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SUMMARY REPORT TO THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES

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Potential For Improvements In The Civilian Health And Medical Program Of The Uniformed Services B-133142

Department of Defense

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 19, 197

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133142

Dear Mr. Chairman:

Reference is made to your request of October 20, 1969, that we make a comprehensive review of the military Medicare program--now called the Civilian Health and Medical Program of the Uniformed Services.

This is the fifth and final report in response to your request. It summarizes the information included in our four earlier reports, and presents our observations on several additional aspects of the program.

We have not obtained written comments from the Department of Defense on matters discussed in this report, but in conducting the review, we have discussed the substance of our findings with officials responsible for the program.

As arranged with your office, we are providing the Department of Defense with copies of this report. We plan to make no further distribution unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable George H. Mahon
Chairman, Committee on Appropriations
House of Representatives

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ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
GAO	General Accounting Office
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services

COMPTROLLER GENERAL'S SUMMARY REPORT
TO THE COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES

POTENTIAL FOR IMPROVEMENTS
IN THE CIVILIAN HEALTH AND
MEDICAL PROGRAM OF THE
UNIFORMED SERVICES
Department of Defense
B-133142

D I G E S T

WHY THE REVIEW WAS MADE

The Committee Chairman asked the General Accounting Office (GAO) to make a comprehensive review of the Civilian Health and Medical Program of the Uniformed Services. (See app. I.) Modifications to the request, agreed to by the Chairman's office, are discussed on pages 10 and 11.

Four reports have been issued on the program as the work was completed. They are:

--The Civilian Health and Medical Program of the Uniformed Services (interim report), May 19, 1970.

--Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen, March 16, 1971.

--Potential for Reducing Hospital and Administrative Costs Under the Civilian Health and Medical Program of the Uniformed Services, April 16, 1971.

--Costs of Physician and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services, July 1971.

Chapters 2 through 4 of this report summarize these earlier reports, and the remaining chapters contain the findings of the review of additional aspects of program activities.

FINDINGS AND CONCLUSIONS

Evaluation of total costs incurred

Annual program costs have increased from $33 million in fiscal year 1957 to over $237 million in fiscal year 1970. About $163 million of this increase has occurred since fiscal year 1966. Estimated 1971 costs will be almost $300 million. (See pp. 8 to 10.)

One-half of the cost increase in recent years was attributed by GAO to the additional benefits and the new beneficiaries authorized by the Military Medical Benefits Amendments of 1966. The remainder was due primarily to the higher cost of medical care and the increased use of the program by beneficiaries. (See pp. 8, 12 to 14, 18 and 19.)

Evaluation of fees

Program beneficiaries generally were charged the same for comparable care and services as were other hospital patients, and average payments to physicians under the program generally were in line with average payments made under other health programs. (See pp. 12 and 20.)

Evaluation of administrative expenses

The Office for the Civilian Health and Medical Program of the Uniformed Services had exercised limited managerial control; opportunities for cost reductions either had not been identified or had not been acted upon. GAO believes that the potential exists for substantial reductions in administrative costs. (See pp. 15, 21, 27 to 29, and 47 to 50.)

Eligibility of program participants

Procedures and controls over the issuance and recovery of identification cards--which are used to identify eligible beneficiaries to those who furnish medical care--were deficient at all nine military installations GAO visited. (See pp. 32 to 36.)

Adequacy of audits and reviews made by Government agencies

Audits made by the Department of Health, Education, and Welfare's Audit Agency have been adequate for determining the allocation and allowability of program administrative costs. The scope of the audits and time allowed for performing them in the past have been too limited, however, for the audits to function as an effective tool for management in several important areas of operations and cost effectiveness. Effective implementation of the Audit Agency's plans for expanded coverage of program activities should result in valuable benefits to the Government. (See pp. 15, 23, and 29.)

Improvements are also needed in reviews of program activities made by Defense organizations. (See pp. 16, 23, 29 and 50 to 53.)

Information program

There has been some improvement in the information program. About 92 percent of over 230 married active duty servicemen interviewed by GAO were aware of the program in varying degrees. As the information program becomes more effective, it is reasonable to expect that the use of the program and the associated costs will increase. (See pp. 41 to 44.)

Nonavailability of care at military hospitals

At the nine military hospitals visited, GAO did not find improper issuances of nonavailability statements--authorizations to obtain care from a civilian hospital. (See pp. 37 to 40.)

RECOMMENDATIONS OR SUGGESTIONS

Detailed recommendations which were presented in earlier reports are set forth in chapters 2 through 4. Additional recommendations for improving the program are shown in chapters 5, 8, and 9. (See pp. 16, 24, 25, 30, 31, 36, 46 and 48.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

Written comments have not been requested from the Department of Defense on matters contained in this report. In discussions with the Executive Director of the program, however, GAO was provided with a listing of actions recently taken to improve program operations. GAO believes that these actions, if properly implemented, will be beneficial. (See p. 53.)

MATTERS FOR CONSIDERATION BY THE COMMITTEE

Reduction in the lengths of hospital stay would have a significant effect on Federal expenditures for hospital care. Therefore the Committee may wish to consider the need for an analysis of the factors affecting lengths of stay, to identify steps that can be taken to reduce them without sacrificing the quality of medical care. (See p. 16.)

CHAPTER 1

INTRODUCTION

HISTORY AND FEATURES OF THE PROGRAM

The Civilian Health and Medical Program of the Uniformed Services[1] (CHAMPUS) provides medical care benefits from civilian sources for dependents of active members, retirees and their dependents, and the dependents of deceased members. The program, formerly called the Dependents' Medical Care Program (referred to as Medicare until the larger Social Security Administration program preempted the name), became effective on December 7, 1956. The program was redesignated CHAMPUS on January 1, 1967, to more fully indicate the expanded mission resulting from the Military Medical Benefits Amendments of 1966 (Pub. L. 89-614). These amendments increased the benefits available under the program and the beneficiaries eligible for the program.

Under the original program as authorized by the Dependents' Medical Care Act of 1956 (10 U.S.C. 1071) only dependent spouses and children of active duty members were eligible for benefits. The amendments added retirees and their dependents and the dependents of deceased members. At age 65 these added beneficiaries, who become entitled to medical care under the Social Security Medicare Program, lose their eligibility for CHAMPUS benefits. Also, benefits are not payable under CHAMPUS to the extent that the costs of medical care are paid by other insurance provided by law or through employment to retired members, their dependents, or dependents of deceased members.

The determination of eligibility for CHAMPUS is the responsibility of the uniformed service of which the

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[1] The term "uniformed services" includes the Army, Navy, Air Force, Marine Corps, the Coast Guard, and the commissioned corps of the U.S. Public Health Service and the National Oceanic and Atmospheric Administration (formerly the Environmental Science Services Administration).

sponsor[1] is or was a member. Eligible persons are issued an identification card on which eligibility for CHAMPUS is indicated.

Benefits available under the program cover a wide range of health and medical services. Initially these benefits included only physician services furnished on an inpatient basis and hospital care. The amendments added outpatient care, drugs, and, for dependents of active duty personnel, special handicap care. Specifically excluded from the program were routine physical examinations, routine care of the newborn, routine eye examinations, and dental care--except handicapping conditions and care furnished as a necessary part of medical or surgical treatment.

Costs of the medical services provided to eligible beneficiaries are shared by the Government and the beneficiary. The cost-sharing arrangement which applies to dependents of active duty members is different from that which applies to retirees, their dependents, and the dependents of deceased members. A special cost-sharing arrangement applies to the handicap program, where the active duty member pays a part of the monthly cost of care based upon his pay grade. These arrangements are described in the earlier reports.

Dependents of active duty members residing with their sponsors must obtain a nonavailability statement certifying that, as determined by the local commander, it is not practicable for the required inpatient care to be furnished by facilities of the uniformed services. This statement authorizes the dependent to obtain treatment at a civilian facility. All other CHAMPUS beneficiaries have the freedom to select a uniformed service or a civilian medical facility without being required to obtain the nonavailability statement.

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[1]A sponsor is or was an active duty member or a retired member of the uniformed services from whom a dependent derives eligibility for medical care under CHAMPUS.

HOW THE PROGRAM IS ADMINISTERED

Responsibility for administration of the program has been delegated from the Secretary of Defense and the Secretary of Health, Education, and Welfare, through channels, to the Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). Activities of OCHAMPUS include (1) development and implementation of a public information program to inform entitled personnel of the available benefits, (2) preparation of a manual explaining policies and procedures for use by providers of services, (3) preparation of suggested changes to the regulations and to a booklet explaining the program, and (4) operation of an information center for providing assistance to families with handicapped children.

OCHAMPUS has contracted with the Blue Cross and Blue Shield medical agencies, private insurance companies, State medical societies, or combinations of these organizations to process and pay all claims for medical care, except those from Canada and Mexico and some special claims which are processed at OCHAMPUS. The Blue Cross Association and Mutual of Omaha Insurance Company have contracted with OCHAMPUS for paying hospital claims. Blue Cross pays claims in 33 States, the District of Columbia, and Puerto Rico. Mutual of Omaha pays hospital claims from the remaining 17 States.

There are 45 different contractors, or fiscal agents as they are commonly called, who process physician, drug, and handicap claims for the 50 States, the District of Columbia, and Puerto Rico. Of these fiscal agents, 22 are also the fiscal agents (carriers) for the Social Security Medicare Program.

