DOCUMENT RESUME

00508 - [A0751626]

Loss of Millions of Dollars in Revenue Because of Inadequate Charges for Medical Care. B-133142; FGMSD-76-102. March 8, 1977. 17 pp.

Report to the Congress; by Robert F. Keller, Acting Comptroller General.

Issue Area: Accounting and Financial Reporting (1208); Health Programs: Reimbursement Policies and Utilization Controls (2800).
Contact: Financial and General Management Studies Div.
Budget Function: Health: Health Care Services (051); National Defense: Department of Defense - Military (except procurement & contracts) (551).
Organization Concerned: Department of the Air Force; Department of the Army; Department of the Navy; Department of Defense.
Congressional Relevance: Congress; House Committee on Armed Services; Senate Committee on Armed Services.
Authority: (24 U.S.C. 34; P.L. 79-51). DOD Instruction 7230.7. Executive Order 11116. Executive Order 11609. O.M.B. Circular A-25.

A review was conducted of policies and procedures used for determining and charging rates for medical care in military medical facilities. Pertinent accounting records and reports were also reviewed. Findings/Conclusions: Persons other than active and retired military personnel and their dependents must pay for the medical care they get in military medical facilities. The rates charged paying patients are so low that about $12 million in medical costs are not recovered annually. Computations of full reimbursement rates excluded many costs of medical operations because of inconsistencies in accounting data submitted by the military services to the Department of Defense and because of the exclusion of certain costs by the Department in computing the rates. Reimbursements could be increased by about $3.2 million annually if full charge rates were increased to recover all costs of providing medical care. Reimbursements could be increased another $8.7 million annually if the special charges for U.S. civilians and foreign nationals and their dependents working for the Government overseas were revised to recover the costs of providing the medical care. Legislative history indicates that the charges should be high enough to recover costs. Recommendations: The Secretary of Defense should provide the military services with specific guidance for reporting accounting data so that complete and consistent costs are used to compute reimbursement rates; establish procedures so that all applicable costs are included in rate computations; and revise the rates periodically. Rates for inpatient and outpatient medical care which are intended to recover all costs should be increased. (Author/SC)

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Loss Of Millions Of Dollars In Revenue Because Of Inadequate Charges For Medical Care

Department of Defense

Persons other than active and retired military and their dependents must pay for the medical care they get in military medical facilities. Legislative history indicates that the charges should be high enough to recover the costs of the medical care provided.

The rates charged paying patients are so low that about $12 million in medical costs are not recovered annually.

GAO is recommending that Defense use complete cost data for determining rates to be charged and revise present rates to recover costs of providing medical care.

The Department of Defense has instructed military departments to increase rates charged U.S. employees overseas effective April 1, 1977, and is revising its accounting system to provide the information necessary to develop more accurate reimbursement rates.

FGMSD-76-102

MAR 8,1977

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

B-133142

To the President of the Senate and the
Speaker of the House of Representatives

Overseas military medical facilities are charging token rates to certain categories of patients for medical care, which has resulted in the U.S. Government subsidizing the cost of this care. Rates charged for medical care provided by military medical treatment facilities to paying patients should be higher to recover the cost of providing such care as intended by pertinent legislation.

The Department of Defense concurs in our proposal and has taken actions which will increase the reimbursement rates charged paying patients. Action is still needed to identify all costs of providing care. We believe the report will be useful to the House and Senate Appropriations Committees in evaluating Defense's 1978 budget requests.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Defense; and the Secretaries of the Army, Navy, and Air Force.

ACTING Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

LOSS OF MILLIONS OF DOLLARS IN REVENUE BECAUSE OF INADEQUATE CHARGES FOR MEDICAL CARE
Department of Defense

D I G E S T

The Defense Department needs to improve its accounting policies and increase some charges for medical care to recover costs incurred. By doing this, Defense could increase its revenue by about $12 million annually.

