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DEFENSE HEALTH CARE

Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon

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The Honorable Sam Nunn
Chairman
The Honorable Strom Thurmond
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Ronald V. Dellums
Chairman
The Honorable Floyd D. Spence
Ranking Minority Member
Committee on Armed Services
House of Representatives

This report responds to the requirement in the National Defense Authorization Act for Fiscal Year 1993 (P.L. 102-484, § 712) that the Comptroller General and the Director of the Congressional Budget Office (CBO) report to the Congress on their evaluations of the Secretary of Defense's certification on expanding the CHAMPUS Reform Initiative (CRI).[1] The CBO is reporting separately on its cost estimates related to the expansion.

On August 20, 1993, the Secretary of Defense certified to the Congress that CRI, with some benefit revisions and managerial changes, would be the most efficient method of providing health care to beneficiaries in Washington and Oregon.[2]

Background

Under both CRI and the modified CRI program, private-sector contractors provide health care services for CHAMPUS-eligible beneficiaries. Under both programs, beneficiaries may choose one of three options: (1) a health maintenance organization program called CHAMPUS Prime, which offers improved benefits and reduced beneficiary out-of-pocket costs as compared to standard CHAMPUS; (2) a preferred provider organization called CHAMPUS Extra, which requires a higher level of beneficiary cost

[1]The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for a substantial portion of the health care that civilian hospitals, physicians, and other providers give to Department of Defense (DOD) beneficiaries. Retirees and their dependents and dependents of active-duty personnel and of deceased members receive care from these providers if they cannot obtain it at military facilities. CRI currently operates in California; Hawaii; New Orleans, Louisiana; and in the areas surrounding three military hospitals that will be closed by September 30, 1993.

[2]This report refers to the program proposed for expansion of CRI as the "modified CRI program."

sharing than under CHAMPUS Prime; and (3) continuation in standard CHAMPUS.

The Department of Defense Appropriations Act, 1993 (P.L. 102-396, § 9032), directed the expansion of the CRI demonstration to Washington, Oregon, and Florida. However, section 712 of the National Defense Authorization Act for Fiscal Year 1993 (P.L. 102-484) prohibits expansion of CRI to any additional location unless the Secretary certifies that it would be the most efficient method for providing health care services to covered beneficiaries in the new location. In making this determination, the Secretary is required to consider CRI's cost effectiveness and its effect on access to and the quality of care provided.

In 1993, RAND completed an evaluation of the CRI program in California and Hawaii. RAND found that CRI was 8 percent more expensive than standard CHAMPUS in those two states during the evaluation period.[3]

In an effort to reduce program costs, DOD is planning to implement a program in Washington and Oregon that differs somewhat from the CRI program now operating in California and Hawaii. Compared to the existing program, the modified CRI program achieves a higher degree of cost sharing by imposing annual enrollment fees on beneficiaries and increasing beneficiary copayments to higher levels than those under CRI. It also differs by including several managerial changes designed to reduce the program's cost to the government. One of these changes is the use of civilian primary care physicians to serve as "gatekeepers" to control access to nonemergency outpatient services at military treatment facilities by CHAMPUS Prime enrollees. Under the CRI program in California and Hawaii, beneficiaries are free to use the outpatient services in military hospitals at their own discretion.

Scope and Methodology

Jointly with CBO representatives, we interviewed DOD health care officials as well as contractor personnel responsible for the analyses underlying DOD's certification. We also reviewed extensive documentation regarding the procedures, assumptions, and data used in those analyses, primarily those of the cost comparison of the modified CRI program and standard CHAMPUS program. We also reviewed RAND studies that assessed the impact of CRI on health care utilization, costs, and access to care in California and

[3]Susan D. Hosek, et al., Evaluation of the CHAMPUS Reform Initiative, Vol. 3, Health Care Utilization and Costs, RAND, R-4244/3-HA (1993).