OCHAMPUS contracts with the fiscal agents are the cost-reimbursement type, under which administrative costs incurred in processing and paying claims are paid by OCHAMPUS. These costs are normally paid at a provisional rate for each claim processed pending a final determination of costs based on audits made by the Department of Health, Education, and Welfare's auditors.

Effective January 1, 1970, OCHAMPUS began converting from a system of funding fiscal agents in advance for payment of claims to a correspondent bank method. Under the

correspondent bank method, necessary funds are wired to the fiscal agent's bank after the fiscal agent has written the checks to the providers of care. The checks are released by the fiscal agent after the funds arrive at the bank. This method eliminates the former situation, in which the interest-free funds were held by the fiscal agents.

Each of the uniformed services budgets separately for CHAMPUS. The funding program for CHAMPUS is a consolidation of the programs of all the uniformed services prepared by the Office of the Surgeon General, Department of the Army.

PROGRAM COSTS

Our report dated May 19, 1970, showed the trends in the costs of CHAMPUS from its inception through fiscal year 1969 and discussed the annual changes. It showed also that the total costs for benefits provided under CHAMPUS generally had followed the trend of medical care prices in the Consumer Price Index over the years, although the rate of increase for CHAMPUS was greater during fiscal years 1968 and 1969. Benefit payments made by the Government for fiscal year 1970 were $237.5 million compared with $218 million[1] for fiscal year 1969. Costs were allocated to the period in which care was provided, regardless of when the payment was made.

A substantial part of the increase in annual program costs--from $32.9 million for fiscal year 1957 to $237.5 million for fiscal year 1970--occurred because the program expanded as a result of the 1966 amendments. About $79.8 million, or 49 percent of the $163.1 million increase from fiscal year 1966 to fiscal year 1970, was attributable to the additional benefits and the additional beneficiaries authorized by the amendments. Other reasons for the increase were the higher cost of medical care and the increased use of the program by beneficiaries.

Current estimates made by OCHAMPUS of the costs of program benefits for fiscal years 1969, 1970, and 1971 will exceed the budgeted costs shown in the President's budget, as follows:

Fiscal year	Presidential budget	OCHAMPUS estimates	Excess over Presidential budget
1969	$205,800,000	$229,041,000	$23,241,000
1970	225,700,000	270,335,000	44,635,000
1971	226,900,000	294,727,000	67,827,000

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[1]The difference from the $197.3 million shown in our May 1970 report is due to fiscal year 1969 claims processed since our previous report.

Benefit payments made by the Government in fiscal year 1970 were distributed as follows:

	Number of claims (percent)	Program costs (percent)
Dependents of active duty members	64	74
Dependents of retirees and deceased members	27	20
Retired members	9	6

Hospital costs

Hospital costs are the major part of the CHAMPUS expenditures, the $140.5 million paid for hospital care in fiscal year 1970 being 59 percent of total program costs. CHAMPUS hospital costs increased for all types of beneficiaries in fiscal year 1969. The number of claims paid for dependents of active duty members decreased slightly in fiscal year 1970, but the number of claims paid for other types of beneficiaries increased. OCHAMPUS reported that the increased use of civilian hospitals was due, in part, to the closing of some military medical facilities which had served a sizable number of retirees, their dependents, or dependents of deceased members.

The average cost per hospital claim increased from $183 in fiscal year 1966 to $378 in fiscal year 1970, an increase of 107 percent. The average length of hospital stay increased from 5.6 days in fiscal year 1966 to 7.2 days in calendar year 1969. The increase was due primarily to the addition in January 1967 of benefits for long-term hospitalization for emotional disorders and chronic diseases and to the fact that an older age group was under the expanded coverage.

Physician costs

As shown in our report dated May 19, 1970, physician costs began rising sharply in fiscal year 1967 after being relatively stable during most of the program. Total physician costs increased from $27.2 million in fiscal year 1966

to $84.4 million in fiscal year 1970, an increase of 210 percent. For example, as part of the additional benefits authorized by the 1966 amendments, CHAMPUS costs for outpatient psychiatric treatment were $7.4 million in fiscal year 1970 compared with $1.2 million in fiscal year 1967.

Handicap benefits

The handicap portion of CHAMPUS represented about 4 percent of total CHAMPUS costs in fiscal year 1970. The costs and number of claims increased from $6.7 million and 27,000 in fiscal year 1969 to $8.9 million and 37,000 in fiscal year 1970. The major change was the increase for dental handicapped cases. Use of the program also increased substantially as more military families became aware of the availability of the benefits.

Outpatient drug program

The Government paid $2.8 million for 140,000 drug claims in fiscal year 1970 compared with $1.8 million for 117,000 claims in fiscal year 1969. Individual prescriptions increased from 580,000 to 844,000. Increased usage was attributed to the increased awareness on the part of beneficiaries of the scope of prescription coverage.

Our review was limited to the CHAMPUS portion--in the United States, Puerto Rico, Canada, and Mexico--of the overall Uniformed Services Health Benefits Program. The overall program includes medical care benefits in facilities of the uniformed services as well as under CHAMPUS. Care may be obtained, on a space available basis, by retirees at facilities of the Veterans Administration and by dependents of active duty members from Indian or Alaskan native medical facilities.

Because of the lack of criteria and data for determining the reasonableness of charges and profits made by hospitals and physicians--as requested by the Committee--agreement was reached with the office of the Chairman to concentrate our efforts on comparing

--hospital charges to CHAMPUS with charges made to other medical programs and to uninsured persons and

--payments made to physicians under CHAMPUS with payments made under other medical programs.

It was also agreed that we would report on large amounts paid to physicians under CHAMPUS during selected periods. The results of this work are summarized in chapters 2 and 3.

Four previous reports on CHAMPUS have been issued to the Committee under B-133142 as shown below.

Title	Date of issue
The Civilian Health and Medical Program of the Uniformed Services	May 19, 1970
Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen	March 16, 1971
Potential for Reducing Hospital and Administrative Costs Under the Civilian Health and Medical Program of the Uniformed Services	April 16, 1971
Costs of Physician and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services	July 1971

CHAPTER 2

HOSPITAL CHARGES, ADMINISTRATIVE COSTS

AND OTHER MATTERS RELATED TO HOSPITAL CARE

This chapter briefly summarizes the detailed report on this subject dated April 16, 1971, previously furnished to the Committee on Appropriations, House of Representatives.

INCREASED COSTS

Increased hospital charges, along with such other factors as expanded benefits and the addition of new classes of eligible beneficiaries (authorized by the Military Medical Benefits Amendments of 1966), and increased use of the program have significantly increased costs of the program since its inception in 1956. The major increase occurred in recent years when costs for hospital care increased from $46.2 million in 1966 to $134.5 million in 1969. (See pp. 8 to 13 and exhibit A of the detailed report.)

COMPARISON OF HOSPITAL CHARGES

A comparison of hospital claims paid under CHAMPUS with amounts paid under several medical insurance programs and a review of hospital billing procedures showed that CHAMPUS beneficiaries generally were charged the same for comparable care and services as were other hospital patients. We found that, although hospital charges had been consistently applied, the total charge per claim for insured patients, including CHAMPUS beneficiaries, had exceeded that for uninsured patients primarily because of a longer average length of hospital stay. (See pp. 14 to 20 of the detailed report.)

The average length of hospital stay for maternity cases involving care without complications under the program differed widely among hospitals and among geographical areas. Also, the average length of stay for maternity cases under CHAMPUS was longer than that for similar cases in military hospitals. Significant savings to the program could be made if, without reducing the quality of care, the lengths of stay for maternity cases could be brought more into line

with the shorter lengths of stay experienced at some hospitals. But we are not in a position to say whether a shorter length of stay is feasible. (See pp. 15 and 19 to 23 of the detailed report.)

Hospitals generally charged less than cost for maternity care but recovered their total costs by charging more than cost for other services. It appears that hospital charge systems are designed, in general, to recover total operating costs rather than costs for specific services. As a result of these practices, CHAMPUS pays less than cost for maternity cases, which constitute about one third of the hospital claims under the program. In contrast, the Federal Employees Health Benefits Program received less advantage from maternity cases because, during the period 1966-69, only 11 percent of hospital admissions under that program were for such care. (See pp. 17 to 19 of the detailed report.)

Total payments to hospitals under CHAMPUS were significantly affected by hospital reimbursement agreements between participating hospitals and the Blue Cross Plans administering the program. These agreements generally provide that the hospitals--in consideration of the Plans' making prompt payments and thereby minimizing collection efforts and eliminating bad debts--accept less than their normal charges for services rendered to the Plans' subscribers. The benefits of these agreements were given to the program by 39 of the 52 Blue Cross Plans which process CHAMPUS claims. In fiscal year 1968 this practice resulted in the program's paying about $2.3 million less than would have been paid without the benefits of these agreements.

The 13 remaining Plans reimbursed hospitals for CHAMPUS claims on different bases from those used for their own private subscribers. We estimate that the program could have saved about $850,000 annually had the Plans been able to extend to the program the more favorable reimbursement rates. (See pp. 24 and 25 of the detailed report.)

