United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Defense, Committee on Appropriations, U.S. Senate

July 1989

DEFENSE HEALTH CARE

Workload Reductions at Military Hospitals Have Increased CHAMPUS Costs

GAO/HRD-89-47

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226377

July 10, 1989

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

This is our report on the increasing number of patients being referred from military medical facilities to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the resulting impact on CHAMPUS costs. Our review was in response to a provision in the Senate Committee on Appropriations report accompanying the fiscal year 1987 authorizations bill for the Department of Defense and your letter of April 7, 1987.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Defense; and interested congressional committees. We will also provide copies to other parties on request.

This report was prepared under the direction of David P. Baine, Director of Federal Health Care Delivery Issues. Other major contributors are listed in appendix IV.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Dependents of active duty members of the military services, retirees, and dependents of retired and deceased members are eligible for care in military medical facilities when space, staff, and necessary resources are available. When these beneficiaries cannot obtain care from a military facility or do not live near one, they may obtain care from civilian providers. However, the government pays for a substantial portion of the medical care provided by civilian hospitals and physicians through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

In 1987 the Senate Committee on Appropriations expressed its concern about unprecedented increases that were occurring in CHAMPUS costs and the increasing numbers of patients being referred from military medical facilities to civilian providers. Between fiscal years 1985 and 1987, CHAMPUS costs rose from $1.4 billion to about $2.1 billion.

In response to a request from Senator Daniel K. Inouye, on behalf of the Senate Committee on Appropriations, GAO examined the extent to which reduced access to military facilities may have contributed to CHAMPUS cost increases. Specifically, GAO ascertained

- the extent to which beneficiary access to health care at military facilities has decreased in recent years;
- where the reductions were occurring (inpatients, outpatients, or both) and whether they were occurring in facilities of all the military services; and
- the reasons for reduced access.

Background

Worldwide, there are more than 500 military medical facilities—168 military hospitals and hundreds of clinics. The first priority of military facilities is to treat active duty members. When space, staff, and other resources are available, however, they also care for military retirees and dependents.

For outpatient care, these beneficiaries can choose between military facilities and civilian hospitals and physicians under CHAMPUS. For inpatient care, however, beneficiaries who live within an approximate 40-mile radius of a military facility (its catchment area) must obtain a nonavailability of service statement from the military facility before seeking nonemergency care from a private provider under CHAMPUS.

Results in Brief

From fiscal years 1985 to 1987, the Department of Defense (DOD) significantly decreased the amount of medical care provided to beneficiaries in its facilities. Beneficiary inpatient admissions decreased about 64,000 (11 percent); outpatient visits decreased about 2.7 million (10 percent). The greatest decrease took place in Navy facilities. Air Force facilities also experienced decreases, but substantially less. In Army facilities, inpatient admissions increased slightly, but outpatient visits decreased.

These decreases were the cumulative result of a variety of factors, including a reduction in the number of patients certain specialists could see, staff shortages in critical specialties, increased readiness training and deployments, and an increased emphasis on quality assurance, which decreased the amount of physicians' time available for direct patient care.

The amount and cost of care provided under CHAMPUS has increased in part because the amount of care provided to beneficiaries at military facilities has declined. Other reasons for CHAMPUS cost increases include an overall increase in the cost of providing medical care, an increase in the number of military beneficiaries, and an increase in the rate at which they utilize the medical care system. DOD has initiated several actions designed to increase the availability of services at military facilities and reduce CHAMPUS costs. These initiatives, however, have not been in operation long enough to determine their impact.

Principal Findings

Military Facilities' Beneficiary Workload Has Declined

As shown in table 1, for fiscal years 1985-87, services to beneficiaries decreased significantly, with the greatest decrease in Navy facilities.

Table 1: Changes in Beneficiary Inpatient Admissions and Outpatient Visits Between Fiscal Years 1985 and 1987

Service	Change in inpatient admissions	Percent change	Change in outpatient visits	Percent change
Navy	−44,900	−32	−2,200,000	−33
Air Force	−19,500	−10	−199,000	−2
Army	400	0	−243,000	−2

Reasons for Decrease in Facility Workload

There are several reasons why military medical facilities are treating fewer beneficiaries, but the extent to which any one reason individually explains the decrease is unquantified. Among the more significant reasons are these:

- The military services reduced the number of deliveries per obstetrician to improve safe care levels. (See p. 25.)
- Position vacancies, although not always significant in terms of numbers, contributed to decreases in military facilities' workload and increases in referrals to CHAMPUS. (See p. 29.)
- The military services adopted a new nurse staffing method designed to better determine the care needed by patients on the basis of the severity of their medical conditions. When actual staffing levels were lower than the recommended level, military facilities reduced the number of beds available in order to assure safe levels of care. (See p. 30.)
- Increased readiness training and deployments of medical personnel to temporary duty stations reduced the time available for patient care. (See p. 32.)
- The amount of time that medical staff must spend on Quality Assurance programs has increased, thereby reducing the time available for direct patient care. (See p. 34.)

Workload Decrease Contributed to the CHAMPUS Increase

The reduction to 64,800 beneficiary inpatient admissions to military facilities between fiscal years 1985 and 1987 was accompanied by a 50,800 increase in the number of inpatient admissions paid under CHAMPUS, 49,900 of them in military facility catchment areas. Similarly, with the reduction of about 2.7 million outpatient visits in military facilities, the number of outpatient visits paid under CHAMPUS increased by about 2.5 million, 1.8 million in military facility catchment areas. During this period, CHAMPUS costs increased $700 million.

Decreases in military facility-provided medical care and increases in CHAMPUS-paid care do not correspond exactly for several reasons, such as beneficiaries (1) choosing to not seek care under CHAMPUS because they have other insurance, (2) having not incurred medical care expenses in excess of the deductible amounts they must pay, or (3) postponing necessary medical care. (See p. 22.)

Recommendations

In view of the recent initiatives by DOD, designed to increase the availability of services at military facilities and to reduce CHAMPUS costs, GAO is making no recommendations.

Agency Comments

DOD agreed with the report's findings and conclusions. (See p. 37.)

Contents

Figures

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRI	CHAMPUS Reform Initiative
DOD	Department of Defense
GAO	General Accounting Office
OCHAMPUS	Office of the Civilian Health and Medical Program of the Uniformed Services
USAF	United States Air Force

Introduction

Department of Defense (DOD) medical care consists of (1) direct care provided by the Army, Navy, and Air Force and (2) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Direct care is provided in over 500 military treatment facilities, ranging in size from small clinics with limited capabilities to large hospitals with extensive capabilities and medical teaching programs. Of these medical facilities, 168 are military hospitals, of which 129 are located in the United States—37 operated by the Army, 25 by the Navy, and 67 by the Air Force.

The medical department of each military service is headed by a surgeon general who administers the medical facilities. The Assistant Secretary of Defense (Health Affairs) is responsible for overall supervision and policy guidance for DOD medical care activities.

The military services are required to provide needed medical care to active duty members, either through their facilities or through care purchased from private providers. As used in this report, beneficiaries are defined as dependents of active duty members, retirees, and dependents of retired and deceased members. All are eligible for care in military medical facilities when space, staff, and necessary resources are available. Approximately 9 million people are eligible for care in military facilities: 2.3 million active duty members, 2.8 million dependents of active duty members, and 3.7 million retirees and dependents of retired and deceased members; about 6 million of the 9 million people are eligible for CHAMPUS-financed care. According to DOD records, the estimated budget for the direct medical care program, exclusive of medical facility construction costs, was about $9.3 billion for fiscal year 1989. Active duty members pay nothing for care in military facilities; beneficiaries pay a daily fee—$8.05 for inpatient care in fiscal year 1989—but pay nothing for outpatient care.

Beneficiaries obtain medical care from civilian providers under CHAMPUS when they cannot obtain it from a military facility or do not live near one. CHAMPUS beneficiaries do not pay premiums. They do, however, pay for a portion of their treatment when services are obtained. The government and the beneficiary share the costs for services. The cost-sharing provisions for each type of beneficiary are shown in table 1.1.

Table 1:1: CHAMPUS Beneficiary Cost-Sharing Provisions

Beneficiary type	Inpatient	Outpatient
Dependents of active duty members	Each admission—$25 or the amount charged for inpatient care in a military medical facility ($8.05 per day in fiscal year 1989), whichever is greater.	(a) Annual deductible—$50 per dependent or $100 per family and, then, (b) 20 percent of allowable charge.
Other beneficiaries	25 percent of allowable charges, or $210 per day, whichever is less.	(a) Annual deductible—$50 per dependent or $100 per family and, then, (b) 25 percent of allowable charge.

Note: Beginning in October 1987, beneficiaries' annual copayment liability was capped at $1,000 for dependents of active duty members and at $10,000 for other beneficiaries.

The Office of CHAMPUS (OCHAMPUS—at Fitzsimons Army Medical Center, near Denver) is responsible for administering CHAMPUS. CHAMPUS is under the policy direction of the Assistant Secretary of Defense (Health Affairs).

Beneficiaries who need inpatient care are required to seek that care from military facilities if they live within the catchment area (an approximate 40-mile radius). If the military facility cannot provide the care, it issues a nonavailability statement, which authorizes the beneficiary to obtain care under CHAMPUS. Nonavailability statements are not required for (1) emergency or outpatient care, (2) beneficiaries who reside outside the military medical facility catchment area, or (3) beneficiaries who have other health insurance.

Beginning in fiscal year 1986, CHAMPUS has experienced annual cost increases significantly above those expected. As shown in table 1.2, by fiscal year 1987, CHAMPUS costs had risen to about $1.96 billion, an increase of about $590 million (43 percent), over the fiscal year 1985 costs of about $1.37 billion. During the same period, DOD's medical care costs (excluding CHAMPUS) increased from about $7.84 billion in fiscal year 1985 to about $9.53 billion in fiscal year 1987, an increase of about $1.69 billion (21.6 percent).

