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April 10, 1998

The Honorable Stephen E. Buyer
Chairman, Subcommittee on Military Personnel
Committee on National Security
House of Representatives

Subject: Defense Health Care: Operational Difficulties and System
Uncertainties Pose Continuing Challenges for TRICARE

Dear Mr. Chairman:

The enclosed information responds to your follow-up questions concerning our testimony before the Subcommittee on February 26, 1998, on the status of TRICARE. This information supplements our testimony before the Subcommittee. Because TRICARE represents a redesign of the Department of Defense's (DOD) \$15.5 billion health care system and affects over 8.2 million eligible beneficiaries, we will make copies of this correspondence available to other interested parties upon request.

If you have any questions or would like to discuss this information further, please contact me at (202) 512-7101.

Sincerely yours,

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Enclosure

GAO/HEHS-98-136R Status of TRICARE

160223

SUPPLEMENTAL INFORMATION
ON THE STATUS OF TRICARE

This enclosure details your questions and our responses, which supplement information in our testimony before your Subcommittee, Defense Health Care: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (GAO/T-HEHS-98-100, Feb. 26, 1998).

PRIME ENROLLMENT

1. **In your statement you said that DOD has achieved less than optimal enrollment in the TRICARE Prime option. However, during our previous panel discussion, we heard that enrollment at most locations has far exceeded program goals. According to our previous witnesses, regions 4, 9, and the Central region all met their five-year enrollment goals within the first 18 months of TRICARE implementation. Can you explain the apparent disparity between the previous panels' claims of surpassing enrollment goals and your comment that TRICARE Prime enrollment has not met expectations?**

DOD established enrollment targets for the number of beneficiaries it would like enrolled in the TRICARE Prime option. DOD expected that 100 percent of active duty members would enroll in Prime by the end of 1996 and that at least 90 percent of non-active duty beneficiaries targeted for enrollment would enroll in Prime within 1 year of TRICARE implementation in each region.¹ These targets were jointly developed by the regional lead agents and military treatment facilities (MTFs) with input from top management of Health Affairs. In testifying before the Subcommittee, TRICARE contractors claimed that they exceeded their enrollment projections, which are much lower than DOD's enrollment targets. For example, in the Central region, the contractor projected an enrollment of 172,000 beneficiaries for the first year of implementation—a level much lower than DOD's target of about 600,000 beneficiaries for the first year. According to the contractor, as of the end of February 1998, it had enrolled more than 325,000 beneficiaries and exceeded its estimated enrollment projections. However, the enrollment was still substantially below DOD's target. Furthermore, programwide, DOD has fallen short of its enrollment expectations for both active duty members and targeted non-active duty beneficiaries. As of October

¹As of October 1997, the population targeted for enrollment represented about 67 percent of eligible non-active duty beneficiaries, or about 2.3 million people. The target population does not include beneficiaries who report having non-DOD insurance.

1997, in those regions where TRICARE had been implemented for at least a year, only about 57 percent of those targeted, or about 1.1 million beneficiaries, had enrolled.

PROGRAM ASSESSMENTS

2. **You stated that DOD's efforts to set goals for, and to measure, access and quality are incomplete, and therefore do not enable DOD to fully assess whether TRICARE has improved beneficiaries' access to and quality of health care. What is DOD's ability to monitor adherence to access standards within military treatment facilities? Within the civilian network?**

Through its beneficiary surveys, DOD collects some programwide data on beneficiaries' satisfaction with military health care. To supplement beneficiary satisfaction data, we recommended in 1996 that DOD collect data on the timeliness of appointments in order to measure TRICARE's performance in improving beneficiary access.² Almost 2 years later, DOD has made some progress, but has yet to implement fully our recommendation that it measure TRICARE performance. DOD collects data on timeliness of appointments at the MTFs through questionnaires to beneficiaries who recently had an outpatient visit. DOD also collects data on timeliness of appointments with civilian providers through its annual beneficiary survey, although as we reported in 1996 these annual survey data are based on beneficiaries' perceptions and do not measure DOD's actual performance against its access standards. Although this access data is available, the TRICARE Management Activity within the Office of the Assistant Secretary of Defense for Health Affairs is not using it to measure TRICARE's performance in improving beneficiary access against DOD's standards.

