savings derived from PPO networks and their wide availability has provided the cornerstone of FEHB cost containment since 1991.

In 1994, 10 of the 14 FFS plans, representing almost 98 percent of FEHB enrollees in such plans, negotiated discounts on billed charges with PPO hospital networks which saved the Program $716,000,000. Each of the 14 plans used various other approaches to discount hospital services, such as, billing audits and prepayment and prompt payment discounts which generated Program savings of $70,000,000, and non-directed hospital networks which saved another $20,000,000. The hospital PPO networks reduced billed charges to each plan by average discounts ranging from 10 to 36 percent; in contrast, non-directed network discounts ranged from 9 to 20 percent.

All 10 FFS plans with hospital PPO arrangements also had arrangements with physician PPO networks which saved $316,000,000 in 1994; average plan discounts off billed charges varied from 11 to 34 percent and were usually based on negotiated fee schedules. Several plans obtained further discounts through retrospective reviews of physician billings which saved $53,000,000. We think these savings speak for themselves. Although savings from non-directed PPOs are not insignificant, it is clearly more desirable for the carriers to seek greater penetration of PPOs.

Who Do Cost Savings Benefit?

Contracts with FFS carriers in the FEHB Program require that all savings accrue to the benefit of the Program and where possible to individual members. In PPO arrangements, subscribers who obtain services from network providers benefit directly through lower rates and higher reimbursement of covered expenses. The savings achieved through the use of non-directed PPOs may or may not be returned to individual members, depending on whether or not sufficient information is made available regarding members. In cases where member identification is not possible or practical, the savings are credited to the entire plan and result in reduced rates for all enrollees.

Controversy Surrounding Non-Directed Networks

You invited my views on seeking a General Accounting Office review of these practices. OPM understands that the American Medical Association and the American Hospital Association believe these arrangements are improper because they use discounts a provider has not contractually accepted. The American Association of Preferred Provider Organizations (AAPPO), which represents 300 PPOs, disagrees. They believe physicians do not always understand the contractual arrangements which allow vendors access to previously-negotiated fee discounts. They suggest better provider awareness and some industry standards for provider discount agreements would resolve many problems. OPM expects FEHB carriers to employ ethical and legal business practices. We believe the courts are the appropriate forum to address questionable practices.

OPM View on Non-Directed PPOs

We believe it is desirable to allow FEHB carriers freedom to seek the maximum use of discounts available in the health care marketplace and to choose those that they believe will enhance their competitive positions in the Program. An enduring strength of the FEHB Program has been its flexibility in adapting to health care marketplace dynamics and we want to continue to foster this. At the same time, we know from experience that the bulk of FEHB cost savings come from traditional

PPO networks and our cost containment strategy will emphasize greater use and availability of PPO networks, particularly hospital PPOs.

Questions Submitted by Representative Dan Burton

Non-Directed PPOs

Misleading Health Care Providers

The American Medical Association (AMA) and the American Hospital Association (AHA) are engaged in efforts to eliminate the practice of silent PPOs in the marketplace because they have found that plans that use such practices mislead providers and are often fraudulent.

Question: In light of the AMA's and AHA's concerns regarding misleading practices in discounting payments to hospitals and physicians, has OPM taken any steps to assure that in implementing its directive to FEHB carriers "to have in place procedures to capture discounts from bills presented and/or contract to do so," that such practices are not permeating the program?

Answer: OPM expects carriers to employ ethical and legal business practices. We believe the courts are the appropriate forum to address questionable practices. Under the FEHB Program, decisions about how to obtain the lowest available price for covered goods and services are carrier judgments. FEHB plans which use non-directed PPOs have advised OPM that discounts are consistent with contracts between the vendor and providers because: (1) the vendor gives contracted providers or provider networks a monthly directory of contracted client-payers eligible to access discounts and weekly notification of all re-priced claims, and (2) there have been virtually no provider complaints to the health plan. If OPM suspects that a subcontractor of any FEHB carrier is acting fraudulently, we will direct the carrier to promptly investigate this and terminate the relationship if fraud is confirmed, and we will advise the Inspector General.

Question: Inasmuch as providers enter into contractual arrangements with legitimate PPOs in return for the expectation that FEHB enrollees will utilize their services, are you concerned that "silent or non-directed PPOs" will undermine the trust of providers in dealing with FEHB carriers? If health care providers lose trust in managed care networks because of the practices of silent PPOs, will this result in higher prices for all carriers, and ultimately all enrollees of the FEHB Program?

Answer: Non-directed PPOs are legitimate if there is a contractual agreement with the provider allowing a fee discount. Health care providers choose to allow discounts for many reasons unrelated to directed services, such as

prepayment and prompt payment discounts. We understand that hospitals typically belong to both types of PPO networks and apparently do not believe this compromises the basic tenets of a traditional, directed PPO network. The FEHB plans that contract with non-directed PPOs do not see this as undercutting the value of other networks since the benefit designs provide substantial financial incentives to direct patients to directed PPO providers and this is regularly communicated to plan members.

Traditional PPO networks, which offer payer discounts to health plans that in turn direct or channel patients to cost-effective providers, have been the cornerstone of FEHB cost-containment since 1991. Currently, every fee-for-service plan that is open to all FEHB enrollees obtains discounts on hospital services through PPO networks, and several also have integrated arrangements for non-directed discounts that reduce payments for billed charges. By far, the greatest cost-saver to date has been hospital PPO networks which achieved savings of $716,000,000 in 1994. The PPO discounts to FEHB plans from hospital networks ranged from 10 to 36 percent. Non-directed network discounts ranged from 9 to 20 percent in the same year and produced savings of $20,000,000. OPM estimates that the FEHB could save up to $2.5 billion between 1995-99 through increased use and expansion of PPO hospital networks. This will be our main cost-containment strategy.

Ethical Practices

OPM maintains minimum standards for health benefit carriers to perform the contract in accordance with prudent business practices which include "legal and ethical business and health care practices." (Federal Employees Health Benefits Acquisition regulation (48 CFR 1609.701(b)(2)).

Question: Since the AHA and the AMA, the trade associations representing the nation's 4,000 hospitals and 300,000 physicians, have raised their concerns over the ethics and legality of the practice of "silent PPOs" to your attention, what are OPM's plans to address their concerns as they relate to the practices of FEHB carriers and their vendors?

Answer: We understand that the American Association of Preferred Provider Organizations (AAPPO), which represents 300 Preferred Provider Organizations (PPOs) nationwide, believes that the AMA and the AHA have overstated the extent of fraud in connection with non-directed PPO discounts. They advise that problems often stem from provider inexperience with contract management, provider reliance on inadequate accounting and patient-tracking systems, or provider confusion due to delay in receiving notice of new accounts with the PPO, leading to the assumption there is unauthorized use of network discounts.

As stated previously, FEHB carriers who use non-directed PPO discounts state that provider complaints relating to discounts have not been a problem. If OPM suspects that a subcontractor of any FEHB carrier is acting fraudulently, we will direct the carrier to promptly investigate this and terminate the relationship if fraud is confirmed, and we will advise the Inspector General. If some vendors, in fact, are engaging in deceptive contracting or other provider fraud, the courts are the appropriate forum for dealing with this.

Full Disclosure

The confusion surrounding whether a health care provider should discount a patient's bill based on whether it is a directed network or a non-directed network could be solved by requiring full disclosure to the provider of that information.

Question: Why doesn't OPM require FEHB carriers and their vendors to implement a full disclosure policy?

Answer: We believe the heart of the controversy relates to contractual agreements between PPO network administrators and individual network providers, and that the solution will depend on better standards for such agreements throughout the health care marketplace. Moreover, we are not experiencing problems of this nature in the FEHB Program.

Questions submitted by Representative James P. Moran

Coordination of FEHBP and Medicare Coverage

I am concerned about coordination of Medicare and FEHB benefits for married couples, both of whom are eligible for FEHB participation because one spouse is working for the government and the other is a federal retiree age 65 or over. In my district, there are many couples who both work for the federal government who may, at some time, find themselves in this situation. I understand that, under FEHB, the usual rule is that, for federal retirees, Medicare pays first, and FEHB pays second (thereby paying costs not paid by Medicare), *and* the FEHB plan usually waives its own copayments and deductibles. Thus, most federal employees and retirees are under the impression that, once they turn 65 and are covered by Medicare *and* FEHB, they will have virtually full coverage for medical costs and will not pay copayments and deductibles.

However, if a couple both of whom are eligible for FEHB, were to elect a *family policy* under FEHB while the spouse is still working, Medicare will not pay first for the retiree's medical care, and the FEHB plan will not waive copayments and deductibles for the retiree. I would like your answers to four questions:

Question: First, please explain the difference between OPM's and HCFA's interpretation of Section 1862(b) of the Social Security Act regarding Medicare as the secondary payer when a couple is eligible for group health insurance like FEHB. What are the effects on married retirees of this difference of opinion and how is the issue going to be resolved?

Answer: Section 1862(b)(1)(A)(i) of the Social Security Act states that Medicare is secondary to group health plan benefits when the individual age 65 or older is covered under the group health plan by reason of the current employment status of the individual (or the individual's spouse).

Accordingly, when a Federal annuitant is covered as a family member under FEHB through their Federally-employed spouse's enrollment, FEHB is primary and Medicare is secondary because the annuitant has FEHB coverage through the "current employment status" of his or her spouse.

However, if a Federal annuitant has FEHB coverage under their own enrollment, Medicare is primary and FEHB is secondary for the annuitant and, if the annuitant elects FEHB family coverage and has a Medicare-eligible employed spouse age 65 or over, for the spouse. The reason Medicare is primary for both the annuitant and spouse is that the Federal annuitant does not have FEHB coverage based on either spouse's "current employment status" but because of annuitant status.

We are not aware of a different interpretation by the Health Care Financing Administration (HCFA).

Question: Second, regardless of the current law, what do you think the policy should be regarding coordination of benefits for Medicare and FEHB when both spouses of a couple are eligible for FEHB? Do you think this committee should consider clarification or modification of the law?

Answer: Under the current law, the deciding factor in determining whether FEHB or Medicare is the primary payer is whether or not non-Medicare health plan coverage is based on "current employment status." We think that this is a satisfactory approach and we defer to HCFA on the desirability of clarification or modification of the Medicare law.

Question: Third, if OPM's interpretation of Medicare secondary payer rules prevails, I am concerned that OPM's literature should adequately alert FEHB-eligible couples, one of whom is retired and Medicare-eligible, to the consequences of which spouse's name is on a FEHB family policy. Would you be willing to address this concern and how might you go about it?

Answer: We share this concern and we have addressed it with improved

guidance in the section entitled "This Plan and Medicare" in the 1997 benefit brochures for FEHB fee-for-service plans. Each brochure cover directs the reader where to find a summary of 1997 benefit changes and clarifications.

The above-mentioned section outlines rules which apply to FEHB enrollees and their covered family members who are entitled to benefits from the FEHB plan and Medicare. The rules explain when Medicare or FEHB is the primary payer. The rules in the 1997 brochure have been revised to make it clear that when a Medicare-eligible individual age 65 and over has FEHB coverage as an eligible family member of another FEHB enrollee, the determination of whether FEHB or Medicare is primary for the family member is based on whether the individual who carries the FEHB enrollment is a Federal employee or retiree.

If the enrollee is a Federal employee the FEHB plan is the primary payer, but if the enrollee is a Federal retiree Medicare is the primary payer.

Question: I would also like to know what kind of guidance is available for retirees when they turn age 65 and must make a decision about participating in Medicare Part B in addition to FEHB.

Answer: In addition to the benefit brochures of FEHB plans discussed above, OPM gives new annuitants with FEHB coverage a pamphlet entitled "Information for Retirees and Survivor Annuitants About the Federal Employees Health Benefits Program" which discusses coordination with Medicare. Federal retirees turning age 65 should also obtain information published by HCFA on the Medicare Program, particularly the "Medicare Handbook."

Questions submitted by Representative Constance Morella

BC/BS Prescription Drug Benefits

Question: Did you discuss any other ways to save money other than mail order with BC/BS? Have you made your decision for 1997?

Answer: Other changes which the carrier proposed and OPM considered were to increase the coinsurance percentage paid by all Standard Option enrollees, including those covered by Medicare Part B, at both preferred and non-preferred retail pharmacies, and to require BC/BS High Option Plan members with Medicare Part B to pay the coinsurance paid by other High Option enrollees at both preferred and non-preferred pharmacies.

OPM did not accept either of those proposals. We concluded that the coinsurance

for all Plan members under Standard Option should not increase when utilization data indicated that 61 percent of the Plan's costs for prescription drugs were incurred by retired members with Medicare Part B as primary coverage who, in the absence of any coinsurance requirement, used more costly retail pharmacies for 90 percent of their prescriptions. These utilization trends were the opposite of those of other plan members. We further concluded that the High Option benefit should not change because the already higher premiums for that coverage made it possible to absorb the additional costs without a premium increase.

The change we agreed to affects only that portion of the Service Benefit Plan membership that is primarily responsible for the significant adverse prescription drug utilization trends. It gives them an incentive and opportunity to make cost-conscious and judicious provider selections like other Standard Option enrollees. We believe that retirees with Medicare Part B who are judicious in the selection of providers and pharmaceutical products will experience minimal, if any, increases in out-of-pocket expenses. The principle of some cost sharing is an important element in OPM's comprehensive effort to keep the rate of FEHB premium increases as low as possible.

There is no change in the BC/BS Standard Option prescription drug benefit for 1997.

Question: In addition to my concerns with the actual policy, I think that both OPM and BC/BS did not adequately inform federal retirees of the changes. Do you have plans to better communicate any changes in any of the plans to the people who will be affected?

Answer: The cover of the 1997 benefits brochure of each FEHB plan lists a page number where the reader may locate a summary of all benefit changes and clarifications.

Question: I heard from many of my constituents who had problems with mail order earlier this year. Did OPM do any kind of analysis to determine whether the mail order firm was capable of handling the increased volume? What did OPM do to remedy this situation?

Answer: The BC/BS Service Benefit Plan Mail Order Drug Program has been available under the FEHB Program since 1987 and has been very successful; our experience is that almost all enrollees who have used it like it. In Customer Satisfaction Surveys which Gallup conducted for BC/BS in 1994 and 1995, the Mail Order Program received ratings of 4.8 and 4.7, respectively, on a scale of 1 to 5 (with 5 being Very Satisfied); the Retail Pharmacy Program received ratings of 4.6 and 4.5, respectively.

To ensure that the quality of service from mail order would not diminish in the face of greater demand, OPM conducted on-site visits to observe procedures at processing facilities and then reviewed the carriers' plans for handling projected increases in volume. In addition, the BC/BS contract and enrollee brochure specify mail order delivery standards for acceptable service. For prescriptions ordered by phone or facsimile, the standard requires processing within 2 business days so the enrollee may expect to receive the medication within 7 calendar days; the standard for mailed-in prescriptions requires processing within 5 business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days.

