

decline overall--medical care will inevitably constitute an even larger share of DoD's overall budget than it already does.

Inefficiencies in the Military Health Care System

One reason that DoD's health care costs have risen so much is inefficiencies inherent in the department's delivery of health care and its allocation of resources. DoD argues that its direct health care system is more efficient than that in the private sector. Indeed, according to the section 733 study, on a case-by-case basis the costs of comparable medical procedures are lower in military facilities than their average in the civilian sector.

Yet two areas of inefficiency contribute substantially to DoD's difficulties in controlling costs. One is that beneficiaries make heavy use of the military health care system, much more than comparable civilians. In 1992, for example, 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 the differences in use by age and sex, comparable military beneficiaries consumed about 675 days of hospital care per 1,000 people and made 7.3 outpatient visits per person.

Not just one but several reasons might explain why military beneficiaries use more care than comparable civilians. The most obvious reason is the generosity of the military's health care benefits. For example, military beneficiaries pay little or nothing out of pocket for their health care when they use a military medical facility. Therefore, they have little reason to economize on their use of care.

The way that the military finances, delivers, and manages health care is also important to an understanding of why military beneficiaries use more health care than civilians. Historically, military managers and providers have done little to curb the use of medical services by beneficiaries. In fact, for years DoD provided military medical commanders with funds based on levels of delivery of medical services to beneficiaries, regardless of the necessity or appropriateness of the services. Hospital managers were actually rewarded for delivering more care than necessary in a military treatment facility.

Furthermore, since military medical managers were not accountable for the total amount spent on CHAMPUS--or the total amount of care that beneficiaries received under CHAMPUS--they faced no incentive to coordinate the delivery of care between the direct care system and CHAMPUS. DoD officials note that the military's coordination of care delivered in the direct care system and CHAMPUS has been poor over the years, permitting beneficiaries to use both parts of the military

health care system with relatively few constraints. In principle, the use of nonavailability statements is supposed to limit access to care under CHAMPUS to those cases that the direct care system cannot handle. But poor coordination has probably resulted in overuse of care by military beneficiaries and greater pressures on DoD's medical budget.

Another factor that hampers cost containment is the way that health care resources are allocated and managed throughout the military health care system. Traditionally, the Congress and DoD have carved the total medical budget into many parts, providing each service with its own share of the budget as well as stipulating how much must be spent, for example, on operation and maintenance of the system versus salaries for military medical personnel. Those restrictions have limited DoD's flexibility to ensure that resources are allocated efficiently and that health care is delivered cost-effectively. They illustrate the general problem of how to structure the military's health care delivery system in a way that makes the best use of its resources. To do that, DoD needs to be able to decide whether to provide health care in its own system or to purchase it from the private sector.

How Satisfied Are Beneficiaries?

Despite the substantial number of military treatment facilities that DoD operates, in recent years one of the most persistent complaints among beneficiaries has been their inability to receive care at military medical facilities, forcing them to rely instead on CHAMPUS. But beneficiaries have complaints about CHAMPUS as well. For example, out-of-pocket costs are higher under CHAMPUS than for the nearly free care provided in the direct care system. Moreover, retirees over the age of 65 are excluded from coverage under CHAMPUS when they become eligible for Medicare.

Complaints from beneficiaries will probably rise in the future as more of them find that they cannot rely on military medical facilities. DoD expects that between 1989 and 1999, the proportion of all beneficiaries living outside the service areas of military facilities will jump from 22 percent to 30 percent. That increase will be greater among retirees and their families than among active-duty personnel and their families. By 1999, about 40 percent of the population of retirees and their families--including almost half of those over the age of 65--will live more than 40 miles away from a military medical facility compared with less than 20 percent of active-duty personnel and their families.

Closing so many military hospitals accounts to a significant extent for the rise in population in areas without military medical facilities. But the voluntary relocation of beneficiaries to areas without medical facilities, which may occur when

an active-duty member retires from military service to start a second career, may also explain some of the trend.

