

CHAPTER II

SOME OPTIONS FOR RESTRUCTURING SUPPORT

SERVICES PROVIDED TO MILITARY PERSONNEL

The Department of Defense provides a wide range of services for military personnel and their dependents, including child care, schools, commissaries and exchanges, legal services, family housing, and medical care. These services are important components of the total compensation package that the military uses to attract and retain active-duty personnel. Consolidation and streamlining in these areas could mean consolidating responsibility for a particular support activity among the various services. Alternatively, it might mean a reduced role for DoD as a direct producer of such services and increased reliance on the private and public infrastructure that serves the U.S. population as a whole.

This chapter examines options in two support areas: medical care and family housing. In the case of medical care, the duplication of assets among the services and the cost-effective delivery of military medical care are both important concerns. The medical care option would address them by consolidating management responsibility at the DoD-wide level for all aspects of care--whether care is provided at military medical facilities or in civilian health care facilities. In the case of family housing, the primary issue is the trade-off between relying on private-sector housing and continuing to use on-base housing. The options examined here focus on consolidating funding for family housing benefits (both housing allowances and DoD housing units) within each service in a way that will encourage more use of private-sector housing when it is cost-effective.

MEDICAL CARE

Medical care is a key part of the military compensation package for active-duty personnel and their families. It is also a major benefit enjoyed by retirees and their family members. Care is provided or administered by a number of DoD organizations that make up the Military Health Services System (MHSS).

DoD faces two related challenges in providing quality medical care to its beneficiaries. Its key challenge is to operate a cost-effective health care system. However, achieving that goal--and taking the steps needed to deliver cost-effective care--is not easy because of an organizational framework that divides management and fiscal authority over the Military Health Services

System among four separate organizations and reduces the potential for allocating and using medical resources efficiently.

Background: The Military Health Services System

In fiscal year 1994, the Department of Defense will spend about \$15 billion to support the Military Health Services System. The MHSS is one of the largest health care systems in the nation. Together, the Army, Navy, and Air Force operate the direct care system, which consists of about 135 medical centers and regional and community hospitals plus more than 500 clinics worldwide. In 1994, more than 55,000 civilian personnel and about 140,000 active-duty military personnel worked for or in support of that system of care.

That substantial military medical establishment has a twofold mission: wartime readiness, which requires having the capability to meet the armed services' wartime medical needs; and the peacetime benefit mission, which means providing medical care during peacetime to uniformed personnel and other eligible beneficiaries, including dependents of active-duty personnel and retirees, their dependents, and survivors.

Historically, the capacity of the military hospitals and clinics (military treatment facilities, or MTFs)--in terms of the number of hospital beds and physicians--has fallen short of requirements for both missions. Wartime requirements during the Cold War, which reflected the scenario of an all-out conventional war in Europe, exceeded the services' ability to care for projected combat casualties and nonbattle disease and injury rates. DoD's plans during that period also included substantial backup hospital capacity for extended care through contingency agreements with the Department of Veterans Affairs and civilian hospitals under agreement with the National Disaster Medical System. Along with those plans, DoD also relied on reserve physicians and still does.

Peacetime demand has also exceeded the capacity of the military medical establishment, prompting the Congress in 1966 to establish the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), DoD's traditional fee-for-service insurance program that covers most of the care that beneficiaries receive from civilian health care providers when care in military facilities is not available. By way of illustration, more than 8.5 million people are eligible to receive health care through the military, though only 6.5 million actually do use the military health care system. Military medical facilities provide the majority of care to those who use the military health care system; CHAMPUS provides the rest.

Post-Cold War Requirements for Medical Care

Today, however, the size of the military medical establishment is more than adequate to meet the requirements of the wartime mission. Instead, it is the demand for health care by eligible military beneficiaries during peacetime that drives the size of today's military medical establishment.

These findings for the post-Cold War era are based on a major review of the Military Health Services System recently completed by the Department of Defense. In this so-called "733 Study," mandated by the Congress in Section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993, DoD analyzed peacetime and wartime requirements for health care. Two major objectives of the 733 Study were to determine the scale of the wartime mission for military medical care in the post-Cold War era, and to determine independently how to provide cost-effective care in peacetime to eligible military beneficiaries.