3. **Do you have any estimate of when these measurement efforts are expected to be completed?**

Beginning this summer, DOD plans to test an expansion of its efforts to collect data on timeliness of appointments by sending questionnaires to beneficiaries who recently had outpatient visits with civilian providers. They also plan to begin using and analyzing the data available to measure DOD's actual performance against the access standards. DOD estimates that these measurement efforts will be well under way by next summer and fully complete by summer 2000.

²Defense Health Care: New Managed Care Plan Progressing, But Cost and Performance Issues Remain (GAO/HEHS-96-128, June 14, 1996).

4. **Based on your own program assessments, how well are these standards being met? How satisfied are enrolled beneficiaries with this program?**

We cannot report on how well the access standards are being met because the TRICARE Management Activity is not reporting data on the timeliness of appointments, and we did not collect these data ourselves. However, we are beginning a review of beneficiary access to TRICARE, which will provide information on the extent to which beneficiaries have problems accessing military health care. This review is being designed to include specific information on appointment availability and timeliness.

As we noted in our testimony, DOD's most recent survey results show that overall beneficiaries are very satisfied with military health care, although they report much lower satisfaction with access. Furthermore, beneficiary satisfaction levels with MTF outpatient care, on average, exceed those in civilian HMOs.

CONTRACTING PROCESS

5. **As you are well aware, there have been numerous complaints about the contracting process since the start of the TRICARE program. The complaints principally have been that the process is extremely cumbersome, complex, costly, and not terribly objective. The fact that GAO sustained protests of the final two TRICARE contracts to be awarded--region 1 and regions 2 and 5, as well as an earlier contract award for regions 9, 10, and 12--seems to many to support these complaints. Based on your knowledge of the TRICARE contracting process, do you believe it is flawed and needs to be overhauled?**

DOD's efforts to award contracts have been hindered by some problems. In 1995 we reported that problems such as DOD's failure to evaluate offerors' bids according to solicitation criteria led to the sustained protest of an early award covering California and Hawaii.³ In response, DOD put in place improvements such as a revised methodology for evaluating bids, which it believed would reduce the chance of protests being sustained. The recent sustained protests indicate, however, that problems with bid evaluations continue. In 1995 we recommended that DOD consider alternative approaches for contracting, including simplifying the next round of TRICARE procurements. In response to this and other recommendations, DOD is developing a more simplified procurement approach that is designed to overhaul its

³Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, Aug. 3, 1995).

contracting process. DOD plans to use the new process this summer as it begins to recomplete the first of the existing TRICARE contracts.

- 6. Are you familiar with DOD's efforts to modify the cumbersome TRICARE contracts, and if so, do you believe these modifications are the right ones? What other changes do you believe need to be made to this process?**

DOD's new procurement approach, called TRICARE 3.0, is designed to incorporate performance-based requirements and best commercial practices. According to DOD, to the maximum extent possible, the 3.0 contracts will describe the performance desired, in terms of outcomes to be achieved, and the offeror will propose methods and processes to achieve those desired outcomes. DOD is soliciting and incorporating industry comments as it develops the new request for proposal. DOD is eliminating many of the government-specified processes included in previous TRICARE contracts, since DOD's goal is to allow offerors to use their own best commercial practices in the new TRICARE contracts. While the effectiveness of these changes remains to be seen, we support DOD's decision to simplify the process while incorporating private industry best practices.