CHARGES FOR MEDICAL CARE SHOULD RECOVER COST

Medical care at military facilities is provided on a reimbursable basis to

--anyone needing emergency care,

--U.S. civilians and their dependents assigned to Federal jobs overseas, and

--certain foreign nationals (military and civilian) and their dependents.

Legislative history indicates that charges for medical care should recover costs and the rates charged should be changed periodically so that free or relatively free medical services are not given. Regulations of the Office of Management and Budget and the Department of Defense also provide that full costs to the Government should be charged for services rendered.

The Secretary of Defense is responsible for prescribing rates for hospital and dispensary services. The rates charged by the Department of Defense include (1) special rates for certain persons at medical facilities overseas and (2) full reimbursement rates for individuals at U.S. and overseas locations who are not normally authorized care in military medical facilities. Special

rates are token charges while full reimbursement rates are intended to recover the full cost of providing medical care.

SPECIAL RATES NOT JUSTIFIED

Since 1943 U.S. civilians and foreign nationals and their dependents working for the Government overseas have paid the special rate of only $1 a visit for outpatient medical care. During an outpatient visit, patients can receive doctor's care, prescriptions, and such medical services as laboratory tests and X-rays. Obviously, the $1 charge does not recover the cost of outpatient medical care. In some cases, comparable outpatient care obtained for $1 overseas would cost $85 in the United States. (See p. 3.)

Foreign nationals and their dependents employed by the U.S. Government overseas are charged a special rate of $5 a day for inpatient care. This charge is supposed to cover all hospital care received and has not changed since 1943.

Reimbursements could be increased by more than $8.7 million annually if special charges for medical care were revised to recover costs of providing the care. (See p. 3.)

In October 1976 GAO proposed to the Secretary of Defense that rates be revised to recover the full cost of providing medical care. The Department of Defense informed GAO that effective April 1, 1977, military departments will increase (1) the special rate charged U.S. employees from $1 for each outpatient visit to $20 and (2) the rate charged foreign nationals for inpatient service from $5 to $168. Further, GAO found that Defense has underway a study to develop a clear definition of what service will be covered by the $20 fee. In those cases where care provided involves only minimal medical procedures, consideration is being given to charging a nominal fee or no fee at all.

Defense's action to revise the rates will significantly increase the amount of reimbursements; however, GAO believes that the new rates will not recover all costs that should be recovered. (See pp. 6 to 10.)

CHARGES FOR MEDICAL CARE DO NOT RECOVER COSTS AS REQUIRED

Rates for inpatient and outpatient medical care which are intended to recover all costs should be increased. Computations of full reimbursement rates excluded many costs of medical operations because of (1) inconsistencies in accounting data submitted by the military services to the Department of Defense and (2) exclusion of certain costs by the Department in computing the rates. Increases in the full reimbursement rates to recover all costs of providing medical care could bring in over $3.2 million annually. (See pp. 6 to 10.)

GAO is recommending that the Secretary of Defense (1) provide the military services with specific guidance for reporting accounting data so that complete and consistent costs are used to compute reimbursement rates, (2) establish procedures so that all applicable costs are included in rate computations, and (3) revise the rates periodically. The Department of Defense agreed that not all costs are included in rate computations and informed GAO that it was giving high priority to developing the uniform accounting procedures needed to provide more complete information for determining reimbursement rates. Defense, in improving its hospital accounting system, will be able to consider whether it will be feasible to charge rates which approximate more closely the cost of care received by each patient in lieu of charging one rate for all inpatient care and one rate for all outpatient care.

Contents

ABBREVIATIONS

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

CHAPTER 1

INTRODUCTION

During fiscal year 1975, maintaining military medical facilities overseas cost the United States about $200 million. The primary function of these facilities is to provide medical care to U.S. military personnel and dependents. About 8 percent of the medical care workload at these facilities involved the treatment of U.S. civilians and non-U.S. civilians working for the U.S. Government, as well as certain foreign civilian and military personnel and their dependents. During fiscal year 1975, persons who were charged for the medical care received occupied about 70,000 bed-days and made about 686,000 visits as outpatients.