As it turned out, there was a huge and immediate shift to mail order by Medicare Part B-covered annuitants so that the demand for mail order services doubled during January 1996, far exceeding the anticipated rate of increase and causing numerous service problems. When OPM became aware of this, we directed the plan to take immediate action to remedy the situation and to provide weekly reports to OPM on the progress. BC/BS, in conjunction with its mail order provider, Medco, responded by developing an aggressive operational strategy to increase processing capacity and adequate capability to meet FEHB customer service standards was achieved in a matter of weeks.

Question: Regarding H.R. 2009: If OPM is specifically trying to get FEHB carriers to consider medical foods and other cost-effective, alternative therapies in a broad range of cases, wouldn't the agency support Congressional recognition of medical foods as an appropriate covered benefit? H.R. 2009 does not require FEHBP carriers to implement any specific policy regarding coverage of medical foods. Wouldn't the legislation simply strengthen OPM's goal of promoting consideration and use of medical foods, as a doctor deems appropriate?

Answer: OPM believes that the best way to provide FEHB benefits for alternative therapies such as medical foods is through the flexibility that the Program already has to respond to enrollee needs and changes in accepted health care practices through annual contract negotiations. We are concerned that listing any specific benefit coverage, such as medical foods, in the FEHB law will create pressure for listing a great many other types of care in the law or even mandating benefits for specific services. At best, this would be contrary to good administration, and at worst it would undermine the Program's effectiveness and increase costs.

JUDICIAL CONFERENCE OF THE UNITED STATES
WASHINGTON, D.C. 20544

THE CHIEF JUSTICE
OF THE UNITED STATES
Presiding

L. RALPH MECHAM
Secretary

August 9, 1996

Honorable John L. Mica
Chairman
Subcommittee on the Civil Service
Committee on Government Reform
and Oversight
B-371C Rayburn House Office Building
Washington, DC 20515

Honorable James P. Moran
Ranking Minority Member
Subcommittee on the Civil Service
Committee on Government Reform
and Oversight
B-371C Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman and Representative Moran:

I understand that the Subcommittee on the Civil Service may hold a hearing in September 1996 on the Federal Employees Health Benefits Program. As Secretary to the Judicial Conference of the United States, the policy-making body of the federal judiciary, I am pleased to submit this statement of my concerns regarding the application of the Federal Employees Health Benefits Program to the Judicial Branch.

I appreciate your taking the time to consider these views.

Sincerely,

Leonidas Ralph Mecham
Secretary

Enclosure

cc: Honorable W. Earl Britt
Honorable Barefoot Sanders

Statement of Leonidas Ralph Mecham
Director of the Administrative Office of the United States Courts
to the
House Committee on Government Reform and Oversight Subcommittee on the Civil Service

Mr. Chairman and Members of the Subcommittee, I am Leonidas Ralph Mecham, Director of the Administrative Office of the United States Courts. As you may know, the Administrative Office performs many support functions for the courts, including administering the budget, procuring supplies and space, and providing personnel services.

I submit this statement to express my concerns regarding the Federal Employees Health Benefits Program (FEHBP). In addition, I would like to comment on H.R. 3462, the "Federal Health Program Benefit Change Accountability Act." Under H.R. 3462, the Office of Personnel Management (OPM) would be required to notify Congress of: (1) the nature of what each change entails; (2) the reason for the change; (3) the cost of the change; and (4) the impact on access to and quality of care.

The federal judiciary's recent experience with the Blue Cross and Blue Shield Service Benefit Plan ("Service Benefit Plan") suggests to me that this legislation is necessary. I should note that nearly 46 percent of judicial officers and employees are enrolled in the Service Benefit Plan--that is, of the approximately 24,000 judicial officers and employees who participate in the FEHBP, more than 11,000 are covered by the Service Benefit Plan. The judiciary will contribute about $57 million this year to the FEHBP premiums of judicial officers and employees.

A central feature of the Service Benefit Plan is its preferred provider network. The preferred provider network is a form of managed care which offers enrollees lower copayment

levels when they use certain health care providers. Enrollees who use nonparticipating providers pay more substantial copayments. As you may know, under a little-noticed change to the Service Benefit Plan which took effect on January 1, 1996, enrollees are reimbursed based on local Medicare participating fee schedule amounts (rather than the former "usual, customary and reasonable" amounts) for charges by nonparticipating providers (that is, health care providers who have not signed on to the Service Benefit Plan's network). As a result of the change, some enrollees who expected Blue Cross and Blue Shield to pay up to 80 percent of their medical costs, found that their health insurer was paying only 10 percent of those costs. Indeed, some judges in the New York metropolitan area became personally responsible for charges of nearly $10,000.

Upon learning of this problem with the Service Benefit Plan, I wrote to James King, the Director of the Office of Personnel Management (OPM), asking him to act to mitigate the effect of this change upon judicial officers and employees. I am pleased to state that OPM and Blue Cross and Blue Shield amended the arrangement for reimbursing enrollees for charges by non-participating providers. Under the agreement, enrollees will be reimbursed for between 60 and 64 percent of their medical charges. While this agreement is certainly beneficial, I note that last year, these enrollees would have been reimbursed for between 75 and 80 percent of the "usual, customary and reasonable" amounts. More troublesome, I understand that, for 1997, the Service Benefit Plan will not reimburse enrollees based on the "usual, customary and reasonable" amounts and may reapply the Medicare fee schedule.

The judiciary appreciates OPM's interim response to this critical situation; however, we do not believe this arrangement treats the underlying problems--(1) timely and sufficient notice

to agency administrators and employees of health benefits information, and (2) the question of access to quality care. Moreover, we are concerned about the level of benefits under the Service Benefit Plan for 1997.

Adequacy of Notice to Agency Health Benefits Administrators and Employees

Understanding health care benefits can be difficult. For this reason, it is essential that during each annual "open season" employees be provided information about how benefits under the FEHBP meet their individual needs. OPM should prepare FEHBP health benefits brochures in a uniform and understandable fashion. At present, the brochures read more like contract documents which more than challenge even the most knowledgeable employee's ability to comprehend them.

During the past several months, I have heard from quite a few judicial officers and employees who state that they receive insufficient information about health benefits and the options available to them during the annual "open season." The "open season," which lasts only for a period of four weeks, does not permit an employee to effectively compare how the benefits available under each plan meet his or her unique needs. In some instances employees may choose from as many as 10-15 local plans.

The brochure describing the Service Benefit Plan, which OPM distributed during the most recent "open season," reports on more than 25 changes and clarifications. An enrollee has to refer to five separate pages in the benefits brochure in order to find the change in procedure for reimbursing enrollees for charges by non-participating providers. The brochure omits Medicare fee schedule data and fails to convey the magnitude and full scope of the potential consequences of the change to the reimbursement methodology. For example, the

Service Benefit Plan could have illustrated the nature of the change by publishing in the brochure a comparison of the cost of a surgical procedure, such as a gall bladder operation, using the "reasonable and customary" allowance and the Medicare allowable rate. It seems to me that such a significant change in the largest FEHBP plan should be highlighted and brought to the attention of agency health benefits administrators, as well as employees.

Another problem is the absence of uniform application of terms and definitions in annual health plan brochures. This problem makes comparisons of plans difficult for employees. For example, federal employees who are interested in a fee-for-service plan will have to estimate their out-of-pocket costs under three distinct methodologies: (1) the Medicare fee schedule in the case of the Service Benefit Plan; (2) "reasonable and customary" amounts based on data compiled by Medical Data Research under the Postmaster Benefit Plan; and (3) "reasonable and customary" amounts based on data compiled by the Health Insurance Association of America in the cases of the Government Employees Hospital Association, National Association of Letter Carriers, and American Postal Workers Union. These differences make comparisons of plans difficult and complex.

OPM should also provide timely and sufficient notice to agency officials about fundamental changes in the FEHBP so that agency administrators can be responsive to employees. It seems to me that H.R. 3462 would help treat the problem of notice.

The Problem of Quality Care

While the change to the Service Benefit Plan applies to enrollees nationwide, it seems to have had a disproportionate effect on enrollees in certain areas of the country (including New York, Kentucky, Wyoming, and Alaska). In most areas of the country, Blue Cross and Blue

Shield has providers (doctors and hospitals) who fall into three tiers--preferred, participating, and non-participating. Preferred providers accept Blue Cross/Blue Shield fees. Participating providers are likely to charge somewhat more than Blue Cross/Blue Shield rates. Non-participating providers (and this includes some excellent specialists) set their own fee schedule. In some areas, such as New York City, the middle tier of participating physicians is no longer available. Thus, enrollees must choose between preferred and non-participating physicians. I understand that the New York metropolitan area local Blue Cross and Blue Shield plan has been unable to attract quality specialists with its preferred provider allowance. For example, none of the physicians at Sloan-Kettering (a major cancer treatment center) and only 118 of the 1,412 physicians at New York Hospital are Blue Cross and Blue Shield preferred providers. As a result, many enrollees find that they must use non-participating physicians. I should note that Blue Cross and Blue Shield no longer recruits participating physicians. Thus, the problem of too few preferred providers and participating physicians is likely to become more widespread. The practice of penalizing enrollees who must use nonparticipating physicians appears to be questionable and places an unduly onerous burden on enrollees. For example, a federal officer or employee who travels out-of-town and requires emergency surgery is not likely to be in a position to determine whether he or she is being admitted to a preferred hospital and is being attended to by a preferred anesthesiologist and surgeon.

I believe that enactment of H.R. 3462 will further OPM's effort to provide access to quality health care not only for employees of the judicial branch but for all government employees.

What Can Be Done?

A recent Newsweek report on health maintenance organizations suggests that enrollees consider the matter of quality of care. It states:

> At the very least, your health plan should pass certain objective standards. While there's no universally revered stamp of approval, accreditation by the NCQA [National Committee for Quality Assurance] comes close. To get it, a plan is judged on 50 different characteristics, like how well it checks out doctors' credentials. Of the 222 plans in the country that have been reviewed by the NCQA, only 37 percent won full accreditation. Ellen Spragins, *Does Your HMO Stack Up?*, Newsweek, June 26, 1996, at 58.

The NCQA is a non-profit organization which is widely regarded as a leader in the effort to educate health care consumers on the quality of care provided by managed care organizations (such as Health Maintenance Organizations). I understand that some major private sector employers, such as GTE and Xerox, require that managed care providers in their programs be NCQA accredited. OPM has recently announced that for the 1996 open season it will inform federal employees of the managed care providers that have received an NCQA accreditation; however, the agency will not require managed care providers to seek such accreditation as a condition of participation in the FEHBP.

The judiciary applauds this initiative to educate federal employees; however, we believe that third-party accreditation should be required of all FEHBP providers. Federal employees should enjoy the same level of quality care as their private sector counterparts, and we encourage you to give OPM the resources to accomplish such an initiative.

Presently, OPM solicits customer satisfaction information in connection with the FEHBP open season which covers some of these items. However, the survey results illustrate only enrollees' overall satisfaction with their respective FEHBP plan. The sample used is limited

and the results tend to be self-realizing. We believe that the survey should be augmented by a rigorous assessment of each plan by an independent third party.

Judiciary Initiatives

I have recently directed Administrative Office staff to prepare materials on FEHBP benefits for the 1996 open season in order to supplement OPM information. This information will be made available to judicial officers and employees through the nearly 400 health benefits coordinators located in court units nationwide. While this will be helpful, it is apparent that the judiciary cannot treat this problem alone.

Therefore, I believe support for H.R. 3462 is warranted, and I encourage OPM to make every possible effort to provide timely and sufficient notice to federal agencies and employees regarding changes to the FEHBP. I would be pleased to respond in writing to any questions you might have. Thank you for considering these views.

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Testimony on

The Hearing Care for Federal Employees Act
H.R. 1057

Submitted by the
American Speech-Language-Hearing Association

United States House of Representatives
Committee on Government and Oversight
Civil Service Subcommittee
Oversight Hearing on Health Benefits for Federal Employees
September 5, 1996

10801 Rockville Pike • Rockville, MD 20852 • (301) 897-5700

The American Speech-Language-Hearing Association (ASHA) appreciates the opportunity to support wholeheartedly the Hearing Care for Federal Employees Act, H.R. 1057. This legislation would provide access to audiologists under the Federal Employees Health Benefit Program (FEHBP). The American Speech-Language-Hearing Association is the professional and scientific association of over 87,000 audiologists, speech-language pathologists, and speech, language, and hearing scientists. Over 12,600 of our members are audiologists hold the certificate of clinical competence awarded by ASHA.

We know that to accurately diagnose the absence or presence of a hearing loss or related balance disorder requires an audiological evaluation. If there is a hearing or balance problem, the severity of the disability and the need for rehabilitation or prosthetic device also requires an audiological evaluation.

ASHA enthusiastically supports H.R. 1057 because:

- federal employees need audiologists' services;
- the Hearing Care for Federal Employees Act is consistent with the Health Insurance Portability and Accountability Act of 1996;
- the current lack of coverage for audiology services under FEHBP ignores the importance of hearing and its relationship to functional independence for millions of Americans;
- other federal health care plans, such as Medicare and Medicaid, as well as most private health plans cover audiology services;

- audiologists are the professionals specifically educated and qualified to provide diagnostic and rehabilitative audiology services; and
- fears that passage of H.R. 1057 would set a potentially costly precedent is unfounded.

Federal Employees Need Audiology Services

A newborn baby with a history of premature birth, hyperbilirubinemia, and apnea was treated at a major university medical center pediatric program. The neonatologist and pediatrician referred the infant to an audiologist because of a high risk of hearing loss. An audiologist examined the infant and performed an auditory evoked response test, that is, an electrophysicological measurement auditory function that correlates with hearing.

Coverage of the procedure was denied under the FEHBP only because "...under this patient's coverage, benefits are not available for these services rendered by this provider of care." On appeal, the coverage was again denied because "...the diagnostic test rendered on November 25, 1989, ...under the provisions of the Service Benefit Plan, [the audiologist] does not meet the criteria of a covered provider." These denials occurred despite supporting documentation from the neonatologist, pediatrician, and an otolaryngologist.

This case illustrates that the medical community believes such coverage is essential. Research indicates that if hearing loss is detected and treated early the long-term academic, communication, and social consequences of hearing loss is mitigated. Only the rules of the

carrier deny access to such care. If the hearing loss is medically treatable, such care must commence as well. However, approximately 80% of hearing losses are not treatable through medical or surgical means and require the services of an audiologist for appropriate rehabilitation and selection and fitting of amplification devices.

Access to hearing services from an audiologist are vital in cases such as these. The services that an audiologist provides are essential. Please see Appendix A for the scope of audiology practice.

