REPORT TO THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES

Potential For Reducing Hospital And Administrative Costs Under The Civilian Health And Medical Program Of The Uniformed Services B-133742

Department of Defense

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

APRIL 16, 1971

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

B-133142

Dear Mr. Chairman:

The General Accounting Office has made a review of costs related to care furnished by hospitals under the Civilian Health and Medical Program of the Uniformed Services. The review was made in accordance with your request of October 20, 1969. This is our third report pursuant to this request. We expect to issue a summary report on the results of our review shortly.

We have not obtained written comments from the Department of Defense on the matters included in the report. We have discussed these matters with officials of the Office for the Civilian Health and Medical Program of the Uniformed Services, the Blue Cross Association--prime contractor--and four Blue Cross Plans--subcontractors--where audit work was performed.

We plan to make no further distribution of this report 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

P
X The Honorable George H. Mahon
(1) Chairman, Committee on Appropriations H 30
House of Representatives

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

POTENTIAL FOR REDUCING HOSPITAL AND ADMINISTRATIVE COSTS UNDER 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 Chairman of the Committee on Appropriations, House of Representatives, asked the General Accounting Office (GAO) by letter of October 20, 1969, 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 page 6.

This report--GAO's third in this area--deals with three matters identified by the Chairman as topics of special interest.

- --Charges made by hospitals for care furnished to beneficiaries under the program.
- --Related administrative costs.
- --Audits of payments to hospitals and of administrative costs of the program.

Also GAO examined into the overall rise in hospital costs and the efforts made to contain them, since they directly influence program costs.

Written comments have not been obtained from the Department of Defense on matters discussed in this report.

FINDINGS AND CONCLUSIONS

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, Pub. L. 89-614), 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.)

Tear Sheet

APRIL 16, 1971

Comparison of hospital charges

Comparison of hospital claims paid under this program with amounts paid under several medical insurance programs and review of hospital billing procedures showed that program beneficiaries were generally charged the same for comparable care and services as were other hospital patients.

GAO found that, although hospital charges had been consistently applied, the total charge per claim for insured patients, including program beneficiaries, had exceeded that for uninsured patients, primarily because of a longer average length of hospital stay. (See pp. 14 to 20.)

The average length of hospital stay for maternity cases under the program differed widely among hospitals and among geographic areas. The average length of stay for maternity cases under the program 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 experience of those hospitals where the lengths of stay are shorter.

GAO is not in a position to say whether a shorter length of stay is feasible or attainable. (See pp. 15 and 19 to 23.)

Hospitals generally charge less than cost for maternity care but recover 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, the program 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 the program were for such care. (See pp. 17 to 19.)

Total payments to hospitals 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 program claims. In fiscal year 1968 this 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 program claims on different bases than those used for the Plans' private subscribers claims.

The program could have saved at least $850,000 annually, GAO estimates, had the Plans been able to extend to the program the more favorable reimbursement rates. (See pp. 24 and 25.)

Rising cost of hospital care

Salaries account for almost two thirds of hospital operating expenses. The rise in salary expense is the major reason for the recent dramatic increase in the cost of hospital care.

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

Other contributory factors 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.)

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 discourage unnecessary hospitalization.

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 discussed in chapter 5. 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.)

Reasonableness of administrative costs

Payments by the Office for the Civilian Health and Medical Program of the Uniformed Services to selected fiscal agents for costs incurred in

processing hospital claims were, for the most part, allowable under contract provisions.

The Office, however, has exercised limited managerial control, and opportunities for cost reductions had not been identified or had not been acted upon by responsible officials. There is potential for substantial reductions in administrative costs. (See pp. 61 and 62.)

Savings would have been achieved if the Office 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 fiscal year 1968. (See 61 to 69.)

GAO believes that further savings may be possible if the Office were to

--take advantage of differences in certain geographical areas between the administrative costs per claim charged by the Blue Cross Plans and those charged by Mutual of Omaha Insurance Company, and

--award contracts for paying hospital claims on a competitive basis. (See pp. 66 and 67.)

Adequacy of audits

The Department of Health, Education, and Welfare's Audit Agency audits of selected fiscal agents that we reviewed 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.)

RECOMMENDATIONS OR SUGGESTIONS

713

2 The Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services, should consider

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

--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 the program 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 the program; and

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

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.)

Tear Sheet

Contents

ABBREVIATIONS

CHAMPUS Civilian Health and Medical Program of the Uniform Services

GAO General Accounting Office

HEWAA Health, Education, and Welfare Audit Agency

OCHAMPUS Office for the Civilian Health and Medical Program of the Uniformed Services

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

POTENTIAL FOR REDUCING HOSPITAL AND ADMINISTRATIVE COSTS UNDER 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 Chairman of the Committee on Appropriations, House of Representatives, asked the General Accounting Office (GAO) by letter of October 20, 1969, 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 page 6.

This report--GAO's third in this area--deals with three matters identified by the Chairman as topics of special interest.

--Charges made by hospitals for care furnished to beneficiaries under the program.

--Related administrative costs.

--Audits of payments to hospitals and of administrative costs of the program.

Also GAO examined into the overall rise in hospital costs and the efforts made to contain them, since they directly influence program costs.

Written comments have not been obtained from the Department of Defense on matters discussed in this report.

FINDINGS AND CONCLUSIONS

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, Pub. L. 89-614), 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.)

Comparison of hospital charges

Comparison of hospital claims paid under this program with amounts paid under several medical insurance programs and review of hospital billing procedures showed that program beneficiaries were generally charged the same for comparable care and services as were other hospital patients.

GAO found that, although hospital charges had been consistently applied, the total charge per claim for insured patients, including program beneficiaries, had exceeded that for uninsured patients, primarily because of a longer average length of hospital stay. (See pp. 14 to 20.)

The average length of hospital stay for maternity cases under the program differed widely among hospitals and among geographic areas. The average length of stay for maternity cases under the program 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 experience of those hospitals where the lengths of stay are shorter.

GAO is not in a position to say whether a shorter length of stay is feasible or attainable. (See pp. 15 and 19 to 23.)

Hospitals generally charge less than cost for maternity care but recover 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, the program 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 the program were for such care. (See pp. 17 to 19.)

Total payments to hospitals 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 program claims. In fiscal year 1968 this 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 program claims on different bases than those used for the Plans' private subscribers claims.

The program could have saved at least $850,000 annually, GAO estimates, had the Plans been able to extend to the program the more favorable reimbursement rates. (See pp. 24 and 25.)

Rising cost of hospital care

Salaries account for almost two thirds of hospital operating expenses. The rise in salary expense is the major reason for the recent dramatic increase in the cost of hospital care.

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

Other contributory factors 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.)

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 discourage unnecessary hospitalization.

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 discussed in chapter 5. 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.)

Reasonableness of administrative costs

Payments by the Office for the Civilian Health and Medical Program of the Uniformed Services to selected fiscal agents for costs incurred in

processing hospital claims were, for the most part, allowable under contract provisions.

The Office, however, has exercised limited managerial control, and opportunities for cost reductions had not been identified or had not been acted upon by responsible officials. There is potential for substantial reductions in administrative costs. (See pp. 61 and 62.)

Savings would have been achieved if the Office 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 fiscal year 1968. (See 61 to 69.)

GAO believes that further savings may be possible if the Office were to

--take advantage of differences in certain geographical areas between the administrative costs per claim charged by the Blue Cross Plans and those charged by Mutual of Omaha Insurance Company, and

--award contracts for paying hospital claims on a competitive basis. (See pp. 66 and 67.)

Adequacy of audits

The Department of Health, Education, and Welfare's Audit Agency audits of selected fiscal agents that we reviewed 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.)

RECOMMENDATIONS OR SUGGESTIONS

The Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services, should consider

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

--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 the program 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 the program; and

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

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.)

CHAPTER 1

INTRODUCTION

The General Accounting Office, in response to a request from the Chairman, Committee on Appropriations, House of Representatives, has reviewed the Civilian Health and Medical Program of the Uniformed Services[1] (CHAMPUS). This report discusses the results of the review of the hospital component of CHAMPUS in the United States. Under that component, medical care is provided in civilian hospitals to dependents of active duty members, to dependents of deceased members, and to retired members and their dependents. The scope of our review is described on pages 76 and 77.

The review was directed toward examining into (1) the reasonableness of fees charged and profits realized by participating hospitals, (2) the causes for rising medical costs in hospitals and the methods being employed to control them, (3) the reasonableness of administrative costs incurred to process CHAMPUS claims, and (4) the adequacy of audits made by the Department of Health, Education, and Welfare's Audit Agency--the principal agency conducting audits at fiscal agents' offices--of the administrative costs incurred and the benefit payments made for hospital services under CHAMPUS.

Because of the lack of criteria and data for determining the reasonableness of hospital charges and profits--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. The results of our comparisons are discussed in chapter 3.

The responsibility for administering CHAMPUS has been delegated by the Secretary of Defense and the Secretary of

---

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

Health, Education, and Welfare, through channels, to the Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), who functions under the jurisdiction of the Surgeon General, Department of the Army. OCHAMPUS, located at Fitzsimons General Hospital near Denver, Colorado, was established for the purpose of administering CHAMPUS in the United States, Puerto Rico, Canada, and Mexico.

The Blue Cross Association, located in Chicago, Illinois, has served as a prime contractor for the payment of hospital inpatient claims in 33 states, the District of Columbia, and Puerto Rico since the inception of the program in 1956. The Blue Cross Association subcontracts to 52 of its 80 member Blue Cross Plans for the processing and payment of CHAMPUS claims. Mutual of Omaha, the other prime contractor, processes hospital claims for the remaining 17 states through its central office in Omaha, Nebraska. Appendix II contains a listing of the geographic areas administered by the Blue Cross Association and Mutual of Omaha and the names and locations of the 52 participating Blue Cross Plans.

CHAPTER 2

INCREASED COST AND USE OF HOSPITAL SERVICES UNDER CHAMPUS

Rising costs of medical care, discussed in chapter 4, and other contributory factors, such as expanded benefits and the addition of new classes of beneficiaries authorized by the Military Medical Benefits Amendments of 1966, and increased use of CHAMPUS have caused significant increases in hospital costs since inception of the program in 1956. A substantial part of the increase occurred after 1966, costs having increased from $46.2 million in 1966 to $134.5 million in 1969. Exhibit A shows total hospital payments under CHAMPUS from its inception through 1969.

INCREASED BENEFITS AND NEW CLASSES OF BENEFICIARIES UNDER CHAMPUS

The Armed Forces have traditionally provided medical care to dependents of service members in facilities of the uniformed services when it could be provided without interfering with providing necessary care to active duty personnel. Prior to CHAMPUS, dependents who resided at locations where medical facilities of the uniformed services were not available or where the facilities were being fully utilized had to pay the full cost for care they obtained from civilian sources. Further, considerable disparity existed among the branches of the uniformed services in the types of medical care provided and in the categories of dependents designated as eligible to receive care at uniformed services facilities.

The Dependents Medical Care Act of 1956 (Pub. L. 84-569) authorized dependent spouses and children of active duty members of the uniformed services to receive medical care benefits from civilian hospitals and physicians. The act directed the Secretary of Defense to contract with civilian sources for certain authorized medical care for eligible dependents. The act included definitions of the categories of dependents who were eligible and the types of medical

care to be provided in facilities of the uniformed services. The program became effective on December 7, 1956.

The Military Medical Benefits Amendments of 1966 expanded the coverage to include retired members and their dependents and the dependents of deceased members. The amendments also authorized additional services from civilian sources for eligible CHAMPUS beneficiaries.

Although statistics for a precise measurement of the effect of the 1966 amendments were not readily available, our analyses indicated that about 46 percent of the total increase in program costs from fiscal year 1966--which included costs for dependents of active duty personnel only--to fiscal year 1969 was attributable to the addition of new classes of beneficiaries and the expansion of benefits authorized by the 1966 amendments. The remaining increased costs stemmed from increased use of the program by beneficiaries and from higher medical costs.

INCREASED USE OF CHAMPUS BY BENEFICIARIES

In recent years an increasing number of beneficiaries have used the benefits available under CHAMPUS. Although exact figures were not available, we estimated, on the basis of a special OCHAMPUS study, that approximately 400,000 of the 6 million eligible beneficiaries used CHAMPUS in fiscal year 1969--an increase of about 30,000 over the number of beneficiaries who received benefits in fiscal year 1968 and nearly double the number who received benefits prior to expansion of the program. Care for dependents of active duty members represented about three fourths of the hospital costs under CHAMPUS during 1969, but OCHAMPUS expects a greater percentage of expenditures for other eligible dependents in future years.

The following table shows that the increase in paid hospital claims from fiscal year 1966 to fiscal year 1969 was about 40 percent.

Fiscal year	Number of paid hospital claims
1966	254,353
1967	282,334
1968	325,792
1969	355,348

Since 1967 there has been a definite upward trend in admissions of CHAMPUS beneficiaries to civilian hospitals as a percent of the total admissions of the beneficiaries in both civilian and military hospitals. Also, as admissions of dependents of active duty personnel to civilian hospitals have increased, admissions to uniformed services hospitals have declined by almost the same amount. The following data from the 13th annual CHAMPUS report shows the relationship between admissions to civilian and uniformed services hospitals.

Estimated Admissions of
all Eligible CHAMPUS Beneficiaries to
Civilian and Service Hospitals in
the United States and Puerto Rico
During Calendar Years 1967-69

Category of beneficiary	Number of admissions: Civilian hospitals (note a)	Number of admissions: Service hospitals (note b)	Admissions in civilian hospitals as a percent of all admissions
	(thousands)		
Dependents of active duty personnel:			
1967	244.9	372.2	39.7
1968	262.4	353.7	42.6
1969	271.5	341.3	44.3
Retired personnel:			
1967	11.3	52.5	17.7
1968	16.7	56.3	22.9
1969	20.2	58.6	25.6
Dependents of retired or deceased personnel:			
1967	38.3	82.9	31.6
1968	55.2	86.1	39.1
1969	66.9	89.2	42.9
All eligible beneficiaries:			
1967	294.5	507.6	36.7
1968	334.3	496.1	40.3
1969	358.6	489.1	42.3

[a]Due to lag in submission of claims, 1969 admissions are slightly understated.

[b]Includes Army, Navy, Air Force, and Public Health Service hospitals.

In contrast to the more than 44 percent shown in the table for 1969, OCHAMPUS reported that in 1960 about 32 percent of all admissions of dependents of active duty personnel were to civilian hospitals.

Additional data on the estimated number of admissions and the average daily patient load in civilian hospitals are shown below.

Estimated Admissions and Average Daily Patient Load of Dependents of Active Duty Personnel in Civilian Hospitals in United States and Puerto Rico Fiscal Years 1960-69

Fiscal year	Civilian hospital admissions (note a)	Average daily patient load
1960	193,800	3,000
1961	209,400	3,200
1962	247,200	3,800
1963	238,500	3,700
1964	234,300	3,600
1965	212,600	3,300
1966	210,800	3,200
1967	236,100	3,600
1968	247,500	4,100
1969	271,700	4,700

[a]Due to lag in submission of claims, 1969 admissions are slightly understated.

