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MEDICARE SUBVENTION DEMONSTRATION

Pilot Satisfies Enrollees, Raises Cost and Management Issues for DOD Health Care

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Abbreviations

BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare and Medicaid Services
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
DSH	disproportionate share hospital
GME	graduate medical education
HCFA	Health Care Financing Administration
LOE	level of effort
MTF	military treatment facility
NDAA	National Defense Authorization Act for Fiscal Year 2001
TMA	TRICARE Management Activity
TROA	The Retired Officers Association

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Congressional Committees

In recent years, the Congress has sought to improve health care benefits for Medicare-eligible military retirees. In the past, these retirees[1] were not eligible for the Department of Defense's (DOD) TRICARE health care program and were able to get care from military treatment facilities (MTF) only when space was available. By law, DOD was not responsible for providing a full range of services to these Medicare-eligible retirees and could not receive payments from Medicare for those services that it provided them. The DOD Medicare subvention demonstration,[2] established by the Balanced Budget Act of 1997 (BBA),[3] was designed to test an alternate way of providing health care coverage to retirees through DOD.

The demonstration allowed retirees to enroll in new DOD-run Medicare managed care plans, known as TRICARE Senior Prime, at six sites. The Senior Prime plans offered enrollees the full range of Medicare-covered services as well as additional TRICARE services, with minimal copayments. At the same time, Senior Prime gave enrollees improved access to MTF care. The demonstration authorized DOD to receive payment from Medicare if MTFs continued to spend as much on retirees as they had in the past. The demonstration, which began in 1998, was originally authorized for a 3-year period.

During the demonstration period, new legislation altered the manner in which retirees receive health care coverage through DOD. Under provisions of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (NDAA),[4] military retirees age 65 and older became eligible for TRICARE coverage as of October 1, 2001. The NDAA also extended Senior Prime for 1 year, through December 2001, with the possibility of extension and expansion. DOD has decided, however, not to extend Senior Prime or implement it in other areas. Nonetheless, DOD's

[1]Throughout this report, we use the term "retirees" to refer to military retirees and their dependents and survivors aged 65 and over, unless otherwise noted.

[2]"Subvention" means a transfer of money from one federal department to another.

[3]P.L. 105-33, sec. 4015, 111 Stat. 251, 337 (42 USC 1395ggg).

[4]P.L. 106-398, sec. 712, 114 Stat. 1654, 1654A-176.

experience with Senior Prime illustrated issues that DOD may face in its future efforts to serve military retirees and other beneficiaries.

The BBA directed us to evaluate the demonstration during its initially authorized period.[5] The law required us to study a broad range of issues, including the demonstration's effects on beneficiaries, its costs to DOD and Medicare, and any difficulties that DOD encountered in managing the demonstration. As mandated by the BBA, we have issued a series of reports on the demonstration to date.[6] This is our last report on the demonstration. Our objectives are to describe (1) the demonstration's appeal to beneficiaries, why some joined and others did not, and the reactions to the demonstration of those who joined and (2) difficulties DOD encountered in managing patient care and costs.

To address these issues, we drew on our interviews with DOD and Health Care Financing Administration (HCFA)[7] officials and our visits to the demonstration sites both during the start-up phase and toward the end of the initial demonstration period. In addition, we analyzed data from our mail survey of about 20,000 Medicare-eligible military retirees in the demonstration areas. We supplemented the survey data with reports and administrative data from DOD and HCFA, but did not independently verify their data. (See appendix I for a discussion of our survey and methods.)

Several features of the demonstration limit the generalizability of our findings. First, the demonstration sites are not representative of all MTF service areas. MTF resources are greater in the demonstration areas than in most other areas.[8] In addition, sites' ability to support the demonstration was a factor in site selection. Second, the sites in many ways remained in a mode of implementing the demonstration; consequently, we were unable to observe Senior Prime in a period of routine operation. Third, our

[5]Although the demonstration was extended for 1 year, our evaluation is confined to the initial demonstration period, which ended December 31, 2000.

[6]A list of related GAO products is included at the end of this report.

[7]On June 14, 2001, the secretary of health and human services announced that the name of HCFA had been changed to the Centers for Medicare and Medicaid Services. In this report, we refer to HCFA when our work and findings apply to the organizational structure and operations associated with that name.

[8]Although most retirees eligible for the demonstration lived near a military medical center offering a wide array of specialty care, in other areas far fewer live near MTFs that offer similar services.

findings are particular to the context in which Senior Prime took place. As an important demonstration project, Senior Prime received a great deal of management attention at a limited number of locations; if it had been expanded nationwide, results might have differed. Finally, we cannot generalize retirees' demand for Senior Prime to their future demand for MTF care, in large part because retirees will be able to obtain care in the civilian sector with TRICARE covering most of their Medicare cost-sharing.

Our evaluation of costs was confined to 1999, the first full year of the demonstration, because more recent data were not available in time for our analysis. Findings during this initial period would not necessarily apply fully were Senior Prime to continue.

We performed our work from March 2001 through November 2001 in accordance with generally accepted government auditing standards.

Results in Brief

The demonstration showed that retirees were interested in enrolling in low-cost military health plans and that DOD was able to satisfy its Senior Prime enrollees. By the close of the initial demonstration period, about 33,000 retirees—over one-fourth of those eligible—were enrolled in Senior Prime and more were on waiting lists. The access to military care that Senior Prime provided was particularly attractive to enrollees. Over 80 percent reported that they joined Senior Prime because they preferred military care. After enrolling, most retirees reported that they were able to get the care that they needed with minimal out-of-pocket costs. Few enrollees decided to leave Senior Prime. While enrollees were generally positive about the program, a minority reported difficulties getting care. When asked why they did not join Senior Prime, over 60 percent of nonenrollees said that they were satisfied with their existing health coverage, and few cited a dislike of military care. Before the demonstration, a minority of nonenrollees had relied on MTF care; under the demonstration, most of these nonenrollees experienced reduced access to military care. About 40 percent of these retirees who had previously relied on MTFs said that they decided not to enroll in part because they expected to continue to get MTF care.

While the demonstration had positive results for enrollees, it also highlighted three challenges confronting the military health system in managing patient care and costs. First, the demonstration revealed the need to manage care more efficiently: although DOD satisfied enrollees and gave them good access to care, in doing so it incurred high costs.

These high costs were largely due to enrollees' heavy use of services, which substantially exceeded that of comparable Medicare beneficiaries. Although MTFs generally tried to restrain inappropriate utilization, some features of the military health system weakened their incentives to moderate utilization and costs. For example, MTFs could reduce care for nonenrollees when resources were strained. Senior Prime's low cost-sharing, although beneficial for enrollees, encouraged them to use services and made it more difficult for DOD to control utilization. Second, although DOD was able to establish and operate the demonstration, its efforts were hindered by limitations in its data and data systems. Officials had difficulty producing reliable, timely, and complete information on retirees' care. This hampered their ability to implement the demonstration's complex payment mechanism as well as to monitor enrollees' health care costs and utilization. While DOD is taking steps to improve its data, basic data problems—such as the inability to segregate costs for seniors—are pervasive and persistent. Finally, the demonstration illustrated the tension between the military health system's commitment to support military operations and promote the health of active-duty personnel and its commitment to provide care to civilians—dependents of active-duty personnel, retirees and their families, and survivors. As Senior Prime illustrated, caring for seniors—who require more complex care than younger and healthier patient groups—can help prepare medical personnel to treat complex medical and surgical cases while deployed. However, providing care to civilians can also constrain MTFs' efforts to meet their military mission. For example, in selecting staff for deployment, MTFs sometimes avoided selecting clinicians with substantial civilian care responsibilities so civilian care would not be disrupted. Conversely, rotations and deployments can complicate the provision of care to civilians and reduce the continuity of their care.

In commenting on a draft of this report, DOD said that the report identified some of the challenges it faced in implementing and managing the demonstration, while noting limitations in the report's generalizability as well as several issues concerning data systems. The Centers for Medicare and Medicaid Services (CMS) said that the report was accurate and met its objectives.

