CBO TESTIMONY

Statement of
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NOTICE

This statement is not available for public release until it is delivered at 2:00 p.m. (EDT), Monday, May 10, 1993.

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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the military health care system. My testimony focuses on the costs of that system and covers a range of issues, including:

- The projected rise in military health care spending;
- The underlying reasons for the rise in spending;
- How the health care demonstration projects by the Department of Defense have affected costs; and
- Some key steps necessary to hold down medical costs in the future.

BACKGROUND ON THE MILITARY HEALTH CARE SYSTEM

The Department of Defense (DoD) runs one of the largest health care systems in the nation. In fiscal year 1993, about 8.5 million people were eligible to receive health care through the system. This number includes men and women on duty in the active forces and reserves, their spouses and children, and retired military personnel and their dependents and survivors who are registered with the Defense Enrollment Eligibility Reporting System (DEERS)--a system for registering eligibility for exchange privileges, health care, and other benefits.

Fewer than 8.5 million people, however, actually use the military health care system. Since DoD does not require beneficiaries to enroll in a specific military health care plan, DoD can only guess at the total number of actual users. Based on a 1984 survey of beneficiaries conducted by DoD, the Congressional Budget Office (CBO) estimates that 90 percent of active-duty dependents and 57 percent of retirees and their families rely on the military health care system. These percentages work out to roughly 2.2 million active-duty dependents and 2.2 million retirees and their families.

Some personnel, particularly retirees, depend on sources outside the military for some or all of their health care--Medicare, for example. Others have private insurance, perhaps through their own employment or their spouse's employment, and use it to pay for health care in the civilian sector. These so-called "ghost" eligibles, however, can reenter the military system at any time.

Beneficiaries who choose to use the military's health care system receive most of their care through the direct care portion of the system. Other care is given by civilian providers who are reimbursed by a traditional insurance program known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

The Direct Health Care System

The direct health care system, the larger of the two parts of the military system, is made up of hospitals and clinics operated by the Army, Navy, and Air Force. It includes 140 hospitals and 553 clinics worldwide and employs more than 54,000 civilians, as well as 146,000 active-duty military personnel. Almost all of the care that beneficiaries receive through the direct care system is supplied by military physicians working at the Military Treatment Facilities (MTFs).

By law, active-duty personnel are entitled to care in the military hospitals and clinics, and they receive priority over all other potential users. Indeed, all care provided to active-duty personnel comes through the direct care system or is paid for by it. Active-duty personnel are not eligible to use CHAMPUS.

Some personnel who are not on active duty also use the direct care system when space is available. Dependents of active-duty personnel are legally eligible to receive care in military facilities and are second in priority only to active-duty personnel. They receive most of their health care in military hospitals and clinics. Retirees and their dependents and survivors,

who are also eligible by law to receive care in military facilities, are last in priority for access to the direct care system.

The Civilian Health and Medical Program of the Uniformed Services

When direct care is not available to eligible personnel, or when military facilities are located too far away, some beneficiaries can use CHAMPUS. Those eligible for CHAMPUS include dependents of active-duty personnel along with retirees under age 65 and their dependents and survivors.

CHAMPUS is a traditional insurance program, covering most of the cost of care that beneficiaries receive from civilian health care providers. Although the civilian sector provides almost all of the care financed by CHAMPUS, civilian providers working under the Partnership Program furnish some within the direct care system. When beneficiaries reach age 65, Medicare replaces CHAMPUS coverage.

The Military's Health Care Budget

In fiscal year 1993, DoD will spend just over $16 billion to support the military health care system. Roughly $12.5 billion will be spent on the direct care system. Those funds finance the pay and benefits of the military and civilian health care providers and the costs for operating and maintaining the direct care system. CHAMPUS costs of about $3.5 billion consume the rest of DoD's health care budget.

The military health care budget can also be categorized by the nature of the expenses. The total 1993 budget of $16 billion includes about $9.5 billion in costs directly related to providing peacetime medical care to beneficiaries. The remaining expenses are either general costs associated with maintaining a medical establishment, such as funding for military construction, or the costs of being prepared to supply medical care in time of war. Included in this second category are the costs of medical training courses, educational stipends for physicians and nurses, research, and operations that directly support military activities.

