CBO TESTIMONY

Statement of
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NOTICE

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Madam Chairman, I appreciate the opportunity to discuss the budgetary outlook for the military's health care system. In 1992, the Department of Defense (DoD) will spend more than $15 billion on health care, including more than $10 billion that is directly related to delivering peacetime medical services. The Administration's planned reductions in active-duty personnel should reduce the total number of beneficiaries in the military health care system by about 6 percent between now and 1997. Yet health care costs are still likely to rise. Indeed, the Congressional Budget Office (CBO) projects that, under the Administration's plan for personnel cuts, spending on peacetime medical services would increase to $12 billion between 1992 and 1997--a five-year jump of 17 percent. Over that same period, the total budget for national defense would increase by only about 2.4 percent to about $291 billion.

DoD appears to be budgeting for increases in health care costs that are consistent with CBO's projections. But it may still be a challenge to accommodate military health care costs that rise about seven times faster than the overall budget.

If military health care costs must be held down, what are the options? It may be possible to contain costs through the Coordinated Care Program, which, in its reliance on managed care, is related to the CHAMPUS Reform Initiative and Catchment Area Management demonstrations. (CHAMPUS

stands for the Civilian Health and Medical Program of the Uniformed Services.) Yet such programs also carry a risk of higher costs if improved services and benefits attract beneficiaries who are not now using the military health care system. Holding down costs may therefore require a broader restructuring of the health care system.

BACKGROUND ON THE HEALTH CARE BUDGET

DoD runs one of the nation's largest systems of health care. Military treatment facilities include 164 hospitals around the world--126 of them in the United States--and more than 500 separate outpatient clinics. In 1990, at least 52,000 civilian personnel and 157,000 active-duty military personnel worked directly for or in support of the system. In addition, DoD offers CHAMPUS, a traditional insurance plan that permits beneficiaries to receive care from civilian providers and pays the largest part of the bill.

In 1992, the total cost of military health care will amount to more than $15 billion. That includes the salaries of health care providers, both military and civilian, and all the day-to-day operating costs of the military's hospitals and clinics. Also included are costs of about $3.7 billion for the CHAMPUS program. In addition, the military health care budget funds a wide array of

other activities: medical training courses, educational stipends for physicians and nurses, organic support for tactical units, epidemiological surveys, and basic research, to name but a few.

Last year saw a major change in how DoD organized the budget for its health care system. Consistent with a directive by the Deputy Secretary of Defense, the Assistant Secretary of Defense for Health Affairs now has authority over a consolidated "Defense Health Program." The program's budget totals $9.1 billion, most of which consists of operation and maintenance money covering such things as the salaries and benefits of civilian employees; supplies of x-ray film, food, drugs, and utilities in military treatment facilities; and reimbursements to civilian providers under the CHAMPUS program. The health program budget excludes the salaries and benefits of health care providers and support staff who are on active duty; those personnel remain under the budgetary purview of the military services.

In order to capture the cost trends that will be most affected by changes in numbers of beneficiaries, this testimony focuses on a different slice of the health care budget--namely, the costs directly associated with peacetime medical care. Those costs amount to more than $10 billion in 1992. The sum includes the salaries of all health care providers, both military and civilian, and the other costs of providing patient care in hospitals and clinics. A

relatively small amount--$400 million to $500 million--pays for care supplied to active-duty personnel outside the system of direct care. The remaining $3.7 billion funds CHAMPUS.

It is important to focus on the total costs of peacetime health care. In recent years, the Congress has tended to focus its concern on rising costs in CHAMPUS. Unlike spending inside military hospitals and clinics, spending under CHAMPUS constitutes a single, highly visible, and extremely elastic line item in the budget.

But CHAMPUS costs are inextricably linked to other parts of the health care budget. They soared during the last decade when military hospitals and clinics cut back on the access of nonactive-duty beneficiaries to health care services. Yet in the 1990s this trend could be reversed as more space becomes available in military facilities. Moreover, the line dividing CHAMPUS and direct care resources is becoming increasingly blurred because DoD now spends CHAMPUS money on alternative projects. Under one such project, the Partnership Program, civilian physicians sign agreements with DoD to treat CHAMPUS beneficiaries in a military treatment facility at CHAMPUS expense. In 1989, about 10 percent of CHAMPUS's outpatient visits were handled by Partnership physicians working in military clinics; by 1990, that proportion had climbed to 15 percent.