Since expectations among beneficiaries vary so extensively, DoD is unlikely to be able to satisfy all of their concerns. The most difficult challenge that DoD faces may lie in attempting to satisfy those beneficiaries who believe that they are entitled to free health care for life at military medical facilities. For example, all of the services promise beneficiaries health care for life. The Air Force even implies that the health care benefits provided will be free of charge to all beneficiaries.²

Yet providing all care free of charge to beneficiaries has never been guaranteed by law, and to change existing statutes to create such an entitlement would be prohibitively expensive. Costs would rise substantially for DoD as retirees and their family members began to rely on the military health care system as much as active-duty personnel and their family members do now.³ Costs would also rise if DoD attempted to extend the same health care benefits--at the same price--to beneficiaries living far from military medical facilities. Since the costs of civilian health care vary widely among geographic regions, the risk of such cost increases would clearly be higher for DoD in some areas of the country than in others.

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2. In its recruiting brochure the Air Force says that it will offer retirees "medical and dental care with no deductions for health insurance."
 3. Compared with active-duty personnel and their families, retirees and their family members rely on the military health care system less. Based on a survey conducted by DoD in 1984, about 57 percent of retirees and their family members rely on military health care, compared with about 90 percent of active-duty families and 100 percent of active-duty personnel.

CHAPTER IV

THE TRICARE PROGRAM

In 1993, the Department of Defense announced it would move forward with a new approach to military health care known as Tricare. That program builds on the findings of several years of testing and evaluating many new approaches to providing health care and is now under way in certain parts of the country. By the end of 1997, DoD plans to have the Tricare program fully in place nationwide (see Box 1).¹

CONGRESSIONAL REQUIREMENTS FOR TRICARE

Congressional requirements underlie many of the provisions of Tricare. In an effort to address the concerns of beneficiaries, the Congress directed DoD to establish a uniform health benefit structure nationwide that offered beneficiaries a choice of three health care plans, with one of those three plans modeled on civilian health maintenance organizations (HMOs). In addition, the Congress stipulated that both the triple option and the HMO option by itself--Tricare Prime--must not be any more costly to the government than the present system. Put another way, Tricare Prime by itself--and Tricare as a whole--must be at least budget neutral.² Other features of the Tricare program that affect the system of financing and delivering health care in the military are also the result of Congressional requirements. Examples include capitated budgeting, the regional management structure, and the competitive process of awarding managed care contracts.

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1. The description of Tricare and the analysis presented in this chapter are based on the proposed rules for the implementation of the Tricare program published in the *Federal Register*, vol. 60, no. 26 (February 8, 1995). Since that time, the Department of Defense has proposed a rule change that would allow retirees and their dependents under the age of 65 who enroll in Tricare Prime (a health benefit option offered under the Tricare program) to receive higher-priority access to care at military facilities than dependents of active-duty personnel who do not enroll in Tricare Prime. That change has not been considered in the description and analysis of Tricare in this chapter. At this time, it is unclear how, or how much, the change would affect Tricare costs or enrollments and access for various groups of beneficiaries.
 2. With respect to the Tricare program as a whole, budget neutrality is defined here in accordance with section 720 in the conference report of the National Defense Authorization Act for Fiscal Year 1994: "The combined cost of care in the military treatment facilities and under the Civilian Health and Medical Program of the Uniformed Services will not be increased as a result of the expansion." With respect to Tricare Prime, budget neutrality is defined here in accordance with section 731 of the same statute: "The costs incurred by the Secretary [of Defense] under each managed care initiative that includes the option are no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enrolled in the option."

BOX 1.

MAJOR OBJECTIVES AND FEATURES OF THE TRICARE PROGRAM

The Tricare program is intended to provide a more uniform set of health care benefits to eligible military beneficiaries and to bring health care spending under control. To achieve those goals, the Department of Defense 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 new triple option health benefit structure.

Financing and Delivering Health Care More Efficiently

One of the ways that DoD plans to redesign its system of financing and delivering health care services is through a new management structure. That new structure is based on establishing 12 health service regions within the United States and assigning responsibility for coordinating the financing and delivery of health care in each region to a "lead agent." In each region, DoD will appoint the commander of one of the region's medical centers as the lead agent. Lead agents will have many management responsibilities, including coordinating the delivery of care within the region by military and civilian providers.

