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Report to the Chairmen, and the Ranking Minority Members, Senate and House Committees on Armed Services

February 1994

DEFENSE HEALTH CARE

Expansion of CHAMPUS Reform Initiative Into DOD's Region 6

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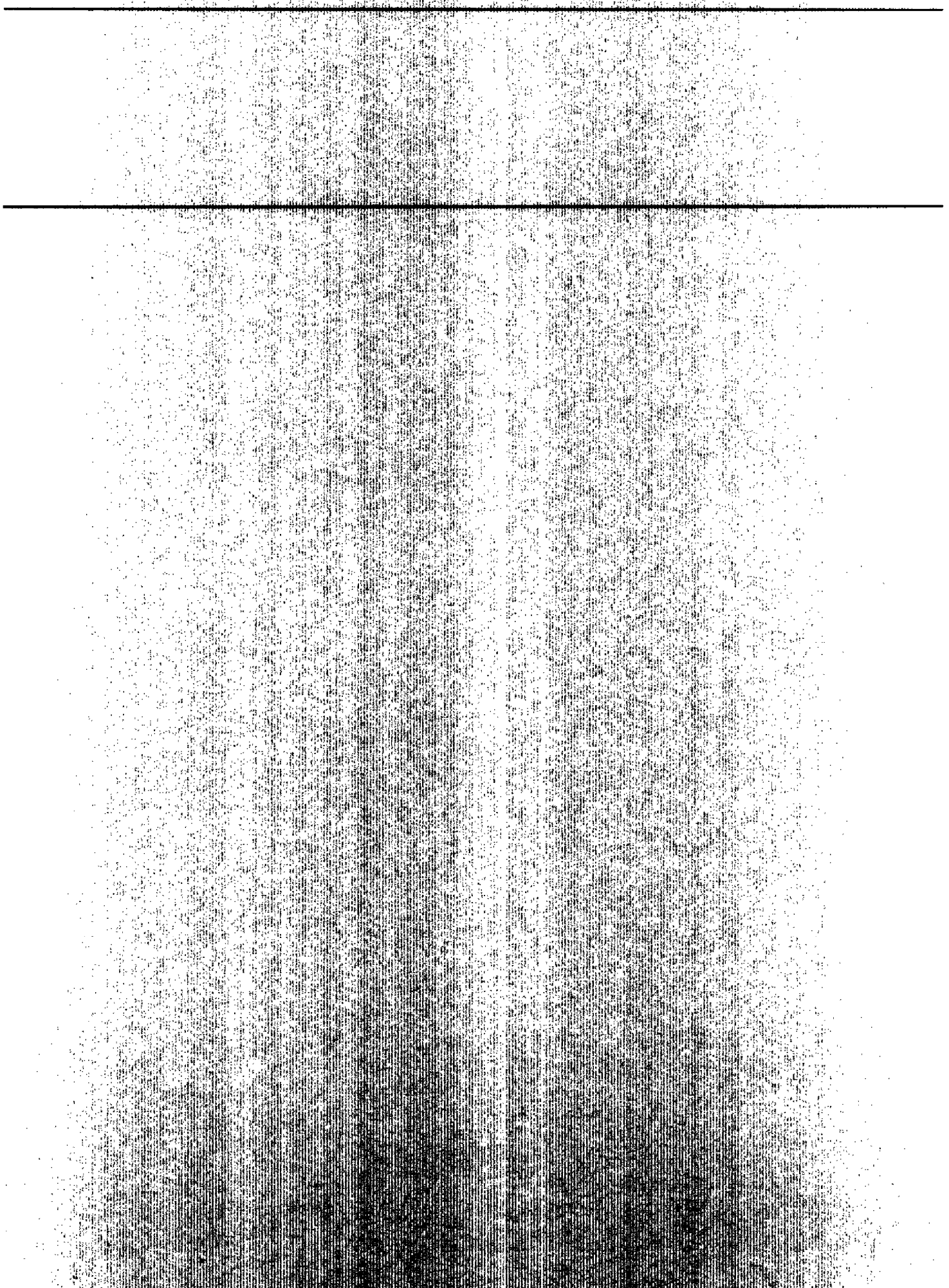

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Health, Education, and
Human Services Division

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February 9, 1994

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.

