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DEFENSE HEALTH CARE

Lessons Learned From DOD's Managed Health Care Initiatives

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SUMMARY

For the past several years, DOD has been testing several health care initiatives aimed at controlling health care costs, improving access, and providing high quality care. The lessons learned from developing and operating these initiatives can provide useful information and insight for how DOD should best proceed in implementing managed care throughout its health care system. For example:

-- To achieve equity and help achieve budgetary goals, DOD and the Congress need to work together to establish a uniform health care benefits and cost sharing package for each category of beneficiary, regardless of where beneficiaries live or receive their care.

-- Because military health care lacks sufficient systems, incentives, and controls to encourage the delivery of efficient and cost-effective health care, improvements are needed in several areas such as accountability, budgeting and resource allocation, training, and information systems. DOD is planning several improvements in these areas.

-- As contracting for health care services will probably increase because of decreases in DOD's own medical staffing, experience has shown that contracting poses challenges and risks that DOD needs to address. DOD needs to determine when contracting will and will not be appropriate. As we have previously testified, DOD should use a blend of the managed care models it has tested thus far, given that military capabilities and staffing vary considerably around the country. Also, appropriate safeguards need to be established to assure high quality and accessible care that protect beneficiaries and the government against poor contractor performance.

We commend DOD for its progress to date in moving toward a managed health care environment because we continue to believe that, while not a panacea, managed care does offer the potential for gaining more control over costs, improving beneficiary access, and offering high-quality care.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss DOD's efforts to reform its military health care system. To do this, we will briefly look back at where the Department has been and look forward to where it wants to go.

While many details of the Administration's national health care reform proposal are yet to be unveiled, DOD finds itself in a position of having substantial information and experience on several pressing health care challenges. Some of these challenges -- particularly those relating to cost containment and access to care -- parallel those sure to be faced by the entire nation as we move toward a reformed national health care system. Other challenges such as maintaining an adequate medical readiness capability are unique to DOD as it attempts to carry out its responsibilities for providing peacetime care as well as supporting our forces in time of war.

As you know, Mr. Chairman, DOD several years ago embarked on a series of initiatives aimed at controlling its health care costs, improving the quality of care, and increasing beneficiaries' access to health care services. These efforts essentially involve shifting the Department's health delivery activities to a managed health care environment and making maximum use of military hospitals. Among DOD's most notable initiatives have been the CHAMPUS Reform Initiative (CRI), Catchment Area Management projects, the Partnership Program, mental health managed care projects, and most recently DOD's Coordinated Care program.

We have monitored these projects closely and believe that the lessons learned in developing and operating them can provide useful information and insight for how DOD should best proceed in implementing managed care throughout its health care system. (See App. I for a list of our previous reports and testimonies on these activities.)

I want to reiterate, Mr. Chairman, that we believe managed care holds promise for gaining additional control over costs and improving beneficiary access while maintaining high-quality care. DOD's transition to managed care has not been easy, and important lessons have been learned concerning features that need to be in place as DOD's managed care efforts continue. I would like to highlight several of these here today, namely the need for:

-- uniform health care benefits and cost sharing requirements within individual categories of beneficiaries,

-- organization and budgeting systems that provide managers the appropriate incentives to manage beneficiaries' care efficiently, and

-- consideration of a variety of factors as DOD continues to contract for health care services.

UNIFORM BENEFITS AND COST SHARING

DOD and the Congress need to work together to establish a uniform benefits package with uniform cost sharing for each category of beneficiary,[1] regardless of where beneficiaries live or receive their care. Such a change would provide greater equity than now exists and should help to contain costs.

Currently, beneficiaries who can access a military hospital which has the specific capabilities they need, receive essentially free care. Those who cannot access or do not want to go to a military hospital have the option of using CHAMPUS until age 65 when they become eligible for Medicare; however there is considerable cost sharing involved under both the CHAMPUS and Medicare programs.[2]

DOD's managed care initiatives in certain geographic areas have also created differences in benefits and cost sharing. For example, some of the initiatives offer enhanced preventive care benefits, some have eliminated deductibles, and others have reduced the amount of beneficiary copayments required.

Additionally, potential hospital closings resulting from military base closures may leave many retirees without prescription drug benefits and having to pay substantial penalties to obtain Medicare supplemental insurance (Part B) which covers physician services and outpatient hospital care. These changes have contributed to confusion and uncertainty among beneficiaries as to what their medical benefits really are.

