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

March 12, 1987

NOTICE

This statement is not available for public release until it is delivered at 2:00 p.m. (EST), Thursday, March 12, 1987.

Madam Chairman, thank you for the opportunity to discuss the CHAMPUS Reform Initiative (CRI). The CRI--which the Department of Defense plans to phase in beginning this fall--would make major changes in the military health-care system. The CRI has several aims, but I will focus today on how it might affect the costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). My testimony represents preliminary results of a study on military medical care that the Congressional Budget Office (CBO) is preparing for this Subcommittee.

It is too early to estimate the most likely cost of CRI. Bids from private companies that would manage civilian care under CRI are just now being sought. Nonetheless, because current plans could require far-reaching decisions on CRI next year, it is important to begin now to assess what it might do. CBO has identified five key issues that, once CRI is fully in effect, will significantly affect the costs of medical care. If CRI resolves these issues favorably, the annual cost of medical care for those not on active duty could decline by more than $400 million below costs likely to prevail under current health-care policy. But if CRI resolves the issues unfavorably, costs could grow by more than $800 million a year.

Of course, CRI is intended to do more than contain costs. It could improve beneficiaries' access to medical care and so increase overall satisfaction with military life. CRI could also improve coordination between military medical treatment facilities and civilian facilities, perhaps, in the process, improving medical readiness during wartime. These

potential benefits are clearly important, but they are beyond the scope of my testimony today.

OVERVIEW OF MILITARY HEALTH CARE

CBO estimates that in 1986 the cost of providing medical services to DoD beneficiaries exceeded $6.5 billion. Over two-thirds of that money paid for the care of those who would be affected by CRI: nonactive beneficiaries, including dependents of active-duty personnel, retired military personnel, and their dependents and survivors (see Table 1).

Direct Care

Nonactive beneficiaries receive most of their military health care through the "direct care" system, the network of 168 hospitals and several hundred clinics operated by the military services, (Indeed, inactive beneficiaries make up almost three-fifths of the workload in those facilities.) CBO estimates that the Department spent over $2.9 billion in 1986 providing nonactive beneficiaries with direct care. The beneficiaries themselves pay relatively little. Outpatient visits are free, and most hospital admissions are charged at less than $8 a day.

CHAMPUS

The CHAMPUS program supplements the direct care system by reimbursing nonactive beneficiaries for care obtained in the private sector, at a cost to

TABLE 1. FISCAL YEAR 1986 COSTS OF PROVIDING MILITARY MEDICAL CARE (WORLDWIDE)a/

Population	Source of Care	1986 Cost ($ billions)	Change from 1985 (Percent)
Active Duty	Military Treatment Facilities	$1.9 b/	+0.2
Nonactive Duty	Military Treatment Facilities	$2.8 c/	-6.3
Nonactive Duty	Civilian Health and Medical Program of the Uniformed Services	$1.7	+26.5
Total		$6.5	+2.9

SOURCE: Congressional Budget Office

a. Excludes funds for activities relating to wartime readiness, recruitment, various base operations and procurements, and to care of patients who are neither on active duty, dependents of active personnel, retired military, nor dependents or survivors of retired military personnel. Total cost for all medical activities in 1986 exceeded $10 billion. (Table costs do not add to total because of rounding.)

b. Average unit costs are based on medical reimbursement rates set by the Assistant Secretary of Defense (Comptroller). The reimbursement rate per inpatient day was $452 in 1985, $441 in 1986; the rate per outpatient visit was $56 in 1985, $58 in 1986. Inpatient days totaled 1,969,814 in 1985; 1,950,924 in 1986. Outpatient visits totaled 18,531,673 in 1985; 18,399,461 in 1986. (Data on utilization from the Department of Defense, Selected Medical Care Statistics.)

c. Same reimbursement rates as in b, above. Nonactive days numbered 3,206,890 in 1985; 2,950,113 in 1986. Visits numbered 27,198,942 in 1985; 26,201,871 in 1986.