Although the number of dependents of active duty personnel increased by only 9 percent from fiscal year 1960 through fiscal year 1969, annual admissions to civilian hospitals of these beneficiaries increased by about 40 percent, or nearly 78,000.

About 61,000 of the 78,000 increase in hospital admissions occurred during fiscal years 1967-69. OCHAMPUS reported that the major reason for this increase appeared to be the increase in family separations caused by the military buildup in Southeast Asia. OCHAMPUS reported also that, on the basis of civilian hospital admissions, dependents residing apart from their sponsors[1] increased from 52.4 percent in fiscal year 1965 to 72.3 percent in fiscal

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

year 1969, or 20 percent. Dependents of active duty members who reside apart from their sponsors may select care in either civilian or uniformed services hospitals, whereas those who reside with their sponsors must use military hospitals.

OCHAMPUS believes that two other factors may have caused the increased utilization of civilian hospitals by CHAMPUS beneficiaries: (1) the increased work load in military hospitals, caused by the Vietnam conflict, which has reduced the number of beds available for dependents and retired personnel and (2) the closing of military installations, including hospitals convenient to residences of many retirees and their dependents.

Review of Defense-wide data showed that the use of military hospital beds by CHAMPUS beneficiaries had decreased. We could not determine whether this was because the beds were needed by military personnel or because of family separations. It seems that the need for beds by military personnel was not the primary reason for decreased use of the beds by CHAMPUS beneficiaries, because the total available beds in military hospitals that were occupied in 1967-69 averaged less than 80 percent. Details follow.

Utilization of beds at fixed military medical facilities	Calendar year 1967	1968	1969
Total operating beds	43,005	45,070	43,868
Total occupied beds	32,255	35,774	33,992
Percent occupied	75.0	79.4	77.5
Total beds occupied by active duty personnel	21,383	25,561	24,005
Percent of total occupied	66.3	71.5	70.6
Total beds occupied by retired personnel	2,018	2,078	2,122
Percent of total occupied	6.2	5.8	6.2
Total beds occupied by dependents	7,467	7,164	6,919
Percent of total occupied	23.2	20.0	20.4
Total beds occupied by other personnel	1,387	971	946
Percent of total occupied	4.3	2.7	2.8

CHAPTER 3

COMPARISON OF HOSPITAL CHARGES FOR CHAMPUS BENEFICIARIES WITH CHARGES FOR OTHER PROGRAMS AND UNINSURED PATIENTS

A comparison of hospital claims paid under this program with amounts paid under several medical insurance programs and a review of hospital billing procedures showed that CHAMPUS beneficiaries were generally charged the same fees for services as were all other hospital patients. A comparative analysis of randomly selected claims covering the same or very similar services at 20 hospitals showed no evidence that CHAMPUS beneficiaries were being inexplicably charged more than, or being hospitalized longer than, patients of medical-hospitalization insurance programs. CHAMPUS and privately insured patients generally paid more for hospital services, however, than did uninsured patients, mainly because uninsured patients were usually hospitalized for shorter times.

It was beyond the scope of this review to make a detailed review of hospital cost accounting and charge systems, but we did find that there was no direct correlation between operating costs and charges for individual hospital services. In general, the hospitals' charge systems were designed to recover total operating costs, rather than costs for specific or separable services. Thus charges for some hospital services exceeded the costs incurred to provide the services and charges for other hospital services did not recover related costs.

Specifically, our review indicated that hospitals generally undercharged for maternity care, which accounted for about one third of the CHAMPUS hospital claims, and recovered the costs not allocated to maternity care by charging more than related costs for services provided by other departments and for ancillary services. Although we could not determine the number of hospitals following this practice, it appears to be common and probably reduces total hospital payments under CHAMPUS.

Our review of maternity claims showed that the average total charge and average length of stay differed among hospitals. We believe that efforts to reduce lengths of stay should be given serious consideration because shorter lengths of stay would offer significant potential to reduce the overall costs of the hospital component of CHAMPUS. We are not, however, in a position to say whether shorter lengths of stay are feasible or attainable.

We found that the total payments to hospitals under CHAMPUS were significantly affected by the reimbursement agreements between the participating hospitals and the Blue Cross Plans responsible for administering CHAMPUS. Because 39 of the 52 Blue Cross Plans paid CHAMPUS claims on the same basis they used to pay claims for their own subscribers, the total amount of the hospital claims paid by CHAMPUS during fiscal year 1968 was $2.3 million less than billed charges. For the remaining 13 Plans, we estimate that the program could have saved at least $850,000 annually if the Plans had been able to extend to CHAMPUS the more favorable reimbursement rates for paying hospital claims.

COMPARISON OF HOSPITAL CHARGES

At four Blue Cross Plans located across the United States, we compared hospital charges to CHAMPUS beneficiaries with hospital charges to beneficiaries of the Federal Employees Health Benefits Program (hereinafter referred to as the Federal employees program)--high option--and Blue Cross private insurance programs. The average charges for similar hospital claims were compared, by hospitalization program, for 20 selected hospitals.

Comparison of hospital charges and lengths of stay at individual hospitals

Our review of randomly selected maternity claims--under the diagnostic code for care without complications--showed that the average total charge and average length of stay for CHAMPUS beneficiaries were generally in line with those for similar claims for patients insured under the Federal employees program and Blue Cross private insurance programs. On an individual-hospital basis, comparison of an equal number of paid maternity claims showed no evidence that CHAMPUS beneficiaries were, as a practice, charged more than, or hospitalized longer than, patients under

insurance programs. Also we found that hospital charges for room and board and ancillary services were consistently applied to all patients.

The average total charge for CHAMPUS maternity claims was lower than the average charges for insurance programs at nine of the 20 hospitals, higher than the average charges at six hospitals, and between the program averages at the remaining five hospitals. Exhibits B through E show details of our comparisons of the claims for the 20 hospitals, categorized under the four Blue Cross Plans we visited.

Within each hospital, differences in the average total charge for maternity claims among the insurance programs were generally due to differences in the average length of stay. The average lengths of stay ranged from 2.3 days to 5.5 days at the 20 hospitals. At hospitals where the average total charge for CHAMPUS maternity claims was higher than those for similar claims under the other programs, the average length of stay for CHAMPUS patients was longer.

We randomly selected hospital claims paid under CHAMPUS for six additional diagnostic codes for comparison with similar claims paid by the insurance programs. Although these additional diagnostic codes accounted for a high volume of CHAMPUS claims processed by each of the four Blue Cross Plans, the number of claims paid to a single hospital was not large enough for a meaningful statistical analysis. Our review of the individual claims under these six diagnostic codes showed that the daily room and board charges under the insurance programs were comparable. The difference in the total charge for each claim was due primarily to wide variations in the lengths of stay, which appeared to stem from the medical considerations of the individual cases.

Comparison of hospital charges for insured and uninsured patients

Our review showed that uninsured patients were charged the same fees as those customarily charged patients under CHAMPUS and insurance programs but that the total charges per claim for uninsured patients were less than those for

insured patients receiving similar medical care, primarily because of a shorter average length of stay.

Hospital officials said that the general operating policy was to treat all patients the same whether or not they were insured. At one hospital we were told that, to prevent financial hardships, admissions personnel attempt to place uninsured patients in ward accommodations rather than in more expensive rooms.

Our review and comparison of hospital claims paid during the period January to June 1969 for maternity care without complications at six hospitals showed that the average total charge and average length of stay were less for uninsured patients than for insured patients. The following table summarizes the data obtained at three hospitals under the Blue Cross Plan in Denver.

Average per claim for maternity care

	Hospital 1		Hospital 2		Hospital 3	
	Uninsured patients (10 cases)	Insured patients (33 cases)	Uninsured patients (16 cases)	Insured patients (48 cases)	Uninsured patients (10 cases)	Insured patients (30 cases)
Total charge	$300	$330	$253	$324	$284	$307
Length of stay (days)	3.1	3.4	3.6	4.4	3.2	3.8

Our review and comparison of similar claims for uninsured and insured patients at three hospitals under the Blue Cross Plan in Richmond, Virginia, showed similar findings. Hospital officials stated that the differences between uninsured and insured patients in lengths of stay and other hospital services were not due to hospital policies or billing practices. They said that the physicians determine both lengths of stay and hospital services. They attributed the lower average length of stay primarily to demands from the uninsured patients and to physicians' decisions to minimize, where possible, the total hospital charges to uninsured persons.

Hospital charges for maternity care

Our review indicated that, although hospital charge systems were designed to recover total costs, the charge for

a specific hospital service was not always set to recover the cost of providing that particular service. Hospital officials and other medical experts stated that hospitals generally charged less than cost for maternity care and other selected services and charged more than cost for ancillary services, such as pharmacy services, central services,[1] and laboratory services. For example, analysis of the financial statements prepared by certified public accountants for two hospitals for the 6-month period ended June 1969 showed the following relationship of costs to revenues, based on equating the cost for each service to 100 percent.

Hospital service	Hospital A		Hospital B	
	Cost	Revenue	Cost	Revenue
	(percent)			
Maternity care	100	63	100	63
Pharmacy	100	245	100	302
Central	100	247	100	215
Laboratory	100	166	100	150

A Blue Cross Association official stated that all Blue Cross insurance programs were operated on an actuarial basis which ensured that premium rates covered the programs' total hospital payments. But it is recognized that payments to hospitals for maternity cases under each insurance program are less than related hospital costs and that hospitals recover the shortfalls in the charges for other services.

We found that hospitals had traditionally charged less than cost for maternity care. This is because maternity care, although normally involving relatively short lengths of stay, requires the use of high-cost services, such as labor and delivery rooms, anesthesia, and the nursery. Additionally, the hospital facilities and staff employed for maternity care are somewhat more fixed and less flexible than those for many other categories of hospital care and

---

[1] Includes such items as supplies and general services.

their use by maternity patients is subject to uncontrollable fluctuations.

Under these circumstances any medical care program that has a preponderance of hospital claims for services which are billed below cost, e.g., CHAMPUS, is being subsidized by other programs having a lesser proportion of similar claims. The high percentage of maternity cases--about one third of total hospital claims--under CHAMPUS serves to reduce the total hospital payment to an amount less than that which would be paid if hospital charges for maternity care were based on costs. By comparison, data obtained from the Blue Cross Association showed that the Federal employees 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. The extent to which unrecovered maternity costs are recovered by charging more than cost for other hospital services furnished to CHAMPUS beneficiaries was not determinable.

Comparison of hospital charges and lengths of stay in different geographic regions

Our review at four Blue Cross Plans of 840 randomly selected maternity claims for care without complications showed that the average total hospital charge and the average length of hospital stay for CHAMPUS beneficiaries were comparable to those for patients covered by other programs.

Program	Number of claims reviewed	Average total charge	Average length of stay (days)
CHAMPUS	240	$349	4.0
Federal employees--high option	240	361	3.9
Blue Cross	360	352	4.0
Total	840		

Further analysis of this data showed that the average charge and length of stay varied among the Blue Cross Plans. As shown below, for CHAMPUS maternity claims the average charge was lowest in Denver and highest in Oakland, California, while the average length of stay was lowest in Oakland and highest in Cincinnati, Ohio.

	CHAMPUS		Federal employees program		Blue Cross	
	Average charge per claim	Average length of stay (days)	Average charge per claim	Average length of stay (days)	Average charge per claim	Average length of stay (days)
Richmond	$367	3.9	$360	3.8	$369	4.0
Cincinnati	346	4.4	343	4.4	338	4.2
Denver	315	3.9	358	4.1	337	3.9
Oakland	369	3.6	384	3.2	363	3.3

LENGTHS OF HOSPITAL STAY FOR MATERNITY CASES

Our review showed that, although the lengths of stay for CHAMPUS maternity cases were generally comparable to those of cases under other programs, efforts to reduce the lengths of stay for CHAMPUS maternity cases should be considered, because of the potential to reduce program costs significantly by eliminating services which may not be medically necessary. Another indication that such efforts are warranted is that the average length of stay in civilian hospitals for the 104,000 CHAMPUS maternity claims for care without complications during 1969 was 4.2 days. This was longer than the average length of stay for similar maternity cases in Navy and Air Force hospitals. Data for maternity care without complications in Army hospitals were not available.

During 1969 about 25,000, or 23 percent, of all CHAMPUS maternity claims were paid to hospitals located in the Mountain and Pacific Census Regions of the United States. The average length of stay for these claims was 3.8 days. The average lengths of stay in the seven more easterly census regions for maternity claims ranged from 4.3 to 5.1 days and averaged 4.6 days. If the 3.8-day average length of stay experienced in the Mountain and Pacific Census Regions applied to all CHAMPUS maternity cases in 1969, significant savings could have been realized. Pertinent data for the nine census regions across the United States are shown on page 22.

An analysis by the Commission on Professional and Hospital Activities[1] of almost 900,000 maternity claims for care received in 1967 and 1968 at 972 hospitals showed that the average length of stay for maternity claims for care without complications was 4.1 days. For half of these claims the average length of stay was 4 days or less.

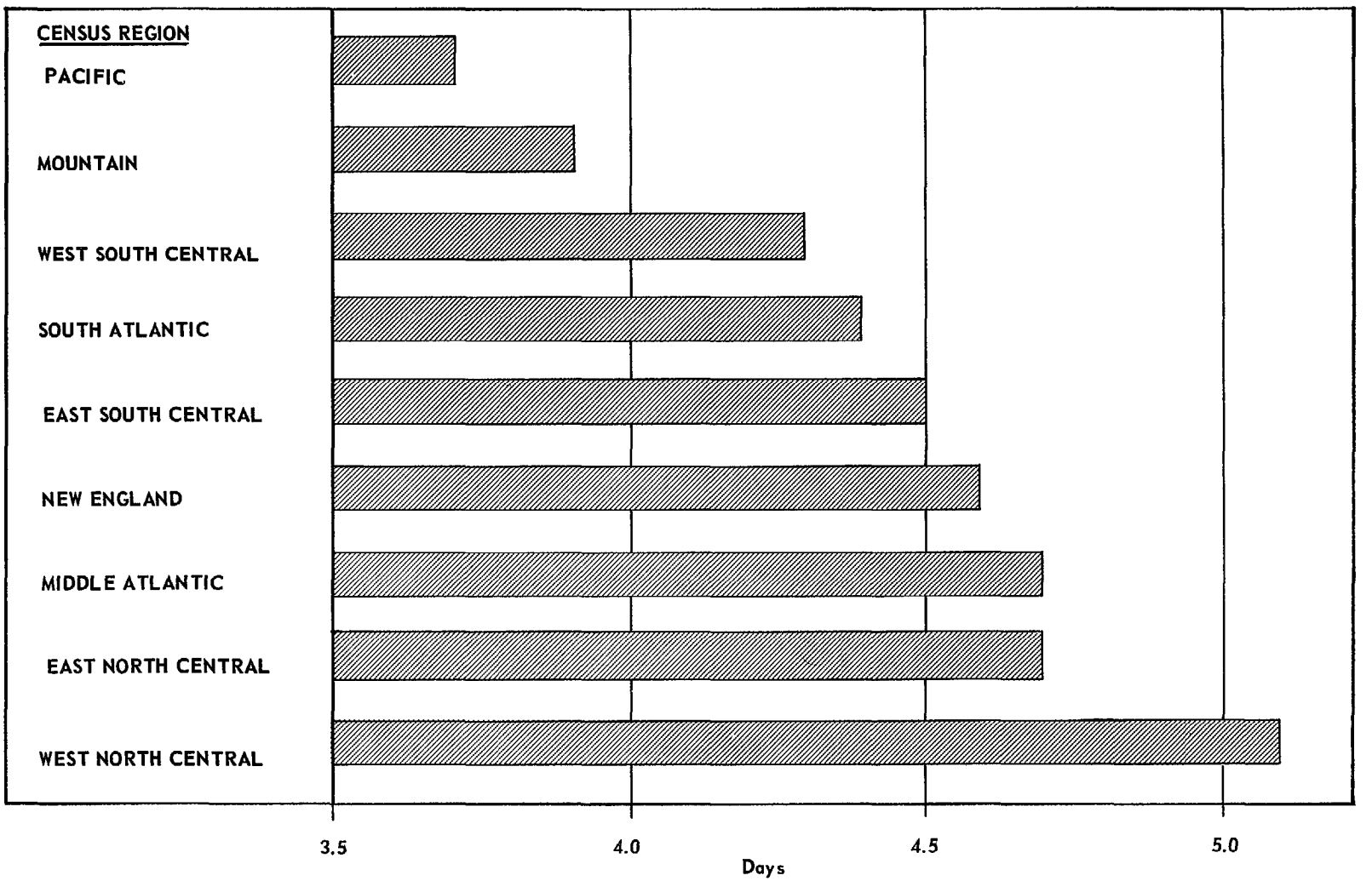
The average length of stay for maternity claims for care without complications in Navy and Air Force hospitals

---

[1]Sponsored by such organizations as the American Hospital Association and the American College of Physicians.

