

C O N G R E S S I O N A L T E S T I M O N Y



RAND

*The CHAMPUS Reform Initiative:
Implications for Military Health
Care Reform*

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Mr. Chairman, I am pleased to be here today to discuss CRI (the CHAMPUS Reform Initiative), which is the Department of Defense's large test of what is commonly called a managed-care health program. My statement will describe CRI, summarize the results of our evaluation, and discuss some implications of these results for the future of military health care.

DESCRIPTION OF THE CHAMPUS REFORM INITIATIVE

The Department of Defense implemented CRI in California and Hawaii beginning in August 1988 and continuing to the present. CRI modified both the CHAMPUS program and its interface with military treatment facilities, or MTFs. CRI has three goals: to improve beneficiaries' access to care and their satisfaction with it, to slow the growth in health care costs, and to maintain the quality of care. To achieve these goals, the program contracts with a civilian health care firm to manage the provision of all CHAMPUS services for a set price (with some adjustments) and to coordinate its efforts with the MTFs in the area. CRI is a very complex program, so I will describe only its main features.

The most visible feature of CRI is its two new health care options, which are added to the standard CHAMPUS program.

- The first new option, CHAMPUS Prime, resembles a health maintenance organization, or HMO. Out-of-pocket costs for Prime enrollees are minimal, and more preventive services are covered. In return, Prime enrollees are covered only for health care provided by MTFs or by a selected "network" of civilian health care providers who have agreed to discount their fees. Enrollees are assigned to

primary-care physicians, who act as their “gatekeeper” to specialty care. Enrollees are not eligible for the standard CHAMPUS or Extra options. The gatekeeper, the discounts, and a utilization review program for high-cost services are the principle cost-containment devices in CHAMPUS Prime.

- The second new option, CHAMPUS Extra, allows those who are not enrolled in Prime to realize some decrease in copayments if they use providers from the Prime network. Those who take advantage of the Extra option may switch to non-network providers and the standard CHAMPUS option at any time. Costs are contained in this program through discounts and utilization review.

To improve access, maintain quality, and increase coordination of MTF care and CHAMPUS, CRI also required the contractor to develop other programs. These include:

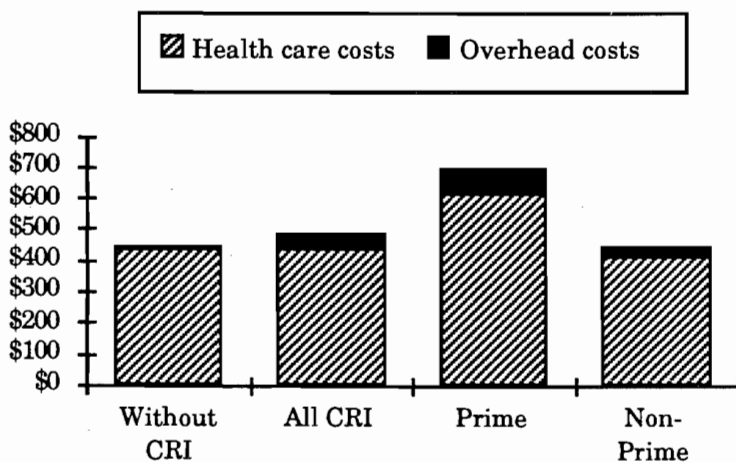
- A Health Care Finder in each MTF directs beneficiaries needing care to the most cost-effective source for that care, either military or civilian. At the same time, the Health Care Finder assists beneficiaries in accessing needed care.
- Resource Sharing agreements between the MTFs and the contractor allow the contractor to purchase resources to be used in the MTF for more efficient provision of care to CHAMPUS beneficiaries.
- Quality Assurance and Utilization Review programs maintain quality, control costs, and improve the appropriateness of the care provided through CHAMPUS.

The Fiscal Year 1987 DoD Authorization Act, which authorized the CRI demonstration, required an independent evaluation of the CRI program. DoD

asked RAND to conduct that evaluation. Our evaluation compared access, satisfaction, cost, and quality outcomes in 11 areas that had CRI¹ with outcomes in similar areas that did not implement CRI. We compiled an extensive data base on outcomes in late 1990, about two years after the demonstration began.

