CHAMPUS AND PROSPECTIVE REIMBURSEMENT

Staff Working Paper

April 1983

Congressional Budget Office

Congress of the United States

PREFACE

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has grown rapidly in recent years. One key reason has been the steep rise in the cost of hospital care. Between 1981 and 1982, in the country as a whole, the average expense per hospital admission increased by almost 16 percent.

Earlier this year, in hopes of controlling rapidly rising outlays, the Congress enacted a significant change in the way the Medicare program pays hospitals. This paper, prepared at the request of the House Armed Services' Subcommittee on Military Personnel and Compensation, explores linking CHAMPUS with Medicare's new system of prospective reimbursement as a way to contain CHAMPUS' growth. It describes Medicare's new system and considers the advantages and potential drawbacks to CHAMPUS of linkage. In keeping with CBO's mandate to provide objective analysis, this study offers no recommendations.

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SUMMARY

Rising payments to hospitals and physicians have been a growing burden to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS reimburses military families who obtain care from civilian providers when care at military hospitals or clinics is not available. One suggestion to hold down rising payments has been to link CHAMPUS with the system of prospective reimbursement that Medicare will soon use.

It is widely felt that prospective reimbursement offers the best hope of containing rising Medicare costs. Under the new system, the Medicare payment for different diagnoses will be set in advance and will not be based on an individual hospital's costs. This will give hospitals a strong incentive to hold down costs, since hospitals that hold costs below the Medicare payment rate can keep the difference, and those that do not must absorb the loss.

Linking CHAMPUS with Medicare would hold down rising CHAMPUS costs and prevent hospitals from shifting costs from Medicare to CHAMPUS. This change would, however, entail considerable effort on the part of CHAMPUS, and CHAMPUS would have to guard against some potential drawbacks.

BACKGROUND

The Department of Defense (DoD) provides care to its eligible beneficiaries through military facilities or through use of civilian providers. Eligible beneficiaries include active-duty personnel and their dependents, along with retirees and their dependents and survivors. The system of military facilities includes more than 160 hospitals and 300 clinics--supported by 151,000 military and civilian personnel--and costs roughly $4.5 billion to operate in fiscal year 1982.

When military facilities are unavailable or not able to provide certain types of care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) reimburses beneficiaries for medical services obtained in the private sector. Dependents of active-duty personnel are reimbursed for most of the costs of inpatient care in civilian hospitals; they only pay the greater of $25 per hospital stay or $6.55 a day--a nominal amount. Retirees and their dependents and survivors are reimbursed for 75 percent of their allowable charges for hospital care. In 1982, CHAMPUS spent roughly $650 million in hospital reimbursements for more than 300,000 admissions to civilian hospitals.

CHAMPUS has experienced sharply rising costs. Between 1981 and 1982, CHAMPUS' payments for hospital care rose by roughly 20 percent. Since CHAMPUS finances services purchased in the private sector, its experience reflects that of the entire medical care system. Between 1981 and 1982, in the country as a whole, inpatient expenses per admission rose at an average rate of 15.6 percent; this was six percentage points more than the increase in prices hospitals pay for labor and supplies.

This six-percentage-point difference results from physicians ordering larger numbers of increasingly sophisticated diagnostic and therapeutic services for each patient. But many health experts have pointed out that intensity of treatment, and hence cost, need not have risen so fast. The rate could have been slowed without compromising the quality of care by discontinuing ineffective procedures and using other procedures more judiciously. A lack of incentives to consider costs on the part of patients and physicians is one of the reasons little attention has been paid to curtailing procedures that do not contribute much to better health.

The existing system of reimbursing hospitals has been one reason for the absence of incentives to contain costs. Third-party payers exert little pressure to contain costs because they pay either on the basis of incurred costs--as did Medicare--or simply pay whatever a hospital charges, however high that may be. Earlier this year, however, the Congress enacted a significant change in the manner in which Medicare pays hospitals by establishing a system of prospective reimbursement.

MEDICARE REIMBURSEMENT UNDER THE SOCIAL SECURITY ACT AMENDMENTS OF 1983

Under the new system of prospective payment, Medicare will determine in advance the rates at which hospitals will be reimbursed for each Diagnostic Related Group (DRG). DRGs are designed to group patients into categories that cost roughly the same to treat and that make clinical sense to physicians. For example, all patients over age 70 who are admitted to a hospital for removal of a gall bladder and related surgical procedures fall into one of the 467 DRGs. Reimbursement will also vary with the hospital's location (urban or rural area, and which of nine census divisions the hospital is in) and with prevailing local wages. Additional payments will be made to teaching hospitals and for cases with exceptionally long lengths of stay.

Prospective payment will be phased in to minimize disruptions; over the next three fiscal years, the DRG method will be used to determine an increasing portion of the payment amount for each case, and the hospital's own cost base will be used to determine the decreasing remainder. By the fourth year, Medicare will use only the DRG method to determine payments,

and payment will cease to vary with census division. During 1984 and 1985, rates of payment for each DRG will grow no faster than the prices hospitals pay for labor and supplies plus one percentage point. Thereafter, a panel of experts will review the appropriateness of this approach to updating payments and advise the Secretary of Health and Human Resources, who will have final say.