Table 1.2: DOD Medical Care Costs (Fiscal Years 1985-87)

Dollars in millions

				Change from FY 1985 to 1987	
	FY 1985	FY 1986	FY 1987	Amount	Percent
CHAMPUS	$1,371	$1,735	$1,964	$593	43.2
Non-CHAMPUS	7,841	8,651	9,532	1,691	21.6
Total	**$9,212**	**$10,386**	**$11,496**	**$2,284**	**24.8**

In contrast to DOD medical care costs, total national health care expenditures, as shown in table 1.3, increased about 18 percent for calendar years 1985-87.

Table 1.3: Total National Health Care Expenditures (Calendar Years 1985-87)

Dollars in billions

				Change from CY 1985 to CY 1987	
	CY 1985	CY 1986	CY 1987	Amount	Percent
Expenditures	$371.4	$404.0	$438.9	$67.5	18.2

Note: Includes payments by patients; private health insurance; and federal, state, and local governments.

Source: Health Care Finance Review, Department of Health and Human Services.

In April 1986, OCHAMPUS officials noted a significant increase in the volume of claims received for the period January through March 1986. An OCHAMPUS analysis showed that most of the increased costs associated with the large number of claims was attributed to care received by beneficiaries residing within military medical facilities' catchment areas. A March 1987 follow-up study for selected catchment areas by the Office of the Assistant Secretary of Defense (Health Affairs) compared CHAMPUS claims for the first 6 months of 1985 with claims for the first 6 months of 1986. The study showed that increases in CHAMPUS inpatient admissions corresponded to decreases in admissions to military facilities in the selected catchment areas; much of this shift to CHAMPUS occurred in catchment areas served by Navy medical facilities.

Objectives, Scope, and Methodology

The Senate Committee on Appropriations, in its report accompanying the fiscal year 1987 DOD appropriations bill, expressed concern about (1) the unprecedented increase in CHAMPUS costs during fiscal year 1986 and (2) the magnitude of patient referrals from military facilities to civilian providers under CHAMPUS. The Committee stated its intent to request

that GAO review the alleged military facilities' "dumping" of patients on CHAMPUS. Accordingly, in an April 7, 1987, letter, Senator Daniel K. Inouye of the Committee requested that we determine

- the extent to which beneficiary access to medical care in military facilities has decreased in recent years;
- whether the reduced access is occurring in inpatient services, outpatient services, or both;
- whether the reductions are occurring in treatment facilities of all the military services or are limited to specific services; and
- the reasons for the reduced access to care.

Senator Inouye also stated that beginning in the spring of 1986, CHAMPUS had experienced significant cost increases. He said that DOD had attributed these cost increases, in large part, to the shifting of care from military facilities to CHAMPUS. Accordingly, we also examined the extent to which decreases in beneficiaries' access to military facilities' care contributed to CHAMPUS cost increases.

Because military medical facilities do not compile complete data to show the extent to which beneficiaries sought, but were denied, care, we were unable to quantify whether access to care in military medical facilities has decreased. Although the facilities' records of nonavailability statements issued (indicating care was sought but was unavailable) provide an indicator of decreased access for inpatient care, they are not required for outpatient care. Therefore, we used annual changes in medical facility workload as a proxy for decreased access to inpatient and outpatient care. (We also used nonavailability statement data for measuring access to inpatient care.) We limited our scope to the Air Force, Army, and Navy medical facilities located in the United States because these were the subject of concerns about reduced access.

Decreased Access to Care

To meet the objectives relating to decreased access to care, we obtained data on medical services provided to active duty members and beneficiaries by Army, Navy, and Air Force medical facilities during fiscal years 1985, 1986, and 1987. We obtained data on (1) facilities' inpatient admissions and outpatient visits and (2) the number of nonavailability statements issued by the facilities. We compiled and analyzed these data to determine changes in facility workloads and nonavailability statements issued for fiscal years 1985-87. We also compiled and analyzed data by type of beneficiary served and by medical specialty. We verified

our data with officials in the Army and Air Force Offices of the Surgeons General and with officials in the Naval Medical Command.

Reasons for Decreased Access

To determine the reasons for the decrease in access to military medical facilities, we interviewed military medical department officials and analyzed reports and policy documents. We obtained the individual military services' year-end medical personnel staffing inventories for fiscal years 1985-87. We also obtained (1) Army staffing data from the Health Services Command and the Army Personnel Center, (2) Navy officer staffing data from Naval Military Personnel Command computer tapes, (3) Navy enlisted and civilian staffing information from the Naval Medical Command, and (4) Air Force data from the Air Force Office of the Surgeon General and the Military Personnel Center. We analyzed the staffing data to determine changes in medical staffing between fiscal years 1985 and 1987.

We were unable to accurately determine, from servicewide perspectives, the extent to which staffing reductions contributed to decreases in access at military facilities. Staffing data (including the Medical Corps, Nurse Corps, and Medical Service Corps) proved difficult to analyze because of inconsistencies and discrepancies between the various data sources and because some data were not retained. For each military service, staffing-level data varied significantly from one source to another, including data published in Defense Manpower Statistics, staffing data in the Defense Medical Information System, and data provided by the Office of the Surgeon General. In addition, we were told that much of the servicewide data we requested for fiscal year 1985 were no longer available.

We also noted difficulty in assessing staffing in an April 1987 report.[1] This report concluded that it was not possible to evaluate the number and mix of staff currently available to meet requirements because of lack of complete, reliable, and consistent data.

To obtain more detailed information on reasons for reduced medical services at military medical facilities, we visited three Army, five Navy, and three Air Force facilities. We selected these facilities because they (1) had substantial reductions in medical services provided to beneficiaries and (2) served catchment areas in which CHAMPUS costs had substantially increased. We selected more Navy than Army and Air Force

[1] Medical Readiness: Progress in Stating Manpower Needs (GAO/NSIAD-87-126, Apr. 29, 1987).

facilities because (1) the Navy had the largest decrease in workload and (2) the catchment areas served by the Navy facilities had the largest CHAMPUS cost increases. Appendix I shows which Army, Navy, and Air Force facilities we visited and how they ranked in terms of decreases in inpatient admissions and catchment area CHAMPUS cost increases nationwide (comparing the first 6 months of fiscal year 1985 with the same period in 1987).

In total, for fiscal years 1985-87, the 11 facilities we visited accounted for a decrease of about 29,600 beneficiary admissions (about 46 percent of the total decrease) and a reduction of about 623,100 beneficiary outpatient visits (about 24 percent of the total). The catchment areas served by these facilities accounted for about $170 million (24 percent) of the $700 million increase in CHAMPUS benefit costs from fiscal year 1985 to 1987.

At each of the facilities, we obtained data by medical specialty on inpatient admissions and outpatient visits; we analyzed changes during fiscal years 1985, 1986, and 1987. We also obtained and analyzed data on nonavailability statements issued between fiscal years 1985 and 1987 and determined staffing trends for those medical departments that (1) collectively accounted for 50 percent or more of a facility's decrease in beneficiary admissions or (2) collectively accounted for 50 percent or more of the nonavailability statements issued. We interviewed the heads of those medical departments, as well as commanding officers, nursing directors, and other hospital officials, to obtain opinions on the reasons for the decreased workload between fiscal years 1985-87. We also obtained information on training, deployments, and quality assurance program requirements to determine whether they had a measurable effect on a facility's workload. We obtained operation, maintenance, and equipment budgets for fiscal years 1985-87; we analyzed these budgets to identify their effects on a facility's ability to provide care to beneficiaries.

Extent to Which Decreased Military Medical Facility Workload Increased CHAMPUS Costs

To determine the extent to which decreased military medical facility workload contributed to CHAMPUS cost increases, we obtained CHAMPUS cost and workload data (the number of inpatient admissions and outpatient visits paid for under the program) from OCHAMPUS for fiscal years 1985-87. We obtained CHAMPUS cost and workload data for the year in which the care was received so that the data would be comparable with the military facility data. The CHAMPUS data were incomplete because of (1) the time lag involved in receiving and processing claims and (2) a

CHAMPUS policy that allows the beneficiary up to 2 years from the date care is received to file a claim. Accordingly, we used CHAMPUS's historical factors to estimate final costs and workload statistics for the 3 years. We analyzed these data to determine changes in CHAMPUS inpatient admissions, outpatient visits, and costs for fiscal years 1985-87.

We separately analyzed CHAMPUS-wide data; combined catchment area data; and Army, Navy, and Air Force catchment area data. We also identified CHAMPUS cost increases that were not related to reduced military facility medical services. We excluded from our analyses catchment areas served by U.S. Coast Guard hospitals and Uniformed Services Treatment Facilities (formerly Public Health Service hospitals).

In conducting our work, we noted a number of inconsistencies between data obtained from the Defense Medical Information System, the military services, and the individual facilities visited. Although much of the data we obtained were computer generated, we did not conduct a formal reliability assessment of the systems that generated them. However, we did discuss data differences with appropriate officials and made a judgment as to which data were the most accurate. For verification, we also submitted to the military services' medical departments some data that we questioned. We conducted our review in accordance with generally accepted government auditing standards. Our work was done between April 1987 and August 1988.

Beneficiary Workload Has Decreased in Military Facilities

Beneficiary workload in military facilities has decreased, particularly in Navy facilities and to a lesser extent in Air Force facilities. Workload in Army facilities has remained relatively stable. During fiscal years 1985-87, overall inpatient admissions in military facilities decreased by about 64,000 (11 percent), while outpatient visits decreased by almost 2.7 million (10 percent). Workload decreased for all major categories of beneficiaries—dependents of active duty members, retired members, and dependents of retired and deceased members. The largest decreases in inpatient admissions were in obstetrics/gynecology and pediatrics. The largest deceases in outpatient visits were in obstetrics/gynecology, pediatrics, and family practice services.

CHAMPUS costs have risen significantly as a result of the decreases in military facilities workload. Benefit costs increased over $700 million from fiscal years 1985 to 1987. About $690 million of the increase was for beneficiaries living in the United States. Of the $690 million increase, about 79 percent was for care to beneficiaries living in military facility catchment areas.

Extent of Beneficiary Workload Decreases in Military Facilities

DOD-wide, inpatient admissions of beneficiaries decreased from about 581,000 in fiscal year 1985 to about 517,000 in fiscal year 1987, a decrease of approximately 64,000 (11 percent). Beneficiary outpatient visits to military facilities decreased by about 10 percent—from about 25.8 million in fiscal year 1985 to about 23.1 million in fiscal year 1987.