AVERAGE LENGTH OF STAY – CHAMPUS MATERNITY CLAIMS

1969



also generally was lower than that for CHAMPUS beneficiaries in civilian hospitals. The average lengths of stay for maternity cases in Navy and Air Force hospitals were 3.7 and 4.1 days, respectively. The average lengths of stay in these military hospitals also varied, by hospital, from a high of 5.3 days to a low of 3 days. At 44 percent of the hospitals, the average length of stay was less than 4 days. Furthermore, our analyses showed that the average length of stay at 107 Navy and Air Force hospitals was shorter than that for CHAMPUS beneficiaries in civilian hospitals in seven of the nine census regions. During 1969 the average length of stay for all maternity cases in Army hospitals was 4 days. This average is less than the 4.4 days for all CHAMPUS maternity cases in 1969.

We believe that the variations suggest that the longer average length of stay for maternity cases in civilian hospitals may be due to nonmedical reasons. Pertinently, data for the Federal employees program showed that patients with broader insurance coverage were hospitalized longer, on the average, than were other patients. (See p. 43.)

Action has reportedly been initiated by two neighboring hospitals in Chicago, Illinois, to centralize obstetrics and gynecology care in a new specialized hospital facility and to increase hospital efficiency and economy for maternity care through a minimal-length-of-stay program. Under the program patients will be discharged from 1 to 1.5 days after giving birth. The reduced length of hospital stay should result in lower cost to both the patients and the hospital through more efficient utilization of facilities.

REIMBURSEMENT METHODS USED FOR PAYMENT OF CHAMPUS HOSPITAL CLAIMS

The 52 Blue Cross Plans administering CHAMPUS reimburse hospitals for their regular business subscribers on the basis of either a negotiated rate or 100 percent of billed charges. Of the 52 plans, 39 reimbursed hospitals for CHAMPUS claims under the same reimbursement formulas used for their regular Blue Cross subscribers. This resulted in CHAMPUS's paying $2.3 million less than the charges billed by the hospitals during fiscal year 1968. The remaining 13 Plans were unable to extend to CHAMPUS the more favorable formulas which hospitals voluntarily had contracted with the Plans for paying claims against their regular subscribers. We estimate that at least $850,000 could be saved annually if the Plans were able to extend to CHAMPUS the more favorable formulas for paying hospital claims.

We found that the 39 Plans which extend their reimbursement formulas to CHAMPUS had various types of agreements with hospitals. Of these 39 Plans, 33 reimbursed hospitals on the basis of negotiated formulas providing for payment on the basis of 85 to 99 percent of total charges billed by the hospitals and six reimbursed hospitals on the basis of 100 percent of billed charges.

The remaining 13 Plans also had agreements with hospitals for paying claims against their priviate subscribers. These agreements provided for reimbursing hospitals for 84 to 99 percent of billed charges. Of the 13 Plans, nine did not extend the lower rates to CHAMPUS, which reimbursed hospitals at 100 percent of billed charges, and four did obtain for CHAMPUS a rate less than billed charges, which resulted in payments of $383,000 less than billed charges. The rates obtained, however, required CHAMPUS to pay for services about $248,000 more than Blue Cross Plans would have paid for their regular business subscribers.

We found no evidence that OCHAMPUS and the Blue Cross Association had attempted after 1963 to obtain for CHAMPUS the more favorable Blue Cross reimbursement formulas for paying hospital charges in 13 Blue Cross Plan areas. OCHAMPUS officials said that they had no legal basis for obtaining these reimbursement arrangements with hospitals, but,

pertinently, the contract with the Blue Cross Association provided that the association and the Blue Cross Plans make available to the Government the benefit of the Blue Cross formulas, where possible. Blue Cross Association officials said that they had attempted to obtain these arrangements for CHAMPUS in 1963 but had failed, because of the unwillingness of the hospitals which are not obligated to extend to CHAMPUS their reimbursement agreements with Blue Cross.

Blue Cross Association officials stated that hospitals accepted payment of less than billed charges from Blue Cross because it paid its claims promptly and was not a collection risk, i.e., it cost less to process claims of Blue Cross subscribers than it did those of non-Blue Cross subscribers because bad debts were not incurred. We believe that this reasoning applies equally to CHAMPUS.

We believe also that OCHAMPUS, together with the Blue Cross Association, should attempt to obtain for CHAMPUS the more favorable terms for paying charges that the hospitals contracted with the 13 Blue Cross Plans.

CHAPTER 4

RISING COST OF MEDICAL CARE IN CIVILIAN HOSPITALS

The rapid rise in medical costs in the last few years, particularly for hospitalization, has increased the cost of CHAMPUS significantly. The overall cost of the hospital component of CHAMPUS increased from about $46.7 million in 1966 to about $135.8 million in 1969. Hospital costs represented from 55 to 67 percent of the total cost of CHAMPUS during each of the 4 years.

Although CHAMPUS was expanded in 1966 and the benefits paid by the program have increased annually, it is essentially still a supplementary program designed to complement the capability of the medical facilities of the uniformed services. About 42 percent of the total inpatient hospital care for military dependents and retired personnel in 1969 was provided under CHAMPUS; the remainder was provided in military hospitals. Also in 1969 CHAMPUS beneficiaries constituted less than 1 percent of the 28 million admissions to short-term community hospitals and the related $16 billion in hospital expenditures.

Nevertheless Government expenditures for medical care provided by civilian hospitals to CHAMPUS beneficiaries is substantial and is rapidly increasing. Since the increase in costs for hospitalization of CHAMPUS beneficiaries is directly influenced by the general increase in costs of hospitalization, we geared this segment of our review to identifying (1) the major reasons for rising hospital costs for all patients, (2) the prospects for future hospital costs, and (3) the efforts being made to contain hospital costs, which are discussed in chapter 5.

Hospital salary increases are the major reason for the rapid rise in hospital costs in the last several years. These increases were due, in great measure, to the fact that hospital employees have traditionally been underpaid and to the fact that their salaries have recently been catching up with salaries paid in other industries.

Another reason for the rising costs has been the increase in the number of complex services provided by hospitals, such as intensive care facilities and coronary treatment centers.

EFFECT OF SALARIES ON HOSPITAL COSTS

Published studies of hospital costs and statements made to us by physicians and hospital administrators during discussions emphasized that the cost of employees services was primarily responsible for the recent dramatic increase in hospital costs. At the 12 hospitals we visited, salary expense for 1969 ranged from 57 to 72 percent of each hospital's operating expenses and available data showed that this cost element had increased substantially in recent years.

On a national average, salary expense constitutes almost two thirds of a hospital's total operating expense. All community hospitals in the Nation experienced payroll increases averaging 74 percent from 1965 through 1969. Data on salary expense obtained at the 12 hospitals we visited shows the significance of the salary increases, as follows:

Hospital	Payroll costs					Total increase	
	1965	1966	1967	1968	1969	Amount	Percent
	(000 omitted)						
1	$3,800	$4,100	$ 5,000	$ 6,300	$ 7,400	$3,600	95
2	1,400	1,600	2,000	2,400	2,700	1,300	93
3	3,500	3,800	4,200	4,600	5,200	1,700	49
4	4,200	4,400	5,200	6,500	8,300	4,100	98
5	400	800	1,200	1,500	1,900	1,500	375[a]
6	8,200	9,400	10,900	13,400	15,700	7,500	92
7	5,100	5,500	6,200	7,700	9,200	4,100	80
8	5,100	6,000	7,100	8,000	9,300	4,200	82
9	500	600	700	900	1,200	700	140
10	(b)	4,200	4,700	4,900	5,600	-	-
11	3,000	3,300	4,300	4,700	5,300	2,300	76
12	(b)	1,300	2,800	3,800	4,600	-	-

[a]Due largely to change in method of reporting departmental expenses.

[b]Information not obtainable.

About one half of the total payroll increase for community hospitals in recent years was caused by salary increases. The remainder of the increase was due primarily to an increased hospital work force, which has resulted in an increase in the ratio of hospital employees to patients.

Our review showed that the major reasons for the significant salary increases in recent years were the enactment of labor and wage legislation and the effect of unionization.

Labor and wage legislation

Historically, nonprofessional, semiskilled hospital employees have been low paid; these low-paying hospital jobs were not included under the Federal minimum wage law until February 1, 1967, and then at only $1 an hour. The law provided that the minimum rate increase by 15 cents an hour annually until a minimum rate of $1.60 an hour is reached in 1971.

The labor and wage legislation had the greatest impact on hospitals located in the southern part of the Nation. Some surveys have indicated that the major part of increased salary costs resulted from increasing the wages of higher paid hospital employees in order to maintain a graduated wage structure within the hospital and not from elevating the low-paid employee salaries to the new legal minimum.

Employee unionization

Unionization of hospital employees is occurring in the highly industrialized areas of the country. The number of non-Federal hospitals having collective-bargaining contracts was less than 10 percent of all hospitals in the Nation in 1967.

Officials at several of the hospitals we visited commented on the significant impact the threat of unionization had had on the hospital employees' salaries. They stated that, to avoid unionization and to hold competent staff, wages were maintained at levels comparable to union wage scales. For example, hospitals compete regionally for their nursing staff, and hospital officials stated that union wage scales, especially for nurses were influencing salaries of other hospital employees.

Officials at a local hospital association said that the trend was toward unionization and that unionization of hospitals would increase costs further because of jurisdictional limitations. They stated that a registered nurse was permitted to perform only specified tasks and that adherence to such limitations increased both the number of employees required by a hospital and the related costs.

Administrators at hospitals we visited believed, in general, that the status of hospital employees as an underpaid group had been largely corrected and that, for the most part, these employees were currently receiving salaries comparable to similar groups in industry. Thus, although they anticipate further salary increases, they expect the rate of increase to decline and follow more closely the pattern of industrial wages and the cost-of-living index.

Increased hospital work force

In 1950 the number of hospital employees per patient averaged 1.78. By 1968 the number had increased to an average 2.65 employees per patient. Where the information was available, we obtained the number of hospital employees per patient at the hospitals we visited for 1965-69, as follows:

	Number of hospital employees per patient day					Percent increase
Hospital	1965	1966	1967	1968	1969	or decrease(--)
1	2.46	2.68	2.88	2.98	2.73	10.98
2	3.08	3.19	3.31	3.01	3.26	5.84
3	3.02	2.93	2.94	2.85	2.87	-4.97
4	2.62	2.77	3.18	3.55	3.25	24.05
5	2.38	2.40	2.64	2.54	2.72	14.29
6	2.39	2.46	2.46	2.46	2.79	16.74
7	2.43	2.51	3.05	3.85	2.84	16.87
8	2.80	2.76	2.60	2.86	3.08	10.00

During the period 1965-69, there was a total increase of 438,000 employees, or 32 percent, at all community hospitals. During that period hospital admissions increased by 1.8 million, or about 7 percent. Thus the increasing patient load only partially explains the increase in the number of employees.

The increases in the number of hospital employees cannot, for the most part, be offset by increases in employee productivity, since many of the additional employees are engaged in providing new hospital services resulting from advances in medical technology. The salaries related to the increased employees-per-patient ratio show up in higher charges to patients.

INCREASE IN HOSPITAL SERVICES

Since 1966 nonsalary hospital expenses in short-term general hospitals in the United States have increased from $4 billion to $6.8 billion, or about 70 percent. This has resulted primarily from the new high-cost services being made available in community hospitals and from the increase in the number of services customarily provided to patients.

New high-cost hospital services available in community hospitals

Historically, according to one source, advanced therapeutic services were provided almost exclusively by university medical schools or by medical centers in large metropolitan areas. During the 1960's the role of the community hospitals changed and inpatient services grew in complexity. The American Hospital Association stated that additional services in large hospitals generally included intensive care facilities, coronary treatment centers, renal dialysis facilities, and organ banks, which manifest the progress and developments of medical science. In small hospitals, new services are generally those of registered pharmacists or pathologists, expanded surgical and emergency lifesaving devices, and more extensive outpatient services.

The following table, based on information supplied by hospitals in reply to an American Hospital Association inquiry, indicates the growth in the number of community hospitals providing certain additional services.

Service	Percent of hospitals providing service 1963	1968	Percent increase
Intensive care unit	18	42	133
Pharmacy	53	72	36
Postoperative recovery room	63	73	16
Outpatient department	40	46	15

Our review at 12 hospitals showed that some had obtained high-cost equipment to expand their capability to furnish the following related services.

--Sophisticated radiation therapy
--Hemodialysis treatment
--Cerebral arteriogram
--Isotope machine treatment
--Inhalation therapy
--Cardiovascular treatment

These services involve the acquisition of expensive equipment and frequently of highly trained personnel to operate it; thus the improved medical care has increased hospital expenditures substantively.

The American Hospital Association reported that during the 1960's hospitals increasingly were offering comprehensive health care services. For example, the following statistics for 1969 show that a large number of community hospitals had psychiatric inpatient units.

Number of hospital beds	Number of hospitals	Percent of hospitals having psychiatric inpatient units
6 to 24	330	1.2
25 to 49	1,205	2.6
50 to 99	1,386	3.8
100 to 199	1,227	11.2
200 to 299	564	24.3
300 to 399	333	47.4
400 to 499	194	60.3
500 or more	207	77.8

Also many outpatient services now being furnished by hospitals traditionally have been furnished at the physicians' offices. About one of every three outpatient visits to hospitals is to emergency rooms; the remainder are to clinics or are referrals for laboratory, radiology, or similar services.