Hawaii. We did our work from March to September 1993 in accordance with generally accepted government auditing standards.

Results in Brief

DOD certified the modified CRI program as the most efficient method of health care delivery in Washington and Oregon after comparing it with the standard CHAMPUS program. DOD compared the two programs on the basis of access to care, quality of care, and cost to the government. We believe that the comparison was done in a reasonable way and thus fairly estimated the two health care delivery methods' likely costs, quality, and access.

However, by basing its certification only on a comparison of the modified CRI program and standard CHAMPUS, DOD does not know how the other health care delivery methods it is currently operating or testing in various parts of the country compare with the modified CRI program or standard CHAMPUS. As a result, we do not believe that DOD's comparative base was inclusive enough for it to know that the modified CRI program is the most efficient method of providing health care in Washington and Oregon.

DOD's Certification Based on Comparison of Modified CRI and Standard CHAMPUS Programs

DOD based its certification of the modified CRI program as the most efficient method of health care delivery in Washington and Oregon on a comparison of the modified CRI program to the standard CHAMPUS program. DOD compared the two programs on the basis of access to care, quality of care, and government cost.

Based on the RAND study of CRI, DOD concluded that there would be no discernible difference between the modified CRI and standard CHAMPUS in terms of quality of care. Regarding access to care, DOD concluded that the modified CRI program would be superior to the standard CHAMPUS program because of its reduced out-of-pocket expenses for beneficiaries and its designation of program personnel to help beneficiaries identify health care providers to best meet their needs.

The primary focus of the analytical comparison was on the government's cost of delivering health care under each program. DOD contracted with Lewin-VHI Inc. to conduct a comparative cost analysis of the two programs. Lewin-VHI drew on historical data from the standard CHAMPUS program in estimating CHAMPUS costs. To estimate the cost of the modified CRI program, Lewin-VHI identified program features that seemed likely to decrease costs relative to standard CHAMPUS, such as the ability to obtain

discounts from health care providers. Lewin-VHI also identified other features that would increase costs, such as the increase in health services utilization due to reduced beneficiary out-of-pocket costs provided by the modified CRI program. The contractor then estimated the size of the effects on the government's cost of each identified feature of the modified CRI program.

This comparison resulted in an estimate that costs under the modified CRI program would be about equal to or slightly less than those under the standard CHAMPUS program in Washington and Oregon. Combining these results with the previously cited conclusions that (1) there would be no discernible difference between the two programs in quality of care and (2) the modified CRI program would increase access to care, DOD certified that the modified CRI program was the most efficient method of health care delivery for Washington and Oregon.

Our examination of the RAND study of CRI in California and Hawaii showed that DOD's conclusions on quality of care and access to care under the modified CRI program were consistent with RAND's findings. RAND did not find any basis for concluding that implementation of CRI resulted in a change in quality of care from that provided under the standard CHAMPUS program. A RAND survey of beneficiaries' opinions on barriers to access to care under CRI, as well as a comparison of beneficiary out-of-pocket costs under both programs, support the conclusion that the modified CRI program would provide greater access to health care than does the standard CHAMPUS program.

The cost comparison approach employed by Lewin-VHI also appears reasonable. We agree with Lewin-VHI on the modified CRI program features that seem likely to increase and decrease costs relative to standard CHAMPUS. We also believe the Lewin-VHI assumptions on the magnitude of these likely changes to be generally well supported. On this basis, we conclude that the methods used by Lewin-VHI to estimate the costs of the modified CRI program proposed for implementation in Washington and Oregon are sound.

Certification Did Not Address Other Health Care Delivery Methods

DOD's certification compares the modified CRI program to the standard CHAMPUS program and not to other managed health care delivery methods it has been testing for some time. A significant difference between these other managed care programs and both the CRI and modified CRI programs is that the former rely on military hospital commanders and other military

personnel rather than a private contractor to administer the program. One advantage of these programs is that DOD does not have to pay a contractor an allowance for profit as it does for the CRI and modified CRI programs.