For active duty members, inpatient admissions and outpatient visits increased for fiscal years 1985-87. The increase, however, was not nearly as great as the decrease in beneficiary admissions and visits.

Greatest Decrease in Inpatient Admissions in Navy Facilities

The greatest decrease in inpatient admissions for beneficiaries occurred in Navy facilities. Of the DOD-wide reduction of 64,000 inpatient admissions for fiscal years 1985-87, about 44,900 (70 percent) were in Navy facilities. Admissions to Air Force facilities over the same period decreased about 19,500. Army admissions, in contrast, increased slightly—by about 400.

Inpatient admissions to Navy facilities decreased 31.5 percent, from about 142,700 in fiscal year 1985 to about 97,800 in fiscal year 1987. The Navy's largest decrease occurred between fiscal years 1985 and 1986, when admissions decreased by about 29,600, followed by a further decrease of about 15,300 in fiscal year 1987.

For the Air Force, inpatient admissions decreased about 9 percent, from about 205,300 in fiscal year 1985 to about 185,800 in fiscal year 1987. Air Force admissions decreased by about 8,600 between fiscal years 1985 and 1986, with a larger decrease of about 10,900 for fiscal years 1986-87.

Admissions to Army facilities increased from about 233,100 in fiscal year 1985 to about 233,500 in fiscal year 1987, an increase of less than 1 percent. Army admissions decreased by about 2,800 between fiscal years 1985 and 1986, but increased by about 3,200 in fiscal year 1987.[1]

The inpatient admissions for all three services for fiscal years 1985-87 are shown in figure 2.1.

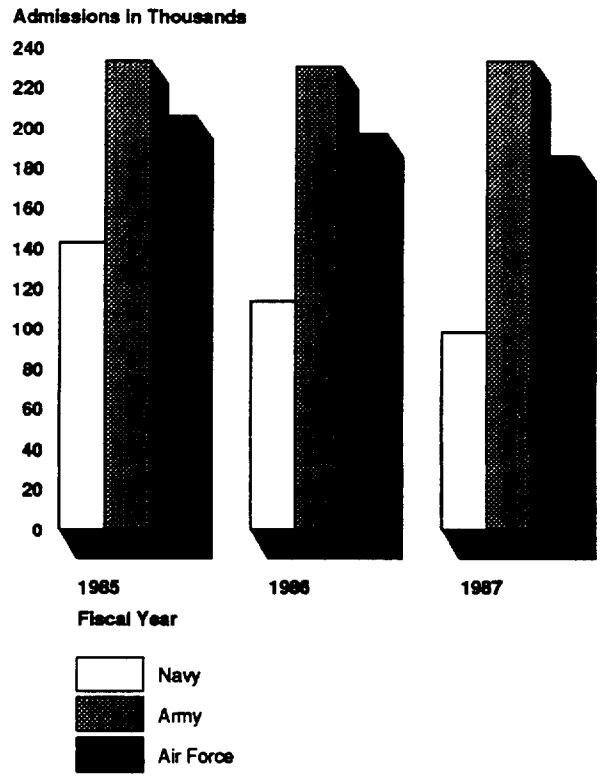
In contrast to the decrease in inpatient admissions of beneficiaries, admissions for active duty members increased from about 236,700 in fiscal year 1985 to about 252,500 in fiscal year 1987, an increase of 15,800 (about 7 percent). Considering inpatient admissions for both active duty members and beneficiaries, the net decrease in admissions from fiscal year 1985 to 1987 was about 48,200 (6 percent).

DOD-wide, inpatient admissions decreased from fiscal years 1985 to 1987 in all three beneficiary categories. In two of the categories (dependents of active duty members and dependents of retired and deceased members), admissions declined 14.3 percent; in the third category (retirees), admissions decreased 10.3 percent. The percentages of decrease, however, varied considerably by military service, as shown in appendix II. For example, inpatient admissions of dependents of active duty members remained about the same in Army facilities, but decreased by over 30 percent in Navy hospitals.

Of the seven medical specialty categories by which inpatient admission data were obtained, obstetrics/gynecology cases showed the greatest decrease in admissions of beneficiaries. For fiscal years 1985-87, admissions in this medical category declined by over 27,000 (17 percent). Of this decrease, obstetrics represented 60 percent. Navy obstetrics/gynecology admissions decreased by over 19,000; Air Force admissions decreased by over 8,000; and Army admissions increased slightly—by less than 1,000. Pediatrics was the medical specialty category that

[1]Army figures include admissions to Brooke Army Medical Center, which was consolidated with some Air Force facilities under a joint medical command in 1987. Had Brooke not been included, the Army's admissions would have shown a decrease of about 100 between fiscal years 1985 and 1987.

Figure 2.1: Beneficiary Inpatient Admissions to Military Medical Facilities
(Fiscal Years 1985-87)



showed the next largest decrease in inpatient admissions, with a decrease of almost 21,000 (or 15.5 percent). Pediatric admissions decreased in hospitals of all three military services, but the decrease was the largest in Navy hospitals—about 15,600. Inpatient admissions decreased also in internal medicine, surgery, orthopedics, and psychiatry.

Nonavailability Statements Increased as Inpatient Admissions Decreased

The number of nonavailability statements issued by military facilities increased by about 34,800 between fiscal years 1985 and 1987. This shows that there was an increase in the number of instances of beneficiaries living within the catchment areas of military facilities seeking, but not obtaining, medical care from the facilities. Thus, decreases in inpatient admissions were not due to decreases in the demand for care. The increase in the number of nonavailability statements issued did not match the decrease in military facility inpatient admissions because nonavailability statements are not required when a beneficiary (1) lives

outside the catchment area or (2) has other insurance that pays a portion of the bill normally paid by CHAMPUS. In addition, nonavailability statements also are not required for emergency admissions to civilian hospitals.

Of the 34,800 increase in nonavailability statements issued, about 21,600 (62 percent) were issued by Navy facilities; most of them (15,100) were issued for fiscal years 1985-86. Nonavailability statements issued by the Air Force increased 7,400; of this increase, 5,800 took place during fiscal years 1986-87. The Army, despite its slight increase of about 400 inpatient admissions between fiscal years 1985-87, increased by nearly 5,800 the number of nonavailability statements issued over this period, with much of the increase for fiscal years 1985-86. Two possible reasons for the Army increase are (1) demand for care has increased and (2) beneficiaries are crossing over to the Army when Navy or Air Force facilities are not able to provide requested care. Over the 2-year period, Army facilities, whose catchment areas overlap at least one Navy or Air Force facility catchment area(s), issued over 2,900 of the Army's increase of 5,800 nonavailability statements.

The number of nonavailability statements issued by each of the military services for fiscal years 1985-87 is shown in figure 2.2.

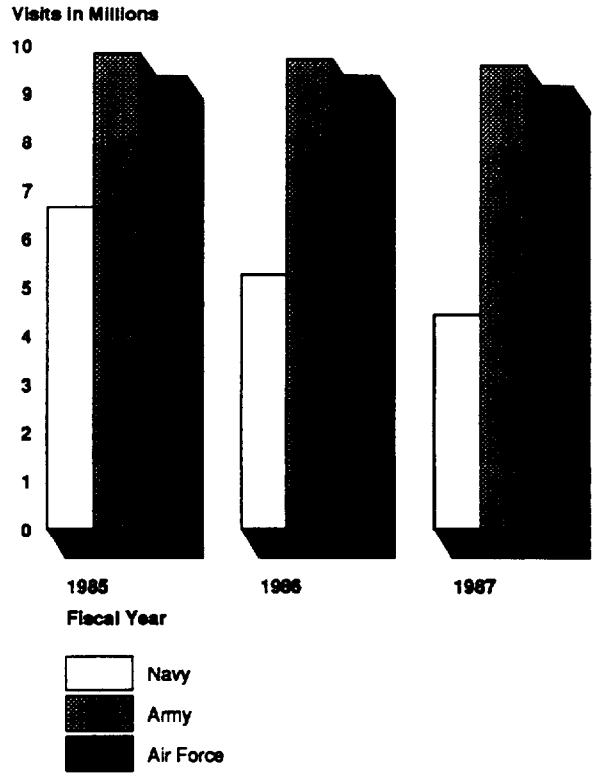
Obstetrics/gynecology cases accounted for the greatest decreases in military facility inpatient admissions, as well as the greatest increase—almost 19,000 (57 percent)—of nonavailability statements issued for fiscal years 1985-87. Nonavailability statements issued for internal medicine showed the next greatest increase, about 5,900 (50 percent), followed by psychiatry, with an increase of about 5,000 (42 percent).

Beneficiary Outpatient Workload Decreased at Military Facilities

Beneficiary outpatient visits decreased at all three services' facilities for fiscal years 1985-87. DOD-wide, outpatient visits decreased from about 25.8 million in fiscal year 1985 to about 23.1 million in fiscal year 1987, a decrease of about 2.7 million (about 10 percent). Although outpatient visits of beneficiaries decreased, outpatient visits of active duty members increased by about 577,000 (4 percent).