RISING COST OF HOSPITAL CARE

The rise in salary expense, which accounts for almost two thirds of hospital operating expenses, is the major reason for the dramatic increase in the cost of hospital care

in recent years. The Nation's community hospitals have experienced an average payroll increase of 74 percent during the period 1965-69, mainly because of increased salary expenses and increased hospital work forces which have resulted in more hospital employees per patient. Hospital employees have traditionally been underpaid, but, due to labor and wage legislation and to the effect of unionization, hospital employees' salaries have increased significantly in recent years. (See pp. 26 to 31 of the detailed report.)

Other factors contributing to rising hospital costs are

--new high-cost services now available in community hospitals, and

--the increase in the number of services customarily provided. (See pp. 32 to 35 of the detailed report.)

EXTENT THAT HOSPITAL COSTS MIGHT BE REDUCED

Medical officials believe that reducing unnecessary hospital admissions and shortening the lengths of hospital stay to the minimum number of days needed for good quality care can reduce medical care costs significantly. Attempts currently are being made to control unnecessary hospital admissions and lengths of stay, but current patterns of health insurance provide little incentive to encourage general acceptance.

Studies indicate that the prepaid group practice method for delivery of medical care may be more economical than the more common fee-for-service method. The prepaid group practice method, which emphasizes preventive care, motivates physicians to limit hospital use to the minimum consistent with good care. The fee-for-service method lacks similar incentives to limit hospital use.

Other methods being used to control hospital costs are service-sharing agreements, utilization review committees, preadmission testing, employee incentive programs, reimbursement incentive programs, and the planning and coordinating of hospital services. Serious problems exist that must be solved if the attempts to control rising hospital

costs are to have a significant impact. (See pp. 39 to 60 of the detailed report.)

REASONABLENESS OF ADMINISTRATIVE COSTS

Payments by OCHAMPUS to selected fiscal agents for costs incurred in processing hospital claims were, for the most part, allowable under contract provisions. OCHAMPUS, however, has exercised limited managerial control, and opportunities for cost reductions had not been identified or had not been acted upon by responsible officials. We believe that there is a potential for substantial reductions in administrative costs. (See pp. 61 and 62 of the detailed report.)

Savings would have been achieved if OCHAMPUS had eliminated the claims review procedure of the Blue Cross Association--a prime contractor--since the procedure essentially duplicates reviews previously made by Blue Cross Plans--the subcontractors. Investigations should have been made into the wide variances in administrative claim rates paid to the 52 Plans. The rates ranged from $1.25 to $8.64 per claim during 1968. (See pp. 61 to 69 of the detailed report.)

We believe that further savings might be possible if OCHAMPUS were to take advantage of differences in certain geographical areas between administrative costs per claim charged by Blue Cross Plans and those charged by Mutual of Omaha and were to award contracts, on a competitive basis, for paying the claims. (See pp. 66 and 67 of the detailed report.)

ADEQUACY OF AUDITS

Audits by the Department of Health, Education, and Welfare's Audit Agency at selected fiscal agents where we made our review were adequate for determining the allowability and allocability of administrative costs. But the scope of the audits and the time spent on them were too limited for the audits to function as an effective tool of management for such matters as the reasonableness of administrative costs and hospital charges, the eligibility of beneficiaries, and the efficiency of fiscal agents. (See pp. 70 to 72 of the detailed report.)

In December 1967 OCHAMPUS created its own review team to evaluate contractor performances, but it did not visit any hospital fiscal agents until September 1970. (See p. 65 of the detailed report.)

RECOMMENDATIONS OR SUGGESTIONS

We believe that the Executive Director, OCHAMPUS, should consider

--looking into the differences in certain geographical areas between the administrative costs per claim charged by the Blue Cross Plans and those charged by Mutual of Omaha and, where it appears advantageous to do so, changing fiscal agents;

--requesting proposals from other commercial insurance firms to act as fiscal agents for the program;

--investigating the causes for differences in operating efficiency which appear to exist among fiscal agents and taking necessary action to improve operations of the less efficient agents;

--attempting to obtain the more favorable Blue Cross reimbursement formulas for paying hospitals in areas where CHAMPUS is not obtaining them;

--discontinuing the duplicate claim review procedure of the Blue Cross Association;

--arranging with Department of Health, Education, and Welfare's Audit Agency officials for an expansion of the audit effort and scope of review of CHAMPUS; and

--initiating a pilot program to determine the feasibility and economy of paying CHAMPUS claims on a prepaid group practice basis. (See pp. 74 and 75 of the detailed report.)

MATTERS FOR CONSIDERATION BY THE COMMITTEE

Reductions in the lengths of hospital stay would have a significant effect on Federal expenditures for hospital

care. Therefore the Committee may wish to consider the need for an analysis of the factors affecting lengths of stay, to identify steps that can be taken to reduce them without sacrificing the quality of medical care. (See pp. 21 to 23, 40 to 44, and 75 of the detailed report.)

CHAPTER 3

COST OF PHYSICIAN AND PSYCHIATRIC CARE

The payments to physicians, including psychiatrists; the surveillance over the cost and quality of services; and the related administrative costs and audits are the subjects of our report issued in July 1971 to the Committee on Appropriations, House of Representatives. The subject matter of that report is briefly summarized in this chapter.

As of September 30, 1970, physician claims under CHAMPUS were being paid under 48 contracts with Blue Shield and Blue Cross agencies, State medical societies, and private insurance companies. These organizations processed and paid $84.4 million in physician fees under CHAMPUS for fiscal year 1970. (See pp. 7 and 8 of the detailed report.)

USE OF THE REASONABLE-CHARGE CONCEPT TO PAY PHYSICIANS

Maximum-fee schedules for paying physician claims were discontinued and the reasonable-charge concept was adopted in 1967 and 1968. Under the reasonable-charge concept, also adopted by the Social Security Medicare program in 1966, a physician receives his customary charge for each service rendered, as long as it is within the prevailing level of charges made for the service by other physicians in the same locality.

Physician profiles--histories of each physician's past charges for a specific medical service, which are used to determine each physician's customary charge for that service--were adopted by the program for determining reasonable charges. The prevailing charge, derived from individual physician profiles, was the charge most frequently and widely used by physicians in a locality for a particular medical procedure.

We noted that the controls provided by the use of profiles were somewhat limited, since they enabled physicians, over a period, to influence the amounts they would receive

for specific procedures by charging higher fees which would eventually provide the justification for increased fees. (See p. 9 of the detailed report.)

Our tests and studies by the Department of the Army show that average amounts paid for selected medical procedures have increased as much as 70 percent in some States since the reasonable-charge concept has been adopted. Reasons given by fiscal agent officials for the increase included (1) the use of usual and customary fees encouraged physicians to develop a higher profile, through increased charges in their billings, (2) the trend toward specialization, and (3) the fact that, under fee schedules, some physicians had charged only what they knew was allowable, although their normal charge might have been higher. (See pp. 9 and 17 of the detailed report.)

We found that there was little standardization among the fiscal agents in the bases for paying claims against CHAMPUS. Many did not consider customary charges of physicians and paid fees based on schedules of allowances or relative value scales--a method of determining the amount of a physician's fee for a particular service by using agreed levels of units of effort and an assigned value per unit. (See pp. 10 to 13 of the detailed report.)

The establishment of physician profiles for paying reasonable charges does not appear feasible or economical for many CHAMPUS fiscal agents, because (1) the volume of claims for many medical procedures is insufficient for valid profiles and (2) the costs for establishing and maintaining profiles are high. (See pp. 14 and 15 of the detailed report.)

A different procedure for determining fees to be paid to physicians under CHAMPUS may be warranted because of problems or potential problems in implementing the reasonable-charge concept--such as the significant increase in, and the reduced control over, the level of physician fees--and because of the high administrative costs associated with the use of physician profiles. (See pp. 14 to 18 of the detailed report.)

COMPARISONS OF PAYMENTS TO PHYSICIANS

Average payments made for selected procedures under CHAMPUS generally were in line with average payments under other health care programs. Comparisons of amounts charged by individual physicians against CHAMPUS with amounts charged against other health care programs for the same medical procedures showed that some physicians charged one program more than they charged another for the same service--possibly because of complications in individual cases. We found, however, no indications of CHAMPUS' being charged consistently higher amounts. (See pp. 19 to 25 of the detailed report.)

SUBSTANTIAL AMOUNTS PAID TO INDIVIDUAL PHYSICIANS, CLINICS, AND GROUP PRACTICE ORGANIZATIONS

The number of physicians or clinics and group practices receiving more than $20,000 from CHAMPUS in 1969 increased about 72 percent over the previous year. Of these, 13 physicians--eight of whom were psychiatrists--received over $50,000 each. (See pp. 25 and 26 of the detailed report.)

PSYCHIATRIC CARE

Psychiatric care benefits under CHAMPUS generally are more liberal than those under other health programs. Approval is required for more than 90 days of care, but there is no limitation on the dollar value or the number of days of care that may be authorized. Extensive care was being provided to program beneficiaries and several psychiatrists were being paid large amounts under CHAMPUS. There is a need for guidelines for authorizing psychiatric care and a need for some controls over the extent to which this care is furnished. (See pp. 27 to 32 of the detailed report.)

The fiscal agents included in our review made no attempts to determine whether patients receiving psychiatric care in high-cost facilities could obtain the prescribed care in lower cost facilities. (See p. 33 of the detailed report.)

We found that psychiatric care had been approved and provided in facilities which did not conform to criteria prescribed by OCHAMPUS. (See pp. 33 to 37 of the detailed report.)

