

Despite the improvements that DoD hopes to make in the readiness of its reserve personnel, some analysts believe that recruiting and retaining the reserve medical personnel called for by DoD's plans may be difficult. For example, some employers may not be willing to promote physicians who are in the reserves. Self-employed physicians who are in the reserves may fear the consequences for their practice of being recalled to active duty. Those issues are clearly relevant to any debate about the appropriate mix of active and reserve personnel.

ALTERNATIVES TO TRICARE

Placing primary emphasis on the wartime mission would lead to a major restructuring of the military health care system. The direct care system would be downsized to levels consistent with wartime requirements, and DoD would not be able to move forward with the Tricare program as planned. Instead, eligible military beneficiaries--perhaps with the exception of active-duty personnel--would have to receive their health care in the civilian sector.

Military beneficiaries could receive access to health care from nonmilitary providers in many ways. One particular approach, supported by the National

TABLE 7. COMPARISON OF WARTIME MEDICAL REQUIREMENTS FOR ACTIVE AND RESERVE PHYSICIANS

	1987		1999 ^a			
	Requirements		Base Case ^b		Augmented Case ^c	
	Number	Percentage of Total	Number	Percentage of Total	Number	Percentage of Total
Active	13,396	42.5	4,000	44.4	6,300	43.4
Reserve	<u>18,100</u>	<u>57.5</u>	<u>5,000</u>	<u>55.6</u>	<u>8,200</u>	<u>56.6</u>
Total	31,496	100.0	9,000	100.0	14,500	100.0

SOURCE: Congressional Budget Office.

- The 1999 requirements for physicians are based on the findings of the Section 733 Study of the Military Medical Care System.
- The base case includes the minimum number of physicians needed to treat casualties from a theater of war.
- The augmented case exceeds the base case by including physicians needed during peacetime to continue with several other activities, including training, providing relief for physicians in locations outside the Continental United States, and staffing hospitals in those locations.

Military Family Association, would give beneficiaries access to care through the Federal Employees Health Benefits program as well as through the military health care system (see Box 6 for a description of the FEHB program). In requesting a CBO study of military medical care, the Subcommittee on Personnel of the House National Security Committee asked CBO to consider FEHB alternatives to Tricare.

CBO developed a basic option modeled on the premium-sharing arrangements between the government and nonpostal employees (see Table 8 for a summary of the eligibility of beneficiaries for care). Since under any FEHB plan beneficiaries would face higher premium and out-of-pocket costs than under today's military coverage or Tricare, CBO also developed two alternatives to the basic option. Both of those additional options would enrich the benefits offered to military beneficiaries above the basic option by increasing the government contribution under the FEHB program. As a result, both of those options would lead to increases in enrollment levels and

BOX 6.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal Employees Health Benefits (FEHB) program is the source of health insurance for more than 9 million people. That number includes employees and retirees of the federal government and their dependents. Enrollment in the FEHB program is voluntary. In fact, not everyone who is eligible for enrollment chooses it: about 15 percent to 20 percent of the total eligible population of federal workers and retirees decides not to enroll in FEHB for a variety of reasons. For example, a married employee may opt for coverage through the employer of his or her spouse.

Participants in FEHB have a wide range of choices of types of plans and providers. Premiums and levels of benefits vary among plans. Two basic types of health insurance plans are offered: fee-for-service plans (including preferred provider options) and prepaid plans such as health maintenance organizations. Enrollees must also elect either self-only or self and family coverage.

The federal government and enrollees share the cost of each plan's premium. In 1995, the average premium contribution that the government will pay will be about 72 percent; employees will pay the remaining 28 percent. (Annuitants pay a slightly higher percentage of the average premium.) Postal Service employees, however, pay a smaller share of the premium--roughly 14 percent based on their share of the premium in 1995. The share of the premium paid by the government and an individual employee or annuitant varies by plan, based on a formula outlined in statute.

For nonpostal employees, the government's contribution to any plan's premium is based on a fixed dollar amount equal to 60 percent of the average of the high-option premiums for what are referred to as the "Big Six" plans but no more than 75 percent of any plan's premium. The Office of Personnel Management calculates that average based on six different plans.