For fiscal years 1985-87, Navy outpatient visits by beneficiaries decreased by about 2.2 million (33 percent); Air Force visits decreased by about 199,000 (2 percent); and Army visits decreased by about 242,000 (2.5 percent). The Navy's largest decrease was for fiscal years 1985-86, when outpatient visits decreased by about 1.4 million, followed

Figure 2.2: Number of Nonavailability Statements Issued by Each Military Service (Fiscal Years 1985-87)

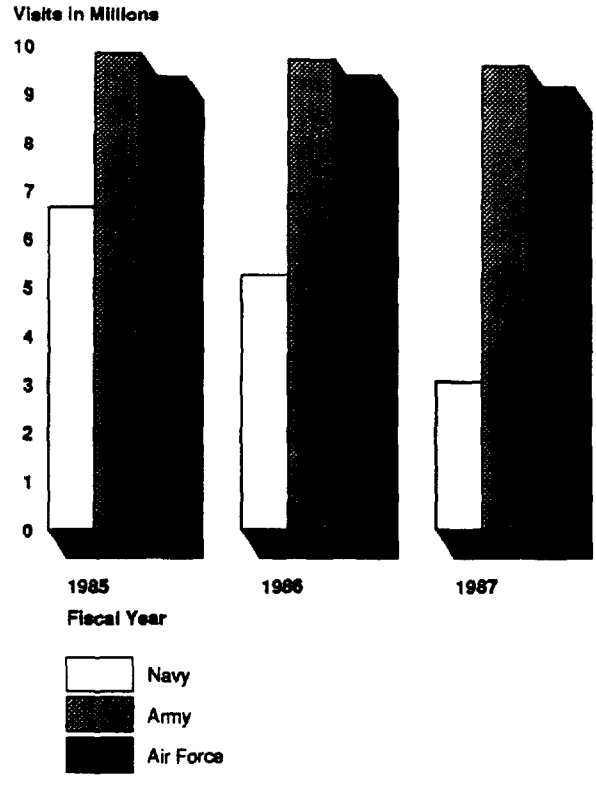


by a further decrease of about 823,000 in fiscal year 1987. Air Force outpatient visits increased by about 33,000 for fiscal years 1985-86, then decreased by 232,000 in fiscal year 1987. Army decreases were about the same each year: 121,000 for fiscal years 1985-86 and 122,000 for fiscal years 1986-87. In figure 2.3, the numbers of outpatient visits by military services are shown for fiscal years 1985-87.

Outpatient visits by all categories of beneficiaries decreased for fiscal years 1985-87. Visits by dependents of retired and deceased members decreased most, about 12 percent. Outpatient visits by dependents of active duty members decreased about 7 percent, while visits by retirees decreased about 1 percent.

Data were not available by medical specialty to separate beneficiaries' outpatient visits from active duty members' visits. Overall, however, the greatest reductions in the number of outpatient visits for fiscal years 1985-87 were in the obstetrics/gynecology specialty, in which visits

Figure 2.3: Outpatient Visits to Military Treatment Facilities by Beneficiaries
(Fiscal Years 1985-87)



decreased 11 percent. Of the remaining 11 medical specialties for which outpatient data were kept, pediatrics had the next largest decrease in outpatient visits, about 10 percent. Other specialties with significant decreases in visits included internal medicine and surgery, both with about a 6-percent decrease, and family practice, with a 5-percent decrease.

CHAMPUS Increases Resulted From Fewer Beneficiaries Being Treated at Military Facilities

For fiscal years 1985-87, CHAMPUS benefit costs rose from $1.4 billion to $2.1 billion. Of the $700 million increase, $690 million was for CHAMPUS payments to beneficiaries residing in the United States. Much of the $690 million increase can be attributed to an increase in utilization brought about by a reduction in inpatient and outpatient workload at the military medical facilities in the United States. The workload reduction, however, was not the sole contributor to increased CHAMPUS costs. Other factors that we identified included inflation in medical care costs

and increased utilization resulting from increases in the number of eligible beneficiaries and in the demand for services.

CHAMPUS Costs Increased in Areas Served by Military Facilities

The effect of reductions in military facilities' workload on CHAMPUS costs for fiscal years 1985-87 can, in large part, be explained by examining CHAMPUS costs for medical care to beneficiaries living within an approximate 40-mile radius—the catchment area—of the U.S. facilities. These beneficiaries are required to seek inpatient care first from military facilities; they are also likely to seek outpatient care from the facilities because they can obtain the care at no cost to themselves. Inability to get care at military facilities causes beneficiaries to seek care from alternative sources; our data indicate that many beneficiaries used CHAMPUS when care at military facilities was unavailable.

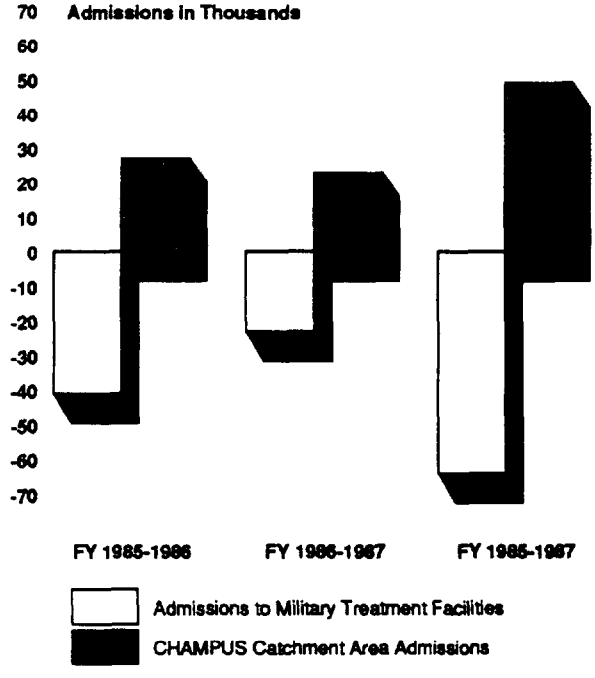
The CHAMPUS payment increases were concentrated in catchment areas. Of the $690 million increase in CHAMPUS costs for fiscal years 1985-87, about $547 million (79 percent) was for care to catchment-area beneficiaries. Of the $477 million increase in CHAMPUS inpatient costs, about $389 million (82 percent) was for care to catchment-area beneficiaries. Of the $214 million increase in CHAMPUS outpatient costs, about $157 million (73 percent) was for care to catchment-area beneficiaries.

In the base year of our study, fiscal year 1985, about 63 percent of CHAMPUS costs was for care to beneficiaries living in military facility catchment areas. By 1987, the share of CHAMPUS increased to about 68 percent.

Although inpatient admissions to military facilities decreased by 64,000 for fiscal years 1985-87, the number of inpatient admissions paid by CHAMPUS increased by 50,800; of these admissions, 49,900 were for beneficiaries living in catchment areas of military facilities. The yearly reduction in military hospital admissions and increases in CHAMPUS-paid admissions of beneficiaries residing in catchment areas is shown in figure 2.4.

Outpatient visits at military facilities, as discussed previously, decreased about 2.7 million for fiscal years 1985-87. During this period, CHAMPUS outpatient visits increased by almost 2.5 million, with about 1.8 million of those visits attributable to beneficiaries living in military facility catchment areas. The yearly change in outpatient visits at military facilities and visits paid by CHAMPUS for beneficiaries living in catchment areas is shown in figure 2.5.

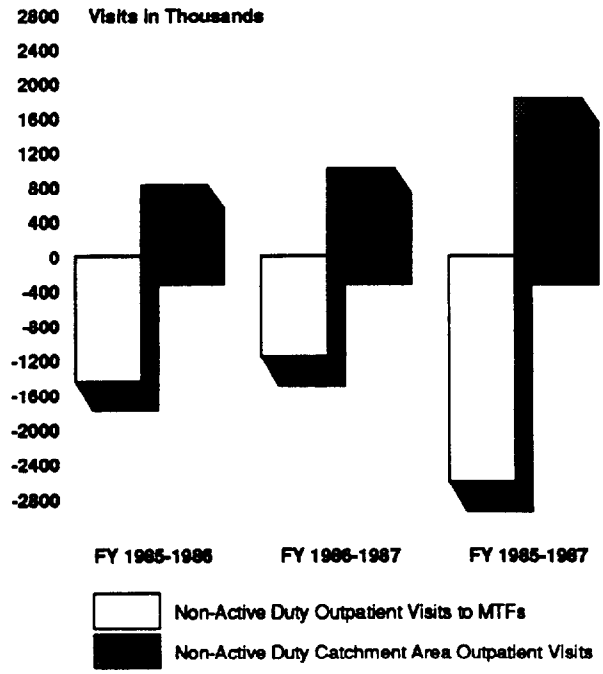
Figure 2.4: Decline in Inpatient Admissions to Military Medical Facilities Compared to Increased CHAMPUS Admissions in Military Medical Facility Catchment Areas



The increase in CHAMPUS workload and decrease in military facility workload does not exactly match for several reasons:

- Beneficiaries may have other insurance that they use instead of CHAMPUS when services are not available in military facilities.
- Beneficiaries may postpone or not get treatment, possibly because of CHAMPUS cost-sharing requirements.
- Beneficiaries eligible for care in military facilities are not identical to those eligible under CHAMPUS. For example, beneficiaries reaching the age of 65 retain eligibility for care in military facilities but lose eligibility under CHAMPUS.
- Beneficiaries may use civilian providers and not file a CHAMPUS claim because they do not meet the outpatient deductible requirement.
- Benefits under CHAMPUS are not identical to medical services available in military facilities. For example, beneficiaries can receive a complete physical examination in a military facility, but this service is not reimbursable under CHAMPUS.

Figure 2.5: Decline in Outpatient Visits to Military Medical Facilities Compared With Increased CHAMPUS Outpatient Visits in Military Medical Facility Catchment Areas



- CHAMPUS and military facilities do not count outpatient visits the same way. In maternity services, for example, each obstetrics visit to a military facility would be counted separately; under CHAMPUS, there would be no count because all such visits are included in the obstetrician's overall charge for the maternity service.

Other Factors Contributing to Increased CHAMPUS Costs

Other factors that contributed to the $690 million increase in CHAMPUS costs were (1) inflation in medical care costs and (2) increased CHAMPUS utilization, which was caused by an increase in the number of eligible beneficiaries and an increased demand for services.

The increases in medical care costs, calculated using OCHAMPUS-provided inflation factors for fiscal years 1986-87, accounted for about $65 million (9 percent) of the increase. The cost attributable to increased numbers of eligible beneficiaries totaled about $9.6 million, or 1 percent of the increase in CHAMPUS costs. This increase was calculated using data provided by the Defense Enrollment Eligibility Reporting System.

Although we were unable to quantify its effect precisely, increased demand for psychiatric services also contributed to increased CHAMPUS costs. In this specialty, the number of beneficiary admissions paid under CHAMPUS exceeded by over 2,700 the reduction in psychiatric admissions at military facilities for fiscal years 1985-87. In addition, although the number of psychiatric outpatient visits to military facilities remained fairly steady during the 1985-87 period, CHAMPUS data showed an increase of more than 204,000 visits paid for by it during the same period. Between fiscal years 1985 and 1987, we estimate that the additional demand for psychiatric care, both inpatient and outpatient, cost CHAMPUS about $69 million, or about 10 percent of the total $690 million increase in CHAMPUS costs.

