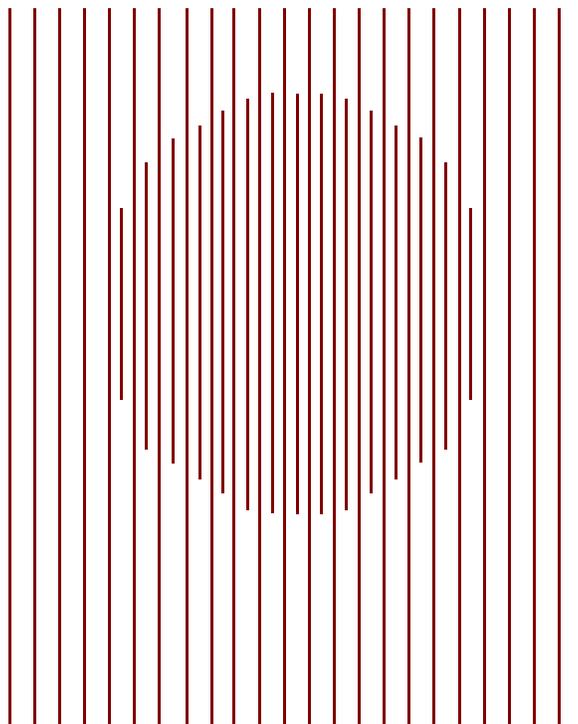


CBO PAPERS

**RESTRUCTURING MILITARY
MEDICAL CARE**

July 1995



CONGRESSIONAL BUDGET OFFICE

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SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515**

NOTES

Unless otherwise indicated, all years referred to in this paper are fiscal years.

Numbers in tables may not add to totals because of rounding.

PREFACE

The Department of Defense operates an extensive military medical system, primarily to maintain the capability of combat forces in wartime by providing medical care for active-duty personnel. In peacetime, military medical personnel train for their wartime mission and also provide care for dependents of active-duty personnel and retirees and their families. With the end of the Cold War, wartime requirements for medical care declined so dramatically that policymakers are now faced with the question of whether to maintain a medical establishment that is far larger than needed to perform its primary mission.

This paper, prepared at the request of the House Committee on National Security, examines the way in which the military medical system trains for wartime and the extent to which providing peacetime care contributes to that mission. The paper also analyzes the department's ability to offer peacetime health care cost-effectively. A number of alternative ways of performing the wartime mission and providing health care to eligible military beneficiaries are examined in this paper. But in keeping with the Congressional Budget Office's (CBO's) mandate to provide objective analysis, it makes no recommendations.

Ellen Breslin Davidson of CBO's National Security Division prepared the paper under the general supervision of Cindy Williams and Neil M. Singer. Elizabeth Chambers of CBO's Budget Analysis Division provided the cost analysis under the direction of Michael A. Miller. The author gratefully acknowledges the invaluable assistance of CBO colleague Nathan Stacy, who developed the analysis of wartime medical training, prepared the sections on the Navy's experience with a civilian hospital and the R Adams Cowley Shock Trauma Unit in Baltimore, and assisted with the overall project. The author also wishes to thank Sheila Roquitte for her analysis of the 1992 health care survey of military beneficiaries and Lane Pierrot for her thoughtful review of the paper. Contributors and reviewers in other divisions of CBO included Joseph Antos, Linda Bilheimer, Sandra Christensen, David Delquadro, Julia Jacobsen, Jeffrey Lemieux, and Murray Ross. The author also expresses her appreciation to the many staff members from the Army, Navy, Air

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June E. O' Neill
Director

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SUMMARY

The Department of Defense (DoD) currently operates an extensive military medical system that is the chief source of health care for about 6.4 million people, including 1.7 million uniformed personnel. The need for the system stems primarily from its mission to care for military personnel in wartime. In peacetime, military medical personnel train for their wartime mission and also provide care for active-duty personnel, their dependents, and retirees and their families.

With the end of the Cold War, wartime requirements for medical care declined dramatically. Although the size of the medical system has been reduced somewhat in response, recent analysis by DoD has suggested that the department could make additional sharp reductions in the number of facilities and personnel. But military medical officials strongly oppose any further reductions. They contend that military medical facilities and the care they provide in peacetime are critical to train military medical personnel and ensure medical readiness for wartime. They also believe that maintaining a large medical establishment is necessary to attract, recruit, and retain medical personnel.