In a letter dated December 27, 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 Arkansas, Oklahoma, and portions of Louisiana and Texas (DOD's health service region 6).[2] We and CBO have previously reported on

[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 were closed in 1992 and 1993. In July 1993, DOD awarded a contract to continue CRI in California and Hawaii. This award was subsequently protested by two unsuccessful bidders. On December 20, 1993, GAO sustained the protest on the basis that DOD did not follow the evaluation scheme for technical and cost proposals as stated in the solicitation.

[2]DOD has established 12 health service regions throughout the country and is working toward developing a single, integrated health care network for each region. This report refers to the program proposed for expansion of CRI as the "modified CRI program."

DOD's certification for expanding CRI to Washington and Oregon (DOD's region 11).[3]

Background

Under both CRI and the modified CRI program, private-sector contractors provide managed health care services under regional, at-risk contracts for CHAMPUS-eligible beneficiaries to supplement the care provided in military hospitals and clinics. Under both programs, beneficiaries may choose one of three options: (1) a health maintenance organization program called Prime, which offers improved benefits and reduced beneficiary out-of-pocket costs as compared to standard CHAMPUS; (2) a preferred provider organization called Extra, which requires a higher level of beneficiary cost-sharing than under Prime; and (3) a continuation in standard CHAMPUS.

The Department of Defense Appropriations Act, 1994 (P.L. 103-139 § 8025) directs DOD to implement, nationwide, managed care contracts similar to CRI by September 30, 1996, and to award four such contracts in fiscal year 1994. Expansion of CRI is also subject to section 712 of the National Defense Authorization Act for Fiscal Year 1993 (P.L. 102-484), which 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. The law, as amended by section 720 of the National Defense Authorization Act for Fiscal Year 1994 (P.L. 103-160), also requires the Secretary, in considering cost-effectiveness, to ensure that the combined cost of care in military facilities and under CHAMPUS will not increase to either the government or beneficiaries, as a result of the expansion.

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.[4] In an effort to reduce program costs, DOD is planning to implement the modified CRI program, which differs somewhat from the CRI program now operating in California and Hawaii. The modified CRI program imposes annual enrollment fees on beneficiaries and increases beneficiary copayments. It

[3]Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (GAO/HRD-93-149, Sept. 20, 1993) and Evaluating the Cost of Expanding the CHAMPUS Reform Initiative Into Washington and Oregon, CBO (Nov. 1993).

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

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 Prime enrollees. Under the CRI program in California and Hawaii, Prime enrollees, until recently, were free to use the outpatient services in military hospitals at their own discretion.

RAND's evaluation also included a comprehensive analysis of beneficiaries' access to care under each of the health care options offered under CRI as well as an evaluation of the quality of care provided under each option. RAND concluded that beneficiaries' access to care under CRI was superior to that under standard CHAMPUS primarily because of reduced out-of-pocket costs for those who chose the Prime and Extra options and because of the designation of program personnel to help beneficiaries identify health care providers to meet their needs. RAND also concluded that there was no discernable difference in the quality of care received under CRI.

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. In addition, we reviewed extensive documentation regarding the procedures, assumptions, and data used in those analyses, primarily those pertaining to the estimated combined costs of care in military facilities and from civilian providers under the modified CRI program. We also reviewed RAND's study that assessed the impact of CRI on health care utilization, cost, beneficiaries' access to care in California and Hawaii and the quality of the care provided. Although we did most of our work on this DOD certification in January and February 1994, we also drew on an extensive amount of work we have previously done concerning both the CRI program in California and Hawaii and DOD's proposed expansion of CRI in the states of Washington and Oregon. All of these efforts were conducted in accordance with generally accepted government auditing standards.