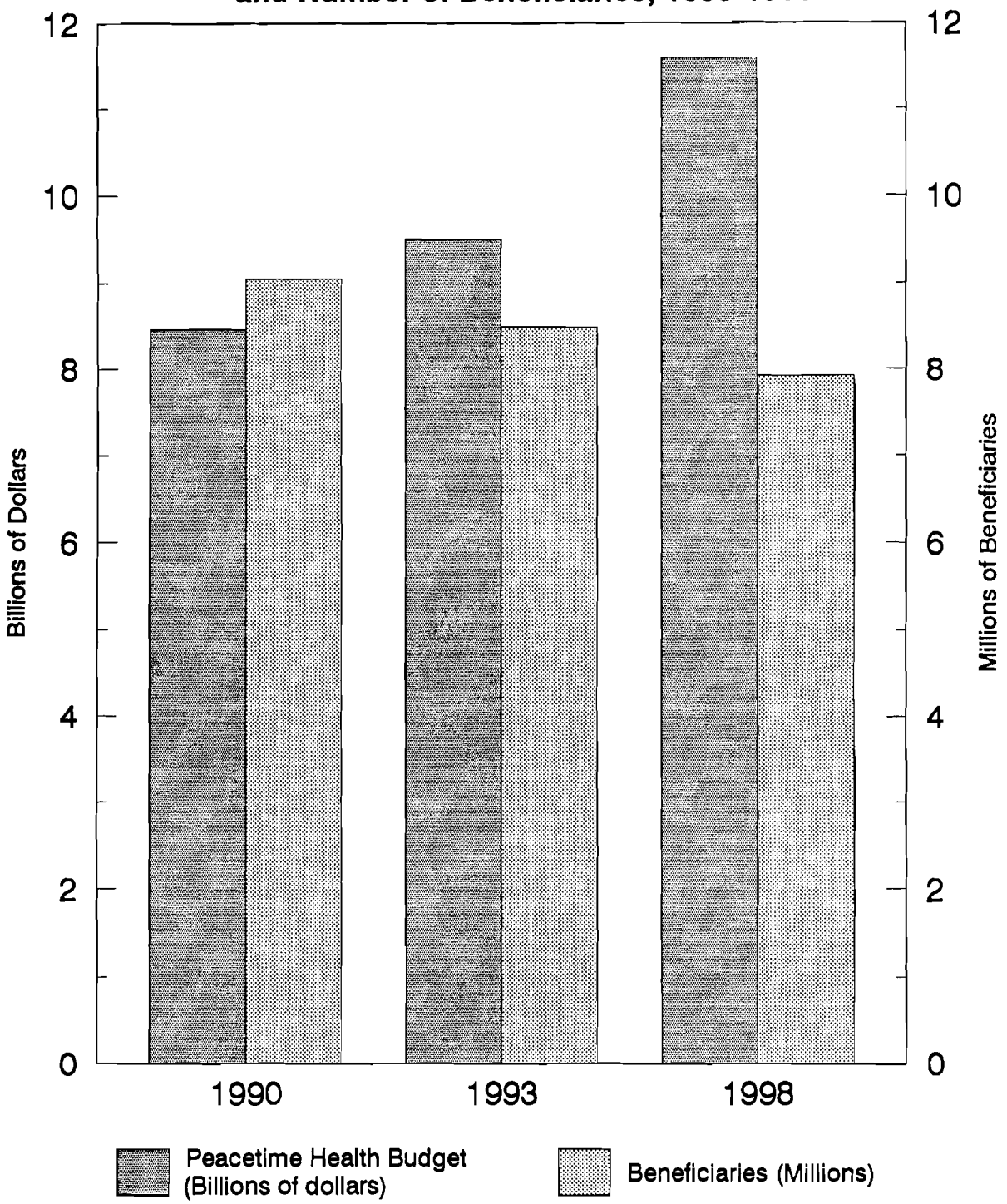
PROJECTING SPENDING ON MILITARY HEALTH CARE

How will military health care costs change as the number of military personnel declines during the next few years? The DoD model that CBO used to project costs focuses only on the $9.5 billion in 1993 costs directly related to providing peacetime care to beneficiaries. Those costs are most affected by changes in the size of military forces.