DoD is also counting on another new initiative to improve the efficiency of the military health care system. In 1994, the department adopted a new method of financing the health care delivery systems of the military called capitated budgeting. Under capitated budgeting, the department allocates its health care resources to each military department and in turn to each hospital commander. Each allocation is based on a fixed amount per beneficiary for providing all health care to the population within the hospital's defined service area.

Building on the Existing Capacity of Health Facilities

Tricare also introduces a new way for DoD to contract for civilian health care resources by extending fixed-price contracts--placing the contractor at some financial risk for increases in costs--for managed care support services. When fully phased in, those contracts will change the current Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to include in each region a network of civilian providers that augments the capacity of the military medical facilities. Contractors will also support the lead agents in each region by providing fiscal and administrative support services and by applying managed care strategies such as utilization management at military medical facilities.

Offering a Triple Option Health Benefit Structure

With the support of the managed care contractors, DoD plans to redesign its benefit structure by offering eligible beneficiaries a choice of three options: Tricare Prime, a plan

BOX 1.
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modeled after private-sector health maintenance organizations; Tricare Standard, the standard CHAMPUS benefit plan; or Tricare Extra, a preferred provider option that beneficiaries participating in Tricare Standard are allowed to use on a case-by-case basis.

Tricare Prime is the only one of the three options that requires beneficiaries to enroll. Enrollment would be free for active-duty personnel and dependents, but retirees would pay an annual fee of \$230 for single and \$460 for family coverage. Beneficiaries who are 65 years of age or older would not be allowed to enroll in Tricare Prime under provisions governing CHAMPUS eligibility. That provision would affect mostly retirees and their families, who make up almost all of the population of older beneficiaries.

All three options would require that beneficiaries seek care through the direct care system before they could receive care from a civilian provider. Access to military medical facilities would continue to be based on today's system of priorities. Hence, active-duty personnel, who would automatically be enrolled in Tricare Prime, would continue to receive first priority for care at a military facility. Family members of active-duty personnel, whom DoD will strongly encourage to enroll in Tricare Prime, would remain second in priority only to active-duty personnel. Retirees and their dependents and survivors would continue to receive lowest priority. Moreover, dependents of active-duty personnel who enrolled in Tricare Prime would receive higher-priority access to the military's health care facilities than those who did not enroll in Tricare Prime.

In using civilian providers, however, each of the health benefit options would work somewhat differently. Similar to a health maintenance organization, Tricare Prime requires beneficiaries to enroll and agree to obtain all of their care from the military health care system through a network of designated civilian and military providers. In return for surrendering some freedom to choose their doctors, enrollees in Tricare Prime benefit from less paperwork, potentially enhanced coverage, and lower out-of-pocket costs than do users of Tricare Standard or Extra when they obtain care from a civilian provider. Tricare Prime offers beneficiaries an additional option to obtain care from civilian doctors outside the network at a higher out-of-pocket cost.¹ (That feature is referred to as a point-of-service option.) But whatever the option--Tricare Prime, Standard, or Extra--beneficiaries who are 65 years of age or older would not be eligible to receive care in the civilian sector and be reimbursed by DoD. That policy is consistent with the rules governing CHAMPUS eligibility.

1. Lewin-VHI, Inc., *Methodology and Assumptions Used in Analysis of Uniform Benefit Options for the MHSS*, Report to the Assistant Secretary of Defense (Health Affairs) (Fairfax, Va.: Lewin-VHI, December 2, 1994).

WILL TRICARE ACHIEVE ITS OBJECTIVES?

Although Tricare attempts to resolve the problems of the military health care system, the program suffers from a number of specific deficiencies in design that call into question its ability to achieve its objectives. Consider, for example, the effects of Tricare on beneficiaries, the efficiency of the military health care system, and the budget.