Background

Two large health programs—TRICARE and Medicare—influenced the design and operation of the Medicare subvention demonstration.

TRICARE

The military health system has three missions: (1) maintaining the health of active-duty service personnel, (2) medically supporting military operations, and (3) providing care to the dependents of active-duty personnel, retirees and their families, and survivors. In fiscal year 1999, DOD's annual appropriations included about $16 billion for health care, of which over $1 billion funded the care of seniors.

In the mid-1990s, DOD implemented the TRICARE framework for military health care in response to rapidly rising costs and beneficiary concerns about access to military care. Its goals were to improve beneficiary access and quality while containing costs. TRICARE offers health care coverage to approximately 6.6 million active-duty military personnel, retirees, dependents, and survivors under age 65. These beneficiaries have three main options: TRICARE Prime, a managed care option; TRICARE Extra, a preferred provider option; and TRICARE Standard, a fee-for-service option. A new option, TRICARE Plus, allows beneficiaries to enroll with a primary care provider at participating MTFs.[9] TRICARE covers inpatient services, outpatient services such as physician visits and lab tests, and skilled nursing facility and other post-acute care. It also covers prescription drugs, which are available at MTFs, through DOD's National Mail Order Pharmacy, and at civilian pharmacies.[10] TRICARE delivers care through over 600 MTFs—such as medical centers, community hospitals, or major clinics that serve military installations—and a network of civilian providers managed by DOD's managed care support contractors. Managed care support contractors also assist beneficiaries and support regional DOD management by providing services such as enrollment and utilization management.

[9]TRICARE Plus was implemented on October 1, 2001. It gives enrollees access to MTF primary care providers but does not guarantee them access to MTF specialty care. TRICARE Plus will not be implemented at all MTFs; the availability of TRICARE Plus and the number of enrollees will be based on MTF commanders' determination of available capacity.

[10]A small copayment is required for prescriptions filled by mail order or at civilian pharmacies but not for prescriptions filled at MTFs.

DOD Health Care for Medicare-Eligible Military Retirees

There are about 1.5 million retired military personnel, dependents, and survivors age 65 or older residing in the United States. About 600,000 of these seniors live within 40 miles of an MTF. In the past, retirees had access to all MTF and network services through TRICARE until they turned age 65 and became eligible for Medicare, at which point they could only use military health care on a space-available basis—that is, when MTFs had unused capacity after caring for higher priority beneficiaries. In the 1990s, downsizing and changes in access policies led to reduced space-available care throughout the military health system. Moves to contain costs by relying more on military care and less on civilian providers under contract to DOD also contributed to the decrease in space-available care. As is the case today, MTF capacity varied from a full range of services at major medical centers to limited outpatient care at small clinics. Some retirees aged 65 or older relied heavily on military facilities for their health care, but most did not, and about 60 percent did not use military health care facilities at all. Retirees could obtain prescriptions from MTFs, but not from TRICARE's National Mail Order Pharmacy or network of civilian pharmacies. In addition to using these DOD resources, retirees could receive care paid for by Medicare and other public or private insurance for which they were eligible.

Significant changes in retiree benefits and military health care occurred in 2001 as a result of the NDAA. This legislation gave older retirees two major benefits:

- **Pharmacy benefit**. Effective April 1, 2001, retirees age 65 and older were given access to prescription drugs through TRICARE's National Mail Order Pharmacy and at civilian pharmacies.[11]
- **TRICARE eligibility**. Effective October 1, 2001, retirees age 65 and older enrolled in Medicare part B became eligible for TRICARE coverage—commonly termed TRICARE For Life. As a result, TRICARE is now a secondary payer for these retirees' Medicare-covered services—paying most of their required cost-sharing. This includes copayments required of retirees enrolled in civilian Medicare managed care plans. Retirees are eligible to enroll in TRICARE Plus but are not allowed to enroll in TRICARE Prime.

[11]Beneficiaries who turned age 65 prior to April 1, 2001, automatically qualify for this benefit. Those who turned age 65 on or after that date must be enrolled in Medicare part B to obtain the pharmacy benefit.

Medicare

Medicare is a federally financed health insurance program for persons age 65 and older, some people with disabilities, and people with end-stage kidney disease. Eligible beneficiaries are automatically covered by part A, which covers inpatient hospital, skilled nursing facility and hospice care, as well as some home health care. They also can pay a monthly premium to join part B, which covers physician and outpatient services as well as those home health services not covered under part A. Traditional Medicare allows beneficiaries to choose any provider that accepts Medicare payment and requires beneficiaries to pay for part of their care. Most beneficiaries have supplemental coverage that reimburses them for many of the costs that Medicare requires them to pay. Major sources of this coverage include employer-sponsored health insurance; "Medigap" policies, sold by private insurers to individuals; and Medicaid, a joint federal-state program that finances health care for low-income people.

The alternative to traditional Medicare, Medicare+Choice, offers beneficiaries the option of enrolling in managed care or other private health plans. All Medicare+Choice plans cover basic Medicare benefits, and many also cover additional benefits such as prescription drugs. Typically, Medicare+Choice managed care plans have limited cost-sharing but restrict members' choice of providers and may require an additional monthly premium.

The Medicare Subvention Demonstration

Under the Medicare subvention demonstration, DOD established and operated six Medicare+Choice managed care plans, called TRICARE Senior Prime, at sites selected jointly by DOD and HCFA. Enrollment in Senior Prime was open to military retirees enrolled in Medicare part A and part B who resided within roughly 40 miles of a participating MTF. About 125,000 retirees were eligible for the demonstration. DOD capped enrollment at about 28,000 for the demonstration as a whole; each MTF had its own enrollment cap. In addition, retirees enrolled in TRICARE Prime who had a primary care provider at a demonstration MTF could "age in" to Senior Prime upon reaching age 65, even if MTFs' enrollment caps had been reached.

Senior Prime offered enrollees the full range of Medicare-covered services as well as additional TRICARE services, notably prescription drugs. It also gave them higher priority for care at MTFs than retirees who did not join the program. Enrollees paid the Medicare part B premium, but no

additional premium to DOD.[12] Care at MTFs was free of charge, but enrollees had to pay any applicable cost-sharing amounts when MTFs referred them to the civilian network for care (for example, $12 for an office visit). All primary care was provided at MTFs, but DOD purchased some hospital and specialty care from the civilian network. Purchased care was used for services not available at MTFs as well as when MTFs did not have sufficient capacity in particular specialties.

Although the demonstration was authorized to begin in January 1998, implementation was delayed, and the first site began delivering care in September 1998. All sites were operational by January 1999. The six demonstration sites are in different regions of the country and include 10 MTFs that vary in size and types of services offered (see table 1), as well as by managed care penetration in the local Medicare market. The five medical centers offer a wide range of inpatient services and specialty care as well as primary care. They accounted for over 75 percent of all enrollees in the demonstration. The two San Antonio medical centers had 38 percent of all enrollees. The four community hospitals have more limited capabilities, and the civilian network provided much of the specialty care. At Dover, the MTF is a clinic that offers only outpatient services, thus requiring all inpatient and specialty care to be obtained at another MTF or purchased from the civilian network.

[12]Although DOD could charge enrollees a premium for Senior Prime, as any Medicare+Choice organization can, it chose not to do so.

Table 1: Characteristics of Participating MTFs Varied

Demonstration site, location of military treatment facility	Facility type	Eligible retirees[a]	Total enrollment[b]	Percentage of demonstrationwide enrollment
Colorado Springs				
Fort Carson Colorado Springs, Colo.	Community hospital	6,530	2,371	7
U.S. Air Force Academy Colorado Springs, Colo.	Community hospital	8,458	1,750	5
Dover				
Dover Air Force Base Dover, Del.	Clinic	3,894[c]	1,062	3
Keesler				
Keesler Air Force Base Biloxi, Miss.	Medical center	8,309	3,507	11
Madigan				
Fort Lewis Tacoma, Wash.	Medical center	21,072	4,674	14
San Antonio				
San Antonio Area				
Fort Sam Houston San Antonio, Tex.	Medical center	21,354	5,928	18
Lackland Air Force Base San Antonio, Tex.	Medical center	15,153	6,523	20
Texoma Area				
Sheppard Air Force Base Wichita Falls, Tex.	Community hospital	2,820	1,074	3
Fort Sill Lawton, Okla.	Community hospital	4,873	1,467	4
San Diego				
San Diego, Calif.	Medical center	34,485	4,751	14
Total		**126,948**	**33,107**	**100[d]**

Note: Although the law specifies six test sites, for the purpose of analysis we treat the San Antonio area and the Texoma area, which are roughly 300 miles apart, as separate sites.