SUMMARY OF THE CRI EVALUATION FINDINGS

We found that access and satisfaction did improve, with almost all of the improvement occurring in CHAMPUS Prime. We estimated that costs for adults in CRI were 9 percent higher than they would have been without the new program (see figure below). The higher costs were largely due to two factors: major increases in utilization by Prime enrollees and a high administrative cost to operate the program. As for quality of care, data were limited, but we did not find any evidence that CRI fell short of maintaining quality.



**Cost per adult beneficiary in California and Hawaii
(Evaluation sites, May-October 1990)**

¹These 11 areas contained three-quarters of all CHAMPUS beneficiaries in the two-state CRI demonstration area.

In the rest of my statement, I will focus on access to care and costs. Since the outcomes of the demonstration differed for Prime enrollees versus those who did not enroll, I will discuss the two groups separately.

Beneficiaries Enrolled in CHAMPUS Prime

According to the evaluation results, CHAMPUS Prime did improve access to care and satisfaction for enrolled beneficiaries, but the cost was high. Most of the improvements in access that we detected were in Prime. Enrollees reported access problems less than half as often as we estimate they would have without CRI. Due to the enhanced coverage in Prime, they were also more likely to have had recommended preventive care. In part because of the better access in Prime, enrollees generally reported higher satisfaction with the care they received in the military system. When we asked enrollees directly about the Prime program, more than 90 percent said the program was at least as good as what they had before and that they would join again.

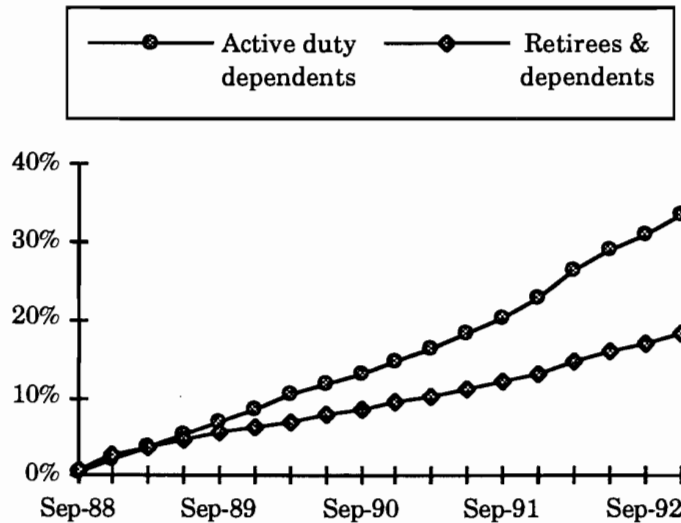
Enrollees responded to the better benefits and access by substantially increasing their utilization of health care services. For example, the average number of MTF and CHAMPUS outpatient visits per adult beneficiary increased by almost 50 percent in Prime, though the increase for children was small. For the adults, higher utilization and lower cost sharing in turn led to an increase in government costs of over 50 percent. These increases occurred despite the contractor's discounting and utilization review programs, and control of specialty referrals through the primary-care gatekeeper and the Health Care Finder.

Some of the utilization increase apparently can be traced to the structure of primary care in Prime. The option attracted a disproportionate number of persons who had been using MTFs for primary care and assigned them at enrollment to civilian primary-care providers; the result was a substantial increase in the fraction using CHAMPUS. Some of this utilization increase might be avoided in the future if the MTF assumed a greater primary care role for enrollees.

The increases in beneficiary demand that resulted from the enhanced benefits in Prime are consistent with other research on cost-sharing. However, costs in Prime were probably higher than in a comparable civilian plan for several reasons. First, we found that some families dropped other insurance after they enrolled in Prime. Dual coverage is probably more common in the military population because DoD does not charge a premium. As civilian employers increase the premium contributions and cost-sharing in their health plans, generous DoD plans such as CHAMPUS Prime will attract more of these so-called “ghost” beneficiaries. Second, our results indicate that CRI removed, at least for Prime enrollees, what had been a cost-containment mechanism before CRI—poor access to the free care provided in the MTFs.

The cost increase due to Prime is likely to increase over time without a redesign of the benefits. The proportion of the beneficiaries enrolled in California and Hawaii has continued to climb steadily, even though the continuation of the program has been uncertain (see figure below). In late 1990, almost 15 percent of all beneficiaries were enrolled in the areas we studied, and now the enrollment rate is over 25 percent in all CRI areas. We cannot be certain that the later enrollees used as much care as the early enrollees we studied, but their use would have to be dramatically lower to

bring CHAMPUS Prime costs in line with standard CHAMPUS. Areas without an MTF could experience even larger increases in costs in Prime because they have a higher proportion of retired beneficiaries, for whom the cost increase was especially high.