The issue of cost sharing is a controversial one that requires careful consideration. Many military members, retirees, and their families believe that they were promised free health care for life and that requiring additional cost sharing of any kind for dependents and retirees would be reneging on that promise. These beneficiaries also argue that it would impose an unreasonable burden on the military community, particularly for lower ranking enlisted members and their families.

On the other hand, budget constraints and prevailing employer practices suggest a need to adopt some significant cost sharing

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[1]Dependents of active duty members, retirees and their dependents, and survivors and their dependents.

[2]Cost sharing for dependents of active-duty members who receive inpatient care under CHAMPUS is the same as for care they receive in a military hospital.

requirements in military health care. For example, employee cost-sharing is almost universal in the private sector with the imposition of premiums, deductibles, and copayments of medical bills. Additionally, RAND's evaluation of the CHAMPUS Reform Initiative pointed out that the Initiative's minimal cost sharing, first dollar coverage, and coverage of preventive services resulted in beneficiaries' heavy utilization of medical services, contributing to the Initiative's high overall costs. Continued consideration should be given to establishing a cost sharing system which either exempts the lower enlisted ranks or minimizes the extent to which they are required to contribute toward the cost of their health care.

DOD's difficulties with implementing the Coordinated Care program were largely due to controversy over what the benefits package would look like. This suggests that deliberations on the benefits package should be separate from decisions regarding other issues affecting the delivery of managed health care services.

Military beneficiaries, like other health care consumers, have varying health care needs and preferences. Some desire an emphasis on primary and preventive health care; others need more specialty care. For this reason, we believe that DOD's managed care program should continue to offer beneficiaries a choice of health plans in which to enroll for a specified period of time. Such options, in our opinion, will stimulate competition and efficiency among plans. At the same time, early beneficiary enrollment will facilitate the military health managers' ability to plan for the health care delivery needs of their enrolled population.

ORGANIZATIONAL AND BUDGETARY ISSUES

Military health care currently lacks sufficient systems, incentives, and controls to encourage the delivery of efficient and cost-effective health care. In short, improvements are needed in several areas such as accountability, budgeting and resource allocation, training, and information systems.

For example, military hospital commanders currently do not control beneficiaries' access to most outpatient care delivered in civilian settings, nor do they have fiscal responsibility for such care. Without responsibility for the cost, quality, and accessibility of all health care within their service areas, hospital commanders have incentives to push certain types of care onto the more expensive CHAMPUS system, thereby increasing the government's overall costs and giving up direct responsibility for the quality of care obtained from private providers. DOD has proposed designating twelve military medical centers as "lead agents", responsible for managing all medical care in defined geographic areas notwithstanding whether that care is provided by military or civilian sources.

Similarly, DOD plans to adopt a budgeting system that allocates resources based on the demographics of its beneficiary population to replace its current system of allocating resources based on the amount of workload that a hospital can generate. Military hospitals currently have incentives to admit patients inappropriately and retain them longer than medically necessary to justify additional resources. The Army has gained considerable experience over the last two years with a budgeting system similar to that which DOD plans to adopt department-wide. In our view, DOD's experience with its managed care initiatives demonstrates that these concepts are workable and provide better fiscal controls and needed accountability.

To support their new responsibilities, military health care managers need more accurate and timely data from information systems than is now available. Problems with information systems have been universally cited by service officials over the past few years as we monitored the status of DOD's managed care projects.

Also, DOD's managed care initiatives have shown that additional expertise and training in managed care principles and techniques are essential for DOD's managers. DOD will need to invest heavily in training its principal health care managers. We view very positively DOD's recent emphasis on ensuring that individuals selected for hospital commands possess the knowledge, skills, and experience needed to perform successfully in a managed care environment.

In another vein, several opportunities exist to streamline the present DOD medical structure and make better use of medical personnel. Pressures to reduce the size of the services' medical corps increase the need to look for ways to achieve greater economies and efficiencies from the system. Three areas of potential improvement are:

-- consolidating the administrative and command structures of the services' medical departments,

-- reducing the administrative and clerical duties of physicians and reexamining their work schedules to allow them to provide more direct patient care, and

-- increasing medical resource sharing with the Department of Veterans Affairs.

CONTRACTING FOR HEALTH CARE SERVICES

Contracting for health care services will probably increase as DOD's own medical staffing decreases. While contracting can help DOD meet the continuing demand for health care, experience has shown that it poses other kinds of challenges and risks that DOD will need to address.