[a]As of December 31, 2000.

[b]As of December 31, 2000. Total enrollment includes age-ins.

[c]As of June 1998.

[d]Percentages do not add to 100 due to rounding.

Source: *TRICARE Senior Prime Plan Operations Report* (Washington, D.C.: DOD, Dec. 31, 2000). The number of eligible retirees (by site and total) is drawn from DOD's Defense Enrollment Eligibility Reporting System (DEERS).

The BBA established rules for Medicare to follow in paying DOD for Senior Prime care. It authorized Medicare to pay DOD in a way that was similar to the way it pays civilian Medicare+Choice plans, with several major exceptions:

- Senior Prime's capitation rate—a fixed monthly payment for each enrollee—differed from the Medicare+Choice rate in several ways. The Senior Prime rate was set at 95 percent of the rate that Medicare would pay civilian Medicare+Choice plans in the demonstration areas, consistent with a belief that DOD could provide care at lower cost than the private sector. The rate was further adjusted by excluding the part of the Medicare+Choice rate that reflects graduate medical education (GME) and disproportionate share hospital (DSH) payments,[13] as well as a percentage of payments made for hospitals' capital costs. The GME exclusion took into account the fact that GME in the military health system is funded by DOD appropriations, and the DSH exclusion recognized that DOD medical facilities do not treat the low-income patients for whom DSH payments compensate hospitals. The law directed HCFA and DOD to determine the amount of the capital adjustment, and the two agencies agreed to exclude two-thirds of the capital costs reflected in the Medicare+Choice rate.
- The Senior Prime capitation rate was to be adjusted if there was "compelling" evidence that enrollees were healthier or sicker than their Medicare fee-for-service counterparts. The adjustment was intended to reflect whether Senior Prime enrollees would be expected to be significantly more or less costly than the average Medicare beneficiary. HCFA and DOD agreed that if the difference between the adjusted and unadjusted payments equaled or exceeded 2.5 percent, then that would be compelling evidence that enrollees' health status differed from that of their Medicare counterparts. In that case, the Medicare payment would reflect the adjustment.
- The BBA required that, before DOD could receive Medicare payment, participating MTFs must spend as much on care for retirees age 65 and older as they did prior to the demonstration. This threshold amount—termed DOD's baseline level of effort or LOE—was intended to prevent the federal government from paying for the same care twice, through both DOD appropriations and Medicare.

[13]GME payments cover Medicare's share of teaching hospital expenses incurred in training medical interns and residents. DSH payments assist hospitals that treat a disproportionate number of uninsured and indigent patients.

- The total amount that Medicare could pay DOD for the demonstration was capped at $50 million in 1998, $60 million in 1999, and $65 million in 2000.[14]

The demonstration was initially scheduled to end in December 2000. The NDAA extended the demonstration for 1 year—through 2001—with the possibility of further extension and expansion. However, DOD allowed Senior Prime to end on December 31, 2001, because the new TRICARE For Life program provides health care coverage to older military retirees. DOD has stated that Senior Prime enrollees will have priority for enrollment in TRICARE Plus, which began at the former demonstration MTFs in January 2002.

As authorized by the BBA, the demonstration was to include a second component—Medicare Partners. Under Medicare Partners, a demonstration MTF would be allowed to contract with civilian Medicare+Choice plans to provide selected MTF services to military retirees enrolled in the civilian plans. According to DOD, lack of interest among local Medicare+Choice plans was key to its decision not to implement the Medicare Partners program. Plans may have had little incentive to participate in Medicare Partners and pay for MTF care because retirees already were eligible for such care at DOD's expense—when space was available.

Demonstration Illustrated Retirees' Interest in Military Health Care, Had Positive Impact on Enrollees

The demonstration showed that DOD health care plans based at MTFs could attract many retirees, particularly those who were recent users of military care. Retirees said they were attracted to Senior Prime by the quality and convenience of MTF care, as well as by the program's low cost-sharing. After enrolling, most reported that they were able to get the care that they needed at little expense. Most retirees who did not enroll in Senior Prime reported that they were satisfied with their existing health care coverage.

[14]See *Medicare Subvention Demonstration: DOD Costs and Medicare Spending* (GAO-02-67, Oct. 31, 2001) for a description of how Medicare's final payment to DOD is determined.

Senior Prime Met Enrollees' Expectations for Access to MTFs, Quality Health Care, and Low Costs

Senior Prime's enrollment showed that there was substantial demand among retirees for DOD health care plans based at MTFs, and also that demand varied by site. By December 2000, Senior Prime had attracted roughly 33,000 enrollees—over one-fourth of all retirees eligible to join. (See table 2.) Over 6,500 of these enrollees had aged-in from TRICARE Prime after turning age 65.[15] The percentage of eligible retirees who enrolled varied significantly, from 14 percent at San Diego to over 40 percent at Keesler and Lackland Air Force Base.[16] However, these figures understate retirees' interest in Senior Prime: during the demonstration, 6 of the 10 MTFs reached their maximum enrollment and had to establish waiting lists.

[15]Most retirees eligible to age-in did so. Although enrollment at each MTF was capped, age-ins were not counted against the caps. Consequently, after most MTFs had reached or approached their caps, the majority of new enrollees were age-ins.

[16]For a discussion of site variation in enrollment at the beginning of the demonstration, see *Medicare Subvention Demonstration: Enrollment in DOD Pilot Reflects Retiree Experiences and Local Markets* (GAO/HEHS-00-35, Jan. 31, 2000).

Table 2: Enrollment at the Subvention Demonstration Sites Varied

Demonstration site, location of military treatment facility	Eligible retirees[a]	Total enrollment[b]	Percentage of eligible retirees enrolled
Colorado Springs			
Fort Carson Colorado Springs, Colo.	6,530	2,371	36
U.S. Air Force Academy Colorado Springs, Colo.	8,458	1,750	21
Dover			
Dover Air Force Base Dover, Del.	3,894[c]	1,062	27
Keesler			
Keesler Air Force Base Biloxi, Miss.	8,309	3,507	42
Madigan			
Fort Lewis Tacoma, Wash.	21,072	4,674	22
San Antonio			
San Antonio Area			
Fort Sam Houston San Antonio, Tex.	21,354	5,928	28
Lackland Air Force Base San Antonio, Tex.	15,153	6,523	43
Texoma Area			
Sheppard Air Force Base Wichita Falls, Tex.	2,820	1,074	38
Fort Sill Lawton, Okla.	4,873	1,467	30
San Diego			
San Diego, Calif.	34,485	4,751	14
Total	**126,948**	**33,107**	**26**

[a]As of December 31, 2000.

[b]As of December 31, 2000. Total enrollment includes age-ins.

[c]As of June 1998.

Source: *TRICARE Senior Prime Plan Operations Report* (Washington, D.C.: DOD, Dec. 31, 2000). The number of eligible retirees (by site and total) is drawn from DEERS.

Senior Prime's strong link to military care was particularly attractive to retirees. When asked why they wanted to join Senior Prime, enrollees most often cited reasons related to military care, such as the quality of care at MTFs, a preference for military care, and the convenience of local MTFs. (See table 3.) Most enrollees had used MTFs to some extent the year before enrolling in the program, and about 60 percent had relied on these facilities for most or all of their care. In part, this reflected the design of the program. To be eligible for Senior Prime, retirees must have used military care since becoming Medicare-eligible.[17] However, DOD relied on retirees' answers to a question about prior MTF use and did not verify their answers. Over half of enrollees believed that by joining Senior Prime they would be able to get appointments at MTFs more easily. This is not surprising, given that Senior Prime offered retirees the same priority access to MTFs as younger retirees enrolled in TRICARE Prime. Senior Prime attracted some retirees—about 3,500—who had not recently used MTFs; most of these retirees nonetheless cited a preference for military care. Retirees who were attracted to Senior Prime varied in their health care coverage before the demonstration. About 30 percent had had traditional Medicare exclusively. The remainder had had supplemental insurance coverage in addition to traditional Medicare or were enrolled in a civilian Medicare managed care plan.[18]

[17]This requirement did not apply to retirees who had been Medicare-eligible since July 1, 1997, a little over a year before the program began.

