

CBO TESTIMONY

Statement of
Neil M. Singer
Acting Assistant Director
National Security Division
Congressional Budget Office

on
Reforming the Military
Health Care System

before the
Subcommittee on Military Forces and Personnel
Committee on Armed Services
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NOTICE

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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the future of the military health care system. My testimony focuses on the plans of the Department of Defense (DoD) to reform that system and covers a range of issues, including:

- o An overview of the military health care system;
- o The obstacles to reforming the military health care system;
- o DoD's plan to implement its Tricare managed care program nationwide; and finally,
- o Modifications to the Tricare program and other strategies to improve the cost-effectiveness of the military health care system.

THE MILITARY HEALTH CARE SYSTEM

The Department of Defense operates one of the largest health care systems in the nation. Together, the Army, Navy, and Air Force operate about 135 medical centers and regional and community hospitals and more than 500 clinics worldwide. This substantial military medical establishment has a twofold mission: wartime readiness, which means having the capability to meet the armed services' wartime medical needs; and the provision of medical

care during peacetime to uniformed personnel and other eligible beneficiaries, including dependents of active-duty personnel, retirees, their dependents, and survivors.

Historically, the capacity of military hospitals and clinics (military treatment facilities, or MTFs) 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.

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 cost of 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 beneficiaries are eligible for military health care, though only 6.5 million actually choose to use the military health care

system. A substantial number of beneficiaries--2 million people--depend on sources outside the military for some or all of their health care. Some rely on Medicare. Others have private insurance, perhaps through their own employment or their spouse's employment, and use it to pay for health care in the civilian sector.

Military medical facilities provide the majority of care to those who use the military health care system; CHAMPUS provides the rest. Active-duty personnel, who have priority over all other potential users, receive almost all of their care in military hospitals and clinics. Their dependents are second in priority and receive care when space is available; in practice, military facilities provide the preponderance of dependents' medical care. Retirees and their dependents and survivors are also eligible to receive care in the MTFs, but they rank lowest in priority and actually receive the majority of their care in civilian settings, with reimbursement under CHAMPUS or other insurance policies.

In fiscal year 1994, DoD will spend about \$15 billion to support the military health care system. In real terms, that amount is one-third greater than the budget for the system just 10 years ago. The total medical budget no longer consumes 3 percent, but rather 6 percent, of the total defense budget.

Besides the mounting pressure on the department to control costs, the hybrid nature of care at the MTFs and through CHAMPUS has been widely seen as unsatisfactory by beneficiaries, the services themselves, and the Congress. In response, the department has conducted a number of tests of alternative programs in recent years. The most recent of these tests, the CHAMPUS Reform Initiative (CRI), attempted to incorporate into military health care new approaches to managed care being used in the civilian sector. DoD's current plans for restructuring its health care system are an outgrowth of its experience with CRI.

PROBLEMS IN THE PROVISION OF MILITARY HEALTH CARE

Beneficiaries and providers in the military health care system face few incentives to economize on care. Two factors are largely responsible for this situation: a benefit structure with low cost-sharing requirements that encourages excessive use by patients, and a paucity of constraints on providers to curb the delivery of unnecessary and inappropriate health care. These problems are compounded by the interplay between the services' wartime and peacetime missions.

The Generosity of the Military Health Care Benefit

Compared with other health care plans, the military health care benefit is extremely generous. Care in the MTFs is virtually free to eligible beneficiaries. Beneficiaries face no deductible and virtually no copayments for outpatient care and prescription drugs. Even for inpatient care, some beneficiaries pay only nominal fees, while others pay nothing. Eligible military beneficiaries are not subject to any premium or requirements to enroll in a military health care plan, but instead are free to receive all, some, or none of their care from the military health care system.

The generosity of the benefit structure may help to explain why, compared with the U.S. population at large, military beneficiaries under the age of 65 make heavy use of health care. In 1992, civilians in the United States under the age of 65 consumed about 530 days of hospital care per 1,000 people and made 4.5 outpatient visits per person. Even after adjusting for differences in use associated with age and sex, comparable military beneficiaries consumed about 676 days of hospital care per 1,000 people and made 7.3 outpatient visits per person. Thus, military beneficiaries used hospital care at a rate about one-fifth higher, and outpatient care at a rate two-fifths higher, than the general population.

Despite these generous benefits, however, not all eligible military beneficiaries receive their care from the MTFs. Even among active-duty dependents, many are unable to gain access to care at the MTFs and instead rely on CHAMPUS. Some simply live too far away from the MTFs, and others prefer alternative coverage to what is available through CHAMPUS. About 10 percent of active-duty families have other health insurance coverage and may not rely on the military health care system at all for their care.

Similarly, many retirees and their families depend on sources outside the military for some or all of their care. Retirees and their dependents over the age of 65 receive care through Medicare. Many other retirees have private insurance through either their own or their spouse's employment and use it to pay for health care in the civilian sector. Based on the most recent survey by DoD, almost 60 percent of retirees are covered by private insurance policies.

