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DEFENSE HEALTH CARE

Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacles

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

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Defense Health Care: Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacles

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss proposed changes and improvements to the military health system (MHS). The year 2000 has been proclaimed by the Department of Defense (DOD) as the year to address the many problems confronting military health care. DOD considers health care one of its major quality-of-life issues important to maintaining a quality force and has asked for the Congress' assistance in dealing with health issues, much as it did last year with other quality-of-life issues such as pay and retirement.

Many suggestions for altering the health care system are being voiced. They spring from retirees' demands that DOD provide health care for life as promised in recruiting brochures, from the desire to address inequities in current benefits, from concerns about improvements needed for recruiting and retention, and from the overarching complaint that the military health system as it exists today just doesn't work. This has obviously created significant pressure to address the various concerns and possibly reform the military health care system. Your efforts to satisfy and address all these concerns require making major policy decisions, such as who should and can receive military health care benefits and at what cost to the beneficiary and the government.

While ultimately these decisions rest with the Congress, I am here today to provide information to assist you in making these difficult decisions. I plan to discuss the various proposals to expand the military health care benefit, especially those for older retirees, including describing the nature of the enhancement, the present or potential challenges in implementing these proposals, and overall cost implications.[1] My discussion will also focus on the broader perspective of the appropriate size and structure of the military health system – a fundamental consideration for any policy decision regarding the military health benefit. Additionally, I will discuss the obstacles that impede improvements in the TRICARE program, particularly in terms of accessing appointments and claims processing. My comments are based on recent analyses as well as a substantial body of work we have done over the past several years on the MHS, retiree issues, and TRICARE operations.

In summary, the various legislative proposals and DOD's fiscal year 2001 budget request offer benefit enhancements much-sought-after and popular with the beneficiaries, but would have limited impact on retention. Several

[1]For the remainder of this statement, the term "retirees" refers to military retirees and their dependents and survivors. Further, the term "older retirees" refers to retirees who are aged 65 and older.

would expand and/or make permanent existing demonstration projects aimed at improving access and pharmacy coverage for older retirees, who have seen their military health care benefits erode and are not eligible for the Federal Employees Health Benefits Program (FEHBP) like civilian government retirees. However, the experience to date of the Medicare subvention and FEHBP demonstrations pose many cost and operational concerns that should be fully assessed before final decisions to expand these projects are made. The cost implications of expanding the benefit as contained in the proposals are significant, potentially adding as much as $10 billion a year. Other proposals would eliminate cost sharing for active-duty dependents who obtain care from civilian providers, thus removing what many see as an inequity in the benefit structure. Eliminating cost sharing for health benefits, however, runs counter to conventional health care cost containment strategy because research has shown that the lack of cost sharing leads to unnecessary utilization and higher costs.

It appears to us that the most significant gap in military health care coverage is a pharmacy benefit for those older retirees who do not have access to military pharmacies. Targeting benefit enhancement to this need may provide the most benefit for the least cost in the short term. In the longer term, and on a broader level, we believe that the MHS size and structure need to be fundamentally reassessed in terms of how to best achieve its readiness mission. Some have suggested that the system can be made significantly smaller and provide even better training for wartime needs. If this is true, the savings achieved from such a substantial downsizing effort could provide the fiscal resources to fund expanded benefits, such as the government share of FEHBP premiums.

Mr. Chairman, you also asked that I address the obstacles and impediments that need to be overcome to make TRICARE more user-friendly and efficient. We have issued a number of reports on this topic and, generally speaking, improvements can and should be made. Among the most important are improvements in appointment scheduling and claims processing – the subject of most of the complaints voiced by beneficiaries and providers. Additionally, there appear to be significant efficiency opportunities remaining in DOD's pharmacy program.

Before addressing these issues in more detail, I would like to briefly summarize the pressures and challenges facing the MHS, because any discussion of altering it or its benefits must begin with an understanding of this complex system.

Challenges and Complexities of the Military Health System

The MHS is a large and complex organization with multiple responsibilities. Most care is provided through about 580 DOD medical centers, hospitals, and clinics worldwide, with regional networks of civilian providers supplying the remaining care. DOD also operates a 4-year medical university and an extensive graduate medical education program, trains health professionals to provide combat health care, conducts medical research on a wide range of social and environmental diseases, and oversees the operations of several hundred medical personnel on assignments around the world. Through these activities, DOD's health establishment responds to its two missions: wartime readiness -- maintaining the health of service members and treating wartime casualties; and peacetime care -- providing for the health care needs of the families of active-duty members, retirees and their families, and survivors. Today, about 8.2 million active-duty personnel, their dependents, and retirees are eligible to receive care in this estimated $16 billion-a-year program.