[18]This includes enrollment in a Medicare managed care plan, Medicare supplemental insurance, and employer-sponsored insurance. The estimate excludes enrollees who aged-in from TRICARE Prime. For details on enrollees' prior membership in Medicare managed care plans, see appendix II.

Table 3: Most Enrollees Cited Military Care as a Reason for Enrolling in Senior Prime

Reason	Percentage who cited as a reason for enrolling[a]	Percentage who cited as the main reason for enrolling[b]
I receive high quality health care at military health care facilities	82	36
I prefer military health care over nonmilitary health care	81	28
The military health care facility is the most convenient place for me to receive care	76	14
I will be able to get appointments at military health care facilities more easily	56	4
The doctors have a good reputation	55	1
It will save me money on health care	54	8
I will have better benefits or coverage	52	3

Notes: Retirees were asked why they wanted to enroll in Senior Prime and were given a list of possible reasons as well as an "Other" option in which they could write their own answers. Retirees first circled as many reasons as applied to them and then indicated which was their main reason for enrolling. These data are from our survey of enrollees at the start of the demonstration. Retirees who enrolled later in the demonstration, including age-ins from TRICARE Prime, gave similar reasons for joining the program. Many also indicated that they had done so because it was easy to move to Senior Prime from TRICARE Prime or because they had liked TRICARE Prime.

[a]Percentages do not add to 100 because respondents could select more than 1 reason.

[b]Percentages do not add to 100 because only the top 7 reasons are listed.

Source: GAO survey of military retirees.

Although less important than the link to military care, other features of Senior Prime also appealed to retirees. The program's low cost-sharing was attractive to retirees; about half of enrollees saw joining Senior Prime as a way to save money on health care expenses. This was true even though many enrollees had only minimal out-of-pocket costs before joining the program, due in part to their use of free MTF care. In addition, about half of enrollees saw joining Senior Prime as a way to obtain improved health care benefits or coverage.

After enrolling in Senior Prime, retirees reported that they were able to get the care that they needed at little expense. When asked what they liked about Senior Prime, the majority of enrollees cited access-related features such as the ability to get all the care that they needed and the ability to get appointments when needed. (See table 4.) This is not surprising, given that enrollees had more hospital stays and outpatient visits than before the demonstration and used significantly more services than their Medicare fee-for-service counterparts. Enrollees also reported that they received good care at their MTFs and that they liked their MTF doctors. Despite their heavy use of services, most enrollees also were pleased with the low cost of their care. They reported few financial barriers to obtaining care and that their spending on health care services was minimal. About two-

thirds of enrollees reported no out-of-pocket costs; their costs were low even at smaller sites where network care, which required copayments, was more common.

Table 4: Enrollees Cited Access to Care, Low Cost-Sharing as Positive Features of Senior Prime

Reason	Percentage who cited as something they liked about Senior Prime[a]	Percentage who cited as the main thing they liked about Senior Prime[b]
I get all the care that I need	88	22
I do not have to pay (or pay very much) for care	81	7
I am able to get an appointment when needed	81	13
I do not have to submit bills	81	2
When I go for appointments, I do not wait long	79	2
I like my primary care doctor	77	7
The MTF is convenient to where I live	74	3
I like seeing MTF doctors	73	6
I receive good care at the MTF	71	23
Senior Prime is less expensive than civilian care	69	3
I can get all my care at MTFs	67	8
I like specialists at the MTF	57	2

Notes: Toward the end of the demonstration, retirees were asked what they liked about Senior Prime and were given a list of possible items as well as an "Other" option in which they could write their own answers. Retirees first circled as many items as applied to them and then indicated which was the main item.

[a]Percentages do not add to 100 because respondents could select more than 1 reason.

[b]Percentages do not add to 100 due to rounding.

Source: GAO survey of military retirees.

Once enrolled, relatively few retirees decided to leave Senior Prime—another indication of enrollees' satisfaction with the program. Early in the demonstration, disenrollment rates were relatively low compared with other Medicare managed care plans.[19] Disenrollment remained low throughout the demonstration, averaging about 2 percent during the last year of the initial demonstration period.

Although retirees generally were positive about Senior Prime, some reported difficulties. Over 70 percent of enrollees reported that there was nothing about the program that they disliked. Very few enrollees reported that they did not like their doctors, that they did not get good care at

[19]See GAO/HEHS-00-35.

MTFs, or that Senior Prime refused them treatment. However, 13 percent of enrollees reported that they did not like having to wait too long to get an appointment, 13 percent cited not being able to see the same primary care doctor every time, and 8 percent cited difficulty making appointments. In addition, among those few who disenrolled from Senior Prime, the most commonly cited reasons for doing so were these same three access-related difficulties as well as the inability to use regular Medicare benefits while enrolled in the program—that is, the inability to have Medicare pay for services not authorized by Senior Prime.

Most Nonenrollees Were Satisfied with Their Existing Health Coverage

Most retirees who did not enroll in Senior Prime reported that they were already satisfied with their existing health care coverage, and few cited negative attitudes about military care. When asked why they did not try to enroll in Senior Prime, over 60 percent of nonenrollees cited satisfaction with their current coverage. (See table 5.) About one-third said they did not have enough information about Senior Prime or did not understand it. Although the sites used many means of providing information about Senior Prime to local retirees, many retirees surveyed early in the demonstration had not previously heard of the program. The lack of information about Senior Prime remained an issue later in the demonstration as well; at the end of the demonstration, many retirees still reported this as one reason for not wanting to enroll. Other major reasons for not enrolling included not wanting to join a managed care organization and the belief that Senior Prime might not be permanent.[20] Few nonenrollees—about 9 percent—reported that they decided not to join Senior Prime because they disliked military care.

[20]In our first survey we did not include the temporary nature of the demonstration as a reason for not enrolling but found that 2 percent of retirees had written in that reason. In our second survey, when we included this as a possible reason, we found that over 25 percent of nonenrollees indicated it was a reason for not joining Senior Prime but only 13 percent said it was their main reason.

Table 5: Most Nonenrollees Were Satisfied with Their Current Coverage

Reason	Percentage who cited as a reason for not enrolling[a]	Percentage who cited as the main reason for not enrolling[b]
I am satisfied with my current coverage	62	44
I have not received enough information on Senior Prime	30	13
I do not understand Senior Prime	30	11
I do not want to join a managed care organization	24	10

Notes: Retirees were asked why they did not try to enroll in Senior Prime and were given a list of possible reasons as well as an "Other" option in which they could write their own answers. Retirees first circled as many reasons as applied to them and then indicated which was their main reason for not enrolling. These data are from our survey at the start of the demonstration. Retirees who became eligible later in the demonstration cited similar reasons for not enrolling.

[a]Percentages do not add to 100 because respondents could select more than 1 reason.

[b]Percentages do not add to 100 because only the top 4 reasons are listed.

Source: GAO survey of military retirees.

Nonenrollees' access to care was generally unaffected by the demonstration, but among the minority who had previously relied on military care, most experienced reduced access to MTFs.[21] When asked at the start of the demonstration why they had not joined Senior Prime, many of the nonenrollees—almost 40 percent—who were later "crowded out" of MTFs had said that they were able to get military health care when they needed it. This suggests that they did not forsee that space-available care would decline as a result of the demonstration. By the end of the demonstration, about 20 percent of those who were crowded out had tried to join Senior Prime. However, most sites had reached their enrollment caps, and retirees who applied after the caps were reached were placed on a waiting list.

[21]See *Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs* (GAO-02-68, Oct. 31, 2001) for a further discussion of nonenrollees' access to care under the demonstration.