Potential demand for health care by beneficiaries not now served by the MTFs poses both a problem and an opportunity for the military health care system. The problem is that if either additional capacity became available in the MTFs (for example, as a result of the defense drawdown) or alternative sources of care became more costly, the generosity of the military health care benefit might encourage use of military care by eligible military

beneficiaries who now use non-DoD sources. This risk is high considering that almost a quarter of DoD's total eligible population now relies on non-DoD sources for health care. But if additional demand by this so-called ghost population did not materialize, DoD might be able to reduce its overall costs of medical care by providing additional care at the MTFs to beneficiaries who currently are forced to rely on CHAMPUS. Even for this population, however, better access to the MTFs could also mean higher overall rates of health care use. In effect, beneficiaries who pay little out of pocket for their health care have almost no reason to economize.

Practice Patterns of Military Providers

Compounding the problems arising from the generosity of the military health care benefit are the incentives facing military providers to deliver more care to eligible military beneficiaries in the MTFs than the latter would receive under CHAMPUS. Among the most obvious factors influencing a physician's treatment of a patient are the supply of hospital beds and the economic incentives of the health care delivery and financing system. Based on the substantial hospital capacity of the military medical facilities, physicians thus can prescribe more and longer hospital stays than private-sector providers would offer.

Additional inefficiencies have arisen because budgets for the military health care system historically have been set on the basis of workload. Hospital commanders thus have had an economic incentive to fill their hospital beds. The policies of the specific services in treating patients also tend to create differences between the practice patterns of military and civilian physicians. Hospitalizing military beneficiaries for tooth extractions is just one example of the major differences in practice patterns between military and civilian physicians.

DOD'S CURRENT APPROACHES TO IMPROVING MILITARY HEALTH CARE

The Department of Defense has recently completed two major initiatives to improve the provision of health care to military beneficiaries. One is the so-called 733 study, mandated by the Congress in section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993, that analyzed peacetime and wartime requirements for health care. The second is the department's decision to move forward with the Tricare program and adopt a "triple option" benefit structure that would encourage beneficiaries to participate in more efficient managed care programs.

The 733 Study

The major objectives of the 733 analysis were to determine the wartime mission for military medical care in the post-Cold War era, and to determine how independently to provide cost-effective care in peacetime to eligible military beneficiaries. The wartime mission was adjusted 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, the resulting estimates of wartime requirements are substantially lower than those based on Cold War scenarios. Equally significant was the study's finding that MTF capacity is now well above projected wartime requirements, in contrast to the situation that existed during the Cold War. Had DoD taken into account the backup capacity provided by the Department of Veterans Affairs or even the National Disaster Medical System, wartime requirements would have been even lower and the excess capacity of the military health care system even higher.

The peacetime portion of the study examined the economics of sizing the military medical establishment. To determine if care provided in military treatment facilities is more cost-effective than care received under CHAMPUS, DoD simulated what would happen to total medical costs if the capacity of the MTFs expanded modestly to "recapture" the care provided in

the civilian sector under CHAMPUS. The analysis concluded that, for individual episodes of treatment, it costs less to provide care in the MTFs than through CHAMPUS. Recapturing CHAMPUS's workload, then, on a one-for-one basis would lower DoD's costs.

Nonetheless, the study found that improving access to care at the MTFs would increase total medical costs, because savings from recapturing individual cases would be more than offset by increases in the volume of care provided at the MTFs. The principal reason for this finding is that improved access would encourage some "ghost" beneficiaries to reenter the military health care system and forgo receiving care from other non-DoD sources, leaving DoD to pay for the care that third-party health plans would otherwise have paid. A secondary reason is that the rates of health care use among beneficiaries are higher when they receive care at the MTFs, because it is virtually free to beneficiaries and military providers tend to deliver more care than civilian practitioners.

Tricare

In December 1993, DoD submitted a plan to the Congress for establishing a managed care plan nationwide, referred to as Tricare. The goals of this plan

are to ensure that eligible military beneficiaries have access to stable, high-quality health care benefits and to improve the efficiency of the military health care system. To accomplish those goals, DoD proposes to establish a new approach to delivering and financing health care in the military on a regional level that will include both a system of capitated budgeting and a new triple option benefit package.

Triple Option Benefit Structure. The Tricare program would offer eligible military beneficiaries three options for health benefits. One choice would be to enroll in Tricare Prime, a plan modeled after approaches of private-sector health maintenance organizations (HMOs), but with a point-of-service option that would permit enrollees to retain the freedom to choose their own doctor. A second choice would be to continue using the standard CHAMPUS benefit plan, called Tricare Standard. A third choice for those using Tricare Standard would be to participate in Tricare Extra--a preferred provider option, or PPO --on a case-by-case basis. Neither Tricare Standard nor Tricare Extra requires beneficiaries to enroll. For all military beneficiaries, the MTFs would continue as the primary source of care, augmented by a network of civilian health care providers.