TABLE 4. HEALTH CARE BENEFITS UNDER THE TRICARE PRIME OPTION OF THE TRICARE PROGRAM

Beneficiary Category	Inpatient and Outpatient	
	Direct Care System	Civilian Providers
Active-Duty Service Members (ADs)	Automatically enrolled. First-priority access to care at the military treatment facilities (MTFs).	Not eligible (may receive some specialty and emergency care).
Active-Duty Dependents (ADDs)	Eligible to enroll. Enrollees are referred by their primary care physician and have access to care on a resource-available basis at the MTF behind ADs.	Enrollees are referred by their primary care physician.
Retirees, Their Families, and Survivors Under Age 65	Eligible to enroll. Enrollees are referred by their primary care physician and have access to care on a resource-available basis at the MTFs behind ADs and ADDs.	Enrollees are referred by their primary care physician.
Retirees, Their Families, and Survivors Age 65 and Over	Not eligible to enroll.	Not eligible.

SOURCE: Congressional Budget Office based on data from the Department of Defense.

NOTE: All beneficiaries who are enrolled in Tricare Prime are assigned a military or civilian primary care physician. Before enrollees may receive care in either an MTF or the civilian sector, they must seek a referral from their primary care physician. In most cases, the primary care physician will attempt to refer enrollees to an MTF for their care. However, if care is not available or beneficiaries live too far away from an MTF, certain beneficiaries may use civilian providers under certain circumstances. Civilian provider networks, which are established under managed care support contracts, are reimbursed under a program called the Civilian Health and Medical Program of the Uniformed Services.

Effect on Beneficiaries

The Congressional Budget Office projects that, under Tricare, DoD will not be able to meet its Congressional mandate of offering beneficiaries a more uniform and stable benefit nationwide. Active-duty members and their families, who account for over 60 percent of current users of military health care, would receive improved access at lower cost. But some retirees and their dependents and survivors, who make up the remainder of users, may find their access to treatment in military facilities more limited. Others may even find the costs of their care higher than they do currently (see Tables 4 and 5). The reasons are threefold.

TABLE 5. HEALTH CARE BENEFITS UNDER THE TRICARE EXTRA AND TRICARE STANDARD OPTIONS OF THE TRICARE PROGRAM

Beneficiary Category	Inpatient and Outpatient	
	Direct Care System	Network of Civilian Preferred Providers or Non-Network Civilian Providers
Active-Duty Service Members (ADs)	Receive care under Tricare Prime.	Not eligible.
Active-Duty Dependents (ADDs)	Eligible. Access to care on a resource-available basis at the military treatment facilities (MTFs) behind ADs and ADD Prime enrollees.	Eligible, but may need a nonavailability statement.
Retirees, Their Families, and Survivors Under Age 65	Eligible. Access to care on a resource-available basis at the MTFs behind ADs and ADDs.	Eligible, but may need a nonavailability statement.
Retirees, Their Families, and Survivors Age 65 and Over	Eligible. Access to care on a resource-available basis at the MTFs behind ADs and ADDs.	Not eligible.

SOURCE: Congressional Budget Office based on data from the Department of Defense.

NOTE: A nonavailability statement is a certification from a military hospital that says it cannot provide the care a beneficiary needs. All beneficiaries must first seek their care through the military treatment facilities. If care is not available or beneficiaries live too far away from an MTF, certain beneficiaries may use civilian providers under certain circumstances. Civilian provider networks are established under managed care support contracts. Civilian providers are reimbursed under a program called the Civilian Health and Medical Program of the Uniformed Services.

First, the services intend to continue to provide access to care at military medical facilities on the basis of priority status and to charge more for care in the civilian sector than for care received at a military medical facility.³ Consequently, many retirees and their families will continue to receive less access to care at military facilities and will pay more for their care than active-duty personnel and their families.