TABLE 8. HEALTH CARE BENEFITS UNDER A SYSTEM
REDUCED TO WARTIME REQUIREMENTS

Beneficiary Category	Direct Care System		Federal Employees Health Benefits Program
	Inpatient	Outpatient	Inpatient and Outpatient
Active-Duty Service Members (ADs)	Some care in military treatment facilities (MTFs). Most care through civilian providers.	Most care in MTFs. Some care through civilian providers.	Not eligible to enroll.
Active-Duty Dependents (ADDs)	Not eligible.	Not eligible.	Option to enroll.
Retirees, Their Families, and Survivors Under Age 65	Not eligible.	Not eligible.	Option to enroll.
Retirees, Their Families, and Survivors Age 65 and Over	Not eligible.	Not eligible.	Option to enroll. Receive both Parts A and B coverage under Medicare. ^a

SOURCE: Congressional Budget Office.

NOTE: This type of arrangement for health care benefits assumes the Civilian Health and Medical Program of the Uniformed Services would be eliminated.

a. Medicare Part A is Hospital Insurance. Medicare Part B is Supplementary Medical Insurance.

government costs above those expected under the basic option (see Appendix C for a discussion of the method used to calculate enrollment rates under each of the three FEHB options).¹⁰

Option 1: The Government Pays About 72 Percent of the Average FEHB Premium

Under this basic option, DoD would offer dependents of active-duty personnel and retirees and their family members the opportunity to enroll in the FEHB program on a voluntary basis.¹¹ As an employer, DoD would pay the government's share of the

10. All analyses presented in this chapter are based on the current FEHB program as administered by the Office of Personnel Management.

11. In keeping with the spirit of the FEHB program, military beneficiaries are assumed to have an annual opportunity to elect or change plan enrollment. However, military beneficiaries would have to elect plan enrollment before 62 years of age—and remain enrolled after that in a plan offered under the FEHB program—to maintain their eligibility for a plan offered under FEHB.

premiums for the plans that beneficiaries actually select, or an average of about 72 percent of the plans' costs; beneficiaries would pay the remaining 28 percent.¹² Since the contribution paid by the government would vary by plan, some beneficiaries would pay a higher or lower share of the premium based on their selection of plan.

In addition, the department would ensure that all of its military beneficiaries over the age of 65 had full coverage under Medicare, including both coverage under Part A (Hospital Insurance) and voluntary coverage under Part B (Supplementary Medical Insurance). To ensure that all eligible beneficiaries had full coverage under Medicare, DoD would pay the enrollee's premium under Medicare Part B, including fees for those beneficiaries who waived coverage when they first became eligible. In turn, those Medicare eligibles enrolling in an FEHB plan would receive their primary coverage through Medicare and secondary coverage through FEHB. That secondary coverage could prove to be quite generous for many people, since some FEHB plans provide a wraparound policy to cover what Medicare does not.

Beneficiaries other than active-duty personnel would no longer have the option to receive care from the military system, regardless of their enrollment in the FEHB program. The direct care system would be redirected toward the wartime medical mission. CHAMPUS would be eliminated. Consequently, the availability of peacetime care in military facilities would be sharply curtailed. DoD would retain the responsibility to provide care for active-duty personnel only, which it could meet through some combination of its military hospitals, clinics, and care purchased from the civilian sector.

Effects on Coverage and Access to Care. One major effect of this approach is that it would place all categories of non-active-duty beneficiaries on an equal footing. Today's military health care system does not, nor will Tricare. Instead, today's system of access to care at military medical facilities puts active-duty personnel before active-duty dependents; retirees and their families have lowest priority. Tricare will modify that system of priorities to consider whether beneficiaries are enrolled in Tricare Prime. The FEHB approach would eliminate those rankings, since all beneficiaries would have equal access through their chosen plans.