With an Active-Duty Force of 1.4 Million, Costs Increase by 22 Percent

CBO projects that, if no changes take place in military health care policies, costs will rise over the next few years despite the drawdown in forces. If active-duty personnel are reduced in number to 1.4 million by 1997, as the Administration apparently intends to propose, peacetime health costs will rise by 22 percent between 1993 and 1998 in nominal terms--from $9.5 billion to $11.6 billion (see Figure 1 and Table 1). Cost increases between 1993 and 1998 would have been even higher in the absence of a 7 percent decline in the total number of beneficiaries eligible for military health care. (See Table A-1 on page 30 for the overall decline and shifts in the eligible beneficiary population between 1990 and 1998.)

Figure 1: Trends in Military Health Care Spending and Number of Beneficiaries, 1990-1998



SOURCE: Congressional Budget Office projections based on the Department of Defense's Resource Analysis and Planning System.

NOTE: Assumes an active-duty force of 1.4 million by 1997.

With an Active-Duty Force of 1.2 Million, Costs Rise by 18 Percent

Moderately larger reductions in personnel would not reverse the trend toward higher health care costs. For example, if the active-duty force were drawn down to 1.2 million by 1997--about 14 percent below the Administration's plan--CBO projects that health care costs directly related to patient care would still rise by 18 percent between fiscal years 1993 and 1998 (see Table 1).

TABLE 1. PROJECTED COSTS FOR BENEFICIARY CARE IN FISCAL YEAR 1998

Active-Duty Force (Millions)	1.6	1.4	1.2
Percentage Increase in Health Care Spending Between 1993 and 1998	26	22	18
Health Care Costs in 1998 (Billions of dollars)	12.0	11.6	11.2

SOURCE: Congressional Budget Office projections based on the Department of Defense's Resource Analysis and Planning System.

Assumptions Underlying the Projections

To project costs through 1998, CBO made several key assumptions. It assumed that the reduction in the number of active-duty military personnel would lead to a parallel decline in the number of their dependent beneficiaries. The beneficiary population of retirees and their dependents and survivors, however, is not closely related to future personnel levels and actually increases by about 9 percent between 1993 and 1998. This rise could be even larger if the drawdown of active-duty personnel results in a large number of early retirements. An average inflation rate of 7 percent a year was assumed for this period for both the direct care system and CHAMPUS outpatient care. To reflect DoD's current policies and efforts to control costs, a lower rate of 4 percent was used for CHAMPUS inpatient care.

The total capacity of the direct care system was held constant at 1990 levels, consistent with the Congress's desire to limit reductions in medical personnel. The decreasing demand from the drawdown therefore had its greatest effect on CHAMPUS costs. CBO assumed that planned base closings and realignments would be fully carried out, with medical personnel and resources reallocated to other facilities.

UNDERLYING REASONS FOR RISING HEALTH CARE COSTS

A number of factors are driving military medical care costs higher. Many of them also underlie the Administration's concern with the spiraling costs of the national health care system.

Inflation in Medical Prices

Inflation in the U.S. health care sector--as measured by the medical care component of the consumer price index (CPI)--has risen by 7.9 percent a year from 1982 to 1991, almost twice the rate of growth in the overall CPI during that period (4.1 percent). Some of this growth results from factors normally thought of as inflation, such as higher salaries and increases in the prices of equipment. But the consumer price index does a poor job of adjusting for improvements in technology and other changes that may improve the quality of care. Moreover, the CPI does not measure the growth in the total costs of medical care; it only measures changes in out-of-pocket costs for consumers. As a result, the "true" rate of inflation in medical prices is unknown.

Whatever the true rate, the factors driving up the health care portion of the CPI also affect the cost of military health care. Medical price increases

in the civilian sector, of course, directly affect CHAMPUS. But they also have an impact on costs in the direct care system. For example, DoD must eventually increase the pay and bonuses of its health care providers to remain competitive with levels of compensation in the private sector. The military services must also budget for the increasing costs of medical equipment.

The Role of the Health Care Consumer

High costs also result because consumers have difficulty making informed choices about health care. In most markets, consumers compare what they must pay for goods and services with information they have about the value of those goods and services. In contrast, in the health care market, consumers frequently lack information governing their choices of medical treatment or are not qualified to assess the information they do have.

Low Cost Sharing

Many beneficiaries in the military medical system pay little or nothing out of pocket for their health care. Within the direct care system, for example, beneficiaries pay nothing for outpatient care and prescription drugs. For

inpatient care, enlisted retirees pay nothing. Active-duty service members and retired officers pay only a small fee of $4.75 a day, while active-duty dependents and dependents of retirees pay only a slighter higher daily fee of $9.30.