CHAMPUS Maximum Allowable Charge (CMAC)

- 7. You discussed a recent GAO study which found some physicians are unhappy with the CHAMPUS maximum allowable charge (CMAC).⁴ The study concluded that current physician complaints about reimbursement levels are focused on the discounted CMAC rates paid to TRICARE network physicians. Some physicians told GAO that they considered the discounts unacceptable, and as a result, they would not join the TRICARE network but would continue to treat military beneficiaries as non-network physicians. To what extent are complaints about CMAC tied to complaints about Medicare reimbursement rates in general? Based on the recent CMAC study, do you believe the CMAC structure needs to be modified?**

The American Medical Association and medical society members we interviewed told us that the full CMAC rate paid under TRICARE Standard (generally equivalent to the Medicare rate), though not desirable, is acceptable. While physicians' complaints about reimbursement levels are more focused on the discounted CMAC rates paid to

⁴Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS-98-80, Feb. 26, 1998).

network physicians, most physicians told us that it was the combination of low payment and numerous administrative "hassles" that contributed to their frustration with the TRICARE program. In many cases, physicians said that while they would be willing to accept discounted CMAC rates to maintain their patient base, the administrative impediments provided significant disincentives to joining the TRICARE network. Since physicians continue to treat military beneficiaries and accept discounted CMAC rates, it does not appear that the CMAC structure needs to be modified. However, as we recommended in our report, in order to attract and maintain physicians in a program with Medicare-based reimbursement rates, DOD, along with the managed care support contractors, needs to address the administrative problems that are causing physicians to become disillusioned with the TRICARE program.

COST-REDUCTION TECHNIQUES

- 8. You stated that an important cost-saving feature of DOD's partnership between military and civilian health care entities under TRICARE is resource sharing. Under resource sharing, the contractor supplements the capacity of a military hospital or clinic by providing civilian personnel, equipment, or supplies. According to your written statement, DOD had estimated that resource sharing could save about \$700 million over 5 years. However, in a recent GAO study, you found that DOD and the contractors had made agreements likely to save only about five percent of the Department's overall resource sharing goal.⁵ Other than confusion about how resource sharing works, what factors do you attribute to the under-use of this potentially cost-effective measure?**

Last summer we reported that problems impeding progress on resource sharing agreements include the lack of clear program policies and priorities, uncertainty about cost effects on the MTFs, lack of financial rewards for the MTFs entering into these agreements, and changes in MTF capacities after contractors developed their bids. We also reported that DOD had revised policies, improved training and analytical tools, and taken other steps to promote resource sharing under the contracts. However, these efforts had not been sufficient to achieve the needed results, and significant future savings as a result of resource sharing are not likely. Furthermore, DOD is now placing less reliance on resource sharing with the recently awarded contracts for region 1 and regions 2 and 5, and DOD plans not to include a resource sharing feature in its future TRICARE 3.0 contracts.

⁵Defense Health Care: TRICARE Resource Sharing Program Failing to Achieve Expected Savings (GAO/HEHS-97-130, Aug. 22, 1997).