Demonstration Underscored Challenges in Managing Care and Costs Within the Military Health System

While the demonstration had positive results for enrollees, it also highlighted several challenges that confront the military health system in managing patient care and costs. The high costs generated by enrollees' care revealed the need to deliver care more efficiently. In addition, difficulties encountered in obtaining and managing data during the demonstration underscored problems that DOD officials generally face in monitoring patient care and costs. Finally, the demonstration illustrated the tensions between the military health system's commitment to care for active-duty personnel and support military operations and its commitment to provide care to civilian family members and retirees.

High Senior Prime Costs Are Associated with Weak Incentives for Managing Care

Senior Prime's experience revealed the need to deliver care more efficiently, and differences in sites' utilization suggested that this might be possible. Although DOD satisfied its new senior enrollees and gave them good access to care, it incurred high costs in doing so.[22] These high costs were largely due to enrollees' heavy use of medical services, which substantially exceeded that of comparable Medicare beneficiaries.[23] If DOD had delivered fewer services, it is possible that enrollees would have been less satisfied. However, we found that the number of outpatient visits by enrollees affected their satisfaction with care only slightly. Furthermore, substantial site differences in utilization—with little difference in enrollee satisfaction—provide evidence that some sites were able to satisfy enrollees with fewer services and, consequently, lower costs. This suggests that other sites could have reduced utilization somewhat without sacrificing enrollee satisfaction.

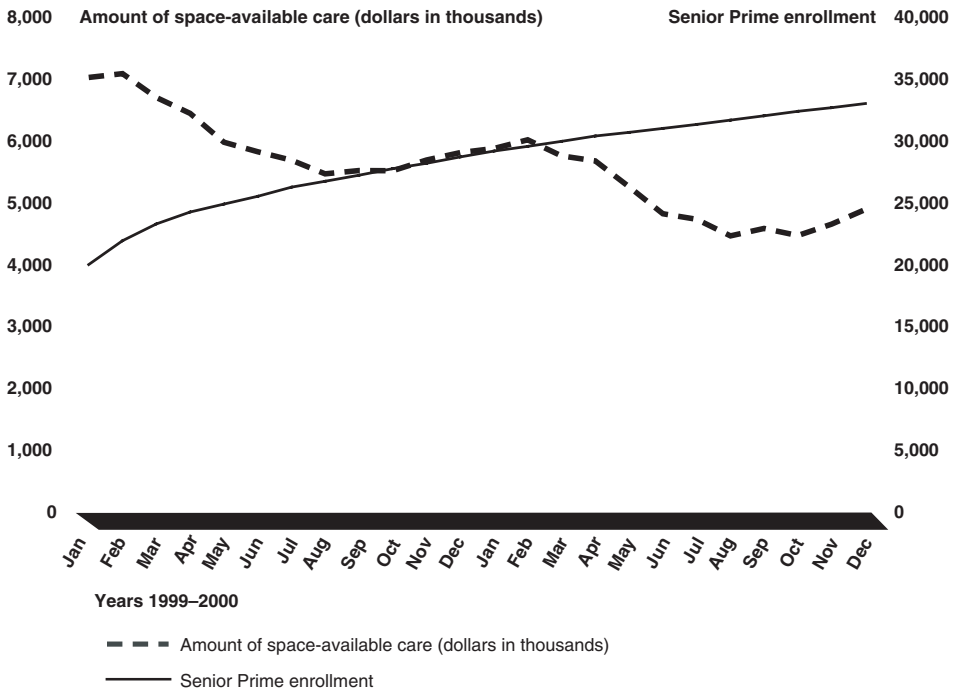
Although sites' costs varied, managers at all sites faced similar disincentives to containing utilization and costs. MTFs generally tried to restrain inappropriate utilization, but basic features of the military health system's financial and management practices weakened their incentives to moderate utilization and costs. First, while MTFs cannot spend more than their budget, several factors act as safety valves for budgetary pressure:

[22]Costs varied by site. At all sites, average costs exceeded the local Senior Prime rate by at least 20 percent.

[23]For further discussion of DOD's costs and enrollees' use of services, see *Medicare Subvention Demonstration: DOD Costs and Medicare Spending* (GAO-02-67, Oct. 31, 2001).

- The primary factor is space-available care: when resources required for enrollees increase, space-available care declines and those who are not enrolled are less able to get MTF care. This was observed during the demonstration: as Senior Prime enrollment climbed, the amount of space-available care provided to nonenrolled seniors decreased. (See figure 1.)

Figure 1: As Senior Prime Enrollment Grew, Space-Available Care Declined



Note: Space-available care is expressed as a centered 3-month moving average.

Source: GAO analysis of *Databook for TRICARE Senior Prime Demonstration Sites* (Washington, D.C.: DOD, Aug. 10, 2001).

- MTFs can request supplemental funding from their respective services. During the demonstration, every MTF requested supplemental funding either for Senior Prime specifically or for the MTF generally, and all received some added funds. Although MTFs cannot always count on receiving such funding, the potential to obtain extra funds reduces incentives for moderating utilization.
- MTFs can try to defer some utilization until the following fiscal year—for example, by postponing elective surgery or issuing prescriptions on a 60-day rather than a 90-day basis. At the end of fiscal year 2000, officials from several sites told us that they were considering this approach to staying

within their budgets, and at the time of our visits at least one had implemented it.

Second, MTFs have no direct financial incentive to manage care purchased from the civilian network. At the local level, MTF providers refer patients for services that, depending on MTF resources and capacity, may be obtained from network providers. However, MTFs are not directly responsible for the costs of network claims; DOD funds purchased care centrally, thereby reducing sites' incentive to trim unnecessary network utilization.[24] An additional factor unique to the demonstration was the lack of incentives for the managed care support contractors to limit utilization in Senior Prime. Under the demonstration, these contractors authorized network services but bore no risk for the costs of enrollees' care. Consequently, they had no financial incentive to limit use of specialists and other civilian network providers.[25]

Third, Senior Prime's low cost-sharing, although beneficial for enrollees, limited DOD's ability to control utilization and costs. Research has shown that patients tend to use more care when their out-of-pocket expenses are low.[26] Therefore, copayments tend to encourage patients to curb their use of health care services. In Senior Prime, however, there were few financial incentives for enrollees to reduce their use of health care services. Enrollees had no annual deductible; furthermore, care within MTFs, where most services were delivered, was free and copayments for visits to network providers were small.[27]

Finally, practice patterns among military physicians may also explain part of the high costs and utilization seen in Senior Prime. High utilization is not unique to the demonstration: studies have shown that the military

[24]However, DOD encourages MTFs to deliver care in-house when possible in order to maximize the use of MTFs.

[25]In TRICARE Prime, the managed care support contractors bear part of the risk for beneficiaries' purchased care costs.

[26]See Physician Payment Review Commission, *Annual Report to Congress, 1997*, Chapter 15, and Sandra Christensen and Judy Shinogle, "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review*, Fall 1997.

[27]Low cost-sharing is a feature of TRICARE Prime as well, although its terms differ somewhat from Senior Prime's.

health system has higher utilization than the civilian sector.[28] As with civilian physicians, military physicians' training, experience, and the practice style of their colleagues affect their use of procedures and tests, their readiness to hospitalize patients, as well as their recommendations to patients about follow-up visits and referrals to specialists.[29]

Limitations in Data and Data Systems Posed Problems for DOD Managers

Although DOD was able to establish and operate the demonstration, its efforts were hampered by limitations in its data and data systems. Throughout the demonstration, officials had difficulty producing reliable, timely, and comprehensive information on retirees' care. This hampered their ability both to implement the demonstration's payment mechanism and to monitor enrollees' health care costs and utilization.