Because some FEHB plans would provide full wraparound coverage for services and cost-sharing requirements not covered by Medicare, military beneficiaries who are eligible for Medicare would also benefit substantially from this option. For example, most FEHB plans would provide 100 percent coverage for prescription drugs for such beneficiaries, all of whom would have their employee premiums for

12. Annuitants would actually pay about 29 percent of the average premium for a plan offered under the FEHB program.

enrollment under Medicare Part B paid by DoD. However, beneficiaries who are eligible for Medicare would still be required to pay their share of the premium for the plan they chose under the Federal Employees Health Benefits program.

Even under the FEHB approach, access to care could still vary by region, since not all FEHB options are available in all parts of the country. But military beneficiaries would have many more choices than they have today through the military health care system. Active-duty dependents could have at least as many choices as federal civilian employees, ranging from fee-for-service plans (with or without a preferred provider option) such as Blue Cross/Blue Shield to prepaid HMOs. The lack of available information on where retirees live makes it difficult to determine what plans might be available to them. But the availability of plans other than fee-for-service ones may not be particularly important to most federal retirees. In fact, over 85 percent of all federal annuitants enroll in fee-for-service plans that enable them to choose their physicians. Over 55 percent of annuitants choose Blue Cross/Blue Shield alone.

A military beneficiary's actual choice to enroll in any FEHB plan--and the plan actually chosen--depends on many more factors than just the number of choices. How the department carries out this option, how much it would contribute to each plan's premium, and the alternative options that beneficiaries may have for private health insurance will all affect their behavior.

Effect on Government Costs. Under Option 1, the Congressional Budget Office estimates that the total cost to the government in fiscal year 1996 would be \$7.3 billion (see Table 9). Based on that estimate, the cost to the government would be substantially less than the savings that could be realized by downsizing and restructuring the military's direct care system.¹³ Net annual savings after full implementation could be on the order of \$1.7 billion (not including the costs of closing military medical facilities). Savings would probably be somewhat greater in comparison with Tricare once it is fully established.

Those estimates of costs assume that the present approach to calculating FEHB premiums would be retained. DoD would pay at least the government's share of the premiums of the plans actually selected by beneficiaries or an average of about 72 percent of the plans' cost. (Under current statute, the actual contribution that the department would make toward any plan's premium could not exceed 75 percent of

13. CBO estimates that about \$9 billion could be saved each year from downsizing the military health care system, as illustratively examined in this paper. However, that estimate does not take into account the costs of closing military treatment facilities, or the cost of providing an alternative source of health care for non-active-duty beneficiaries.

any plan's premium.) Enrollees would pay the remaining 28 percent of the average premium.

In addition, the estimated cost of providing coverage for active-duty dependents and retirees and their families under FEHB includes an evaluation of how adding those beneficiaries who enroll to the covered population would affect the costs of

TABLE 9. CBO'S ESTIMATES OF COSTS TO THE GOVERNMENT FOR FISCAL YEAR 1996 UNDER THREE OPTIONS OFFERING MILITARY BENEFICIARIES ENROLLMENT IN THE FEHB PROGRAM (In millions of dollars)

Beneficiary Category	Option 1 ^a	Option 2 ^b	Option 3 ^c
Costs to the Department of Defense^d			
Dependents of Active-Duty Personnel	1,933	3,245	3,825
Retirees and Dependents Under 65	1,673	3,150	4,013
Retirees and Dependents 65 or Older	<u>2,325</u>	<u>2,628</u>	<u>2,869</u>
Subtotal	5,930	9,023	10,707
Costs to Medicare^e			
Retirees and Dependents 65 or Older	1,363	1,363	1,363
Total Costs to the Government			
Dependents of Active-Duty Personnel	1,933	3,245	3,825
Retirees and Dependents Under 65	1,673	3,150	4,013
Retirees and Dependents 65 or Older	<u>3,687</u>	<u>3,990</u>	<u>4,231</u>
Total	7,293	10,385	12,069

SOURCE: Congressional Budget Office.

NOTE: FEHB = Federal Employees Health Benefits.

