



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

April 29, 2011

Honorable Joe Wilson
Chairman
Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

As you requested, the attached analysis explains in more detail CBO's estimate of the Administration's proposal to place certain limitations on enrollment in the Uniformed Services Family Health Plan. CBO estimates that enacting this proposal would reduce direct spending by \$104 million over the 2012-2021 period.

I hope this information is helpful. The CBO staff contact for this analysis is Matt Schmit.

Sincerely,

A handwritten signature in black ink that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf

Attachment

cc: Honorable Susan A. Davis
Ranking Member

Honorable Joe Wilson
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cc: Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services

Honorable Adam Smith
Ranking Member

Honorable Carl Levin
Chairman
Senate Committee on Armed Services

Honorable John McCain
Ranking Member

April 29, 2011

Estimate of the Administration's Proposal to Limit Enrollment in the Uniformed Services Family Health Plan

The Administration's budget request for fiscal year 2012 includes a proposal to begin limiting enrollment in the Uniformed Services Family Health Plan (USFHP). CBO's analysis indicates that because of uncertainty about the process used to determine the payment rates, providing health care through the USFHP probably costs the government more than providing that care through other federal health programs. CBO estimates that enacting the proposal would reduce federal direct spending by \$104 million over the 2012-2021 period. An explanation of that estimate is provided below.

Background

The Uniformed Services Family Health Plan is an association of six nonprofit Health Maintenance Organizations that took ownership and control of Public Health Service hospitals in the early 1980s. By law, the Department of Defense (DoD) is required to enter into agreements with those entities to provide care to beneficiaries of the military health system (10 U.S.C. 1073 note). Beneficiaries who live in a location served by one of the six HMOs may elect to discontinue their regular TRICARE or Medicare coverage and instead enroll in USFHP. (TRICARE is the military's health care program.) Currently about 110,000 individuals are enrolled in USFHP plans; most of those individuals are military retirees or dependents of retirees, and about 40,000 are Medicare-eligible.

CBO estimates that DoD's payments to USFHP plans will total about \$1.1 billion in 2011. Of that amount, about \$720 million will be for Medicare-eligible beneficiaries. Per capita payments for Medicare-eligible beneficiaries are paid from the Department of Defense Medicare-Eligible Retiree Health Care Fund (MERHCF) and are considered mandatory. For those enrolled in USFHP, there are no reimbursements or cost sharing by Medicare.

Payments to the USFHP entities are made on a fixed per capita basis. The plans receive a fixed dollar amount for each individual enrolled in their plan, with appropriate adjustments for age, gender, and geographic price differences. Once the payments are made, the USFHP plans assume all risk for the health care costs incurred by enrolled individuals. By law, the payments are supposed to reflect the actual historical cost to the USFHP plans of providing care to the enrolled beneficiaries (also referred to as the "experience rate"). However, the payments are not supposed to exceed the cost that would have been incurred by the federal government if those enrollees had received their

care in military treatment facilities, the regular TRICARE health benefit programs, or Medicare/TRICARE-for-Life.¹ That limit on payments is also referred to as the “ceiling rate.” The ceiling rate is meant to ensure that the cost to the government of providing health care through USFHP is, at the very least, no greater than if the care was provided through other federal health programs.

In the President’s fiscal year 2012 budget request, the Administration proposes to close off USFHP enrollment to Medicare-eligible beneficiaries. Those currently enrolled in USFHP would be allowed to remain in the program for as long as they wish. However, anyone who enrolled after the end of 2011 would be forced to leave USFHP once they reach the age of 65. At that point, such individuals would move to the regular Medicare/TRICARE-for-Life benefit (see footnote 1). The Administration believes this proposal would result in a net savings to the federal government because (1) the actuaries for the Office of the Secretary of Defense (OSD) believe that DoD is paying the USFHP plans rates in excess of what it would normally cost to provide care to those populations under Medicare/TRICARE-for-Life, and (2) because a small number (about 9 percent) of Medicare-eligible beneficiaries enrolled in USFHP do not pay Medicare Part B premiums, which they would have to pay if they were instead forced to use Medicare/TRICARE-for-Life.

CBO’s Analysis

In theory, if the USFHP plan rates are set correctly, contracting with USFHP should not result in increased costs to the federal government, and hence there should be no savings from this proposal. However, both the experience rates and the ceiling rates are speculative and difficult to accurately determine. Beneficiaries in DoD’s health system receive care from multiple different sources in both the federal government and private sector. Estimating the appropriate rates requires compiling imperfect data and making adjustments based on assumptions about the health of the people who enroll in USFHP and the kinds of costs they might incur if they instead received care from other government benefit programs.

Given the range of uncertainty around the rates, there is some probability that the rates are set too high and some probability that they are set too low. It is highly unlikely that the rates exactly equal what it would normally cost the government to provide health care to TRICARE beneficiaries.