DoD of $1.7 billion in 1986. The importance of CHAMPUS vis-a-vis direct care varies with different types of services. CHAMPUS covers about 17 percent of all outpatient visits (military treatment facilities handle the remaining 83 percent), 23 percent of the hospital days for obstetrical care, 40 percent of the hospital days for medical and surgical care, and 90 percent of the inpatient psychiatric days.

Numerous rules restrict the use of CHAMPUS to make sure that beneficiaries use it primarily when care in military facilities is not available or not accessible. For hospital care, families that live inside "catchment areas"--within roughly 40 miles of a military hospital--must get a statement from their local medical commander indicating nonavailability of care in military facilities before using CHAMPUS. Exceptions are made for families that have private health insurance, because CHAMPUS pays only costs not covered by private insurance. Families living outside catchment areas may use CHAMPUS freely for hospital care. Once admitted to a civilian hospital under CHAMPUS, active dependents pay the same as if in a military facility, generally $7.55 a day; retirees and their dependents pay 25 percent of the hospital's charges.

All beneficiaries, regardless of where they live, may use CHAMPUS freely for outpatient care. But they have to pay a deductible of $50 per individual (up to a family limit of $100), plus 20 percent of costs beyond the deductible if from an active-duty family; 25 percent if from a retired family.

THE COST PROBLEM FOR CHAMPUS

The rising costs of the CHAMPUS program have caused considerable problems. Since 1980, the cost of defense medical activities excluding CHAMPUS has increased about 110 percent (from $4 billion to over $8 billion); the CHAMPUS program has increased in cost by over 143 percent. In 1986 alone, CHAMPUS costs rose by 26 percent. Such rapid growth has led to major shortfalls in budgeted funds that required sizable and disruptive shifts from other DoD programs: $100 million in 1982, and $400 million last year. Moreover, CHAMPUS has made a supplemental request for $340 million and anticipates also needing an additional $85 million to balance its books for 1987.

What accounts for CHAMPUS's cost problems? The CHAMPUS program has had little control over key factors that drive its costs: the availability of care in military treatment facilities, the number of "ghost" eligibles--people who may choose to use CHAMPUS in one year but not the next--and the extent of private insurance coverage.

Military Availability

Experience in 1986 underscores CHAMPUS's sensitivity to changes in the availability of care in military facilities. The Navy decided to redistribute certain medical specialties to make better use of its limited resources. As a result, Navy hospitals and clinics treated significantly fewer nonactive patients in 1986 than in 1985. For example, during the quarter ending

September 1986, Navy hospitals in the United States admitted 25 percent fewer active dependents and retirees than during the same period the year before. Air Force and Army facilities also treated fewer nonactive beneficiaries in 1986.

As the availability of direct care lessened, the CHAMPUS workload increased. During the early months of 1986, CHAMPUS claims for hospital admissions inside catchment areas rose 11 percent; claims for outpatient visits increased 23 percent. Thus, it is clear that CHAMPUS costs depend on policies in the military hospitals and clinics. Since it generally costs less to treat patients in currently operating military facilities than to pay for their care under CHAMPUS, shifts to CHAMPUS tend to raise overall health-care costs.

Beneficiary Use

Other factors can also cause CHAMPUS costs to grow. In 1982, for instance, one contributor to cost growth appears to have been the rise in U.S. unemployment, from 7.5 percent in 1981 to 9.5 percent in 1982, which stripped many beneficiaries of their private health insurance. Those beneficiaries--a large number of whom were ghost eligibles who had not previously used their military benefits—turned to CHAMPUS. Many of them have continued to use CHAMPUS, despite the economic improvement, perhaps because rising premiums and coinsurance rates in the private health insurance market have made other coverage too costly. Another contributor was the sign-up drive for the Defense Enrollment Eligibility Reporting

System, which, among other things, publicized the availability of CHAMPUS benefits to military retirees and their survivors.

Not all the problems with CHAMPUS are related to costs. Beneficiaries complain about tangled rules and long delays in processing claims. Physicians resent slow payment of bills and out-of-date fee schedules.