Some CHAMPUS users also bear only modest out-of-pocket costs. For inpatient care, active-duty dependents pay only $9.30 a day or $25 per hospital stay, whichever is more. Retirees do pay substantially higher out-of-pocket costs for inpatient care financed by CHAMPUS. For outpatient care, all CHAMPUS users face both a deductible and copayments.

Compared with typical limits on out-of-pocket costs in the civilian sector, active-duty dependents face a relatively lower limit, while retirees face a moderately higher limit. Active-duty dependents face a limit of $1,000 on total out-of-pocket costs on CHAMPUS-covered medical bills in any fiscal year, while retirees face a limit of $7,500. Even where limits are high, however, the incentives to use medical resources efficiently are weakened for many beneficiaries by supplemental or "wraparound" insurance policies that pay part or all of the individual's out-of-pocket costs.

Beneficiaries who pay little out of pocket for their health care have little reason to economize on care. This tendency may help explain why,

compared with civilians, military beneficiaries use more health care. For example, compared with the U.S. population at large, dependents of active-duty personnel make heavy use of the hospital. In 1990, civilians in the United States under the age of 65 consumed about 535 days of hospital care per 1,000 people. Even after adjusting for differences in use associated with age and sex, active-duty dependents under the age of 65 living in the United States consumed about 720 days of care either within the direct care system or financed by CHAMPUS. Thus, active-duty dependents used hospital care at a rate more than one-third higher.

Few Incentives for Military Providers to Economize

Like beneficiaries, providers in the military health care system have few incentives to curb the delivery of unnecessary and inappropriate health care. In the direct care system, DoD has historically provided each military hospital commander with a budget based on the quantity of care delivered and the level of resources used at the military treatment facility. To increase the facility's budget, therefore, the MTF commander only has to deliver more care and use more resources. This system could change in 1994, when DoD plans to introduce a budgeting system based on the number of potential beneficiaries and anticipated patterns of use.

CHAMPUS providers also have an incentive to increase the volume of care they provide because they are paid on the basis of fee for service. DoD, however, has tried to curb this problem through an aggressive review of use, particularly for mental health services. DoD has also tried to reduce CHAMPUS costs through such efforts as negotiating discounts with providers.

DOD'S MANAGED CARE DEMONSTRATION PROJECTS

Among its efforts to control both the level and growth of health care costs, DoD has experimented with managed care to improve the incentives facing providers. Broadly defined, managed care is a strategy for curbing costs by reducing the use of unnecessary and inappropriate care. Civilian experiments have shown that the effectiveness of managed care in reducing use and costs varies widely. Group-and staff-model health maintenance organizations (HMOs) have been the most successful in reducing the use and costs of health care because they have well-integrated financing and delivery systems. Looser forms of managed care such as preferred provider organizations (PPOs) have been less effective in generating savings.

Evidence of above-average use of medical care by military beneficiaries suggests that the military health care system might yield

significant savings under managed care. Since hospital use is high, the potential savings are great. The results of DoD's managed care demonstrations, however, have shown how difficult it is to achieve savings without a well-integrated financing and delivery system.

DoD has tried several approaches to managed care, beginning in 1988 with the CHAMPUS Reform Initiative in California and Hawaii. Later efforts include the Catchment Area Management demonstrations (begun in 1989); the preferred provider organization in the Southeastern region (started in 1990); the Army's Gateway to Care program, initiated in 1992 and based on DoD's Coordinated Care Program, which was outlined in the same year; and the TRICARE project, which began in October 1992. All of DoD's managed care demonstrations share three specific goals: to constrain costs, to increase beneficiaries' access to health care and overall satisfaction, and to maintain or improve the quality of care. These goals are not easily reconcilable.

Those demonstration projects represent quite different approaches to managed care. Although some are still in progress and results are incomplete, I will review what is known about cost control under three of these programs: the CHAMPUS Reform Initiative, the Catchment Area Management projects, and the Army's Gateway to Care program.

The CHAMPUS Reform Initiative

In 1988, DoD began the CHAMPUS Reform Initiative (CRI), a managed care demonstration program in California and Hawaii. More recently, in 1991, DoD started a small CRI program in New Orleans. CRI places a contractor in charge of all care to CHAMPUS beneficiaries. The contractor operates under a risk-sharing arrangement with the government, whereby the contract price can be adjusted under various circumstances.