The authority for prescribing the rates to be charged was initially given to the President. However, this authority has been delegated to other individuals over the years. In January 1964 the Director of the Bureau of the Budget (now Office of Management and Budget) was given the authority by Executive Order No. 11116, August 1963. Seven years later, Executive Order No. 11609, July 1971, which is currently in effect, gave the Secretary of Defense responsibility for prescribing the rates.

PERSONS AUTHORIZED USE OF MILITARY MEDICAL FACILITIES

Public Law 78-51 (24 U.S.C. 34), enacted May 10, 1943, authorized the treatment of other than Navy and Marine Corps personnel and their dependents at overseas naval hospitals and dispensaries. Individuals authorized medical treatment included U.S. Government employees, U.S. contractor employees and their dependents, and anyone needing emergency care. The legislation did not authorize medical care for such individuals in Army and Air Force medical facilities, but the Army and Air Force provided and continue to provide medical care on a similar basis. We are not aware of any evidence that the Congress opposes providing such care in Army and Air Force medical facilities.

RATES SHOULD RECOVER COSTS OF PROVIDING MEDICAL SERVICES

Public Law 78-51 requires that charges for medical care in military facilities shall change from time to time. House report 193 accompanying House bill 1936, which later became Public Law 78-51, indicated that the rates charged should be "compensatory" so that "free or relatively free services"

would not be given. The charges first established by Executive Order 9411 in December 1943 were $1 for an outpatient visit and $5 a day for inpatient care. These rates were used until Executive Order No. 11116, August 1963, established two rates each for inpatient and outpatient care as follows.

Inpatient rates

Foreign nationals employed by the U.S. and their dependents--$5 a day.
All others--$37 a day.

Outpatient rates

U.S. employees and dependents--$1 a visit.
All others--$8 a visit.

The $5 and $1 rates were considered special rates applicable to specific categories of patients at overseas medical facilities while the $37 and $8 rates were considered full reimbursement rates applicable in the United States and overseas to all patients not in the special categories. Defense officials could not explain why special and full reimbursement rates were established nor identify written justification supporting the rationale for using different rates.

Guidance in Office of Management and Budget Circular A-25, September 1959, and Department of Defense Instruction 7230.7, July 1973, provides that reimbursement rates should recover the full cost of providing services.

Since 1943 the special rates have remained the same. Full reimbursement rates, however, have changed. For fiscal year 1976, for example, full reimbursement rates were $147 a day for inpatient care and $19 a visit for outpatient care. For fiscal year 1977 the rates were increased to $168 and $20, respectively.

CHAPTER 2

SPECIAL RATES SHOULD BE ELIMNATED

Over $8.7 million in additional revenues could be collected annually if the Department of Defense eliminated special rates and established rates based on cost recovery. Although health care costs have increased substantially since 1943, the special rates of $1 a visit for outpatient care and $5 for each day in the hospital have not changed. We believe that special rates are unrealistic and do not meet the intent of existing legislation.

Civilians working overseas for the Government and their dependents are provided complete doctor's care, medical services, tests, and prescriptions at the special rate of $1 an outpatient visit. Foreign nationals working for the U.S. Government also receive complete inpatient care at a special rate of $5 an inpatient day. U.S. civilians are not authorized the special inpatient rate.

An example of medical care and services given to a U.S. civilian employee for $1 during an outpatient visit to a military medical facility overseas is shown below.

Medical care and service	Average U.S. cost
Medical examination	$30
Electrocardiogram	20
Laboratory tests including chemistry I, urinalysis, and hematology	25
Chest X-rays	10
Total	$85

The special rates at overseas medical facilities provide civilians with relatively free medical care. About 85 percent of the U.S. civilians paying the $1 special rate have medical insurance covering the cost of certain outpatient medical services. The U.S. Government shares with these civilians the cost of the medical insurance coverage. In essence, then, the Government is providing a subsidy to the medical insurance companies since it is also paying the medical care costs chargeable to the insurance companies.