For example, DOD needs to carefully determine when contracting will and will not be appropriate. As we testified last year, we believe that DOD should use a blend of the managed care models it has tested thus far, given that military capabilities and staffing vary considerably around the country. Some hospitals or regions will need to contract for management services. Some will need help in delivering health care, and others will need both.

Second, DOD needs to carefully determine the size of its procurements, including the scope of geographical coverage, to assure sufficient competition among qualified bidders in order to gain maximum advantage of economies of scale and local health care knowledge and conditions.

Third, appropriate safeguards need to be established to assure high quality and accessible care that protect beneficiaries and the government against poor contractor performance. DOD has gained valuable experience concerning these matters with several of its managed care contracts. For example, CRI's early claims processing problems, compounded by the contractor's poor financial condition required substantial government intervention to protect itself and beneficiaries in the event of the Initiative's collapse. Also, in fixed price, risk sharing contracting arrangements such as used in CRI and a mental health project in Virginia, where there are financial incentives for the contractor to restrict medical care to beneficiaries, strong quality assurance and utilization management programs are particularly important.

Finally, DOD's contracting experience also suggests that it needs to work toward facilitating smoother transitions when contractors change. DOD experiences difficulties every time it changes contractors for processing health care claims of civilian providers. Smooth transitions when changing managed health care contracts will be even more important because it will potentially involve changing the network of providers who deliver care to beneficiaries and thus may interrupt the continuity of care and relationships between patients and their physicians.

CONCLUSIONS

We commend DOD for its progress to date in moving toward a managed health care environment because we continue to believe that, while not a panacea, managed care does offer the potential for gaining more control over costs, improving beneficiary access, and offering high-quality care. As the country moves toward national health care reform, DOD should be in a position to not only adopt the main principles embodied in the so called managed competition model but, based on its experiences thus far, it should be able to provide useful information and assistance to others, both in the public and private sectors, in implementing the program.

The lessons that have been learned to date demonstrate, however, that many significant implementation obstacles and difficulties remain. Overcoming them will require innovation, patience and, above all compromise in order to reach consensus among widely differing views. It is also crucial that expectations for the success of managed care be tempered by realism about the prospects for immediate beneficial results. DOD and the country are dealing with difficult and costly health care problems with many implications for all those affected by the health care system. It will take time to work through how best to equitably accommodate those affected, while achieving the goals of controlling cost growth, improving access, and maintaining quality. DOD will also need the continued support and, at times, critical input from this and the other key congressional committees as it implements this ambitious concept throughout its system.

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Mr. Chairman, this concludes my prepared statement. We would be glad to answer any questions you or other members of the Subcommittee may have.

Related GAO Products

Defense Health Care: Additional Improvements Needed in CHAMPUS's Mental Health Program (GAO/HRD-93-34, May 6, 1993).

Letter to Representative Patricia Schroeder on DOD's Efforts to Evaluate Psychiatric Care (GAO/HRD-93-19R, Mar. 31, 1993).

Defense Health Care: CHAMPUS Mental Health Demonstration Project in Virginia (GAO/HRD-93-53, Dec. 30, 1992).

Defense Health Care: Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries (GAO/T-HRD-92-27, Apr. 28, 1992).

Defense Health Care: Obstacles in Implementing Coordinated Care (GAO/T-HRD-92-24, Apr. 7, 1992).

Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991).

Defense Health Care: Implementing Coordinated Care--A Status Report (GAO/HRD-92-10, Oct. 3, 1991).

Defense Health Care: Health Promotion in DOD and the Challenges Ahead (GAO/HRD-91-75, June 4, 1991).

DOD's Management of Beneficiaries' Mental Health Care (GAO/T-HRD-91-30, May 15, 1991).

The Military Health Services System--Prospects for the Future (GAO/T-HRD-91-11, Mar. 14, 1991).

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (GAO/HRD-90-131, Sept. 7, 1990).

Potential Expansion of the CHAMPUS Reform Initiative (GAO/T-HRD-90-17, Mar. 15, 1990).

Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

CHAMPUS Reform Initiative: Unresolved Issues (GAO/T-HRD-87-4, Mar. 12, 1987).

Defense Health Care: CHAMPUS Reform Initiative: Unresolved Issues (GAO/HRD-87-65BR, Mar. 4, 1987).

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