The Social Security Administration reported in January 1970 that the distribution of health expenditures, by type, had changed considerably. In the past the percentage of expenditures paid to physicians in private practice was greater than the percentage paid to hospitals. According to statistics of the Social Security Administration--shown

below--there has been a complete reversal of the former ratios, which may be another indicator that hospitals are now providing an increased amount of services. Some of the change in ratios may be due, however, to the fact that hospital costs have been rising more rapidly than have physicians costs. (See our report entitled "The Civilian Health and Medical Program of the Uniformed Services," B-133142 May 19, 1970.)

Year	Total health expenditures (note a)	For hospital care		For physicians' services	
		Expenditures	Percent of total	Expenditures	Percent of total
	(000,000 omitted)			(000,000 omitted)	
1929[b]	$ 3,644	$ 664	18.2	$ 1,005	27.6
1935[b]	2,935	763	26.0	774	26.4
1940[b]	3,956	1,013	25.6	973	24.6
1950	12,867	3,845	29.9	2,755	21.4
1955	18,036	5,929	32.9	3,680	20.4
1960	26,973	9,044	33.5	5,684	21.1
1965	40,591	13,520	33.3	8,745	21.5
1966	45,114	15,485	34.3	9,156	20.3
1967	50,935	18,029	35.4	10,287	20.2
1968	57,103	20,751	36.3	11,562	20.2

[a]Includes such items as dental care, nursing-home care, drugs, eyeglasses, construction, administration, hospital care, and physicians' services

[b]Partial expenditures.

Increase in number of services customarily provided to hospital patients

Some physicians are prescribing increased amounts of diagnostic work for patients. Hospital and other medical officials stated that malpractice suits had provided "an incentive" to physicians to request additional tests for their patients. The increase in the number of malpractice suits discourages selective use of diagnostic and other

hospital services, and, of course, the more these services are used the higher the charges to the patients.

The total number of laboratory tests performed at many of the hospitals we visited increased substantially from 1966 to 1969. The increase was about 100 percent at one hospital. Part of the increase in laboratory services was attributable to new procedures, such as testing of amniotic fluid of pregnant women for Rh incompatibility and immunofluorescent examination for renal biopsy study which previously was a research procedure.

The trend in many of the radiology departments we visited was toward more service. For example, one department's inpatient work load increased from about 9,000 examinations in 1966 to about 16,000 in 1969, but the increase in the number of inpatients during this period was slightly less than 10 percent. At another hospital, the number of radiology tests given per admission increased from 1.31 in 1965 to 1.63 in 1969.

PROSPECTS FOR FUTURE HOSPITAL COSTS

The Blue Cross Association has reported that the increase in hospital costs is the result of many different factors. Some of the factors influencing increases in hospital use are population growth, the increase in the availability and number of hospital beds, and the increase in the number of persons having some form of third-party health care insurance. Consideration of these factors indicates that the Nation will experience a further increase in medical expenditures if the current trend in hospitalization continues.

Population growth

The civilian population and total number of hospital admissions increased steadily during the period 1965-69, as follows:

	Population	Percent increase	Hospital admissions	Percent increase
1965	191,894,000	-	26,463,000	-
1966	193,767,000	0.98	26,897,000	1.6
1967	195,666,000	.98	26,988,000	0.3
1968	197,560,000	.97	27,276,000	1.1
1969	199,685,000	1.08	28,254,000	.4

The Census Bureau projects a further increase of over 10 million persons in the Nation's population by fiscal year 1975. Therefore, on the basis of past experience, an increase in the total number of persons to be hospitalized and in related medical expenditures seems likely.

Availability of hospital beds

The total number of hospital beds in community hospitals has increased from about 505,000 in 1950--about 3.35 beds per thousand population--to about 806,000 in 1968--about 4.08 beds per thousand population. The Blue Cross Association reports that beds per thousand population is one of the best predictors of total hospital use.

The trend in number of beds per thousand population has been steadily increasing while the hospital occupancy rate also has been increasing. This indicates that as more beds are made available they are used and supports the contention of several hospital authorities that, in the health industry, supply may create its own demand.

Third-party health care insurance

A Blue Cross Association study shows that persons who have some form of third-party health care insurance are likely to use hospital facilities more often than persons who have no insurance and that insurance coverage has a relationship to hospital use. In addition, the following table, prepared from data included in a Social Security Administration publication, indicates that an increasing percentage of total expenditures for hospital care is being paid by persons who have some form of third-party insurance.

Year	Consumer expenditures for hospital care (note a)	Payments made by private insurance	Percent
	(billions)		
1950	$1.9	$0.7	37
1965	8.3	5.8	70
1968	9.9	7.3	74

[a]Excludes public expenditures, such as those for the Medicare and Medicaid programs.

On the basis of prior experience, it seems that in the future, as more people are covered by insurance, more expenditures will be made for hospital care. According to estimates, about 35 million persons have no hospital insurance coverage.

Pertinently, there is growing agreement among medical experts that good health care is a basic human right of all Americans, regardless of their ability to pay. Additionally, there is growing concern that the rising cost of health care is pricing persons out of the market and widespread

feeling that everyone must eventually be covered by some form of national comprehensive health insurance.

Since experience has shown that as more persons become insured more use is made of medical facilities, a national health insurance program probably would further escalate the cost of health care. The above statement is predicated on the following observations: in the early days of voluntary health insurance, when only hospitalization was covered, the result was more hospitalization by the insured and, when coverage was expanded to include surgical procedures, more surgical services were furnished to the insured.

CHAPTER 5

EXTENT THAT HOSPITAL COSTS MIGHT BE REDUCED

Medical officials believe that reducing unnecessary hospital admissions and shortening the lengths of stay of hospitalized patients 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 discourage unnecessary hospitalization. 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.

Other methods being used to control hospital costs include the sharing of service agreements by hospitals, use of utilization review committees,[1] pre-admission-testing programs, employee incentive programs, and hospital reimbursement incentive programs. Our study of these methods showed that some progress was being made; however, serious practical problems, such as those indicated in this chapter, must be overcome if these methods are to be successful on a large scale.

CURRENT HOSPITAL DELIVERY SYSTEM MILITATES AGAINST CONTAINING COSTS

Some medical officials feel that current hospital cost problems are inherent to the system used for the delivery of medical care and that the system must be changed to achieve a significant impact in reducing or containing hospital costs. But there is no general agreement as to what format the change should take or from where the impetus for change should come.

---

[1] An organized activity, usually consisting of physicians, which evaluates quality, quantity, and timeliness of the medical care provided.

The current system can be characterized as a random growth of the methods used by a large number of uncoordinated and independent nonprofit hospitals. There is virtually no competition among hospitals, and the investment risk has been minimized by the insurance reimbursement methods which, in general, ensure recovery of reasonable costs. Consequently there has been little incentive for hospitals to reduce costs. Further, because hospitals have not adopted uniform cost accounting systems, it is impracticable, if not impossible, to make specific cost comparisons for use in evaluating the relative efficiency of individual hospitals.

To improve the efficiency and effectiveness of the existing medical care delivery system, areawide health planning agencies have been created to set health goals and to decide how to achieve those goals most effectively with available resources. Most of these agencies are in the developmental stages and have not yet had a significant impact on the existing system. The agencies have experienced serious organizational and functional problems which must be resolved before the agencies can expect to significantly reduce or contain future hospital costs.

NEED FOR HOSPITALIZATION

The number of hospital admissions in the Nation has been increasing; in 1969 there were over 28 million admissions. The president-elect of the American Hospital Association has said that as many as 20 percent of high-cost hospital beds often are occupied by persons who do not really need them. Other medical officials feel that, by reducing the significant number of unnecessary hospital admissions, cost reductions can be made.

A major reason for unnecessary admissions is that the medical system is geared to treating persons in hospitals. Most insurance policies cover costs related to hospitalization but do not cover all nonhospital care. Pertinently, an American Hospital Association official said recently that the patterns of health insurance tended to encourage unnecessary hospitalization and that they must be reversed.

A study of the Federal employees program, which covers over 7 million persons, indicated that the use of hospitals

was influenced by the type of health insurance coverage. For example, data for one Federal employees program policy, offering outpatient care and comprehensive hospital benefits showed significantly less use of hospitals than did data for policies which basically offered benefits primarily for hospital inpatient treatment.

Currently the Sacramento County Medical Society, Sacramento County, California, is sponsoring an experimental program to find ways of reducing hospital costs. One objective of the program is to determine whether hospitalization is medically necessary. The need for hospitalization for an individual patient is reviewed by a center which matches the diagnosis made by the physician against a set of norms. If the center does not certify that hospitalization is needed, the participating insurance carrier will not guarantee payment if the patient is admitted to a hospital. Although the program apparently is successful, there are no indications of its wide acceptance by hospitals, physicians, and insurance carriers.

LENGTH OF HOSPITALIZATION

From 1960 through 1969, the average length of stay per hospital admission has steadily increased. In 1969 it was 8.3 days, an increase of seven tenths of a day from 1960. The American Hospital Association has estimated that, at current prices, one tenth of a day in the average length of stay costs $1 billion a year. Association officials attributed this increase to the Medicare program and to the availability of more complex treatments, but no studies have been conducted to determine what part of the increase applies to each reason.

Our analyses of available statistical data showed that the average length of stay varied widely among the geographic regions of the country and that it consistently tended to be longer in the eastern part of the country than in the western part. It is generally accepted that the lengths of stay for comparable diagnoses depend, in large part, on professional mores which differ widely from region to region.

Also available statistics show differences in the average length of stay by geographic region compared to the number of residents per available hospital bed. Regions which had a greater number of residents per available bed frequently had a shorter average period of hospitalization, as shown below.

	Calendar year 1968	
Census Region	Average length of stay (days)	Number of residents per available hospital bed
Pacific	7.1	270
West South Central	7.3	256
Mountain	7.4	240
East South Central	7.5	263
South Atlantic	8.0	277
East North Central	8.7	245
New England	8.9	237
West North Central	9.0	196
Middle Atlantic	9.9	236

Also we noted, in comparing data for 1967 and 1968, that in seven of the nine regions the average length of stay had increased while the potential number of residents per available bed had decreased. For example, in the Mountain Census Region the number of residents per bed had decreased from 255 to 240 but the average length of stay had increased from 7.1 days to 7.4 days.

American Hospital Association officials stated that, although they were concerned with such regional variances, there might be valid reasons for them. The association currently has no data to indicate what these reasons may be. Furthermore, it has no authority to take corrective action if it is needed. American Medical Association officials could not explain the differences, but, like the officials of the American Hospital Association, they are an advisory group.

Blue Cross Association stated that one of its primary responsibilities was to reduce hospital stays and that it currently was studying the variables. The Blue Cross Association feels that the average length of stay can be reduced by controlling the number of available hospital beds but that the cooperation of hospitals and physicians is necessary to influence a change.

Analyses of statistical data furnished by the Blue Cross Association indicates that the type of insurance coverage held is a factor to the average length of stay. On the average, subscribers having the high-option coverage under the Federal employees program stayed in the hospital longer than subscribers having the low-option coverage for the same types of care, as shown below.

	Average length of stay							
	Medical treatments				Surgical treatments			
	Individual policies		Family policies		Individual policies		Family policies	
Year	High option	Low option	High option	Low option	High option	Low option	High option	Low option
	(days)							
1966	10.9	8.2	7.9	6.4	10.2	7.6	6.8	6.1
1967	10.9	8.4	8.1	6.5	9.9	7.1	6.8	6.1
1968	11.1	8.7	8.3	6.8	10.0	7.2	6.9	6.1
1969	11.1	8.9	8.3	6.9	10.0	7.8	6.9	6.2

An experimental program to reduce the average length of stay is currently under way in the Pacific Census Region, which now has the shortest average length of stay in the country. The program objective, besides determining whether hospitalization is medically necessary, is to determine how long a patient should stay in the hospital. According to the Blue Cross Digest, the program, which monitors physician and hospital practices from preadmission to discharge, reduced the patient-days to 23.6 percent below the national average and saved $541,800 in its first 141 days of operation.

POTENTIAL METHODS FOR CONTAINING OR REDUCING COSTS

Research of medical literature and discussions with medical officials have shown that many methods are being tried to reduce the rate of hospital cost increases. Some of the more widely suggested methods are service-sharing agreements, utilization review committees, pre-admission-testing programs, employee incentive programs, and hospital reimbursement incentive programs, which are discussed below.

Service-sharing agreements

The American Hospital Association supports the concept of voluntary sharing of services by two or more hospitals. A recent joint study--sponsored by the association and by the Department of Health, Education, and Welfare--concluded that shared services possessed the best potential for cost reduction or containment in hospitals.

There are many cases where hospitals voluntarily participate in service-sharing agreements, such as those involving computer programs, blood banks, laboratory services, and in-service education programs. We were informed that over 100 potential shared-service projects were available for use. There are, however, many hospitals which prefer to operate independently and which are not participating in sharing programs. No information is readily available on the number of sharing programs in use by hospitals, but the American Hospital Association is currently taking an inventory.

Some of the factors mentioned by the American Hospital Association and hospital officials as being obstacles to further acceptance of service-sharing agreements were:

1. Prestige. Most large community hospitals want the capability of providing all types of diagnostic and therapeutic services.

2. Sharing of medical facilities was opposed by some doctors.

3. Difficulty of getting cooperation. Some hospitals feared loss of their identity.

4. Legal implications. Until 1968 the Internal Revenue Service rules discouraged joint enterprises and shared facilities were not tax exempt. Recent legislation provided for tax exemption of joint enterprises undertaken by tax-exempt hospitals, but hospital laundry cooperatives were not included in the exemption.

5. Hospitals did not like to share the "profit areas" of their operation. Pertinently, we found that hospital charges were based on recovering total hospital expenses plus a small amount for growth and development, which we term "profit." The hospitals did not always try to recover costs of each particular service through the charges for that service. Consequently, revenues from some services showed losses and others showed profits.

We found that some hospitals had installed expensive equipment that duplicated the equipment and service of neighboring hospitals which were experiencing low utilization rates of the particular equipment. For example, one hospital had three radiation therapy units, one of which initially cost about $500,000. These units were capable of treating 80 patients a day, but the hospital was treating about 60 patients a day. The units were also expensive to operate because of the requirement for highly skilled operating employees. Two other hospitals in the same area each had a radiation therapy unit. One hospital performed about 500 treatments a month, or about 17 a day; the other would not estimate the number of treatments it performed. We believe that these circumstances indicate that there is potential for better utilization of expensive equipment, i.e., handling the total area requirements with fewer units that are operated on a shared basis.

A Presidential commission recently found that, of 777 hospitals having facilities to perform open-heart operations, 250, or about 32 percent, had not performed any such operations during the year the commission made its study; 476, or about 61 percent, had performed less than one such

operation a week; and 225, or about 29 percent, had performed less than one such operation a month. An article in a national publication stated that in 1968, 20 hospitals in New York City offered open-heart surgery but that five of them had performed two thirds of all such surgery.