- a. Assumes that the government pays about 72 percent the average premium under the FEHB program.
- b. Assumes that the government pays 85 percent of the average premium under the FEHB program.
- c. Assumes that the government pays 100 percent of the average premium under the FEHB program for dependents of active-duty personnel and about 90 percent for retirees and dependents.
- d. Includes increases in the costs to the Department of Defense from making premium payments on behalf of military beneficiaries enrolling in the FEHB program and from paying enrollees' premiums under Medicare Part B (including fines for those beneficiaries who waived coverage when they first become eligible).
- e. Includes increases in the costs of Part A and Part B coverage under the Medicare program.

both DoD and Medicare. As well as the cost to DoD of providing military beneficiaries with coverage under FEHB, the estimate assumes that Medicare costs would increase under both Parts A and B. In addition, the estimate assumes that DoD would pay an enrollee's premium under Medicare Part B, including fees for those beneficiaries who waived coverage when they first became eligible.

Among the most important factors affecting CBO's cost estimate of the base option is the number of people who would enroll in the FEHB program. Also important is the effect on average health insurance premiums after military beneficiaries enroll in this program (see Box 7).

Effect on Enrollment. CBO assumes that, under the basic option, fewer dependents of active-duty personnel and retirees and their families under the age of 65 would enroll in the FEHB program than rely on the military health care system today. Conversely, CBO assumed that a significantly greater number of beneficiaries who are 65 years of age and eligible for Medicare would enroll in a plan offered under the FEHB program (see Table 10). According to DoD, about 90 percent of the dependents of active-duty personnel and 57 percent of retiree beneficiaries and their dependents under the age of 65 rely on the military health care system for their care. Roughly 30 percent of retirees over the age of 65, however, rely on the military for their care today.

Effect on Out-of-Pocket and Premium Expenses for Beneficiaries. Compared with their out-of-pocket expenses for care in the military health system today, military beneficiaries would have to pay substantially more on average to enroll in a plan offered under the FEHB program. For most beneficiaries, the largest effect would stem from additional premium costs. In addition, under most plans, beneficiaries would face copayments different from those under any of the three Tricare options.

Nevertheless, the improved coverage that many FEHB plans offer might enable some beneficiaries to save by canceling CHAMPUS supplemental insurance policies or other private coverage. Under Tricare, costs for different groups of beneficiaries will depend heavily on access to treatment in military facilities. Tricare Prime would probably cost active-duty dependents less than most HMO plans offered through FEHB. Choices are more difficult to analyze for retirees than for dependents of active-duty personnel, since they rely more heavily on other nonmilitary sources of insurance. For most retirees, FEHB alternatives would probably be more costly than Tricare Prime. A definitive answer to how net out-of-pocket expenses would change depends on unknown factors, such as the actual out-of-pocket expenses for CHAMPUS supplemental insurance or private insurance today and how those expenses would change under Tricare Prime.

BOX 7.
EFFECT ON AVERAGE FEHB PREMIUMS

Assuming that military beneficiaries are pooled together with other participants in the Federal Employees Health Benefits (FEHB) program, estimating the impact on the average premium is essential to calculating the costs to the government and to enrollees in the FEHB program. Several factors associated with offering military beneficiaries enrollment in FEHB are likely to affect premiums. Changes would arise from several differences between FEHB participants and military beneficiaries, including the distribution of the population by age and sex, the size of the family, the health status of the population, the type of coverage purchased--self only or family--and finally, the choice of health care plan.

On balance, military beneficiaries are unlikely to have a significant impact on FEHB premiums. That conclusion stems from analyzing the distribution of the population by age and sex. Despite differences between the age and sex distribution of all military beneficiaries eligible to enroll in the FEHB option and all people with coverage under the FEHB, the impact on the health insurance premiums under FEHB arising from those differences is likely to be negligible. (See Appendix C for a discussion of CBO's analysis to determine the impact on premiums from adding military beneficiaries to the pool of enrollees in the FEHB program.)