It is because of this dual role that DOD is often challenged in providing health care. During the Cold War, the MHS was designed to support a full-scale war with the Soviet Union, anticipating large numbers of casualties and a need for in-theater medical treatment facilities. Following the collapse of the Soviet Union, defense analysts believed future conflicts would be of limited duration and involve smaller numbers of troops. Given this changed threat, the overall size of the active-duty force has been reduced by one-third since the mid-1980s, requiring a smaller MHS, fewer military medical personnel, and the closure of a number of hospitals and clinics. In recent years, the number of military medical personnel has declined by 15 percent and the number of military hospitals has been reduced by one-third. Some critics suggest that the MHS is still twice as large as needed.

Meanwhile, the mix of the beneficiary population has changed over the past 15 years. Between 1985 and 1999, the percentage of active-duty beneficiaries, for whom the MHS is primarily intended to serve, declined from 26 percent to 19 percent. During this period, the percentage of older retirees grew from 7 percent to 17 percent. The MHS has become primarily a provider of care to beneficiaries other than active-duty members, with family members of active-duty personnel and military retirees making up about 80 percent of the beneficiaries. It is providing care to these nonactive-duty beneficiaries that has strained the MHS over the last decade.

The downsizing of the military structure and the growing demand for care from nonactive-duty beneficiaries was concurrent with significant growth in health care costs. Between 1980 and 1990, DOD health care costs grew by almost 225 percent, compared to about a 166 percent increase in national health expenditures. During this period, the medical portion of the Defense budget doubled, from 3 percent of the total to 6 percent. During the 1990s, the MHS budgets generally leveled off, but with increased health care costs, full funding of the military health care system continues to be an issue. DOD now estimates that $6 billion over present spending is needed to cover unanticipated costs over the next 5 years just to maintain the current program.[2]

To respond to the competing pressures from downsizing, increased costs, and the increased demand for care by an aging beneficiary population, DOD decided to adopt many of the changes occurring in the civilian health care arena, and implemented a managed care program called TRICARE in the mid-1990s. TRICARE offers beneficiaries three health care options: TRICARE Extra is the preferred provider option, TRICARE Standard is the fee-for-service option, and TRICARE Prime is the health maintenance option. Contractors, who are referred to as managed care support contractors, are responsible for processing claims, providing customer service (which may include appointment functions), and creating networks of civilian providers for the Prime and Extra Options. Only the Prime option requires beneficiary enrollment, and DOD considers it the best option for controlling costs and improving care access and quality. Active-duty members are automatically enrolled in Prime, but their family members and retirees under age 65 have the option to enroll. Retirees aged 65 and older are not eligible to enroll in Prime, but DOD has the authority to provide care to them (as well as any other nonenrolled beneficiary) in military treatment facilities (MTFs) as long as space and resources are available; retirees receive this space-available care at little or no cost. However, because priority for care is given to beneficiaries enrolled in Prime, the amount of space available care is decreasing, especially for older retirees.

Although TRICARE is considered as having a uniform benefit, the copayment structure of Prime has created an inequity. Beneficiaries who receive care at an MTF are not required to pay copayments, whereas those who receive care from a civilian network physician must pay a small copayment. Because the health care services available vary by size and

[2]DOD classifies unanticipated costs into “fact-of-life” and “Congressional actions” categories. Fact-of-life costs are those costs that are higher than budgeted for, such as contract price adjustments and increased pharmacy costs. Congressional actions are those costs attributable to new legislative mandates that were not funded by Congress, such as increased pharmacy benefits and custodial care.

type of military facility, so does beneficiaries' ability to get free care from the direct care system. When active-duty members and their families move from one base to another, they often have to relearn their health care program, including how to make an appointment, how much care can be provided at the MTF, and what portion of care must be obtained from civilian providers. These variations in health care offerings have caused confusion and inequities among beneficiaries.