DOD's experience with the demonstration's payment mechanism illustrated DOD's problems with data and data systems. At the beginning of the demonstration, DOD needed to determine the cost of the care that participating MTFs had provided to military retirees prior to Senior Prime—an amount referred to as DOD's baseline level of effort or LOE. This step was critical in determining how much payment, if any, DOD would earn from Medicare. However, DOD's data systems did not permit it to isolate the costs of retirees' previous MTF care, and DOD had to undertake a substantial effort to estimate its baseline LOE—an effort made more difficult by deficiencies in the source data on MTF costs. The payment mechanism also required DOD to collect information on enrollees' inpatient and outpatient diagnoses to determine whether enrollees were significantly more or less healthy than other Medicare beneficiaries—in which case, Medicare's payment to DOD would be adjusted. DOD and HCFA agreed to use a method of assessing enrollees' health status that involved both inpatient and outpatient data. DOD took

[28]See Susan D. Hosek and others, *The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health Care System* (Santa Monica, Calif.: RAND, MR-407-PA&E, Jan. 1994), and The Institute for Defense Analysis and Center for Naval Analysis Corporation, *Evaluation of the TRICARE Program FY 1998 Report to Congress* (Washington, D.C.: 1998).

[29]In civilian health care, much of the variation in use of health care among states and counties is attributed to the clinical practice styles of their physicians. See W.P. Welch and others, "Geographic Variation in Expenditures for Physician Services in the United States," *New England Journal of Medicine*, Vol. 328, No. 621 (Mar. 4, 1993); John E. Wennberg and Alan Gittelsohn, "Small Area Variations in Health Care Delivery," *Science* Vol. 182, No. 4117 (Dec. 1973); and *The Quality of Medical Care in the United States: A Report on the Medicare Program* (American Hospital Association, 1999).

over 1 year to assemble the final data and later stated that the outpatient data may have omitted certain items and may have contained coding errors. Overall, although DOD completed the tasks necessary to implement the payment mechanism, its efforts consumed considerable time and resources due to data problems.

DOD's data systems were not well-suited to monitoring health care costs and utilization—an impediment to effective management. At the local level, data limitations reduced site officials' ability to monitor Senior Prime costs. At first, the sites operated with little information on the costs of enrollees' care. For care provided at MTFs, sites' data systems could not isolate costs specific to Senior Prime enrollees. For care provided outside MTFs, claims submitted by network providers recorded the costs of civilian care, but there were delays between the time services were provided and when complete claims data were available. About 1 year into the demonstration, cost information available to site officials improved. In the fall of 1999, DOD's TRICARE Management Activity (TMA)[30] office began distributing periodic Senior Prime databooks, which provided information on enrollment, utilization, cost, and satisfaction for each site.[31] Sites found that these databooks were a useful resource; for the first time, they were able to compare their sites' costs to the Senior Prime capitation rate. However, neither the databooks nor the systems on which they were based permitted the sites to identify the cases or practices that led to high costs. Moreover, the information was not timely—the lag was usually 6 months or more—and changed over time as problems in underlying data and calculations were identified and corrected. For example, the databook reports on the costs of enrollees' care changed repeatedly as mistakes were uncovered and corrected, reducing confidence in comparisons to the Senior Prime capitation rate.

[30]TMA performs TRICARE-wide support functions, such as managing information technology and data systems and selecting, directing, and paying the managed care support contractors. TMA officials were responsible for evaluating and supporting the subvention demonstration.

[31]The databooks were primarily intended for internal use in monitoring and tracking the program. Compiling the databooks was a complex task and took a substantial commitment of resources, partly because staff had to collect and manipulate data from separate and incompatible data systems. Although they were a mechanism for sharing information with the sites, according to TMA officials the databooks were not intended to be a management tool. Nonetheless, they were the only data available to sites that allowed them to compare their costs and utilization to those of other sites.

Data limitations also hindered officials' ability to monitor enrollees' use of health care services. Sites had information on utilization, but had difficulty integrating data from MTF and network providers and encountered data of questionable accuracy. These problems undermined the ability of managers and physicians to obtain a comprehensive picture of the care provided to individuals or to groups of patients. In addition, site officials told us they had some difficulties using benchmark utilization rates from civilian managed care to help understand the patterns in Senior Prime utilization. They were sometimes uncertain about the quality and credibility of the underlying data used to generate Senior Prime measures, and often found that comparisons between Senior Prime and civilian rates were distorted by differences in clinical and coding practices.[32] Comparisons between the sites were also problematic. Some officials cited differences in coding practices as a partial explanation of site differences in utilization rates.

While DOD is making efforts to improve its data and data systems, its fundamental data problems are pervasive and persistent. Key data-related difficulties include inaccurate and incomplete data, systems that produce usable data only after substantial delays, and the inability to segregate costs for particular patient groups, such as seniors. In addition, DOD's separate, unconnected systems for recording inpatient and outpatient MTF care, and for MTF and network care, complicate data collection and analysis. Most important, the lack of strong incentives for MTFs to achieve efficiency in delivering care reduces officials' demand for improved data and related tools. Officials told us about efforts to improve data and data systems, some resulting directly from the demonstration. The demonstration's requirements for reporting quality and cost information, including the need for MTF commanders to certify data submitted to HCFA, led to increased scrutiny of data systems by national and local managers. Officials at several sites noted that the demonstration had stimulated MTF efforts to generate better data, for example, by more accurately recording and coding patient visits and diagnoses. In addition, DOD's new Data Quality Management Control program, initiated in November 2000, introduced data quality as a formal management objective

[32]Some sites reported that, despite extensive adjustments to the data, their measures were not entirely comparable to the civilian benchmarks.

and made MTF commanders more accountable for their data.[33] It is too early to tell whether DOD's recent efforts to make MTFs more accountable for data quality will have an impact that is systemwide and sustained. Although the new data quality program may give MTF managers added reason to improve their data, it does not alter their incentives for using those data.

Demonstration Illustrated Tension between Military Mission and Civilian Care Responsibilities

The demonstration illustrated a central challenge confronting the military health system: dealing with the tensions that arise from its commitment to support military operations and care for active-duty personnel while providing care for their family members and retirees. As part of its mission, the military health system is responsible for medical support of military deployments, from small humanitarian engagements to major military actions. The military health system must ensure that clinicians and other medical personnel have the skills they need when deployed and must maintain the health of active-duty personnel. Like other large employers, DOD also provides health care coverage for the families of active-duty personnel and for retirees. Unlike most other employers, DOD provides much of its beneficiaries' care in its own facilities. Overall, MTFs' experiences during the demonstration highlighted ways in which the provision of care to civilians, in particular older retirees, can both support and hinder the military mission. It also illustrated the ways in which that mission complicates the delivery of civilian care.

Senior Prime demonstrated that providing care to civilian beneficiaries can contribute to the mission of providing medical support for military operations. According to DOD, during wartime and peacetime military operations (such as humanitarian or peacekeeping missions), most cases encountered are commonplace medical or surgical conditions, not complex illnesses or injuries requiring specialized skills. Consequently, clinicians with broad general training and experience are able to manage most conditions they are likely to see. However, clinicians supporting military operations are likely to encounter some complex medical and surgical cases. They therefore need experience with patients requiring complex care—rather than young, generally healthy adults and children

[33]This program is an outgrowth of a task force DOD established in 1998 partly in response to our report on data limitations relevant to the demonstration. (See *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns* (GAO/HEHS-99-39, May 28, 1999).) The task force addressed the military health system's need for data quality improvements.

requiring routine care—to ensure that they are prepared to provide complex care in the field.[34] Senior Prime illustrated how seniors can contribute to the skills needed for deployment. MTF officials reported that enrollees gave medical staff experience with conditions that are relevant to both wartime and peacetime operations but are not typically seen among younger patient groups. Although the underlying causes of illness and injury differed from what would occur on the battlefield, seniors' needs for complex care, such as vascular and orthopedic surgery and intensive care, helped prepare staff to treat complex cases while deployed. Treating seniors also prepared staff for humanitarian missions, on which they may encounter individuals who are older or who have chronic conditions.[35]

However, as Senior Prime also demonstrated, providing civilian care can interfere with an MTF's efforts to meet its military medical mission. Not all services provided to civilians contribute directly to providers' preparedness for deployment. For example, according to officials at one MTF, under Senior Prime some specialists were providing more routine care to seniors and seeing fewer of the complex cases important for training, compared to before the demonstration. In addition, MTFs' responsibility for primary care influenced the selection of medical staff for deployments. Several MTFs chose to deploy specialists or others who were not primary care managers, rather than disrupt primary care teams and patients. In this way, civilian care posed a constraint for officials in meeting their primary mission. Finally, increased demands for care among civilian beneficiary groups have the potential to affect the care of active-duty personnel—the primary population that the military health system is intended to serve. Although active-duty personnel receive priority for MTF care, the assignment of MTF appointment slots to civilians can affect how quickly active-duty personnel get care.[36] During the demonstration, officials found little evidence that, at its small scale, Senior Prime had led to a decline in active-duty personnel's access to care or satisfaction with

[34]See "Concept Paper on Enrollment in TRICARE Plus for MTF Commanders," TRICARE Management Activity, July 3, 2001.