Another actual case illuminates the problems specific to the FEHBP system. A retired federal employee was referred by a physician to an audiologist because of suspected middle and inner ear pathology. Diagnostic services were requested to identify the location of the problem in the auditory mechanism. Unfortunately, the charges for the procedures performed, even though deemed necessary, were not reimbursable under the FEHBP because the provider was an audiologist rather than a physician – and this even though the physician knew the audiologist was the best professional to perform the procedure.

In the examples above, it is clear that audiological services are needed to ensure that proper medical care is provided. The importance of hearing to human function cannot be overstated. This sensory deficit - hearing loss - is invisible and is often overlooked.

Hearing Care for Federal Employees Act is Consistent with the Health Insurance Portability and Accountability Act of 1996

ASHA believes that Congress took an important first step when it passed the Health Insurance Portability Act. H.R. 1057 has the same main attribute as the new health insurance law. Under the current FEHBP, individuals with the pre-existing condition of hearing loss are denied the right to proper diagnostic and rehabilitation services because the audiologist is not included as a provider under major FEHBP policies. H.R. 1057 will remove the lack of access to audiologists' services. The Health Insurance Portability and Accountability Act also eliminates job lock. H.R. 1057 would do the same for potential federal government employees who would lose audiology benefits for themselves and their dependents.

Federal and Private Health Care Plans Cover Audiology Services

Medicare covers diagnostic audiology services. Section 1861(11)(ii)(1) defines the services related to hearing and balance assessment services. These services are limited to those provided by a qualified audiologist who is legally authorized to provide such services under state law. For states that do not regulate the profession of audiology, the ASHA Certificate of Clinical Competence in Audiology is required.

Medicaid mandates audiology services under the early and periodic screening, diagnosis and treatment (EPSDT) program for children and includes audiology as an optional service for adults. The regulations related to services for individuals with speech, hearing and language disorders is found in Title 42 of the **Code of Federal Regulations** at section 440.110:

> (C) Services for individuals with speech, hearing and language disorders. (1) 'Services for individuals with speech, hearing, and language disorders' means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist....

Moreover, other federal programs such as the Occupational Health and Safety Administration Hearing Conservation Program and the Longshoremen's and Harbor Workers' Compensation Act clearly define the role of the audiologist in providing and supervising industrial hearing conservation programs.

In 1986, the Health Insurance Association of America (HIAA) sent a Report on Consumer and Professional Relations to its member companies describing the scope of audiology and speech-language pathology services and concluded that "...audiology services are important rehabilitation and habilitation programs." In describing licensure and certification requirements for audiologists, HIAA stated, "There is no requirement for medical prescription or supervision since the profession is autonomous." Further, in 1991, ASHA conducted a survey of the Fortune 500 and Service 500 companies in order to determine coverage for audiology services. More than 80% of the companies surveyed covered audiology assessment to establish a diagnosis.

Audiologists are Specifically Educated and Qualified to Provide Services

Audiologists must earn a master's or doctoral degree in audiology from an accredited university, successfully complete a clinical fellowship under the supervision of a certified audiologist, and pass a standardized national competency examination administered by the Educational Testing Service (ETS) of Princeton, New Jersey, to hold state licensure or the ASHA Certificate of Clinical Competence in Audiology. A copy of the certification requirements is contained in Appendix B of this testimony.

ASHA's preferred practice patterns for audiology were developed "...as a guide for ...audiologists and as an educational tool for professionals, members of the general public, consumers, administrators, regulators, and third-party payers." They describe the nature of the services provided and the importance of their utility for the public (see Appendix C for select practice patterns).

Concern Over Setting a Precedent is Unfounded

H.R. 1057 is an important cost-containment measure and provides more streamlined coverage to persons at risk for or with hearing loss and related disorders. The legislation is an important step in eliminating discrimination against non-physician providers by a health plan. ASHA is aware that the Office of Personnel Management opposes H.R. 1057 because it holds that mandating coverage of practitioners is but the first step towards legislating benefits (May 16, 1995, letter for Chairman Mica to Richard D. Wright, of Brunswick, Georgia). Mandating practitioner coverage has already occurred. The reasons for adding these other

health care practitioners is that they, like audiologists, were excluded from providing covered benefits to federal employees and their families. Such other practitioners may be able to provide covered services at reimbursement rates below those being paid by FEHBP plans to medical doctors.

Conclusion

For reasons stated above, ASHA fully supports the Hearing Care for Federal Employees Act, H.R. 1057. In addition, we emphasize that:

- With the aging of the U.S. population, there is growing consumer demand and need for direct access to audiologists. Currently, consumers complain to the audiologist when they cannot receive audiology services from the audiologist of their choice. Because consumers may ultimately receive the service in a physician's office, the incentive to ask their benefits advisor directly to revise the benefit is lost. Therefore, consumers have requested that audiologists work with OPM or Congress to change the structure of FEHBP.

- The basic thrust of FEHBP is to have reasonable minimum standards for health benefit plans (see Section 8902 (e) of the FEHBP law) and to ensure direct access to specific health professionals (see Section 8902 (k)(1)). Further, the FEHBP law includes providing benefits from providers other than hospitals and physicians (Section 8903 (1)). Thus, H.R. 1057 is consistent with the current

statute.

The current FEHBP benefit limits hearing-related services to physicians' offices. There, assessment services are usually rendered by an audiologist, not the physician who has only a limited education in audiologic assessment and rehabilitation. ASHA affirms the need for a level playing field so that competition can take place and consumers can have equal access to the provider of their choice. Currently, consumers may not protest the exclusion of audiologists because the audiologist with a referral of an FEHBP participant advises the patient/consumer that the federal employee health benefit plan does not extend to audiology services when rendered by a private practitioner. The consumer then has to make an appointment with a physician, usually with referral from the audiologist. Valuable time and resources are wasted because of bias inherent in the FEHBP system. Recall that most hearing loss is not medically treatable, thus adding costly expense for limited or no benefit. Audiologists are well-educated to refer for medical assessment when case history and diagnostic findings indicate that this is an appropriate course of treatment.

The American Speech-Language-Hearing Association will provide any assistance possible to clarify the need for coverage of audiology services in the FEHBP. ASHA thanks the Committee for this opportunity to express our support for H.R. 1057.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Scope of Practice in Audiology

Ad Hoc Committee on Scope of Practice in Audiology

This scope of practice in audiology statement is an official policy of the American Speech-Language Hearing Association (ASHA). The document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Audiology and approved in 1995 by the Legislative Council (8–95). Members of the ad hoc committee include David Wark (chair), Tamara Adkins, J. Michael Dennis, Dana L. Oviatt, Lori Williams, and Evelyn Cherow (ex officio). Lawrence Higdon, ASHA vice president for professional practices in audiology, served as monitoring vice president. This statement supersedes the Scope of Practice, Speech-Language Pathology and Audiology statement (LC 6-89), Asha, *April 1990, 1–2.*

Scope of Practice in Audiology

Preamble

This statement delineates the scope of practice of audiology for the purposes of (a) describing the services offered by qualified audiologists as primary service providers, case managers, and/or members of multidisciplinary and interdisciplinary teams; (b) serving as a reference for health care, education, and other professionals, and for consumers, members of the general public, and policy makers concerned with legislation, regulation, licensure, and third party reimbursement; and (c) informing members of ASHA, certificate holders, and students of the activities for which certification in audiology is required in accordance with the ASHA Code of Ethics.

Reference this material as: American Speech-Language-Hearing Association. (1996, Spring). Scope of practice in audiology. *Asha, 38* (Suppl. 16).

Index terms: Scope, audiology; scope of practice, audiology; practice guidelines, audiology; standards of practice, audiology

Audiologists provide comprehensive diagnostic and rehabilitative services for all areas of auditory, vestibular, and related disorders. These services are provided to individuals across the entire age span from birth through adulthood; to individuals from diverse language, ethnic, cultural, and socioeconomic backgrounds; and to individuals who have multiple disabilities. This position statement is not intended to be exhaustive; however, the activities described reflect current practice within the profession. Practice activities related to emerging clinical, technological, and scientific developments are not precluded from consideration as part of the scope of practice of an audiologist. Such innovations and advances will result in the periodic revision and updating of this document. It is also recognized that specialty areas identified within the scope of practice will vary among the individual providers. ASHA also recognizes that professionals in related fields may have knowledge, skills, and experience that could be applied to some areas within the scope of audiology practice. Defining the scope of practice of audiologists is not meant to exclude other postgraduate professionals from rendering services in common practice areas.

This scope of practice does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. It may serve, however, as a model for the development or modification of licensure laws.

The schema in Figure 1 depicts the relationship of the scope of practice to ASHA's policy documents of the Association that address current and emerging audiology practice areas; that is, preferred practice patterns, guidelines, and position statements. ASHA members and ASHA-certified professionals are bound by the ASHA Code of Ethics to provide services that are consistent with the scope of their competence, education, and experience (ASHA, 1994).

Audiologists serve diverse populations. The client population includes persons of different race, age,

gender, religion, national origin, and sexual orientation. Audiologists' caseloads include persons from diverse ethnic, cultural, or linguistic backgrounds, and persons with disabilities. Although audiologists are prohibited from discriminating in the provision of professional services based on these factors, in some cases such factors may be relevant to the development of an appropriate treatment plan. These factors may be considered in treatment plans only when firmly grounded in scientific and professional knowledge.

Definition of an Audiologist

Audiologists are autonomous professionals who identify, assess, and manage disorders of the auditory, balance, and other neural systems. Audiologists provide audiological (aural) rehabilitation to children and adults across the entire age span. Audiologists select, fit, and dispense amplification systems such as hearing aids and related devices. Audiologists prevent hearing loss through the provision and fitting of hearing protective devices, consultation on the effects of noise on hearing, and consumer education. Audiologists are involved in auditory and related research pertinent to the prevention, identification, and management of hearing loss, tinnitus, and balance system dysfunction. Audiologists serve as expert witnesses in litigation related to their areas of expertise.

Audiologists currently hold a master's or doctoral degree in audiology from an accredited university or professional school. ASHA-certified audiologists serve a 9-month postgraduate fellowship and pass a national standardized examination. Where required, audiologists are licensed or registered by the state in which they practice.

Audiologists provide services in private practice; medical settings such as hospitals and physicians' offices; community hearing and speech centers; managed care systems; industry; the military; home health, subacute rehabilitation, long-term care and intermediate-care facilities; and school systems. Audiologists provide academic education in universities to students and practitioners in audiology, to medical and surgical students and residents, and to other related professionals. Such education pertains to the identification, assessment, and nonmedical management of auditory, balance, and related disorders.

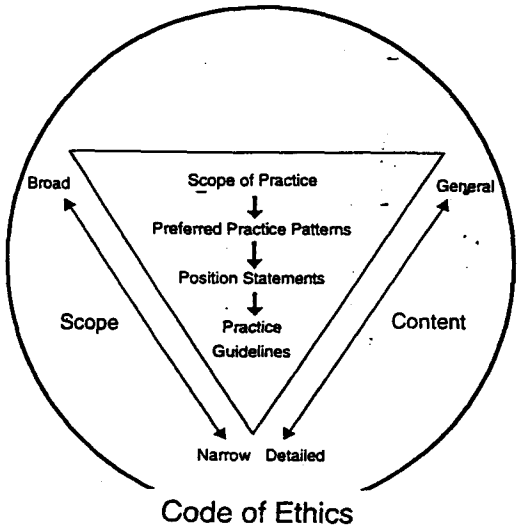


Figure 1. Conceptual Framework of ASHA Policy Statements.

The documents depicted in this diagram together serve as a guide to professional practice in audiology.

Scope of Practice

The practice of audiology includes:

1. Activities that identify, assess, diagnose, manage, and interpret test results related to disorders of human hearing, balance, and other neural systems.

2. Otoscopic examination and external ear canal management for removal of cerumen in order to evaluate hearing or balance, make ear impressions, fit hearing protection or prosthetic devices, and monitor the continuous use of hearing aids.

3. The conduct and interpretation of behavioral, electroacoustic, or electrophysiologic methods used to assess hearing, balance, and neural system function.

4. Evaluation and management of children and adults with central auditory processing disorders.

5. Supervision and conduct of newborn hearing screening programs.

6. Measurement and interpretation of sensory and motor evoked potentials, electromyography, and other electrodiagnostic tests for purposes of neurophysiologic intraoperative monitoring and cranial nerve assessment.

7. Provision of hearing care by selecting, evaluating, fitting, facilitating adjustment to, and dispensing prosthetic devices for hearing loss—including hearing aids, sensory aids, hearing assistive devices, alerting and telecommunication systems, and captioning devices.

8. Assessment of candidacy of persons with hearing loss for cochlear implants and provision of fitting, programming, and audiological rehabilitation to optimize device use.

9. Provision of audiological rehabilitation including speechreading, communication management, language development, auditory skill development, and counseling for psychosocial adjustment to hearing loss for persons with hearing loss and their families/caregivers.

10. Consultation to educators as members of interdisciplinary teams about communication management, educational implications of hearing loss, educational programming, classroom acoustics, and large-area amplification systems for children with hearing loss.

11. Prevention of hearing loss and conservation of hearing function by designing, implementing, and coordinating occupational, school, and community hearing conservation and identification programs.

12. Consultation and provision of rehabilitation to persons with balance disorders using habituation, exercise therapy, and balance retraining.

13. Design and conduct of basic and applied audiologic research to increase the knowledge base, to develop new methods and programs, and to determine the efficacy of assessment and treatment paradigms; dissemination of research findings to other professionals and to the public.

14. Education and administration in audiology graduate and professional education programs.

15. Measurement of functional outcomes, consumer satisfaction, effectiveness, efficiency, and cost-benefit of practices and programs to maintain and improve the quality of audiological services.

16. Administration and supervision of professional and technical personnel who provide support functions to the practice of audiology.

17. Screening of speech-language, use of sign language (e.g., American Sign Language and cued speech), and other factors affecting communication function for the purposes of an audiologic evaluation and/or initial identification of individuals with other communication disorders.

18. Consultation about accessibility for persons with hearing loss in public and private buildings, programs, and services.

19. Assessment and nonmedical management of tinnitus using biofeedback, masking, hearing aids, education, and counseling.

20. Consultation to individuals, public and private agencies, and governmental bodies, or as an expert witness regarding legal interpretations of audiology findings, effects of hearing loss and balance system disorders, and relevant noise-related considerations.

21. Case management and service as a liaison for the consumer, family, and agencies in order to monitor audiologic status and management and to make recommendations about educational and vocational programming.

22. Consultation to industry on the development of products and instrumentation related to the measurement and management of auditory or balance function.

23. Participation in the development of professional and technical standards.

Outcomes of Audiology Services

Outcomes of audiology services may be measured to determine treatment effectiveness, efficiency, cost-benefit, and consumer satisfaction. In the future, specific outcome data may assist consumers to make decisions about audiology service delivery. The following listing describes the types of outcomes that consumers may expect to receive from an audiologist.