One of the managed care approaches that DOD is testing is the Catchment Area Management (CAM) program. DOD began implementing the program in 1989 at Fort Sill, Oklahoma, and Fort Carson, Colorado, and subsequently implemented the program at two Air Force sites and one Navy site. Generally, the program at each location is managed by the commander of the military treatment facility in that area. Four of the five programs continue to operate either as a CAM project or under a different name following the expiration of the demonstration period. The CAM program at the remaining location (Bergstrom Air Force Base, Texas) has been terminated with the planned closure of the hospital.

Another approach DOD is testing is TRICARE, which began in the Tidewater area of Virginia in October 1992. TRICARE is similar to the CAM program but varies in one important respect. Unlike the CAM projects, which is operated by an individual military service, TRICARE is controlled and operated by a Commanders' Board consisting of military treatment facility commanders at Fort Eustis (Army), Langley Air Force Base (Air Force), and the Naval Hospital, Portsmouth (Navy). TRICARE represents DOD's first attempt to operate a triservice managed care project. TRICARE relies on contractor support for developing its provider network and operating one of its three centers established to provide beneficiary assistance.

DOD officials cited three reasons for not considering these approaches when making their determination of the most efficient method of health care delivery in Washington and Oregon. They stated that

- there was no specific statutory requirement for them to consider delivery methods other than CRI;
- the Department of Defense Appropriations Act, 1993, prohibits the use of funds for any health care delivery program other than one that incorporates the scope of benefits and program management structure of the CRI program as implemented in California and Hawaii; and
- the information available on the other health care delivery methods cited earlier was insufficient to permit a credible cost estimate to be developed.

Regarding the first point, although the statute does not specifically require DOD to consider these other health care delivery methods, it does require that DOD certify that CRI is the most efficient method before expanding it to

other areas. DOD's exclusion of approaches other than the modified CRI program from this comparison casts doubt on whether the certification of the modified CRI program is accurate and fully informed.

Concerning the second point, the statutory direction that prohibits DOD from implementing any delivery methods that differ from the basic design of the existing CRI program does not, in our view, preclude DOD from including such methods in a comparison to determine whether the modified CRI program is the most efficient. If, after considering these other methods, the modified CRI program is determined not to be the most efficient method, DOD could seek legislative changes to permit it to implement the most efficient method in Washington and Oregon.

Regarding the third point, we recognize that DOD faces problems in making estimates without complete information on the operation of other health care delivery methods it has been testing for some time. Its apparent inability to make such estimates constitutes a significant impediment in its ability to know whether the modified CRI program is the most efficient delivery method for the two states.

Conclusions

DOD's determination that the modified CRI program would be a more efficient health care delivery method in Washington and Oregon than standard CHAMPUS was done in a reasonable way and produced fair cost estimates. However, because DOD does not yet have what it considers to be sufficient data to estimate the costs of other health care delivery methods, it does not know whether the modified CRI program is the most efficient method of providing health care in Washington and Oregon and, thus, does not have an adequate basis for its certification.

Agency Comments

Officials in DOD's Office of the Assistant Secretary of Defense (Health Affairs) reviewed a draft of this report and stated that DOD did consider other health care methods now being tested before certifying that the modified CRI program would be the most efficient method of health care delivery for Washington and Oregon. They reiterated, however, that there are not enough empirical data to judge these other methods.

We have made changes as appropriate to our draft report as a result of DOD officials' comments. Their comments, however, reinforce our view that DOD does not know whether the modified CRI program is the most efficient health care delivery method for Washington and Oregon.

We are sending copies of this report to the Secretary of Defense; the Director, Office of Management and Budget; and other interested congressional committees. We will also make copies available to others upon request.

The report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. If you have any questions, you may contact him at (202) 512-7101. Major contributors to this report are listed in appendix I.

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