It is important to point out that while it is becoming more difficult to receive no-cost care in DOD medical facilities, older military retirees generally have access to health care. Virtually all receive Medicare part A coverage.[3] To supplement part A, many older retirees pay the extra monthly premium required for Medicare part B which covers physician and other outpatient services. In addition, some purchase supplemental policies called Medigap from private insurers that provide additional coverage. Some of the policies provide prescription drug coverage up to specified limits. Furthermore, about one-half of older military retirees have private health insurance coverage. Finally, military retirees – though not their dependents – can receive health care benefits by enrolling in the Department of Veterans Affairs health care system.[4] Unlike federal government employees and retirees, military members and retirees are not eligible for FEHBP.

Older retirees who are able to receive health care from DOD report relatively high satisfaction with their care. A recent DOD survey showed that beneficiaries aged 65 and older appear to be more satisfied with their personal doctor, nurse, and medical facility than any other group. However, according to the survey, their overall satisfaction with military health care has declined. Since 1996, the percentage of older retirees satisfied with military health care has dropped from 71 percent to 63 percent. Beneficiaries including older retirees continue to report higher satisfaction with civilian care than military care. Despite having access to other sources of medical coverage, many retirees and others contend that DOD as a former employer promised them "free medical care for life," and that this promise has been broken. DOD has acknowledged that such a promise was implied. The statutory language does not entitle older retirees to medical care in military facilities but does allow them to receive care on a space available basis.

[3]Medicare Part A covers inpatient hospital, skilled nursing, and home health needs. Medicare Part B covers physician and other outpatient services, as well as home health services. Neither provides outpatient prescription drug coverage.

[4]The number of veterans who can enroll is subject to limits based on resources. However, such limits have yet to be imposed.

In response to these concerns, and as a result of legislation, DOD has begun efforts to improve the MHS for its beneficiaries. Demonstration projects targeted to older retirees have begun or are just beginning, including

- the Medicare Subvention demonstration, also known as TRICARE Senior Prime, through which older retirees can use their Medicare benefit to receive care from DOD, and DOD will be reimbursed for a portion of the cost of that care by the Health Care Financing Administration (HCFA), the agency that administers the Medicare program;
- the FEHBP demonstration, through which older retirees have access to most of the same health plans as federal civil service retirees, and agree to pay a share of the premiums;
- the TRICARE Senior Supplement project, through which older retirees can use TRICARE Standard and Extra to supplement Medicare, including coverage of prescription drugs; and
- the Pharmacy Pilot project, through which older retirees can obtain prescription drugs through DOD's mail-order program or network of retail pharmacies.

Although the introduction of managed care to the MHS is one of the most significant changes to the system over the last decade, other efforts have also been undertaken in an effort to improve the system. DOD and the military services' Surgeons General recognize that their medical system continues to evolve and its appropriate size and relative costs and effectiveness will continue to undergo intense scrutiny. As a result, in 1998, DOD began 29 separate initiatives to modernize MHS management. These initiatives were prompted by increasing concerns about whether the right medical resources were in the right places to meet readiness needs as well as to optimize peacetime health care. These initiatives address the full spectrum of issues within the health system, many of which we and others have reported on, such as centralized purchasing, pharmacy management, outsourcing functions, improved information systems, and increased access to appointments.

Observations on Proposals to Expand Benefits

A number of legislative proposals have been introduced to expand and enhance the military health benefit. Most of the proposals focus on enhanced benefits for older retirees, and would expand or make permanent the demonstration projects currently under way. These demonstration projects are designed to address the availability, cost, and coverage of health care for older military retirees, given the converging

effects of downsizing, a growing retiree population, and the introduction of TRICARE. These demonstrations are in early stages of implementation and, so far, conclusive evidence regarding beneficiary acceptance, program cost, and the Department's ability to adequately administer the demonstration projects has yet to be established. While these proposals offer benefits that are attractive to beneficiaries, they have significant cost implications and may not yield improvements in recruiting and retention. Predicting or estimating the cost implications is difficult, however, because DOD does not have adequate cost or utilization data upon which to base estimates.