¹ The military’s health care program, TRICARE, comprises nine health plans that cover uniformed service members, retirees, and their dependents in the United States and abroad. When a beneficiary of the military health system becomes eligible for Medicare, they usually move to the TRICARE-for-Life program. Under TRICARE-for-Life, Medicare acts as the first payer and TRICARE provides secondary wrap-around coverage that covers almost all remaining out-of-pocket costs. There are no enrollment fees for TRICARE-for-Life, but beneficiaries are required to enroll in and pay premiums for Medicare Part B.

CBO believes that the evidence suggests the rates paid to the USFHP plans exceed what it would cost the government to provide care under Medicare/TRICARE-for-Life. That conclusion is based on a number of factors:

- DoD recently contracted with an independent consulting firm (the Hay Group) to evaluate their USFHP rate process. The firm noted in its final report that the lack of a clear definition of the experience rate had caused the ceiling rate to become the de facto negotiating point in annual rate negotiations.² CBO believes this result significantly decreases the likelihood that the amounts paid to USFHP are equal to or less than the cost to provide care under Medicare/TRICARE-for-Life.
- Analysis by DoD’s actuaries indicate that USFHP is costing the government more than Medicare/TRICARE-for-Life. Their estimates use Medicare data for those who use TRICARE-for-Life and show that the current ceiling rates could be as much as 20 percent higher than they should be (after adjustments for geography and age). The DoD office that helps establish the ceiling rates uses county level expenditures for all Medicare beneficiaries. CBO has reviewed the methodology used by the actuaries and agrees that the use of data derived from the TRICARE-for-Life population is probably a better indicator of the health care costs for this beneficiary group.
- A significant difference between the ceiling rates developed by the USFHP program managers and the OSD Office of the Actuary centers around the use of health status adjustments. The per capita rates developed by the USFHP program office are adjusted upward with “health status” factors to account for the fact that USFHP plans may be attracting enrollees who are sicker than beneficiaries who prefer to use other government health benefit programs. For fiscal year 2011, those adjustments increase the underlying per capita rates used for USFHP by over 20 percent. CBO is concerned that the model used to generate the health status adjustments for USFHP may have an inherent upward bias.³

² Hay Group, *Development of Capitation Rates for the Designated Provider Program: Review of Current Methods and Potential Alternative Approaches* (prepared for the Office of the Secretary of Defense, November 18, 2010) p. 15.

³ The health status adjustments used for the USFHP ceiling rates are generated using the Medicare Hierarchical Condition Categories (HCC) model, which was originally developed to adjust payments to Medicare Advantage plans. Since the Centers for Medicare and Medicaid Services (CMS) began using the HCC model in 2004 there has been some concern that differential reporting of risk-adjustment factors in Medicare Advantage plans and the fee-for-service sector results in an upward bias in payment adjustments for beneficiaries enrolled in Medicare Advantage plans. CMS has continued to make adjustments to its HCC model to address those issues, but it should be of concern here given the prominence of the health status adjustment in constructing the USFHP ceiling rates. See Medicare Payment Advisory Commission, *Medicare Payment Policy: Report to the Congress* (March 2011) p. 309. Also see Congressional Budget Office, *Designing a Premium Support System for Medicare* (December 2006), pp. 10-11.

- In its analysis of the USFHP rate building process, CBO identified several areas where additional costs were included in the ceiling rates that perhaps should not have been. For instance, the rates include an adjustment of \$10 to \$20 per month for care provided by the USFHP plans that would normally have been provided by the Department of Veterans Affairs (VA). There is nothing in the underlying statutes that prohibits a USFHP enrollee from using VA health care and we have seen no evidence that those enrolled in the VA health system are forgoing all care at VA facilities in favor of USFHP. While VA does seek reimbursement from DoD health plans in certain instances, it is unlikely that all of those costs are being borne by USFHP rather than VA.⁴

In our estimate of the Administration's proposal, CBO used rates that are halfway between the 2011 ceiling rates negotiated by DoD and rates estimated by the OSD Office of the Actuary. Because we only have two sets of rates to compare and there is significant uncertainty around each of them, we have no basis with which to form a more accurate distribution of possible outcomes. Thus, following our standard approach in such cases, CBO estimates the actual rates should be halfway between the two DoD calculations (see Table 1).

After applying those rates to the appropriate population numbers and taking into account mortality and cost growth, the rates CBO calculated would result in mandatory savings of \$104 million over the 2012-2021 period when compared to current USFHP ceiling rates (see Table 2). Spending from the MERHCF would be reduced by \$521 million over that period, while spending by Medicare would increase by \$422 million, CBO estimates. In addition, CBO estimates that receipt of Medicare Part B premiums would increase by \$5 million over the 2012-2021 period, because all those individuals who would have previously enrolled in USFHP would have to enroll in Medicare B so they could use the TRICARE-for-Life benefit.