Under CRI, beneficiaries are offered two alternatives in addition to standard CHAMPUS: CHAMPUS Prime (an HMO) and CHAMPUS Extra (a PPO). CHAMPUS Prime is similar to a health maintenance organization in that beneficiaries enroll in the plan and agree to obtain all of their care through designated providers (those in the contractor's civilian network or in the MTF).

In return for surrendering some freedom to choose their doctors, enrollees in CHAMPUS Prime benefit from less paperwork, enhanced coverage, and lower out-of-pocket charges than users of standard CHAMPUS. Indeed, accounting for other insurance as well, data from a Rand Corporation evaluation of CRI indicate that in 1990 the out-of-pocket costs and other insurance payments for active-duty dependents fell from an estimated 25

percent of total costs under standard CHAMPUS to only 8 percent under CHAMPUS Prime. Retirees and their dependents cut their out-of-pocket costs and other insurance payments from about 50 percent under standard CHAMPUS to only 12 percent under Prime.

CHAMPUS Extra is more like a preferred provider organization. It requires no enrollment. If beneficiaries choose to use providers selected by the contractor for a particular episode of care, then beneficiaries pay less out of pocket and benefit from the lower prices accepted by network providers.

CRI included several other features to coordinate use of care by beneficiaries between CHAMPUS and the military treatment facilities, as well as to improve access and curb costs. CHAMPUS referral centers were established to make efficient referrals between the civilian and military sectors to ensure that patients are treated in the least costly setting. Other measures to lower costs include reviews of use and quality and agreements on sharing resources that encourage the contractor to make greater use of the military treatment facilities.

Despite efforts to manage the use of care by beneficiaries, however, CRI apparently has not been effective in reducing total use and costs. A Rand study showed that, when costs in both CHAMPUS and the direct care

system are taken into account, 1990 per capita costs for all CHAMPUS users were roughly 11 percent higher in California and Hawaii under CRI than in matching control areas.

Cost increases stemmed from two specific factors: the higher overall level of outpatient care, particularly for Prime enrollees, and the higher overhead costs in CRI areas than in non-CRI ones. Successful health maintenance organizations are able to achieve savings by offsetting any increases in outpatient care and costs with reductions in inpatient use and costs. CHAMPUS Prime, however, has not functioned like a successful HMO because enrollees continued to have unimpeded access to military treatment facilities. CRI achieved savings on the civilian inpatient side by shifting care to underused military treatment facilities. But increases in the costs from higher outpatient care and administration overwhelmed these savings.

Administrative costs and contractor profits in CRI ran close to 25 percent of CHAMPUS health care costs, compared with about 5 percent under standard CHAMPUS. Finally, the generous health benefit package under CHAMPUS Prime attracted some ghost beneficiaries back into the military health care system, even encouraging some to drop their private insurance, and thus added to the overall costs of CRI.

Catchment Area Management

In contrast to CRI, where a private contractor was given the responsibility to manage beneficiaries' care under CHAMPUS, the Catchment Area Management (CAM) projects gave local military commanders the responsibility for management. Commanders managed all civilian and military health care services delivered to the enrolled population residing within a catchment area (the 40-mile radius around a military hospital). DoD's CAM demonstrations began in five different locations in 1989 and 1990 and will be completed in late 1993.

To constrain costs, CAM hospital commanders have relied on two major strategies: negotiating discounts with networks of health care providers and increasing the use of the military treatment facilities by hiring civilian providers. In an early evaluation of the CAM projects, CBO found that CAM managers succeeded in carrying out both of these strategies.

CAM's success in holding down costs, however, appears to have been mixed. As with the CHAMPUS Reform Initiative, total demand for outpatient care apparently increased within the CAM demonstration areas. Whereas outpatient visits by non-active-duty beneficiaries fell by 4 percent at most Army medical facilities, outpatient visits rose at the two CAM sites that

CBO examined--by 6 percent at Fort Sill and by 23 percent at Fort Carson. CBO's analysis found that Fort Sill failed to achieve offsetting inpatient savings, and total costs at the Fort Sill CAM rose 22 percent between 1989 and 1990 compared with a systemwide increase of just 12 percent during the same period. Cost containment was more successful at Fort Carson, where reductions in inpatient costs fully offset increases in the costs of outpatient care, and total costs rose by only 5 percent between 1989 and 1990.