Public Law 78-51, enacted in 1943, authorized hospital and dispensary services overseas for U.S. and non-U.S. civilians working for the Government. A committee report accompanying the House bill which became Public Law 78-51 contained

provisions concerning charges for medical care. This report stated "it is intended that these charges shall be compensatory" so that medical care "will not be furnished free or relatively free to such persons." In keeping with this intent, the law made provision to change the rates from time to time.

Our review showed that, if in fiscal year 1976 the rates had been revised as intended by law, a rate to recover costs of an outpatient visit would have been at least $23 1/ a visit. During fiscal year 1975, patients--mostly U.S. civilians--made over 315,000 outpatient visits to medical facilities overseas and paid only $1 a visit. Over $6.9 million in additional reimbursement could have been collected in fiscal year 1976 if the rate of $23 a visit had been charged to the same number of persons.

The Air Force did not maintain statistics showing how many foreign national civilians received care at the $5 rate. However, records showed that the Army and Navy provided over 10,150 inpatient days of medical care in fiscal year 1975 to foreign national civilians who were U.S. employees. We believe that over $1.8 million in additional revenues could have been collected by the Army and Navy in fiscal year 1976 if a cost recovery rate of $183 1/ per inpatient day had been charged for the same number of inpatient days. Additional revenues could also be collected by the Air Force from the foreign national civilians who were charged the $5 inpatient rate.

Defense officials could not explain why the special reimbursement rates had not changed in 33 years nor why no action had been taken to change the rates even though it was recognized that rates for medical care should be based on full recovery of costs. In January 1975 the Air Force was directed to develop, jointly with the Army and Navy, an instruction to simplify the reimbursement rate structure and standardize charges. A revised instruction was proposed in May 1975, with recommendations to the Secretary of Defense to charge full reimbursement rates in lieu of special rates. However, no action had been taken to implement the recommendations.

CONCLUSIONS

To comply with the intent of the law, rates charged for medical care given in military facilities to paying patients should recover the cost of providing that care.

1/Our cost analysis is discussed in ch. 3 and app. I.

In October 1976 we proposed that the Secretary of Defense discontinue the special $1 outpatient and $5 inpatient rates and begin charging rates that recover the cost of providing medical care. (See also recommendations on p. 9.)

AGENCY ACTIONS

In a letter dated January 11, 1977, the Assistant Secretary of Defense (Health Affairs) concurred in our suggestion and informed us that the Assistant Secretary of Defense (Comptroller) had issued instructions to the military departments which will, beginning April 1, 1977, increase special rates charged U.S. employees in overseas areas from $1 to $20 for outpatient visits and from $5 to $168 per day for inpatient care. Also, we found that Defense has underway a study to develop a clear definition of what service will be covered by the $20 fee. In those cases where care provided involves only minimal medical procedures, consideration is being given to charging a nominal fee or no fee at all.

Although Defense's action to change the rates will significantly increase reimbursements, the new rates will not recover complete costs of medical care provided. The accounting system from which these rates were derived did not provide for accumulation of all costs. (See ch. 3.)

CHAPTER 3

FULL REIMBURSEMENT RATES ARE TOO LOW

Full reimbursement rates charged to civilians at U.S. and overseas military facilities need to be higher to recover full costs of medical care provided. Many elements of cost are excluded in computing rates to be charged. Standard accounting procedures are needed so that uniform and complete accounting data are reported by the military services and pertinent costs are used by the Department of Defense in determining reimbursement rates. Reimbursements can be increased by at least $3.2 million annually if the development of full reimbursement rates is based on more complete cost information.