Utilization review committees

Hospital utilization review committees, consisting primarily of physicians, were the first mechanisms established to review length of hospitalization, but this was not the committees' only concern. American Hospital Association and American Medical Association officials informed us that utilization review committees could be beneficial if used to determine whether the amounts and types of medical services prescribed for the patients were justifiable and consistent with the diagnoses. Although utilization review has contributed to the control of cost per inpatient by establishing patterns for hospital care, the reduction of hospital costs is not the primary concern of the committees.

Although some committees have been effective, the American Hospital and American Medical Association officials were unable to comment on the overall effectiveness of such committees. Reasons given by the associations were that good data for a statistical study of utilization review committees were not available and that the scope and activities of such committees varied widely from hospital to hospital.

Although generally cases were selected for review on a random basis, the criteria used by committees for selecting such cases varied widely. Also some hospitals treat committees as an educational program. For example, one hospital immediately places all new physicians on the utilization review committee for a 6-month period. At another hospital the stated purpose of its committee was:

> "*** a fact-finding, educational instrument of the Medical Staff designed to improve patient care and to assure that all the in-patient service given is necessary and could not be provided as effectively in the doctor's office, the home, the out-patient service department. The committee has

no disciplinary function, is not a police body, nor a scientific research group attempting to measure the precise magnitude of over or under utilization. It is intended that, in general, the attending physician will make all decisions regarding hospital utilization of his patient, but it is hoped that all medical staff members and all clinical departments will use comparable standards and policies."

Pre-admission-testing programs

Pre-admission-testing programs are being used by some medical officials to lower hospital costs through reducing the average preoperative hospital stay for selected diagnostic cases. Performing selected preoperative tests on an outpatient basis prior to admittance of the patient to the hospital can reduce the patient's hospital stay. Pre-admission-testing programs appear to be operating effectively in certain geographic regions. Such programs are not yet widespread, and certain innate problems, as indicated below, must be solved before the programs will have a significant impact on hospital costs.

Officials of the American Hospital Association and the American Medical Association agreed that a major obstacle preventing general acceptance of pre-admission-testing programs was the current medical care delivery system. Traditionally, physicians have determined and controlled the type of diagnostic testing to be performed after the patient is admitted to the hospital. Some officials feel that establishing a set of tests to be administered on an outpatient basis before a patient is admitted to a hospital challenges the position of the physician as the person who directs and controls diagnostic testing.

Other problems that have been cited as preventing general acceptance of preadmission testing are:

1. It is not available under all insurance programs.

2. It may not be readily accepted by hospitals operating at a low average-occupancy rate where greater turnover of patients may mean more empty beds.

3. A patient may feel that it is more convenient to stay in the hospital for tests because of the distance of his residence from the hospital and for other reasons.

4. Physicians want assurance that the tests are currently valid.

Hospital officials had different opinions regarding the benefits of preadmission testing. One hospital administrator said that the pre-admission-testing concept was excellent and could save many days of health care. Another hospital administrator said that preadmission testing had been tried at his hospital but that the ensuing problems had caused the program to fail; he stated that the program had inconvenienced the patients. Other hospital administrators stated that the physicians apparently felt that such a program was an inconvenience to both themselves and the patients and that significant cost benefits from the use of a pre-admission-testing program might not be realized immediately.

Employee incentive programs

Various employee incentive programs are being used by some hospitals, but the number of hospitals using such programs is not known. American Hospital Association officials observed that most employee incentive programs currently being used were ineffective, primarily because the hospital industry lacked standards to relate productivity to job assignments. Therefore, since the industry has not determined a way to measure the extent to which incentive programs have affected hospital costs, it appears that the cost impact of such programs cannot be measured. Until a monetary effect on hospital costs can be demonstrated, it appears unlikely that employee incentive programs will become widely accepted by the hospital industry.

Although the American Hospital Association has no formal policy regarding employee incentive programs, the association does support experimentation with such programs and believes that there is some potential for them in improving the productivity and efficiency of hospital employees. Because of the lack of employee work standards, association officials feel that, at the present time, the development and use of employee incentive programs depends solely on the ability, initiative, and qualifications of individual hospital administrators.

A recent study of employee incentive programs jointly sponsored by the association and the Department of Health, Education, and Welfare concluded that work standards should be determined and tested before incentive programs were

initiated. The study concluded also that the skills required to develop such standards were not usually available in hospitals.

Our contacts with officials at the 12 hospitals we visited indicated little enthusiasm for employee incentive programs, and many of the hospitals had no such programs. Some regional association officials considered incentive programs to be inappropriate for hospitals, and some hospital administrators felt that incentive programs were difficult to manage and somewhat ineffective.

One authority in the field of medical economics believes that there may also be a legal difficulty associated with the use of employee incentive programs and that restrictive Federal tax policy could be disastrous by discouraging innovative personnel policies. The legal difficulty concerns the question of whether a tax-exempt, nonprofit institution can legally operate a profit-sharing program without jeopardizing its tax-exempt status.

Reimbursement incentive programs

There is general agreement that the current method for reimbursing hospitals--a cost-based method--provides little incentive for hospitals to control their costs. Although the American Hospital Association, the Blue Cross Association and the Federal Government are all conducting studies and experiments to identify reimbursement methods that will provide incentives for cost control, it appears to us that no one knows which method will succeed at controlling hospital costs in the near future.

American Hospital Association representatives stated that current reimbursement experiments involved the use of pre-negotiated-rate programs, i.e., target rates established for a defined period of time. Hospitals whose costs are lower than the target rates receive incentive awards, and hospitals whose costs exceed the target rates are assessed penalties. Participation in such programs is voluntary on the part of hospitals.

Association representatives stated further that it was too soon to determine whether the association's experimental program would be accepted by a majority of the hospitals. In general, they believe that any incentive reimbursement system, including the pre-negotiated-rate program, will be supported only to the extent that hospitals can expect to realize economic gains.

Association officials believe that the differing needs of individual hospitals operating under poor budgeting practices and an inadequate central cost accounting system at many hospitals have made the implementation of a pre-negotiated-rate program very difficult.

The Blue Cross Association does not, at the present time, specifically endorse the use of any one incentive reimbursement method over another. The association believes that continued experimentation is necessary. About 12 of the 80 Blue Cross Plans have adopted a pre-negotiated-reimbursement method or are now experimenting with one. Of the 12 Plans, seven are located in New York State where the method is required by law.

Blue Cross Association officials believe that acceptance of a pre-negotiated-rate method or any other incentive reimbursement method depends on the design of the method and the degree of risk involved to the hospital. According to Blue Cross Association experience, some hospital administrators are uncertain as to whether they have authority to commit their hospitals to rate agreements and others have refused to enter into commitments because of the risk involved. Further, one Blue Cross Official is quoted in a publication as having asked what incentive there was for hospitals to try anything different as long as they could get full cost reimbursement.

The Federal Government is encouraging experiments with incentive reimbursements methods. In 1967 the Secretary of Health, Education, and Welfare was authorized to develop and engage in such experiments. As of March 12, 1970, the Department had conditionally approved only five reimbursement experiments which are in the States of New York, Connecticut, Maryland, and California. This has been regarded as a disappointingly slow start.

Prepaid group practice

A different type of program concerning the delivery of medical care, currently being used on a small scale, is the prepaid group practice method. The prepaid group practice method may be defined as a program which makes available comprehensive medical care services and which is based on the principles of prepayment, group practice, preventive medicine, voluntary enrollment, and interrelated hospitals and medical offices.

Several studies have indicated that the prepaid group practice may be a more economical method of delivering medical service than the more common fee-for-service method. Officials of the American Hospital Association, the American Medical Association, and the Blue Cross Association stated that they were currently either studying or planning to study the prepaid group practice method to determine the validity of the economies being claimed for it. None of these associations are opposed to the method.

A major difference between the fee-for-service method and prepaid group practice method is that, in contrast to the limited incentives that the fee-for-service method gives to hospitals and physicians to control their costs, the prepaid group practice method provides hospitals and physicians with monetary incentives. The economies claimed for the prepaid group practice method stem from reducing unnecessary doctoring and lengths of hospital stay and increasing outpatient and preventative treatments. The economies also are attributed to the fact that the prepaid group practice method reverses the tendency under the customary method to stimulate hospitalization and instead motivates physicians to control and limit hospital utilization to the minimum considered to be essential by physicians.

A published study of the Federal employees program indicates that, under the Blue Cross-Blue Shield Plan and the Aetna Indemnity Plan, utilization in terms of patient-days per 1,000 insured persons has been twice as high as under the prepaid group practice method. This is shown below for nonmaternity hospital services under the high-option portion of the Federal employees program.

Plan	Patient-days per 1,000 insured persons		
	1961-62	1963-64	1967
Blue Cross-Blue Shield	882	919	914
Aetna	760	949	945
Prepaid group practice	460	453	394

The same study shows (see table below) that an average 82 percent of the subscribers of prepaid group practice plans received care on one or more occasions during 1967 compared with an average 28 percent and 25 percent for Blue Cross and Aetna subscribers, respectively, and that the prepaid group practice plans hospitalized about half as many persons as did the other plans and provided substantially more out-of-hospital service than did Blue Cross-Blue Shield or Aetna.

Plan	Subscribers receiving benefits in 1967	
	Any benefits	Inpatient
	(percent)	
Prepaid group practice	81.9	4.5
Blue Cross-Blue Shield	27.7	10.0
Aetna	24.9	9.0

The above statistics for Blue Cross-Blue Shield and Aetna may be understated to the extent of care furnished under applicable deductibles.

Also the rates of hospitalization for surgical operations in 1967 differed substantially, as shown below.

	Inpatient rates per 1,000 insured persons in 1967	
	Blue Cross-Blue Sheild	Prepaid group practice
Tonsillectomy and adenoidectomy	7.3	2.4
Appendectomy	2.1	1.4
Cholecystectomy	1.9	1.0
Female surgery	8.6	4.8

The differences did not seem to be explained by the differences in ages of the subscribers because differences still existed when comparing annuitants and when comparing active employees.

The study concluded that prepaid group practice plans showed a relatively high utilization of outpatient services and a relatively low utilization of inpatient services and that the utilization data had a considerably broader potential application than only to the Federal employees program. Several other evaluations of prepaid group practices confirm the results of the Federal employees program study.

The Public Health Service is encouraging the growth of prepaid group practices and is facilitating the establishment of prepaid group practice plans in 24 cities. Financing has been made possible by section 3 of the Comprehensive Health Planning and Public Health Services Amendments of 1966 (Pub. L. 89-749, approved November 3, 1966).

The growth of prepaid plans has been slow. In 1968 about 2 percent of the population was covered by these plans and there were only 17 prepaid plans in the country; the largest plan had about 2 million subscribers. Some of the reasons for the slow growth are:

1. Plans are available only in selected geographic areas.

2. Members face problems when traveling outside the area where their plans operate.

3. Legislation bars such plans in 17 States.

4. Choice of physicians is limited.

5. Funds for expansion are limited.

OCHAMPUS officials stated that new methods should be developed to deliver quality health services more economically than the current method. They said that they were studying the prepaid group practice concept and would like to initiate a pilot program for CHAMPUS, probably for retired military beneficiaries, a relatively less mobile group than dependents of active duty personnel.

Planning and coordination of hospital services

Areawide planning is in its infancy, and there is disagreement between the major national health organizations as to what type of plan will function best. The American Medical Association, for example, favors voluntary planning groups, whereas the American Hospital Association feels that voluntary planning groups cannot be effective without State legislation supporting enforcement of the decisions of such groups on all hospitals within the area.

American Hospital Association officials stated that it was highly unlikely that effective planning would result in any significant reduction in the cost of health care services. They also felt that planning should be concerned with assessing the total health care needs and with ensuring the most efficient use of resources consistent with those needs.

Most community hospitals providing short-term care are independently operated, nonprofit institutions which lack the incentives to participate effectively in regional planning systems. The majority of these hospitals function under cost-reimbursable formulas which provide little incentive to contain costs. We believe that there is considerable evidence that these circumstances have served to stimulate hospitals to generate the capability of providing a complete range of services within each hospital and that these conditions could impair effective cost management of areawide health services.

Planning agencies have been established under the joint support and cooperation of Federal, State, and local governments and the voluntary efforts of some hospitals, physicians, insurers, and community officials. They have not been successful in gaining widespread support and generally lack authority to establish and implement comprehensive health care plans. Thus the growth of hospital facilities and services has, for the most part, been uncoordinated and unstructured.

The Comprehensive Health Planning and Public Health Services Amendments of 1966 authorized the making of grants to

States for establishing and operating comprehensive planning agencies with the objective of organizing each State's total health resources toward providing comprehensive health services. Participation on the part of individual hospitals was to be voluntary.

It was initially estimated that the development of a sophisticated level of comprehensive State and regional planning, as envisioned under the act, would take from 3 to 5 years. At a conference on comprehensive health planning sponsored by the American Hospital Association in October 1968, some 2 years after passage of the act, it was found that development had not progressed as anticipated and that implementation would take longer than anticipated.

Major problem areas cited as restraining development of comprehensive planning were (1) lack of qualified personnel, (2) uncertainty as to who controlled the planning process and had final authority in the total planning structure, and (3) the relationship of the statewide planning agencies to the hospitals and to existing voluntary health-planning agencies. Hospital administrators were concerned that their hospitals' participation in these planning efforts would result in loss of autonomy and would prohibit their retaining the mobility to meet their separate responsibilities.

It seems to us that voluntary participation in effective areawide planning systems requires that all aspects of hospital operations and all decisions made regarding the size, scope, and extent of hospital services should be subject to review and approval by an external group. This would result, of course, in some reduction in the authority and independence of each institution and would challenge institutional status and prestige. It would also require, in some cases, that individual institutional goals be tempered and modified to conform to the objectives of the areawide or regional planning structure.

Establishment of effective, but purely voluntary, hospital planning systems is, at best, a long-range process under these circumstances. The need for areawide planning systems seems to be desirable, if not essential, to achieve more effectiveness, efficiency, and economy in providing

hospital services. Also the success of such systems depends not only on the ability to gain the full support of hospital management but also on the full cooperation of physicians and third-party insurers. The physicians determine, to a great extent, what types and levels of service capacities the hospitals must maintain and also the extent and frequency of hospital utilization. The third-party insurers are an integral part of the system, because they are a major source of revenue for hospitals.

In addition, the support of the associations representing the industry is also needed. Principal officials of the American Hospital Association informed us that, although they were in favor of areawide health planning agencies, they felt that planning should be linked to hospital reimbursement methods. In their "Statement on the Financial Requirements of Health Care Institutions and Services" dated February 12, 1969, the association set guidelines for a program to overcome the financial shortcomings that had plagued health care institutions. The guidelines provided that purchasers of care, collectively, meet the full financial requirements of the institutions providing that care.

The statement provided also that health care institutions have an essential role in (1) the designation of the areawide health planning agency and (2) the development and implementation of areawide health plans which recognize the total needs of the community and the interrelationships among health care institutions serving that community.

Principal officials of the Blue Cross Association informed us that they substantially endorsed the full reimbursement and compulsory areawide planning concepts of the American Hospital Association. American Medical Association officials informed us that, since planning groups were in the infant stage and had yet to prove their effectiveness, it would be premature to say whether they should have fiscal responsibility.