Subvention Start-Up Raises Issues of Vifability and Effectiveness for DOD

Several bills have been introduced that would either authorize the expansion of the Medicare Subvention demonstration project or make the project permanent nationwide. The 3-year, six-site Medicare Subvention demonstration project was authorized by the Balanced Budget Act of 1997, which allows older retirees to enroll in a new DOD-run managed care plan called TRICARE Senior Prime. Under the demonstration, which ends December 31, 2000, Medicare can pay DOD for the health care provided to the older retirees enrolled in Senior Prime, subject to certain legislative requirements and conditions agreed upon by DOD and HCFA. The demonstration's stated goal is to implement an alternative for delivering accessible and quality care to older military retirees without increasing the cost to Medicare or DOD. A critical element of achieving this goal is establishing an accurate baseline for DOD's spending on older retirees; DOD receives payments from HCFA only when DOD's current spending on care for the demonstration has exceeded that baseline.

We found that the start-up period of Senior Prime was successful.[5] Despite unanticipated delays, the six demonstration sites met the requirements for Medicare managed care plans, enrolled substantial numbers of beneficiaries, and began delivery of health care services at the first site on September 1, 1998. Beneficiaries participating in the project seem pleased with the care they are receiving.

However, as a managed-care option, Senior Prime poses several challenges for DOD. While DOD's experience with managing care under TRICARE Prime might appear to be a model for Senior Prime, that experience has proven to be only partly transferable to the demonstration. Unlike Prime, Senior Prime is designed to participate with private plans in

[5] *Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues* (GAO/GGD/HEHS-99-161, Sept. 28, 1999).

the Medicare+Choice market.[6] Under this design, MTFs are expected to manage their resources so that costs on average do not exceed their capitated payment from Medicare – a fixed amount per enrollee. In addition, from a clinical perspective, DOD faces demands under Senior Prime that it does not face under Prime. First, the need to stay within the capitated payment makes the effective coordination of care and management of utilization more important than in Prime. Second, older retirees tend to have more chronic conditions and require more care than patients enrolled in Prime, and this also puts a premium on coordinating care. Third, Senior Prime, as a Medicare+Choice option, must offer a broader range of services, including home health care and skilled nursing facility care, than are offered under Prime.

Early indications are that subvention may not be a good business proposition for DOD – that is, its revenues from HCFA may not cover its costs. Fourteen months after the end of calendar year 1998, the first period for which DOD could receive reimbursement, DOD is just getting the data together to permit a final determination as to whether HCFA should provide reimbursement. It is questionable whether DOD will get any money from HCFA for 1998 because DOD's provision of care to the over-65 population may not have exceeded the required level-of-effort – the threshold that triggers Medicare payments.[7] For 1999, DOD may meet the threshold to obtain payment from HCFA, but questions remain whether those payments will even cover DOD's costs of purchasing care from private hospitals and physicians for subvention participants.[8]

While there is considerable interest in the program at the demonstration sites, our analysis suggests caution in generalizing to other possible subvention sites. About one-fifth of the eligible older retirees in the demonstration areas have enrolled in Senior Prime, which represents over 90 percent of the enrollment goal. However, there is no guarantee that interest at other sites would be the same. In fact, the enrollment rates at the demonstration sites differ considerably, with enrollment at some sites exceeding the goal, while at another site, only about one-half of the enrollment goal was achieved. In addition, the demonstration sites are not

[6]As an alternative to traditional fee-for-service Medicare, beneficiaries may choose the Medicare+Choice option, which permits them to enroll in private Medicare health maintenance organizations and other private health plans.

[7]We discuss the calculation of the subvention demonstration's level of effort and its role in determining Medicare payments to DOD in *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns* (GAO/HEHS-99-39, May 28, 1999).

[8]We reported that DOD lacks an information system that can produce credible cost data on its individual beneficiaries and groups, which also calls into question DOD's ability to manage its overall health care system in GAO/HEHS-99-39, May 28, 1999.

representative of all military health care service areas. For example, when the demonstration sites are compared to non-demonstration sites, we found that the demonstration sites have a disproportionate number of retirees living near military medical centers, which provide access to a broad range of services and are better positioned to provide the full continuum of Medicare services. Furthermore, DOD and HCFA chose the demonstration sites in part for their ability to meet the conditions of participation HCFA requires of private Medicare+Choice organizations, and at least some of the other facilities in the MHS may find it difficult to meet these standards. Finally, the authorizing legislation for the demonstration requires GAO to evaluate the project, answering questions about the quality of care that Senior Prime enrollees receive, their satisfaction with that care, the cost of the project to Medicare, and the effect of the project on the availability of care for the nonenrolled. This report will be completed in June 2001.