The wartime mission was sized to reflect current defense policy, which calls for the capability to fight two nearly simultaneous major regional conflicts. Although the study adopted a number of conservative assumptions, which tended to increase the work-load requirements, the resulting estimates of wartime requirements are substantially lower than those based on Cold War scenarios. Equally significant was the study's finding that the capacity of military treatment facilities is now well above projected wartime requirements, in contrast to the situation that existed during the Cold War.

The reduction in wartime requirements means that the decision to size the military medical establishment should be based on the cost-effectiveness of that system to meet the peacetime demand. DoD concluded that, for individual episodes of treatment, it costs less to provide care in the MTFs than through CHAMPUS. Nonetheless, the study found that improving access to care at the MTFs would increase total medical costs, since savings from recapturing individual cases would be more than offset by increases in the volume of care provided at the MTFs. Key to this finding is that improved access to care at the MTFs would encourage "ghost" beneficiaries (those eligible to use the military health care system who do not do so) to reenter the system and forgo receiving care from other non-DoD sources--leaving DoD to pay for the care that private insurance would otherwise have paid. A secondary reason--albeit still important--is that rates of health care use are higher among beneficiaries receiving care at the MTFs than for those relying on CHAMPUS. The explanation is twofold: MTF care is virtually free to beneficiaries, and military providers tend to deliver more care than civilian practitioners.

In sum, DoD cannot provide care more cost-effectively in the military treatment facilities than through CHAMPUS or other civilian plans. That conclusion applies unless DoD can control the demand by beneficiaries for care at the military treatment facilities.

Efforts by DoD to Improve the
Cost-Effectiveness of the Military Health Services System

Efforts are now under way by DoD to improve the cost-effectiveness of the peacetime health care delivery system and ensure the readiness of all military medical personnel for wartime. To improve the capability of the Military Health Services System to meet the peacetime mission most cost-effectively, DoD has a new approach, called Tricare, for delivering and financing health care in the military on a regional level. Two of the major components of Tricare are a new management structure and a system of capitated budgeting.

Under the new management structure, DoD has divided the country into 12 health service regions, within each of which DoD has appointed a military medical "lead agent" with responsibility for coordinating the delivery of health care. Each lead agent will be responsible for developing a plan for regional health services in conjunction with the hospital commanders of the military medical facilities within the region. Each plan is expected to outline how the region intends to meet the goals of managed care--particularly how it would set up a civilian provider network and adopt utilization management. The objective of this approach is to ensure both the cost-effective integration of CHAMPUS care with that at the military treatment facilities and a coordinated approach to care by the three military departments.

Capitated budgeting is another major feature of the Tricare program that attempts to improve the efficiency of the Military Health Services System. To give the military departments a fiscal incentive to control costs, DoD introduced a system of capitated budgeting in 1994. Under capitated budgeting, each of the military departments, and in turn each hospital commander, receives a fixed amount per beneficiary for providing all health care to the population within its hospital's defined service area. The allowance per beneficiary is based on the sum of all the costs of providing care through the Military Health Services System, including military medical personnel resources that fall under the purview of the services.

Option to Adopt HMO Staffing Patterns at the Military Facilities

In addition to a new method of financing and delivering health care to military beneficiaries, Tricare plans to introduce several of the managed care strategies that are now a part of many civilian plans. These strategies represent positive steps toward improving the cost-effectiveness of the Military Health Services System: for example, extending current guidelines on the appropriateness of inpatient care to the military treatment facilities and establishing "gatekeepers" to control the use of outpatient care.

Nonetheless, introducing mechanisms to improve the cost-effectiveness of the military's health care system may not be sufficient. Delivering peacetime health care most cost-effectively may require a more stringent examination of the level of resources necessary to support the military health care system. As designed, Tricare would essentially preserve the military medical establishment, along with the historical level of resources used to support that system of health care. If inefficiencies are part of the current medical system, Tricare's approach to reform may tend to perpetuate them.