Other differences between eligible military beneficiaries and subscribers and their dependents under the FEHB program could affect premiums under FEHB. Their effects have not been calculated in this analysis, however, since they are uncertain. For example, one of those factors that CBO has not accounted for is that the number of people covered under a family policy would be higher among current subscribers than it would be for dependents of active-duty personnel enrolling in the FEHB program who purchase a family policy. The reason is largely that the active-duty sponsor would remain the responsibility of DoD. That difference would tend to lower the health insurance premiums under the FEHB program that result from adding military beneficiaries to the pool of current participants. It also has the potential to generate savings for the government from lower fixed government contributions but possibly higher costs for current participants. The choice of health care plan would also have an impact on the FEHB premiums.

Another way that military beneficiaries could affect FEHB premiums is if only high-risk individuals enrolled--or those with a higher probability of incurring illness--than current FEHB participants. If that situation occurred, FEHB premiums would probably rise to reflect the change in the underlying risk pool. How likely is that to happen? The greater the number of military beneficiaries who purchase a plan under the FEHB program, the lower the risk of attracting only high-risk individuals to the program. That is because there is no reason to believe that military beneficiaries on the whole are any healthier or sicker than the pool of current participants in the FEHB program. Alternatively, the danger of attracting only high-risk individuals to FEHB increases as fewer military beneficiaries opt to enroll. Of course, many other possible effects on the FEHB program have not been analyzed in this paper. Furthermore, many other changes might take place in the FEHB program--in the absence of this option to allow military beneficiaries to enroll--that could also affect FEHB premiums. Those changes have not been analyzed in this paper.

A similar pattern applies to beneficiaries choosing Tricare Standard: active-duty dependents would pay less than in some FEHB fee-for-service plans, whereas some retirees could pay about the same or more than under FEHB alternatives. However, retirees 65 years of age or older stand to benefit the most and experience reduced out-of-pocket expenses, assuming the plan of their choice becomes the wraparound benefit to their coverage under Medicare.

Option 2: Increase the Government's Contribution to 85 Percent of the Average FEHB Premium

The Congress could consider options to increase voluntary enrollment rates in the FEHB program by raising the average premium contribution that the government

TABLE 10. ENROLLMENT RATES OF ELIGIBLE MILITARY BENEFICIARIES IN THE FEHB PROGRAM UNDER THREE OPTIONS (In percent)

Type of Coverage	Dependents of Active-Duty Personnel (All Ages)	Retirees and Dependents	
		Under 65	65 or Older
Option 1^a			
Self Only	70	52	95
Family	70	37	95
Option 2^b			
Self Only	100	78	100
Family	100	54	100
Option 3^c			
Self Only	100	96	100
Family	100	70	100

SOURCE: Congressional Budget Office.

NOTE: FEHB = Federal Employees Health Benefits.

- a. Assumes that the government pays about 72 percent of the average premium under the FEHB program.
- b. Assumes that the government pays 85 percent of the average premium under the FEHB program.
- c. Assumes that the government pays 100 percent of the average premium under the FEHB program for dependents of active-duty personnel and about 90 percent for retirees and dependents.

makes on behalf of military beneficiaries. Any such option would obviously lead to higher government costs relative to the basic option, offsetting all of the savings from the basic option.

Under the first of two illustrative alternatives to Option 1, CBO raised DoD's share of the premiums of the plans actually selected by beneficiaries to an average of about 85 percent, in contrast to the 72 percent assumed under the basic option. Enrollees would pay the remaining 15 percent of the average premium, almost equal to what postal employees now pay on average (14 percent).

Effect on Government Costs. CBO estimates that the total cost to the government for this option would be \$10.4 billion a year (see Table 9). Unlike Option 1, the cost to the government would be more than the savings that could be realized by downsizing and restructuring the military's direct care system. Net annual costs after full implementation could be on the order of \$1.4 billion (again, not including closing costs for the military medical facilities).

Relative to the basic option, Option 2 would increase the costs to the government by about another \$3.1 billion. Medicare costs would not rise under this option relative to the basic option, since the latter already takes into account all changes in Medicare spending for 100 percent of the eligible population.