To date little progress has been made in implementing the American Hospital Association program. By the end of 1969, only six States had enacted legislation which would sanction the decisions of areawide planning agencies. The six States use the licensing authority as the governmental sanction for enforcing planning decisions.

CHAPTER 6

REASONABLENESS OF COSTS PAID FOR ADMINISTRATION OF CHAMPUS

Our review showed that the administrative costs paid by OCHAMPUS to the Blue Cross Association and selected Blue Cross Plans--hospital fiscal agents--for processing CHAMPUS hospital claims were, for the most part, allowable under contract provisions. OCHAMPUS has exercised little or no managerial control over the fiscal agents, however, and opportunities for cost reductions had not been identified or had not been acted upon by OCHAMPUS officials.

We estimated that more effective management of the program might have resulted in substantial savings. For example, we were able to identify potential savings of $60,000 if CHAMPUS were to take advantage of differences between Blue Cross Plans and Mutual of Omaha claim-processing rates in some geographical areas, potential additional savings if OCHAMPUS were to award contracts on a competitive basis to the lowest bidders, and potential savings of $80,000 if the Blue Cross Association's duplicate claim review procedure were eliminated.

Further reductions in administrative costs could result from improved control and direction of the activities of the individual fiscal agents. For example, savings in excess of $200,000 a year could be effected if a way could be found to eliminate the significant number of claims being returned by Blue Cross Plans to hospitals for revision. Additional savings would result from eliminating the same problem for the other prime contractor, Mutual of Omaha, and from raising the efficiency of those Blue Cross Plans which may be operating less efficiently than others.

CONTROL OVER PERFORMANCE OF HOSPITAL FISCAL AGENTS NEEDS IMPROVEMENT

OCHAMPUS is responsible for negotiating and administering contracts with fiscal agents and for such other functions as budgeting of and accounting for program funds, analyzing

statistical data, and preparing and distributing educational material about the program to beneficiaries and hospitals.

OCHAMPUS control over the performance of the individual fiscal agents--the Blue Cross Association, the Blue Cross Plans, and Mutual of Omaha--needs improvement. This is evidenced by the continued rise in administrative costs and by the wide variances in administrative rates of the fiscal agents to process claims. The rates ranged from $1.25 to $8.64 per claim in fiscal year 1968. OCHAMPUS officials were unaware of the causes of these variances.

Continued rise in costs of processing CHAMPUS claims

The costs incurred by CHAMPUS fiscal agents for processing hospital claims have recently increased significantly, as shown in the following table.

Blue Cross Association and 52 Blue Cross Plans

Fiscal year	Administrative expense	Number of claims	Rate per claim
1967	$ 603,852	178,143	$3.39
1968	932,342	204,303	4.56
1969	1,849,413[a]	375,743[a]	4.92

[a]Data are for the 18-month period ended December 31, 1969.

Mutual of Omaha

Fiscal year	Administrative expense	Number of claims	Rate per claim
1967	$ 176,688	88,788	$1.99
1968	356,815	119,336	2.99
1969	419,536	126,748	3.31

OCHAMPUS and Blue Cross Association officials were unaware of the specific causes of the rapid rise in administrative expense. Officials of the Blue Cross Plans said that the rise in costs was due to wage increases, inflationary increases in other expenses, and improvements or changes made in cost-estimating procedures and accounting systems.

In our discussions with Blue Cross Association officials, they suggested that two contributory causes of the increased costs were the increased volume of claims resulting from the expansion of the program by the 1966 amendments and the increased number of family separations. (See ch. 2.)

Our review of the accounting records and cost data used by the Blue Cross Association and four selected Blue Cross Plans to support the association's administrative cost proposals showed that, for the most part, costs claimed were allowable and allocable, i.e., properly charged for services rendered and benefits received. We did question approximately $8,000 of a total of $152,000 in costs claimed by one Plan during the period July 1, 1966, to December 31, 1969. The costs questioned resulted primarily from computational errors by the Plan's accounting personnel. The Plan's officials agreed with our findings and made the appropriate adjustment.

In fiscal year 1968 the administrative costs of the Blue Cross Association and the Blue Cross Plans rose 54.4 percent over 1967. Part of the rise stemmed from a 23.8-percent increase in Plan employees, primarily claim examiners and related supervisory personnel assigned to CHAMPUS work. During the same period, however, the average number of claims processed--accepted for payment, returned, or rejected--by each claim examiner decreased by 8.9 percent.

The CHAMPUS claims manager at the Blue Cross Association stated that a claim examiner should process approximately 10,000 to 15,000 claims a year. From information furnished by the Blue Cross Plans, we found that only one of the 33 Plans having work-load data had equivalent full-time employees who processed more than 10,000 claims each in 1968. The average number of claims processed by each employee of these Plans was significantly below 10,000. There were approximately 93 equivalent full-time employees--including supervisors, computer personnel, clerks, and claims examiners--assigned to CHAMPUS work at these Plans. Of these 93 employees, 52 were claim examiners who processed a total of 184,467 claims. The number of claims processed a year by each of the 52 claim examiners averaged 3,549.

The following table, which compares employee production and the processing cost per claim at some low- and high-volume CHAMPUS Plans, indicates, in our opinion, significant differences in operating efficiencies among the Plans.

	Plan's volume of CHAMPUS work--fiscal year 1968				
	Low volume			High volume	
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Number of claims processed	4,790	4,264	4,133	9,232	12,039
Equivalent full-time employees:					
Claim examiners and supervisors	1.10	2.01	2.33	1.35	3.50
All employees	1.28	3.10	4.03	2.23	4.50
Number of claims processed per employee:					
Claim examiners and supervisors	4,354	2,121	1,774	6,838	3,440
All employees	3,742	1,375	1,026	4,140	2,675
Cost per claim	$2.57	$4.74	$5.12	$3.70	$6.23

We believe that the differences in the cost per claim among the Plans are not necessarily due to different qualities in the claim review processes among the Plans. As stated on page 68, the Blue Cross Association, which reviews CHAMPUS hospital claims from all fiscal agents, questioned less than 2 percent of the claims in fiscal year 1968. Also Blue Cross Association officials agreed that the data developed during our review showed sufficient evidence to warrant further consideration by them of the potential inefficiencies of the Plans in processing CHAMPUS claims.

One contributing cause for the continued rise in administrative costs was the significant number of claims being returned by the Plans to the hospitals for review. We estimated that Blue Cross Plans incurred additional administrative expenses of $226,000 in 1968 for this reason. Both

Blue Cross Association's and Mutual of Omaha's experience in returning claims was about 30 percent of claims received. This compares unfavorably with much lower rates for Blue Cross insurance programs and the Federal employees program.

Blue Cross Association officials were unaware of the causes of the large number of claims' being returned. OCHAMPUS officials stated that returned claims had been a problem area from the inception of the program and that a solution had not been found. We were further informed that most Plans were taking steps to attempt to reduce the number of claims being returned. None of the officials questioned were aware of the causes of the wide variances in rates per claim charged by Blue Cross Plans.

We believe that one of the reasons for this lack of awareness of OCHAMPUS officials was that insufficient effort was given by OCHAMPUS to reviewing the performance of its fiscal agents. In December 1967 OCHAMPUS created its own review team to evaluate contractor performance and to ensure contract compliance, but this team did not visit any hospital fiscal agents until September 1970, when it made its first visit to the Blue Cross Association.

Another reason for the lack of awareness of OCHAMPUS was the limited scope of the audit work performed by the Department of Health, Education, and Welfare's Audit Agency at the Blue Cross Association and at selected Blue Cross Plans. This audit work is discussed in chapter 7.

On the basis of the circumstances discussed in this section, we believe that improved control and direction by OCHAMPUS over the activities of the fiscal agents should result in reductions in administrative costs.

NEED FOR COMPETITION AND INCENTIVES TO REDUCE COST OF PROCESSING CLAIMS

Our analysis indicated that OCHAMPUS might be able to reduce administrative costs and benefit payments by taking advantage of certain differences between Blue Cross and Mutual of Omaha claim-processing rates. Savings might be realized from having other insurance firms process CHAMPUS claims.

OCHAMPUS is paying a wide range of rates for processing hospital claims. In fiscal year 1968, Mutual of Omaha's rate per claim was $2.99 and Blue Cross's rate was $4.56. The Blue Cross rate is the average of 52 individual Blue Cross Plan rates which ranged from $1.25 to $8.64 per claim. Of the 52 Plans, 33 had rates higher than Mutual of Omaha's rate.

Comparison of the claim rate of Mutual of Omaha with that of the Blue Cross Plans for 1968 indicated that administrative costs could be reduced substantially by using the lower claim rate in each geographic area. For example, Mutual of Omaha processes in Omaha CHAMPUS claims for 17 States therefore its cost per claim of $2.99 in fiscal year 1968 applied to all claims processed, regardless of the geographic area in which the claim originated. We estimated that there might have been savings of about $60,000 if the claims-processing work of eight Blue Cross Plans, whose cost per claim was higher, had been performed by Mutual of Omaha.

Also it appears that, in other geographic areas for which Mutual of Omaha is currently processing CHAMPUS claims, OCHAMPUS could obtain savings by having Blue Cross Plans process these claims and by taking advantage of the more favorable reimbursement formulas with hospitals that were available to some Blue Cross Plans. (See ch. 3.) Similar observations were reported to OCHAMPUS in February 1966 by a group from Columbia University that had studied payments made by fiscal agents.

Blue Cross Association and Mutual of Omaha have been the two prime contractors since 1956 when the program commenced. Their contracts have been renewed on a fiscal-year

basis, and no significant changes have occurred in the administrative responsibilities of the contractors. In 1956 several Blue Cross representatives assisted in the development of the basic statute. In negotiating the contracts for reimbursing hospitals in 1956, the Secretary of Defense prescribed that hospitals in the eastern and western areas of the United States be reimbursed by Blue Cross and that hospitals in the remaining 17 States be reimbursed by an organization in the insurance industry. Ultimately Mutual of Omaha was chosen as the contractor.

We believe that OCHAMPUS should consider using the fiscal agent having the lowest claim rate in each geographical area and, if there are no substantial differences in potential service, should contract with the one which would be the most economical.

Incentive-type contract needed

Since the inception of the program in 1956, OCHAMPUS has negotiated cost-reimbursable contracts with the Blue Cross Association and Mutual of Omaha for the administrative expenses they incur.

We discussed with Blue Cross Association officials the lack of incentives in the contracts for fiscal agents' reducing administrative costs by increasing the efficiency and economy of their operations. These officials concurred that the present contract provisions lacked such incentives and suggested several types of cost-incentive-type contracts that might be mutually advantageous.

We believe that OCHAMPUS should consider negotiating incentive-type contracts with its fiscal agents so as to provide them with practical encouragement for improving their efficiency and reducing their operating costs.

BLUE CROSS ASSOCIATION CLAIMS REVIEW PROCEDURE

Most of the Blue Cross Association's effort, as a prime contractor, is devoted to processing and paying hospital claims submitted against CHAMPUS by the 52 Blue Cross Plans, as subcontractors. About $80,000 of the $108,990 paid to the Blue Cross Association in fiscal year 1968 resulted from the review of individual claims. We believe that management of the overall operations of the Plans should be given increased emphasis by the Blue Cross Association.

Our review showed that Blue Cross Association employees manually performed item-by-item reviews of data shown on CHAMPUS claim forms and that the Blue Cross Plans did the same. In addition, four Plans made computer tests of data similar to those made by the Blue Cross Association, five other Plans made other tests of the data which the Blue Cross Association reviewed, and 10 Plans indicated that computer edits would be added to their review processes in the near future.

The Blue Cross Association's claims review procedure makes little contribution to the processing of claims. The Blue Cross Association's computer edit is made to assure OCHAMPUS that the data it uses in its reports are valid. The Blue Cross Association's manual review is designed to check primarily for missing certifications and signatures on claim forms. In fiscal year 1968 the Blue Cross Association questioned less than 2 percent of the claims received from Plans. No records are kept as to the amounts, if any, that were involved in the claims that were questioned. Also a test we made of claims at three Plans indicated that claim examiners were doing an adequate job of (1) establishing the eligibility of CHAMPUS beneficiaries and (2) checking the mathematical accuracy and completeness of the claim forms.

CHAMPUS is the only health program, including the Federal employees program, Medicare, and private Blue Cross health insurance programs, for which the Blue Cross Association performs a type of claims review. We believe that the claims review procedure performed by the Blue Cross Association largely duplicate procedures performed previously by

Blue Cross Plans, that they serve little purpose, and that consideration should be given to discontinuing them.

Officials of the Blue Cross Association agreed that the review procedure may not be needed but stated that OCHAMPUS required it. An OCHAMPUS official stated that he planned to look into this matter.

CHAPTER 7

ADEQUACY OF REVIEWS OF FISCAL AGENTS

The Department of Health, Education, and Welfare's Audit Agency (HEWAA) audits of the Blue Cross Association and selected Blue Cross Plans were adequate for determining the allowability and allocability of proposed administrative costs, but the scope of the audits and the time spent on them were too limited for evaluating the reasonableness of these costs. We believe that HEWAA, to make this evaluation, should examine into the need for the administrative services and determine whether the Blue Cross Association and the Blue Cross Plans were performing efficiently and effectively those services found to be necessary.

Our review indicated that HEWAA needed to expand its audit work to cover determining (1) the eligibility of CHAMPUS beneficiaries and (2) whether hospital charges to CHAMPUS beneficiaries are reasonable when compared with charges to other patients for the same or similar services.

In October 1967 the Defense Contract Audit Agency, which has the basic responsibility for auditing CHAMPUS contracts, entered into an agreement which provided that HEWAA review the handling of CHAMPUS work by the Blue Cross Association, the Blue Cross Plans, and Mutual of Omaha. This agreement was necessary because HEWAA audits some of the same fiscal agents' handling of the much larger Government medical program--Medicare--and could advantageously coordinate the audit work under both programs. The Defense Contract Audit Agency manual, which HEWAA agreed to use, states that, with respect to CHAMPUS, the primary audit objectives are to determine (1) whether administrative costs claimed for processing claims are allowable, reasonable, and allocable, (2) whether hospital charges are for authorized services furnished to eligible beneficiaries, and (3) whether the charges are reasonable.

Our review of work performed by HEWAA at the Blue Cross Association and at four selected Blue Cross Plans showed that the scope and quality of the review work performed was, for the most part, adequate for determining the allowability and allocability of proposed administrative

costs. We took no significant exception to the work performed.

We believe, however, that HEWAA's work for determining the reasonableness of these administrative costs was not adequate, because of its limited scope and the brief time spent on the audits. For example, we found no documentation to indicate that HEWAA had reviewed and evaluated the need for the Blue Cross Association's duplicate claim review procedure, the wide variances in administrative rates paid to the Plans for processing claims, or other administrative matters discussed in chapter 6.

We believe also that HEWAA's audit effort to determine the eligibility of beneficiaries can be improved by expanding the scope of the audit. Tests made by the audit staffs were performed primarily to determine the mathematical accuracy and completeness of the claim form, rather than to establish the claimant's eligibility. We believe that, although establishing eligibility is primarily the responsibility of the hospitals, the audit program should be revised to require auditors to determine whether hospital procedures are adequate for establishing the eligibility of patients and whether hospital employees are familiar with regulations governing the payment of CHAMPUS benefits. We noted only one case where the auditors had requested a branch of the service to confirm the claimant's period of entitlement.