One way to build on the incentives to be introduced under Tricare as well as address one of the demand factors raised in the 733 Study--that is, higher rates of health care by military beneficiaries--would be to encourage providers to deliver care in a more economical manner. DoD could achieve that goal at the military treatment facilities by establishing the requirements for active-duty physicians based on the experience of health maintenance organizations (HMOs). HMOs are generally accepted as a cost-effective way to deliver care to a defined group of enrollees by controlling their use of health care and delivering services as economically as possible. Specifically, this option would require the military treatment facilities to adopt new patterns of physician staffing based on the experience of HMOs. Adopting HMO standards would also be consistent with the department's plans for establishing Tricare--a program of managed care--nationwide.

Civilian HMO staffing patterns would require about 150 physicians per 100,000 beneficiaries.¹ Adjusting for the disproportionately larger number of beneficiaries 65 years or older using the military health care system, DoD might need about 160 physicians per 100,000. Assuming that roughly 5.1 million beneficiaries actually use the military treatment facilities worldwide,

1. The number of physicians needed to meet the HMO-based standard of 150 physicians per 100,000 is based on data reported by the Group Health Association of America, Inc., *HMO Industry Profile, 1993 Edition* (Washington, D.C.: GHAA, Inc., 1993). Roughly 150 physicians per 100,000 would put the military between the 50th and 75th percentile for all HMOs.

DoD will provide an estimated 185 physicians per 100,000 beneficiaries (roughly 9,500 physicians) in fiscal year 1995.

The estimated baseline ratio of 185 physicians per 100,000 (or 9,500 physicians) reflects several adjustments to the total number of active-duty physicians. In fiscal year 1995, DoD actually plans to have a physician end strength of about 13,000. That number includes all active-duty physicians, medical residents and fellows, and a work force of about 600 civilian physicians. (The total work force of physicians is well above DoD's projected post-Cold War wartime requirement of around 5,000 active-duty physicians.) Not all physicians are available to provide peacetime care. To account for that factor, about 3,500 physicians (reducing the number from 13,000 to 9,500) were excluded from this option. First, CBO excluded two categories of physicians: those assigned exclusively to the wartime mission, such as aviation and undersea specialists; and interns. Second, the option assumes that residents and fellows are only 35 percent as productive as full-time-equivalent physicians. Finally, the option assumes that active-duty physicians are only 95 percent as productive as their civilian counterparts because of the time they devote to readiness training.

Adopting HMO staffing patterns at military treatment facilities could lead to substantial savings, first from reducing the number of physicians and then from reducing the use of health care by beneficiaries that would follow cuts in staffing. Compared with an estimated 185 physicians per 100,000 beneficiaries in the services' 1995 work forces, putting HMO staffing patterns into effect might result in a cut of about 11 percent in total physician end strength. Such a reduction of nearly 1,500 physicians would permit a cut in the total medical budget of about \$20 million in 1995 and close to \$430 million over the next five years (see Table 3).

Those estimated savings assume that the reductions are in addition to drawdowns already planned for military and civilian physicians. The estimates of savings also assume a three year phase-in of HMO staffing standards. This option assumes no additional savings from reducing the use of health care by beneficiaries.

Impact of HMO Staffing Patterns on Peacetime Medical Care

Reducing the number of military physicians would decrease access to military medical care by beneficiaries. Indeed, HMO staffing patterns assume significantly lower levels of health care use by enrollees than the military

TABLE 3. SAVINGS FROM ADOPTING HMO STAFFING PATTERNS
(In millions of dollars)

	1995	1996	1997	1998	1999	1995- 1999	Long-Term Annual Savings ^a
Budget Authority ^b	20	60	100	120	130	430	110

SOURCE: Congressional Budget Office.

NOTES: Includes savings from reducing physicians. Figures in the 1995-1999 period are in current dollars.
HMO = health maintenance organization.

- a. Long-term savings estimates are based on savings from the federal government. They are expressed in 1995 dollars.
- b. Rounded to the nearest \$10 million.

currently provides to its beneficiaries. The Congress might agree that such lower rates of use are desirable for the military. The higher rate of health care use by military beneficiaries compared with HMO rates, however, underscores the differences in practice patterns between military physicians and those who work in civilian HMOs. Unless the way that military physicians practice medicine were to change, reductions in the number of physicians could lead to rationing or poorer service for beneficiaries.