FEHBP Demonstration Has Low Enrollment and Uncertain Future

Several bills have also been introduced to provide DOD beneficiaries with access to FEHBP plans. Some of the legislative proposals would expand the demonstration project for older retirees to additional sites, while other proposals would give all retirees, regardless of age, and their family members, the opportunity to enroll in FEHBP. The DOD FEHBP demonstration is a 3-year test that allows older retirees, and their dependents and survivors[9] who reside in eight designated areas to enroll in health plans that participate in the permanent, civilian FEHBP. Specifically, the demonstration allows them to choose among fee-for-service plans offered nationally and managed care plans offered locally.[10] Offering FEHBP could provide additional coverage for services not covered under Medicare. For example, many of the plans provide coverage for prescriptions and place caps on out-of-pocket costs, and some offer dental benefits – none of which is offered by Medicare. Military retirees view the lack of access to FEHBP as a major inequity considering that federal civilian retirees are offered this program.

Coverage under this project began January 1, 2000, but as of February 2000, only 3 percent of the over 70,000 eligible to participate had enrolled. Relatively low enrollment in DOD FEHBP plans may not be surprising,

[9]In addition, Medicare-eligible members of a military retiree's family may enroll for self-only or family coverage–even if the military retiree is not Medicare-eligible. Also, Medicare eligibility is not required for two other categories eligible for this demonstration project: former spouses of military service members who have not remarried, and family members of a deceased active-duty or retired military service member.

[10]The plans open to older retirees in the demonstration are the same plans that participate in the civilian FEHBP. Certain plans were allowed to opt out of the demonstration if the plan's service area did not overlap the demonstration area substantially or if the plan was small.

given the alternative coverage available to demonstration eligibles. Many of them may be satisfied with their current health care coverage – for example, Medicare+Choice plans, employer-sponsored health insurance, and Medigap – or with no-cost, space-available access to military treatment facilities. Moreover, potential enrollees may consider the DOD FEHBP premiums to be too high, even though DOD pays a substantial portion of the total premium. The monthly premium paid by the enrollee ranges from $43 to $286 for self-only policies and from $87 to $605 for family policies, and the plans with lower premiums are generally the most popular. For example, Blue Cross/Blue Shield, which has the lowest fee-for-service premiums in the demonstration, accounts for 46 percent of demonstration enrollment, while the Postmasters Benefit Plan, which has the highest fee-for-service premiums in the demonstration, accounts for less than one-half of 1 percent of demonstration enrollment.

At least two additional factors might have depressed enrollment in the DOD FEHBP plans. First, eligibles might have been reluctant to enroll because the demonstration is temporary. Second, difficulties in the marketing campaign may have left potential enrollees without sufficient information to make enrollment decisions. The FEHBP informational materials were designed for civilian employees who had considerable experience with the program before they retired. By contrast, military retirees as a rule do not have this experience and the materials sent to them did not fully explain how the DOD FEHBP health plans and Medicare benefits fit together. As a result, many eligibles probably did not understand the advantages that FEHBP plans could offer. In addition, little information was provided in Spanish, the dominant language in Puerto Rico – a demonstration site that accounts for 12 percent of the demonstration's eligibles.

When the 5-week open enrollment period ended in mid-December 1999, the enrollment rate stood at less than 1 percent. In response, the Office of Personnel Management and DOD extended the open enrollment period for 60 days and sent eligibles additional information, including a pamphlet that answered questions about the demonstration and Medicare. In addition, DOD held town hall meetings in each demonstration area. After this extension period, enrollment had increased from the December level. Nonetheless, only 3 percent of eligibles have joined a DOD FEHBP health plan by mid-February 2000.

Given that the DOD is only 3 months into the demonstration, it is too early to state definitively which factors account for low enrollment and whether enrollment will increase next year. If DOD strengthens its marketing efforts during the next open enrollment period (fall 2000), the enrollment

rate may increase. However, if the perception of high premiums is deterring people from enrolling or if they are satisfied with their current coverage, then any increase in the enrollment rate may be modest.

While offering older retirees the opportunity to participate in the FEHBP could provide additional coverage for services not covered under Medicare, DOD has estimated that providing this option across the nation could cost as much as $1.6 billion annually. The potential costs could be significantly higher if legislative proposals creating a more generous benefit were to be adopted. One proposal recommends that all retirees and their family members be offered enrollment in FEHBP, with the government paying the full costs for certain retirees. Cost estimates for adopting this proposal run as high as $10 billion per year.