BASE-CASE PROJECTIONS OF HEALTH CARE COSTS

To project the peacetime costs of medical care, CBO relied on DoD's own planning tool, the Resource Analysis and Planning System (RAPS). Feed the model assumptions about trends in the population of active-duty personnel and other beneficiaries, and about capacity in military treatment facilities, and the model projects future costs based on patterns of health care use in 1989 (the most recent fiscal year for which complete data are available).

Key Assumptions

In its base-case projection of costs, CBO followed the Administration's current personnel plans. Between now and 1997, those plans call for reducing DoD active-duty military personnel to a level of 1.6 million. The number of active-duty personnel in Europe, an important component of health care costs, is assumed to be reduced to a level of 150,000. A proportionate number of medical personnel and amount of resources is shifted from Europe to military treatment facilities in the United States. The base-case projection also assumes that the total capacity of military treatment facilities remains steady through 1997, an assumption consistent with Congressionally mandated limitations on reductions in medical personnel. Medical personnel and

resources associated with the hospitals that are slated for closure (consistent with the recommendations of the Defense Base Closure and Realignment Commissions and subsequent Congressional action) are assumed to be transferred to other installations.

As for medical care prices, CBO's base-case projections assume that they will continue to rise sharply in the absence of broad-based reform of the U.S. health care system. Based on past trends in the medical component of the consumer price index, CBO projects that medical prices will continue to increase at a rate of about 7 percent a year.

Projected Costs

Under these assumptions, peacetime health care costs in the military will increase in nominal terms by roughly $1.7 billion between 1992 and 1997, to about $12 billion. That rise represents growth averaging 3 percent to 4 percent a year--significantly lower than in the past; for the military health care budget as a whole, increases have averaged about 8 percent a year during the past five years. The projected slowdown in the rate of growth in costs reflects expected declines in the beneficiary population and workload (see discussion below).

CBO's projections appear to be consistent with the planned growth in DoD's budget. The latest Future Years' Defense Plan calls for increases in the military health program that average about 4 percent a year between 1993 and 1997. Although the health program budget includes costs that are not directly related to the level of peacetime medical care, the trends are similar.

While growth might slow down, health care costs would still be increasing much faster than the total defense budget. Under the Administration's plan, the budget for national defense would grow from $283.8 billion in 1992 to $290.6 billion by 1997, an increase of 2.4 percent. Thus, the share of DoD's resources consumed by peacetime health care costs would rise under CBO's base case to just over 4 percent.

THE EFFECT OF POPULATION CHANGES

The slowdown in the growth of the peacetime costs of military medical care reflects an overall decline in beneficiaries along with shifts in the composition of that population.

Overall Decline

The number of beneficiaries eligible to receive military health care now stands at about 8.7 million. That includes 2 million uniformed personnel, their roughly 2.6 million dependents, and 1.7 million retired military personnel and their 2.3 million dependents and survivors.

Under the Administration's current defense plan, the total eligible population will be 6 percent smaller in 1997 than in 1992. DoD active-duty end-strength will decline to 1.6 million, a decrease of about 13 percent from 1992. Active-duty dependents would presumably experience a parallel decline, to about 2.2 million. The population of retired military personnel and their dependents and survivors is projected to increase by a modest 2 percent, to a total of 4.1 million.

Decline in Beneficiaries Eligible for CHAMPUS

The 6 percent decline in the overall population masks substantial shifts among its various subgroups. One important subgroup--personnel eligible to use the CHAMPUS insurance program--would drop by 10 percent between 1992 and 1997. CHAMPUS eligibles include all dependents and retirees who are less

than 65 years old. On reaching age 65, most nonactive-duty beneficiaries become eligible for Medicare and so lose their right to CHAMPUS. Only about 3 percent of retirees aged 65 or older continue under CHAMPUS.

The disproportionate decline of 10 percent in CHAMPUS eligibles reflects the expected fall in active-duty dependents as the size of the active-duty force is reduced. Added to that figure is an expected 7 percent drop in the number of retired military personnel and their dependents who are less than 65 years old.

Beneficiaries Eligible for Medicare Grow Sharply

In contrast to beneficiaries eligible for CHAMPUS, those eligible for Medicare will increase by about 28 percent between 1992 and 1997. The growth in beneficiaries eligible for Medicare puts upward pressure on military medical care costs because older people make greater use of health care resources.

However, this shift toward older beneficiaries may be less important to the military health care system than it would be for a civilian system. Although the use of health care services intensifies rapidly with age, DoD

does not pay most of the bill for its older beneficiaries. On reaching age 65, most of them become eligible for Medicare and so lose their right to the CHAMPUS insurance program. Older beneficiaries are still eligible for care in military hospitals, but only if space is available. Otherwise they must rely on Medicare to help pay for their care at civilian facilities.