1. Interpretation of otoscopic examination for appropriate management or referral;

2. Identification of populations and individuals
   a. with or at risk for hearing loss or related auditory disorders,

   b. with normal hearing or no related auditory disorders,

   c. with communication disorders associated with hearing loss,

   d. with or at risk of balance disorders, and

   e. with tinnitus.

3. Professional interpretation of the results of audiological findings;

4. Referrals to other professions, agencies, and/or consumer organizations;

5. Counseling for personal adjustment and discussion of the effects of hearing loss and the potential benefits to be gained from audiological rehabilitation, sensory aids including hearing and tactile aids, hearing assistive devices, cochlear implants, captioning devices, and signal/warning devices;

6. Counseling regarding the effects of balance system dysfunction;

7. Selection, monitoring, dispensing, and maintenance of hearing aids and large-area amplification systems;

8. Development of a culturally appropriate, audiologic, rehabilitative management plan including, when appropriate:

   a. Fitting and dispensing recommendations, and educating the consumer and family/caregivers in the use of and adjustment to sensory aids, hearing assistive devices, alerting systems, and captioning devices;

   b. Counseling relating to psychosocial aspects of hearing loss and processes to enhance communication competence;

   c. Skills training and consultation concerning environmental modifications to facilitate development of receptive and expressive communication;

   d. Evaluation and modification of the audiologic management plan.

9. Preparation of a report summarizing findings, interpretation, recommendations, and audiologic management plans;

10. Consultation in development of an Individual Education Program (IEP) for school-age children or an Individual Family Service Plan (IFSP) for children from birth to 36 months old;

11. Provision of in-service programs for personnel, and advising school districts in planning educational programs and accessibility for students with hearing loss; and

12. Planning, development, implementation, and evaluation of hearing conservation programs.

References

American Speech-Language-Hearing Association. (1993, March). Preferred practice patterns for the professions of speech-language pathology and audiology. *Asha*, 35 (Suppl. 11), 1–102.

American Speech-Language-Hearing Association. (1994, March). Code of ethics. *Asha*, 36 (Suppl. 13), 1-2.

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AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Standards and Implementations for the Certificate of Clinical Competence in Audiology*

The American Speech-Language-Hearing Association issues Certificates of Clinical Competence to individuals who present evidence of their ability to provide independent clinical services to persons who have disorders of communication. Individuals who meet the standards specified by the Association's Council on Professional Standards may be awarded a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) or a Certificate of Clinical Competence in Audiology (CCC-A). Individuals who meet the standards in both professional areas may be awarded both Certificates.

The Standards for the Certificate of Clinical Competence are shown in bold. The Clinical Certification Board's implementation procedures are shown in regular print under each related standard.

Standard I: Degree

Applicants for either Certificate must have a master's or doctoral degree.

Verification of the graduate degree on an official university transcript is required of all applicants **before the certificate is awarded.** If the degree is not readily available, verification from the official university designee is required. Applicants may apply for certification on completion of coursework and practicum with the recommendation of the program director. The program director should indicate the date the degree will be conferred. Individuals educated in foreign countries must submit official transcripts and evaluations of their degrees and courses. (For further details, refer to the section on foreign applicants in the *Membership and Certification Handbook.*)

Effective January 1, 1994, all graduate coursework and graduate clinical practicum required in the professional area for which the Certificate is sought must have been initiated and completed at an institution whose program was accredited by the Educational Standards Board of the American Speech-Language-Hearing Association in the area for which the Certificate is sought.

All graduate coursework and graduate clinical practicum required in the professional area for which certification is sought (21 graduate semester credit hours of coursework and the 250 graduate clock hours of clinical practicum) that is completed after January 1, 1994 must be initiated and completed in an ESB-accredited program. Graduate coursework and clinical practicum completed in non-ESB-accredited programs before January 1, 1994 will be accepted for ASHA certification. That is, graduate coursework and clinical practicum required in the professional area of certification that was completed before January 1, 1994 does not have to be from an ESB-accredited program. However, if the graduate coursework or clinical practicum is initiated and completed after January 1, 1994, it must be from an ESB-accredited program.

If the master's/entry-level doctoral degree is received at an ESB-accredited program and if the program director verifies that all coursework and practicum requirements have been met, approval of academic coursework and clinical practicum is automatic. In addition, the application must be received in the National Office no later than 3 years from the date the degree is awarded.

The following applicants must complete the full application form and receive a Clinical Certification Board (CCB) evaluation of their academic coursework and clinical practicum: (a) those who apply more than 3 years after the date the degree was awarded by an

Index terms: Standards, audiology, Clinical Certification Board

* All individuals whose applications for certification are postmarked after January 1, 1993, must meet these standards.

institution in which the ESB-accredited program is housed; (b) those who were graduate students and who were continuously enrolled in an ESB-program that had its accreditation withdrawn during the applicant's enrollment; (c) those who satisfactorily completed 21 graduate semester hours of coursework and 250 graduate clock hours of clinical practicum in the area for which certification is sought in a program that held candidacy status for accreditation; and (d) those who satisfactorily completed 21 graduate semester credit hours of coursework and 250 graduate clock hours of clinical practicum in the area for which certification is sought in an ESB-accredited program but (1) received graduate degrees from programs not accredited by ESB; (2) received graduate degrees in related areas; or (3) received graduate degrees from institutions in foreign countries.

Satisfactory completion of both undergraduate and graduate academic coursework and clinical practicum requirements must be verified by the ESB-accredited program director's signature.

Standard II: Academic Coursework

(75 Semester Credit Hours)

Applicants for either Certificate must have earned at least 75 semester[1] credit hours that reflect a well-integrated program of study dealing with (a) the biological/physical sciences and mathematics; (b) the behavioral and/or social sciences, including normal aspects of human behavior and communication; and (c) the nature, prevention, evaluation, and treatment of speech, language, hearing, and related disorders. Some coursework must address issues pertaining to normal and abnormal human development and behavior across the life span and to culturally diverse populations.

All areas of academic coursework, including Basic Science coursework (Standard IIA) and Professional Coursework (Standard IIB), must address issues pertaining to normal and abnormal human development and behavior across the life span and to culturally diverse populations.

All coursework must be verified on an official transcript from a regionally accredited university or college and must be applicable toward the university's degree program.

[1] One quarter credit hour is equivalent to two-thirds of a semester credit hour.

At least 27 of the 75 semester credit hours must be in Basic Science Coursework (see Standard II-A).

At least 36 of the 75 semester credit hours must be in Professional Coursework (see Standard II-B).

At least 27 semester credit hours must be in Basic Sciences and 36 must be in Professional Coursework. The remaining 12 semester credit hours may be distributed between these two areas.

A specific course may be credited usually to no more than two categories. If a course is split, a course description form from the *Membership and Certification Handbook* signed by the course instructor or program director must be submitted. This form must be accompanied by an official course description from the university's course catalogue. At least 1 semester credit hour of the course must address the area in which partial credit is requested.

Up to 6 graduate semester credit hours for a thesis or dissertation may be accepted in the Basic Human Communication Processes or Professional Coursework category. An abstract must be submitted with the application verifying the thesis/dissertation content placement. Academic credit that is associated with thesis or dissertation and for which graduate credit was received may apply in the professional area, but **may not be counted as meeting any of the minimum requirements**. Minimum requirements are defined as 6 semester credit hours in hearing disorders and hearing evaluation; 6 semester credit hours in habilitative/rehabilitative procedures with individuals who have hearing impairment; 3 semester credit hours in speech disorders; 3 semester credit hours in language disorders; and 21 graduate semester credit hours in audiology. Credit earned for research methodology courses, such as Research Methods, Introduction to Graduate Study, and so forth, may be counted toward the 30 semester credit hours of coursework at the graduate level but cannot be used toward any of the minimum requirements.

Standard II-A: Basic Science Coursework

(27 of 75 Semester Credit Hours)

Applicants for either Certificate must earn at least 27 semester credit hours in the basic sciences.

Some coursework must address issues pertaining to normal and abnormal human development, behavior across the life span and to culturally diverse populations. The 27 semester credit hours may be earned at the graduate or undergraduate level. However, graduate credit for these 27 semester credit hours

cannot be counted toward the 30 graduate semester credit hours required in courses pertaining to the nature, prevention, evaluation, and treatment of speech, language, and hearing disorders.

At least 6 semester credit hours must be in the biological/physical sciences and mathematics.

There must be one course in the biological/physical sciences and one course in college-level mathematics. Coursework in the biological/physical sciences may be in such areas as general human anatomy, physiology, biology, chemistry, physics, zoology, microbiology, and so forth. Coursework in mathematics may include college-level statistics. Computer courses such as FORTRAN, COBOL, and so forth, in which a major portion of the course content includes mathematics may be accepted. However, a graduate-level course that devotes a substantial portion to research methodology and a small portion of the course content to statistics cannot be used to meet this requirement. Remedial courses (skill improvement courses), historical mathematics courses, and methodology courses (such as methods of teaching mathematics) may not be used to satisfy this requirement. A course description and/or course outline may be requested by the CCB before rendering a decision.

At least 6 semester credit hours must be in the behavioral and/or social sciences.

The content of coursework in behavioral and/or social sciences should include study that pertains to understanding normal/abnormal human behavior, development across the life span, social interaction, and issues of culturally diverse populations. Typical categories of courses that may be included in these areas include psychology, sociology, gerontology, and so forth. A course description and/or course outline may be requested by the CCB before rendering a decision.

At least 15 semester credit hours must be in the basic human communication processes, to include coursework in each of the following three areas of speech, language, and hearing: the anatomic and physiologic bases; the physical and psychophysical bases; the linguistic and psycholinguistic aspects.[2]

The 15 semester credit hours should be in courses that provide information applicable to the normal development and use of speech, language, and hearing, including:

1. At least one course in anatomic and physiologic bases for the normal development and use of speech, language, and hearing; for example, anatomy, neurology, and physiology of speech, language, and hearing mechanisms.

2. At least one course in the physical basis and processes of the production and perception of speech, language, and hearing; for example, acoustics or physics of sound, phonology, physiologic and acoustic phonetics, perceptual processes, psychoacoustics, and speech/hearing science instrumentation.

3. At least one course in the linguistic and psycholinguistic variables related to the normal development of speech, language, and hearing; for example, linguistics (historical, descriptive, sociolinguistics, culturally diverse populations), psycholinguistics, language and speech acquisition, and verbal learning and verbal behavior.

This coursework should include emphasis in the normal aspects of human communication to give the student a wide exposure to diverse kinds of information in the content areas stated above.

Although coursework in the disorders area may contain content in basic human communication processes, it cannot be used to meet the 15 semester credit hour requirement in the basic human communication processes.

Some of these 15 semester credit hours may be obtained in courses that are taught in departments outside the speech-language pathology and audiology programs. Courses designed to improve the speaking and writing ability of the student (e.g., voice and diction, etc.) cannot be used to meet the 15 semester credit hour requirement in basic human communication processes, nor can courses in general human anatomy and physiology be used towards the requirement of one course in anatomic and physiologic bases.

Standard II-B: Professional Coursework

(36 of 75 semester credit hours)

Applicants for either Certificate must earn at least 36 semester credit hours in courses that concern the nature, prevention, evaluation, and treatment of speech, language, and hearing disorders. Those 36 semester credit hours must encompass courses in speech, language, and hearing that concern disorders primarily affecting children as well as disor-

[2] The three broad categories of required education, and the examples of areas within these classifications, are not meant to be analogous to or imply specific course titles or to be exhaustive.

ders primarily affecting adults. At least 30 of the 36 semester credit hours must be in courses for which graduate credit was received, and at least 21 of those 30 must be in the professional area for which the Certificate is sought.

There must be at least 30 graduate semester credit hours in speech-language pathology or audiology, and 21 of the hours must be in audiology. Some of the coursework must address issues pertaining to normal and abnormal human development, behavior across the life span, and to culturally diverse populations.

Receipt of graduate credit must be verified on an official transcript.

At least 30 of the 36 semester credit hours of professional coursework must be in audiology. At least 6 of the 30 must be in hearing disorders and hearing evaluation, and at least 6 must be in habilitative/rehabilitative procedures with individuals who have hearing impairment. Credits in courses that concern the nature, prevention, evaluation, and treatment of speech and language disorders associated with hearing impairment may be counted.

The 30 semester credit hours of professional coursework required for the Certificate of Clinical Competence in audiology should include at least 6 semester credit hours in hearing disorders and hearing evaluation, and at least 6 semester credit hours in habilitative/rehabilitative procedures. The study of auditory disorders and habilitative/rehabilitative procedures across the life span and in culturally diverse populations should be included. Coursework should include:

- Auditory disorders, such as the nature and cause of pathologies of the auditory system; evaluation of auditory disorders, including assessment of the peripheral and central auditory systems; the effects of auditory disorders on communication; electrophysiological measurements, including intraoperative monitoring; and balance system assessment.

- Habilitative/rehabilitative and preventive procedures, such as selection and use of appropriate amplification instrumentation, tactile aids, cochlear implants, assistive and alerting devices for the hearing impaired; evaluation of individual and group instruments using state-of-the-art instrumentation to assess real ear function of amplification; physical and electroacoustic characteristics of amplification systems and assistive devices, ANSI standards, other national and international specification standards for amplification systems; effects of acoustic and electroacoustic modification on real ear performance; earmold and in-the-ear hearing aid acoustics, impression techniques, and modifications; procedures and equipment for maintenance, troubleshooting, and repair of amplification systems, earmolds, and assistive devices; room acoustics and its effects on speech intelligibility, environmental modifications, interaction with amplification devices; evaluation of speech and language problems of the hearing impaired; and, management procedures for speech and language habilitation and/or rehabilitation of the hearing impaired, including but not exclusive to speechreading, auditory training, and manual communication. A course pertaining exclusively to acquisition of and facility with manual communication systems cannot be counted toward meeting the 6 semester hour minimum requirement in habilitation/rehabilitation but may be included in the total 36 semester credit hours needed in professional coursework.

- Conservation of hearing, such as environmental noise control and identification audiometry.

- Examination of external auditory canal and cerumen management.

- Instrumentation, such as calibration techniques.

Credit earned for thesis, dissertation, research methodology, and other professional issues may be used to satisfy the 30 semester credit hour requirement but may not be counted towards the minimum requirements (6 semester credit hours in hearing disorders and hearing evaluation, 6 semester credit hours in habilitative/rehabilitative procedures, 21 graduate semester hours in audiology).

At least 6 of the 36 semester credit hours of professional coursework must be in speech-language pathology. At least 3 of the 6 must be in speech disorders, and at least 3 must be in language disorders. This coursework in speech-language pathology must concern the nature, prevention, evaluation, and treatment of speech and language disorders not associated with hearing impairment.

It is highly recommended that at least 3 semester credit hours in speech-language pathology be taken for graduate credit.