REIMBURSEMENT RATES DO NOT RECOVER COST OF PROVIDING MEDICAL CARE

Rate computations made by the Department of Defense for fiscal year 1976 excluded over $492 million in costs applicable to patient care. About $3.2 million of these costs applied to paying patients and could have been recovered if complete cost data were used for computing full reimbursement rates. For fiscal year 1976, we estimated inpatient rates were understated by $36 a day and outpatient rates by $4 a visit.

As previously noted in this report, under Public Law 78-51, the Congress intended that rates charged for medical services should compensate the Government for the costs incurred in providing the services. Office of Management and Budget Circular A-25, dated September 1959, and Department of Defense Instruction 7230.7, dated July 1973, also provide that rates should recover the full cost of providing the services. In determining which costs should be included in rate computations, we used the guidance in (1) Office of Management and Budget Circular No. A-25 "User Charges," September 1959, (2) Department of Defense instructions implementing the circular, and (3) the American Hospital Association manual for hospitals "Cost Finding and Rate Setting."

The Office of Management and Budget Circular requires that, for computing rates to be charged for Government services, the cost computation shall cover the direct and indirect costs to the Government of carrying out the activity. The circular also requires that the cost of providing the service shall be reviewed every year and the fees adjusted as necessary. The American Hospital Association manual recommends the specific costs which should be included when determining rates.

At least $3.2 million in additional revenues could have been collected in fiscal year 1976 if all appropriate costs, including the $492 million in costs excluded from the Department of Defense computations, had been considered in determining full reimbursement rates and if the resulting full reimbursement rates had been used. (See app. I.) The $3.2 million estimate represents the portion of additional costs we identified that could have been recovered from patients receiving inpatient care who were charged full reimbursement rates at U.S. and overseas military medical facilities.

We could not determine accurately at either U.S. or overseas military medical facilities the number of persons provided outpatient care on a full reimbursement rate basis. Consequently, our estimate of possible additional revenues is understated.

Certain costs were excluded from the amounts used by Defense to compute full reimbursement rates because (1) there were inconsistencies in the military medical services' accounting, reporting, and budgeting systems and (2) Defense did not identify all costs that should be recovered nor issue specific guidance to the services for reporting these costs.

Inconsistent accounting, reporting, and budgeting systems

In computing reimbursement rates, the Department of Defense used budgeted cost information provided by the military services. Because each of the military services accounted, reported, and budgeted differently for various elements of hospital cost, some elements were not included in the budgets submitted to the Department. As a result, they were excluded from the computation of the reimbursement rates. Examples of costs excluded from the rate determination due to inconsistencies in the systems employed by the military services follow.

1. Utility and maintenance costs for Army hospitals were not reported by the Army to the Department of Defense and were excluded from the reimbursement rate computations. Army personnel estimated that these costs amounted to about $46.2 million.

2. Food costs for patients in Army and Air Force hospitals were not reported, and about $26 million in such costs for these hospitals were excluded from the Department's computations.

Also, fiscal year 1976 dental costs for the three military services were erroneously computed, and patient care costs were understated by approximately $36 million.

Not all recoverable costs identified

Defense did not identify several major elements of cost nor include them in its computations for reimbursement rates.

Medical training costs totaling $222 million were not considered. The American Hospital Association manual on "Cost Finding and Rate Setting" provides that training costs should be considered in determining rates. According to the Association, most authorities believe there is equity in including training costs in patient rates when patients derive direct benefits from training programs.

We also found that military retirement costs were excluded from the rate computation despite the fact that Defense regulations require that retirement costs be included when determining charges for reimbursement. According to a December 1975 study by the Office of Management and Budget and the Departments of Defense and Health, Education, and Welfare, these excluded costs totaled at least $105 million. Also, rates were not adjusted to include additional personnel costs for military and civilian pay raises, which the military services estimated at about $57 million during fiscal year 1976.