Pharmacy Benefit Would Fill Major Coverage Gap

Two bills and two demonstration projects just now beginning are designed to fill a significant gap in coverage for older retirees – coverage for prescription drugs. The Medicare program does not provide coverage for outpatient prescriptions – a major expense for older people, because people tend to use more prescription drugs as they grow older. We recently reported that an estimated 20 percent of Medicare beneficiaries have total individual drug costs of $1,500 or more a year – a substantial sum for many people lacking insurance to help pay for their purchases. Military retirees can get prescription drugs filled at MTFs for free, but these facilities are not readily accessible to all older retirees. DOD has a national mail-order pharmacy benefit that provides prescription drugs to active-duty members, their family members, and retirees under age 65, but older retirees can use this benefit only if they live in areas where bases have closed. The Pharmacy Pilot will provide access to DOD's national mail-order benefit and civilian network pharmacies to older retirees living in two locations that are not base closure sites and are not close to MTFs. Participating retirees must pay an enrollment fee and various copayments, depending on whether they obtain their medicine through the mail or at the retail pharmacy.

Older retirees participating in the TRICARE Senior Supplement demonstration project will also receive a pharmacy benefit similar to the benefit offered in the Pharmacy Pilot. This project, beginning this spring, will allow DOD to assess the feasibility of providing health coverage to older retirees through the TRICARE Standard and Extra options as a supplement to Medicare. The policy would provide coverage for most of the retirees' out-of-pocket costs for Medicare-covered services. Even though the older retirees must have Medicare Part B and pay an annual enrollment fee of $576, this project provides coverage at considerably

lower costs than standard Medicare supplemental policies. In 1999, the annual premium for a Medigap policy with a $1,250 annual limit on drug coverage ranged from approximately $1,400 to $3,000.

DOD estimates that the annual cost of expanding the Pharmacy Pilot project to all older retirees would be between $400 and $600 million, and to provide the TRICARE Senior Supplement could cost as much as $650 million per year. In addition to the Pharmacy Pilot project for older retirees, the Congress also mandated DOD to have a redesigned pharmacy benefit project in place for all currently eligible beneficiaries. Savings achievable through a drug benefit redesign such as we recommended in 1998 could help offset the cost of providing a mail-order and retail pharmacy benefit to the older retirees.[11]

Proposals Eliminating Copayments for Family Members Inconsistent With Private Sector Practices

Several bills propose that family members of active-duty personnel enrolled in TRICARE Prime no longer be required to pay a copayment (currently between $6 and $12 per visit) when they receive care from civilian health care providers. According to the proposals, eliminating the copayment is a quality-of-life improvement for the active-duty personnel and their families and provides a uniform benefit for them. DOD has included $50 million in the fiscal year 2001 budget request to cover this proposal, stating that this will stop service members from having to pay out of their own pockets for health care simply because no appointment is available for their family members in a military hospital or clinic. However, it is important to remember that some family members choose to obtain care from civilian providers, and are well aware of the out-of-pocket cost they will incur.

While uniformity in benefits is desirable and the elimination of copayments will be popular among beneficiaries, we and the Congressional Budget Office have reported that the lack of copayments results in unnecessary utilization, which in turn could exacerbate difficulties military beneficiaries have accessing the military health system.[12] Another way to achieve uniformity is to establish small copayments for care provided in the MTFs, as is standard practice used in the private sector to curb excessive use.

[11] *Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness* (GAO/HEHS-98-176, Jun. 12, 1998).

[12] *Defense Health Care: Appointment Timeliness Goals Not Met; Measurement Tools Need Improvement* (GAO/HEHS-99-168, Sept. 30, 1999) and Congressional Budget Office, *Maintaining Budgetary Discipline: Spending and Revenue Options* (Washington, D.C., Apr. 1999).

Dissatisfaction with Family Health Care and Retiree Health Benefits Are Not Causing Servicemembers to Leave

As stated earlier, health care is considered one of the key quality-of-life issues in the military. Health care is important to active-duty personnel, and many report dissatisfaction with various aspects of the military health care system, including getting appointments, and waiting times at the MTFs. However, as we reported to you last week, health care was not among the most common reasons cited by active-duty personnel for considering leaving the military. Data from DOD's 1999 survey of active-duty personnel indicates, for example, that only about 5 percent of the force consider military health care for their families or themselves to be the primary reason for leaving or for staying in the service.