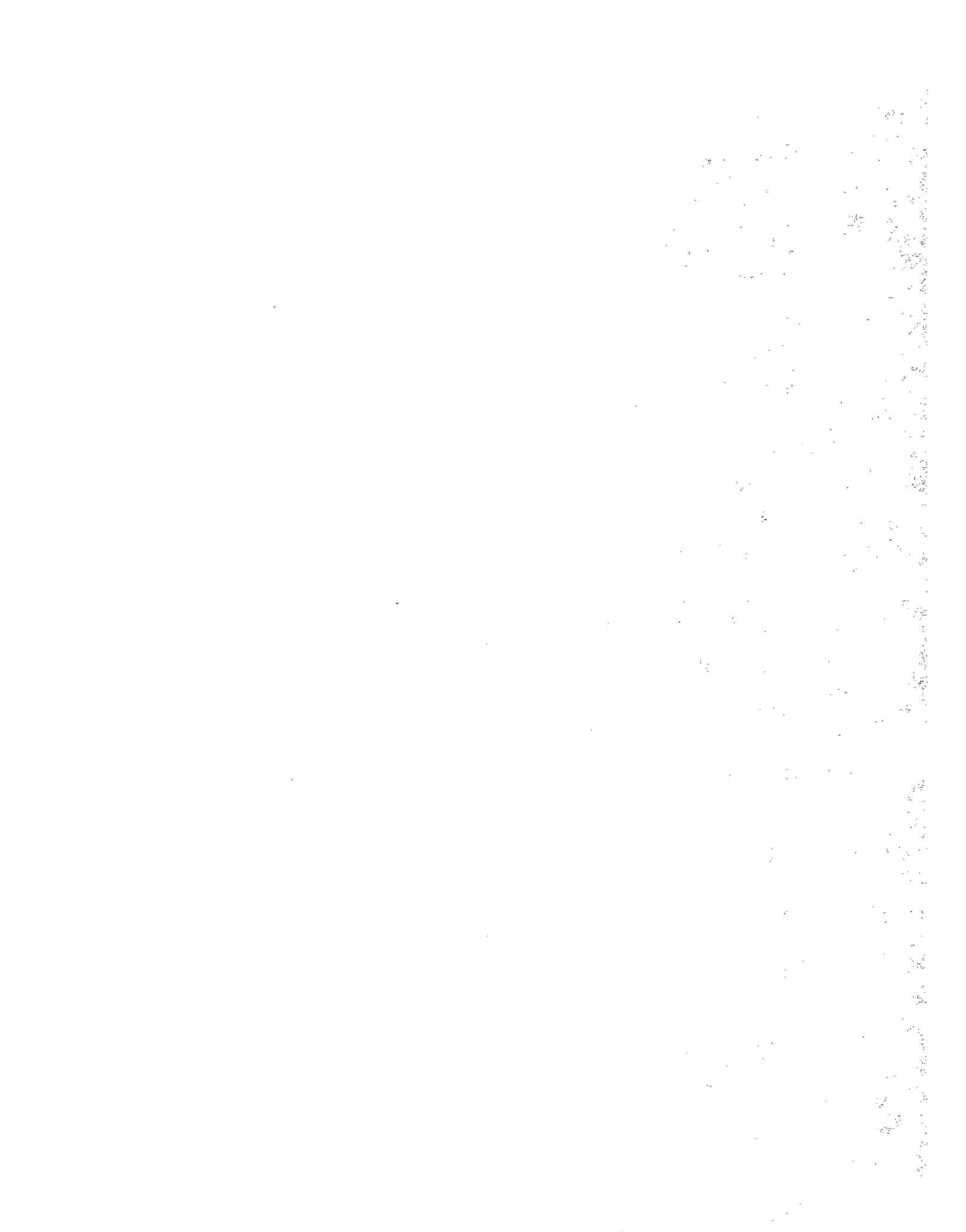
- 9. Is under-use of resource sharing partly due to a lack of incentive at the MTF level since resource sharing "savings" were applied to the overall regional contract, so the individual MTFs do not actually reap any benefits from these complex initiatives? In fact, is it true that the MTFs actually have to pay for the services provided under these agreements, at additional expense to the individual MTF?**

Yes, as stated in our response above, MTF officials cited a lack of incentive to enter into agreements as an impediment to resource sharing, because MTFs do not directly share in savings that result from the agreements. It is true that the agreements can actually increase MTF costs. For example, a resource sharing agreement to provide an anesthesiologist, so that the MTF can perform more surgeries, will in turn result in related radiology, laboratory, and pharmacy costs that the MTF would not have otherwise incurred.

- 10. How much of an impact do you expect resource sharing to have on the effectiveness of the TRICARE program, both in terms of cost and access?**

As we reported, DOD and the contractors have made agreements likely to save only about 5 percent of their overall goal. DOD officials have acknowledged that resource sharing has not achieved the expected savings but stated that lower-than-expected contract award amounts have led to other savings. However, we found that as of May 1997, the existing contracts had been modified as many as 350 times, creating the potential for substantial TRICARE contract cost increases. These potential cost increases, just like the potential losses from lack of resource sharing, would also offset DOD's projected savings. Because DOD has made such little progress with resource sharing and is phasing it out of future contracts, we expect that resource sharing will have a very limited impact on TRICARE's ability to contain costs and increase access.

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