When only the minimum requirement of 6 semester credit hours is met, such study must concern the nature, prevention, evaluation, and treatment of speech and language disorders not associated with hearing impairment. At least 3 semester credit hours must be in speech disorders and at least 3 semester hours must be in language disorders not associated with hearing impairment.

A maximum of 6 academic semester credit hours associated with clinical practicum may be counted toward the minimum of 36 semester credit hours of professional coursework, but those hours may not be used to satisfy the minimum of 6 semester credit hours in hearing disorders/evaluation, 6 hours in habilitative/rehabilitative procedures, or 6 hours in speech-language pathology, or the 21 graduate credits in the professional area for which the certificate is sought.

Academic credit that is associated with clinical practicum and for which graduate credit was received may apply in the professional area, but may not be counted as meeting any of the minimum requirements, including the 21 graduate semester credit hours in audiology. Academic credit that is obtained from practice teaching or practicum work in other professions will not be counted toward the requirement.

Standard III: Supervised Clinical Observation and Clinical Practicum

(375 Clock Hours)

Applicants for either Certificate must complete the requisite number of clock hours of supervised clinical observation and supervised clinical practicum that are provided by the educational institution or by one of its cooperating programs.

Students should be assigned practicum only after they have had sufficient coursework to qualify for such experience. Only direct contact with client or family in assessment, management, and/or counseling can be counted toward practicum. Although several students may observe a clinical session at one time, clinical practicum hours should be assigned only to the student who provides direct services to the client or client's family. Typically, only one student should be working with a given client. In rare circumstances, it is possible for several students working as a team to receive credit for the same session depending on the specific responsibilities each student is assigned. For example, in a diagnostic session, if one student evaluates the client and another interviews the parents, both students may receive credit for the time each spent in providing the service. However, if one student works with the client for 30 minutes and another student works with the same client for the next 45 minutes, each student gets credit for the time he/she actually worked, that is, 30 and 45 minutes – not 75 minutes.

The supervision must be provided by an individual who holds the Certificate of Clinical Competence in the appropriate area of practice.

All observation and clinical practicum hours must be supervised by individuals who hold a current CCC in the area in which the observation and practicum hours are being obtained. (Current means the clinical supervisor must hold certification at the time the supervision is provided.) Only the supervisor who actually observes the student in a clinical session is permitted to sign to give credit to the student for the clinical practicum hours.

Persons holding a CCC in audiology may supervise audiologic evaluations, amplification (hearing aid selection and management), speech and/or language screening for the purpose of initial identification of individuals with other communicative disorders, and aural habilitative and rehabilitative services.

Persons holding a CCC in speech-language pathology may supervise all speech-language pathology evaluation and treatment services, nondiagnostic audiologic screening for the purpose of performing a speech and/or language evaluation or for the purpose of initial identification of individuals with other communicative disorders, and aural habilitative/rehabilitative services.

Although there may be some practicum supervision overlap, the supervision of clock hours in the minor area should be conducted by individuals who are certified in the minor area.

A supervisor with a current CCC must be on site at all times. Only a currently certified clinician may supervise student practicum at on- and off-campus sites. Supervision of clinical practicum must include direct observation, guidance, and feedback by the currently certified supervisor to facilitate development of the student's clinical competence.

Standard III-A: Clinical Observation

(25 clock hours)

Applicants for either Certificate must complete at least 25 clock hours of supervised observation prior to beginning the initial clinical practicum.

Observations serve as a preparatory experience before beginning direct clinical practicum with individuals who have communication disorders.

Those 25 clock hours must concern the evaluation and treatment of children and adults with disorders of speech, language, or hearing.

Actual observations or videotapes may be used for observation purposes.

A student clinician must observe a total of 25 clock hours of evaluation and management. These observations should be relative to, and must precede, clinical assignment with specific types of communication disorders, for example, hearing impairment, selection and use of amplification devices, articulation, language. The observation experience must be under the direct supervision of a qualified clinical supervisor who holds current ASHA certification in the appropriate area.

Supervision may include simultaneous observations with the student or the submission of written reports or summaries by the student for supervisor monitoring, review, and approval.

Standard III-B: Clinical Practicum

(350 Clock Hours)

Applicants for either Certificate must complete at least 350 clock hours of supervised clinical practicum that concern the evaluation and treatment of children and adults with disorders of speech, language, and hearing. No more than 25 of the clock hours may be obtained from participation in staffings in which evaluation, treatment, and/or recommendations are discussed or formulated, with or without the client present.

Direct supervised clinical practicum involves direct time spent in actual evaluation or treatment with clients who present hearing disorders. Time spent with the client or caretaker engaging in information giving, counseling, or training for a home program may be counted as direct contact time if the activities are directly related to evaluation and treatment. Ancillary activities such as scoring tests and writing reports may not be counted. Meetings with practicum supervisors may not be counted under the 25 clock hours for staffing.

At least 250 of the 350 clock hours must be completed in the professional area for which the Certificate is sought while the applicant is engaged in graduate study.

At least 250 clock hours of practicum in audiology must be completed at the graduate level. Any clinical clock hours obtained after January 1, 1994 that are used to meet the requirement of 250 graduate clinical practicum hours in audiology must be initiated and completed in an ESB-accredited program. Graduate clinical clock hours obtained before January 1, 1994 may be from an unaccredited program.

At least 50 supervised clock hours must be completed in each of three types of clinical setting.

The three types of clinical settings may include undergraduate as well as graduate practicum sites, and may be within the organizational structure of the training institution or include its affiliates. Such settings may include separate units/settings within an institution or its affiliates (ICU/surgical units/ nursing homes/ classrooms for hearing impaired children), community clinics, public schools, rehabilitation centers, hospitals, and private practice settings. For the three clinical settings to be classified as different settings, the training institution must determine that the student has gained unique experiences in each one. For example, a student might have experience in an acute-care hospital as well as in a long-term-care hospital.

The applicant must have experience with the evaluation and treatment of children and adults, with a variety of types and severities of disorders of hearing, speech, and language, and with the selection and use of amplification and assistive devices.

Clinical experience should prepare the applicant to practice in the area of audiology according to ASHA's current Scope of Practice (pp. 47-48). Clinical experience should include both individual and group client contact, as well as experience with a variety of types and severity of hearing, speech, and language disorders.

Evaluation shall include collection of relevant information regarding case history, past and present function, selection and administration of reliable evaluation procedures, interpretation of results, and appropriate referrals for additional evaluation and/ or treatment based on the evaluation. Clock hours devoted to counseling associated with the evaluation/diagnostic process may be counted in these categories.

At least 50% of each student's time in each diagnostic evaluation, including screening and identification, must be observed directly by a supervisor.

Both direct and indirect services may be counted under treatment for hearing disorders.

At least 25% of each student's total contact time with each client in clinical treatment must be observed directly by a supervisor. These are minimum requirements and should be adjusted upwards if the student's level of competence and experience warrants.

At least 250 of the 350 supervised clock hours must be in audiology. At least 40 of those 250 clock hours must be completed in each of the first two categories listed below. At least 80 hours must be completed in categories 3 and 4 with a minimum of 10 hours in each of these categories. At least 20 of those 250 clock hours must be completed in category 5:

1. Evaluation: Hearing in children

2. Evaluation: Hearing in adults

Applicants should demonstrate a variety of clinical experiences in screening and evaluation, including electrophysiological test measures such as ABR, intraoperative monitoring, and balance system assessment.

3. Selection and use: Amplification and assistive devices for children

4. Selection and use: Amplification and assistive devices for adults

Applicants should have had a variety of clinical experiences in evaluation, selection, and use of appropriate amplification systems and assistive devices. Applicants should have experience in electroacoustic tests of amplification systems as well as procedures for maintenance and troubleshooting of amplification systems, cochlear implants, earmolds, and assistive devices.

5. Treatment: Hearing disorders in children and adults

Applicants should demonstrate a variety of clinical experiences in treatment of children and adults with hearing disorders. Treatment for hearing disorders refers to clinical management and counseling, including auditory training, and speechreading, as well as speech and language services for those with hearing impairment.

Up to 20 clock hours in the major professional area may be in related disorders.

These clock hours may include but are not limited to hearing conservation programs, cerumen management, and repair of hearing aids.

At least 35 of the 350 clock hours must be in speech-language pathology. At least 15 of those 35 clock hours must involve the evaluation or screening of individuals with speech and language disorders unrelated to hearing impairment, and at least 15 must involve the treatment of individuals with speech and language disorders unrelated to hearing impairment.

Standard IV: National Examination in Audiology

Applicants must pass the national examination in the area for which the Certificate is sought.

The national examination in audiology is designed to assess, in a comprehensive fashion, the applicant's mastery of knowledge of professional concepts and issues to which the applicant has been exposed throughout professional education and clinical practicum. The applicant must pass the examination in audiology within 2 years from the date the coursework and practicum submitted by the applicant are approved by the CCB. The current passing score is 600.

An applicant who fails the examination may retake it. If the examination is not successfully passed within a 2-year period, the applicant's certification application period will lapse. If the examination is passed at a later date, the individual will have to reapply for certification under the standards in effect at the time of reapplication and will be required to pay the appropriate fees.

Standard V: The Clinical Fellowship

After completion of academic coursework (Standard II) and clinical practicum (Standard III), the applicant then must successfully complete a Clinical Fellowship.

The clinical fellowship is designed to foster the continued growth and integration of the knowledge, skills, and tasks of clinical practice in audiology consistent with ASHA's current scope of practice.

The clinical fellowship must be completed within 7 years of the date the academic coursework and practicum were completed. Otherwise, the individual must reapply for certification and must meet the standards in effect at the time of reapplication.

Once initiated, the clinical fellowship must be completed within a maximum of 36 consecutive months.

Because standards may change, it is to the applicant's advantage to initiate the clinical fellowship experience as soon as possible after the academic coursework and practicum have been completed.

The Fellowship will consist of at least 36 weeks of full-time professional experience or its part-time equivalent.

Full-time employment is defined as a minimum of 30 hours per week in direct patient/client contact, consultations, record-keeping, and administrative duties relevant to a bona fide program of clinical work. Part-time equivalency is defined as follows:

(1) 15-19 hours/week over 72 weeks

(2) 20-24 hours/week over 60 weeks

(3) 25-29 hours/week over 48 weeks

Note: Professional experience of less than 15 hours/week does not meet the requirement and cannot be counted toward the clinical fellowship. Similarly, experience of more than 30 hours/week cannot be used to shorten the clinical fellowship to less than 36 weeks.

The Fellowship must be completed under the supervision of an individual who holds the Certificate of Clinical Competence in the area for which certification is sought.

It is the applicant's responsibility to locate and obtain a qualified clinical fellowship supervisor for the clinical fellowship. In the case of multiple clinical fellowship supervisors, a primary clinical fellowship supervisor must be designated, and each clinical fellowship supervisor must hold the Certificate of Clinical Competence in audiology.

It is incumbent upon the clinical fellow to ascertain the current certification status of the clinical fellowship supervisor at the initiation of the clinical fellowship and periodically throughout the clinical fellowship experience.

A Clinical Fellowship Registration Agreement (pp. 71-72) must be submitted to the CCB no later than 4 weeks after initiating the clinical fellowship. The clinical fellowship supervisor will then receive the Clinical Supervisor Information Packet (CSIP) from the CCB. Receipt of the CSIP by the clinical fellowship supervisor acknowledges that the Clinical Fellowship Registration Agreement has been received by the CCB. The CSIP includes the Clinical Fellowship Skills Inventory — Audiology, the Clinical Fellowship Skills Inventory Rating Form, Clinical Fellowship Supervisor's Responsibilities, instructions for the clinical fellowship, and the Clinical Fellowship Report. Failure to submit the mandatory Clinical Fellowship Registration Agreement will result in an extension of the clinical fellowship.

Clinical fellowship supervision must entail the personal and direct involvement of the clinical fellowship supervisor in any and all ways that will permit the clinical fellowship supervisor to monitor, evaluate and improve the clinical fellow's performance. Therefore, it is important to set goals initially and to revise them as needed.

The clinical fellowship experience should be divided into three segments, each representing one third of the total time spent in employment (e.g., a 36-week clinical fellowship would be divided into three 12-week segments; a 72-week clinical fellowship would be divided into three 24-week segments).

The clinical fellowship supervisor must engage in no fewer than 36 supervisory activities during the clinical fellowship experience. This supervision must include 18 on-site observations of direct client contact at the clinical fellow's work site (1 hour equals 1 on-site observation; a maximum of 6 on-site observations may be accrued in one day). At least 6 on-site observations must be accrued during each third of the experience. These on-site observations must be of the clinical fellow providing screening, evaluation, assessment, habilitation, and rehabilitation.

In addition, the supervision must include 18 other monitoring activities. At least 6 other monitoring activities must be completed during each of the three segments of the clinical fellowship. These other monitoring activities may be executed by correspondence, review of video tapes and/or audio tapes, evaluation of written reports, phone conferences with the clinical fellow, evaluations by professional colleagues, and so forth.

The CCB may allow the supervisory process to be conducted in other ways; however, such requests, including a written detailed plan, must be submitted for prior approval to the CCB at the time the mandatory Clinical Fellowship Registration Agreement is submitted. The alternate mechanism for supervision should not be initiated until the CCB has approved the submitted plan. (For further information, see Alternate Mechanism for Supervision on page 22.)

The professional experience shall involve primarily clinical activities.

Eighty percent of the work week must be in direct clinical activities (i.e., assessment, diagnosis, evaluation, screening, treatment, report writing, family/client consultation, and/or counseling) related to the management process of individuals who exhibit communication disabilities. For example, in a 30-hour work week, at least 24 hours must consist of direct

clinical activities; in a 15-hour work week, at least 12 hours must consist of direct clinical activities.

The Supervisor periodically shall conduct a formal evaluation of the applicant's progress in the development of professional skills.

The clinical fellowship supervisor must use the Clinical Fellowship Skills Inventory — Audiology, at least once during each of the three segments of the clinical fellowship to evaluate the clinical fellow's clinical skills. This evaluation must be shared and discussed with the clinical fellow, and the form must be signed and dated by both. All clinical fellowship evaluations must be carried out by the primary clinical fellowship supervisor, who will sign the final report.

No later than 4 weeks after the completion of the clinical fellowship experience, the clinical fellow and the clinical fellowship supervisor must sign and submit a Clinical Fellowship Report and the Clinical Fellowship Skills Inventory Rating Form to the National Office for review by the CCB.

If the clinical fellowship is initiated and successfully completed in a program accredited by the Professional Services Board (PSB) of ASHA, approval of the clinical fellowship is automatic. In such instances, the Director of the PSB program must sign the Clinical Fellowship Report verifying compliance with the clinical fellowship requirements as stated above.

