Statement of
Robert F. Hale
Assistant Director
National Security Division
Congressional Budget Office

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

March 15, 1990

NOTICE

This statement is not available for public release until it is delivered at 2:00 p.m. (EST), Thursday, March 15, 1990.

Madam Chairman, thank you for the opportunity to testify on the costs of the CHAMPUS Reform Initiative (CRI), a new military health care program that is currently being demonstrated in California and Hawaii. Last December, the Department of Defense (DoD) proposed to expand CRI to Arizona, Nevada, and New Mexico. But DoD has established an important criterion: the demonstration should continue only if the actual cost under CRI is likely to remain below what CHAMPUS would have cost without the reform initiative. My testimony today focuses on what is known about how well this criterion has been satisfied.

Based on reports by several independent contractors, DoD has stated that it is "very strongly encouraged by the magnitude of the estimated cost savings achieved by CRI during its first 12 months." Review by the Congressional Budget Office (CBO) of these same reports confirms evidence that CHAMPUS costs have been lower than could be expected from the historical pattern. But only a few months of usable data are available for analysis. Thus, we believe it is too early to be confident about the size of cost reductions or whether it was the provisions of the CRI rather than other factors that brought about these favorable cost results. More substantial evidence will not be available until the end of this year at the earliest. Therefore, if you want assurance that CRI will reduce costs before expanding the program, you will have to wait.

After providing some background on CRI, my testimony addresses two key questions:

- Are costs under CRI lower than what would have been expected based on historical patterns?

- Did CRI or other factors cause the reduction?

BACKGROUND

The Department of Defense operates its own system of hospitals and clinics (the direct care system). But the direct care system cannot provide care to all eligible beneficiaries. Under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), DoD pays a part of the costs of care provided by civilian professionals.

In August 1988, in an attempt to control CHAMPUS costs and provide better care, DoD began a demonstration of a new program, the CHAMPUS Reform Initiative. CRI is to be demonstrated first in California and Hawaii. If successful, it will be gradually established nationwide. CRI requires that DoD enter into a more or less fixed-price contract with a private firm to provide care to eligible beneficiaries. The contractor is to set up new programs to pay for care provided through civilian providers--that is, new

forms of CHAMPUS--and is also supposed to make more efficient use of the military's direct care system.

CRI augments the standard CHAMPUS plan by delivering health care through a Preferred Provider Organization, a network of physicians and hospitals that sign contracts to offer discounted services to beneficiaries.[1] The greater the contractor's success at negotiating favorable discounts, the greater the potential savings.

Even more important in achieving cost savings is the effect that CRI will have on how beneficiaries use health care services. CRI's extensive review of use--including prior authorization for hospital admissions, concurrent reviews of hospital stays, case management of high-cost patients, and careful retrospective reviews of claims--is intended to curb unnecessary use of health care services without harming health. Moreover, providers who belong to the Preferred Provider Organizations set up by CRI may simply practice medicine more economically than their colleagues who practice outside the organization. This more efficient practice would further lower use of health care, and so further reduce costs under CRI.

1. Beneficiaries actually have two new health care options. CHAMPUS Prime offers care through an exclusive Preferred Provider Organization (PPO) plan, which requires users to enroll and make exclusive use of a network of providers in return for added benefits and limited cost-sharing. CHAMPUS Extra offers an optional PPO plan, which allows beneficiaries who do not enroll in CHAMPUS Prime the choice of using the same network of providers in return for decreased cost-sharing. In April, May, and June 1989, these plans accounted for about one-third of payments for CHAMPUS claims.

The third mechanism for holding down costs under CRI is resource-sharing, a feature designed to shift patients into military hospitals. Although it is generally cheaper to care for patients in currently existing military facilities than under CHAMPUS, military hospitals and clinics are often unable to deliver care because of selective shortages or imbalances of key personnel or equipment. Thus, military hospitals must send beneficiaries to civilian providers who are paid out of CHAMPUS funds.