Effect on Enrollment. Enrollment in the FEHB program would vary by beneficiary category, based on the estimated relative change in premium expenses between the military health care system and the FEHB program. Compared with the number of beneficiaries who rely on the military health care system today, this option would increase the number of dependents of active-duty personnel from 90 percent to 100 percent, and retirees and their families who are 65 years of age or older from roughly 30 percent to 100 percent (see Table 10). In addition, a greater number of retirees and their families under the age of 65 would enroll in the FEHB program than rely on the military system today.

Effect on Out-of-Pocket and Premium Expenses for Beneficiaries. As with Option 1, this alternative would increase out-of-pocket expenses for military beneficiaries enrolling in the FEHB program relative to what they pay for care today through the military health care system. For most beneficiaries, the largest effect would stem from additional premium costs. In addition, under most plans beneficiaries would face copayments different from those under any of the three Tricare options.

Considering both out-of-pocket expenses under Tricare and nonmilitary sources of insurance coverage, the net effect would differ among beneficiaries. Tricare Prime would probably cost active-duty dependents less than most HMO plans offered

through FEHB. However, for many retirees, net out-of-pocket expenses might be about the same under FEHB alternatives or Tricare Prime.

A similar pattern applies for beneficiaries choosing Tricare Standard: active-duty dependents would pay less than in most FEHB fee-for-service plans, but many retirees could pay more than under FEHB alternatives. Again, retirees 65 years of age or older stand to benefit the most, assuming the plan of their choice becomes the wraparound benefit to their coverage under Medicare.

Option 3: Limit Beneficiaries' Premiums to Levels Proposed for Tricare Prime

Another and more generous alternative for military beneficiaries than the base option would be to require that military beneficiaries pay only the enrollment fee proposed under Tricare Prime to enroll in a plan offered under the FEHB. That approach would increase the government's contribution to 100 percent for dependents of active-duty personnel and to about 90 percent for retirees and their families. Not surprisingly, this third option would lead to substantially higher levels of enrollment than either of the other two options for retirees and their families under the age of 65 as well as significantly higher costs for the government.

Effect on Government Costs. The Congressional Budget Office estimates that the total cost to the government would be \$12.1 billion a year--substantially above the level of savings that could be realized by downsizing and restructuring the military's direct care system (see Table 9). Net annual costs after full implementation could be on the order of \$3.1 billion (not including costs of closing military medical facilities). This option increases the costs to the government by about \$4.8 billion relative to the basic option, or \$1.7 billion more than Option 2. Medicare costs would not rise under this option relative to the basic option, since Option 1 already takes into account all changes in Medicare spending for 100 percent of the eligible population.

Effect on Enrollment. Under Option 3, 100 percent of dependents of active-duty personnel and 100 percent of beneficiaries 65 years of age or older would be expected to enroll in the FEHB program (see Table 10). CBO also expects that retirees and their families who are under the age of 65 would enroll in large numbers. Overall, this option would serve many more eligible military beneficiaries than the military cares for today.

Effect on Out-of-Pocket and Premium Expenses for Beneficiaries. Government costs would increase substantially under this option because enrollment fees are extremely low under Tricare Prime relative to the average premium for an FEHB plan. Except for dependents of active-duty personnel--who rely chiefly on the military health care

system today--costs for most beneficiaries probably would decline substantially compared with either the basic option or their situation today. The reason is the significantly lower share of the premium that they would have to pay to enroll.

OTHER FACTORS TO CONSIDER UNDER ANY FEHB OPTION

The illustrative options discussed in this chapter explore many of the effects on DoD, Medicare, and beneficiaries of offering military beneficiaries the option to enroll in a plan under the FEHB program. Two other factors, not yet considered, are discussed below.

Administrative Factors

In 1995, the total cost of FEHB to the federal government is about \$16 billion. If coverage was provided to all potential DoD beneficiaries--including ghosts--the size of the FEHB program could increase by almost 75 percent. Even if the ghost population was excluded, the increase in volume would surely increase administrative costs for the program. Those added costs, which CBO has not included in its estimate, would offset only a small fraction of the potential savings. They would not be more than \$20 million a year, based on the current administrative spending patterns of the Office of Personnel Management.