If the clinical fellowship supervisor does not recommend approval of the clinical fellowship experience at the completion of the clinical fellowship, he/she must so indicate on the appropriate section of the Clinical Fellowship Report and must sign it. Then, within 30 days, the clinical fellowship supervisor must submit the Clinical Fellowship Report, the signed Clinical Fellowship Skills Inventory Rating Form, a letter of explanation, and supporting documentation to the CCB.

Following a negative recommendation, the clinical fellow may complete an entirely new clinical fellowship experience and/or request a special review by the CCB.

In order to request a special review the clinical fellow must submit the signed Clinical Fellowship Report and the signed Clinical Fellowship Skills Inventory Rating Form, if not already submitted, a letter of explanation, and supporting documentation of current clinical skills within 30 days of completing the experience. The supporting documentation attesting to current clinical skills must be provided by individuals who hold a current CCC in audiology. It may be necessary for the CCB to share this information with the clinical fellowship supervisor and to solicit any additional information the clinical fellowship supervisor wishes to provide. The Board will then review all information submitted to determine whether the clinical fellowship experience will be approved.

Clinical Certification Board Interpretations on Clinical Practicum and Coursework

Clinical Practicum

In addition to the interpretations given below, students and clinical supervisors are referred to the Code of Ethics, Clinical Practice by Certificate Holders in the Profession in Which They Are Not Certified, and the Scope of Practice, Speech-Language Pathology and Audiology.

1. Persons who hold the CCC in Audiology may supervise

- assessment of the peripheral and central auditory systems, including behavioral and (electro) physiological measurements of the auditory and vestibular functions.
- selection, fitting, and dispensing of amplification, assistive devices, and other systems (e.g., implantable devices).
- conservation of auditory system function, including development and implementation of environmental and occupational hearing conservation programs.
- aural habilitative/rehabilitative services and related counseling services.
- screening for speech or language disorders

2. Persons who hold the Certificate of Clinical Competence (CCC) in speech-language pathology may supervise

- assessment, rehabilitation, and prevention of disorders of speech (e.g., articulation, fluency, voice) and language.
- assessment and rehabilitation of cognitive/communication disorders.
- assessment and rehabilitation of disorders of oral-pharyngeal function (dysphagia) and related disorders.
- assessment, selection, and development of augmentative and alternative communication systems and the provision of training for their use.
- aural habilitative/rehabilitative services and related counseling services.
- enhancement of speech-language proficiency and

communication effectiveness (e.g., accent reduction).

- pure tone air conduction hearing screening

3. Only direct client contact time may be counted as clinical practicum hours. Time spent in scoring tests, in-service training, and writing reports may not be counted.

4. Evaluation refers to those hours in screening, assessment, and diagnosis that are accomplished prior to the initiation of a treatment program. Hours to be counted in the evaluation category may also include reevaluation (another formal assessment). Periodic assessments during treatment are to be considered treatment.

5. Time spent with either the client or a family member while engaging in information seeking, information-giving, counseling, or parental education/involvement may be counted as clinical clock hours (provided the activity is directly related to evaluation and/or treatment).

6. Time spent in a multidisciplinary staffing, educational appraisal and review, or in meetings with professional persons regarding diagnosis and treatment of a given client may be counted up to 25 hours.

7. Conference time with clinical supervisors may not be counted.

Coursework

Credit for a course is allowed only if an official transcript shows a passing grade for the course. Course credits should not be split unless it is absolutely necessary. When necessary, a course may be credited to no more than 2 categories, and no less than 1 semester hour credit should be assigned to each category. For courses with vague titles, such as "Directed Study," "Independent Study," "Audiology II," "Speech Pathology I," and so forth, the applicant must have the instructor or program director complete a course description form (see Appendix H) and submit it along with a copy of the catalogue description. Copies of abstracts of projects, thesis, dissertation must be submitted to the CCB as well.

Students who are not yet professionals should not be reimbursed directly for the provision of clinical practicum services. However, students can receive traineeships, scholarships, and/or stipends. (LC 13-84)

20.0 Basic Audiologic Assessment

Procedures to assess and monitor the status of the peripheral auditory system, which comprises the outer, middle, and inner ear.

Basic audiologic assessment is conducted according to the Fundamental Components of Preferred Practice Patterns, p. 1.

Professionals Who Perform the Procedure(s)

Audiologists.

Expected Outcome(s)

- Basic audiologic assessment is conducted to quantify and qualify, by site of lesion, peripheral hearing loss on the basis of perceptual, physiologic, or electrophysiologic responses to acoustic stimuli and to describe any associated communication disorders.
- Assessment may result in recommendations for further audiologic assessment, rehabilitative assessment, medical/educational referral, hearing aid/sensory assessment, aural rehabilitation, speech or language assessment, or counseling.

Clinical Indications

- Children, adolescents, adults, and elderly persons are assessed when a hearing loss is suspected (for infant and child assessment, see Statement 20.1).
- Basic audiologic assessment is prompted by referral, or by failure of a screening (see Statement 01.0).

Clinical Process

- A case history is obtained. Otoscopic evaluation and, if necessary, cerumen management are performed.
- Assessment includes:
  - Air-conduction and bone-conduction pure-tone threshold measures with appropriate masking
  - Speech recognition thresholds or detection with appropriate masking
  - Word recognition (speech discrimination) measures with appropriate masking

- Other procedures include:
  - Tympanometry, static immittance, and acoustic reflex measures
  - Measurement of auditory evoked potentials (when traditional audiometry cannot be employed)
  - Measurement of evoked otoacoustic emissions
  - Speech and language screening
  - Recently documented measurement procedures
  - Communication inventories
- Patients/clients with identified hearing loss receive follow-up services to monitor audiologic status and to ensure appropriate treatment.

Setting/Equipment Specifications

- Assessments are conducted with calibrated acoustic stimuli (e.g., pure tones, broadband noise).
- Electroacoustic equipment and ambient noise meet ANSI and manufacturer's specification.

Documentation

- Documentation addresses interpretation of test results and the type and severity of the hearing loss and associated conditions (e.g., medical diagnosis, disability, home program).
- Documentation contains pertinent background information, assessment results, interpretation, prognosis, and specific recommendations. Recommendations may address the need for further assessment, follow-up, or referral. When treatment is recommended, information is provided concerning the frequency, estimated duration, and type of service (e.g., individual, group, home program) required.

ASHA Policy and Related References

In addition to the references listed on p. iv, the following references apply specifically to these procedures:

American National Standards Institute. (1981). Reference equivalent threshold force levels for audiometric bone vibrators [ANSI S3.1-1977 (R1981)]. New York: Acoustical Society of America.

American National Standards Institute. (1986). Artificial head bone for the calibration of audiometer bone vibrators [ANSI S3.13-1972 (R1986)]. New York: Acoustical Society of America.

American National Standards Institute. (1987). Specifications for instruments to measure aural acoustic impedance and admittance (aural acoustic immittance) (ANSI S3.39-1987). New York: Acoustical Society of America.

American National Standards Institute. (1989). Specifications for audiometers (ANSI S3.6.-1989). New York: Acoustical Society of America.

American National Standards Institute. (1991). Maximum permissable ambient noise levels for audiometric test rooms (ANSI S3.1-1991). New York: Acoustical Society of America.

American Speech-Language-Hearing Association. (1978). Manual pure-tone threshold audiometry. Asha, 20(4), 297-301.

American Speech-Language-Hearing Association. (1987). Calibration of speech signals delivered via earphones. Asha, 29(6), 44-48.

American Speech-Language-Hearing Association. (1988). Guidelines for determining threshold level for speech. Asha, 30(3), 85-89.

American Speech-Language-Hearing Association. (1991). Guidelines for graduate training in amplification. Asha, 33 (Suppl 5), 35-36.

American Speech-Language-Hearing Association. (1992). External auditory canal examination and cerumen management. Asha, 34 (Suppl. 7), 22-24.

American Speech-Language-Hearing Association. (1993). Definitions of communication disorders and variations. Asha, 35 (Suppl. 10), 40-41.

American Speech-Language-Hearing Association. (1993). Guidelines for audiology services in the schools. Asha, 35 (Suppl. 10), 24-32.

20.1 Pediatric Audiologic Assessment

Procedures to determine the status of the auditory system in individuals whose developmental levels preclude use of a basic audiologic assessment (see Statement 20.0).

Pediatric audiologic assessment is conducted according to the Fundamental Components of Preferred Practice Patterns, p. 1.

Professionals Who Perform the Procedure(s)

Audiologists.

Expected Outcome(s)

- Pediatric audiologic assessment is conducted to quantify and qualify hearing loss on the basis of perceptual, physiologic, or electrophysiologic responses to acoustic stimuli.
- Assessment may result in recommendations for additional audiologic assessment, medical referral, hearing aid/sensory aid assessment, aural rehabilitation assessment, speech and language assessment, or counseling.

Clinical Indications

- Infants, children, and those whose developmental levels preclude the use of a basic or comprehensive audiologic assessment (see Statements 20.0 and 21.0) are assessed when a hearing loss is suspected.
- Assessment is prompted by referral, or by failure of a hearing screening.

Clinical Process

- Case history is obtained. Otoscopic evaluation and, if necessary, cerumen management are performed.
- Assessment includes:
  - Developmentally appropriate behavioral procedures (e.g., behavioral observation, visual reinforcement audiometry, play audiometry) using nonspeech and speech stimuli
  - Speech and language screening

- Other procedures include:
  - Tympanometry, static immittance, and acoustic reflex measures
  - Measurement of auditory evoked potentials
  - Measurement of otoacoustic emissions
  - Recently documented measurement procedures
  - Functional communication measures
- Central auditory function is assessed behaviorally and physiologically with a variety of speech and nonspeech stimuli.
- Patients/clients with identified hearing loss and/or auditory disorders receive follow-up services to monitor audiologic status and ensure appropriate treatment.

Setting/Equipment Specifications

- Assessments use measurable acoustic stimuli (e.g., pure tones, broadband noise).
- Specifications for electroacoustic equipment and ambient noise meet ANSI standards, where applicable.
- Instrumentation is available for monitoring, recording, and reinforcing patients'/clients' responses.

Documentation

- Documentation addresses interpretation of test results and the type and severity of the hearing loss and associated conditions (e.g., medical diagnosis, disability, home program).
- Documentation contains pertinent background information, assessment results, interpretation, and specific recommendations. Recommendations may address the need for further assessment, follow-up, or referral. When treatment is recommended, information is provided concerning the frequency, estimated duration, and type of service (e.g., individual, group, home program) required.

ASHA Policy and Related References

In addition to the references listed on p. iv, the following references apply specifically to these procedures:

American National Standards Institute. (1981). Reference equivalent threshold force levels for audiometric bone vibrators [ANSI S3.1-1977 (1981)]. New York: Acoustical Society of America.

American National Standards Institute. (1986). Artificial headbone for the calibration of audiometer bone vibrators [ANSI S3.13-1972 (R1986)]. New York: Acoustical Society of America.

American National Standards Institute. (1987). Specifications for instruments to measure aural acoustic impedance and admittance (aural acoustic immittance) (ANSI S3.39-1987). New York: Acoustical Society of America.

American National Standards Institute. (1989). Specifications for audiometers (ANSI S3.6-1989). New York: Accoustical Society of America.

American National Standards Institute. (1991). Maximum permissable ambient noise levels for audiometric test rooms (ANSI S3.1-1991). New York: Acoustical Society of America.

American Speech-Language-Hearing Association. (1978). Manual pure-tone threshold audiometry. Asha, 20(4), 297-301.

American Speech-Language-Hearing Association. (1987). Calibration of speech signals delivered via earphones. Asha, 29(6), 44-48.

American Speech-Language-Hearing Association. (1988). Guidelines for determining threshold level for speech. Asha, 30(3), 85-89.

American Speech-Language-Hearing Association. (1989). Audiologic screening of newborn infants who are at risk for hearing impairments. Asha, 31(3), 89-92.

American Speech-Language-Hearing Association. (1990). Guidelines for screening for hearing impairments and middle ear disorders. Asha, 32, (Suppl. 2), 17-24.

American Speech-Language-Hearing Association. (1991). Guidelines for the audiologic assessment of children from birth through 36 months of age. Asha, 33 (Suppl. 5), 37-43.

American Speech-Language-Hearing Association. (1992). External auditory canal examination and cerumen management. Asha, 34 (Suppl. 7), 22-24.

American Speech-Language-Hearing Association. (1993). Definitions of communication disorders and variations. Asha, 35 (Suppl. 10), 40-41.

American Speech-Language-Hearing Association. (1993). Guidelines for audiology services in the schools. Asha, 35 (Suppl. 10), 24-32.

Joint Committee on Infant Hearing. (1991). 1990 position statement. Asha, 33 (Suppl. 5), 3-6.

21.0 Comprehensive Audiologic Assessment

Procedures to assess the status of the peripheral auditory system, the auditory nerve, and the central auditory nervous system or to establish the site of the auditory disorder.

Comprehensive audiologic assessment conducted according to the Fundamental Components of Preferred Practice Patterns, p. 1.

Professionals Who Perform the Procedure(s)

Audiologists.

Expected Outcome(s)

- Comprehensive audiologic assessment is conducted to quantify and qualify hearing loss, by site of lesion, on the basis of perceptual, physiologic, or electrophysiologic response to acoustic stimuli and to describe any communication disorders.
- Assessment may result in recommendations for further audiologic assessment, medical/educational referral, hearing aid/sensory aid assessment, aural rehabilitation assessment, speech and language assessment, or counseling.

Clinical Indications

- Children, adolescents, adults, and the elderly are assessed on the basis of referral, case history, prior audiologic assessment, or medical status.

Clinical Process

- The assessment includes procedures contained in Statement 20.0, Basic Audiologic Assessment.
- Procedures to assess cochlear versus retrocochlear (i.e., eighth cranial nerve, brainstem, or cortical) auditory disorders include:
  - Acoustic reflex threshold
  - Acoustic reflex patterns
  - Auditory evoked potentials
  - Performance intensity--phonetically balanced speech discrimination (PIPB)
  - Evoked otoacoustic emissions
- Procedures to assess central auditory nervous system disorders include:
  - Auditory evoked potentials
  - Brief tone stimuli
  - Distorted speech
  - Dichotic stimuli

- Temporal ordering of stimuli
- Masking patterns
- Physiological measures of brain activity, including blood flow, metabolic rate, and electrical activity

- Procedures for detecting or quantifying pseudohypoacusis include:
  - Comparing pure-tone averages and speech recognition thresholds
  - Bekesy audiometry, including lengthened off-time (LOT) and Bekesy Ascending
  - Delayed auditory feedback, including key tap procedures
  - Stenger tests
  - Acoustic reflex thresholds
  - Auditory evoked potentials
  - Evoked otoacoustic emissions

- Recently documented measurement procedures may supplement assessment.

- Patients/clients with identified hearing loss or auditory disorders receive follow-up services to monitor audiologic status and to ensure appropriate treatment.