With the approval of the local hospital commander, the private CRI contractor can supplement the military hospital with resources (staff, equipment, or supplies) in order to overcome these shortages, and thereby treat patients who might have otherwise used CHAMPUS. Unfortunately, this sharing of resources got off to a slow start in the CRI demonstration in California and Hawaii. Although activity has since quickened, few agreements to share resources were in place during CRI's first year.

COSTS COMPARED WITH HISTORICAL EXPERIENCE

Has CRI reduced costs in California and Hawaii? Before CRI, CHAMPUS costs escalated at a frightful rate. Nationwide, they have risen from less than $500 million in 1979 to more than $2.5 billion in 1988, a 400 percent increase. Within California and Hawaii, the rate of increase has been even steeper. These increases reflect in part the sharp growth in health care costs occurring

nationwide. Because of these trends, one cannot fairly determine the effects of CRI by comparing CHAMPUS costs under CRI with costs in the previous year. One must project what CHAMPUS might have cost based on historical patterns and compare the projection with costs under CRI. Two methods of projecting costs have been used--one "actuarial," the other "statistical."

Actuarial Estimates

For an actuarial analysis of CHAMPUS claims, DoD turned to Mercer Meidinger Hansen, a respected consulting firm. Based on monthly CHAMPUS claims payments between January 1986 and June 1988, the actuaries at Mercer Meidinger Hansen projected likely per capita claims for the August 1988 to July 1989 period (the first 12 months of the CRI demonstration).

Such projections, as the actuaries themselves acknowledge, are inherently imprecise because of the volatility of medical costs and the uncertainty about the exact number of beneficiaries eligible for CHAMPUS. In addition, problems with CHAMPUS's claims data may have introduced more errors into the projections--for example, mistakes in coding categories of coverage. For these reasons, the actuaries presented a range of estimates.

The actuaries estimated that, had historical patterns of costs continued, then CHAMPUS costs in California and Hawaii over the August 1988

through July 1989 period (adjusted for the costs of processing claims) would have ranged between $483 million and $522 million, the midpoint being $502 million. The range depends on different assumptions about per capita health care costs and other factors. Actual payments to the CRI contractor totaled $469 million. Hence, CHAMPUS costs during CRI's operation were 3 percent to 10 percent lower than historical trends would have suggested.

The difference between actual and expected costs was larger in the second six months of the projection period than during the first six months. During CRI's first six months (August 1988 through January 1989), a time marked by severe start-up problems, CHAMPUS costs ranged between 1 percent higher and 7 percent lower than history would have suggested. For the second six months (February 1989 through July 1989), the actuarial projections suggest savings of between 6 percent and 13 percent. These sharp differences underscore the sensitivity of results to the particular choice of months--a sensitivity that will only be reduced as more data become available.

Statistical Estimates

The Rand Corporation used a statistical (or econometric) approach to forecast CHAMPUS expenditures based on historical trends. Essentially, Rand predicts what CHAMPUS costs would have been if experience in California and Hawaii reflected the historical pattern of those states relative to the rest of the country. Rand compared this prediction with actual

CHAMPUS expenditures under CRI. Because the cost data available to Rand were different in form from the data used by the actuaries, the comparisons in my testimony focus on percentage changes rather than on actual dollars.

Although CRI began to offer services in August 1988, severe problems with processing claims in the early months limited Rand to an examination of three months of data--April 1989 through June 1989. During that period, total costs amounted to $115.8 million; during the same three months in 1988, total costs had been approximately $110.7 million. Thus, CHAMPUS costs under CRI grew by 4.6 percent above CHAMPUS costs a year earlier. Based on historical experiences in California and Hawaii compared with the rest of the country, Rand projected that, without CRI or other changes, CHAMPUS expenditures in California and Hawaii during this period would have been between 6.7 percent and 36.7 percent higher than those a year earlier.[2] Because growth in costs under CRI is below the lower bound of this range, evidence indicates that costs were lower than expected. But the wide range of projected costs is an indicator of the immense uncertainty in these projections and, hence, in the conclusions that should be reached.