Apart from the increase in the volume of work, expanding FEHB to cover dependents of military personnel and retirees would raise several administrative issues. One issue that would emerge is how to handle enrollment for active-duty families, who move much more often than other federal workers. Another issue concerns self-only and self and family policies. The FEHB option assumes that spouses of active-duty personnel would be permitted to purchase policies, even though the active-duty member is the employee. Further, in many cases, a spouse without children or an only child in a single-parent family might benefit from purchasing a lower-cost self-only policy. The Office of Personnel Management would have to resolve those administrative questions, perhaps in a manner consistent with the interests of military families.

Budgetary Treatment of FEHB Costs

All of the FEHB options would have pay-as-you-go implications under the budgetary enforcement rules of current deficit reduction laws. First, the employer contribution for premiums of annuitants is considered to be an entitlement subject to pay-as-you-

go procedures. Second, legislation that increased participation in either Medicare Part A or B would also be subject to those procedures. The FEHB options discussed in this chapter would raise Medicare participation because people who now receive care in military treatment facilities would instead be treated in the civilian sector under Medicare.

Under current law, fixed caps on total discretionary spending in the federal budget govern the total amount that can be spent for all individual discretionary programs, including military health care. A reduction in DoD's health care budget--for example, from making the care of retirees age 65 and over the responsibility of Medicare--thus would not necessarily reduce total discretionary spending. Moreover, it particularly could not be used to offset increases in mandatory spending such as Medicare costs. Under the scoring rules of the Omnibus Budget Reconciliation Act of 1993, putting an FEHB option into place for military personnel would require offsets in pay-as-you-go spending and perhaps an adjustment in the legislative cap on discretionary spending.

PUTTING THE OPTIONS TOGETHER

Restructuring the military health care system around its wartime mission would require DoD and the Congress to proceed unambiguously with separating peacetime care from wartime readiness. An incremental approach to changing the size and structure of the military health care system would not work without an increase in funds, since savings would not be sufficient initially to pay for the cost of providing health care to the military population in the civilian sector. Other factors, such as the complexity of the military health care system and the delicate balancing act of the dual responsibilities of the department, would also preclude seriously considering an incremental approach to reducing the size of the military medical establishment.

The options outlined in this chapter present an alternative approach for providing wartime and peacetime medical care. Merely meeting the wartime requirements would permit DoD to reduce its system substantially and adopt a number of new strategies, perhaps including using civilian shock trauma centers and stronger relationships with civilian hospitals. Adopting only some of those options either would leave the department short of meeting wartime requirements or would increase the tension between wartime readiness and peacetime care. CBO's analysis of options for peacetime care are focused on the role of the FEHB program. Although other ways exist to provide peacetime care, the FEHB plans offer the advantages of availability and administrative familiarity in providing coverage for millions of federal employees and retirees and their dependents and survivors.

APPENDIX A

CBO'S METHOD FOR COMPARING DIAGNOSES

TREATED DURING PEACETIME AND WARTIME

This appendix describes the method that the Congressional Budget Office used to determine the match between the diagnoses treated during peacetime at military medical facilities worldwide and those diagnoses that could be expected to occur during wartime. To conduct that analysis, several databases were used and developed. Findings indicate that the care furnished in military medical centers and hospitals in peacetime bears little relation to many of the diseases and injuries that military medical personnel need to be trained to deal with in wartime.

METHOD

CBO compared the diagnoses during peacetime with those expected during wartime based on a standardized diagnoses system, referred to as the International Classification of Diseases, Ninth Revision (ICD-9). Research conducted by the Naval Health Research Center (NHRC) converts patient conditions expected to occur during wartime to the ICD-9 coding scheme. Since the Department of Defense (DoD) already uses the ICD-9 coding scheme to describe the diagnoses treated at the military medical facilities, CBO could match the diagnoses during peacetime and wartime by their ICD-9 codes. Performing that comparison required two specific databases: one consisting of all principal diagnoses for inpatients during peacetime, and a second on patient conditions during wartime and the ICD-9 diagnoses linked to those conditions.