Opponents of this option might also claim that reducing the number of physicians creates only an indirect incentive to improve the efficiency of the Military Health Services System. Military medical facilities could fall short of staff, and CHAMPUS costs might then rise unless the volume of care demanded by beneficiaries declined--two specific problems that would prohibit DoD from reducing the number of health care personnel.² A more direct approach would be to decide on the number and size of military medical facilities to deliver care most cost-effectively, and then to develop staffing patterns based on the volume of care required by the population that the facilities would serve. Other, more direct ways to control health care might be to introduce other constraints on the use of military medical care by beneficiaries, such as copayments on the use of care at military treatment facilities.

2. Section 711 of the National Defense Authorization Act for Fiscal Year 1991 prohibits DoD from reducing military and civilian health care personnel below the numbers of such personnel serving on September 30, 1989, unless DoD certifies to the Congress that the number of personnel is excess to current and projected needs of the services and that reducing it will not increase costs under the CHAMPUS program.

A more serious problem that relates directly to the issue of access to care is the possibility that the number of eligible military beneficiaries electing to use the military health care system might exceed the number assumed in this option. In that event, the problems of excess demand, rationing, and declines in the quality of service would be greater than assumed here. Without a system of universal enrollment, DoD can only guess at the number of beneficiaries actually using its health care system, and the number of physicians assumed in this option might not actually be large enough to meet the target of 160 per 100,000 beneficiaries. Another reason staffing patterns could be too low is that more eligible military beneficiaries--many of whom currently rely on their private insurance as their primary source of coverage--might choose to seek care from the military. Denying them access to the free care at the military treatment facilities would almost certainly be viewed as a loss of their health care benefit.

In view of these uncertainties, this option makes the conservative assumption that beneficiaries receive all of their health care at military medical facilities, though they actually receive about 20 percent of their care under CHAMPUS. If the underlying assumption of a beneficiary population of users of about 5.1 million proves to be true, then the HMO-based standard of 160 physicians per 100,000 beneficiaries for the military could be as much as 20 percent higher than an HMO staffing pattern based only on the care delivered at the military treatment facilities.

Implementing New HMO Staffing Patterns Through Changes in Management Authority

Without a doubt, adopting HMO staffing patterns at the military treatment facilities--and cutting almost 1,500 physicians overall--would confront DoD with a major challenge to reshape the size and composition of its active-duty physician work force. Granting centralized management control over allocating all military medical resources to the military treatment facilities--including physicians--might make it easier for DoD to establish HMO staffing patterns. One single manager in charge of allocating all medical resources might be able to foster greater coordination among the military departments and take advantage of the opportunities to make interservice trade-offs more easily than is possible under the present management structure.

Current Structure of Authority over the Military Health Services System. Today, four separate officials and organizations have fiscal and management authority over the Military Health Services System: the Assistant Secretary

of Defense for Health Affairs and the Surgeons General of the Army, Navy, and Air Force.

The Assistant Secretary for Health Affairs is the principal advisor to the Secretary of Defense for all health policies, programs, and activities, and is responsible for setting policy and overseeing the wartime and peacetime capability of the Military Health Services System. To uphold these responsibilities, the Assistant Secretary has "authority, direction and control [over] the medical personnel, facilities, programs and funding and other resources within the Department of Defense."³ Consistent with that centralized approach to management, one of the major responsibilities of the Assistant Secretary is to develop "a unified medical program to provide resources for all medical activities within the Department of Defense."⁴ In practice, however, several factors limit the overall authority of the Assistant Secretary to supervise the health and medical affairs of DoD, including the method of allocating resources and the roles of the Surgeons General.

Total medical resources to support the Military Health Services System are allocated among the Assistant Secretary and the three military medical departments. The Assistant Secretary has direct control over only a part of the total medical budget, and thus can effectively develop a unified medical program only for the part of the budget that is controlled by Health Affairs--namely, the Defense Health Program (DHP), which totaled about \$9.6 billion in fiscal year 1994. The DHP, which constitutes close to 65 percent of the overall medical budget, consists for the most part of operation and maintenance money covering such things as the salaries and benefits of civilian employees; supplies of X-ray film, food, and drugs; and utility costs in military treatment facilities. Also included are funds for reimbursement to civilian providers under CHAMPUS.