---

2. Rand actually estimated growth in costs between a recent nine-month period and the same period a year earlier. But reliable, detailed data on CRI claims were only available for three months. Rand therefore compared the three-month percentage growth under CRI with the nine-month percentage growth projected in the absence of CRI.

CAUSES OF LOWER THAN EXPECTED COSTS

When viewed together, the actuarial and the statistical findings provide fairly persuasive evidence that costs in California and Hawaii increased under CRI at a lower rate than would have been expected. However, was CRI the cause? To help answer that question, let me turn now to a more detailed analysis of the three months of data available to the Rand Corporation.

Compared with costs in the same three months a year earlier, costs for the three months analyzed by Rand increased by 4.6 percent. That increase reflected several changes:

- A 14 percent drop in costs for claims of inpatient hospital services;
- A 34 percent decrease in the costs of claims for professional and outpatient mental health services;
- Little change in the costs of claims for professional services and for outpatient services other than those for mental health; and
- An increase of several hundred percent in administrative costs.

Administrative Costs

Clearly, CRI caused the rise in administrative costs. The CRI contractor's chores are immensely more complex than those of administrators under the standard CHAMPUS program.

Inpatient Services

CRI's role in reducing the cost of inpatient hospital services is less clear than its effects on administrative costs. Lower costs under CRI were not the result of fewer hospital admissions. Rand found that the number of CHAMPUS admissions in 1988 and 1989 differed by only 0.2 percent. It is possible that CRI reduced inpatient costs because it garnered favorable discounts or because CRI imposed a more effective review of the use of services.

But changes not related to CRI could also have explained the reduction in inpatient costs. Greater use of military hospitals is one possibility. Earlier work by the General Accounting Office confirms that changes in the use of military hospitals have a direct effect on the use of CHAMPUS. For example, when military hospitals cut back the availability of services in 1986 and 1987, CHAMPUS expenses in nearby areas soared as eligible beneficiaries made greater use of civilian health care providers and billed CHAMPUS.

Conversely, when the availability of military services increases, CHAMPUS costs should fall. Between 1988 and 1989, admissions to military hospitals in California and Hawaii increased by 2.5 percent. Based on the relative size of military hospitals and CHAMPUS, that could have led to at least a 5 percent decrease in the number of admissions that CHAMPUS had to finance. More important, it could be that military hospitals handled a more complicated and so more expensive mix of patients--thanks to added staff and the new facilities that opened during 1989. If so, then CHAMPUS costs for hospital care would have been lower than expected even without CRI.

Mental Health Costs

CRI probably has a stronger claim on causing what Rand termed the "astounding" 34 percent decrease in costs of outpatient mental health services than it does the reduction in inpatient costs. The standard CHAMPUS program offers relatively generous benefits for mental health care, which may encourage excessive or unnecessary use. Under CRI, all claims for mental health care are carefully reviewed. Although Rand cannot be sure that the cost decreases resulted from these reviews, the evidence is consistent with this hypothesis.

But some of these savings could disappear. More stringent review of the use of mental health care services has led to extensive appeals of denied

claims. If a large number of these claims are paid on appeal, savings would erode. At this point, no one can estimate the eventual cost of appealed claims.

Other Outpatient Services

Finally, what effect might CRI have had on the cost of outpatient services other than those for mental health? Again, it is not clear. During the three-month period that Rand analyzed, these types of outpatient costs decreased for members of active-duty families and for beneficiaries in Southern California and Hawaii. CRI could have brought about these cost reductions through a combination of discounts and lower rates of use. But factors not associated with CRI could also have reduced costs. It is possible, for example, that visits to the military's civilian-run outpatient clinics (so-called PRIMUS clinics) increased between 1988 and 1989 and that this increase might have held down CHAMPUS use. Data on the use of these clinics are not readily available.