Results in Brief

We found that the analyses conducted in support of DOD's certification for expanding the modified CRI program to DOD's region 6 were done in a reasonable way. Moreover, the analyses fairly represent the likely impact of the modified CRI program on cost, quality, and access.

DOD's Assessment of the Impact of the Modified CRI Program in Region 6

To assess the cost impact of the modified CRI program in region 6, DOD engaged the services of Lewin-VHI, Inc., the same contractor it used to assess the cost impact in Washington and Oregon. For its region 6 analysis, Lewin-VHI first estimated the cost of the standard CHAMPUS program plus the cost of military hospitals and clinics for fiscal years 1995 through 1999. It then estimated the costs of operating the modified CRI program in the region over the same time period and computed the difference.

Lewin-VHI drew on historical data from the standard CHAMPUS program in estimating CHAMPUS costs and estimated the costs of military hospitals and clinics using a modeling system that forecasts military facility workload based on projected changes in the eligible population and capacity. 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 a contractor's 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.

Rather than developing one cost estimate as it did for Washington and Oregon, Lewin-VHI developed three cost estimates for region 6, varying the underlying assumptions[5] to reflect a low cost estimate, a high cost estimate, and a most-likely cost estimate. The most likely and lower cost estimates showed that total military health care costs (military hospitals and clinics and CHAMPUS) under the modified CRI program would be 3.5 percent and 7.7 percent, respectively, less expensive in region 6 than if the standard CHAMPUS program remained in effect. DOD's higher cost estimate showed that total costs with the modified CRI program would be about .8 percent more expensive.

Based on our review of the work conducted by Lewin-VHI to support DOD's certification, we believe that the cost comparison approach it employed for region 6 was reasonable. We agree with Lewin-VHI on the modified CRI program features that seem likely to increase and decrease costs relative to the standard CHAMPUS program. We also found that the Lewin-VHI assumptions on the magnitude of these likely changes were generally well supported. On this basis, we conclude that the methods used by Lewin-VHI

[5]These assumptions included those involving likely beneficiary enrollment, extent of utilization and claims management, varied provider discounts, etc.

to estimate the costs of the modified CRI program proposed for implementation in region 6 are sound.[6]

With regard to the potential impact in region 6 of the modified CRI program on access to care and quality of care, DOD relied on its earlier assessment of these factors done for expanding CRI into Washington and Oregon. That earlier assessment, in turn, was based heavily on beneficiaries' experiences under the CRI program in California and Hawaii which were extensively studied and reported on by RAND in 1993. In effect, DOD used the CRI experiences regarding beneficiaries' access to care and the quality of that care as a proxy for the likely prospective experiences for beneficiaries in both Washington and Oregon and in region 6. On this basis, DOD concluded that beneficiaries' access to care under the modified CRI program would be enhanced and that the quality of care would likely not be changed from that which beneficiaries would receive under standard CHAMPUS. We believe that DOD's approach to predicting the likely impact of the modified CRI program on access and quality is sound, particularly given the lack of more recent experiences than those under CRI.

Agency Comments

We discussed our report with officials in DOD's Office of the Assistant Secretary of Defense (Health Affairs). These officials agreed with our conclusions.

[6]In our September 1993 report concerning the expansion of CRI into Washington and Oregon, we stated that DOD had failed to compare CRI with two other approaches to managed care that it was testing. Since then, the law has been amended to require DOD to implement CRI nationwide by the end of fiscal year 1996. DOD believes that this new congressional direction supports its decision not to compare the cost of the modified CRI program with the cost of other approaches. Although the certification requirement is essentially unchanged, we agree that DOD's options regarding the implementation of CRI are now more restricted.

We are sending copies of this report to the Secretary of Defense; the Director, Office of Management and Budget; and 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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