Health care is also a very important issue to military retirees and, as noted earlier, there is growing discontent among retirees with the health care benefits available to them. However, health care for military retirees has even less effect on retention decisions. Only 3 percent of the force indicated that health care benefits for retirees was a top reason to leave. However, 81 percent of them reported they were likely or very likely to stay in the military for at least 20 years.

Larger Context of Right-Sizing the MHS Needs to be Considered

As I discussed earlier, the MHS is facing significant fiscal pressures. Thus, proposals to expand the program should be carefully crafted to avoid further erosion of the financial condition of the MHS. Also, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what individuals and our nation can afford. This concept applies to all major aspects of government including decisions about military health care. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of the military health system for current and future generations within a broader context of also providing for other important DOD and national needs.

However, in terms of the MHS, an even more fundamental factor must be considered. For several years, the size and structure of the military health system relative to its primary wartime mission have been under evaluation, and some have suggested that further downsizing and restructuring in line with reduced wartime requirements may be in order. It is important to factor the potential for such changes into the choices made about providing care for an aging population through major new benefit programs. DOD's shift toward managed care has increased its emphasis on primary care and specialty care of chronic illnesses and therefore it is in a better position to meet the needs of its nonactive-duty population. However, a health system that is configured to meet these

needs may be less well suited to the demands of major mobilization and wartime conditions.

Some have suggested that if the system were being designed to meet today's wartime requirements, it would be very different. For example, a 1995 study suggested that DOD could reduce its capacity by two-thirds, eliminating all but 11 of its hospitals, and still be able to meet a higher percentage of wartime requirements than during the Cold War.[13] The Congressional Budget Office has estimated that if reductions of this magnitude were made in the system, such substantial savings could occur that DOD could fund the government share of FEHBP premiums for beneficiaries other than active-duty service personnel.

However, before deciding on proposals that either retain care for older beneficiaries in military facilities or provide for them entirely through civilian sources, the training needs of DOD physicians may have to be evaluated. To uphold the "medical readiness" tenet, military medical facilities have a mix of patients of all ages to keep physicians prepared for wartime. This may be difficult if more care is provided through civilian sources. Moreover, it is important to consider the broad issue of whether the physician mix of the military medical system is or should be adequately equipped and trained to provide care for older patients.

Problems With Tricare Today

Altering and expanding health care benefits is one approach to dealing with beneficiary dissatisfaction and increasing needs for care from an aging population. Another is to identify and address TRICARE program management and operational problems. Over the past several years, we along with others have reported on a number of program issues and made recommendations to make the program more user-friendly, less complex, and more efficient and business-like. However, the program still contains a number of impediments or barriers which need to be addressed in order for the program to achieve its intended results. Today I will focus on what I believe are the two most pressing issues – the difficulty of obtaining appointments for care; and the need to pay claims for care provided by civilian providers in an accurate, timely, and efficient manner. Improving services in just these two dimensions would likely go a long way toward increasing beneficiary satisfaction.

[13]The Rand Corporation, *The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health Care System* (1995).

Need to Improve Appointment-Making Processes

Since the inception of TRICARE, beneficiaries have complained about the difficulties they encounter in making appointments for health care, and those complaints continue. Even after enrolling in Prime, beneficiaries are not assured that they can obtain an appointment within the prescribed access standards. Also, just determining whom to call for an appointment can be difficult. In some areas, beneficiaries call a central number at the MTF for all appointments; in others they call the MTF clinics directly; and in still others, a central number operated by contractors. This has created confusion and dissatisfaction within the beneficiary population.

As we reported in September 1999, active-duty and other Prime enrollees have not been able to obtain appointments within the prescribed timeliness standards.[14] Moreover, performance in meeting standards is about the same for active-duty members, who have the highest priority, and nonenrolled beneficiaries, who have the lowest priority. For example, about 20 percent of certain appointments for active-duty members were not scheduled within the standards. In some cases, appointments are scheduled outside the standards at the beneficiary's request for a later appointment to meet personal needs. However, appointments within the standards for enrolled beneficiaries may not be available because nonenrolled beneficiaries have filled available appointment slots ahead of them. There are several options DOD could test to improve the availability of appointments for active-duty and other enrolled beneficiaries. These include more vigorously enforcing systemwide access priorities, to the extent of giving appointments booked for nonenrollees to enrolled beneficiaries in need of an appointment within the standards.