Outpatient costs other than those for mental health care increased for retired family members and for beneficiaries in Northern California. CRI might have had little to do with these increases. But possibly these costs grew because of a factor that I have not yet mentioned but which is related to CRI--"ghost eligibles." Ghost eligibles are beneficiaries who are eligible for military health care benefits but do not use them--perhaps because care

under the military system has been less convenient than care available through, say, insurance provided by a spouse's employer.

In a survey of 2,790 military retirees and dependents who were eligible for CHAMPUS, conducted before April 1989, Rand found that 27 percent had received civilian health care in the previous six months without filing a CHAMPUS claim. Some of these beneficiaries are probably ghost eligibles. CRI's enhanced benefits, lowered cost sharing, and reduced paperwork might have encouraged some of these ghost eligibles to begin using their CHAMPUS benefits, which could explain the increase in costs in Northern California and among retirees.

FUTURE UNCERTAINTIES

Factors not yet fully in effect could alter future costs under CRI. These factors could lead either to higher or lower costs than those suggested by the analysis of the first few months of data.

On the one hand, a continued influx of ghost eligibles could eventually raise CHAMPUS costs to higher than expected levels. During CRI's first few months, potential enrollees are apt to have been uncertain about the benefits of so new a program. Those with private health insurance--ghosts and non-ghosts alike--might have hedged their bets during the first year by keeping

those policies, thus holding down CHAMPUS costs. If their confidence in CRI solidified, they might turn CHAMPUS into a primary payer by dispensing with other coverage.

On the other hand, an increase in agreements to share resources--which are designed to allow CRI to make more effective use of military hospitals--might more than balance the effect of ghost eligibles. As of December 1989, more than 30 agreements were in effect or under negotiation, most of them involving providers and support personnel. Numerous areas hold promise for additional cost-effective agreements.

Another uncertainty relates to the effectiveness of catchment area management, an alternative approach to CRI. In several sites across the country, the military services are experimenting with techniques similar to those of CRI, carried out by local military commanders. These demonstrations will show whether local military medical commands have the capability to conduct utilization reviews, negotiate discounts with providers, and reshape patterns of medical referrals, all with comparatively little assistance from civilian contractors. Time will tell whether or not DoD needs the expertise of a large contractor to realize the benefits of CRI's tools.

AVAILABILITY OF BETTER DATA

That we know so little about CRI's effectiveness would probably not surprise experts in civilian health care. It generally takes new managed care organizations (such as HMOs) two to three years to become operationally effective. For that reason, HMO organizations report information separately for HMOs that are less than three years old and those that are older. At this moment, CRI has been in operation for about 20 months. Thus, a definitive analysis of CRI's effects on costs lies at least another year and one-half away. However, by early next year, the Congress should have a somewhat better idea of the effects of CRI, because the Rand Corporation expects to have conducted a more thorough analysis of six months' worth of data (including the three months already analyzed) from the demonstration.

By next year, the Congress may also have some more information about in-house approaches like the catchment area management programs. Also by next year, the Administration and the Congress might have more information about the long-run outlook for the size of the military. That long-run outlook may suggest more clearly what military bases, and what medical installations, might be closed or reduced in size as arms limitations treaties and political changes trigger a reduction in the number of military forces. This information would be useful before signing contracts that are partially predicated on the availability of military medical care facilities.

CONCLUSION

Madam Chairman, it is not CBO's role to recommend whether or not to proceed with expanding the CRI demonstration to three more states. Evidence shows that costs in California and Hawaii have been lower than expected. Some of those savings were probably the result of the Reform Initiative. Expanding CRI now would increase the portion of the military medical establishment benefiting from any favorable cost results. If the Congress approves expansion of CRI now, however, it would have to do so before having confidence about the size of the cost benefits and, more important, about whether the provisions of the CRI or other factors have led to the favorable cost results. The Congress would also have to expand CRI without a clear view of the likely size of the military medical establishment in years to come.