THE CHAMPUS REFORM INITIATIVE

The CHAMPUS Reform Initiative (CRI) proposes an innovative, though complicated, approach to resolving these problems. The heart of CRI is a fixed-price contract with a private health-care company, or consortium of firms, to provide care for each of six geographic regions. The contractor will assume responsibility for all CHAMPUS care provided to military families and retirees in its region. The Department of Defense plans to implement CRI in three phases, each covering about one-third of CHAMPUS eligibles.

My testimony focuses on CRI provisions to contain costs. CRI contractors will have two main tools for containing costs: the CHAMPUS Prime program and sharing arrangements for staff.

CHAMPUS Prime

The CHAMPUS Prime program will deliver health care through a number of Preferred Provider Organizations (PPO). PPOs are groups of providers, both

physicians and hospitals, that sign contracts to offer discounted services to some beneficiary population.

Enrollment in the CHAMPUS Prime PPO will be voluntary. As an inducement to join, enrollees will receive enhanced benefits for primary and preventive care. In addition, they will pay less out of pocket for outpatient visits and hospital admission than they would under traditional CHAMPUS. Enrollees will, however, give up some freedom of choice: CRI contractors will be able to deny benefits to enrollees who seek care outside the network of preferred providers. Moreover, CHAMPUS Prime PPOs may try to limit use of various medical services.

Those who join CHAMPUS Prime PPOs can still use military facilities if they are available. Allowing this discretion raises some uncertainty over the amount of care that PPOs will actually have to deliver. Beneficiaries who choose not to join CHAMPUS Prime can continue to use military facilities or the traditional CHAMPUS program if they are eligible, or both.

Sharing Staff

Sharing staff is another mechanism that CRI contractors can use to hold down costs. Military hospitals are often unable to deliver care because of selective shortages in professional or support skills, and so must send beneficiaries to CHAMPUS. (Two-thirds of nonavailability statements issued for surgical care cite the absence of professional capability.) CRI will let private contractors, with the agreement of local military medical

commanders, hire qualified civilians to fill these selective shortages, and so permit military hospitals to deliver more care.

It will generally be cheaper for the contractor to treat a patient in a military facility; likewise for the government, because most military hospitals experience periods of underuse. Beyond cutting costs, sharing staff could improve the quality of medical services--to the possible benefit of both peacetime and wartime care--by developing more volume in certain hospital procedures. Civilian experience suggests that military treatment facilities that perform a larger volume of surgical procedures will have better outcomes.

ISSUES AFFECTING CRI COSTS

While CRI offers some important tools for holding down costs, it must also confront the factors that have caused the costs of traditional CHAMPUS to soar. How will these factors combine to influence CRI costs? It is too early to make firm estimates. But CBO has identified five key factors and estimated how much each could affect CRI costs. The five are:

- How much will preferred provider organizations under CHAMPUS Prime reduce costs;

- How many families will join CHAMPUS Prime;

- How many ghost eligibles will return to CHAMPUS;

- What will happen to the extent of private insurance coverage; and

- How much hospital care will CHAMPUS Prime PPOs shift back to military treatment facilities?

PPQ Savings

PPOs are part of a growing trend by civilian health-care payers nationwide to get the same quality of service at lower cost. One estimate has six million people now eligible to use PPOs (44 percent of them live in California, one of six states included in Phase I of CRI). By the spring of 1985, 28 percent of the nation's patient-care physicians had signed contracts with PPOs; in trend-setting California, 80 percent have signed contracts.

One way PPOs save money is by extracting discounts from hospitals and physicians. As more and more physicians find they must join or form contractual relationships with some type of organization to practice medicine successfully, the bargaining power of PPOs increases. But the major mechanism for saving money appears to be utilization review. PPOs carry out preadmission reviews for hospital care, concurrent reviews of hospital stays, and reviews of claims. Many require mandatory second opinions, and closely monitor the numbers of services that physicians and

hospitals provide. And some PPOs use economic incentives to limit use of medical services--one such plan in California lets participating physicians share in the profits when patients use fewer medical services than expected.