We are currently assessing the extent to which the managed care support contractors in Regions 1, 2, 5, and 11 are able to schedule appointments for beneficiaries (one of the administrative tasks they are paid to perform). In these regions, beneficiaries are instructed to call contractor staff using a single toll-free number to make appointments at any MTF within their region. However, our work to date shows that in these four regions, the contractors scheduled only about one-fourth of all the appointments. The primary factor affecting the contractors' ability to schedule appointments is the extent to which the MTFs retain the booking function in the MTF. For example, in one region, over one-third of the appointments are withheld from the contractor. When a beneficiary calls the contractor to request an appointment that is restricted, the appointment clerk may transfer the beneficiary to the MTF, take a message and call the beneficiary back, or just tell the beneficiary he or she has to call the MTF

[14] *Defense Health Care: Appointment Timeliness Goals Not Met; Measurement Tools Need Improvement* (GAO/HEHS-99-168, Sept. 30, 1999).

directly. Thus, what was intended to be a simplified, more user-friendly process can now be a source of confusion and complexity, with beneficiaries unsure as to whether to call the contractor or the MTF to schedule appointments.

MTF physicians told us that some specialty and primary care appointments should be retained and scheduled only by MTF clinic staff due to the complex nature of the care to be provided. However, when comparing like clinics in different MTFs, we found considerable differences in the percentage of appointments scheduled by contractors. For example, the percentage of dermatology appointments booked by contractors ranged from 88 percent in one clinic to zero percent at six other dermatology clinics. Similarly, the contractor scheduled 97 percent of optometry appointments at one clinic, while zero percent were scheduled at eight other optometry clinics. This difference suggests that the medical rationale may be less of a factor than physician resistance to the system and desire to retain control of the appointment function in the MTF.

Program Complexity Impedes Claims Processing Efficiencies

Claims adjudication is the end result of a number of processes associated with the delivery of health care benefits. Everything from initial enrollment and eligibility, to data requirements and reporting needs, can have a profound effect on claims adjudication. Last summer, we reported on claims processing issues that have plagued TRICARE since its inception.[15] We found that a fundamental reason for these problems is the need to thoroughly edit claims before paying them. However, in TRICARE's case, only 47 percent of all claims initially pass through the claims adjudication system without intervention, which is significantly below the industry standard of 75 percent. The remaining claims are manually reviewed, a process that extends processing time and increases opportunities for error. Another factor affecting claims payment is that less than 20 percent of hospital and professional claims are submitted electronically, significantly less than the industry average of 90 percent electronic submission. Electronic claims are faster, more accurate, and less expensive to process than paper claims, which currently cost an average of $7 per claim under TRICARE – double the industry standard.

In response to our work, DOD has contracted with a consulting firm to assess the claims processing system. Initiatives identified through this effort include proposals to improve customer service, provider and

[15] *Defense Health Care: Claims Processing Improvements Are Underway but Further Enhancements Are Needed* (GAO/HEHS-99-128, Aug. 23, 1999).

beneficiary education, and program-wide data quality; and increase electronic claims processing. For example, DOD plans to utilize Medicare protocols for electronic claims submission, including the use of Medicare's provider identification numbers. In addition, DOD has authorized contractors to delay the payment of paper claims as an incentive for providers to submit electronically. This initiative mirrors Medicare's standards for faster processing of electronic claims.

Concluding Observations

As we have reported over the years and reiterated today, the military health system continues to be plagued with operational problems which are a source of beneficiaries' and providers' discontent. Problems such as accessing appointments and processing claims, while significant, are not insurmountable. Increased management attention from DOD could go a long way toward correcting these and other deficiencies, and thereby increasing beneficiary satisfaction.

Further enhancing health benefits, especially for retirees, is likely to be an expensive proposition and, with budget projections showing health care consuming an ever-larger share of the DOD budget, efforts to shore up health care delivery must be balanced against the effect that any changes might have on establishing permanent claims and, thus, future resources. An important factor to consider in this debate is whether further effort to "right-size" the MHS would result in savings that could be used to fund enhanced health benefits.

Mr. Chairman, this concludes my prepared statement. I will be happy to respond to any questions you or other members of the Subcommittee may have.

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