UTILIZATION REVIEWS OF MEDICAL CARE FURNISHED

None of the four fiscal agents included in our review had made utilization reviews--evaluations of the quality, quantity, or timeliness of medical services--on a systematic basis, but one of them had recently implemented procedures which should help in performing adequate reviews. Limited guidance for establishing utilization review procedures has been provided by OCHAMPUS to fiscal agents. We believe that effective utilization reviews are necessary. (See pp. 38 to 41 of the detailed report.)

ADMINISTRATIVE COSTS AND WEAKNESSES IN CONTROLS

Administrative costs of fiscal agents' processing physician claims against CHAMPUS increased from $754,000 in fiscal year 1966 to $5.8 million in fiscal year 1970. Reasons for the increased costs include (1) the need for computerization of fiscal agent operations to handle the increased claims resulting from the expansion of benefits and the increased use of the program, (2) full allocations of costs to CHAMPUS because it became a larger part of fiscal agents' business, and (3) the hiring and training of additional personnel by the fiscal agents to cope with the expanded program authorized by the Military Medical Benefits Amendments of 1966. (See pp. 42 and 43 of the detailed report.)

There is a lack of standards for evaluating the performance of fiscal agents. Widely varying costs for processing CHAMPUS claims and different levels of contract performance have been accepted. During fiscal year 1970 the costs per claim for individual fiscal agents ranged from $2.37 to $9.93. (See pp. 43 to 47 of the detailed report.)

We identified problems in which payments made by the California fiscal agent for physician claims for obstetrical and psychiatric care resulted from errors in computer

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programs and a lack of management controls. We are performing an additional review to ascertain the extent and significance of these deficiencies. (See pp. 29 and 48 of the detailed report.)

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HANDLING OUTPATIENT DEDUCTIBLE AND OTHER INSURANCE PROVISIONS

A deductible is applied against claims submitted for outpatient care. Also payments made to physicians on behalf of certain beneficiaries as a result of other insurance must be applied against related claims under CHAMPUS. We noted that CHAMPUS was incurring additional costs by not limiting the amount physicians receive in these instances to the amount payable through application of the reasonable charge criteria. (See pp. 51 to 57 of the detailed report.)

CHAMPUS legislation requires that all beneficiaries other than dependents of active duty members declare other medical insurance provided by law or through employment. We believe that an opportunity for reduced costs would exist if the same legal and administrative provisions pertaining to other insurance were applied to all beneficiaries. (See pp. 56 and 57 of the detailed report.)

The certification of other insurance on the claim form is worded in a manner which provides no means for indicating that the claimant is covered by other insurance which may pay a portion of the claimed amount. We believe that the certification statement should be revised to elicit a more informative response from the claimant. (See pp. 57 and 58 of the detailed report.)

NEED FOR EXPANDED AUDIT COVERAGE AND RELATED EVALUATION CONTROLS

We found that audit work performed by the Department of Health, Education, and Welfare's Audit Agency in reviewing the activities of CHAMPUS fiscal agents had been limited. The time spent by the Audit Agency on the assignments was insufficient to adequately cover fiscal agents' activities. We believe, however, that the expanded coverage planned by the Audit Agency staffs should result in valuable benefits to the Government. (See pp. 59 to 63 of the detailed report.)

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Reviews of the performance of physician fiscal agents made by the Contract Performance Review Branch of OCHAMPUS were limited by the inability to make adequate evaluations

of activities in the brief time spent on each review. This restricted their effectiveness and precluded overall evaluations of fiscal agents' activities. We believe that these reviews would be more useful to management if they were expanded in scope and were made in depth. (See pp. 60 and 61 of the detailed report.)

RECOMMENDATIONS OR SUGGESTIONS

We believe that the Executive Director, OCHAMPUS, should consider

--developing a more effective and less costly method for determining the amounts to be paid to physicians (see p. 18 of the detailed report);

--issuing guidelines for use in establishing effective controls over psychiatric care, such as more frequent reviews of cases involving extensive outpatient visits, therapy sessions, and hospital stays (see p. 37 of the detailed report);

--seeking ways to use available Government facilities for both inpatient and outpatient psychiatric care of dependents and ways to transfer patients to lower cost civilian or Government facilities whenever it appears to be medically feasible (see p. 37 of the detailed report);

--establishing and enforcing more definitive criteria for approving psychiatric facilities under CHAMPUS (see p. 37 of the detailed report);

--providing guidelines outlining the requirements for acceptable utilization reviews, approving the utilization review systems of the fiscal agents, and conducting effective surveillance to ensure that these systems are properly implemented (see p. 41 of the detailed report);

--establishing performance standards to effectively evaluate and compare the operations of fiscal agents and taking prompt action to improve the operations o

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fiscal agents whenever their costs or levels of performance are considered to be unacceptable (see pp. 49 and 50 of the detailed report);

--applying the reasonable-charge limitation to charges billed to beneficiaries for payment under the deductible provisions and limiting payments to physicians, when combined with other insurance payments, to the reasonable charge for services rendered (see pp. 54 and 56 of the detailed report);

--proposing legislation which would require dependents of active duty members to report other insurance provided by law or through employment (see p. 57 of the detailed report); and

--revising the claim form to elicit a more informative response as to whether the beneficiary has other health insurance coverage (see p. 58 of the detailed report).

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CHAPTER 4

PROGRAM FOR PROVIDING BENEFITS TO HANDICAPPED PERSONS

This chapter summarizes the salient matters included in the detailed report on this subject dated March 16, 1971, previously furnished to the Committee on Appropriations, House of Representatives.

COST SHARING AND LIMITS

The law authorizes care for dependents of active duty personnel who are moderately or severely mentally retarded or seriously physically handicapped but precludes less severe cases from benefits under the handicap portion of CHAMPUS. Members of the uniformed services or their dependents are required to share in the cost of the benefits and must contribute from $25 to $250 a month according to a graduated scale based upon military grade. Maximum benefits of $350 a month[1] for each beneficiary are payable by the Government. (See pp. 5 and 6 of the detailed report.)

INCREASING COSTS OF THE HANDICAP PORTION OF CHAMPUS

Costs of the handicap portion of CHAMPUS have increased annually since inception on January 1, 1967. By June 30, 1970, over $18 million had been paid in benefits, of which about $5.6 million was for dental claims. About 6,000 physical handicap and mental retardation cases were approved by OCHAMPUS from January 1967 through December 1969. Most of the cases involved continuing care rather than care on a one-time basis, such as providing hearing aids and wheelchairs. An estimated 30,000 cases for dental handicap care have been approved by OCHAMPUS. (See pp. 8 and 9 of the detailed report.)

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[1] This maximum applies to the first beneficiary in a family. For additional beneficiaries in a family there is no limitation to the Government's share.

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LIBERAL INTERPRETATION OF LAW

Since the purpose of the law creating CHAMPUS is to create and maintain high morale throughout the uniformed services, OCHAMPUS officials consider the act to be beneficial legislation and have applied a liberal interpretation in approving care to be paid under the program. These liberal approvals of care have increased the costs borne by the Government. (See pp. 10 to 19 of the detailed report.)

ADMINISTRATION OF HANDICAP BENEFITS

Several decisions of the Executive Director, OCHAMPUS, which we believe to be in the interest of good management, have been disapproved or substantially modified by higher headquarters. Consequently, benefits have been liberalized and the Government has incurred added costs. Also the overruling of OCHAMPUS decisions has inhibited the efforts and attitude of OCHAMPUS in carrying out its responsibilities. (See pp. 28 to 32 of the detailed report.)

NEED FOR AUTHORITATIVE STANDARDS FOR DETERMINING DEGREE OF HANDICAP

Specific and authoritative standards were not being used for determining the degree of handicap. We noted inconsistencies in the determinations and the approval of cases which may be questionable. (See pp. 10 to 19 of the detailed report.)

BETTER SUPPORT NEEDED FOR EVALUATION OF CASES

In the absence of specific standards for evaluating the degree of the handicap condition, OCHAMPUS relies upon statements of attending physicians, which in some cases are very brief or incomplete. This has led to poorly supported judgments on whether care will be provided and has resulted in approval of cases under the wrong portion of CHAMPUS. The two alternatives are the program for the handicapped and the basic health and medical program for military dependents generally. (See pp. 20 and 21 of the detailed report.)

Placement under the proper portion of CHAMPUS is important because of the different cost-sharing arrangements

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between the servicemen and the Government and because of the different benefits available. The Government's liability may be more or less depending on these factors and on related considerations. (See p. 20 of the detailed report.)

ERRORS AND OMISSIONS IN DATA USED FOR PAYMENT OF CLAIMS

Claims in the program for the handicapped are paid by fiscal agents hired under contract. The basis for payment of the claims is provided by management plans, which are documents setting forth the medical diagnosis of the beneficiary; the details of the care authorized, including duration; the estimated total cost of the care and the share of the total to be paid by the serviceman; and other pertinent data.

Our review showed many errors and omissions in the management plans. For example, in some cases servicemen's pay grades--which determine the cost-sharing ratio--were incorrect. In other cases information was not properly supported by backup data. Therefore control over the program for the handicapped was seriously impaired. (See pp. 22 to 24 of the detailed report.)