An extensive literature shows that prepaid group practices, such as health maintenance organizations (which resemble PPOs in varying degree), have hospital admission rates about 40 percent lower than traditional insurance plans. This pattern suggests that, at best, the CHAMPUS Prime PPOs could reduce average expenditures for hospital care relative to traditional CHAMPUS by 40 percent. But will civilian experience apply to the military's CHAMPUS Prime? Not many civilian PPOs would allow their patients to opt for low-cost care with another organization; indeed, most private plans define their beneficiary populations with a closed enrollment. Yet many CHAMPUS Prime patients could choose from among over 500 military hospitals and clinics. This discretion could conflict with PPO efforts to limit use of health-care services. What's more, to induce people to join, CHAMPUS Prime will be expected to increase benefits above those available under traditional CHAMPUS while lowering cost-sharing for at least some medical services.

Given these unique features, it seems reasonable to consider a wide range of effects that CHAMPUS Prime could have on average health care expenditures relative to traditional CHAMPUS. For hospital care, CBO assumed no effect at the low end and at the high end assumed the 40 percent reduction realized by some civilian prepaid group plans. (It is even

possible, though perhaps less likely, that CHAMPUS Prime could add to costs by stimulating added demands for health care among the previously underserved beneficiary population.)

Who Will Join CHAMPUS Prime PPOs?

Even if the PPOs in CHAMPUS Prime can achieve substantial savings, CRI will only save large sums if many people join. How many families will sign up? For clues, CBO analyzed data on outpatient visits from the department's 1984 survey of military health care.

Most likely to join may be families that CBO labels "military preference," who receive the majority of their outpatient care through military facilities. Such families make up 40 percent of active families and 30 percent of retired households, and account for one-third of the hospital days covered by CHAMPUS. Somewhat less likely to join CHAMPUS Prime are families that are "civilian preference" with regard to outpatient care, who make up another 10 percent of active households and about 40 percent of retired families; they account for over one-half of CHAMPUS hospital days. Many of these families already have favorable doctor-patient connections that they might have to sever to join CHAMPUS Prime. Least likely to join may be families who only use military care (they seem satisfied with current military facilities) and those only using civilian care (they almost certainly have strong civilian connections).

If only military preference families joined CHAMPUS Prime, then CRI could save between $30 million and $190 million a year (see Table 2). The

TABLE 2. SUMMARY OF ADDED COSTS/SAVINGS (-) ON HOSPITAL EXPENSES UNDER ALTERNATIVE ASSUMPTIONS (In millions of 1988 dollars)[a]

Enrolling Families	Preferred Provider Organization Savings [b] 0%	20%	40%
Military Preference Families [c]			
Baseline Case [d]	-30	-110	-190
Ghosts Join [e]	10	-80	-170
Private Insurance Dropped [f]	0	-90	-180
Ghosts Join and Insurance Dropped	70	-40	-140
Civilian and Military Preference Families [g]			
Baseline Case [d]	-50	-240	-430
Ghosts Join [e]	250	0	-250
Private Insurance Dropped [f]	130	-90	-310
Ghosts Join and Insurance Dropped	840	480	120

a. Estimates show change in costs of non-psychiatric hospital care relative to traditional, fee-for-service CHAMPUS. These assume CRI will not stimulate any increase in beneficiaries' demand for inpatient medical services and ignore possible savings from a prospective payment system.

b. Percentages indicate reductions in average expenditures over traditional CHAMPUS (i.e., the PPOs' efficiency), achieved through a combination of negotiated discounts and constraints on utilization.

c. CHAMPUS Prime attracts only military preference families, who receive most of their outpatient care through military treatment facilities (75 percent on average).

d. Assumes no ghost eligibles enroll in CHAMPUS Prime, no changes in private health insurance, and modest workload shifts to military treatment facilities (20 percent of hospital days inside catchment areas for surgical care under CHAMPUS Prime get shifted).

e. Assumes that all nonmedicare civilian hospital days that were previously paid for outside CHAMPUS come under CHAMPUS Prime.

f. Assumes that all families enrolled under CHAMPUS Prime give up their private health insurance (though they may keep supplemental CHAMPUSpolicies).

g. CHAMPUS Prime attracts also civilian preference families, who get most of their outpatient care from civilian health-care providers (74 percent on average).

lower end of the range assumes CHAMPUS Prime does not reduce average health-care expenditures relative to traditional CHAMPUS; the upper end assumes reductions of 40 percent. If both military preference and civilian preference families join CHAMPUS Prime, CRI could save between $50 million and $430 million a year. All these estimates include savings that CBO assumes would result from some surgical care shifting from civilian to military hospitals. I will address this shift later. Assuming that this shift will in fact occur, CRI as a whole would save money even if PPOs do not reduce CHAMPUS expenditures.