HEWAA reported that hospital charges paid by the four Plans we reviewed were reasonable, but we found no documentation showing that HEWAA had performed any comparative analyses at two of the Plans. At another Plan, the method used to evaluate the reasonableness of hospital charges appeared to us to be inadequate. As the basis for this conclusion, the auditors computed the average charge per day for 248 CHAMPUS claims and for 10,362 claims processed in 1-month under five other programs and compared the two averages. In our view this method does not provide a sound comparison of charges for similar services among the different programs within hospitals. We believe that, to be meaningful, comparisons should be made of charges for similar services by individual hospitals.

In addition, we noted some instances where auditors had not followed their audit program. For instance, the auditors did not

--fully investigate the causes for a 74-percent increase in a Plan's administrative claim rate from 1967 to 1968, although the audit program required that this be done when the rate increased by more than 10 percent, and

--test the adequacy of a Plan's procedures to prevent duplicate payments.

Our report entitled "Observations on Development and Status of the Audit function at the Department of Health, Education, and Welfare" (B-160759, May 9, 1969), in commenting on the quality of audits of grants and contracts, noted similar weaknesses in the performance of these types of audits and inadequacies in the scopes of the reviews.

CHAPTER 8

CONCLUSIONS, RECOMMENDATIONS, AND MATTERS FOR CONSIDERATION BY THE COMMITTEE

CONCLUSIONS

Costs for CHAMPUS have risen significantly in recent years because of (1) expansion of CHAMPUS by Public Law 89-614, (2) increased use of CHAMPUS by beneficiaries, and (3) the dramatic rise in hospital costs. (See ch. 2.)

We conclude:

--That hospital charges to CHAMPUS patients were generally the same as the charges made by the same hospitals for similar services to non-CHAMPUS patients.

--That, in general, the lengths of stay for CHAMPUS patients were about the same as those for all other patients covered by insurance but longer than those for patients who were not insured. Specifically, the lengths of stay for maternity cases varied by geographic area and by whether the patient was hospitalized in a military or civilian hospital. We believe that there is significant potential for reducing the cost of CHAMPUS by reducing, in consonance with good medical care, the lengths of stay for maternity cases.

--That in most cases CHAMPUS paid the same, and in some cases more, than the amounts paid by Blue Cross for its subscribers, for hospital care because, of the availability, or nonavailability of Blue Cross formulas for reimbursing hospitals.

--That, because of the high percentage of maternity cases processed under CHAMPUS--about one third--and the general practice of hospitals of charging less than actual cost for these cases, hospital charges against CHAMPUS have been lower than they would have been had charges for such cases been based on costs.

--That increased hospital costs have been due, primarily, to increases in salary expense and hospital services.

--That serious problems exist, which must be solved if the attempts to control rising hospital costs are to have a significant impact.

--That management of the hospital component of CHAMPUS needs improvement and that little or no effort has been made to effect economies in several potential areas.

--That the scope of HEWAA audits has been too limited to function as an effective tool of management in regard to such matters as the reasonableness of administrative costs and hospital charges, the eligibility of beneficiaries, and the efficiency of fiscal agents.

RECOMMENDATIONS

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 changing fiscal agents where it appears advantageous to do so;

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

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

--attempting to obtain for CHAMPUS the more favorable Blue Cross Plan 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 HEWAA officials for an expansion of the audit effort and the scope of reviews of CHAMPUS; and

--initiating a pilot program to determine the feasibility and economy of paying CHAMPUS claims on a prepaid group practice basis.

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.

CHAPTER 9

SCOPE OF REVIEW

Our review was performed during 1970 at OCHAMPUS, Blue Cross Association, selected Blue Cross Plans, Mutual of Omaha, selected hospitals, hospital and medical associations, areawide planning commissions, and regional offices of HEWAA.

The selected Plans were the Hospital Service of California (Oakland), Colorado Hospital Service (Denver), Blue Cross of Southwest Ohio (Cincinnati), and Blue Cross of Virginia (Richmond). The Plans were selected on the basis of volume of CHAMPUS business, geographic location, and the methods used by the Plans to reimburse the hospitals for services rendered under CHAMPUS.

Our review included an analysis of data on hospital charges and lengths of hospital stay for randomly selected cases for CHAMPUS, the Federal employees program--high option, and several private Blue Cross programs. We selected for analyses hospital claims for seven diagnostic codes that accounted for about 8,500, or 40 percent, of the CHAMPUS claims processed and paid by the four selected Plans during the 6-month period ended June 30, 1969.

We randomly selected CHAMPUS hospital claims paid to 20 hospitals--five hospitals under each of the four Plans--representing about 34 percent of all the claims at the Plans under the seven diagnostic codes. At each of the four Plans, we reviewed CHAMPUS claims and an equal number of similar claims under the Federal employees program--high option--and one Blue Cross program. At two of the four Plans, we reviewed an equal number of similar claims under another Blue Cross program that was available only at those two Plans. The diagnostic codes reviewed are shown in appendix III.

We researched current literature to determine the primary reasons for the increase in hospital costs and the

attempts being made to control these costs. We also interviewed representatives of hospitals and professional organizations in the medical field. In addition, we evaluated the methods used by the Blue Cross Association and selected Blue Cross Plans in arriving at the administrative cost reimbursement rate claimed. We evaluated also the adequacy of recent audit work performed by the HEWAA concerning CHAMPUS contracts.

We did not evaluate the scope of hospital care and hospital services prescribed by physicians or the levels of hospital operational efficiency nor did we make a detailed analysis of hospital cost-accounting systems.

EXHIBIT

EXHIBIT A

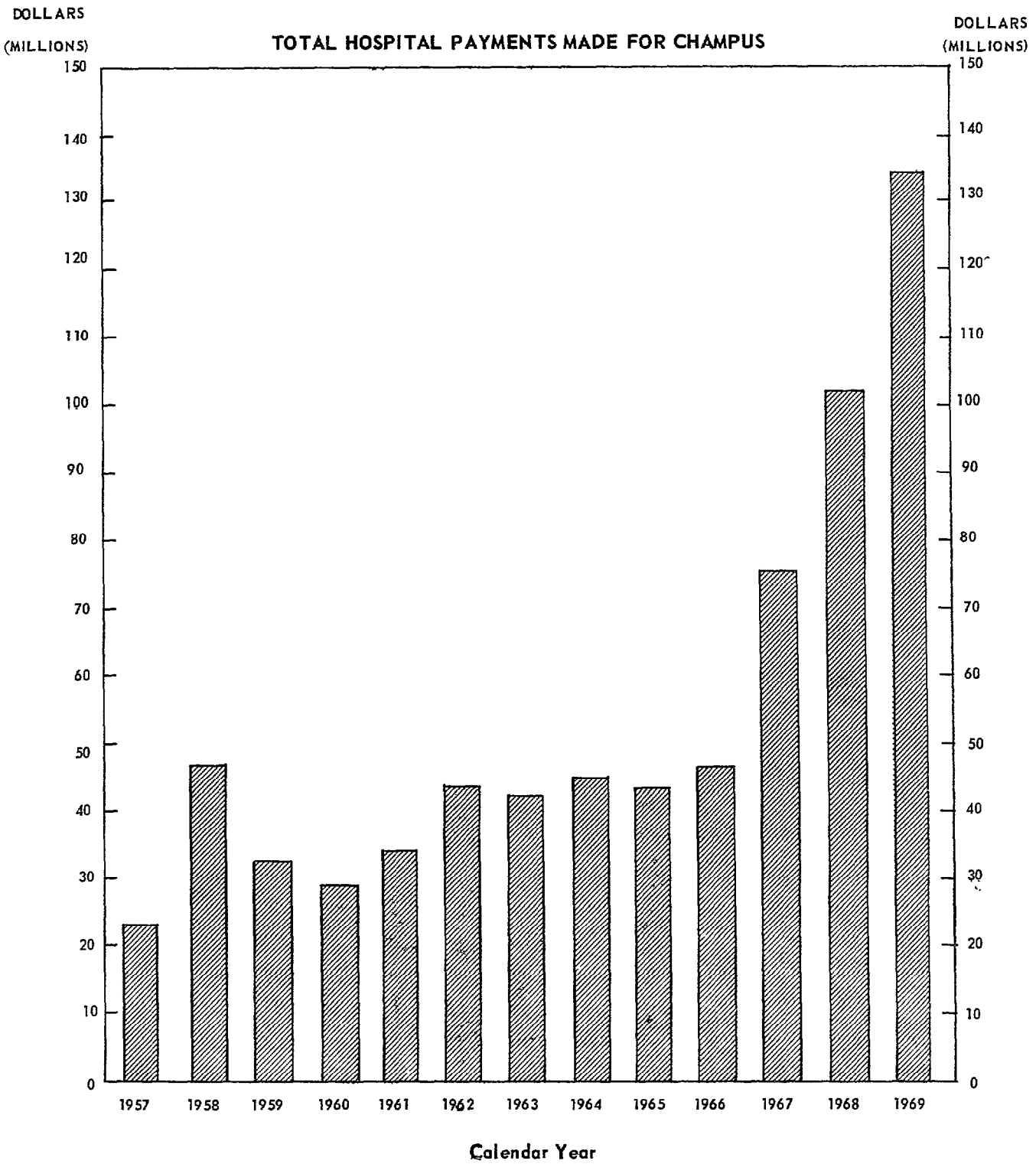
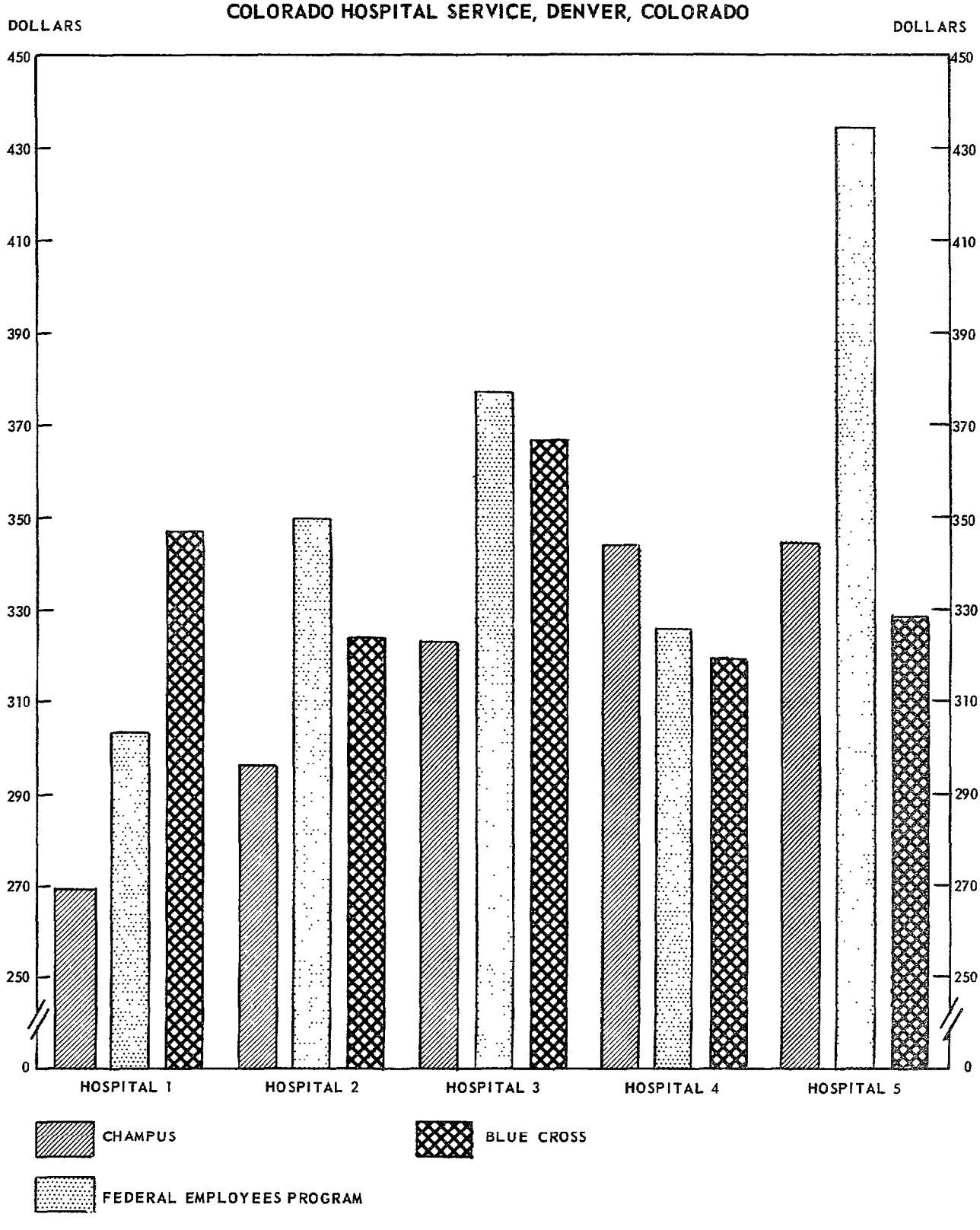

TOTAL HOSPITAL PAYMENTS MADE FOR CHAMPUS
DOLLARS (MILLIONS)
DOLLARS (MILLIONS)
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
Calendar Year