APPROVAL AFTER CARE HAS BEEN RECEIVED OR STARTED

We found, in 62 of 69 randomly selected cases, that approval had been given after the care had been started or had been received, although policy requires advance approval. An OCHAMPUS official said that, in some instances, care had been approved retroactively because beneficiaries had started receiving care before they learned that they were entitled to benefits under the program. He also stated that beneficiaries had applied belatedly for benefits because they were unaware that advance approval was required. Another reason given for retroactive approval was that there were backlogs in processing applications. (See pp. 22 and 23 of the detailed report.)

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WRITTEN INSTRUCTIONS NEEDED
TO ACHIEVE UNIFORM ACTIONS

Because of a lack of written guidance to fiscal agents and because of inadequate control over their operations, the agents made errors in paying claims and used different bases for payment. We found that the agents visited had not determined whether the providers' charges were reasonable. Written instructions are needed to achieve uniform actions by fiscal agents, to minimize confusion, and to ensure that payments conform with policy. (See pp. 25 to 27 of the detailed report.)

USE OF MEDICAL EXPERTISE
AVAILABLE AT FITZSIMONS GENERAL HOSPITAL
AND LONGER TOURS OF DUTY
FOR MILITARY PERSONNEL

Administration should improve if OCHAMPUS makes increased use of medical expertise available at the adjacent Fitzsimons General Hospital and if longer tours of duty are authorized for military personnel in OCHAMPUS or if the positions are assigned to civilians.

After completion of our fieldwork, recently appointed OCHAMPUS officials advised us in December 1970 that more extensive use of medical expertise at Fitzsimons General Hospital was being made. (See pp. 33 and 34 of the detailed report.)

INADEQUATE AUDIT COVERAGE
OF THE HANDICAP PORTION OF CHAMPUS

The most recent audit of OCHAMPUS operations made by the U.S. Army Audit Agency in 1968 did not cover the handicap portion of CHAMPUS. At the four fiscal agents we visited, the Department of Health, Education, and Welfare's Audit Agency's coverage of the program was limited to reviewing any claims for handicap care that chanced to be included in sample selections of claims representing the entire CHAMPUS. Also OCHAMPUS Contract Performance Review Branch personnel do not specifically consider the handicap portion of the program when visiting fiscal agents.

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On the basis of our review of the program for the handicapped, we feel that there is a need for increased audit efforts on the program at both the OCHAMPUS and the fiscal agent level. (See pp. 34 and 35 of the detailed report.)

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of Defense, in consultation with the Secretary of Health, Education, and Welfare, where appropriate, should consider

--revising the criteria and standards for approving handicap care to include, wherever possible, standards established by authoritative medical organizations for use as guidelines in approving benefits;

--seeing that, in approving benefits under the program, due regard is given to economic considerations; for example, using the least costly of comparable treatments;

--reevaluating, in the light of medical evidence, Department of Defense policy decisions that appear to increase the cost of the program unnecessarily;

--reducing turnover in key management positions of OCHAMPUS, by either establishing longer tours of duty for military personnel or assigning civilians to the positions; and

--requiring that groups responsible for audits of the program for the handicapped intensify their efforts. (See p. 36 of the detailed report.)

The Executive Director, OCHAMPUS, should consider

--establishing a committee of medical personnel to decide the types of cases that should be approved;

--establishing a standard format for use by physicians in making diagnoses, to facilitate or encourage the preparation of complete medical statements;

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--providing detailed, written instructions for use by fiscal agents in processing claims for payment;

--requiring that fiscal agents make every effort to determine the reasonableness of charges for care provided and requiring inclusion of certification on handicap claims submitted by all sources of care that the charges do not exceed those for all other patients receiving comparable services; and

--taking steps to reduce to a minimum retroactive approvals of care under the program for the handicapped. (See pp. 36 and 37 of the detailed report.)

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CHAPTER 5

ELIGIBILITY OF PARTICIPANTS UNDER CHAMPUS

The primary means used to indicate eligibility for CHAMPUS benefits is an identification card, which includes a photograph of the person to be authorized benefits and which is issued by the uniformed services at the installation level after eligibility of an individual has been established. A block on the identification card indicates whether the designated person is entitled to CHAMPUS benefits. The identification card is also used for other purposes, such as denoting eligibility for commissary and post or base exchange privileges and admission to military theaters.

Procedures and controls over the issuance and recovery of identification cards were deficient at all nine military installations we visited. We found that (1) some identification cards containing erroneous information were being issued, (2) some cards were not being recovered from dependents no longer eligible, and (3) OCHAMPUS was not always being notified of dependents receiving care at the time the sponsor was separated from military service. Thus, Government funds were expended under CHAMPUS for medical care provided to ineligible recipients and other privileges outside of CHAMPUS could be extended to unauthorized persons.

ISSUE OF IDENTIFICATION CARDS

Personnel at military installations were issuing identification cards containing erroneous information regarding eligibility for CHAMPUS benefits. The rate of error found in our sample test of about 2,200 cards was 2.1 percent. Most of the errors can be attributed to unfamiliarity with regulations governing issuance of the cards and to carelessness of responsible personnel.

Some persons were authorized CHAMPUS benefits after they became ineligible, e.g., in certain instances after beneficiaries had reached their 21st or 65th birthdays, parents of sponsors had been authorized CHAMPUS benefits although not eligible, persons eligible for CHAMPUS had not

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their authorized benefits; and the effective dates inserted on the identification cards had not been correct.

The most common type of error encountered was the incorrect expiration dates shown on 14 cards, which ranged from 1 day to over 3 years beyond the correct expiration date. Eight of these cards had 1- or 2-day errors, and the remaining 6 ranged from 150 days to 1,170 days beyond the correct expiration date.

We found that applications for some dependents' identification cards were incomplete or were not on file with the sponsor's service records; also the applications were not supported by needed backup information. At one Air Force installation, the officer responsible for approving the issuance of identification cards queried the computer to determine whether applicants were eligible dependents. If the computer answered that they were, authorization was given to issue the identification card. This system did not furnish information on whether cards had been issued previously to the dependent and therefore would not prevent the issue of duplicate cards.

RECOVERY OF INVALID IDENTIFICATION CARDS

A dependent's identification card showing entitlement to CHAMPUS benefits becomes invalid when a sponsor is separated from the military service prior to the end of his enlistment or when he is officially classified as a deserter. A card also becomes invalid when either a divorced spouse or a spouse of a deceased sponsor remarries, when dependent children pass their 21st birthday, or when dependents or retired members reach their 65th birthday.

Regulations are not specific and do not assign responsibility for recovering invalid dependent identification cards to any specific function, organization, or person. Consequently the majority of invalid dependent identification cards are not recovered. Records are not kept of cards recovered, and, since entitlements remain available to a holder of a card until the expiration date, it is possible for CHAMPUS or other benefits and privileges to be obtained by holders of invalid cards.

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Procedures for recovery
of identification cards

Air Force, Army, and Navy regulations do not specifically assign responsibilities for recovering identification cards. In general recovery of dependent identification cards seems to rest with the willingness of the sponsor and his dependents to turn in the cards. Navy regulations state that, when an ineligible card holder refuses to surrender his card, the assistance of the Naval Investigations Service will be requested. But a resident agent of the Naval Investigations Service informed us that he acts only when fraudulent use of the card can be demonstrated.

At the installation level procedures for recovery of cards vary considerably. Records of destruction of identification cards are not required by Air Force and Army regulations. Although Navy regulations require such records to be kept, two of the three Navy installations we visited did not do so. Some of the installations we visited kept records on cards turned in, but no reconciliation of these cards and the cards issued was made. Some installations were not aware that they were responsible for recovering dependent identification cards. Procedures for recovery of dependent cards at the installations we visited included:

--Briefings and instructions to sponsors about to be separated concerning turning in identification cards issued to dependents.

--Supplying sponsors with self-addressed, franked envelopes for returning dependents' cards.

--Instructing the sponsor to destroy dependents' cards.

Notification by the uniformed services
of separatees whose dependents are receiving
medical care under CHAMPUS

The Government's cost-sharing responsibility under CHAMPUS terminates when the sponsor separates from the uniformed services or is officially listed as a deserter and when certain other circumstances exist. Sponsors being separated are required to inform their uniformed service whether their dependents are currently receiving care under

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CHAMPUS. When separatees indicate that their dependents are receiving care, their uniformed service is required to notify OCHAMPUS, which in turn notifies the appropriate fiscal agent. The effectiveness of this procedure depends upon the knowledge of the sponsor and his integrity in making the appropriate declaration and upon the timely implementation by all parties involved.

We found that OCHAMPUS was notifying its fiscal agents timely and efficiently but that the uniformed services were not always notifying OCHAMPUS that the dependents of separatees were receiving medical care under the program.

The Army, Navy, and Air Force were requiring separatees to certify whether their dependents were receiving care, but most installations were not reporting the information to OCHAMPUS. Those which did were not doing so timely. Reasons given by responsible installation officials for not notifying OCHAMPUS included a lack of awareness of the reporting requirements and a lack of certification forms.

Of the notifications received by OCHAMPUS during July 1970, 78 percent were from Army installations, and, of the 78 percent, 65 percent were from one installation. With a few exceptions the Navy and Air Force and other Army installations apparently were not notifying OCHAMPUS at all.