These savings are relative to overall military health-care costs under traditional CHAMPUS, assuming those costs grow by the amount of inflation for medical care. (If traditional CHAMPUS were to exploit its recent linkage with medicare by lowering hospital reimbursements, then health-care costs would diminish overall, but savings might also decrease.) Savings are hypothetical in that they assume that CRI is fully implemented in 1988, even though it will be under testing in that year. The estimates make other important assumptions noted in Table 2.

What Will Ghost Eligibles Do?

How many join, and how CHAMPUS Prime will affect costs, are not the only issues that could affect CRI costs. The so-called ghost eligibles--hospital patients eligible for but not using CHAMPUS benefits--could affect costs significantly. For every 10 days of hospital care paid for by traditional CHAMPUS, another 10 days of hospital care for CHAMPUS eligibles is paid

for by other sources. Under CRI, the CHAMPUS Prime program will encourage families to join by enhancing benefits and lowering cost sharing, as well as by improving access to civilian health-care services. These changes may well convince ghost eligibles to begin using their CHAMPUS benefits.

If that happened, CRI would no longer be as likely to hold down costs and could even add to them. Assume, for instance, that both military and civilian preference families join CHAMPUS Prime, and that all ghost eligibles from those family categories also join. Then, Table 2 shows that CRI could still save $250 million a year if CHAMPUS Prime reduces average health-care expenditures by 40 percent, because these efficiencies would more than offset the added costs of the ghost eligibles. But if CHAMPUS Prime does not cut average expenditures, and the ghost eligibles appear, CRI could add as much as $250 million to the annual cost of providing nonactive medical care. (This uncertainty would lessen if beneficiaries had to choose in advance whether to use CHAMPUS Prime; I will discuss the enrollment issue later.)

Private Insurance

Changes in private insurance coverage raise additional cost risks for the CRI. Based on the department's 1984 survey, CBO estimates that 23 percent of military preference families and 45 percent of civilian preference families have private health insurance. Some may receive it through their private employment or to provide additional coverage. Others

may get insurance because they dislike CHAMPUS coverage. Under current law, these private plans must pay first; CHAMPUS acts as a second payer.

A successful CHAMPUS Prime program could induce beneficiaries to discontinue their private health insurance. If that happens, CRI would be even less likely to save money and could add significantly to costs. If no ghost eligibles join, but all CHAMPUS Prime enrollees give up their private insurance, the estimated range of costs under CRI varies from savings of $310 million to added costs of $130 million. If all ghosts join, and they too give up their private insurance, the range varies from added costs of $120 million to added costs of $840 million a year.

Shifts in Workload of Military Facilities

All the estimates I have discussed assume a modest shift in surgical workload--specifically, that CHAMPUS Prime funnels 20 percent of surgical hospital days to currently operating military treatment facilities. This assumption seemed appropriate since such a shift is one goal of the CRI. Indeed, it would probably be to CRI's benefit to shift an even greater percentage of care since the added cost of another patient in a currently operating military facility is generally less than what CHAMPUS Prime would pay in a civilian hospital. Ignoring ghost eligibles, the 20 percent shift would save between $30 million and $50 million a year; a 50 percent shift would save between $70 million and $130 million.

Workloads could also conceivably shift to the detriment of CRI. For example, in 1986, the military hospitals treated fewer patients than in 1985,

sending CHAMPUS costs up sharply. But CBO doubts a repeat of that type of shift in the near term. The policy changes that caused the 1986 problem seem unlikely to recur. Moreover, other recent policy changes--such as the new PRIMUS clinics in the Army and NAVCARE clinics in the Navy--could actually bring more workload back into military facilities.