Despite these different experiences, the CAM demonstrations offer the same basic message as CRI: DoD's ability to realize savings will depend on its ability to control the use of both outpatient and inpatient care at the military treatment facilities.

The Army's Gateway to Care Program

In 1992, the Army began its Gateway to Care Program. The Army's plan incorporates the key features of Catchment Area Management by placing a military commander in charge of all resources and care for the beneficiaries living within that catchment area.

Gateway to Care also includes a system of "capitated" budgeting. This approach links an MTF commander's budget to the population of beneficiaries served, using the total number of eligible people within a catchment area as a proxy for estimating the number of beneficiaries to be served. Under the Army's version of capitation, now in place in 13 catchment areas around the country, each local commander receives a fixed budget for every beneficiary projected to live in that catchment area. The budget is based on costs during a base period (fiscal year 1990, adjusted for two years' inflation). This simple budgeting rule radically alters the incentives inherent in the previous budgeting system. Under that system, a commander received funds based on past workloads. Providing more care therefore meant higher funding.

It is too soon to judge the overall effectiveness of the Gateway to Care program. The Army has reported initial overall success, but a handful of facilities have experienced significant cost overruns. These areas typically have high CHAMPUS costs, population changes related to base realignments and consolidations, or management problems.

KEY FEATURES NEEDED TO CONTROL COSTS

DoD's demonstration projects have shown both the promise and limits of managed care for holding down military health care costs. The challenge is now to combine the successful components of these projects with other initiatives that can increase efficiency and reduce costs.

Capitated Budgeting

DoD has experimented with various forms of capitation under the Gateway to Care Program and Catchment Area Management projects, and indirectly under the CHAMPUS Reform Initiative. Opponents of capitated budgets contend that, if per capita allowances are based on past levels of spending, the approach could "lock in" the inefficiencies in the military health care system, punishing efficient providers and failing to provide inefficient ones with adequate incentives to perform more efficiently. But supporters consider capitation an effective way to contain costs because it imposes a cap on the level of expenditures and eliminates the incentive for managers to increase their budgets by increasing their workload.

DoD has concluded that capitation budgeting holds promise. In fiscal year 1994, the department plans to move forward with capitated budgets for all the services based loosely on the Army's approach to capitation under Gateway to Care.

DoD's likely plan, which is still being reviewed, represents a three-pronged approach. First, budgets for some fixed costs that relate to the military's unique medical infrastructure--such as the Armed Forces Institute of Pathology or costs related to the air medical evacuation system--will not be provided on a capitated basis. Second, budgets for variable costs that relate to the military's unique medical infrastructure--such as extra hospital beds that are maintained to provide wartime capacity, or ophthalmic laboratories--will be capitated against the number of active-duty personnel. And third, budgets for costs that relate to the peacetime health care system will be capitated against the total number of beneficiaries, including active-duty and non-active-duty beneficiaries. For these beneficiaries, DoD plans to derive a per capita cost based on experience in the civilian sector, perhaps including experience under health maintenance organizations.

Capitation budgeting will not be easy to carry out. By its nature, it requires a defined population of beneficiaries, but the military's population is not clearly defined. In most cases, those eligible for care are not required

to enroll in a specific military health care plan. Rather, they can use the military's health care system or private-sector care, as they please.

Efficient use of resources cannot be achieved unless DoD accurately estimates the number of beneficiaries and how much military health care they use. Without this information, DoD will find it difficult to determine a per capita budget that builds efficiency into the system. But to get a firm estimate of the number of beneficiaries and the extent to which they rely on the military health care system, DoD would have to require beneficiaries to designate the system as their only provider of care, and enroll in a specific health care plan as a precondition for using the military system.

Even if the department institutes a system of enrollment, however, capitation by itself may not provide local commanders with the tools to use resources efficiently. The ultimate success of DoD's initiative will depend on the effectiveness of its strategies to control and monitor costs and to enforce capitated budgets.

Incentives for Beneficiaries

DoD has focused on controlling costs through improving incentives to providers, rather than on developing strategies to increase the cost-consciousness of beneficiaries. Indeed, compared with standard CHAMPUS, the benefit package under the CHAMPUS Reform Initiative in California and Hawaii significantly lowered cost-sharing requirements, particularly for enrollees in CHAMPUS Prime. Reduced cost sharing significantly exacerbated the problem of unrestrained demand by beneficiaries for health care.