GOVERNMENT CHARGES ARE LOW COMPARED TO CHARGES IN COMMERCIAL HOSPITALS

Under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) the Government helps eligible military personnel and their dependents pay for health care obtained from civilian sources. To determine the reasonableness of Defense's computed rates, we compared (1) the average rates paid in fiscal year 1975 under the CHAMPUS program, (2) the fiscal year 1976 rates used by Defense, and (3) the rates computed by us. Fiscal year 1975 CHAMPUS rates were the latest available. To make them more comparable with the fiscal year 1976 rates, we adjusted these rates by applying a 9.2 percent inflation factor furnished by the Bureau of Labor Statistics. The schedule below shows that the Defense rate is low compared to the other two rates.

	Defense-computed rate	GAO-computed rate	CHAMPUS average rate
Inpatient day	$147	$183	$176
Outpatient visit	19	23	40

Using American Hospital Association statistics, we compared charges for certain inpatient treatments at commercial hospitals with the rates charged by Defense. Commercial hospital rates vary by the type of treatment provided. On the average, however, Defense rates were below commercial hospital charges for those treatments compared.

CONCLUSIONS

The Defense Department should include more complete cost data in computing reimbursement rates. All direct and indirect costs associated with providing medical care should be determined and used. Defense should clearly define costs to be reported by the services and used for reimbursement rate computations and should require standardized reporting of cost data. Inclusion of applicable direct and indirect costs and use of more complete, standardized cost information would help assure that reimbursement rates charged cover the costs of providing medical treatment. Furthermore, the rates should be revised periodically.

RECOMMENDATIONS

We recommend that the Secretary of Defense:

--Identify all applicable direct and indirect costs associated with providing medical care to paying patients.

--Clearly define cost data to be submitted by the military services for use in reimbursement rate computations and standardize reporting so that all applicable costs are reported completely and consistently.

--Use applicable direct and indirect operational cost when computing full reimbursement rates, including retirement and training costs.

--Periodically revise the rates.

AGENCY ACTION

In his January 11, 1977, letter the Assistant Secretary of Defense (Health Affairs) agreed that not all appropriate

elements of cost have been included in the calculation of reimbursement rates. He agreed that standard accounting procedures are needed and informed us that the Department has given high priority to developing a uniform chart of cost accounts which it intends to implement by October 1, 1977. The Assistant Secretary added that our recommendations will be considered in developing future rates. We were informed that new rates will be established on or before October 1, 1977.

The decision to improve Defense's hospital accounting system was previously conveyed to us in a letter dated October 20, 1976, from the Principal Deputy Assistant Secretary of Defense (Health Affairs). This letter was in response to a report we made to the Acting Assistant Secretary of Defense (Health Affairs) on August 23, 1976, in which we cited a need for better cost and output data.

The actions taken by the Assistant Secretary to improve the accounting system used to compute reimbursement rates should, if effectively implemented, result in the establishment of rates which recover full cost. Further, Defense in improving its hospital accounting system will be able to consider whether it will be feasible to charge rates for medical care which approximate more closely the cost of the care received by each paying patient in lieu of charging one rate for all inpatient care and one rate for all outpatient care.

CHAPTER 4

SCOPE OF REVIEW

We reviewed policies and procedures used for determining and charging rates for medical care in military medical facilities. We also reviewed pertinent accounting records and reports.

In our work we visited the following organizations.

Office of the Secretary of Defense:
- Office of the Assistant Secretary of Defense, Health Affairs
- Office of the Assistant Secretary of Defense, Comptroller

Department of the Army:
- Office of the Surgeon General
- U.S. Army Hospital, Seoul, Korea
- U.S. Army Hospital, Frankfurt, Germany

Department of the Navy:
- Navy Bureau of Medicine and Surgery
- U.S. Naval Regional Medical Center, Yokosuka, Japan
- U.S. Naval Hospital, Naples, Italy

Department of the Air Force:
- Office of the Surgeon General
- U.S. Air Force Hospital, Clark Air Base, Republic of the Philippines
- U.S. Air Force Hospital, Wiesbaden, Germany

