Statement for the Record
of
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before the
Subcommittee on Military Personnel and Compensation
Committee on Armed Services
U.S. House of Representatives

March 9, 1988

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EST), Wednesday, March 9, 1988.

Madame Chairman, thank you for the opportunity to discuss the costs of the military health care system. As you know, the system has several key objectives--it must be ready to meet the demands of war, and it must satisfy the medical needs of more than 9 million active and retired military personnel and their dependents. The system must also meet these goals at a reasonable cost, and I will focus on costs in my testimony.

Since 1979, the cost of all military medical activities has risen by about 170 percent, roughly 40 percent faster than total U.S. spending for health care. The cost of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)--the military's separate insurance program that helps pay for private medical care--has risen by 365 percent, from $485 million in 1979 to more than $2.3 billion today. Such cost growth, as well as other problems with the military's health care system, have led to numerous proposed reforms.

My testimony, which draws from a report by the Congressional Budget Office (CBO) to this committee in January (Reforming the Military Health Care System), reviews three approaches to reform, two of which are slated for testing: The CHAMPUS Reform Initiative (CRI), which will start this August in California and Hawaii, and "catchment area management," which will be phased in next year at several military installations. A third approach, less far-reaching, might be to build on several of the Defense Department's smaller initiatives (for example, PRIMUS outpatient clinics). Each approach has the potential for savings, but each also carries a risk of

higher costs. For example, CBO estimates that a nationwide version of CRI could either save as much as $600 million or add as much as $1 billion to annual CHAMPUS costs, depending on managerial efficiency and the reactions of beneficiaries.

CONTRIBUTORS TO RISING COSTS

What lies behind escalation during the last few years in military health care costs, particularly those for CHAMPUS? Two important causes--growing numbers of military retirees and dependents, and high rates of medical inflation generally--remain largely beyond the control of the Department of Defense (DoD). Two others do not: comparatively heavy use of health care by dependents and retirees, and, at the same time, inefficient use of existing military hospitals.

Heavy Use of Care

On a per capita basis, nonactive beneficiaries visit physicians and are admitted to hospitals more often than other civilians. For example, for every thousand active-duty dependents living inside a military catchment area--the region roughly 40 miles around a military hospital--the Defense Department pays for almost 1,000 hospital days a year, compared with about 600 days for some civilian insurance plans. Moreover, per capita use varies widely from one catchment area to the next, suggesting there could be some leeway in reducing admissions without jeopardizing health.

Growing Use of CHAMPUS

Only about two-thirds of this health care use takes place in the "direct care" system, the network of hospitals and clinics run by the military services. The rest occurs under the CHAMPUS program. Why? A major reason is that budgetary limits have compelled the services to keep many hospital beds empty--in fact, about one available military hospital bed in three is not operational for lack of staff or resources. (Also, until this year, the services have not been individually accountable for increased CHAMPUS spending, and so have had little incentive to economize on CHAMPUS use.) Since treatment in the civilian community is generally more expensive than in existing military facilities, heightened dependence on CHAMPUS raises overall costs, not to mention dissatisfaction among beneficiaries.

THE CHAMPUS REFORM INITIATIVE

If the rise in costs is to be slowed, a reform in CHAMPUS must reduce the use of some health care services, and must make better use of military medical facilities. The CHAMPUS Reform Initiative (CRI) proposes to harness private interests to resolve these issues. A private health care company, operating under a more or less fixed price contract, will use two approaches to reduce escalating costs: sharing arrangements with military treatment facilities for staff and supplies--which should return workload to the direct care system--and preferred provider organizations (PPOs).

Preferred Provider Organizations

PPOs are groups of providers, hospitals, or physicians, that agree by contract to offer discounted services to purchasers of health care. Increasingly popular among cost-conscious employers in the private sector, PPOs achieve their greatest savings by conducting stringent reviews to curb the unnecessary use of services.

The CRI contract for California and Hawaii will let beneficiaries choose between two types of PPOs. Under the rubric of CHAMPUS Extra, beneficiaries will be offered financial incentives to choose from among a list of preferred providers, while remaining free to use any physician or hospital. As an alternative, beneficiaries can join the CHAMPUS Prime program, which will bind them to using preferred providers in return for more generous financial incentives and enhanced benefits.

Uncertainty About Effects of CRI

By negotiating favorable discounts and reducing the use of some health care services, the contractor expects to achieve substantial savings relative to the conventional CHAMPUS program. But CBO's estimates suggest that CRI will only save large sums if many beneficiaries join CHAMPUS Prime or use CHAMPUS Extra. At this point, there is no certainty about who will join CHAMPUS Prime. Nor is there certainty about two other crucial variables:

- The reactions of the so-called "ghosts," beneficiaries eligible for military care who today choose to go outside both military facilities and CHAMPUS for health care. For every medical or surgical hospital admission covered by CHAMPUS, the admission of a "ghost" is paid for by another source, usually private health insurance; and

- Changes in private health insurance coverage. Some military families might decide to drop their other insurance, as has happened before when the Defense Department offered a new health care benefit.

In CBO's January report, we looked at these issues as they affected the Defense Department's original request for proposal (RFP) for the CHAMPUS Reform Initiative. The recently awarded contract differs from the RFP in some details, but it remains susceptible to the various uncertainties I have just mentioned. Therefore, the findings I am about to present, though based on a hypothetical, nationwide version of CRI, still reflect the uncertainty surrounding the program.