Thus, DoD can and does moderate the effects on its health care costs of an aging retired population by regulating access to military treatment facilities. Indeed, among retired military men who live within 40 miles of a military hospital, those aged 65 years or older are only about 30 percent more likely to be admitted to a hospital in the military health care system (directly or under CHAMPUS) than those who are less than 65. In the civilian health care sector, by contrast, men between the ages of 65 and 74 are more than three times as likely to be hospitalized as men who are less than 65.

Increased Space and the Demand for Care

As far as trends in DoD costs are concerned, the increase in beneficiaries eligible for Medicare is less important than the prospect of increased space becoming available in military treatment facilities. Ironically, an increase in space could put upward pressure on costs.

As the number of active-duty personnel and dependents declines, more space will become available. Some retired beneficiaries who now use CHAMPUS will instead be treated in military facilities. That shift should seemingly result in a reduction in the total cost of military medical care, since the cost of military treatment facilities will remain roughly unchanged while CHAMPUS costs fall. However, we know that when space opens up in military treatment facilities, the increase in demand for them is likely to be proportionally greater than any decrease in the use of the CHAMPUS insurance program.

The reasons for the disproportionate increase in demand are threefold. First, a considerable number of retired personnel are eligible to use the military health care system but choose not to do so. Rather than paying CHAMPUS deductibles and copayments, these "ghost" eligibles rely instead on their own financial resources, private health insurance, or the Medicare program. As free or inexpensive care in military treatment facilities becomes more readily available, some of the ghost eligibles may return to the military health care system, pushing up costs to DoD (although perhaps helping to lower costs for payers other than the military).

Second, payments by beneficiaries who visit physicians just a few times a year may not exceed the deductibles imposed by the CHAMPUS insurance

program. Those beneficiaries are mostly retirees who do not currently file claims, so DoD incurs no costs. If the same people are now treated in military facilities, the change will increase costs to the government. Third, when care is inexpensive or free, as it is in the military treatment facilities, people use more of it.

To sum up these phenomena, DoD health care planners devised the so-called trade-off factor, which is based on actual experience. Among retirees and their dependents, an increase of 2.2 visits to a military clinic results in a reduction of only one visit under CHAMPUS. That is, the trade-off between care in military treatment facilities and CHAMPUS is about two to one.

CBO's projections rely on this trade-off factor to estimate the effects on costs of shifting retirees from CHAMPUS to military treatment facilities. The result suggested by the trade-off factor is not all bad: retirees would have better access to military medical facilities. But the phenomenon is one of the reasons that military medical care costs continue to rise despite the decline in the size of the active-duty population.

POLICY CHANGES TO LIMIT GROWTH IN HEALTH CARE COSTS

Even though DoD appears to be budgeting for increases in health care costs similar in size to those CBO projects, accommodating those increases in a period when the overall budget is strictly constrained may still be difficult. Accommodation means that cuts in procurement and force structure will have to be larger than they would have been without the contrary trends. Growth in health care costs will also make it harder to fund other types of activities that may require additional resources, such as research and development or environmental cleanup. Moreover, these problems will worsen if there are significant cuts in the DoD budget beyond those now planned by the Administration.

If military health care costs must be held down, the Congress could consider several possible policy changes:

- Limiting the access to the direct care system of beneficiaries eligible for Medicare;

- Reducing the number of medical personnel on active duty, thus promoting increased reliance on the civilian sector; and

- Putting in place a program of managed care to lower the use of health care services and bring down the average cost of services provided in the civilian sector.

Decrease Access of Beneficiaries Eligible for Medicare

DoD generally has an incentive to hospitalize younger retirees in military treatment facilities rather than to pay their CHAMPUS insurance bills; it also has an incentive to refer retirees eligible for Medicare to the civilian sector and let Medicare pay their bills. How much might DoD save by restricting the access of older retirees to direct care?

To see, CBO modified the base-case scenario to hold constant--among all clinical areas--the share of the direct care workload for beneficiaries eligible for Medicare. Instead of accounting for 14 percent of direct care admissions in 1997, as they do in the base-case projection, senior citizens are held to their current level of about 10 percent.