Those provisions may have the most effect on retirees and their families who are eligible for Medicare, since they will not be able to enroll in the Tricare Prime option and will not receive coverage from the military for any of the care that they receive in the civilian sector.⁴ As a result, beneficiaries who are eligible for Medicare will tend to receive more of their care from civilian providers reimbursed under Medicare or some other payer in the future. In view of that situation, DoD has stated that it would offer beneficiaries eligible for Medicare the opportunity to enroll in Tricare Prime if it had more money. Thus far, DoD has unsuccessfully pursued legislation authorizing reimbursement from Medicare to pay for the care that military treatment facilities furnish to beneficiaries eligible for Medicare (see Box 2).

Second, DoD's policy of enrolling as many active-duty personnel and their families as possible in Tricare Prime and delivering as much of their care as possible in military facilities would limit access to military medical facilities for retirees and their families even more than is true today.⁵

Third, many beneficiaries will not receive the opportunity to enroll in Tricare Prime and instead will have to pay substantially more in Tricare Standard or Tricare Extra. One reason for the limited availability of Tricare Prime is that DoD will find it difficult to meet the requirement of budget neutrality if it offers the plan in areas outside hospital catchment areas (areas within 40 miles of a military treatment facility), since the costs of civilian health care are likely to exceed the cost of care in military facilities. Not only do beneficiaries living outside catchment areas pay more of the cost of their care, but on average they rely more on nonmilitary sources for their care than do beneficiaries who live near military hospitals.

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3. Under Tricare Prime, however, copayments for some medical services will be almost the same regardless of where the care is provided.
 4. Under the rules governing eligibility for CHAMPUS, DoD cannot pay for the cost of care received in the civilian sector for beneficiaries who are eligible for Medicare.
 5. Lewin-VHI, Inc., *Methodology and Assumptions Used in Analysis of Uniform Benefit Options for the MHSS*, Report to the Assistant Secretary of Defense (Health Affairs) (Fairfax, Va.: Lewin-VHI, December 2, 1994).

BOX 2.

MEDICARE REIMBURSEMENT FOR MILITARY CARE

Who should bear the cost of care furnished by military medical facilities to beneficiaries eligible for Medicare? The Congress debated that issue last year, although the issue has been discussed for years. In 1996, about 1.2 million retired military personnel and their dependents who are eligible for Medicare insurance coverage will also be eligible to receive care in the medical facilities of the Department of Defense. For a number of reasons, including the access to available space that those beneficiaries are granted, roughly 30 percent of them will actually use military health care. But for those who do use it, DoD will pay the cost of care out of its annual appropriations, with no reimbursement from Medicare.

During last year's Congressional debate, both the House and Senate Armed Services Committees considered proposals to authorize Medicare to make payments to DoD to cover the cost of such care (termed "Medicare subvention"). Similar proposals have been made in this Congress. One approach included in many proposals is to provide for payments based on the overall rate per enrollee, or capitated amount, that Medicare currently uses to reimburse eligible organizations, such as health maintenance organizations, that have Medicare risk-sharing contracts. Beneficiaries who choose to use the military health care system would have to designate DoD as the sole provider of care, meaning that they would be required to enroll in the Tricare program.

The budget stakes in this issue are significant. In estimating the costs of last year's proposals, the Congressional Budget Office assumed that roughly the same number of beneficiaries eligible for Medicare who receive most of their care in military facilities today--about 25 percent of the eligible population--would enroll in a DoD Medicare health maintenance organization (HMO) option. Based on that assumption, total Medicare payments to DoD would amount to about \$2.7 billion by 2000.

Last year's legislation on Medicare subvention was subject to the pay-as-you-go procedures of budget enforcement. It allowed DoD to spend any amounts it collected from Medicare without subsequent appropriation action. In budget parlance that is called "direct spending" and to be deficit neutral would require offsetting reductions in mandatory or entitlement spending or increases in revenues. Without specific legislative remedies, the increase in Medicare spending for beneficiaries treated in military facilities would simply constitute an additional expenditure from the Medicare Hospital Insurance Trust Fund, which is already projected to run short of funds early in the next century.

One might ask whether a compensating reduction in DoD's appropriations would not maintain deficit neutrality? It would not because DoD's appropriations are tracked along with other discretionary spending on a separate "scorecard" from pay-as-you-go spending. As long as discretionary spending has fixed caps, any savings in DoD's budget from Medicare subvention can be spent on other defense or nondefense discretionary programs. Thus, enacting Medicare subvention alone would increase the deficit by the amount of the Medicare payment.