The military medical departments are part of the chains of command of the Army, Navy, and Air Force. (The Marine Corps comes under the purview of the Department of the Navy.) They have control over the portions of the budget not controlled by the Assistant Secretary of Defense for Health Affairs, chiefly compensation and benefits for active and reserve medical personnel. That part of the budget runs close to \$5.1 billion, or roughly 35

3. See the October 1, 1991, Memorandum of the Office of the Deputy Secretary of Defense on "Strengthening the Medical Functions of the Department of Defense."

4. Ibid.

percent of the total resources available for the Military Health Services System.⁵

Because the military departments retain authority and control over all military medical personnel resources through the budget, as well as through the chain of command, trade-offs that might reduce duplication among the services--and possibly generate savings--are difficult for the Assistant Secretary to make. Similarly, trade-offs between CHAMPUS and the direct care system are more difficult to make under the current structure because the Assistant Secretary cannot require the military departments to share their resources.

Centralizing Authority over the Military Health Services System. Greater opportunities for trade-offs among the military medical departments and between the system of direct care and CHAMPUS--though not necessary for DoD to implement HMO staffing patterns at the military treatment facilities--could help to mitigate any problems of access to care at the MTFs and to ensure that resources are allocated throughout the Military Health Services System most efficiently.

The option discussed here would grant the Assistant Secretary of Defense for Health Affairs control over all military medical resources, including medical personnel resources. In much the same way that the Assistant Secretary allocates Defense Health Program dollars to the three separate medical departments today, the Assistant Secretary would allocate all resources for medical personnel--that is, both dollars and end-strength numbers--to the services in the future. Effectively carrying out this option would also require the Assistant Secretary to control civilian and military medical personnel end-strength numbers, which are now under the control of the services. The Surgeons General would carry on as the senior medical advisors within each service, with continued responsibility for executing policy and providing health care to military beneficiaries.

Advantages of Consolidated Control over Medical Resources. This new structure would have many advantages. Planning and budgeting for the peacetime and medical readiness functions by one single official could lead to improved coordination throughout the Military Health Services System. Cross-sharing of resources among the military medical departments--which now occurs to some extent--could be carried out more systematically. Doing so would help to increase the productivity of the direct care system, reduce

5. In fiscal year 1994, the total medical budget will run close to \$15 billion. That budget includes three major components: the Defense Health Program, Military Medical Personnel, and Military Construction.

reliance on CHAMPUS, and ensure an adequate health care delivery system during wartime.

The increased ability of the Assistant Secretary to make trade-offs among the three military departments and to foster more cross-sharing of resources could also help to reduce any duplication arising from today's unilateral approach to financing health care in the military along service lines. In addition, the Assistant Secretary would be able to make overall trade-offs between the direct care system and CHAMPUS. Together, these improvements in the ability of the Assistant Secretary to allocate resources flexibly would also serve to support the new management structure proposed under Tricare.

Concerns About the Impact of This Option on Wartime Medical Care. Opponents of reducing the number of active-duty physicians--and more broadly, of providing the Assistant Secretary of Defense for Health Affairs with consolidated control over the Defense Health Program and the military personnel resources--might argue that both actions would jeopardize the capability of the Military Health Services System to meet the wartime mission. Specifically, the services--and the Surgeons General--might also be concerned that the Assistant Secretary would give higher priority to the peacetime mission than the wartime one. That fear, however, may not be warranted since the services will remain involved in the budget preparation process.

In fact, the risk of jeopardizing wartime readiness could be much greater in the absence of consolidated management authority for how medical resources are allocated systemwide. Budgetary pressures on the Department of Defense may force the military departments and the Office of Health Affairs to reduce the total medical budget. Maintaining wartime readiness under these circumstances might be impossible unless the services embrace a joint perspective, as noted by the Inspector General of the Department of Defense in the aftermath of the Persian Gulf War. A 1993 report by the Inspector General faulted the services for not sharing their medical assets in the field.⁶ In that same report, the Inspector General also indicated that medical personnel receive insufficient training for wartime given the demands of delivering peacetime medical care. In fact, a more centralized approach to managing the Military Health Services System might very well facilitate more joint planning for wartime to ensure that staff members are adequately trained and medical assets are shared.

6. Department of Defense, Office of the Inspector General, "Medical Mobilization Planning and Execution" (September 30, 1993).