The resulting projections suggest only a modest effect from such a policy. Compared with the base-case projection of $12 billion, the costs of providing peacetime medical services would decline to $11.6 billion, a

difference of only 3 percent. About one-third of the projected saving comes from reductions in CHAMPUS costs. These reductions occur as beneficiaries under 65, who would have otherwise used CHAMPUS benefits, take advantage of spaces in military treatment facilities freed up by the reduction in patients who are eligible for Medicare. The remaining saving comes from reduced costs in military treatment facilities.

One reason for the small saving is that an across-the-board reduction in older patients would free staff and space not necessarily relevant to a younger population. Four clinical areas account for 70 percent of the patients eligible for Medicare who are admitted to military hospitals: internal medicine (36 percent), general surgery (17 percent), cardiology (9 percent), and urology (8 percent). Yet these areas are not the ones primarily required by the younger beneficiaries who would take up the slack space in military treatment facilities. Indeed, these four areas account for only about one-quarter of the patients who are currently admitted to civilian hospitals under CHAMPUS.

DoD could save more money if it referred most or all of its patients eligible for Medicare to civilian hospitals and reorganized its hospitals and medical staff to provide care more appropriate to younger patients. But reorganizing hospitals to meet the needs of younger patients--which would mean emphasizing pediatrics, psychiatry, and obstetrics--might leave DoD

medical personnel less well prepared to meet wartime needs. Moreover, military treatment facilities, especially the large teaching hospitals, need a certain flow of elderly patients and their complicated problems to burnish and maintain the skills of military health care providers. Thus, large-scale shifting of beneficiaries eligible for Medicare to the civilian sector does not appear to be a promising way to hold down military health care costs.

Decrease Medical Personnel on Active Duty

The Congress has expressed a desire to avoid reductions in medical personnel during the overall drawdown of DoD personnel. Thus, CBO's base-case projection of costs assumed no cuts in medical personnel. The Congress has, however, authorized two conditions for making reductions: the personnel being reduced must exceed the current and projected needs of the military departments, and the reduction must not result in an increase in the cost of health care services provided under CHAMPUS.

Following those guidelines, the services have apparently decided to make modest cuts in medical end-strengths. In last year's five-year plan for medical staffing, all three services proposed reducing authorized spaces for medical personnel assigned to the United States between 1991 and 1995. The

Navy would cut physicians and nurses by about 4 percent and enlisted support staff by 1 percent. The Air Force would cut physicians by less than 1 percent and nurses and various military support staff by 8 percent. Finally, the Army tentatively proposed cutting physicians by 4 percent, nurses by 9 percent, and various active-duty support positions by at least 16 percent.

How might such end-strength reductions affect health care costs? Assuming proportionality between staffing and capacity, CBO modified the base-case scenario to translate the above reductions in personnel to reduced capacity in military treatment facilities. As a result, the RAPS model projects a 4 percent swing of patients from military treatment facilities to CHAMPUS, but no significant change in overall costs--indeed, a difference of less than $100 million.

Why so little change? It generally costs more to hospitalize an individual patient under CHAMPUS than in a military hospital. Thus, the shift of patients to CHAMPUS would itself tend to increase costs. But the trade-off factor discussed earlier in this testimony works in the opposite direction and results in little overall change in costs. Among retirees, who would be most affected by a reduction in the capacity of military treatment facilities, the trade-off factor suggests that as staffing is reduced, the reduction in admissions to military facilities would be about twice as large as the

increase in CHAMPUS admissions. Thus, there would be a net decrease in treatment accorded to retirees, which holds down costs.

Establish Managed Care

Putting in place a system of managed care represents a third option for holding down costs. Broadly defined, managed care is a strategy for controlling the use and quality of health care services, as well as costs. It tries to influence decisions that heavily influence costs, such as when care is given, how much is given, where it is provided, and how long treatment continues. To date, the most successful practitioners of managed care have been group model health maintenance organizations (HMOs); they own their own hospitals, require primary care gatekeepers, and rigorously review hospital use. To the extent that DoD emulates the practices of group model HMOs, the option for managed care offers a demonstrable potential for savings.

Since 1988, DoD has put various aspects of managed care to the test in the CHAMPUS Reform Initiative in California and Hawaii and in the Catchment Area Management (CAM) demonstrations in five sites around the country. And now DoD is poised to begin the Coordinated Care Program,

which by the end of 1994 is supposed to have in place a system of managed care on all military treatment facilities in the continental United States.

Will coordinated care hold down future costs to the Department of Defense? The Coordinated Care Program resembles CAM in many details, and CBO has recently reviewed the early results of those demonstrations.[1] Although it is too soon to reach a final judgment about the cost-effectiveness of CAM, CBO's earlier review of the demonstrations points to some revealing trends.