To the extent that the contribution of these other sources of increases in CHAMPUS payments could be quantified, our calculations indicate that they account for about 20 percent of the $690 million increase. The reduction in workload at the military facilities, with an associated increase in utilization of CHAMPUS in catchment areas, might, therefore, account for up to about 79 percent of the increase in CHAMPUS payments.

Reasons for Decreased Beneficiary Workload at Military Medical Facilities

As discussed in chapter 2, one of the most significant reductions in beneficiary workload between fiscal years 1985 and 1987 was for obstetrical care. The main reasons for this were (1) a change in the number of newborn deliveries allowed for each obstetrician in some Navy facilities and (2) shortages of critical members of the obstetrical staff.

Other reasons for workload declines included (1) periodic and sporadic staffing shortages; (2) adoption of a new nurse staffing method, resulting in fewer patients per nurse and fewer admissions because no nurses were added to compensate for the change; (3) additional readiness training and deployments to temporary duty stations, reducing the time staff have available to treat beneficiaries; and (4) an increased emphasis on quality assurance, such as records review, which diverted staff away from direct patient care. Although collectively these reasons clearly contributed to the decreases in beneficiary workload at the facilities, the extent to which each contributed individually cannot be measured.

If successful, several initiatives planned or under way to control CHAMPUS costs could cause a turnaround in the trend of decreased beneficiary workload in military facilities. The initiatives, however, have not been in operation long enough to determine what effect they will have on increasing services to beneficiaries at these facilities.

Reasons for the Decrease in Obstetrics Workload

For fiscal years 1985-87, the obstetrics workload decreased over 13 percent DOD-wide. The two primary reasons for this decrease were (1) a change in the number of deliveries allowed at some facilities and (2) a shortage, sometimes temporary, of critical members of the obstetrics staff.

Change in Number of Allowable Deliveries Caused Workload Decrease

The decrease in obstetrics workload at facilities we visited is shown in table 3.1.

Table 3.1: Obstetrics Inpatient Cases
(Fiscal Years 1985 Through 1987)

Hospital	Fiscal year 1985	1986	1987	Percent decrease from 1985 to 1987
Navy:				
Camp Lejeune	1,918	1,214	1,263	34
Charleston	2,543	2,040	1,455	43
Long Beach[a]	1,112	142	0	100
Portsmouth	4,271	4,093	3,507	18
San Diego	5,441	3,855	2,818	48
Air Force:				
Luke	1,074	832	601	44
Nellis[b]	689	653	562	18
Travis	2,059	1,682	1,458	29
Army:				
Fort Ord	2,673	2,065	1,959	27
Fort Riley	1,768	1,495	1,313	26
Fort Stewart	1,282	1,408	1,205	6

Note: Deliveries and all other obstetrical services for both active duty and nonactive duty patients.

[a]Long Beach closed its obstetrics department in fiscal year 1986.

[b]Live births; obstetric cases not available.

At two of the facilities with the biggest decreases in workload—the naval hospitals in Charleston and San Diego—a policy change limiting deliveries to a monthly number of about 20 for a physician was the primary reason for the decrease. The change was made to improve the safe level of patient care.

Charleston Naval Hospital

At Charleston, the average monthly number of deliveries (live births) for an obstetrician decreased from 34 in fiscal year 1985 to 19 in fiscal year 1987. During the same period, the number of annual CHAMPUS-paid inpatient obstetric cases (most of which are deliveries, according to OCHAMPUS data) in the facility's catchment area increased from 532 to 1,919, an increase from about 44 percent to about 159 per month.

According to Charleston's obstetrics department chairman, the reduction in deliveries was attributable primarily to guidance provided by the Naval Medical Command concerning the provision of obstetrical/gynecological care in Navy medical facilities. In a November 29, 1985, memorandum to the Navy's Geographic Medical Commands, the commander of the Naval Medical Command said that the Navy was facing a major problem in meeting an increase in demand for care while experiencing

limited resource growth. The commander also said that safe levels of care had to be identified for each Navy provider. He further stated that obstetrics/gynecology was the first that had been evaluated within the "safe level of care" context. Accordingly, on the basis of analysis, including the recommendations of the American College of Obstetrics and Gynecology and the Navy obstetrics/gynecology specialty advisor, a maximum monthly level of 20 deliveries for a physician was proposed as the Navy-wide standard. According to Charleston's commanding officer, Charleston's reduced number of deliveries was the result of adopting the Naval Medical Command guidance.

San Diego Naval Hospital

At San Diego, the average monthly number of deliveries for a physician decreased from 37 in fiscal year 1985 to 18 in fiscal year 1987. During the same period, (1) total monthly deliveries, on average, decreased from about 400 to 200 and (2) the annual number of CHAMPUS-paid inpatient obstetrics cases for the catchment area served by this facility increased from 567 to 4,168.

The decrease in deliveries at San Diego was caused by (1) its adoption of the new Navy standard of 20 deliveries per provider per month, (2) hospital management's concern about the hospital's high perinatal mortality rate, and (3) a shortage of obstetrics nurses.

Shortages of Obstetrical Staff

At some facilities we visited, the decrease in deliveries was primarily caused by staff shortages. At the Long Beach Naval Hospital, shortages of critical members of the obstetrical staff caused the closing of the obstetrics department. At other facilities the shortages, although not necessarily in large numbers, were nevertheless important in terms of their effect on the facilities' workload.

Long Beach Naval Hospital

At Long Beach, critical staff shortages caused the facility to close its obstetrics/gynecology service in the spring of 1986. Thus, deliveries sharply decreased—from 1,112 in 1985 to 155 in 1986 to 0 in 1987. CHAMPUS-paid inpatient obstetrics cases for the facility's catchment area increased from about 1,380 in fiscal year 1985 to 3,313 in fiscal year 1987. In July 1986, the facility's two remaining obstetricians were reassigned to higher priority units because of a Navy-wide shortage of obstetricians. Because it is a nonteaching facility in an area with ample civilian medical providers, this facility is in the Navy's lowest priority category for physician assignments.

USAF Hospital, Luke Air Force Base

At Luke, staff shortages caused a decrease in annual deliveries from 635 in fiscal year 1985 to 366 in fiscal year 1987. During the same period, CHAMPUS-paid inpatient obstetrical cases for the catchment area served by the facility increased from 88 to 535. In fiscal year 1985, four obstetricians were assigned to Luke; in fiscal year 1986, two were assigned; and in fiscal year 1987, three were assigned. From March to June 1987, however, only one was assigned, so the facility referred all obstetrics/gynecology inpatients to CHAMPUS during that period.

Silas B. Hayes Army Community Hospital, Fort Ord

At Fort Ord, deliveries decreased from about 150 a month in fiscal year 1985 to about 100 a month in fiscal year 1987. The decrease in deliveries was primarily due to nursing shortages. During the same period, in the catchment area served by the facility, annual CHAMPUS-paid inpatient obstetrical cases increased from 80 to 708. The number of deliveries was reduced at Fort Ord when the chief of the hospital's neonatal nursery determined that the number of nurses assigned did not meet the minimum needed to provide safe levels of care.

Contributing to Fort Ord's decrease in deliveries was an uncertainty about the number of obstetricians who would be on staff during certain physician reassignment periods (usually during the summer months, when military physicians are reassigned). Accordingly, the facility referred to CHAMPUS many patients whose deliveries were expected during the reassignment period. Further complicating the staffing in fiscal year 1986 was that (1) one of the six obstetricians assigned was actually on extended temporary duty overseas and (2) another did not do deliveries.

Winn Army Community Hospital, Fort Stewart

At Fort Stewart, the decrease in deliveries was due to nursing shortages and insufficient nursery space. The hospital's deliveries decreased from about 75 a month in fiscal year 1985 to about 65 a month in fiscal year 1987. During the same period, the annual number of CHAMPUS-paid inpatient obstetrics cases in the facility's catchment area increased from 870 to 1,310.

Other Reasons for Overall Decrease in Workload

In addition to identifying reasons for decreases in the obstetrics workload, we identified several reasons for the overall decline in the beneficiary workload, such as

- medical position vacancies going unfilled, which necessitated referring patients to CHAMPUS;
- a change in the method of nurse staffing;
- increased medical readiness training and deployments to temporary duty stations, taking medical personnel away from patient care for beneficiaries; and
- an increased emphasis on quality of care.

Position Vacancies Contributed to Workload Decrease

Most of the facilities we visited experienced increased vacancies in key medical positions for fiscal years 1985-87 as a result of unfilled positions, transfers, retirements, or resignations. Although the vacancies may not appear to be significant in terms of their numbers, they nevertheless contributed to decreases in military facilities' workload and increases in referrals to CHAMPUS.

David Grant USAF Medical Center, Travis Air Force Base

According to this facility's workload data, cardiology experienced one of the largest inpatient workload reductions because of increased staff vacancies. Legal proceedings against one cardiologist prevented him from practicing medicine during the first three quarters of fiscal year 1986; moreover, this facility was short a cardiologist from June 1986 through mid-August 1987.

During this time period, inpatient admissions of beneficiaries decreased about 14 percent for fiscal years 1985-87. Outpatient visits of beneficiaries decreased about 6 percent during the same period. CHAMPUS-paid inpatient admissions for the hospital's catchment area increased 19 percent during this period, while CHAMPUS-paid outpatient visits for the catchment area increased 34 percent.

San Diego Naval Hospital

This facility's decrease in beneficiary inpatient workload was primarily due to staff vacancies for critical members in primary care and general surgery. Because about one-half of the patients who require surgery are usually seen initially by the primary care clinics, staff shortages in these clinics affected the hospital's surgical workload. Before the summer of

1985, 15 to 20 physicians were assigned to these clinics. During the summer of 1985, however, most of the physicians were deployed to sea, leaving the clinics with 4 to 5 physicians.