<u>Unauthorized use of identification cards to obtain CHAMPUS benefits</u>

Unnecessary costs are being incurred under CHAMPUS because the uniformed services are not recovering dependent identification cards and are not notifying OCHAMPUS of dependents' receiving care at the time their sponsors separate from the uniformed services. These costs are incurred because the source of care cannot determine whether an identification card contains correct information nor whether the holder of the card is an eligible beneficiary. Thus care received by holders of invalid cards could go undetected.

In examining the claims of 346 married individuals who separated early or were listed as deserters, we found that about $4,800 in CHAMPUS costs had been incurred by dependents

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for care after the dates their sponsors had been officially separated from the uniformed services or had been listed as deserters. Eleven sponsors had dependents who received unauthorized care. The dependents of two of them incurred CHAMPUS costs of about $1,600 and $1,200, respectively. Three of the sponsors were deserters and eight were early separatees.

During the first 8 months of 1970, OCHAMPUS sent to the services, for collection, 57 cases involving payments for unauthorized care. The payments exceeded $32,000. Except for four cases payments were made on behalf of ineligible beneficiaries--such as parents and grandchildren--on the basis of identification cards which should not have been issued and on behalf of dependents of sponsors who had been discharged early or had been officially listed as deserters.

RECOMMENDATION

Because of the potential for incurring substantial costs by the unauthorized use of identification cards, we recommend that the Secretary of Defense direct that regulations and procedures of the military services be strengthened to ensure, insofar as is practicable, proper issuance and recovery of identification cards.

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CHAPTER 6

MEDICAL CARE NONAVAILABILITY STATEMENTS

Dependents of active duty personnel residing with their sponsors are required to have, except for emergencies, nonavailability statements when applying for civilian hospitalization in the United States and Puerto Rico. These statements are used for only the immediate medical care required and are issued to dependents by uniformed services facilities when the required care cannot be provided at a nearby uniformed services medical facility. All other CHAMPUS beneficiaries have the freedom to select a uniformed services or a civilian medical facility without being required to obtain the nonavailability statement.

At the nine military hospitals we visited, persons issuing the statements were aware of hospital conditions and capabilities. Over 1,400 nonavailability statements were issued by the nine hospitals during the 6 months ended June 30, 1970. We did not find improper issuances of nonavailability statements; however, we did find that (1) some differences existed in the policies among the services for issuing nonavailability statements, (2) determinations as to whether care could be furnished at nearby facilities had not been made on a routine basis, and (3) shortages of staff and facilities at military hospitals had caused increased use of CHAMPUS.

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POLICIES AMONG THE UNIFORMED SERVICES

There are some differences in policies for issuing nonavailability statements among the uniformed services and among individual hospital commanders. Consequently under similar circumstances, dependents tend to receive different treatment. More consistency in this area appears to be needed.

The CHAMPUS joint regulation provides that, with few exceptions, dependents of active duty members residing with their sponsors be required to obtain inpatient care in uniformed services facilities when such facilities are within reasonable distances of their residences and are capable of providing the needed care. Differences noted in the policies of the services and among hospital commanders at the installations we visited follow.

--The Air Force was the only branch of service that considered a dependent's lack of confidence in military hospitals or their personnel as a sufficient reason to warrant issuing a nonavailability statement. Of the statements issued at three Air Force locations, 20 percent were issued because of dependents' preferences for treatment in civilian rather than military hospitals.

--The Air Force was the only branch of service that followed a policy of issuing nonavailability statements when a conflict of opinion existed between civilian and military physicians on the necessity for a particular treatment. Joint regulations issued in September 1970, however, made this policy applicable to all uniformed services.

--The Navy's "Home Port Rule" results in Navy dependents' being considered to be residing with their sponsors if the sponsors' ships have as their home ports the same cities or areas where the dependents reside, even though the ships may be at sea. We have been informed that this often results in hardships to the dependents and lowers the morale of the sponsors. In contrast, once a soldier or airman is sent overseas his dependents are no longer considered to be residing with him and they do not require nonavailability statements to obtain care in civilian facilities.

NEED TO CHECK AVAILABILITY OF CARE AT OTHER UNIFORMED SERVICES FACILITIES

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The CHAMPUS joint regulation provides that, where there are two or more medical facilities of the uniformed services in a locality and the inpatient care required by a dependent cannot be furnished at the facility of the service to which he applies, the other facilities of the uniformed services in the area be asked to provide the care. A nonavailability statement is authorized only after it has been determined that the care cannot be furnished at any of the other uniformed services facilities.

Military medical facilities in the three areas we visited were not routinely checking the potential for provisio

of care at neighboring facilities of other branches of the uniformed services. Since this practice could result in an unnecessary use of civilian sources of care, it is essential that the policy requiring coordination with nearby facilities of the uniformed services be implemented effectively.

COSTS INCURRED UNDER CHAMPUS DUE TO SHORTAGES IN MILITARY HOSPITALS

Shortages of staff and medical facilities at military hospitals have resulted in increased use of CHAMPUS. About 61 percent of all nonavailability statements issued during the 6-month period ended June 30, 1970, by the nine military installations we visited were issued because staff and facilities were not available when needed for types of care ordinarily available to dependents in the issuing facility. Reasons cited were increased hospital admissions caused by the war in Southeast Asia, the fact that higher priorities had been assigned to more complex operations in operating rooms, and cutbacks of civilian hospital employees ordered by the Department of Defense.

At one hospital we visited, the number of nurses in the obstetrics ward had been reduced from 10 to four, and, during an 8-month period in 1970, 556 nonavailability statements were issued for obstetrics care. During the same months in 1969, only 16 nonavailability statements were issued for obstetrics care by the hospital. The hospital commander stated that he had been required to reduce total civilian personnel and that a decrease in obstetrics services had been more appropriate than reductions in services to active duty personnel. Thus the Department of Defense action has increased the use of civilian hospitals, but the increased costs to CHAMPUS are offset to some degree by related savings in military hospital operating costs.

At another military hospital, when operating room time was insufficient, nonavailability statements were issued for all individuals under age 18 requiring tonsillectomies and adenoidectomies. We estimate that this practice increased CHAMPUS costs about $139,000 annually. In addition, we noted that a U.S. Public Health Service hospital in the same area had not been fully utilized and had had operating room time available. The military service

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concerned had a policy to work with the Public Health Service hospital on a professional basis but not for referral of patients.

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CHAPTER 7

IMPROVEMENTS NEEDED IN CHAMPUS INFORMATION PROGRAM

The program to educate beneficiaries about CHAMPUS appears to have shown some recent improvement. About 92 percent of the married active duty officers and enlisted men interviewed during our review were aware of CHAMPUS in varying degrees. Earlier Department of Defense studies found a substantially lower ratio of informed personnel. Despite this improvement there are several important areas where greater efforts are needed. These include the need for (1) better coordination within the Department of Defense in implementing the CHAMPUS information program and (2) better control over the content of informational material.

In this area our review was limited to examining efforts made by OCHAMPUS in educating CHAMPUS beneficiaries and to determining the awareness of CHAMPUS benefits among active duty members of the Army, Navy, and Air Force.

RESPONSIBILITY FOR CHAMPUS INFORMATION

The authority and responsibility for the development and implementation of a complete public information program was delegated by the Surgeon General, Department of the Army, to OCHAMPUS in January 1969. OCHAMPUS later established a Public Affairs Office, but it was not operational until mid-1970.

The OCHAMPUS information program includes distributing press releases, maintaining a speakers bureau, and providing supplemental printed material for beneficiaries and for selected groups, such as information officers, recruiters, and coordinators at the installation level. Despite the quality and quantity of information disseminated about the program by OCHAMPUS, the actual education of beneficiaries and distribution of information on CHAMPUS remains largely the responsibility of the individual uniformed services. OCHAMPUS has no means of obtaining follow-up information concerning how, in what manner, or to what extent, the information it furnishes to the services is used.

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PROBLEMS IN IMPLEMENTING THE INFORMATION PROGRAM

The Army Audit Agency in 1968 identified some problems of the information program. These were (1) the late and incomplete distribution of an official pamphlet explaining the major program changes caused by the 1966 amendments, (2) the uncontrolled issue of supplemental publications, (3) the lack of clarity and the incompleteness of information in publications, and (4) the lack of formal training for counselors at military installation information centers.

The Subcommittee on Supplemental Service Benefits, House Armed Services Committee, reported in December 1969 that there was no clear understanding as to who was responsible for the CHAMPUS information program. The Subcommittee found that OCHAMPUS had the responsibility for developing an information program but that the responsibility for informing beneficiaries was in the hands of the individual services. The Subcommittee recommended that the Department of Defense issue directives clearly setting out the responsibility by agency for the various functions associated with the CHAMPUS information program and providing authority to one official to make sure that these functions are carried out.

In January 1971 the Subcommittee reported that implementation of its earlier recommendation concerning responsibility for the information program still had not been achieved. The Subcommittee report pointed out that a clear line of authority had to be provided below the Assistant Secretary level to see that needed information programs were carried out promptly and efficiently. The Subcommittee recommended that the Department of Defense, when submitting its appropriation request, include a request for financing informational activities on benefits, such as those available under CHAMPUS.

We noted that a recent Army publication substantially had misstated a CHAMPUS policy in condensing it for printing and that, because OCHAMPUS did not receive an advance copy in sufficient time, the erroneous information had been published. We were informed by OCHAMPUS officials that this would result in numerous complaints to OCHAMPUS.