Securing reimbursement from Medicare on the basis of capitated payments would help DoD to defray the cost of providing health care, but it would not necessarily guarantee beneficiaries eligible for Medicare any better access to a military facility than they have today. Access to a military facility would continue to be determined on the basis of location, capacity, and priorities. DoD could arrange for an enrollment option for those eligible for Medicare in areas without military facilities. But doing so would simply duplicate benefits currently available from Medicare HMOs in the civilian sector.

Another reason that many beneficiaries will not receive an opportunity to enroll in Tricare Prime has to do with the differences among regional civilian health care markets--a factor totally beyond the control of DoD. Constrained by the requirement for budget neutrality, DoD will be better able to offer Tricare Prime in noncatchment areas with developed networks of managed care providers (and thus, perhaps, lower costs of care) than in other noncatchment areas where managed care markets are less mature. Hence, the availability of the Tricare Prime option will vary even among noncatchment areas.⁶

Effect of Tricare on the Efficiency of the Military Health Care System

Tricare stops short of making most of the changes that are needed to remedy the inefficiencies that have plagued DoD's management and delivery of health care. Improving coordination among the services--and between the direct care system and CHAMPUS--is one essential factor. Lead agents need to know the number of beneficiaries in their regions, and each lead agent requires the flexibility to reallocate personnel and resources among facilities operated by different military services and between the military and civilian parts of the system.

In addition, controlling the total volume of care demanded by beneficiaries would require placing tight restrictions on their use of care in both CHAMPUS and the direct care system. Copayments could modify the incentives of beneficiaries to use more care than may be medically necessary. Premiums could encourage beneficiaries to commit themselves to opt in or out of the military system. Even with Tricare's management changes, however, the military health care system would probably fail to achieve the significant savings and efficiencies that the Congress has sought and that more tightly managed systems of care have produced in the civilian sector.

Management Approach Maintains Autonomy of the Services. Under current plans for Tricare, lead agents assigned to organize the delivery of health care on a regional basis will lack the authority they need. Tricare retains the current command and control structure of the three separate services. As a result, since commanders will continue to report to their separate services, a lead agent from one service is likely to find it difficult to exert authority over hospital commanders from other services. Capitated budgeting might help a lead agent by introducing strong incentives for the services to coordinate the delivery of care for beneficiaries in each region. But

6. Removing the requirement that the HMO option by itself be budget neutral would offer DoD greater flexibility to provide all beneficiaries with the triple option benefit structure, but it could also add to the budgetary pressures on the department to hold down the overall cost of the Tricare program.

whatever benefits capitated budgeting offers are likely to be compromised by DoD's plans to continue to allocate resources separately through each service under a capitated financing system. Under that approach, the number of beneficiaries to be served within that service area will determine each hospital commander's resources. As a result, the lead agent will have only limited ability to allocate resources among the various facilities within his or her region.

Poor Coordination Between Direct Care and CHAMPUS. Similarly, Tricare does not achieve its objective of creating a "seamless" system of care between the direct care system and CHAMPUS, even though that goal is vital to managing the total volume of care that beneficiaries receive. Tricare allows civilian contractors to manage care in the civilian sector and the military medical manager to retain separate authority over decisions about use in military facilities.⁷ Decisions about the use of care by a military hospital commander would not have to be binding on the private contractor providing managed care support within that hospital commander's jurisdiction. Nor would decisions by a contractor that certain types of care were medically unnecessary have to be binding on a military hospital commander, who might choose to furnish such care if resources were available.

Population Remains Undefined. Another key weakness of Tricare is that the population will remain undefined. Historically, DoD has been unable to plan accurately because it has had no enrollment system for beneficiaries. Beneficiaries can move in and out of the system as they please, relying on it for all, some, or none of their care. DoD has relied on surveys to determine how many beneficiaries use the system and to what extent the military is their primary or secondary source of coverage.