**Percent of Eligible Beneficiaries Enrolled in Prime
All CRI Areas**

Beneficiaries Not Enrolled in Prime: The Effects of CHAMPUS Extra

The redesign of standard CHAMPUS to include CHAMPUS Extra, the option that allows those not enrolled in Prime to save some money, appears to have had only minor effects on beneficiaries' access to care and satisfaction. Beneficiaries who did not enroll in Prime, particularly those with chronic health problems, did report fewer problems accessing health care than their counterparts in non-CRI areas. For all nonenrollees, satisfaction with access to the MTFs was slightly higher and satisfaction with other aspects of the military health system was unaffected.

CRI decreased the costs of health-care services for nonenrollees—both the costs paid by DoD and those paid by beneficiaries. With CHAMPUS administrative costs added in, CRI costs for this group were equal to the amount we estimated that they would have been without CRI.

Extra tries to contain costs by shifting beneficiaries to civilian providers who accept lower payments and deliver fewer inappropriate services. Beneficiaries receive an inducement to make this shift in the form of lower cost-sharing. Extra can also reduce costs by allocating patients between the MTF and CHAMPUS in a more efficient manner. That is, patients who can be treated at lower cost in the MTF can be referred there, and the same for CHAMPUS; also, the contractor can add resources to the MTF to improve efficiency.

For successful cost containment, the savings achieved through these mechanisms must be larger than any increase in costs from two potential sources. The first source is the increase in health care use that can be expected to occur with lower patient cost-sharing and easier access to care. The second source of higher costs is the added administrative overhead needed to operate Extra.

There is little evidence to suggest that the lower cost-sharing in Extra induced beneficiaries to demand more care. We do see evidence, though, of a trade-off between health care costs and program administrative costs. The effort to lower utilization and provider fees required a substantial administrative overhead, and the savings from lower utilization were offset by the higher costs of administration during the period we evaluated.

IMPLICATIONS FOR THE FUTURE

In closing, I would like to comment briefly on the lessons learned from CRI and the questions it raises for the future. CRI's Prime option has demonstrated one way to improve access to care and beneficiary satisfaction in this complex health care system. However, the option failed to meet its cost-containment objective. In contrast, CHAMPUS Extra was able to provide a more modest benefit improvement without raising costs. Further development of this option might well lead to cost reduction. I must caution, however, that the health care markets in California and Hawaii are atypical in some ways that may have facilitated managed care. Therefore, DoD will need experience with managed care in other areas to determine the effectiveness of this approach to providing military health care.

Another major demonstration program, Catchment Area Management (CAM), is expanding DoD's experience with managed care. CAM adds to the CRI experience because the CAM program differs in its geographic location, benefit design, and management approach. The five CAM demonstration sites are located in Oklahoma, Colorado, Arizona, Texas, and South Carolina, areas with varying health care characteristics. All the CAM sites have developed enrollment options that have less generous benefit packages than the Prime package. Furthermore, the benefits vary across CAM sites. Finally, care is managed by the MTF commander in CAM instead of by a civilian contractor. The commander manages all DoD health resources in his or her area, including CHAMPUS funds.

We are also evaluating CAM, using the same methods we used to evaluate CRI. We have just begun to analyze the CAM data, so I cannot give

you any results yet. We do know, though, that the beneficiaries who enrolled also reported favorable attitudes towards the program.

The experience from both demonstrations is being incorporated into the Comprehensive Study of the Military Health Care System, which was requested in Section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993. The language directs DoD to evaluate alternatives to the current system for providing health care to military beneficiaries.

I would like to close by observing that the experience with CHAMPUS Prime highlights the importance of a carefully designed military health benefit. A comprehensive health benefit is seen as an essential support for active duty families, who must move frequently and cope with the absence of their active duty members. Military retirees view their health care benefits as an important part of the compensation they were promised. However, many military beneficiaries do have private employer health coverage. If DoD improves the benefit it provides, more beneficiaries can be expected to shift their health care from employer plans to the DoD system. The declining DoD budget could not easily accommodate an increase in health care costs if beneficiaries make this shift. Thus, as the national health care system is reformed, DoD needs to look for ways to meet its obligations to its beneficiaries that do not lead to excessive cost growth.