Setting/Equipment Specifications

- Assessments are conducted with calibrated acoustic stimuli (e.g., pure tones, broadband noise).

- Electroacoustic equipment and ambient noise meet ANSI and manufacturer's standards, where applicable.

Documentation

- Documentation addresses interpretation of test results and the type and severity of the hearing loss or auditory disorder and associated conditions (e.g., medical diagnosis, disability).

- Documentation contains pertinent background information, assessment results, interpretation, prognosis, and specific recommendations. Recommendations may address the need for further assessment, follow-up, or referral. When treatment is recommended, information is provided concerning the frequency, estimated duration, and type of service (e.g., individual, group, home program) required.

ASHA Policy and Related References

In addition to the references listed on p. iv, the following references apply specifically to these procedures:

American National Standards Institute. (1981). Reference equivalent threshold force levels for audiometric bone vibrators [ANSI S3.1-1977 (R1981)]. New York: Acoustical Society of America.

American National Standards Institute. (1986). Artificial headbone for the calibration of audiometer bone vibrators [ANSI S3.13-1972 (R1986)]. New York: Acoustical Society of America.

American National Standards Institute. (1987). Specifications for instruments to measure aural acoustic impedance and admittance (aural acoustic immittance) (ANSI S3.39-1987). New York: Acoustical Society of America.

American National Standards Institute. (1989). Specifications for audiometers (ANSI S3.6-1989). New York: Acoustical Society of America.

American National Standards Institute. (1991). Maximum permissable ambient noise levels for audiometric test rooms (ANSI S3.1-1991). New York: Acoustical Society of America.

American Speech-Language-Hearing Association. (1978). Manual pure-tone threshold audiometry. Asha, 20(4), 297-301.

American Speech-Language-Hearing Association. (1987). Calibration of speech signals delivered via earphones. Asha, 29(6), 44-48.

American Speech-Language-Hearing Association. (1988). Guidelines for determining threshold level for speech. Asha, 30(3), 85-89.

American Speech-Language-Hearing Association. (1988). The short latency auditory evoked potentials. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1993). Definitions of communication disorders and variations. Asha, 35 (Suppl. 10), 40-41.

American Speech-Language-Hearing Association. (1993). Guidelines for audiology services in the schools. Asha, 35 (Suppl. 10), 24-32.

22.0 Electrodiagnostic Test Procedures

Procedures to assess the functional status of the central or peripheral nervous and associated sensory systems using electrophysiologic testing methods.

Electrodiagnostic test procedures is conducted according to the Fundamental Components of Preferred Practice Patterns, p. 1.

Professionals Who Perform the Procedure(s)

Audiologists.

Expected Outcome(s)

- Electrodiagnostic test results describe the clinical status of specific neural systems or pathways and their associated sensory elements. The neurophysiologic information derived from these procedures assists in differential diagnosis, in assessing states of respective neural pathways, and in management planning.

Clinical Indications

- Electrodiagnostic test procedures may be indicated for a patient/client with signs, symptoms, or complaints, for whom central or peripheral nervous system disease or disorder is suspected.
- Electrodiagnostic studies are indicated for objective evaluation of sensory sensitivity of function. Evaluations are conducted with patients/clients who are difficult to test by conventional behavioral methods, to supplement behavioral information, or to resolve conflicting information.

Clinical Process

- Patient/client is prepared for the procedure using appropriate stimulators, and recording electrodes are applied with accepted techniques.
- Electrodiagnostic procedures may be conducted.
- Meaningful data descriptors are extracted from the electrophysiologic response. These data are compared with normative data.

Setting/Equipment Specifications

- Power-line-operated instruments conform to minimum ANSI safety requirements.
- Recording and stimulating electrodes conform to acceptable sterile conditions.

- Electrodiagnostic testing is conducted in an environment that is satisfactorily free of electrical interference so as not to affect the measurement of neuroelectric potentials. When determining thresholds via the measurement of acoustically evoked neuroelectric potentials, ambient noise levels meet ANSI specifications.

Safety and Health Precautions

- AC-line-powered equipment is grounded adequately for equipment and patient/client.
- The professional performing electrodiagnostic procedures knows facility-specific emergency medical protocol.
- Safe levels of electrical stimulation are presented.

Documentation

- Electrodiagnostic equipment, electrode types and sites, electrical stimulation probes, acoustic transducers, and stimulating and recording parameters are specified in writing at the time of the procedure.
- Clinical events (e.g., patient/client sleep status, sedation, procedural problems, patient/client comments, home program) are recorded at the time of the procedure.
- A summary report includes an interpretation of electrodiagnostic findings in relation to normative data and recommendations.

ASHA Policy and Related References

In addition to the references listed on p. iv, the following references apply specifically to these procedures:

American National Standards Institute. (1985). Safe current limits for electromedical apparatus [ANSI/AAMI ESI-1978 (R1985)]. New York: Acoustical Society of America.

American National Standards Institute. (1991). Maximum permissable ambient noise levels for audiometric test rooms (ANSI S3.1-1991). New York: Acoustical Society of America.

American Speech-Language-Hearing Association. (1990). Competencies in auditory evoked potential measurement and clinical applications. Asha, 32 (Suppl. 2), 13-16.

American Speech-Language-Hearing Association. (1992). Position statement and guidelines for neurophysiologic intraoperative monitoring. Asha, 34 (Suppl. 7), 34-36.

22.1 Auditory Evoked Potential Assessment

Procedures to assess auditory function using electrophysiologic testing methods.

> **Auditory Evoked Potential Assessment is conducted according to the Fundamental Components of Preferred Practice Patterns, p. 1.**

Professionals Who Perform the Procedure(s)

Audiologists.

Expected Outcome(s)

- Auditory evoked potential (AEP) assessment describes the clinical status of the auditory neural pathway and associated sensory elements.
- Neurophysiologic information assists in differential diagnosis and in estimating hearing threshold sensitivity.
- Assessment may result in recommendations for treatment, follow-up, or in referral for other services.

Clinical Indications

- Auditory evoked potential procedures may be indicated for patients/clients of all ages with signs, symptoms, or complaints, for whom central or peripheral auditory nervous system disease or disorder is suspected.
- Auditory evoked potential assessments are indicated for objective evaluation of auditory sensitivity or function. Evaluations are conducted with patients/clients who are difficult to test by conventional behavioral methods, to supplement behavioral information, or to resolve conflicting information.

Clinical Process

- Patient/client is prepared for the procedure using recording electrodes applied with accepted techniques.
- Traditional AEP procedures include:
  - Short latency response (SLR)
    - Auditory brainstem response (ABR)
    - Electrocochleography (ECochG)
  - Middle latency response (MLR)
  - Late/long latency response (LLR)

- Meaningful data descriptors are extracted from the electrophysiologic response. These data are compared with normative data.

Setting/Equipment Specifications

- Power-line-operated instruments conform to minimum ANSI safety requirements.
- Recording and stimulating electrodes conform to acceptable sterile conditions.
- AEP testing is conducted in an environment that is satisfactorily free of electrical interference so as not to affect the measurement of AEPs. When determining thresholds via the measurement of AEPs, ambient noise levels meet ANSI specifications.

Safety and Health Precautions

- AC-line-powered equipment is grounded adequately for both equipment and patient/client.
- The professional performing the procedures knows facility-specific emergency medical protocols.
- Safe levels of electrical stimulation are presented.

Documentation

- AEP equipment, electrode types and sites, acoustic transducers, and stimulating and recording parameters are specified in writing at the time of the procedure.
- Clinical events (e .g., patient/client sleep status, sedation, procedural problems, patient/client comments, home program) are recorded at the time of the procedure.
- A summary report includes an interpretation of AEP findings in relation to appropriate normative data and recommendations.

ASHA Policy and Related References

In addition to the references listed on p. iv, the following references apply specifically to these procedures:

American National Standards Institute. (1985). Safe current limits for electromedical apparatus [ANSI/AAMI ESI-1978 (R1985)]. New York: Acoustical Society of America.

American National Standards Institute. (1991). Criteria for permissable ambient noise during audiometric testing (ANSI 3.1-1991). New York: Acoustical Society of America.

American Speech-Language-Hearing Association. (1990). Competencies in auditory evoked potential measurement and clinical applications. Asha, 32 (Suppl. 2), 13-16.

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August 7, 1996

The Honorable James B. King
Director
Office of Personnel Management
1900 E Street, N.W.
Washington, D.C. 20415

Dear Director King:

On behalf of the American Medical Association (AMA), I am writing to express our concerns regarding your recent letter in response to an inquiry from Representative John Mica, Chairman, Subcommittee on Civil Service, Committee on Government Reform and Oversight (dated May 14, 1996), regarding a provision in the "Annual Call Letter" for proposed benefit and rate changes for plans participating in the Federal Employee Health Benefits Program (FEHBP Letter No. 96-08A, March 4, 1996). We share Representative Mica's interest in the "Annual Call Letter's" instruction that encourages and promotes the use of "silent or non-directed PPOs" in the fee-for-service plans. We are especially troubled by your affirmative response to the Congressman's question regarding whether plans are expected to capture discounts from bills by utilizing "silent PPOs."

The AMA maintains that physicians are being short-changed by billing programs that create payment discounts for payors who are not entitled to them by using practices known as "silent" or "non-directed" preferred provider organizations (PPOs). Under conventional PPO arrangements, physicians and providers offer discounted fees to payors in exchange for "preferred provider" status that attract more patients. This "quid pro quo" is the basis for the discounts offered. With "silent PPOs," however, PPO discounts are applied to indemnity patients not contractually covered by the PPO. This leads to providers being unable to rely on -- and ultimately, to offer -- legitimate discounts. I have taken the liberty of enclosing the joint AMA and American Hospital Association white paper, PROVIDERS BEWARE: GUARDING AGAINST SILENT PPOs, which illustrates the problems with these arrangements from both the physician and hospital point-of-view.

More specifically, your letter to Representative Mica clearly states that carriers participating in FEHBP have been directed to consider cost effective practices and that "methods studied should include but not be limited to 'silent' or 'non-directed' preferred provider organizations." The AMA strongly opposes the use of "silent PPOs" and urges you to reevaluate your endorsement, albeit tacit, of this questionable practice. While we understand that the actual language of the "Annual Call Letter" is less clear, we are deeply concerned that the Office of Personnel Management (OPM) is actively working to expand the use of

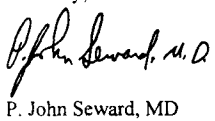
additional "savings" to the FEHBP program, these types of physician and hospital discounting schemes inevitably undermine legitimate preferred provider networks causing health care costs to rise while intentionally misleading providers in the interim.

In addition, it has come to our attention that OPMs own minimum standards for which health benefit carriers are to comply includes an injunction to carriers that states that they "must perform the contract in accordance with prudent business practices" and that this shall include "legal and ethical business and health care practices" (See Federal Employees Health Benefits Acquisition regulation, 48 CFR 1609.701 (b)(2)). We strongly support these provisions yet doubt whether many of the "silent PPOs," could measure up against these standards. While we understand that OPM has not actually instructed carriers under FEHBP to use "silent PPOs" we would urge OPM to review its instructions and practices with regards to "cost effectiveness" especially as they relate to these problematic entities.

Clearly, the AMA believes that physicians and other health care providers are being harmed by "silent PPOs." While we understand the interest in finding savings under the FEHB program, we believe that under the laws of economics that any reductions in spending achieved from the use of "silent PPOs" will be followed by increases in the long-term. We urge you to refrain from directing FEHBP carriers and their subcontractors from utilizing "silent PPOs" in the future because we believe that they are questionable at best and often unethical or fraudulent at worst. We also believe that such action has a potentially significant "spill-over" effect to the private marketplace.

We look forward to your response on this important matter in the near future.

Sincerely,



P. John Seward, MD
Executive Vice President

Enclosure

JUNE 1995

PROVIDERS BEWARE:

GUARDING AGAINST SILENT PPOs

RESELLING CONTRACT RATE DISCOUNTS THROUGH "SILENT" OR NON-DIRECTED PPOs AND DISCOUNTED INDEMNITY PLANS

American Hospital Association

American Medical Association

Physicians dedicated to the health of America

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EXECUTIVE SUMMARY

Health care providers, including doctors, hospitals and health systems, are being victimized by billing schemes that create payment discounts for payors who aren't entitled to them. These payors obtain preferred-provider discounts without providers' consent under practices known as **"silent"** or **"non-directed" PPOs.** Depending on the patient volume, providers could be losing tens of thousands of dollars, if not hundreds of thousands of dollars, on inappropriately applied discounts.

In preferred-provider organization (PPO) arrangements, providers offer discounted fees to payors in exchange for "preferred provider" designations that attract more patients. With "silent" PPOs, PPO discounts are applied to indemnity patients not covered by a PPO.

Here's how it works: Suppose a payor receives a $4,000 medical bill, but doesn't want to pay the full amount. The payor contacts a PPO broker who has access to a list of providers and discount levels for several PPOs. The payor learns that the provider is under contract with a PPO for a 25 percent discount. The payor then recalculates the bill, taking 25 percent off the original $4,000 amount. The new bill refers to the PPO's discount as the reason for the lower payment, even though the patient is not covered by that PPO.

Upon receiving the discounted bill, the provider's accounting or billing department verifies that the hospital or physician group has a contract with the PPO. But, unless the specific patient's treatment or admission records are searched to determine coverage, it is impossible to confirm that the patient is not a PPO member. Thus, many providers are granting discounts they're not obligated to give.

Efforts to identify and stop these arrangements are essential. At a minimum, providers should:

- scrutinize their PPO contracts and their dealings with payors;
- protect themselves by refusing to sign PPO contracts permitting the sale of discount information;
- And, as a further precaution, conduct audits to determine whether PPO discounts are being applied inappropriately to indemnity patients.

BACKGROUND

This is the second alert from the AHA and AMA that describes a practice that both associations initially reported on in October 1994. It explains Silent PPOs in more detail and recommends ways for providers to protect themselves from these discounting practices.

The term "Silent PPO" was used in the first alert to describe this practice since that term appeared in marketing materials distributed by at least one entity that promotes these practices. Another, perhaps more accurate, characterization of these practices is "secondary market in contracted rates." The secondary market exists for payors who are able to obtain discounted contract rate information and reprice provider bills that then are submitted to unsuspecting providers.

This secondary market, which operates under an array of names, permits PPOs and network brokers to sell hundreds of millions of dollars in provider discounts to payors, brokers, and other entities. These may well be discounts that the providers never intended to grant and which may not be permitted by the providers' PPO contracts.

Access to contracted rates reportedly is sold to a broad base of payors responsible for: indemnity lives, out-of-network care, workers' compensation, automobile accident medical claims and self-insured employers (either self-administered or contracting for third party administrative services). Many payors routinely use the contracted rate information to calculate discounts reflected on Explanation of Benefits forms sent by payors to providers.