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Coordination and cooperation of the uniformed services with OCHAMPUS concerning the information program is limited and in some cases is nonexistent. We found that desk packets prepared for recruiters of the uniformed services by OCHAMPUS had been designed to provide the recruiters with information concerning CHAMPUS. During our review OCHAMPUS was in the process of mailing 1,200 packets to Army recruiters and 900 to Air Force recruiters. The Navy and Marine Corps, however, had not responded to the OCHAMPUS request for permission to mail the packets to their recruiters.

RESULTS OF THE INFORMATION PROGRAM

An Army staff study in 1968 reported that 34 percent of married Army personnel were not aware of the changes in CHAMPUS caused by the 1966 amendments and that about 45 percent, although aware of the changes, were unaware of any details. The Army Audit Agency estimated that 57 percent of the OCHAMPUS complaints reviewed in 1968 had been caused by lack of understanding of the program.

A Department of Defense survey in January 1970 showed that 75 percent of enlisted personnel in the lower enlisted grades (E-5 and below) and 46 percent of those in the higher enlisted grades (E-6 and above) were not well-informed about CHAMPUS.

Our interviews of over 230 married service personnel--including officers--in the Army, Navy, and Air Force showed that almost 92 percent of those interviewed were aware, in varying degrees, of CHAMPUS or of a medical program which paid for civilian medical care of their dependents. About 51 percent had a fair knowledge of available benefits, and 8 percent had no knowledge of the program. Other servicemen interviewed knew of a medical program for their dependents, but they had no detailed knowledge of available benefits. The overall impression we received from the latter group of servicemen was that they did not care to learn the details of the program. They felt that they knew to whom they could go for assistance or information if the need arose.

We also noted that, of those servicemen with 12 months or less service, 89 percent had little or no knowledge of the benefits available to them. These servicemen with

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dependents appear to have the greatest potential need for CHAMPUS but seem to have the least knowledge of the program.

We were informed that OCHAMPUS would attempt to have the uniformed services give a 15-minute orientation on CHAMPUS to all incoming personnel as part of their mandatory indoctrination. OCHAMPUS foresees no difficulty in getting this requirement implemented by the Army but feels that Department of Defense assistance is needed to get the plan adequately implemented by the other uniformed services.

CONCLUSIONS

We believe that there is a need for better coordination within the Department of Defense for promoting CHAMPUS benefits. In addition, controls over the content of informational material issued by the uniformed services appear to be necessary, to prevent misstatements of OCHAMPUS policies and complaints about the program.

In view of the recommendations for improving the information program made by the Subcommittee on Supplemental Service Benefits, House Armed Services Committee, we have no recommendations at this time.

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CHAPTER 3

POTENTIAL SAVINGS BY PURCHASING MEDICAL EQUIPMENT

FROM GOVERNMENT SOURCES

Purchase of medical equipment is authorized under both the basic and handicap portions of CHAMPUS. The purchasers who may be either CHAMPUS beneficiaries or providers of care are reimbursed by CHAMPUS fiscal agents. Our review has shown opportunities for savings if this equipment is purchased from Government supply sources rather than civilian vendors.

Costs recorded by CHAMPUS for medical equipment in 1969 amounted to nearly $500,000--over $353,000 under the handicap portion of CHAMPUS and over $141,000 under the basic portion of the program. In addition, medical equipment was rented under the basic portion at a cost of over $82,000. Some rentals were made through a lease-purchase arrangement which provided that the equipment would revert to the beneficiary when rental payments equaled the purchase price. The costs recorded by CHAMPUS in 1969 for purchases of medical equipment are shown below by category.

Type of equipment	CHAMPUS costs
Hearing aids	$206,000
Orthopedic devices	68,000
Prosthetic devices	49,000
Nebulizers	16,000
Other items (note a)	155,000
	$494,000

[a] Includes wheelchairs, iron lungs, hospital beds, etc.

We noted that the types of medical equipment purchased by CHAMPUS beneficiaries were frequently available from Government supply sources at prices considerably less than those that civilian vendors were charging. The following table shows the results of our comparisons of a sample of

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five items purchased by CHAMPUS beneficiaries from civilian sources and the cost for comparable items from Government supply sources.

Equipment	Cost from civilian vendor	Cost from Government supply source	Difference
Hospital bed	$397	$221	$176
Hearing aid	345	127	218
Do.	350	110	240
Wheelchair	289	173	116
Do.	220	184	36

Certain items of medical equipment are stocked at military hospitals and at Veterans Administration hospitals. Veterans Administration officials told us that there would be no major problem in supplying medical equipment for CHAMPUS beneficiaries. They said that the Veterans Administration procured some items for the Department of Defense because of the lower prices which result from volume purchasing.

RECOMMENDATION

We recommend that the Executive Director, OCHAMPUS, examine into the potential savings available if satisfactory arrangements can be made for CHAMPUS beneficiaries to purchase medical equipment from Government sources of supply.

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CHAPTER 9

ADDITIONAL MATTERS ON CHAMPUS ADMINISTRATION

Our earlier reports on the hospital, physician, and handicap portions of CHAMPUS discussed certain weaknesses in administration of the program. (See chs. 2, 3, and 4.) Other weaknesses in the administration of CHAMPUS are discussed below. These concern (1) the surveillance by OCHAMPUS over claims processing and paying activities of fiscal agents, (2) the high number of claims returned or rejected by fiscal agents, (3) Defense Contract Audit Agency Audits, (4) the audits of OCHAMPUS by the U.S. Army Audit Agency, and (5) the Inspector General's inspections of fiscal agents.

SURVEILLANCE BY OCHAMPUS OVER CLAIM PROCESSING AND PAYING ACTIVITIES OF FISCAL AGENTS

We found that OCHAMPUS controls over claim processing and paying activities of fiscal agents were inadequate. Improvements were needed in OCHAMPUS procedures for processing claims data provided by the fiscal agents.

OCHAMPUS audits of claims paid by fiscal agents were sporadic and ineffective. The claims examiners making the audits had received no formal training and had no written guidance to aid them in performing the audits. Only limited supervisory reviews of work done by claims examiners had been made.

The audits consisted primarily of scanning computer listings to identify questionable claims either (1) prior to a visit to a fiscal agent by an OCHAMPUS Contract Performance Review Team or (2) when examiners had time to review the listings. Few claims are examined. Fiscal agents were notified of the claims questioned by the claims examiners; but, although they were supposed to notify OCHAMPUS of the disposition of claims which had been questioned, many of the agents had not done so. The claims examiners had not taken any follow-up action on the questioned claims after July 1969, and potential adjustments in the suspense files were dated as far back as March 1967.

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OCHAMPUS has no control over adjustments initiated by fiscal agents. These adjustments appear in listings submitted by fiscal agents without explanations. Ordinarily the adjustments are due to erroneous payments made to the source of care.

Submission of claim forms to OCHAMPUS

Physician fiscal agents sent over a million claim forms to OCHAMPUS in fiscal year 1970. OCHAMPUS utilized the documents in verifying error checks made on a sample basis, in making special studies, and in identifying potential third-party liability cases. Except for potential third-party liability cases, the claims forms were disposed of after about 3 months. Few of the documents were actually used by OCHAMPUS.

In September 1969 OCHAMPUS decided that hospital fiscal agents should submit only those claims involving potential third-party liability but failed to notify one of the two hospital fiscal agents to stop submitting all claims. In view of the OCHAMPUS procedure that requires computer listings with data on paid claims to be submitted by the fiscal agents, we suggested in July 1970 that OCHAMPUS preselect claims on a statistical basis for review and audit and that fiscal agents not be required to submit all paid claims forms.

In November 1970 OCHAMPUS implemented our suggestion that not all claims forms be submitted by the fiscal agents. As a result OCHAMPUS estimated a savings of $150,000 a year--$125,000 in reduced salaries of fiscal agent employees handling and shipping the claims and $25,000 in reduced postage. The fiscal agents are now required to submit only a preselected sample of paid claims forms and those claims involving potential third-party liability.

Recommendation

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We recommend that the Executive Director, OCHAMPUS, develop and implement follow-up procedures on claims questioned by OCHAMPUS and require that fiscal agents inform OCHAMPUS of the disposition of such claims. We recommend also that manuals and other forms of written guidance be made available to assist claims examiners in claims audit and verification.

RETURNED OR REJECTED CLAIMS

The large number of claims either (1) returned to the source of care or to the beneficiary for correction, revision, or additional information or (2) rejected for payment for such reasons as ineligibility has been a major problem hindering efficient operation of CHAMPUS. During fiscal year 1970 physician fiscal agents rejected or returned more than 480,000 claims--over 28 percent of the claims processed for payment. Hospital fiscal agents rejected or returned approximately 24 percent of the claims. These percentages have remained relatively constant since fiscal year 1968.

The rate for returned claims has been much higher than that for rejected claims--during fiscal years 1968 through 1970, returned claims represented an average of more than 20 percent of claims processed for payment. This increases administrative costs of claims processing, causes backlogs of unprocessed claims, and creates dissatisfaction with CHAMPUS, as evidenced by complaints concerning delayed payments.

OCHAMPUS became aware of this problem about October 1967 when physician fiscal agents began submitting claims activity reports. The matter was subsequently brought to the attention of OCHAMPUS by special study and audit groups in January and June 1969. No effective corrective action, however, has yet been developed.