APPENDIX I

COMPARISON OF COMPUTATIONS OF REIMBURSEMENT RATES FOR FISCAL YEAR 1976

Estimated Costs of Inpatient and Outpatient Care

Explanation of costs	Defense	GAO	Difference
	(thousands)		
Estimated costs submitted by the military services	$2,315,000	$2,315,000	$ -
Estimated real property depreciation	19,381	19,381	-
Less estimated costs for dental care (-)	-324,479	-288,400	36,079
Additional costs identified by GAO:			
Personnel wage increases in fiscal year 1976	-	56,700	56,700
Food procurement - Army and Air Force	-	26,100	26,100
Base support for Army hospitals	-	46,200	46,200
Military retirement and wage acceleration	-	105,000	105,000
Medical training costs	-	222,000	222,000
Total cost for inpatient and outpatient care	$2,009,902	$2,501,981	$492,079

Computation of Inpatient Reimbursement Rate

	Defense	GAO	Difference
Costs allocated to inpatient care (52% of total cost) (note a)	$1.045 billion	$1.301 billion	
Estimated inpatient days	7.1 million	7.1 million	
Reimbursement rate for inpatient day	$147	$183	$36

Computation of Outpatient Reimbursement Rate

	Defense	GAO	Difference
Costs allocated to outpatient care (48% of total cost) (note a)	$0.965 billion	$1.200 billion	
Estimated outpatient visits	51.4 million	51.4 million	
Reimbursement rate for outpatient visit	$19	$23	$4

a/Department of Defense breakdown of total cost for inpatient and outpatient care is based on a study prepared by the Air Force.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

11 JAN 1977

Mr. D. L. Scantlebury
Division of Financial and General
Management Studies
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Scantlebury:

This is in reply to your letter of October 19, 1976 to Secretary Rumsfeld regarding your draft GAO Report, "Loss of Millions of Dollars in Revenue Because of Inadequate Charges for Medical Care." (Code 90347) (OSD Case #4467).

The Department of Defense concurs in the [illegible] recommendation that rates charged for medical care provided by military medical treatment facilities to paying patients should recover the cost of providing that care.

The Assistant Secretary of Defense, Comptroller has issued instructions to the Military Departments which will increase the special rates charged employees of the United States in overseas areas from $1 and $5 to $20 and $168 effective 1 April 1977. (See attached memorandum, 10 Nov 76). Exceptions will be allowed where local union contracts or agreements with foreign governments are in effect which incorporate the old rates of reimbursement. These contracts and agreements will be honored until expiration.

The report concludes that full reimbursement rates are too low, that all appropriate costs are not included in the calculation, and that standard accounting procedures are needed to help insure that uniform and complete accounting data are reported and used in determining reimbursement rates.

The Department fully agrees that standard accounting procedures are needed and has given high priority to the development of a uniform chart of cost accounts and performance measures. An initial draft of the procedures is currently being reviewed with the objective of implementing the system on 1 October 1977.

APPENDIX II

We would also agree that all appropriate elements of cost have not been included in the calculation. Utility and maintenance costs for Army hospitals, food costs for patients in Army and Air Force hospitals, and retirement costs for medical personnel should be included in the calculation. A portion of training costs should also be included - that portion which contributes directly to patient care; however, we do not believe that the costs of conducting military unique training should be included. This cost element will require further study and evaluation to determine the percentage of training costs which should be included.

Based on the above, it could be concluded that current rates are too low; however, until the current inconsistencies in the accounting system are eliminated, we cannot determine whether the rates are in fact too low.

The recommendations included in the report will be considered in the development of future rates; however, the accuracy of the rates will be questionable until such time as a uniform accounting system is in operation.

We appreciate your analysis of this subject area. The results of your review will be helpful in improving management in the Department of Defense.

Sincerely,

Robert N. Smith, MD

Robert N. Smith, M.D.