Tricare begins to build a better foundation for DoD by requiring enrollment in the Tricare Prime option. But the department would still face a challenge in planning for those who decide not to enroll in Tricare Prime, be they beneficiaries who use the system today or ones who are not currently using it. Those factors introduce considerable uncertainty: CBO estimates that less than half of the non-active-duty beneficiaries using the system today will enroll. Furthermore, about 30 percent of those eligible to use military health care in the United States--2 million beneficiaries--do not do so at present. That "ghost" population would continue to create major cost and management uncertainties under Tricare.

An efficiently managed system would require DoD to be able to identify the population for whom health care is to be provided. Military providers need to be able to plan for the health care needs of a defined population to develop per capita budgets

7. This rule was proposed by DoD and published in the *Federal Register*, vol. 60, no. 26 (February 8, 1995).

and build cost-effective health care delivery networks. Those strategies can be put into effect only if all eligible beneficiaries commit themselves either to use a military plan or to rely on civilian sources of care. That could be accomplished by establishing a universal enrollment requirement for all beneficiaries who plan to use the military health care system.

Imposing a universal requirement that all beneficiaries enroll in the military health care system as a precondition to their use of that system, however, may be beyond the reach of DoD. A few years back, the department proposed a policy of enrollment that would lead to excluding beneficiaries from the military facilities if they did not enroll. The Congress vetoed that policy in response to the pleas of beneficiaries. Instead of using sticks to enroll beneficiaries, the Congress directed DoD to use carrots.⁸ The triple option benefit structure--which provides beneficiaries with the option to enroll and incentives to do so--is an outgrowth of that process.

Even if DoD could adopt a universal enrollment requirement, charging military beneficiaries a premium might be viewed by beneficiaries as a reduction in the benefits they receive from the military today. Moreover, because military beneficiaries receive the bulk of their health care benefits in-kind, many would find their disposable income substantially reduced, particularly if their share of the premiums was set at levels approaching those in civilian plans. As a result, DoD would probably have to decide whether to compensate military beneficiaries for all or some part of the premium expense that they would have to pay for medical care.

Effect of Tricare on the Budget

The Congressional Budget Office's estimates suggest that Tricare will increase DoD's costs of health care delivery, despite the statutory requirement that Tricare not raise government costs. CBO estimates that, without Tricare, government costs for the peacetime mission would total \$9.4 billion in 1996. That amount includes only those costs that the Tricare program would affect: the cost of care for all beneficiaries in the United States, through CHAMPUS and the direct care system, without the Tricare program. CBO estimates that if Tricare was fully operational in 1996, those costs of DoD's peacetime health care mission would probably increase by about 3 percent, or about \$300 million, to \$9.7 billion (see Table 6).

8. In section 715 of the conference report for the National Defense Authorization Act for Fiscal Year 1993, the Congress directed DoD to use positive incentives to encourage military beneficiaries to enroll in a health care plan offered by the military.

Based on those estimates, achieving budget neutrality would probably require reductions in the number of beneficiaries served by DoD or some other compensating adjustment, such as higher copayments for care. But as long as the opportunity to use the military health care system remains available to the population of "ghosts"--2 million people--DoD may find such reductions impossible to make.

The Tricare program affects the cost of providing health care to military beneficiaries because of its effects on the behavior of both beneficiaries and providers. Several features of the Tricare program would increase the cost to the government of providing health care to military beneficiaries, whereas other features of the program would lower that cost. Budget neutrality would depend of course on the department's ability to generate sufficient savings under the Tricare program to offset its cost increases.

Among those features of Tricare that would increase the cost to the government are lower out-of-pocket costs for beneficiaries under Tricare Prime and Tricare Extra, the expected increase in demand from offering more generous benefits, and the higher administrative costs to the government of replacing the traditional CHAMPUS program with managed care support contracts.