Vacancies in staff surgeon positions also led to the workload decline in surgery. Between January and September 1986, the facility lost 10 staff surgeons through retirement, transfer, or resignation, but only 2 of the 10 vacancies were filled. As a result, from 1985 to August 1986, the number of staffed general surgery beds declined from 100 to 58. In addition, trauma and critical care services had to be terminated. The number of CHAMPUS-paid general surgical admissions for the hospital's catchment area increased from 457 in fiscal year 1985 to 642 in fiscal year 1986, more than a 40-percent increase.

The facility's outpatient workload decrease was primarily due to staff vacancies in the pediatric clinic and in the primary care clinics. Since mid-1986, the pediatric clinic has had to loan one of its pediatricians to an active-duty treatment clinic on a full-time basis. Additionally, the facility reduced the number of clinic visits so that the pediatricians could provide more direct supervision to physicians in the residency program. According to facility officials, the increased supervision has resulted in a 10- to 15-percent decrease in outpatient visits. In the primary care clinics, staff shortages not only affected surgical inpatient workload, as discussed above, but also caused a two-thirds to three-fourths decrease in outpatient visits.

Inpatient admissions for beneficiaries decreased about 38 percent for fiscal years 1985-87; outpatient visits decreased about 42 percent during the same period. CHAMPUS-paid inpatient admissions for the catchment area served by the facility increased 118 percent during the same period; CHAMPUS-paid outpatient visits for the area increased 95 percent.

A New Nurse Staffing Method Resulted in Nurses Being Assigned to Care for Fewer Patients

A new method of nurse staffing contributed to a decrease in inpatient workload. The services adopted this new staffing method for nurses because of a recommendation by the Joint Commission on Accreditation of Health Care Organizations. In 1980, the Commission recommended that military medical departments implement a system by which the nurse staffing mix (number and type of nurses) is determined on the basis of patient care requirements. Consequently, the Army and the Navy developed a new nurse staffing system—the patient acuity system—which they implemented in 1984. The Air Force developed its own system but, at one of its commands, is also testing the Army and Navy

system. If the test is successful, within 2 to 3 years, the Air Force plans to implement the system at all of its facilities.

In general, the patient acuity system categorizes patients by level of required care. The hours of nursing care required and the recommended number and type of nurses needed to meet these requirements are calculated using the number of patients in each category. The actual number and type of nurses assigned is then compared with the recommended staffing to determine whether staffing levels are appropriate. If the actual staffing level in a given unit differs from the recommended level, either (1) the staffing is adjusted to the recommended level or (2) the number of admissions is adjusted to match the actual number and type of nursing staff available.

Officials at nearly all the facilities we visited told us that the patient acuity system has resulted in nurses being assigned to care for fewer patients and thus has contributed to workload declines.

Portsmouth Naval Hospital

At Portsmouth, differences between the number and type of nurses available and the recommended staffing levels resulted in nurses being assigned to care for 126 fewer authorized beds. According to the director of nursing services, the reduction of authorized beds from 524 to 398, and consequently the number of patients served, was necessary to assure the safe care of patients consistent with the new staffing system. For fiscal years 1985-87, CHAMPUS-paid inpatient admissions increased 37 percent in the catchment area served by the hospital.

San Diego Naval Hospital

At San Diego, an overall shortage of nurses, compounded by differences between actual nurse staffing levels and those recommended by the patient acuity system, caused this facility to close beds. According to the director of nursing services, this facility had from 42 to 85 fewer nurses than authorized in fiscal years 1986-87. Because of this shortage, as well as actual nurse staffing levels that were below those recommended by the patient acuity system, the facility reduced its operating capacity by 18 pediatric beds, 24 internal medicine beds, and 30 surgery beds.

Camp Lejeune Naval Hospital

At Camp Lejeune, according to the director of nursing services, since May 1986 the imbalance between authorized and available nurse staffing levels has caused the closing of an orthopedics ward, a pediatrics ward, and an internal medicine ward. For fiscal years 1985-87, CHAMPUS-

paid inpatient admissions increased 55 percent for the facility's catchment area.

David Grant USAF Medical Center, Travis Air Force Base

At Travis, the imbalance between authorized and recommended nurse staffing levels resulted in the November 1985 reduction (which was in effect for fiscal years 1986-87) in 10 beds on an internal medicine ward. This reduction in beds was a result of a 4-month monitoring of the ward, which established that its nurse staffing level was insufficient.

Training and Deployments of Medical Personnel Contributed to Workload Decline

Increased readiness training and deployments of medical staff, in all three military services, to temporary duty stations also contributed to the workload decline between fiscal years 1985-87. Although military officials cited increased readiness training and deployments as a major reason for reduced services at military facilities, data showing this were limited. Only the Navy had compiled deployment data for fiscal years 1985-87. According to these Navy data, staff-days spent on readiness training and deployments of medical staff increased from 19,801 in fiscal year 1985 to 31,984 in fiscal year 1986 to 38,949 in fiscal year 1987. The Army had compiled deployment data for the 3-year period, but not readiness training data. According to the Army data, staff-days spent on deployments of medical staff increased from 26,594 in fiscal year 1985 to 32,776 in fiscal year 1986 to 42,917 in fiscal year 1987. The Air Force had not compiled either type of data, but, according to officials of Air Force facilities we visited, the number of staff-days spent on readiness training has increased over the past few years.

Camp Lejeune Naval Hospital

At Camp Lejeune, the total number of staff-days spent on readiness training and deployments increased from 2,293 in calendar year 1986 to 4,320 in 1987. In 1987, a medical team was deployed to sea with the fleet from June to November, and a surgical team was deployed from June to September. The medical team consisted of 6 officers (3 surgeons, 1 anesthesiologist, 1 operating room nurse, and 1 Medical Services Corps officer) and 13 enlisted personnel. According to hospital officials, the deployment of the six operating room enlisted technicians on the surgical team resulted in the closing of one or two operating rooms during the period of deployment.

San Diego Naval Hospital

At San Diego, staff-days spent on readiness training and deployments increased from about 3,500 in fiscal year 1985 to nearly 22,000 in fiscal year 1987. In this year, most of the readiness training and deployments involved teams that are deployed for 3-month periods year-round with Navy and Marine Corps amphibious units. These teams, which are to augment the fleet's medical team, consist of three physicians, a nurse anesthetist, and an operating room nurse. According to the facility's mobilization planning official, the number of deployments is expected to double for fiscal year 1988 because of the activity in the Persian Gulf.

Charleston Naval Hospital

At Charleston, staff-days spent on readiness training and deployments increased from 1,264 in 1985 to 1,720 in 1986 to 2,191 in 1987. For 1987, the facility's chief of mobilization and planning estimated that physicians and nurses spent 1,202 staff days on readiness training and deployment. On one occasion, according to the chief, staff consisting of an orthopedist, a surgeon, an anesthesiologist, an operating room nurse, and a nurse anesthetist were deployed for 105 days. Other staff—such as general practitioners, radiologists, and pediatricians—were also deployed to temporary duty stations at various times of the year. In addition, technicians and corpsmen personnel were deployed for a total of 6.7 staff-years during fiscal year 1987. The technicians involved included those assigned to the operating room, laboratory, X-ray, pharmacy, and independent duty (for example, serving on submarines).

David Grant USAF Medical Center, Travis Air Force Base

At Travis, facility staff determined that the number of staff-days spent on readiness training increased from 3,832 to 6,665 for fiscal years 1985-87. Most of the training consisted of a new 3-day training exercise, implemented in about January 1986, that is required for all medical personnel. Several training sessions are scheduled in advance during the year to minimize disruption to facility operations.

USAF Hospital, Luke Air Force Base

At Luke, the number of medical staff involved in readiness training increased from 107 in fiscal year 1986 to 217 in fiscal year 1987. Much of the increase was due to an increased emphasis on Air Transportable Hospital training, in which the number of participating staff more than doubled for fiscal years 1986-87. This training involves a cross section of medical staff, such as physicians, nurses, and technicians.

Increased Quality Assurance Activities Contributed to Workload Decline

The amount of time that medical staff must spend on Quality Assurance programs for the military services has increased in recent years. Essentially, these programs are intended to (1) systematically monitor and review the practice of medicine at each facility and (2) identify and resolve problems in the delivery of medical care. Because these programs require extensive involvement by medical staff, primarily physicians, the time physicians have available to spend with patients is reduced. For example, physicians must document various quality assurance activities in medical records, worksheets, report forms, and committee meetings.

San Diego Naval Hospital

At San Diego, the number of staff involved in the Quality Assurance Program increased from 12 in fiscal year 1985 to 17 in fiscal year 1987. This facility now has 18 to 20 departmental Quality Assurance committees, which require a minimum of 2 to 4 hours a month on committee activities from participants, and an executive committee, which requires a considerable amount of time each month from participants. In past years, according to the facility's Quality Assurance Program director, these committees existed but were not very active, and some did not meet regularly. According to facility officials, the Quality Assurance Program has required more staff time. For example, only about 10 percent of patient charts were previously reviewed; all are now reviewed as a result of the Quality Assurance emphasis.

Portsmouth Naval Hospital

At Portsmouth, according to facility officials' estimates, the number of staff-days spent on the Quality Assurance Program increased from about 3,400 in fiscal year 1985 to about 5,700 in fiscal year 1987. During the same period, the number of medical staff involved in managing the program also increased, from 13 to 22.

David Grant USAF Medical Center, Travis Air Force Base

At Travis, the number of full-time staff involved in Quality Assurance has increased from one in fiscal year 1985 to three in fiscal year 1987. According to the chief of the inpatient records department, the facility's increased emphasis on Quality Assurance has resulted in more paperwork for physicians and more recordkeeping for the records department.

Irwin Army Community Hospital, Fort Riley

According to Fort Riley's Quality Assurance coordinator, the emphasis has continually increased since the Quality Assurance Program was established in fiscal year 1984. For fiscal years 1984-87, the number of staff involved in the Quality Assurance Program grew from one to two, with a third staff position authorized but filled. This facility did not keep records on the staff time involved in Quality Assurance activities.