If beneficiaries' costs are increased to raise cost-consciousness, copayments would be the most effective method because their cost sharing is required every time services are used. One-time premiums (and even deductibles) offer only partial impetus for beneficiaries to control their use of care.

Like capitated budgets, however, increased cost sharing will be difficult to establish. Beneficiary groups have historically viewed increases in cost-sharing requirements as a reduction in benefits. The results of the 1992 DoD Health Care Survey, which asked beneficiaries of the military health care system how much they would be willing to pay to join a civilian or military

health maintenance organization, should be useful in judging whether or not beneficiaries will pay more for guaranteed access to care through an HMO.

Changes in the CHAMPUS Reform Initiative

Despite the difficulty of implementing the types of changes necessary to hold down costs, DoD has shown that it is willing to try. Building on its experience in California and Hawaii, and acting under Congressional direction, the department has moved to expand the CHAMPUS Reform Initiative into sites in Texas and Louisiana where military bases are closing. CRI will provide health care to the retirees and other beneficiaries under age 65 who remain after the bases are gone.

In these areas where bases are closing, CRI will have a new benefit structure that includes an enrollment fee and higher copayments for certain services provided under CHAMPUS Prime. Enlisted active-duty families below the rank of E-5 are exempt from these charges. This new schedule of benefits, however, apparently will not apply in California and Hawaii. Instead, after considerable review, the CRI contract in those states is about to be extended under the original structure of benefits.

DoD has also considered adding a number of changes to improve both the structure and efficiency of CRI, where applicable, including expanding the local commander's authority over the use of CHAMPUS care and bringing rates of use at military treatment facilities more in line with the civilian sector. Most important, DoD plans to strengthen the role of the gatekeeper (primary care physician) to control Prime enrollees' use of care in the military treatment facilities.

THE LINK TO NATIONAL HEALTH CARE REFORM

Reform of the military health care system will have to take into account the changes soon to be proposed for the national health care system. How the military will be integrated into that new proposal is not yet clear. But regardless of whether or not some military beneficiaries are covered, the new national system is likely to have profound effects on military health care.

Some personnel now eligible to use the military health care system--retirees, for example, and perhaps dependents--may be covered under the new national system. In that case, DoD would be able to shrink its health care programs. Depending on how much reduction occurs, the department might

then have to create new programs to ensure that doctors with appropriate skills are available in the event of war.

If the military population is not included in national health care reform, then more of today's beneficiaries may want to use the military system. The proposed new system may increase costs to beneficiaries or limit their choice of providers, prompting more people to switch to military facilities. Such a shift could further increase DoD's health care costs.

Because the effects of the new national system on military health care could be profound, this Committee should consider the effects of all relevant national health care reforms when undertaking far-reaching changes in the military system. In making future decisions, the Committee may also want to consider DoD's comprehensive study of military health care. This so-called Section 733 report, which is due in December of this year, will presumably recommend reforms in the military health care system for peacetime and war and discuss the effects of national health care reform on the military system. The report may therefore provide the starting point for debate.

CONCLUSION

Holding down the cost of health care would make it considerably easier to reduce the defense budget while maintaining a capable military. Effective cost control, however, is likely to involve far-reaching changes, perhaps including increases in cost sharing and more effective limits on the amount of care that is provided.

Such changes would be difficult to bring about. But the military will not be alone. The reforms necessary to hold down costs in the national system of health care will also involve wrenching institutional change. In both systems, however, the alternative--tolerating rapid cost increases indefinitely--is unacceptable.

TABLE A-1. NUMBER OF BENEFICIARIES ELIGIBLE FOR MILITARY HEALTH CARE

Groups of Beneficiaries	Number of Beneficiaries (Thousands) 1990 (Estimated)	1993 (Estimated)	1998 (Projected)	Percentage Change 1990-1998	1993-1998
Active-Duty[a]	2,252	1,964	1,595	-29.2	-18.8
Active Dependents[b]	2,916	2,530	2,102	-27.9	-16.9
Retired and Dependents[c]					
Younger than 65	2,964	2,961	2,980	0.5	0.6
Older than 65	923	1,031	1,247	35.1	21.0
Total	9,055	8,486	7,924	-12.5	-6.6
Younger than 65	8,132	7,455	6,677	-17.9	-10.4
Older than 65	923	1,031	1,247	35.1	21.0

SOURCE: Congressional Budget Office projections based on the Department of Defense's Resource Analysis and Planning System.

a. Active-duty includes all uniformed personnel: active-duty, full-time National Guard and Reserve, United States Coast Guard, National Oceanic and Atmospheric Administration, and Public Health Service Commissioned Corps.

b. Active dependents include the dependents of all uniformed personnel.

c. Retired and dependents also include survivors of deceased active-duty or retired service members.