Each of the health benefit options will work somewhat differently. Similar to an HMO, Tricare Prime requires beneficiaries to enroll in the plan

and agree to obtain all of their care through a network of military and designated civilian providers. In return for surrendering some freedom to choose their doctors, enrollees in Tricare Prime benefit from less paperwork, enhanced coverage, and lower out-of-pocket charges than users of Tricare Standard when they obtain care from a civilian provider. The point-of-service feature of Tricare Prime, however, gives beneficiaries an additional option to obtain care from civilian doctors outside the network, albeit at higher out-of-pocket costs. Many of the features of Tricare Prime, such as the existence of a civilian or military primary care physician to manage the beneficiaries' use of health care, may make it more likely that enrollees will receive better access to the MTFs than nonenrollees. But by law access to the MTFs will continue to be granted on the basis of available space and priority status.

Beneficiaries wishing to enroll in Tricare Prime would have to pay an annual enrollment fee before they use any care at all, except dependents of junior enlisted personnel, who would pay nothing. As of this date, all other dependents of active-duty personnel would pay an annual enrollment fee of \$35 for single coverage or \$70 per family. Retirees and their family members would pay an annual enrollment fee of \$50 for single coverage and \$100 for families.

But by no means are the proposed enrollment fees for Tricare Prime--or, for that matter, the cost-sharing requirements--carved in stone. In fiscal year 1994, the Congress directed DoD to develop a uniform benefit option, modeled after civilian HMOs, that would reduce out-of-pocket costs for enrollees and be budget neutral. The DoD Comptroller has insisted that any such HMO option reduce the department's net costs. As currently designed, Tricare Prime would fail to meet both Congressional and Comptroller tests of budget neutrality.

The department has a number of options under consideration for its HMO-style program that would eventually replace Tricare Prime and attempt to reduce enrollees' out-of-pocket costs while achieving budget neutrality or perhaps even savings for DoD. All of the options are based on varying the cost-sharing requirements for care received under CHAMPUS and the MTFs, compared with those requirements under the present benefit structures and managed care demonstration programs. Some of the options consider only changes in requirements for care received under CHAMPUS; these would significantly reduce out-of-pocket costs for beneficiaries through removal of the deductible and some combination of lower inpatient and outpatient copayments. Other options would simply extend copayments to the use of certain types of care--such as outpatient care--at the MTFs.

Based on the cost-sharing requirements outlined for each benefit option, DoD apparently set the enrollment fee for each option to be budget neutral, holding constant the assumption that enrollees must have lower out-of-pocket costs. The results of DoD's analysis of these options have not yet been released, but preliminary indications are that few of the options can reduce out-of-pocket costs while resulting in budget neutrality or savings for DoD. Moreover, none of the options would hold beneficiaries liable for a premium comparable to those required to join a civilian HMO.

Of course, beneficiaries may elect to continue under Tricare Standard. In doing so, they will also continue to have access to the MTFs on a space-available basis and in order of their priority status. When care is not available at the MTFs, beneficiaries under Tricare Standard will retain the freedom to choose their own doctors, but they will pay higher out-of-pocket costs than under Tricare Prime. On a case-by-case basis, however, they may choose to use Tricare Extra. Under that program, beneficiaries who choose to use designated civilian providers for a particular episode of care pay less out of pocket and benefit from the lower prices accepted by network providers.

New Management Structure. In 1993, DoD established 12 health service regions across the country. Within each region, DoD has appointed a military medical "lead agent" (the commanding officer of the major military medical center in the region) with responsibility for carrying out the Tricare program. One of the major responsibilities of the lead agents will be to coordinate the delivery of health care within a region. Specifically, each lead agent will be responsible for developing a regional health services plan 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--and in particular its plans for both setting up a civilian provider network and adopting utilization management.

To supplement the capacity of the MTFs to meet the health care needs of each region's beneficiaries, DoD plans to extend fixed price, at-risk contracts for managed care support in all 12 regions. Under the overall authority of the lead agent, contractors will be responsible for developing networks of civilian health care providers and for providing other fiscal and administrative support to the lead agents in areas such as utilization management. The lead agent will be responsible for ensuring the integration of the civilian provider network and the MTFs, as well as ensuring that the three military departments are working together.

Capitated Budgeting. Capitated budgeting is another major feature of the Tricare program that attempts to improve the efficiency of the military health care system. To give hospital commanders 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 commander, receives a fixed amount per beneficiary for providing all health care to the population within the hospital's defined service area.

By limiting future budgets to a fixed amount per person, DoD hopes to revise the current set of economic incentives facing military providers in the MTFs and encourage commanders to deliver only care that is both necessary and appropriate. This approach, if carried out effectively, would reverse a system of budgeting on the basis of historical patterns by MTFs in providing care and using resources. That budgetary process rewarded hospital commanders with larger budgets if they provided more health care. DoD's approach to capitation eliminates most of those incentives. The way that DoD plans to execute this method of budgeting, however, poses two major problems--both of which could undermine the effectiveness of capitation. Specifically, the method could lock in inefficiencies and could create conflicting financial incentives for MTF commanders.