Certain costs and types of care will be excluded from the new method of prospective payment, at least for the next few years. Capital-related costs--which include depreciation, interest, and rent--will continue to be paid on the basis of reasonable cost. Today they constitute about 6 percent of Medicare's payments to hospitals. The Congress did, however, include provisions in the Social Security Act Amendments that will ensure modification in Medicare's reimbursement of capital costs by 1986. The prospective payment plan does not affect hospitals specializing in long-term care, rehabilitation, children's care, and psychiatric care.

The new system will increase hospitals' incentives to contain costs. If a hospital's expenses in treating a patient are less than the payment assigned to that patient's DRG, the hospital keeps the savings; if the hospital exceeds the set payment, it must absorb the difference.

LINKING CHAMPUS WITH MEDICARE

To link CHAMPUS with Medicare's system of prospective reimbursement, current law would have to be changed to permit DoD to use Medicare's new method. Also, hospitals and other institutions participating in Medicare would have to be required by an amendment to the Social Security Act to participate in CHAMPUS. This second step is critical because Medicare is responsible for roughly 35 percent of community hospital revenues, while CHAMPUS is responsible for less than 1 percent. If CHAMPUS tried on its own to set lower payments, hospitals might turn away CHAMPUS patients or bill them for additional charges.

Advantages to CHAMPUS

Linkage with Medicare would enable CHAMPUS to negotiate lower reimbursements to hospitals than under current law. At present, CHAMPUS usually negotiates discounts from hospital charges averaging 5 percent, but Medicare, by virtue of its clout with hospitals, today has a system that leads to reimbursements more than 20 percent less than hospital charges. Consequently, even before Medicare's system of prospective reimbursement goes into effect, linkage could reduce CHAMPUS' outlays for hospital care by roughly $100 million in 1984. Although it is probably too late in the year to achieve these savings by 1984, they suggest the potential for future reductions. Moreover, the savings to CHAMPUS would grow in future years

as Medicare implements its prospective reimbursement system, since Medicare outlays are projected to be 9 percent lower by 1986 than they would have been under cost reimbursement.

Even without linkage, CHAMPUS could benefit from any cost reductions hospitals make in response to Medicare's new system of reimbursement so long as these cost reductions are reflected in lower charges. But linkage would also protect CHAMPUS from increases in charges that hospitals might initiate to offset losses from lower prospective payments.

Effort Required to Implement Linkage

Achieving these savings would entail considerable effort on the part of CHAMPUS and its fiscal intermediaries. CHAMPUS would not be able to use the specific DRG payment rates that are being determined for Medicare because those served by CHAMPUS are younger. Within many DRGs, younger patients typical of CHAMPUS' population would be less costly to treat during their hospital stay than would older patients typical of Medicare's population. And DRGs for obstetrical and pediatric cases are not relevant to Medicare, though they constitute much of CHAMPUS' workload. Thus, CHAMPUS would need to assemble data to set prospective payment rates for certain DRGs. This would mean a change in the way those managing CHAMPUS claims--mostly Blue Cross plans--record data about patients.

Prospective reimbursement based on DRGs can be quite sensitive to errors in patient data. For this reason, CHAMPUS would need an ongoing system of quality control to monitor recording practices. This would be especially important to ensure that hospitals could not artificially inflate their reimbursements.

Potential Drawbacks to Linkage

Many of the drawbacks to linking CHAMPUS with Medicare stem from a lack of experience with the new system of prospective reimbursement and consequent uncertainty about the system's operation and effect.

For example, the new system of prospective payment could reduce access to quality care. If faced with lower payments, some hospitals might admit fewer CHAMPUS and Medicare patients, particularly those most costly to treat. Still other hospitals with relatively large proportions of Medicare or CHAMPUS patients might only be able to reduce costs at the expense of quality.

CHAMPUS might be able to minimize problems by observing Medicare's experience for a year or two before fully implementing

prospective reimbursement. And to guard further against potential problems, CHAMPUS could first try out prospective reimbursement in one or two regions before extending the method to all of them.

Another problem is that a few CHAMPUS beneficiaries could pay more under a DRG-based system than under current law. Each DRG contains a range of patients whose charges now vary extensively. Despite the overall reduction in reimbursements projected under a DRG system, the 25 percent copayment for some CHAMPUS patients could exceed what they pay now.

Phasing in the DRG method should, however, lessen the effects of swings in the rate of reimbursement. To further soften the burden on families who would suffer higher costs, the Congress could impose a cap on out-of-pocket expenses: a limit of $2,500 per family, for example, could cost CHAMPUS about $30 million annually. A cap might also have other advantages--most importantly, it might convince families to give up supplementary insurance policies that now diminish the effects of CHAMPUS' cost-sharing provisions. A cap would protect families from extraordinary medical expenses, but still leave most medical expenses subject to the restraining influence of cost sharing.

CONCLUSION

By providing hospitals with incentives to hold down costs, prospective reimbursement offers the hope of significant reductions in expenditures for the nation's medical care. Linking CHAMPUS with Medicare would offer the same hope for military medical costs and would avoid the risk of hospitals shifting Medicare costs to CHAMPUS. If the Congress wants the option to link Medicare and CHAMPUS in the next year or so, it should require that DoD begin now to develop data and plans that will be needed. The time required to develop those plans would give the Congress an opportunity to observe and act on any problems that Medicare has in implementing prospective reimbursement.