CAM gives local managers control over most or all of the health care resources in a particular geographic area and challenges the managers to provide good care while also holding down costs. The CAM sites generally have tried to save money in two ways: by negotiating discounts with civilian providers, and by making greater use of military treatment facilities. In setting up networks of private physicians, local medical commanders were able to negotiate discounts--typically ranging between 10 percent and 30 percent--against prevailing CHAMPUS charges. To increase the use of military treatment facilities, all the CAM sites have hired civilian physicians to work inside military facilities under the partnership program. Moreover, some of

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1. Congressional Budget Office, "Managed Care in the Military: The Catchment Area Management Demonstrations," CBO Papers (September 1991).

the sites require that primary care physicians always refer patients to military specialists rather than civilian specialists.

What is the bottom line? For a possible answer, one could look at the CAM programs at two Army bases, Fort Carson and Fort Sill. Between 1989 and 1990, the total cost of running the military health care system rose by about 12 percent. Fort Carson did considerably better than average: its health care costs rose only about 5 percent. Fort Sill did worse than average: its costs climbed about 22 percent.

Why the difference? The data are not sufficient to permit firm conclusions. Clearly, however, Fort Carson and Fort Sill succeeded in boosting the use of outpatient services by nonactive-duty beneficiaries. Although outpatient visits to Army facilities nationwide declined by 4 percent between 1989 and 1990, they rose 6 percent at Fort Sill and 23 percent at Fort Carson.

Yet, in producing these increases, the two sites apparently did not so much reduce CHAMPUS costs as raise the total demand for outpatient services (through increased numbers of users and greater utilization per user). Fort Carson evidently countered the increase in outpatient care by shifting inpatient care--particularly in obstetrics--from CHAMPUS to the military

hospital. As a result, its admissions for direct care grew by about 20 percent. Thus, Fort Carson illustrates the potential gain from shifting selected patients, particularly those in obstetrics, to military hospitals.

Fort Sill apparently did not offset the increase in outpatient care by shifting inpatient use in-house. This experience highlights a potential problem for the Coordinated Care Program: countering increases in use will require procedures for managing the delivery of health care services inside military treatment facilities. Otherwise, costs to DoD may rise.

Trends in the civilian health care system might exacerbate the problem. Surveys show that businesses are obliging their employees to carry a larger share of the health care burden through increased premiums, higher deductibles, and copayments. Rapidly rising health care costs may force more and more small business to eschew health insurance for employees altogether. Retired families, which make up the largest part of the military's ghost population, will be affected by these civilian trends. As employers diminish the appeal or availability of private health insurance, increasing numbers of ghosts may appear in the military health care system.

Even if the Coordinated Care Program improves the efficiency of military health care, increased demand for care could escalate the upward rise in costs. Add to this the growth of expensive, new medical technologies and costs could rise still faster.

Should that happen, the only remaining remedy may be a fundamental restructuring of military health care benefits. Such an effort would raise some tough questions. Should all beneficiaries, especially retirees and their dependents, be allowed unlimited access to military treatment facilities at little or no cost? Regardless of where care is rendered, should military beneficiaries carry a larger share of the cost burden through increased deductibles and copayments, or through health insurance premiums? Can DoD identify and limit recourse to high-cost and low-benefit tests or procedures? The Congress may have some answers to these questions when DoD completes its comprehensive study of the military medical care system required by last year's National Defense Authorization Act.

In mandating the comprehensive study, the Congress underscored that more is at stake than the cost of peacetime medical services. First and foremost, the military health care system exists to support the armed forces

in time of war. As DoD transforms the structure of the armed forces to accommodate reduced threats to U.S. security, it may also alter its approach to wartime health care. The restructuring might involve fewer active-duty medical personnel, fewer hospitals and clinics, and fewer programs of graduate medical education. Such changes would undoubtedly intensify the need to restructure peacetime health care benefits.

CONCLUSION

Madam Chairman, the coming drawdown in active-duty personnel will help to moderate future increases in health care expenses. But under current policies, those costs are likely to continue to rise much faster than the overall DoD budget. Although further cost reductions may be possible from the Coordinated Care Program, savings will be assured only if military medical managers emulate the managed care practices of their civilian HMO counterparts. Even then, costs may accelerate if the program attracts ghost beneficiaries back into the military health care system. Substantial savings may ultimately require a broader restructuring of the system.