Enclosure

APPENDIX II

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

COMPTROLLER

10 NOV 1976

MEMORANDUM FOR Assistant Secretaries of the Military Departments (FM)
Assistant Secretaries of the Military Departments (M&RA)

SUBJECT: Special Reimbursement Rates for Medical Care

Pursuant to the authority provided in 24 U.S.C. 34, as implemented by Executive Order No. 11116, August 5, 1963, special reimbursement rates for medical care of U.S. employees overseas and their dependents were put into effect on January 1, 1964. Because of increases in the cost of providing medical care, changes in international economic conditions, and improvements in the Federal Health Care Benefits Program such blanket rates are no longer valid and are in need of revision.

Accordingly, you are advised that pursuant to the authority delegated to the Secretary of Defense by Executive Order No. 11609, July 27, 1971, the special reimbursement rates for medical care provided to employees of the United States, and their dependents by hospitals and dispensaries overseas are revised as follows:

For inpatient care, of employees of the United States who are not citizens of the United States and their dependents (This rate is now paid by employees who are citizens)	$168.00 per day
For each outpatient treatment, examination, or consultation of employees of the United States and their dependents (This rate is now paid by employees in the United States)	$ 20.00 per visit

The revised reimbursement rates provided above become effective April 1, 1977, except where local union contracts or agreements with foreign governments are in effect which incorporate the old rates of reimbursement. These contracts and agreements will be honored until expiration. We need notification of these contracts and agreements since the authority to set the special rates authorized by the Executive Order cannot be redelegated to officers of the military departments. Requests for exceptions to the revised rates in all other cases shall be submitted to OASD(C) for review and approval.

It is requested that prompt action be taken to notify all overseas employees of the revised reimbursement rates.

Fred P. Wacker

Fred P. Wacker
Assistant Secretary of Defense

cc: Directors, Defense Agencies

PRINCIPAL OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

(List current as of January 20, 1977)

	Tenure of office From	To
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
Donald H. Rumsfeld	Nov. 1975	Present
James R. Schlesinger	July 1973	Nov. 1975
ASSISTANT SECRETARY OF DEFENSE (COMPTROLLER):		
Fred P. Wacker	Sept. 1976	Present
Terence E. McClary	June 1973	Aug. 1976
Don R. Brazier (acting)	Jan. 1973	June 1973
Robert C. Moot	Aug. 1968	Jan. 1973
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS):		
Dr. Robert N. Smith	Aug. 1976	Present
Vernon McKenzie (acting)	Mar. 1976	Aug. 1976
ASSISTANT SECRETARY OF DEFENSE (HEALTH AND ENVIRONMENT):		
Vernon McKenzie (acting)	Mar. 1976	Mar. 1976
James R. Cowan	Feb. 1974	Mar. 1976
DEPARTMENT OF THE ARMY		
SECRETARY OF THE ARMY:		
Martin R. Hoffman	Aug. 1975	Present
Howard H. Callaway	May 1973	July 1975
SURGEON GENERAL OF THE ARMY:		
Lt. Gen. R. R. Taylor	Oct. 1973	Present
DEPARTMENT OF THE NAVY		
SECRETARY OF THE NAVY:		
J. William Middendorf II	June 1974	Present
John W. Warner	May 1972	Apr. 1974

APPENDIX III

	Tenure of office From	To
DEPARTMENT OF THE NAVY (cont.)		
CHIEF, BUREAU OF MEDICINE AND SURGERY:		
Vice Adm. W. P. Arentzen	Aug. 1976	Present
Vice Adm. D.L. Custis	Feb. 1973	July 1976
DEPARTMENT OF THE AIR FORCE		
SECRETARY OF THE AIR FORCE:		
Thomas C. Reed	Jan. 1976	Present
James W. Plummer (acting)	Nov. 1975	Jan. 1976
Dr. John L. McLucas	July 1973	Nov. 1975
SURGEON GENERAL OF THE AIR FORCE:		
Lt. Gen. G. E. Schafer	Aug. 1975	Present
Lt. Gen. Robert Patterson	Aug. 1972	July 1975