[35]During the demonstration, some MTFs continued to care for nonenrolled seniors, in addition to enrollees, to help meet their training needs.

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

care.[37] However, several officials either expressed concern that continued growth in the program could cause difficulties in the future or noted the strain resulting from MTFs' commitment to both active-duty and other patient groups.

Conversely, the demonstration illustrated ways in which the military mission complicates civilian care and can increase costs. Medical personnel absences due to deployments, readiness training, and rotations complicated MTFs' efforts to ensure enrollees' access to and continuity of care, although the extent varied by site. During the demonstration, MTFs experienced temporary shortages in personnel important for seniors' care, including nursing staff and key specialists. Officials took steps to mitigate the effect of these absences on patient care, and enrollees had good access to care overall. However, they were not always able to see the same provider and at times were referred to civilian providers.[38] Personnel absences had implications not only for patient care but also for DOD's costs, particularly when care had to be purchased from network providers. These costs could be significant if personnel absences occurred in large numbers or were extended over a long period.

Concluding Observations

While the demonstration showed that DOD's new MTF-based health plans could attract and satisfy military retirees, it also highlighted challenges that DOD encountered in doing so. The issues DOD encountered in launching and implementing Senior Prime leave open the question of whether the program could have been successfully implemented on a larger scale. Although DOD has chosen not to continue Senior Prime, the demonstration offers lessons about managing the care of seniors and other beneficiary groups.

[37]See *Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities* (GAO-01-671, June 14, 2001).

[38]Recent events illustrated an additional way in which DOD's military mission complicates civilian care. In times of enhanced security at military installations it may be difficult for beneficiaries to access MTFs. Following the terrorist attacks on the World Trade Center and the Pentagon, there were reports of military retirees having difficulty getting care and prescriptions at MTFs in the Colorado Springs area, due to restricted access to area facilities. More broadly, The Retired Officers Association (TROA) notified its members that tightened security at military installations might limit some beneficiaries' ability to get new or refill prescriptions at military pharmacies or to see their providers for new medications. In October 2001, DOD issued guidance for beneficiaries on seeking emergency, urgent, and routine care when military installations are under heightened security.

The challenges revealed by the demonstration relate to DOD's management of health care delivery and costs within the broader military health system:

- The high utilization and costs observed during the demonstration underscore the importance of designing incentives and management practices within DOD that promote efficient care—that is, the delivery of appropriate care and improved health outcomes while discouraging inappropriate utilization and costs.
- As the demonstration illustrated, limitations in DOD data and information systems, as well as weak incentives for greater efficiency, are obstacles to managing military beneficiaries' health care use and costs. Data analysis could help managers target clinical and financial areas needing improvement.
- The demonstration highlighted a strategic issue facing the military health system: how to reconcile its commitment as an employer to provide care to the families of active-duty personnel as well as retirees with its responsibility to provide medical support for military operations.

Agency Comments

We provided DOD and CMS an opportunity to comment on a draft of this report, and both agencies provided written comments. DOD said that the report identified some of the challenges it faced in implementing and managing the demonstration and that the report appropriately noted limitations in the generalizability of its findings. DOD commented that one statement—that difficulties in producing information on retirees' care hampered its ability to implement the demonstration's payment mechanism—was only partially true and somewhat misleading. DOD asserted that the Senior Prime databooks were reasonably timely and reliable and that, once DOD and CMS had agreed on financial policies, the payment mechanism was implemented without significant difficulties. In response to our statement that DOD took over 1 year to assemble the data needed for risk adjustment, DOD emphasized that delays in the risk adjustment process were largely beyond its control. Regarding our statement that DOD's data systems were not well-suited to monitoring health care costs and utilization, DOD stated that its data systems, although not capable of providing all data that might be desired, adequately showed that utilization and costs were high. DOD further stated that high costs and utilization are more attributable to the benefit structure, financial incentives for MTFs, high administrative costs, and MTF practice and capacity issues than to data system weaknesses. Finally, in response to our statement that limitations in DOD data systems are obstacles to managing military beneficiaries' health care use and costs,

DOD stated that, while it is true that MTFs have weak incentives for greater efficiency, the focus on information systems as a primary cause of high costs and utilization is misleading. DOD said that data analysis targeted clinical and financial areas needing improvement early in the demonstration, but noted that systematically responding to clinical and financial issues across multiple services and MTFs is still a problem.

As noted earlier, the Senior Prime databooks were a useful source for site officials in monitoring sites' performance. However, sites did not start receiving the databooks until about a year into the demonstration, and lags affecting the databooks' information limited their usefulness. Moreover, frequent changes in reported costs reduced site officials' confidence in the data. Regarding the demonstration's payment mechanism, it required DOD to collect information on enrollees' inpatient and outpatient diagnoses before the risk adjustment process could begin. Assembling the data was DOD's responsibility and under its control. We cited the time and effort required for DOD to assemble the data as an illustration of its broader difficulties with data and data systems. Concerning DOD's data and data systems, although they showed that the demonstration was generating high costs and utilization, neither the Senior Prime databooks nor the systems on which they were based permitted the sites to identify cases or practices that led to high costs. Finally, we do not cite data system limitations as a primary cause of Senior Prime's high costs and utilization. However, as the demonstration showed, DOD's data limitations are obstacles to managing patient care and costs.

CMS said that the report was accurate and met its objectives. CMS provided technical comments, which we incorporated where appropriate. (DOD's and CMS's comments appear in appendixes III and IV, respectively.)

We are sending copies of this report to the secretaries of defense and health and human services and the administrator of the Centers for Medicare and Medicaid Services. We will make copies available to others upon request.

If you or your staffs have questions about this report, please contact me at (202) 512-7114. Other GAO contacts and staff acknowledgments are listed in appendix V.

William J. Scanlon
Director, Health Care Issues

List of Committees

The Honorable Carl Levin
Chairman
The Honorable John Warner
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Bob Stump
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable W.J. 'Billy' Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Methodology for Evaluating the Subvention Demonstration

In directing us to evaluate the demonstration, the BBA specified that we study three broad areas: the demonstration's effects on beneficiaries, its costs to DOD and Medicare, and difficulties that DOD encountered in managing the demonstration. To address these topics, we surveyed retirees living in the demonstration areas, visited the demonstration sites, interviewed DOD and HCFA officials, and analyzed administrative data and reports from both agencies.

Survey of Retirees

To determine the demonstration's appeal to and effect on military retirees, including why they chose to enroll and their satisfaction with care, we conducted a two-phase mail survey of about 20,000 retirees living in the demonstration areas. The survey was sent to Senior Prime enrollees and to retirees who were eligible for Senior Prime but did not join. We surveyed retirees at the beginning of the demonstration to collect information on their health care experiences before Senior Prime. Toward the end of the initial demonstration period, we resurveyed these retirees to measure changes from their earlier reports. In this second phase, we also surveyed those who had joined Senior Prime since the first survey and those who had become eligible for Senior Prime but had not joined.[1]

Site Visits and Interviews with DOD and HCFA Officials

To collect information on the demonstration's implementation and operation, we interviewed officials and reviewed documents that we obtained during two rounds of visits to the demonstration sites. We first visited the sites within 3 months after each had begun operations to assess their status during the start-up phase and to examine the issues that had emerged in planning and implementing Senior Prime. We conducted follow-up visits about 15 months later. This allowed us to observe the sites at a more mature stage. We examined the demonstration's status, effects on beneficiaries and providers, and other key management issues. We also conducted additional interviews with DOD and HCFA officials.[2]

[1]For information on the first survey, see *Medicare Subvention Demonstration: Enrollment in DOD Pilot Reflects Retiree Experiences and Local Markets (*GAO/HEHS-00-35, Jan. 31, 2000), app. I. For information on the follow-up survey, see *Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs* (GAO-02-68, Oct. 31, 2001), app. I.