Our review at OCHAMPUS and fiscal agent locations has shown that the high rate of claims returned or rejected has been attributed to (1) inadequate education of beneficiaries about CHAMPUS, (2) complex claim forms, (3) carelessness in preparing the claim forms, and (4) the return of forms by fiscal agents prior to searching their files for needed data.

As pointed out in chapter 7, efforts are now being made to improve the program to educate beneficiaries about CHAMPUS. This could have a beneficial effect on the preparation of claim forms.

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OCHAMPUS informally established a committee--which met early in 1969--to recommend changes to the claim forms,

because outside groups, including congressional committees and audit organizations, had recommended simplified claim forms as a means of reducing returns and rejections. This committee and one outside group made recommendations for revising the claim forms, but the recommendations were based on limited information obtained from fiscal agents and a small sample of forms completed by about 20 persons. The committee was abolished, and another committee is to be established to study revising the claim forms and to study a new system for identifying beneficiaries.

OCHAMPUS has proposed a revised claims activity report, which requires a more detailed breakdown of the reasons for returning or rejecting claims, to be made by fiscal agents. We believe that this could provide the information necessary for making sound decisions on revisions to the claim forms.

An embossed identification card has been proposed for use for beneficiary identification and for use as a means of reducing the number of claims being returned because of incorrect data. The same types of problems currently being experienced regarding eligibility determinations (see ch. 5) would continue with embossed cards. Nevertheless, such cards would eliminate many errors by correctly inserting key data on the claim form directly from the embossed card. This would greatly reduce the number of claims returned because of omission or errors in such data, but such advantage might be offset by the increased costs for the cards and related equipment.

In 1970 OCHAMPUS made a study of fiscal agents for 19 States that had high claim return rates. The study group found that fiscal agents in two States did not research their files prior to returning claim forms for correction or additional information. OCHAMPUS directed these fiscal agents to research their files prior to returning claims.

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DEFENSE CONTRACT AUDIT AGENCY AUDITS

Initially responsibility for auditing CHAMPUS and its fiscal agents rested with the U.S. Army Audit Agency. The responsibility for auditing fiscal agents was transferred in July 1965 by the U.S. Army Audit Agency to the Defense Contract Audit Agency.

In October 1967, the Defense Contract Audit Agency made an agreement with the Department of Health, Education, and Welfare whereby the Department of Health, Education, and Welfare's Audit Agency--which makes similar audits of some of the same fiscal agents under the Social Security Medicare Program--would perform the contract audits on a reimbursable basis. Under this agreement the Defense agency retained the overall responsibility for the audits and the Department of Health, Education, and Welfare's Audit Agency agreed to perform the audits in accordance with the Defense agency's audit standards and regulations.

We met with officials of the Defense Contract Audit Agency and were informed that, during the transition period when the Department of Health, Education, and Welfare's Audit Agency was beginning its audits of CHAMPUS contracts, the audit agencies had coordinated to deal with a few problems which arose and that, until June 1970, the Defense agency had reviewed copies of audit reports prepared by the Department of Health, Education, and Welfare's Audit Agency. The Defense agency discontinued its review of these audit reports because of the lack of significant problems. These officials also informed us that they did not manage or direct the performance of the audits of CHAMPUS contracts.

AUDIT OF OCHAMPUS BY THE U.S. ARMY AUDIT AGENCY

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The last audit of OCHAMPUS, made in 1968 by the U.S. Army Audit Agency, although limited in scope, was adequate in the areas of activity which it reviewed. The audit concentrated on the problem of conformance with Army Regulations rather than on overall management effectiveness.

The stated primary purpose of the audit was an evaluation of the effectiveness and efficiency with which OCHAMPUS utilized its resources to accomplish its mission of administering CHAMPUS and reimbursing fiscal agents and individuals for the cost of medical care. The audit included a comprehensive review of automatic data processing activities, a review of the procedures for identifying and processing potential third-party liability cases, an evaluation of the dissemination of information on CHAMPUS to beneficiaries, an analysis of complaint mail, and a review of budgeting and financial management activities.

The report concluded that improvements were needed in the (1) development, distribution, and control of information on the program, (2) design of claim forms and instructions for preparation, and (3) the methods of determining the desirability of purchasing, rather than leasing, automatic data processing equipment. Areas not reviewed in depth were contract administration, including compliance by fiscal agents with contract requirements; overall management of CHAMPUS; staffing of OCHAMPUS; and activities related to approval of handicap and long-term hospitalization cases. We believe that the U.S. Army Audit Agency should include examination of such areas of OCHAMPUS activities in its future audits. Examination of such areas is essential for evaluation of the effectiveness and efficiency of OCHAMPUS.

INSPECTORS GENERAL INSPECTIONS BEST DOCUMENT AVAILABLE

The Inspector General, Office of the Surgeon General, Department of the Army, performed contract compliance inspections of the activities of the fiscal agents approximately every 2 years. He also made periodic inspections of the activities of OCHAMPUS. In addition, the Inspector General, Department of the Army, made an inspection of OCHAMPUS in 1968 as part of his inspection of the Office of the Surgeon General.

The policy statement issued by the Inspector General, Office of the Surgeon General, for guidance of inspectors engaged in procurement inspections stated that:

> "Inspectors General, in their inspection of CHAMPUS contractors, will strive to provide assistance to *** OCHAMPUS *** in the over-all improvement of operations and in the solution of problems."

During the period July 1, 1965, to November 26, 1969, the Inspector General, Office of the Surgeon General, made over 200 inspections of fiscal agents involved in processing claims for medical care provided under CHAMPUS. We reviewed 84 of the latest reports issued during this period and found that the inspections invariably had been completed in a day and that they had followed routine patterns of inquiry. In

general the report format was stereotyped and included sections for commenting on prescribed areas.

On the basis of the limited time spent on these inspections, our review of information contained in the reports, the general absence of significant recommendations, and a lack of identification of significant problem areas, it appeared that inspections made by the Inspector General, Office of the Surgeon General, had been of limited value to management for improving CHAMPUS.

RECENT ADMINISTRATIVE ACTIONS BY OCHAMPUS

In December 1970 the Executive Director, OCHAMPUS, provided us with a listing of actions recently taken to improve CHAMPUS operations. For example, workshops have been initiated for training contractor employees who process claims, and the scope and frequency of contract performance reviews have been increased. A request for additional health care professionals to make inspections of health care facilities has been sent to the Surgeon General, Department of the Army. We believe that many of these actions, together with actions on the recommendations made in this report, if properly implemented, should improve the operation of CHAMPUS.

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CHAPTER 10

SCOPE OF REVIEW

Our examination of CHAMPUS included a review of the authorizing legislation and its background. We reviewed applicable policies, procedures, and practices used in the administration of CHAMPUS. We conferred with appropriate officials responsible for the administration and operation of the program, as well as officials of professional medical organizations.

Our review was performed at OCHAMPUS, near Denver, Colorado and at the offices of selected CHAMPUS fiscal agents. Additional work was performed at various hospitals, hospital and medical associations, areawide planning commissions, military installations, and regional offices of the Department of Health, Education, and Welfare's Audit Agency.

Our work was directed primarily to (1) determining whether amounts paid under CHAMPUS to hospitals and physicians for selected medical and surgical procedures were in line with those amounts paid under Federal and private insurance plans, (2) evaluating the bases for payment of both hospital and physician charges, (3) determining the extent of fiscal agent surveillance of the costs and quality of services provided to beneficiaries, (4) examining into the reasonableness of expenses of the fiscal agents in administering the program, (5) examining into the controls used for establishing the eligibility of program participants, and (6) evaluating the adequacy of audits and reviews of CHAMPUS made by responsible Government agencies.

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APPENDIXES

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Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

October 20, 1969

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Honorable Elmer B. Staats
Comptroller General of the
United States
U. S. General Accounting Office
Washington, D. C. 20548

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Dear Mr. Staats:

In the last several years the cost to operate the military Medicare program has increased substantially. The program was first instituted in fiscal year 1957 at a cost of about $24,500,000. For fiscal years 1966, 1967 and 1968 expenses were about $75,616,000, $108,676,000 and $162,374,000, respectively. The preliminary report of obligations for fiscal year 1969 shows $177,366,000, and the budget estimate for 1970 is in excess of $200 million.

While testimony before the Committee indicates that there has been an annual increase in the number of beneficiaries and an increase in the cost of benefits received, it appears that cost increases are greater than might be expected and not in proportion to benefits derived.

The Committee is interested in knowing whether the fees being paid participating physicians, hospitals, or others for services rendered are in line with those which would be customarily charged to non-subscribers of medical-hospitalization programs. We would also like to know whether any substantial profits have been realized by anyone servicing the program.

We would appreciate the General Accounting Office making a comprehensive review of the military Medicare program and reporting to the Committee on its findings as soon as possible. If you so

desire, various aspects may be reported individually, with a summary report upon completion of all work. The review should include, but not necessarily be limited to the following areas:

1. An evaluation of the reasonableness of total cost incurred by fiscal years.

2. The reasonableness of fees charged and profits realized by participating individuals, medical facilities or other organizations.

3. The reasonableness of expenses incurred in the administration of the program.

4. A determination of the eligibility of participants.

5. The adequacy of audits made by responsible Government agencies of the administration and operation of the program and benefit payments made under the program.

Sincerely,

Chairman

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