Initiatives to Control CHAMPUS Costs

Although not directly related to the causes for the workload decline in military facilities, several initiatives are planned or under way in an attempt to control future cost increases as well as increase the availability of services to DOD beneficiaries. These include

- CHAMPUS Reform Initiative (CRI);
- implementation by CHAMPUS of a prospective payment system for most inpatient care;
- Catchment Area Demonstration Projects;
- Military-Civilian Health Service Partnership Program;
- appropriation of CHAMPUS funds to each of the military services rather than to DOD;
- Project Restore, which established certain goals for military medical departments in order to reduce CHAMPUS costs; and
- contractor-operated primary care clinics.

CRI is the most comprehensive of these initiatives. As discussed in our March 1987 report,[1] under CRI a contractor will be responsible for providing medical care to CHAMPUS beneficiaries in a defined geographical area. Key elements of the initiative include the awarding of fixed price contracts, a voluntary enrollment system providing enhanced benefits, improved coordination between military hospitals and CHAMPUS, and improved Quality Assurance standards. Proposed by DOD and approved by the Congress, CRI is being tested in California and Hawaii. If successful, the initiative is expected to be expanded to other states. One provision of CRI allows contractor personnel to provide medical services in military facilities to CHAMPUS beneficiaries.

Effective October 1, 1987, CHAMPUS started reimbursing hospitals for inpatient care on the basis of diagnosis-related groups—a reimbursement system similar to that used by Medicare. Diagnosis-related groups refers to a prospective payment methodology whereby hospitals are

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

reimbursed on the basis of the patients' diagnosis, regardless of the length of their hospital stays. OCHAMPUS estimates that over $100 million can be saved annually as a result of using this reimbursement system.

Catchment Area Demonstration Projects are being planned that will allow selected facilities in each of the military medical departments to use CHAMPUS funds to increase military facility staff and resources. These projects are planned to begin in fiscal year 1989.

Under the Military-Civilian Health Services Partnership Program, civilian physicians can practice in military hospitals. Discounts in fees to be paid are negotiated with providers because civilian physicians are able to avoid certain overhead costs by using military facilities. Beneficiaries also benefit in that CHAMPUS cost-sharing is eliminated for care received in military facilities.

Beginning in fiscal year 1988, the Congress changed the funding of CHAMPUS by appropriating funds to the individual services rather than providing funds to DOD. The principal objective of this change was to make each military service accountable for CHAMPUS expenditures and thereby more sensitive to program costs.

In September 1987, the Assistant Secretary of Defense (Health Affairs) announced a new effort to control CHAMPUS costs. This initiative, called Project Restore, (1) established certain goals for the military medical departments, including goals for restricting the number of nonavailability statements to be issued, and (2) consolidated a number of miscellaneous efforts aimed at better use of medical facilities and at controlling CHAMPUS costs.

On October 1, 1985, a civilian-operated primary care clinic began operations under contract with the Army. By the end of fiscal year 1990, the Army is programmed to have 10 such clinics; the Air Force, 5; and the Navy, 10. The intent of this program is to expand the accessibility of primary care to beneficiaries, to relieve overcrowding of military treatment facilities, and to provide care at a cost competitive with CHAMPUS.

It is too soon to determine what impact, either individually or collectively, these initiatives will have on increasing the availability of services to beneficiaries at military facilities. To the extent that these initiatives are successful in providing additional resources to military facilities, however, the availability of services should be increased.

Conclusions

It is not possible to measure the extent to which any one of several factors individually contributed to the decreasing workload at military medical facilities. No one single factor stands out as the sole contributor; rather, the decrease is the cumulative result of several changes that military medicine has undergone over the past several years—for example, a change to more stringent delivery standards, staff shortages in critical specialties, increased readiness training and deployments, and an increased emphasis on quality assurance.

Several initiatives under way have the potential to increase the availability or services provided by military facilities, as well as reduce or contain CHAMPUS costs. These initiatives have not been in operation long enough to determine what their impact will be.

Agency Comments

DOD commented on a draft of this report on April 28, 1989 (see app. II). The Department agreed with the report's findings and conclusions. It said that the major factor for increased CHAMPUS costs between fiscal years 1985-87 was a reduction of workload at military hospitals in the United States. It also said that the initiatives to control CHAMPUS costs, discussed in this report, were implemented to improve medical services and reduce civilian health care costs to the government and beneficiaries.

Hospitals Visited by GAO: Rankings in Reduced Inpatient Admissions and in CHAMPUS Cost Increases for Catchment Areas Served by the Hospitals

Military hospital	Ranking in reduced inpatient admissions: Among all 129 hospitals	Ranking in reduced inpatient admissions: Among own service's hospitals	Ranking in CHAMPUS cost increase catchment areas nationwide
Army (37 hospitals):			
Silas B. Hays Army Community California Hospital, Fort Ord	15	1	30
Irwin Army Community Hospital, Fort Riley, Kansas	25	2	39
Winn Army Community Hospital, Fort Stewart, Georgia	100	15	17
Navy (25 hospitals):			
Naval Hospital Camp Lejeune, North Carolina	6	6	9
Naval Hospital Charleston, South Carolina	2	2	6
Naval Hospital Long Beach, California	3	3	2
Naval Hospital Portsmouth, Virginia	4	4	18
Naval Hospital San Diego, California	1	1	1
Air Force (67 hospitals):			
USAF Hospital, Luke AFB, Arizona	14	4	50
USAF Hospital, Nellis AFB, Nevada	26	13	7
David Grant USAF Medical Center, Travis AFB, California	9	1	62

Note: Because full fiscal year 1987 data were not available when we selected hospitals for review, we compared inpatient admissions and CHAMPUS costs from the same 6-month periods in fiscal years 1985 and 1987.

Military Hospital Inpatient Admissions by Beneficiary Category (Fiscal Years 1985-87)

Beneficiary category	Fiscal years 1985	1986	1987
Navy hospitals:			
Active duty	69,201	71,169	74,250
Nonactive duty:			
Dependents of active duty	89,507	70,354	61,236
Retirees	24,698	20,331	17,691
Dependents of retired and deceased	25,454	20,123	16,869
Other	3,027	2,318	2,344
Total	**142,686**	**113,126**	**98,140**
Combined active duty and nonactive duty	**211,887**	**184,295**	**172,390**
Air Force hospitals:			
Active duty	64,888	63,503	65,915
Nonactive duty:			
Dependents of active duty	119,011	112,984	108,663
Retirees	37,037	34,893	33,667
Dependents of retired and deceased	44,243	42,086	39,341
Other	4,313	3,989	4,141
Total	**204,604**	**193,952**	**185,812**
Combined active duty and nonactive duty	**269,492**	**257,455**	**251,727**
Army hospitals:			
Active duty	100,891	116,252	126,295
Nonactive duty:			
Dependents of active duty	128,069	125,413	128,679
Retirees	50,640	50,549	52,197
Dependents of retired and deceased	47,160	45,979	46,643
Other	7,292	7,411	7,649
Total	**233,161**	**229,352**	**235,168**
Combined active duty and nonactive duty	**334,052**	**345,604**	**361,463**

Note: Beneficiaries served by hospitals of each service do not equal totals as cited in chapter 2. Differences are due to two different DOD sources being used. The data used in chapter 2 were verified by the military services but did not show admissions by beneficiary category.

Increase or (decrease) 1985-86		Increase or (decrease) 1986-87		Increase or (decrease) 1985-87	
Number	Percent	Number	Percent	Number	Percent
1,968	3	3,081	4	5,049	7
−19,153	−21	−9,118	−13	−28,271	−32
−4,367	−18	−2,640	−13	−7,007	−28
−5,331	−21	−3,254	−16	−8,585	−34
−709	−23	−26	−1	−683	−23
−29,560	**−21**	**−14,986**	**−13**	**−44,546**	**−31**
−27,592	**−13**	**−11,905**	**−6**	**−39,497**	**−19**
−1,385	−2	2,412	4	1,027	2
−6,027	−5	−4,321	−4	−10,348	−9
−2,144	−6	−1,226	−4	−3,370	−9
−2,157	−5	−2,745	−7	−4,902	−11
−324	−8	152	4	−172	−4
−10,652	**−5**	**−8,140**	**−4**	**−18,792**	**−9**
−12,037	**−4**	**−5,728**	**−2**	**−17,765**	**−7**
15,361	15	10,043	9	25,404	25
−2,656	−2	3,266	3	610	0
−91	0	1,648	3	1,557	3
−1,181	−3	664	1	−517	−1
119	2	238	3	357	5
−3,809	**−2**	**5,816**	**3**	**2,007**	**1**
11,552	**3**	**15,859**	**5**	**27,411**	**8**

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

28 APR 1989

Mr. Frank C. Conahan
Assistant Comptroller General
National Security and
International Affairs Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Conahan:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report entitled, "DEFENSE HEALTH CARE: Workload Reductions at Military Hospitals Have Increased CHAMPUS Costs," dated March 21, 1989 (GAO Code 101319/OSD Case 7940). The DoD agrees with the report.

The Department agrees that the major factor for increased CHAMPUS costs during the FY 1985 - FY 1987 period was workload reductions at military hospitals in the United States. The report notes that this issue has appropriately become the theme of CHAMPUS cost containment efforts. Placing the spotlight on innovative ways to promote the most effective use of existing medical treatment facilities capabilities is the most significant long-term strategy to reduce CHAMPUS costs. Project RESTORE was implemented, as recognized by the GAO, to improve direct care services and reduce civilian health care costs to the Government and beneficiaries. The Department plans to push and strengthen these initiatives. The initiatives will be evaluated to ensure they meet the theme of both cost containment and cost effectiveness.

The findings are addressed in greater detail in the enclosure. (Suggested technical corrections have been separately provided to members of your staff.) The DoD appreciates the opportunity to comment on the draft report.