[2]For information on our methods, see *Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues* (GAO/GGD/HEHS-99-161, Sept. 28, 1999) and *Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities* (GAO-01-671, June 14, 2001).

Retirees' Health Care Utilization and Costs to DOD

To evaluate retirees' health care use and costs under the demonstration, we conducted several analyses using administrative data from DOD and HCFA. In analyzing utilization, we compared enrollees' use of services with that of Medicare fee-for-service beneficiaries in the same areas, adjusting for the relative health of the two populations.[3] To determine the demonstration's impact on the cost to DOD of caring for military retirees, we compared average monthly costs for Senior Prime enrollees to the Senior Prime capitation rates.[4]

[3]For further discussion of our analysis of enrollees' health care utilization, see *Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs* (GAO-02-68, Oct. 31, 2001), app. III.

[4]For further discussion of our analysis of the costs of enrollees' care, see *Medicare Subvention Demonstration: DOD Costs and Medicare Spending* (GAO-02-67, Oct. 31, 2001), app. I. We also analyzed Medicare spending on military retirees under the demonstration. See GAO-02-67, app. II.

Appendix II: Senior Prime Enrollees' Previous Medicare Managed Care Plan Enrollment

Senior Prime attracted a substantial number of retirees who had been enrolled in other Medicare managed care plans just prior to enrolling in Senior Prime. Overall, about 10,000 seniors left other plans to join Senior Prime—about 40 percent of all seniors who enrolled in the program in 1998 and 1999.[1] This percentage varied by site, in part due to local variation in Medicare managed care plan availability. Some sites, such as San Diego and San Antonio, were located in areas with significant Medicare managed care presence. Other sites, such as Texoma and Keesler, were located in areas where retirees generally had few or no other Medicare managed care options. Table 6 provides site-level information on Senior Prime enrollees drawn from other plans. In most cases, plans lost a small number of their members, but one plan lost over 3,400 members—about 4 percent of its members who lived in that subvention area.

Table 6: The Percentage of Senior Prime Enrollees Who Switched from Another Medicare Managed Care Plan Varied by Site

Demonstration site	Percentage of Senior Prime enrollees from other plans
Colorado Springs	58
Dover	17
Keesler	2
Madigan	38
San Antonio area	51
Texoma area	1
San Diego	40

Note: These data do not include enrollees who joined Senior Prime upon turning age 65 and therefore could not have been enrolled in other Medicare managed care plans before joining the program. The percentages include all retirees who enrolled in Senior Prime during 1998 or 1999, even if they later disenrolled.

Source: GAO analysis of data from HCFA's Medicare Enrollment Data Base.

[1]This percentage does not consider retirees who joined Senior Prime upon turning 65 and therefore could not have been enrolled in other plans before joining the program.

Appendix III: Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JAN 30 2002

Mr. William J. Scanlon
Director, Health Care Issues
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Scanlon:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) Draft Report GAO-02-284, "MEDICARE SUBVENTION DEMONSTRATION: Pilot Satisfies Enrollees, Raises Cost and Management Issues for DoD Health Care," dated December 19, 2001.

Overall, DoD finds that the report identifies some of the challenges faced with respect to implementing, administering, and managing the Medicare Subvention Demonstration. In addition, the GAO appropriately identifies the shortcomings in the report with respect to the limited generalization of the findings.

The Department appreciates the opportunity to comment on the draft report. We have enclosed comments, which we hope will strengthen the GAO final report.

Please feel free to address any questions to my project officers on this matter, Dr. Richard D. Guerin, Director, Health Program Analysis and Evaluation (functional) at (703) 681-3623 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT – DATED DECEMBER 19, 2001
(GAO 02-284)

MEDICARE SUBVENTION DEMONSTRATION:
Pilot Satisfies Enrollees, Raises Cost and Management Issues for DoD Health Care

DEPARTMENT OF DEFENSE COMMENTS

The draft report contains no recommendations, however, the Department would like to offer several comments and observations regarding the report.

Page 4, first paragraph: "Officials had difficulty producing reliable, timely, and complete information on retiree's care. This hampered their ability to implement the demonstration's complex payment mechanism...."

***Comment*:** This statement is only partially true and somewhat misleading. Within the context of claims-based data, the TSP Databooks were reasonably timely and generally reliable. The payment mechanism was implemented without any significant difficulties once the financial policies were agreed upon by DoD and CMS. The only extended delay in the financial mechanism occurred due to delays in the risk adjustment process controlled by CMS.

Now on p. 22.

Page 20, last paragraph: "DoD took over one year to assemble the final data...."

***Comment*:** As stated above, delays in the risk adjustment process were largely out of the control of DoD. The risk adjustment was conducted by Fu Associates under contract to CMS.

Now on p. 23.

Page 21, first paragraph: "DoD's data systems were not-well suited to monitoring health care costs and utilization - an impediment to effective management."

***Comment*:** While DoD's data systems are not capable of providing all data that might be desired, they adequately and quite early in the demonstration revealed that utilization and costs were high. Problems of high cost and utilization are more attributable to the benefit structure, financial incentives on the MTFs, high administrative costs, and MTF practice and capacity issues than they are to data system weaknesses.

Now on p. 28.

Page 25, last paragraph: "...limitations in DoD data and information systems...are obstacles to managing military beneficiaries' health care use and costs. Data analysis could help managers target clinical and financial areas needing improvement."

***Comment*:** While it is true that MTFs have weak incentives for greater efficiency, the focus on information systems as a primary cause of high costs and utilization is misleading. Data analysis did target clinical and financial areas needing improvement quite early in the demonstration. Systematically responding to clinical and financial issues across multiple Services and MTFs is a problem yet to be resolved.

Appendix IV: Comments From the Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 15 2002

TO: William J. Scanlon
Director, Health Care Issues
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report "*Medicare Subvention: Pilot Satisfies Enrollees, Raises Cost and Management Issues for DOD Health Care,*" (GAO-02-284)

We appreciate the opportunity to review and comment on the above-referenced report.

The GAO's objectives were to describe the Department of Defense (DOD) Medicare subvention demonstration's appeal to beneficiaries and the management difficulties DOD encountered in managing patient care and costs. We have no comments on the report's conclusions. We find the report to be accurate throughout and we believe it fully satisfies the objectives.

We look forward to working with GAO on this and other issues.

Appendix V: GAO Contacts and Staff Acknowledgments

GAO Contacts

Phyllis Thorburn, (202) 512-7012
Jonathan Ratner, (202) 512-7107

Staff Acknowledgments

In addition to those named above, Robin Burke, Martha Wood, Jessica Farb, Maria Kronenburg, Gail MacColl, Dae Park, Lisa Rogers, and Eric Wedum contributed to this report.

Related GAO Products

Medicare Subvention Demonstration: DOD Costs and Medicare Spending (GAO-02-67, Oct. 31, 2001).

Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs (GAO-02-68, Oct. 31, 2001).

Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities (GAO-01-671, June 14, 2001).

Defense Health Care: Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacles (GAO/T-HEHS/NSIAD-00-129, Mar. 15, 2000).

Medicare Subvention Demonstration: Enrollment in DOD Pilot Reflects Retiree Experiences and Local Markets (GAO/HEHS-00-35, Jan. 31, 2000).

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

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

Medicare Subvention: Challenges and Opportunities Facing a Possible VA Demonstration (GAO/T-HEHS/GGD-99-159, July 1, 1999).

Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustment and Raise Broader Concerns (GAO/HEHS-99-39, May 28, 1999).

Medicare Subvention Demonstration: DOD Experience and Lessons for Possible VA Demonstration (GAO/T-HEHS/GGD-99-119, May 4, 1999).

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