Nonetheless, the medical establishment DoD plans to maintain for the future is larger than needed to meet wartime requirements. DoD's decision to keep such a large establishment may only be appropriate if two conditions are met: that providing peacetime care contributes to DoD's ability to perform its wartime mission and that the department is able to provide peacetime health care cost-effectively.

DOD'S WARTIME MEDICAL MISSION

In March 1995, DoD released its *Medical Readiness Strategic Plan 1995-2001*, the department's blueprint for handling its wartime mission. Although DoD's plan addresses a range of concerns about wartime readiness, one key aspect that it does not deal with in depth is the question of how adequate medical training is in peacetime. Ensuring that military medical personnel are adequately trained for their wartime roles is a critical aspect of performing the wartime medical mission. Findings by the Congressional Budget Office (CBO), however, indicate that the care furnished in military medical centers and hospitals in peacetime bears little relation to many of the diseases and injuries that medical personnel need to be trained to deal with in wartime.

The war-related injuries and illnesses that are likely to occur in a theater of operations fall into two categories of patient conditions: disease and nonbattle injuries (DNBI) and wounded-in-action (WIA). The results of CBO's analysis reveal that some overlap exists between the cases that military medical personnel treat during peacetime and the diseases and nonbattle injuries that they could expect to treat during wartime. Nevertheless, little correspondence exists between peacetime practice and wounded-in-action conditions.

PEACETIME CARE

The military health care system is one of the largest health care systems in the nation, and one of the most complex systems to manage because of its structure. It consists of two parts: the direct care system of military medical centers, hospitals, and clinics; and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), an insurance program that supplements the care that beneficiaries receive at military medical facilities.

The direct care system, the larger of the two parts, provides the bulk of the care received by military beneficiaries. Although medical services in the direct care system are virtually free of charge to the beneficiary, access to them is limited by the resources available. Active-duty personnel have first priority for care, followed by their family members and then by retirees and their dependents and survivors. When direct care is hard to reach or not available, beneficiaries may use CHAMPUS, but their out-of-pocket costs are higher for most services under CHAMPUS than through the direct care system.

PROBLEMS IN PROVIDING HEALTH CARE

In recent years, DoD has tried to improve the performance of its health care system. At the direction of the Congress, the department has tested several ways to provide health care in an attempt to address three specific problems: the increasing cost of the system, its inefficiencies, and dissatisfaction among beneficiaries.

Cost

From 1979 to 1995--during a period when the overall defense budget first rose but then fell almost to its initial level in real terms--DoD's total medical budget grew by about 65 percent, or from \$9.3 billion to \$15.3 billion (in inflation-adjusted dollars).

As a share of DoD's total budget, spending on medical care increased from 4 percent to 6 percent.

Inefficiencies

Bringing health care costs under control would require DoD to address inefficiencies in the department's delivery of health care and its allocation of resources. An indication of inefficiency is that beneficiaries use much more health care than do comparable civilians, in part because neither medical providers nor consumers have adequate incentives to control the use of care. DoD's ability to control costs is further limited by its practice of allocating and managing health care resources separately for each military service.

Dissatisfaction by Beneficiaries

A major complaint among beneficiaries is that their access to health care at military medical facilities is poor and that CHAMPUS is not a satisfactory alternative because of its higher out-of-pocket costs. As a group, military beneficiaries who are age 65 or older may encounter more difficulty than other beneficiaries in gaining access to care through the military health care system. Not only are they ineligible to receive care under CHAMPUS, but they are also last in line for care at military medical facilities. Many beneficiaries believe that on the basis of recruiting promises and history they are entitled to free health care for life at military medical facilities, although the law does not guarantee that benefit.

Satisfying beneficiaries while holding down health care costs presents DoD with an impossible set of challenges. Tighter budgets for defense, coupled with the closing of many military medical facilities, will clearly make peacetime health care even more difficult to provide in the future.