⁴ Since CBO sent its preliminary cost estimate of the Administration's proposal to the Congress, the USFHP program office has proposed some changes to its ceiling rate methodology. One of the changes they are proposing is the use of Medicare expenditure data from the TRICARE-for-Life population rather than county level Medicare data for the population at large. They are also proposing to eliminate the use of the adjustment for care that would have otherwise been provided by VA. It is unlikely that these changes could be formally adopted until late in fiscal year 2011; and their impact on the negotiated rates for future years remains to be seen.

TABLE 1. ESTIMATES OF PER CAPITA HEALTH CARE COSTS FOR MEDICARE-ELIGIBLE BENEFICIARIES OF THE DEPARTMENT OF DEFENSE HEALTH SYSTEM

Age	Current USFHP Rates ^a	Based on Information from the OSD Actuary ^b	Rates Used by CBO for Estimates
65-69	\$14,785	\$10,866	\$12,826
70-74	\$18,174	\$13,549	\$15,862
75-79	\$21,119	\$16,491	\$18,805
80-84	\$22,938	\$19,164	\$21,051
85+	\$23,786	\$21,927	\$22,857

Sources: Congressional Budget Office based on information provided by the Department of Defense.

Note: USFHP = Uniformed Services Family Health Plan; OSD = Office of the Secretary of Defense.

- a. The USFHP rates actually vary based on gender and specific USFHP provider. The numbers here represent an enrollment weighted average of the 2011 rates negotiated for the various USFHP plans.
- b. To provide a fair comparison to the rates currently used by USFHP, the OSD Office of the Actuary reviewed health spending data from regions more likely to have a large USFHP presence and also made some adjustments for health status.

Comparison to Administration Estimate

The Administration estimates that this proposal would reduce outlays from the MERHCF by \$809 million over the 2012-2021 period. The President’s budget further estimates that those savings would be offset by \$530 million in increased outlays for Medicare, resulting in estimated net savings to the federal government of \$279 million over the 2012-2021 period.⁵

Note that CBO’s estimate of net savings are less than half the savings estimated by the Administration because the actuaries updated their rate estimates after the President’s budget for fiscal year 2012 was released and CBO is using those updated figures to inform our analysis. We also use more specific mortality assumptions, different per capita growth rates, and an updated effective date.⁶

⁵ In addition to the savings discussed above, there would also be associated decreases in DoD’s annual contributions to the MERHCF. Those annual payments are determined by DoD’s Office of the Actuary and reflect the added payments to the MERHCF necessary to ensure that fund has sufficient resources to cover the health costs of future DoD retirees who are Medicare-eligible. The payments show up as outlays from the military personnel appropriations and are exactly offset by receipt of those payments into the MERHCF. Therefore, those accrual payments have no net impact on federal outlays.

⁶ CBO’s estimate is based on proposed legislative language submitted by DoD to the Congress in April 2011. CBO’s estimate assumes that the new rules would go into effect near the beginning of fiscal year 2012.

TABLE 2. CBO AND ADMINISTRATION ESTIMATES OF PROPOSAL TO REQUIRE ENROLLEES TO LEAVE USFHP WHEN THEY REACH AGE 65

	Impact on Direct Spending by Fiscal Year, in Millions of Dollars											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021	2012-2021
CONGRESSIONAL BUDGET OFFICE												
MERHCF	*	-2	-6	-13	-25	-43	-64	-90	-121	-157	-46	-521
Medicare Part A	*	1	3	6	11	18	27	38	51	66	21	221
Medicare Part B	*	1	2	5	9	16	25	35	47	61	17	201
Part B Premiums	*	*	*	*	*	*	<u>-1</u>	<u>-1</u>	<u>-1</u>	<u>-2</u>	*	<u>-5</u>
Total ^a	*	*	-1	-2	-5	-9	-13	-18	-24	-32	-8	-104
ADMINISTRATION^b												
MERHCF	-1	-4	-12	-24	-43	-68	-99	-137	-183	-238	-84	-809
Medicare	<u>0</u>	<u>0</u>	<u>0</u>	<u>20</u>	<u>30</u>	<u>50</u>	<u>70</u>	<u>90</u>	<u>120</u>	<u>150</u>	<u>50</u>	<u>530</u>
Total	-1	-4	-12	-4	-13	-18	-29	-47	-63	-88	-34	-279

Sources: Congressional Budget Office and the Office of Management and Budget.

Note: MERHCF = Department of Defense Medicare-Eligible Retiree Health Care Fund;
 USFHP = Uniformed Services Family Health Plan;
 * = -\$500,000 and \$500,000.

- a. For this estimate, budget authority equals outlays.
- b. *Budget of the U.S. Government, Fiscal Year 2012*, pp. 189-190.