TABLE A-2. EFFECTS OF PERSONNEL REDUCTIONS ON DIRECT CARE COSTS AND COMPOSITION OF CARE PROVIDED TO BENEFICIARIES IN FISCAL YEAR 1998

Groups of Beneficiaries	Base Case[a]	Cut Medical Personnel by 5 Percent[b]	Cut Medical Personnel by 10 Percent[c]
Composition of Direct Care			
Inpatient Admissions[d]	677,690	665,392	649,147
Percentage Distribution of Care			
Active-duty	30.11	30.66	31.42
Active dependents	31.12	31.04	31.05
Retired and dependents			
Younger than 65	23.78	23.36	22.87
Older than 65	14.99	14.94	14.65
Outpatient Visits	38,326,074	37,825,574	37,255,862
Percentage Distribution of Care			
Active-duty	31.39	31.80	32.29
Active dependents	34.24	34.12	33.96
Retired and dependents			
Younger than 65	28.24	27.89	27.49
Older than 65	6.13	6.19	6.26
Direct Care Costs			
Total Cost[e] (In billions of dollars)	8.90	8.76	8.59

SOURCE: Congressional Budget Office projections based on the Department of Defense's Resource Analysis and Planning System.

NOTE: Assumes proportionality between staffing and capacity in military medical facilities.

a. Base case assumes an active-duty force of 1.4 million by 1997 and no cuts in medical personnel from 1990 levels.

b. Assumes a cut in medical personnel of 5 percent from 1990 levels.

c. Assumes a cut in medical personnel of 10 percent from 1990 levels.

d. Inpatient admissions are tracked on the basis of discharges in the direct care system.

e. Rough estimate of how military health care resources are allocated between CHAMPUS and the direct care system, based on the projected demand for care by beneficiaries between the two delivery systems and the costs associated with this allocation of care between the military and civilian sectors.

TABLE A-3. EFFECTS OF PERSONNEL REDUCTIONS ON CHAMPUS COSTS AND COMPOSITION OF CARE PROVIDED TO BENEFICIARIES IN FISCAL YEAR 1998

Groups of Beneficiaries	Base Case[a]	Cut Medical Personnel by 5 Percent[b]	Cut Medical Personnel by 10 Percent[c]
Composition of CHAMPUS Care			
Inpatient Admissions	192,111	201,510	214,205
Percentage Distribution of Care			
Active-duty[d]	0	0	0.01
Active dependents	43.27	43.34	42.98
Retired and dependents			
Younger than 65	54.19	53.17	51.78
Older than 65[d]	2.54	3.49	5.23
Outpatient Visits	7,911,556	7,990,466	8,356,948
Percentage Distribution of Care			
Active-duty[d]	1.54	1.53	1.48
Active dependents	35.07	34.74	35.94
Retired and dependents			
Younger than 65	62.41	62.69	61.49
Older than than 65[d]	0.98	1.04	1.09
CHAMPUS Costs			
Total Cost[e] (In billions of dollars)	2.72	2.81	2.97

SOURCE: Congressional Budget Office projections based on the Department of Defense's Resource Analysis and Planning System.

NOTE: Assumes proportionality between staffing and capacity in military medical facilities.

a. Base case assumes an active-duty force of 1.4 million by 1997 and no cuts in medical personnel from 1990 levels.

b. Assumes a cut in medical personnel of 5 percent from 1990 levels.

c. Assumes a cut in medical personnel of 10 percent from 1990 levels.

d. Civilian care that is not reimbursed by CHAMPUS, but paid for by other sources.

e. Rough estimate of how military health care resources are allocated between CHAMPUS and the direct care system, based on the projected demand for care by beneficiaries between the two delivery systems and the costs associated with this allocation of care between the military and civilian sectors.