Other features of the Tricare program could lower the cost to the government. DoD intends to lower the cost of providing care to beneficiaries in military facilities and in the civilian sector by applying management strategies to curb the use of care

TABLE 6. CBO'S ESTIMATES OF CHANGES IN COSTS FOR FISCAL YEAR 1996
UNDER VARYING ASSUMPTIONS ABOUT THE TRICARE PROGRAM

	Net Change in Baseline (In millions of dollars)	Percentage Change from Baseline
Base Case	300	3
Optimistic Case	-100	-1
Pessimistic Case	500	6

SOURCE: Congressional Budget Office.

NOTE: Costs are measured as a percentage change in total government costs without the Tricare program. CBO used a baseline of \$9.4 billion in its calculation. That amount of base spending includes only those costs that would be affected by the Tricare program.

BOX 3.
MODIFICATIONS THAT COULD IMPROVE THE TRICARE PROGRAM

Working with the Congress, the Department of Defense could modify Tricare to address several potential problems raised in this section. The major challenge facing DoD at the moment is to create a tightly structured financing and delivery system out of two subsystems that are largely independent today: the military's direct care system and the civilian services purchased by the military. Although a majority of the care that the military provides to its beneficiaries is delivered at military facilities, a significant portion of the total care is provided to them in civilian settings. That is, about 25 percent of the total outpatient care that the military provides to its beneficiaries--and almost 35 percent of the total number of inpatient days--are covered under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Some of the changes that could be made to the Tricare program are discussed below. All of them are intended to enhance DoD's chances of reducing costs by helping the department make the military health care system operate more efficiently.

A Triservice Command and Control Structure

A triservice command and control structure would provide each lead agent with management control over all personnel and resources within the region, including those from other services. Resources would no longer be allocated separately through each service but would go directly to the lead agent.

An Integrated Management Approach to Utilization

DoD could substantially improve its ability to control the total volume of care delivered to military beneficiaries by better integrating the utilization review activities throughout CHAMPUS and the direct care system. One way to do that would be to assign responsibility for utilization review activities within a region to only one party, either the civilian contractor for managed care support services or the hospital commander.

A Requirement for Universal Enrollment

With the support of the Congress, DoD could adopt the requirement that all beneficiaries who plan to use the military health care system enroll in a military health care plan. Military providers need to be able to plan for the health care needs of a defined population in order to develop per capita budgets and build cost-effective health care delivery networks. Those strategies can be put into effect only if all eligible beneficiaries commit themselves either to use a military plan or to rely on civilian sources of care.

Premiums and Copayments

Imposing copayments for health care benefits--for both military and civilian care--at levels approaching those in civilian plans would offer beneficiaries incentives to use care efficiently. Premiums would also minimize the risk of ghosts reentering the military health care system, thereby improving both regional management of the system and capitated budgeting. For DoD to institute that change, however, the requirement that Tricare Prime must lower out-of-pocket costs for beneficiaries would have to be repealed.

by beneficiaries and by negotiating discounts with providers. In addition, DoD will try to improve coordination between military and civilian providers, not only to improve the use of military facilities but also to control the total volume of care used by beneficiaries.

Sensitivity of the Estimates

The estimated cost of the Tricare program is highly sensitive to many assumptions about the behavior of beneficiaries and providers and more generally about DoD's ability to reform its health care system. Higher administrative costs and increases in demand from a more generous benefit structure, and lower savings from utilization management, will precipitate an even greater increase in government costs.

To highlight the likely effects of the Tricare program on government costs, CBO developed both an optimistic and a pessimistic case from the assumptions used to produce the earlier estimate--the so-called base estimate of costs. Under those different assumptions, the effects of Tricare could range somewhere between additional costs of about 6 percent--more than \$500 million--and savings of less than 1 percent--\$100 million (see Table 6). Since so many of the savings depend on DoD's ability to improve the efficiency of its own system of care, removing the key impediments to efficiency in the direct care system is critical to the success of the Tricare program (see Box 3).

In contrast to CBO's estimates, DoD has projected that Tricare would not add to government costs and would actually generate savings for the department. DoD's analysis assumes that it will be able to meet its objective of improving the efficiency of the military health care system and to make major changes in many of the current relationships built into DoD's health care delivery system.