THE TRICARE PROGRAM

To address the dissatisfaction of beneficiaries and the need to bring health care spending under control, DoD is moving forward with a new approach to providing health care known as Tricare, which it intends to have fully in place nationwide by 1997. Under Tricare, DoD plans to redesign the military health care system in at

least three ways: adopt several new approaches for financing and delivering health care more efficiently, build on the existing capacity of military medical facilities, and introduce a triple option health benefit structure.

Analysis by CBO, however, indicates that Tricare stops short of making most of the changes needed to remedy the inefficiencies that have plagued DoD's management and delivery of health care. CBO's estimates suggest that, on balance, Tricare will increase DoD's cost of health care delivery. Tricare also seems unlikely to provide different categories of beneficiaries with uniform health care benefits. Because DoD plans to continue charging beneficiaries more for care received in the civilian sector than for care provided in military medical facilities, active-duty members and their families, who already benefit most from the military health care system, will tend to gain at the expense of retirees and their dependents and survivors. Some retirees, particularly those who are eligible for Medicare, may pay more out of pocket for their care than they do today.

ALTERNATIVE APPROACHES TO MILITARY MEDICAL CARE

Neither Tricare nor the *Medical Readiness Strategic Plan 1995-2001* is likely to resolve the problems that DoD faces in providing both wartime readiness and peacetime health care. Instead, the Congress may wish to consider alternative approaches to providing peacetime care while meeting the requirements of wartime. This paper examines how DoD could restructure the military health care system based on the reduction in wartime medical requirements.

Under Tricare, most military medical providers will have a limited opportunity to prepare for their wartime mission. Peacetime patient loads, which already bear little resemblance to battle casualties, will probably also be less relevant in the future to the treatment of other war-related diagnoses than they are today, since fewer retirees and their dependents are likely to receive their care at military medical facilities. Practicing medicine more in the civilian sector--and less on patients in the direct care system--might give military medical providers substantially greater exposure to both DNBI and WIA conditions than they receive today.

To improve wartime training and broaden exposure to WIA conditions, the military services could establish affiliations with civilian shock trauma units. CBO's analysis indicates that shock trauma facilities are likely to provide the best wartime training in trauma care and casualty-related diagnoses. Military medical personnel also need exposure to DNBI conditions, which could be obtained from treating a diverse population of patients, such as those in many civilian hospitals.

Downsizing the military's direct care system to wartime requirements would sharply reduce the number of military medical facilities and personnel, forcing DoD to restructure its provision of health care to military beneficiaries. Active-duty personnel would receive their health care in both military and civilian settings; other beneficiaries would depend entirely on the civilian sector. CBO estimates that downsizing the direct care system and eliminating CHAMPUS eventually could reduce annual costs by about \$9 billion. (That estimate does not include the costs of closing military medical facilities, which could be substantial and could defer the realization of savings for several years.) Part of the savings could be used to pay for medical care from alternative sources such as the Federal Employees Health Benefits (FEHB) program.

Such a downsizing would require DoD to strengthen its affiliation with the civilian sector to provide wartime training, employ military medical personnel who are not training in shock trauma units, and meet some of the requirements for caring for active-duty personnel. The department's ability to establish civilian affiliations would depend on local conditions in health care markets, and DoD probably would have to give military medical managers substantial flexibility. Developing closer ties with civilian practice and hospitals might be worth the effort, since it would offer several benefits, including the chance for medical personnel to learn new techniques and work with equipment that might not readily be available in military facilities. Affiliations with civilian hospitals might also offer DoD the advantage during wartime of being able to send recovering casualties to hospitals that are located closer to family members.

One approach to giving military beneficiaries access to civilian health care would be to extend coverage to them through the FEHB program. CBO examined three alternatives based on FEHB coverage: one based on current premium-sharing arrangements between the government and non-postal employees, and two others designed to reduce premium expenses for beneficiaries. The alternatives assume that DoD would ensure that all of its beneficiaries over the age of 65 had full coverage under Medicare.

The FEHB alternatives would give all groups of non-active-duty beneficiaries equal access to medical care through their chosen plans. Today's military health care system does not provide such access, nor will Tricare because of the priorities assigned to different groups. Still, the number of military beneficiaries who would enroll in an FEHB program would vary extensively. A military beneficiary's decision to enroll will depend on a number of factors, including the share of the premium paid by the government and the alternative options that beneficiaries may have for private health insurance.