PRINCIPAL DIAGNOSES FOR MILITARY MEDICAL FACILITIES WORLDWIDE

A database of all inpatient records from all military medical facilities worldwide was constructed based on data from the Central Retrospective Case-Mix Analysis System for an Open System Environment (RCMAS-OSE). RCMAS-OSE is a management information system that the Department of Defense uses to support health care analysis. More than 1 million records are included in that database, reflecting the workload for all military medical facilities worldwide in 1993. Each record contained in the database lists a principal diagnosis, indicating the primary nature of treatment provided to each inpatient. RCMAS-OSE identifies the diagnoses for each inpatient record based on the ICD-9 diagnoses system. Although multiple diagnoses

are listed for each record, CBO considered only primary diagnoses for the analysis presented in this paper.

DIAGNOSES RELATING TO WARTIME CONDITIONS

To conduct the comparison, a second database of diagnoses relating to patient conditions expected during wartime was constructed. That database relied on research conducted by the NHRC and in part on the list of patient conditions maintained by the Defense Medical Standardization Board (DMSB). The DMSB maintains a list of over 300 patient conditions that it considers representative of the injuries and illnesses expected in an operational theater. The chief reason for that list of patient conditions is to project the medical requirements necessary to treat the conditions expected to occur during wartime. Based on the anticipated number of hospitalizations for each patient condition, the list allows the DMSB to determine the medical equipment and personnel that would need to be deployed in a given scenario.

In comparing the diagnoses treated at the military medical facilities with those expected during wartime, CBO relied on the NHRC's method. The center uses a former list of 348 patient conditions maintained by the DMSB as a starting point from which a new list of 314 patient conditions was established and then divided between two diagnostic categories: disease and nonbattle injuries (DNBI) and battle injury or wounded-in-action (WIA). In all, the center's two categories contained 216 DNBI patient conditions and 98 patient conditions of battle injuries.

The Naval Health Research Center has developed a procedure for mapping ICD-9 codes to a patient condition falling into either the DNBI or battle injury category. Because patient conditions are broadly defined but the ICD-9 coding schema is very detailed, multiple ICD-9 codes may make up a single condition and indeed may do so for most conditions. Alternatively, some ICD-9 codes may map to more than one condition.

After developing those two databases, CBO then matched the principal diagnoses treated during peacetime and those expected during wartime, as defined by the NHRC, by their ICD-9 codes (see Table A-1 for the results of that analysis).

MATCHING PEACETIME DIAGNOSES AND THOSE FOR U.S. MARINES IN VIETNAM

Based on the NHRC's system for mapping ICD-9 codes to patient conditions, CBO created a database of certain patient conditions among U.S. marines in Vietnam and their ICD-9 codes. CBO then matched the principal diagnoses treated during peacetime with the wartime conditions (see Table A-2).

That comparison is limited in two specific ways. First, CBO limited its analysis to an examination of only the top 25 diagnostic categories of each type. The top 25 diagnostic categories for DNBI represented 60 percent of the total care delivered to U.S. marines in Vietnam, whereas for battle injuries they represented close to 85 percent of total care (see Table A-3). Second, CBO limited its comparison to the top 50 primary diagnoses treated at military medical centers, which represent only 35 percent of the total care delivered at those facilities (see Table A-4).

R ADAMS COWLEY SHOCK TRAUMA CENTER

To compare the diagnoses expected during wartime and those expected to occur most frequently in a civilian shock trauma unit, the Congressional Budget Office obtained a data set of diagnoses, by ICD-9 code, treated at the R Adams Cowley Shock Trauma Center (see Chapter 2). The list included all records of injuries maintained by the trauma registry for 1993 and the ICD-9 codes for those injuries. The NHRC list of diagnoses expected during wartime was then matched with those representing the injuries treated at the R Adams Cowley Shock Trauma Center on the basis of ICD-9 codes (see Table A-5).