WHAT NAMES ARE USED TO DESCRIBE THIS PRACTICE?

What the AHA and AMA view as a secondary market in contracted rates may be referred to in the field as: silent PPOs, non-directed PPOs, voluntary PPOs, wrap around PPOs, blind PPOs, soft channeling, second tier PPOs, total conversion PPOs, extended managed care network, invisible PPOs, supplemental PPOs, back-end PPOs, discounted indemnity or managed indemnity. Undoubtedly, there are other names to describe this practice.

HOW DOES THIS PRACTICE DIFFER FROM TYPICAL PPO ARRANGEMENTS?

Most providers are familiar with the operation of preferred provider organizations, or PPOs. In fact, the great majority of providers have signed contracts with one or more PPOs. In these contracts, providers agree to a discounted fee schedule in anticipation of receiving additional patient flow as a result of being designated a preferred provider. But providers may not know about this secondary market for discounted contract rates.

Discounted indemnity plans and silent PPOs are not conventional managed care products. They are merely words used to describe a process through which a payor is able to apply a discount to a provider's bill. This is possible when the PPO makes its roster of preferred providers and contracted rates available to other payors and brokers for a fee. The discounts typically are applied to patients who are covered by an employer or payor that has not contracted with the PPO (i.e. plan participant), therefore, the patients are not subject to meaningful financial incentives or other steerage mechanisms which encourage them to select the preferred providers.

WHO IS HARMED? PROVIDERS AND PATIENTS

This practice results in providers losing revenue to which they are otherwise entitled. In addition, patients who may think that their health care bills are covered, may be balance billed by providers who discover that a bill has been repriced through a "silent PPO."

This fluid market in contract rate information exacerbates the imbalance between provider charges and DRG payments. If hospitals continue to lower their charges to address the PPO pricing mechanisms, the hospital's Medicare profiles also drop. Likewise, physician reimbursement under RBRVS may be negatively affected by this vast secondary market in contract rates that is readily accessible to payors.

If the business office or patient account manager is trying to keep aged accounts receivable as low as possible, then these repricing practices will be harder to stop. Cash flow may take precedence over careful analyses of explanation of benefit forms to identify whether the appropriate amount was remitted. In short, for many providers the amount of collection may be less important than its timeliness.

"Silent PPO" discounts are usually applied to patients with indemnity coverage. In these situations, the patient is liable for the provider's reasonable charge, and has the right to indemnification for all or a portion of the bill from the insurer. If the insurer fails to pay to the full extent of its obligation by reducing the provider's charge before paying the 80% (for example) it is obligated to pay, the patient will not receive the level of indemnification he or she is entitled to. The patient loses in two ways: the insurer may be charging premiums that the patient believes are based on the insurer's obligation to pay 80% of the charges, and, the patient is exposed to a potentially larger balance bill from the provider.

WHAT IS AN EXAMPLE OF THIS PRACTICE?

The attached diagram uses a physician's practice to illustrate how the secondary market for contracted rates works. A typical PPO relationship involves a simple exchange of bargains: providers agree to discount their fees in exchange for their designation as "preferred providers." Through the PPO's use of financial incentives, directories and the like, the preferred providers expect that patients will be steered to them. A typical financial incentive may provide that the PPO plan participant, i.e. employers and payors, will pay 90% of a physician's bill if the enrollee chooses a preferred provider, but only 70% if the enrollee does not. In contrast, a traditional indemnity plan pays 80% of the provider's usual and customary fee. PPO plan participants will save money even by paying the higher percentage of a bill because the preferred provider has agreed to accept a lower than customary fee, often dramatically lower.

Once the network of preferred providers is in place, the PPO markets the network to plan participants. The PPO's contracts with providers contemplate this business activity, and generally require the PPO to notify its preferred providers on a regular basis of the addition of new blocks of business. Moreover, enrollees of the PPO carry identification cards which indicate their enrollment in the PPO. These cards aid providers in verifying coverage at the time service is rendered. However, the variety of identification cards in the market can be wilder both enrollees and providers.

Many individuals are reluctant to choose PPOs, HMOs, and other plans which restrict, even to a limited degree, their choice of providers. Thus, a strong demand exists for "freedom of choice," a hallmark of traditional indemnity plans, particularly in certain geographic areas and among certain employee groups. The payors who offer indemnity plans also seek to offer a competitively priced product and are vitally interested in securing provider discounts for their indemnity business. However, these payors may have

difficulty securing discounts for their indemnity products directly from providers because they cannot offer providers steerage mechanisms or other inducements to lower their fees. As a result, these payors seek discounted contract rates from other sources, e.g. (1) PPOs that have negotiated discounted contract rates with providers or (2) contract rate brokers who have purchased "access" to those rates from PPOs.

PPOs meet this demand by selling the information from their roster of preferred providers, including the discounted contract rates for each provider, directly to indemnity payors or to brokers who resell the information to payors. Armed with this information, the payor is able to re-price any claim that it receives from a provider in the PPO's network, simply by referencing the provider's discount level with that PPO and asserting (or implying), as discussed below, that it is entitled to the discount as well. This process enables the payor to avail itself of the PPO's discounted rates even though the beneficiary is not in the PPO.

Suppose that a patient is in a traditional indemnity plan that pays 80% of the usual and customary physician's fee. The patient visits her physician for treatment. At the time service is rendered, the physician telephones the number on the patient's insurance card and verifies her indemnity coverage. The physician provides the needed care and submits a bill to the payor.

At this point, the payor is obligated to pay 80% of the usual and customary physician fee, with no discount. The payor would rather receive a discount, if possible, so it seeks one from a PPO or broker. If the physician has signed a contract with any PPO, the payor will likely gain access to that information. For a fee, the PPO that has a contract with the physician may sell the payor the information on its preferred provider roster. If it does, the payor will be able to reprice the claim from the physician, taking the discount the physician has agreed to with the PPO, and identify the PPO (which the patient does not belong to) on the payor's Explanation of Benefits (EOB) form that accompanies payment of the discounted rate. (Note: Repricing often is done by third party administrators serving the employer/payor.)

Once the physician receives the EOB from the indemnity payor referencing the PPO discount, one of several things may happen. The physician's office staff may not notice the discrepancy, especially if the physician has a contract with the PPO referenced on the EOB. The staff may not compare the EOB with the original verification of coverage, and may simply assume that the payor is entitled to the discount. (Because most payors offer a variety of plans, and the

relationship among plans is not obvious and the wide variety of enrollee identification cards, the office staff may believe that the payor and the PPO are related.)

One the other hand, the staff may note the peculiar circumstance of a PPO discount being applied to a patient with indemnity coverage, and may telephone the payor with an inquiry. (This possibility is more likely in the event that the PPO referenced on the EOB is not one with whom the physician has a contract. More on how that can happen below.) In response to this inquiry, the payor is likely to tell the physician that it is "affiliated" with the PPO in question, and that it receives a discount if one of its indemnity insureds happens to visit a provider under contract with the PPO. Given the trust inherent in the health care system, the constantly changing relationships among payors, and physicians' general lack of detailed knowledge of the terms of their PPO contracts, the physician is likely to accept this explanation, extending to the payor a discount to which it may not be entitled. Likewise, hospitals with numerous managed care contracts may have difficulty coordinating and updating their base of participating PPOs and plan participants, as well as devoting appropriate time to scrutinize each contract.

This secondary market in contracted rates is big business. Several brokers operate nationally, and are quite automated. These brokers establish on-going relationships with payors and provide them with computer software containing the provider rosters of one or more PPOs. This software enables the payor to reprice claims from any provider under contract with any of the PPOs automatically, without having to search for access to a PPO discount for each claim. This practice undercuts the business and rationale for legitimate PPOs, which is to create a network of preferred providers and require that financial incentives and other steerage mechanisms are applied to enrollees.

A payor who deals through a broker in this way may reference the broker when identifying the discount on its EOB forms, rather than the specific PPO whose discount it has used. When dealing through a broker, the payor simply may not know which PPO the provider has contracted with, and therefore which PPO's discount it is using. The payor may only be told that the broker is "affiliated" with a PPO or a national discount network. The payor may only receive contract rate information from the broker. By referencing only the broker on its EOB forms, the payor may add to the provider's confusion when the EOB is received, because the provider is unlikely to have a contract with the broker. In effect, the provider will be asked to honor a discount for an indemnity patient on behalf of a PPO with which the provider has not contracted.

There is plenty of money for providers to lose in this scheme. Generally, the broker receives 30% of the amount it "saves" the payor on each claim. Thus, if a payor is able to discount a provider's claim by $1000, then $300 will be sent to the broker or PPO who made the transaction possible. If a broker is involved, it will generally split its fee with the PPO that supplied the contracted rates. If you as a provider are approached by a broker or told by a payor that they are "affiliated" with a national or regional network; ask to see the "affiliation agreement." Chances are it doesn't exist in writing.

Providers who sign PPO contracts may not have contemplated a secondary market in their PPO discounts, but they may have made one possible by signing contracts with loose language. PPOs may also be violating the letter and spirit of their contracts with providers by selling discount information in this way.

There are common elements to all of these arrangements, including:

- Reliance on numerous and complex Explanation of Benefits forms;
- Reliance on loose contract language that usually favors the silent PPO sponsor and payors;
- Comunications and information systems problems between hospital/medicaloffice admitting departments and billing/accounts receivable functions.

BASIC BUSINESS CONSIDERATIONS BEFORE CONTRACTING

The current realities of the market may dictate what contact terms providers can negotiate with PPOs and other brokers. In some cases, the provider may have to accept the "steered" with the "non-steered" patients if the PPO or broker will not accept firm contract provisions that require financial incentives and other limits on the use of the provider's contract rates.

Also, providers need to determine whether it is worthwhile signing a contract that may be difficult for the provider to implement. Other considerations include:

1. Payor's ability to pay claims;

2. What is the actual number of lives that the PPO might be able to deliver;

3. The past experience of the PPO in directing lives. It is advisable to check the statistics roughly three months before the end of the contract term and ask the PPO to verify the amount of business "steered" to you.

4. Whether the proposed agreement will bring in new business or simply permit the PPO and any party it contracts with to expand the payor base by substituting different amounts of payment for the same patients, thus lowering the average payments the provider receives. In other words, if the PPO is able to rapidly expand its list of payors (with no limits) within your service area, you may be treating patients that otherwise would have come to you and are only substituting the amount of payment.

5. Given your market, is the PPO or plan sponsor likely to bring new business by buying market share (covered lives) from indemnity plans or HMOs. That market strategy is another example of possibly treating the same patients for a different, usually lower, payment.

EXHIBIT A

HOW TO PROTECT YOUR BARGAIN WITH A PPO

Provider education and efforts to identify and stop these arrangements are essential. At a minimum, providers should follow the contracting advice presented below. In addition, providers should check all PPO directories in their facility to verify the accuracy of the list of participating providers for each PPO and/or "network affiliate" of a PPO. A phone call to the isted PPO and/or network affiliate to verify your status as a direct contract participant is recommended.

Careful Contracting

Providers signing PPO contracts should ensure:

- that discounts will be extended only to enrollees of the PPO who have cards identifying them as such;
- that all PPO members eligible for discounts will be subject to steerage mechanisms; contract language that promises "best efforts" by the PPO to steer enrollees usually is of minimal value under most state law;
- that the types of entities that can be added to the network are identified in advance, and that providers receive timely notice when payors or employers are added;
- that all members added to the PPO be subject to the same steerage mechanisms;
- that any discounts applicable to a PPO enrollee be disclosed at the time coverage is verified;
- that the sale or other unauthorized use of contract rate information is specificall prohibited.

SAMPLE CONTRACT PROVISIONS

The AHA and AMA have reviewed numerous PPO contracts in order to understand how this secondary market has gained such a substantial foothold. These contracts are, of course, numerous, but they contain some common provisions. Presented below are sample contract provisions that are especially important to be aware of before executing participating provider agreements:

1. Certain agreements specify that patients eligible for discounts will be subject to steerage mechanisms:

> PPO will provide each Preferred Provider with a list of all Payors who have entered into agreements with PPO to utilize the services of Preferred Providers. PPO shall require Payors to develop effective channeling mechanisms, including financial incentives, for encouraging Participating Patients to use health care providers participating in the PPO.

2. They may also specifically identify the patients to whom provider discounts will apply:

> This agreement provides for each Preferred Provider to provide its full complement of health care services at the rates specified on Schedule 1 to eligible beneficiaries of the Participating Groups and to any Payor Groups that are later added pursuant to this agreement. Each Participating Group will have a contract with the PPO that requires the Group to provide financial incentives for its beneficiaries to use Preferred Providers. No additional Payor will be added to this agreement until the Preferred Providers have had the opportunity to review the proposed PPO - Payor contract.

3. Some of these terms may be incorporated in the definitions of the contract:

> "covered individual" means any individual, employee, member or group member and any dependent insured under a contract issued by the Payor, where such contract provides financial incentives to use the PPO network of Preferred Providers.

4. The financial incentives may be explicit:

> Insurers, through their contractual agreements with PPO, agree to promote the utilization of Preferred Providers by offering financial incentives to Insureds, with a minimum differential of 10%.

5. In some cases, the sponsor of a health benefit plan agrees to contract exclusively with a PPO:

> Sponsor agrees to exclusively offer to the enrollees the "ABC" PPO within the geographical area set forth in Exhibit A. Sponsor also agrees not to enter into any agreements with other providers, medical networks or other entity, directly or indirectly, to provide medical services to its enrollees.

6. Check to determine whether the Client (i.e. payor) of the PPO has agreed in its contract with the PPO network to impose certain duties on the Client's claim administrator to ensure confidentiality of information:

> Claims Administrator will not disclose information, including but not limited to contract rate information, repriced bills from which contract rate data might be derived, and related data, without the written approval of "ABC" PPO. Such confidential information shall not be used by Claims Administrator in any way not expressly authorized under this Agreement.

7. Some PPO agreements may not specifically define the group of beneficiaries eligible for discounts:

> Participating Physicians shall accept the PPO Charge as full payment for Covered Services for Eligible Persons.

PREFERRED PROVIDER ORGANIZATION REGULATION

The 1994 "State Managed Care Legislative Resource" published by the American Managed Care and Review Association (AMCRA) includes a section entitled: "State-by-State Issue Profiles" that describes the status of PPO regulation on a state specific basis. Some states have laws that require PPOs to use incentives to steer patients. In those states where PPO regulation exists, a citation to the applicable law is provided. In addition, this resource includes the phone number for each state's insurance department.

AMCRA's address, phone and fax numbers are:

1200 19th Street, NW
Suite 200
Washington, D.C. 20036

PHONE: (202) 728-0506
FAX: (202) 728-0609

Breaking the silence

The following is among the most common ways that insurers use 'silent' PPOs to obtain discounts on health care claims. Regardless of the scenario, experts say hospitals and doctors can wind up losing out.