Range of Costs or Savings Under a Nationwide Program

If roughly three military families out of five were to join CHAMPUS Prime and no ghosts appeared, a nationwide CRI could save between $200 million

and $600 million a year, depending on the contractors' effectiveness at curbing excessive use. Put another way, CRI could reduce the overall cost of providing health care to nonactive beneficiaries by between 7 percent and 21 percent below the level that is likely to occur in the absence of CRI.

If, however, easier access to health care attracted many ghosts, and encouraged people to drop their private health insurance, costs of a nationwide CRI could rise by at least $350 million a year. And if, at the same time, contractors fail to curb excessive use, the rise in costs might exceed $1 billion.

Under the recently awarded contract, if costs grow beyond expected levels, the contractor and the government will share the overrun. The contractor's loss, however, will be limited to the sum of his planned profit and a small part of his equity investment. Thus, if CRI costs grew substantially, and a nationwide CRI used this type of risk sharing, the government would pay most of the bill.

The most likely eventual outcome for a nationwide CRI probably lies between these extremes of savings and added costs. Certainly, the forthcoming demonstration in California and Hawaii will shed light on the myriad uncertainties surrounding CRI, and show the import of changes from the original RFP. Even after a year of operation, however, a considerable cost risk may remain. The Rand Corporation, which is under contract to conduct an independent evaluation, expects that the full effects of CRI will

not be observed for several years. Therefore, this committee may wish to consider other options for reform that, perhaps, carry less uncertainty.

THE ALTERNATIVE OF CATCHMENT AREA MANAGEMENT

One such option is known as "catchment area management." Rather than depend on a major private health care company, this approach would make military medical commanders exclusively responsible for providing health care to all beneficiaries in their respective catchment areas. It might work as follows. During a limited sign-up period or open season, beneficiaries would choose to enroll in a plan centered around their local military hospital. The military commander would receive enough funds to provide care to all enrolled beneficiaries. Ideally, the funds would be based on the total number of eligible beneficiaries. Commanders then might build up their in-house capabilities, sign agreements with PPOs, or contract out selected services to local providers.

Advantages Compared with CRI

Catchment area management offers two potential advantages over the CRI strategy. By requiring that beneficiaries choose whether or not to participate (referred to as a closed enrollment), it would greatly lessen the uncertainty over the future demand for health care. Moreover, by basing funds on the number of eligible beneficiaries rather than on the amount of

services provided, it would give the military's health care providers strong incentive to reduce the use of expensive hospital care.

Compared with CRI, managing by catchment area would have less potential for savings (and less risk of added costs); two nonactive beneficiaries in ten live outside a catchment area, and so would not be included in a new system. Still, catchment areas produce 90 percent of the direct care system's admissions, and more than half of CHAMPUS's hospital admissions.

Difficulties in Implementation

Initiating catchment area management may, however, take time and money. Managerial flexibility and decentralized control of resources are essential ingredients. Commanders will have to be able to make trade-offs between CHAMPUS funds and other appropriations, have latitude over civilian personnel, be allowed to negotiate and sign contracts, and have adequate information systems. Since the carrot is as important as the stick, the Department of Defense might also have to let individual installations keep some of their savings to meet unbudgeted needs.

Without these changes, catchment area management probably will not work. Moreover, not all military medical commanders will be prepared to deal with the upheavals triggered by catchment area management. An especially hard time might be had by managers of small hospitals in remote locations, where the availability of civilian health care is limited. Excluding

such facilities from catchment area management would have little effect on costs because they serve just 5 percent of nonactive beneficiaries.

BUILDING ON CURRENT INITIATIVES

CRI and catchment area management are not the only options for improving military health care. Over the last few years, DoD has started numerous, smaller-scale programs that could be expanded:

- Fixed-price contracts for mental health care in the Tidewater area of Virginia, to reduce the use of mental health services;

- Special agreements with civilian hospitals around Fort Drum, New York, and with several Veterans Administration hospitals, to limit military construction costs and contain CHAMPUS costs; and

- Civilian-run outpatient clinics--known currently as PRIMUS in the Army and NAVCARE in the Navy--to expand the capability of the military health care system to provide primary and preventive care.

PRIMUS May Raise Costs

Unlike the first two programs, PRIMUS may not be a cost-saver. For example, the Army's first PRIMUS clinic (opened in 1986 in Fairfax, Virginia) cost the government about $50 a visit for a wide range of services, $16 less than the average cost of an adult's visit under CHAMPUS, but $5 more than the average cost of a child's visit under CHAMPUS. More important, the clinic attracted relatively few CHAMPUS users. Instead, it may have both attracted ghosts and increased the frequency of visits, thus spurring a rise in the total demand for care and possibly raising overall health care costs.

OUTPATIENT CHARGES TO OFFSET COSTS

PRIMUS clinics in other parts of the country will not necessarily have the same experience. But even if such clinics ultimately do raise costs, their popularity is such that they may still be a useful part of any health care reform. To offset the costs, the Congress may wish to consider modest charges for outpatient care.

A $5 charge for all nonactive outpatients, excluding survivors and dependents of junior enlisted personnel, would raise about $85 million. How might beneficiaries react? In a 1984 survey, they were asked whether they would be willing to pay $5 a visit in return for enhanced CHAMPUS benefits. Three out of four said yes. Thus, a modest charge--if it is part of a broader package of health care improvements--might be acceptable.

CONCLUSION

Madame Chairman, the reforms I have outlined--CRI, catchment area management, and building on current initiatives--all have the potential to improve health care and save on costs. They also carry a risk of added costs. These risks can be identified, and perhaps ultimately neutralized, through careful demonstrations that put each initiative to the test.