All these factors--shifts in military treatment facilities' workload, ghost eligibles, private insurance changes, and uncertainty over who will join CHAMPUS Prime--pose risks to contractors bidding on the CRI. To minimize the risk to the contractor, the CRI offers contractors retrospective and prospective opportunities to adjust their otherwise fixed prices. If these ways to reduce risk are successful from the contractors' point of view, they may simply transfer some cost risk back to the government. If the contractors view CRI as risky, they may bid high. In either case, it is reasonable to consider ways to minimize uncertainty and so deal with the risk.

MINIMIZING RISKS

There are several approaches that the Congress could consider that would minimize the risks under CRI, or at least make clearer the degree of risk.

Allow a Substantial Test Period

Foremost, one might consider allowing a substantial test period. Currently, DoD will award contracts for Phase I in October, to be followed by a

transition period of six months. Under last year's appropriation language, Phase II might begin as early as one year later. (Phase I will apply chiefly to California, Hawaii, Florida, Georgia, North Carolina, and South Carolina, where about one-third of CHAMPUS eligibles live. Phase II will expand the regions under contract to include another one-third of CHAMPUS eligibles.)

Under those plans, the decision to implement Phase II of CRI will have to be made before any operational experience with Phase I. Much of the data from that phase will not be available or will not have been fully analyzed. Moreover, early data might not be fully representative. For instance, the first wave of CHAMPUS Prime enrollees is apt to be uncertain about the benefits of so new a program. Those with private health insurance might hedge their bets during the first year by keeping those policies, thus keeping costs down. Once their confidence in CRI solidified, they would dispense with other coverage, thus raising costs by turning CHAMPUS into a primary payer. A phase-in of only a few months would miss this effect.

A longer Phase I may uncover positive as well as negative effects. For example, CHAMPUS payment delays and military facility backlogs over the past year or two may have contributed to a great deal of pent-up demand for health care. CRI could release a surge of this demand, improving care dramatically but raising overall costs. Not until the second or third year might demand stabilize.

Inpatient Care

An added patient would generally cost less to treat in a currently operating military facility than under CHAMPUS Prime. But sometimes CHAMPUS Prime might be more economical, at least from the government's standpoint: for certain procedures, or in areas where participating civilian hospitals operate at such very reduced capacities that they are eager to provide low-cost services. To make sure that hospital care gets shifted in the most effective manner, the Congress may want the department to set targets for different catchment areas. Such explicit guidance could help local military medical commanders and private contractors agree on how to distribute care optimally.

Enrollment

Finally, CBO's analysis underscores the risks raised by the uncertain behavior of beneficiaries. How many families will join CHAMPUS Prime? How many ghost eligibles will join? And how will their continued right to elect care in military facilities affect the operation of CHAMPUS Prime? One way to limit the uncertainty, particularly from a contractor's point of view, is to permit an enrollment period during which families would select a single point of contact for their primary care: either CHAMPUS Prime, a military treatment facility, or possibly traditional CHAMPUS. Moving toward such a closed enrollment means less freedom of choice for beneficiaries, although it should be said that even today they do not enjoy unlimited freedom. (Indeed, when the services reduce the availability of

military medical services, they force many beneficiaries to use CHAMPUS.) But there are few actions that would do as much to minimize uncertainty under CRI.

CONCLUSION

Madam Chairman, it is too soon to know with confidence how much CRI will cost. CBO has, however, identified five key issues that will affect CRI costs. Depending on how those issues are resolved, CRI could decrease costs by as much as $430 million a year below levels that would otherwise obtain, or could add to costs by as much as $840 million. Since CHAMPUS now costs about $2 billion year, there is substantial cost risk in CRI. This risk could be reduced by approaches such as providing a substantial test period or adopting a closed enrollment.

I want to emphasize again that CRI has objectives other than cost containment--for example, access to care for beneficiaries and coordination between military facilities and civilian providers. While these issues will no doubt be relevant to your judgments about CRI, my testimony focused only on the budgetary implications of CRI and how the Congress might address them.