Sincerely,

David Newhall, III
Acting

Enclosure

GAO DRAFT REPORT - DATED MARCH 21, 1989
(GAO CODE 101319) OSD CASE 7940

"DEFENSE HEALTH CARE: WORKLOAD REDUCTIONS AT MILITARY HOSPITALS HAVE INCREASED CHAMPUS COSTS"

DEPARTMENT OF DEFENSE COMMENTS

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FINDINGS

FINDING A: Beneficiary Workload Has Decreased In Military Facilities. The GAO reported that, DoD-wide, both inpatient admissions and outpatient visits of beneficiaries to military medical facilities has decreased in recent years. The GAO found that the greatest decrease in inpatient admissions occurred in Navy facilities, which experienced a 31.5 percent decrease from FY 1985 to FY 1987. During this same period, the GAO found that Air Force inpatient admissions decreased about 9 percent, while Army admissions experienced an increase of less than 1 percent. The GAO also found that, in contrast to the inpatient admissions of beneficiaries, admissions for active duty members increased by about 7 percent from FY 1985 to FY 1987. When both active duty members and beneficiaries are considered, the GAO found there was a 6 percent net decrease in admissions for this period. The GAO further found that, DoD-wide, this same trend occurred in all of the three beneficiary categories, and in most of the medical specialty categories. (p. 4, pp. 27-31/GAO Draft Report)

Now on pp. 15-17.

DoD Response: Concur.

FINDING B: Changes in Nonavailability Statements. The GAO reported that, between FY 1985 and FY 1987, the number of nonavailability statements issued by military facilities increased by about 32,500. The GAO found that about 60 percent of the nonavailability statements were issued by Navy facilities, mostly for FY 1985 and FY 1986, while almost 23 percent were for the Air Force. The GAO also found that the Army, despite its slight increase in inpatient admissions, increased the number of nonavailability statements issued during the period. The GAO cited two possible reasons for the Army increase:

- demand for care has increased; and

Enclosure

- beneficiaries are crossing over to the Army when Navy or Air Force facilities are not able to provide requested care.

The GAO concluded the trend in the number of nonavailability statements issued indicates that there was an increase in the number of instances of medical care being sought by beneficiaries living within the catchment areas of military facilities, but not obtainable from the facilities. The GAO further concluded, therefore, that the decreases in inpatient admissions to military facilities were not due to decreases in the demand for care. (p. 4, pp. 31-33/GAO Draft Report)

Now on pp. 17-18.

DoD Response: Concur. The number of nonavailability statements issued by military medical treatment facilities increased from FY 1985 to FY 1987. This trend reflects an increase in the number of instances when medical care is sought by beneficiaries, but is not available.

FINDING C: Changes In Beneficiary Outpatient Workload At Military Facilities. The GAO found that, between FY 1985 and FY 1987, beneficiary outpatient visits decreased at medical facilities of all three Services, with an overall DoD-wide decrease of about 10 percent. The GAO found that, during this period, Navy outpatient visits by beneficiaries decreased by about 33 percent, while Army and Air Force visits decreased by between 2 and 3 percent. The GAO noted that data were not available by medical specialty to separate beneficiary outpatient visits from those of active duty members. The GAO observed, however, that the greatest overall reductions occurred in obstetrics, gynecology and pediatrics. (p. 4, pp. 33-35/GAO Draft Report)

Now on pp. 18-20.

DoD Response: Concur. The Department agrees that, between FY 1985 and FY 1987, beneficiary outpatient visits decreased at military medical treatment facilities of all Services, with an overall DoD-wide decrease of about 10 percent. The GAO does not fully recognize the volume of active duty health care workload, particularly that performed outside fixed medical facilities.

FINDING D: Increases In Civilian Health And Medical Program Of The Uniformed Services (CHAMPUS) Costs. The GAO reported that, between FY 1985 and FY 1987, CHAMPUS benefit costs rose from $1.4 billion to $2.1 billion, with about $690 million of the $700 million increase for CHAMPUS payments to beneficiaries residing in the U.S. The GAO found that about 79 percent of

the $690 million increase was for care provided to beneficiaries located within a 40 mile radius of military medical facilities (i.e., the catchment area). The GAO pointed out that, although inpatient admissions to military facilities decreased by 64,000 between FY 1985 to FY 1987, the number of inpatient admissions paid by CHAMPUS increased by 50,800. Most of these inpatients lived within the catchment areas of military facilities. The GAO noted a similar trend in outpatient visits. While noting several reasons why the increase in CHAMPUS workload and decrease in military facility workload does not exactly match, the GAO concluded that, overall, much of the increase in CHAMPUS costs between FY 1985 and FY 1987 can be attributed to an increase in utilization brought about by a reduction in inpatient and outpatient workload at military medical facilities in the U.S. (p. 5, pp. 35-40/GAO Draft Report)

Now on pp. 21-23.

DoD Response: Concur. The Department agrees that, overall, much of the increase in CHAMPUS costs between FY 1985 and FY 1987 can be attributed to a reduction in inpatient and outpatient workload at military medical treatment facilities in the U.S.

FINDING E: Other Factors Contributing To Increased CHAMPUS Costs. In addition to the workload reduction at military medical facilities, the GAO identified several other factors that contributed to increased CHAMPUS costs. The GAO found that about 9 percent of the increase was the result of inflation in medical care costs. The GAO found that another factor was an increase in the number of eligible beneficiaries, which accounted for about 1 percent of the increase in CHAMPUS costs. A third factor for the increase in CHAMPUS costs identified by the GAO was an increase in the demand for services. In this regard, the GAO estimated that the additional demand for psychiatric care between FY 1985 and FY 1987, cost the CHAMPUS about $69 million, or about 10 percent of the total increase in CHAMPUS costs. The GAO estimated that, overall, factors other than workload reduction at military medical facilities accounted for about 20 percent of the total increase in CHAMPUS costs during that period, while the associated increase in utilization of the CHAMPUS in catchment areas (see Finding D) might account for up to about 79 percent of the increase in CHAMPUS payments. (p. 5, pp. 40-41/GAO Draft Report)

Now on pp. 23-24.

DoD Response: Concur.

Now on pp. 25-28.

FINDING F: Reductions In Obstetrical Care At Military Medical Facilities. The GAO found that one of the most significant reductions in beneficiary workload at military medical facilities, between FY 1985 and FY 1987, was for obstetrical care. The GAO found that, during this period, the obstetrics workload decreased over 13 percent, DoD-wide. The GAO visited five Navy, three Army and three Air Force medical facilities and found that the percentage decrease in obstetrics cases from FY 1985 to FY 1987 ranged from 6 to 100 percent. The GAO identified two primary reasons for the decrease in obstetrics workload:

- a change in the number of deliveries allowed at some facilities; and
- a shortage, sometimes temporary, of critical members of the obstetrics staff. (p. 5, pp. 42-49/GAO Draft Report)

DoD Response: Concur.

FINDING G: Other Reasons For Decreased Beneficiary Workload At Military Medical Facilities. In addition to the decrease in the obstetrics workload, the GAO identified several other reasons for the decline in the military facilities workload. The GAO found that most of the military facilities it visited experienced increased vacancies in key medical positions for FY 1985 to FY 1987. The GAO noted that, while the vacancies may not be significant in terms of numbers, they did contribute to the military facilities workload decline and to increased referrals to the CHAMPUS. A second reason identified by the GAO was a new method of nurse staffing adopted by the Services, known as the patient acuity system. The GAO explained that this system categorizes patients by level of required care and the number of nurses needed is then calculated based on the number of patients in each category. According to the GAO, officials at most of the facilities it visited said this system has resulted in nurses being assigned to care for fewer patients, thus contributing to workload declines. A third reason cited by the GAO was an increase in readiness training and deployments of medical staff to temporary duty stations. The GAO reported that Navy data (the only Service that had compiled such data) showed that staff days spent on readiness training and deployments increased from 19,801 in FY 1985 to 38,949 in FY 1987. The GAO found that a fourth reason for decreased workload at military facilities was an increase in the amount of time medical staff must spend on quality assurance programs. The GAO explained that these programs

Now on pp. 28-35.

require extensive involvement of medical staff, particularly physicians which, in turn, decreases the time available to spend with patients. The GAO concluded that, although the extent cannot be individually measured, collectively these reasons clearly contributed to the decreases in beneficiary workload at the military facilities. (p. 5, p. 42, pp. 49-63/GAO Draft Report)

DoD Response: Concur. The Department agrees that a number of reasons contributed collectively to decreases between FY 1985 and FY 1987 in beneficiary workload at military medical treatment facilities. While the contribution of these reasons is intuitive, their individual contribution to decreased workload is difficult to measure.

FINDING H: Initiatives To Control CHAMPUS Costs. The GAO found that although they are not directly related to the causes for the workload decline at military facilities, several initiatives are planned or underway to control future cost increases and increase the availability of services to DoD beneficiaries. According to the GAO, the most comprehensive is the CHAMPUS Reform Initiative (CRI), discussed in a March 1987 GAO report[1]. The GAO explained that, under the CRI, a contractor will be responsible for providing medical care to CHAMPUS beneficiaries in a defined area and includes a provision allowing contractor personnel to provide medical services in military facilities to CHAMPUS beneficiaries. The GAO noted that the CRI is currently being tested in two states, with plans to expand to other states, if successful. In addition to the CRI, the GAO identified several other initiatives to control CHAMPUS costs, including:

- implementation of a retrospective payment system by CHAMPUS for most inpatient care, similar to that used by Medicare;
- Catchment Area Demonstration Projects, planned to begin in FY 1989 to allow military medical departments to use CHAMPUS funds to increase military facility staff and resources;

[1] GAO/HRD-87-65BR, "DEFENSE HEALTH CARE: CHAMPUS Reform Initiative-Unresolved Issues," Dated March 4, 1989 (OSD Case 7245)

- the Military-Civilian Health Service Partnership Program, which allows civilian physicians to practice in military hospitals;

- the appropriation of CHAMPUS funds to each of the Services rather than the OSD, thus making each Service accountable for CHAMPUS expenditures;

- initiation of Project Restore, which includes the establishment of goals to restrict the number of non-availability statements to be issued; and

- the consolidation of various efforts to better use medical facilities and control CHAMPUS costs.

The GAO concluded that, while it is still too soon to determine what impact these initiatives will have, they have the potential to increase the availability of services provided by military facilities and reduce or contain CHAMPUS costs. (p. 5, p. 42, pp. 63-67/GAO Draft Report)

Now on pp. 35-36.

DoD Response: Concur. A number of initiatives, including those listed above, are underway with the potential to control future cost increases and to increase the availability of military medical treatment facility services to DoD beneficiaries.

RECOMMENDATIONS

o NONE

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