EXHIBIT B

AVERAGE TOTAL CHARGES FOR MATERNITY CLAIMS
PAID DURING THE 6-MONTH PERIOD ENDED JUNE 30, 1969

COLORADO HOSPITAL SERVICE, DENVER, COLORADO



AVERAGE TOTAL CHARGES FOR MATERNITY CLAIMS
PAID DURING THE 6-MONTH PERIOD ENDED JUNE 30, 1969

BLUE CROSS OF SOUTHWEST OHIO, CINCINNATI, OHIO

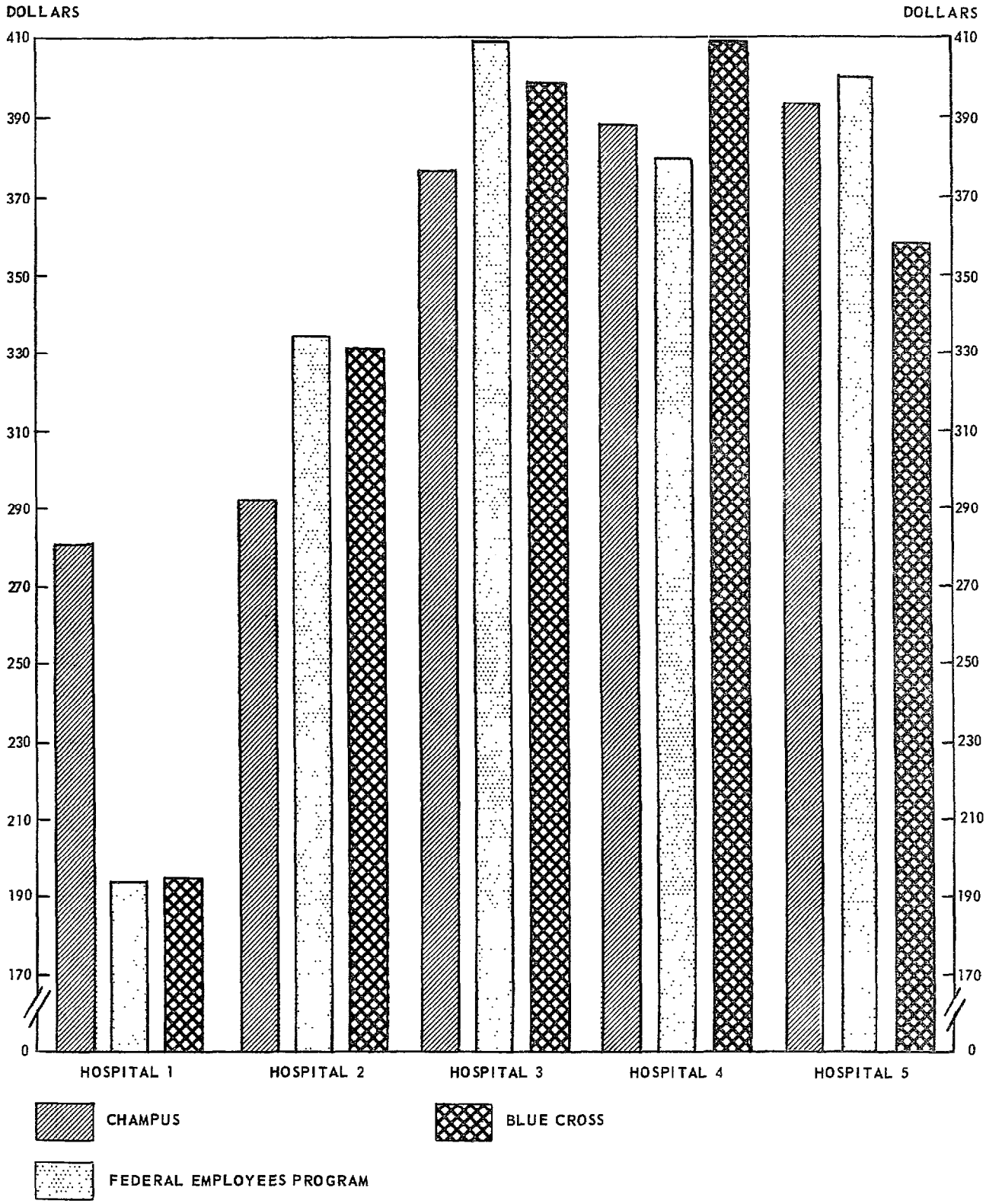
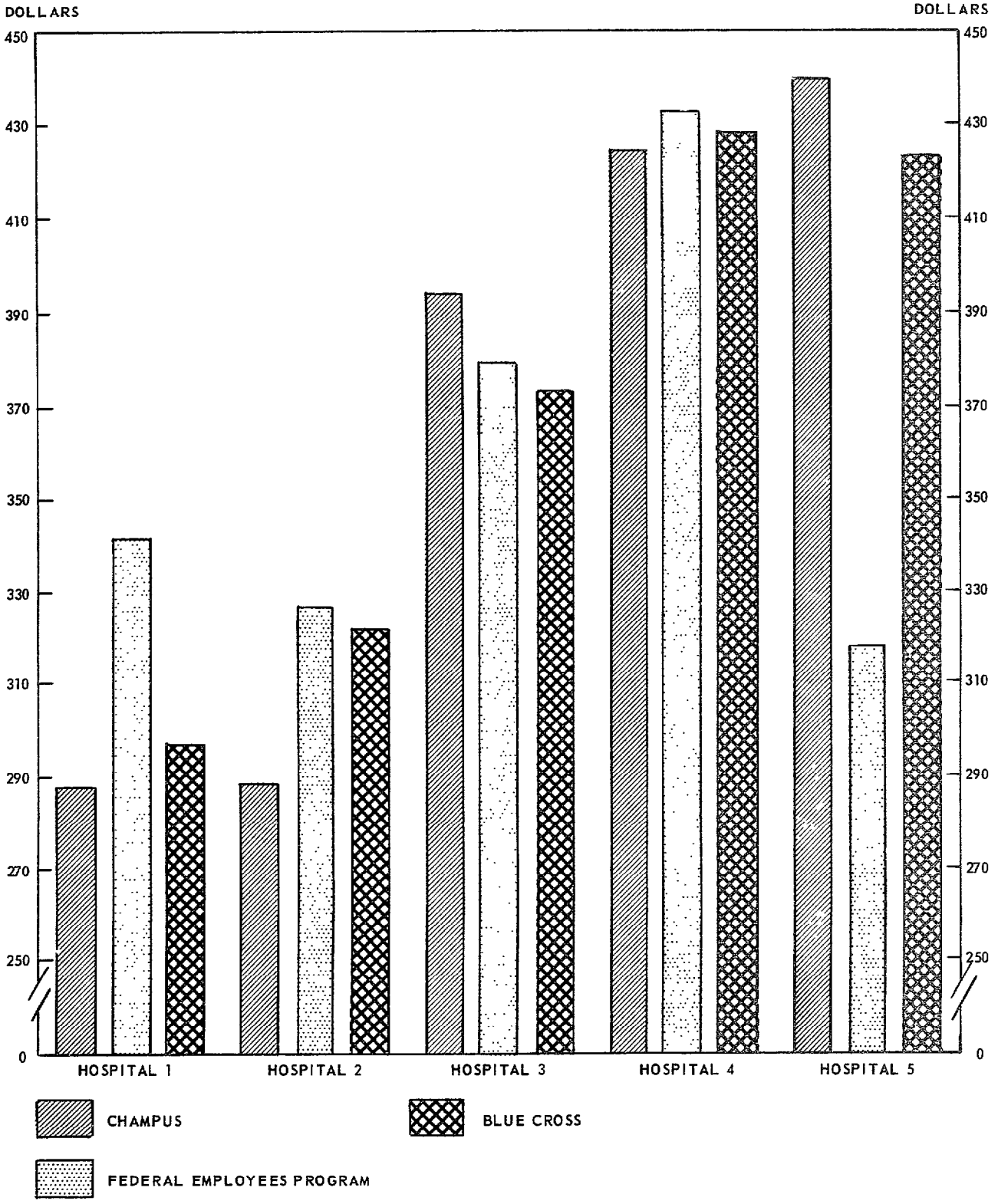


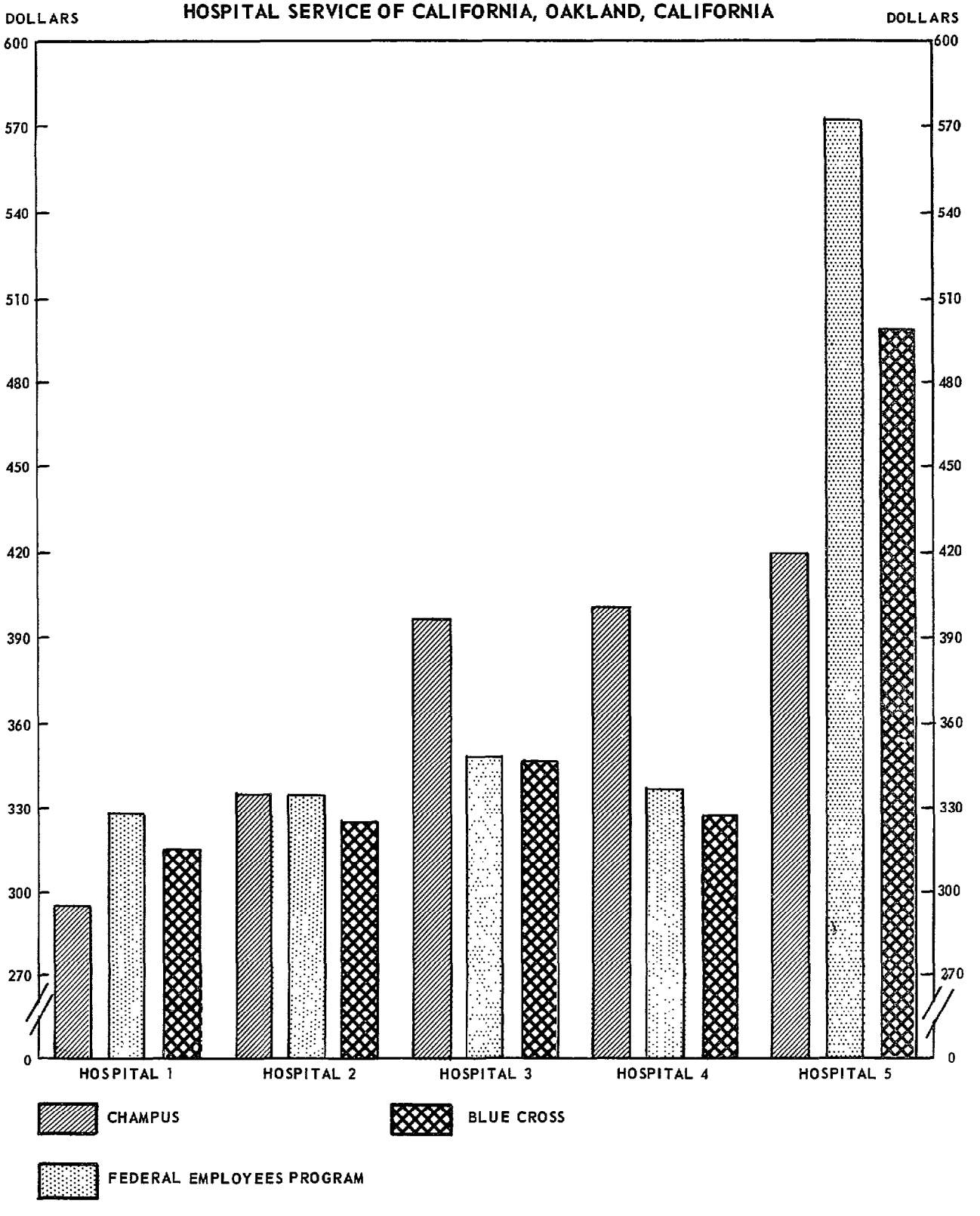
EXHIBIT D

AVERAGE TOTAL CHARGES FOR MATERNITY CLAIMS
PAID DURING THE 6-MONTH PERIOD ENDED JUNE 30, 1969

BLUE CROSS OF VIRGINIA, RICHMOND, VIRGINIA



AVERAGE TOTAL CHARGES FOR MATERNITY CLAIMS
PAID DURING THE 6-MONTH PERIOD ENDED JUNE 30, 1969



APPENDIXES

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

October 20, 1969

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

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

FISCAL AGENTS

PROCESSING INPATIENT HOSPITAL CLAIMS FOR CHAMPUS

BY GEOGRAPHIC AREAS OF RESPONSIBILITY

THE 52 BLUE CROSS PLANS
SUBCONTRACTORS FOR BLUE CROSS ASSOCIATION

Name of the Plan	Location	Geographic area of responsibility
Blue Cross-Blue Shield of Alabama	Birmingham	Alabama
Blue Cross, Washington-Alaska, Inc.	Seattle	(Washington (Alaska
Associated Hospital Service of Arizona	Phoenix	(Arizona (Nevada
Blue Cross of Southern California	Los Angeles	California
Hospital Service of California	Oakland	"
Colorado Hospital Service	Denver	Colorado
Connecticut Blue Cross, Inc.	New Haven	Connecticut
Blue Cross and Blue Shield of Delaware, Inc.	Wilmington	Delaware
Hawaii Medical Service Association	Honolulu	Hawaii
Idaho Hospital Service, Inc.	Boise	Idaho
Blue Cross Hospital Plan, Inc.	Louisville	Kentucky
Associated Hospital Service of Maine	Portland	Maine
Maryland Blue Cross, Inc.	Baltimore	Maryland
Massachusetts Blue Cross, Inc.	Boston	Massachusetts
Michigan Hospital Service	Detroit	Michigan

Name of the Plan	Location	Geographic area of responsibility
Mississippi Hospital and Medical Service	Jackson	Mississippi
Blue Cross of Montana	Great Falls	Montana
New Hampshire-Vermont Hospitalization Service	Concord	(New Hampshire (Vermont
Hospital Service Plan of New Jersey	Newark	New Jersey
Hospital Service, Inc.	Albuquerque	New Mexico
Blue Cross of Northeastern New York, Inc.	Albany	New York
Blue Cross of Western New York, Inc.	Buffalo	"
Chautauqua Region Hospital Service Corp.	Jamestown	"
Associated Hospital Service of New York	New York	"
Rochester Hospital Service Corporation	Rochester	"
Blue Cross of Central New York, Inc.	Syracuse	"
Hospital Plan, Inc.	Utica	"
Hospital Service Corporation of Jefferson County	Watertown	"
North Carolina Blue Cross and Blue Shield, Inc.	Chapel Hill	North Carolina
Blue Cross Hospital Plan, Inc.	Canton	Ohio
Blue Cross of Southwest Ohio	Cincinnati	"
Blue Cross of Northeast Ohio	Cleveland	"
Blue Cross of Central Ohio	Columbus	"
Hospital Service, Inc.	Lima	"
Blue Cross of Northwest Ohio	Toledo	"
Associated Hospital Service, Inc.	Youngstown	"
Blue Cross of Oregon	Portland	Oregon
Blue Cross of Lehigh Valley	Allentown	Pennsylvania

Name of the Plan	Location	Geographic area of responsibility
Capital Blue Cross	Harrisburg	Pennsylvania
Blue Cross of Greater Philadelphia	Philadelphia	"
Blue Cross of Western Pennsylvania	Pittsburgh	"
Blue Cross of Northeastern Pennsylvania	Wilkes-Barre	"
Rhode Island Blue Cross and Blue Shield	Providence	Rhode Island
Blue Cross-Blue Shield of Tennessee	Chattanooga	Tennessee
Memphis Hospital Service and Surgical Association, Inc.	Memphis	"
Blue Cross of Utah	Salt Lake City	Utah
Blue Cross of Virginia	Richmond	Virginia
Hospital Service Association of Roanoke	Roanoke	"
Parkersburg Hospital Service, Inc.	Parkersburg	West Virginia
Wyoming Hospital Service	Cheyenne	Wyoming
Group Hospitalization, Inc.	Washington, D.C.	District of Columbia
Blue Cross of Puerto Rico	San Juan	Puerto Rico

MUTUAL OF OMAHA

Geographic area of responsibility

Arkansas
Florida
Georgia
Illinois
Indiana
Iowa
Kansas
Louisiana
Minnesota
Missouri
Nebraska
North Dakota
Oklahoma
South Carolina
South Dakota
Texas
Wisconsin

DIAGNOSTIC CASES SELECTED FOR REVIEW

Diagnostic code	Description
660	Delivery without mention of complication
650	Abortion without mention of sepsis or toxemia
634	Disorders of menstruation
571	Gastroenteritis and colitis, except ulcerative, persons aged 4 weeks and over
560	Hernia of abdominal cavity without mention of obstruction
550	Acute appendicitis
510	Hypertrophy of tonsils and adenoids

Source: International Classification of Diseases, 1955 Revision, World Health Organization.

U.S. GAO Wash., D.C.